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June 8, 1990

HEALTH POLICY BULLETIN

FOCUS: CON COMMISSION

A year ago on June 7 the CON Commission held its first meeting. To get an assessment of the commission's first year, we talked to Lisa Hadden, its chairperson. The first major task the commission faced, and it looked like an almost impossible assignment, was to examine and revise the interim guidelines for CON reviews that the legislature had incorporated into the CON legislation (P.A. 332 of 1988). Specific timeframes were included in the law, and Hadden observed, "Lots of people didn't think we'd meet the deadlines, but each standard got the time of day." Eleven standards were reviewed, revised, and submitted to the legislature. "All were approved by the governor and the legislature," she noted.

To date the most controversial issue before the commission has been the review standard for CT scanners. The original standard proposed by the commission was regarded as too restrictive and too limiting, particularly for rural facilities. "I think the CT standard was controversial for two reasons: (1) content, which is the access versus efficiency issue, and (2) the ad hoc advisory committee did not come to a consensus, which made a decision much more difficult for the commission," Hadden observed. She also feels the CT standard served as a test in the sense that the legislature and the health care industry were watching to see how the commission would respond to the request that they revisit the standard. "We were able to revisit the issue, and we did it in the timeframe that we promised," she said.

CT scanners may have been the commission's first test but obviously not the last. The next major concern probably is going to be long-term care and how to regulate it. "A lot of controversy is beginning to emerge over how we can best develop that standard. For example, should we include maximum room sizes or give points for the number of Medicaid beds in a home? Some people feel that regulation should be confined to Medicaid and Medicare beds, that private pay beds should not be regulated at all. Others think we should have maximum quality standards as well as minimum standards," observed Hadden. "There is also a significant public policy issue with legislators saying, 'We need more beds,' and the Michigan Department of Social Services saying, 'We don't have any money to pay for it.' "

The commission has adopted an ambitious workplan, really a three-year planning document. "Having a workplan makes us responsive to changing needs, provides for methodical review of each standard, and enables us to use, in a timely way, the input from the ad hoc advisory committees. [Under the law the Michigan Department of Public Health (MDPH) is charged with appointing advisory committees to provide information and recommendations for areas in which technical expertise and practitioner input is recognized as being useful.] We can always change the workplan to reflect new priorities," she said. "The workplan helps to hold the commission and the staff accountable—everybody will know when we are reviewing the standards."

What philosophical principles guide the commission in its decision-making process? The law requires it to consider cost, quality, and access in setting review criteria. "We have lived by that because we have not had enough time as a group to develop a policy style. Also, the commission is subject to turnover," she remarked. Both Hadden and Paul Kehoe, vice-chairperson, have appointments expiring January 1, 1991.

What is the commission's role? "There is a distinction between policy and operation. We are a policy-making body—our job is to develop policies regarding CON review criteria that will serve as a basis for regulation; the MDPH performs the regulatory function. If we were to get involved with individual applicants, we'd lose perspective and defeat the purpose of the commission," she commented. "There appears to be reasonable satisfaction in the provider-consumer community in terms of the substance and process we have used," she noted. It is her view that the legislature has provided direct feedback and is pleased with the commission. Feedback from other sources such as the governor, auto unions, providers, and hospitals has been indirect but still positive.

Hadden observed that most states are grappling with health planning and CON problems. According to her, 37 states and the District of Columbia have CON programs; 13 states have no CON programs but have some mechanism for cost constraints or control through resource allocation, payer reimbursement systems that discriminate against new facilities, or moratoria on some or all capital expenditures. The only consistent trend is that 16 states have zero dollar thresholds for new services, which means that all new technology is under CON review. Her conversations with counterparts in other states suggest that some states that have eliminated CON review are considering reinstating it. For example, in Indiana and Wisconsin, repeal of the CON process has led to unrestrained capital expenditure.

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The legislature, according to Hadden, did a good job when they wrote P.A. 332. "The size of the commission (five members) is good. I am most pleased with its ability to operate as a single unit; in fact, it's hard to tell who the Republicans and Democrats are. We have not yet had a split vote on an issue," she concluded.

Hadden enjoys her job as a member of the commission and its chairperson. She is enthusiastic, hardworking, and energetic. Asked what she would like to do differently if she could, Hadden smiled. "I know it is not feasible, but if we had more staff, we could run four or five ad hoc advisory committees at once and get more done."

FOCUS: INTERIM RELIEF

The dust continues to swirl with great vigor around the Medicaid hospital lawsuit. In its May 25 bulletin telling hospitals how it planned to implement Judge Bell's ruling, the Medical Services Administration (MSA) seems to be taking a "hard-nosed" position. The MSA has interpreted Judge Bell's order requiring the Medicaid program to pay according to the 1986 reimbursement method to mean, among other things, that (1) hospitals will not be paid $18 per newborn to cover costs for tests that were mandated after 1986, (2) high-volume Medicaid hospitals (inner-city) will not be paid the 15-percent special adjuster, while hospitals whose indigent patient volume is under 10 percent will continue to receive an adjuster, and (3) cost outliers for children under age one will no longer be recognized. All are changes in payment that occurred after April 1986.

Adding to the confusion is the fact that the legislature, as it attempts to make budget decisions, now has two studies to chose from. The Michigan Hospital Association (MHA) study, which was part of the lawsuit, alleges that hospitals receive on average about 76 percent of their in-patient costs from the Medicaid program. A study done for MSA by Health Management Associates demonstrates that, using payment-to-cost ratios, the program pays hospitals 92 percent of their costs for treating Medicaid patients.

Much of the difference appears to be methodological. For example, while both studies accept the Medicaid program's method of estimating hospital-specific payments, the MHA study says that the estimates of hospital-specific in-patient costs are much too low. Why? Because the program used an inflation factor enacted by Congress under the Tax Equity and Financial Responsibility Act (TEFRA). The MHA argues that the TEFRA number is arbitrarily low and bears no relationship to inflation; it is lower than the Hospital Market Basket Index compiled for the Health Care Financing Administration, and it is certainly lower than the index compiled by the American Hospital Association (AHA), which uses changes in costs specifically within the hospital industry to measure the effect of inflation on hospital prices. The study done for the Medicaid program by Dan McCandless, Health Management Associates, does not use the inflation rate to compare the ratios between costs and payments; his study uses claims paid in the 4th quarter of 1989 and in the 1st quarter of 1990. McCandless observes that "the whole philosophy behind the DRG is not to pay the exact cost for each and every case but rather to pay an average cost." In his view, while a hospital may lose money on one case, it has an equally good chance to make money on another. He also notes the use of the AHA index in the MHA study, which substitutes proxies for actual costs in the calculation of inflation.

Charles Ellstein, group vice-president, health delivery and finances, MHA, wonders, "Why didn't the Medicaid people bring this up when the judge was trying the suit?" Ellstein has some questions about the MSA study: If 31 hospitals are getting more than their costs or are making a profit as the program alleges, that still leaves 157 hospitals that get less than their costs. He also questions the way the claims examined were selected and maintains that there is a possibility that some claims were excluded to make the results look better. Ellstein is concerned about possible political motivation for the study, since it could have implications for the budget discussions currently going on; that is, does MSA hope to convince the legislature that no more money will be needed for hospital payments, and is it attempting to push the legislature even farther in the direction of competitive bidding?

OF INTEREST

The legislature is holding fast to its intent to adjourn by June 14. The House Committee on Public Health is continuing work on the smaller hospital package (SBs 889–892), and will report out HB 5004 (social worker licensing), HB 5787 (a related fee bill), and HB 5702 (physician's assistants). The Senate Committee on Health Policy plans on June 12 to work on a resolution that Senator Binsfeld is scheduled to introduce shortly. Our understanding is that the resolution will recommend rejecting the CON review standards for nursing home beds and hospital long-term care unit beds.

—Frances L. Faverman, Editor