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August 1992

HEALTH POLICY BULLETIN

FOCUS: THE NEW CON COMMISSION

The state Certificate of Need Commission is charged with helping contain health care costs by setting standards that will ensure that new facilities/equipment in Michigan are built/purchased only where need is demonstrated; the body may create CON review criteria and add or remove services and equipment from the list of activities requiring a CON.

On July 13 the CON Commission held its first meeting since December 1991. With only one holdover, the commission is virtually a new entity. Diane C. Jones was elected temporary chairperson: She is the only member meeting the bylaws' requirement of at least one year's service for the post. A permanent chairperson—most likely Robert McDonough, the Upjohn Company's director of public policy—will be elected at the commission's next meeting, when revised bylaws will take effect.

The meeting proceeded smoothly through new-member orientation, the overview of the commission's statutory responsibilities, and the welcome by the director of the Michigan Department of Public Health (MDPH). Trouble began with the commission's consideration of work plan priorities proposed by the MDPH, which administers the CON program. Acting at the behest of the governor's Human Services Directors' Interagency Work Group, the MDPH had assigned first priority to revising the CON standards for nursing home beds. The work group has asked the MDPH to reconvene the commission's Ad Hoc Advisory Committee on Long-Term Care (such committees advise both the department and the commission, but by law may be convened only by the department), direct it to prepare for department and ultimately commission consideration standards that encompass the work group's earlier recommended changes, and submit them for discussion at the commission's fall 1992 meeting. The work group's proposals include (1) removing nursing home beds from the list of activities requiring a CON, (2) moving to a "fair rental" method of computing capital costs for nursing home Medicaid reimbursement, and (3) limiting the number of beds that may be enrolled in the Medicaid program each year.

Two speakers rose to protest the proposed timetable as being too short. Larry Horwitz, executive vice-president of the Economic Alliance for Michigan, also noted that the proposals from the interagency work group represent a "drastic change," expressed the belief that the recommendations most benefit the budget of the Department of Social Services, observed that the work group's document recommending the changes does not contain adequate justification for them, and finally, argued that the necessity for a CON should not be dropped for nursing home beds. Charles Harmon, executive vice-president of the Health Care Association of Michigan, observed that "the fair rental concept cannot be done in a couple of months." The commission agreed with the objections to moving too quickly and delayed consideration of revised standards for nursing home beds into December. If the standards are changed, they probably would become effective in March 1993.

Another area of disagreement was standards for open heart surgery programs. Commission member Dr. Douglas Wood, dean of the College of Osteopathic Medicine at Michigan State University, expressed concern about the proliferation of open heart surgery programs. He noted the relationship between the number of procedures performed and mortality: When fewer than 180 procedures per physician and 700 procedures per facility are performed annually, the risk-adjusted mortality rate is 13.7 percent, compared to only 2.4 percent for programs with higher numbers. In agreement, Bob Parrish, senior vice-president of the Greater Detroit Area Health Council, urged the commission to give open heart surgery program standards higher priority on the work plan. He noted that $250 million was spent on such surgery in southeastern Michigan last year, an amount thought by many to be too high. Dennis McCafferty, director of group insurance for Detroit Edison Company, stated that open heart surgery cost his company $68 million in 1992. The commission decided to begin consideration of open heart surgery program standards at next month's meeting.

Extra-renal (other than kidney) organ transplant program standards were moved to a position of lower priority on the work plan. Commission members and many in the audience were virtually unanimous in the view that the problem is not a shortage of sites for organ transplantation, but rather a shortage of donated organs. Carla O'Malley, senior vice-president and chief operating officer of the Annapolis and Westland Division of Oakwood United Hospitals, pointed out that it would be useful to know how many CONs for organ transplant programs had been granted and how many denied due to failure to meet the required number of procedures within the parameters of acceptable quality. The commission agreed and deferred discussion of organ transplantation program standards and the consideration of autologous bone marrow transplants programs until 1993.

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The commission decided to retain as a top priority standards for psychiatric programs and beds, an action that had been urged by Michigan Hospital Association representative, Donald Pietruk, and directed its ad hoc committee on psychiatric services to continue working. (The standards presented by the commission several months ago to the legislature and governor were disapproved, leaving the state without standards for psychiatric programs.)

Two observations may be made about the reconstituted CON commission. First, any speculation that this commission will be overly reliant on MDPH staff and more malleable than its predecessor appears to be just that—speculation. Second, this body shows every sign of being as capable as its predecessor and as diligent in safeguarding the public interest. The members' numerous requests for data from the MDPH staff and their inquiry as to the number of advisory committees that may be convened simultaneously suggest that this group will be very active.

The commission has scheduled its next two meetings: September 14 and December 14. The September meeting will be held at the Michigan Chamber of Commerce, 600 South Walnut Street, Lansing, beginning at 10:00 a.m. and concluding at 4:00 p.m.

FOCUS: ALLIANCE FOR HEALTH COST DATA

The Alliance for Health in Grand Rapids has released a study of hospital costs. While Michigan's major newspapers seized on the cost of hospital admissions in Ann Arbor, they failed to note that the state's average rate of increase was at the national level and that Ann Arbor's rate of increase from 1986 to 1990 (37.8 percent) was *less* than the national rate for the same period (40 percent).

The study used adjusted expense per admission as the determining factor in listing high-cost institutions. Lodewyk P. Zwarensteyn, Alliance executive vice-president, was careful to point out that such factors as case mix, teaching and research activity, average length of stay, and relative degree of technological sophistication also enter into costs. Nevertheless, he insists, the average adjusted expense per admission for cities in Michigan compared to others in the nation raises some distressing questions.

The exhibit below compares adjusted expenses and percentage increases in ten metropolitan areas (each containing a world class medical center) from 1986 to 1990. While one may argue that it is unfair to compare Ann Arbor to other Michigan cities, it is difficult to deny that comparisons may be fairly made with Boston, Chicago, Cleveland, and others. Even when matched against these peers, Ann Arbor still is incredibly expensive.

Other data show that while, overall, the adjusted expense per admission in Michigan is high, only one area (Jackson) is above the national average of a 10 percent increase from 1989 to 1990 for such areas, two (Lansing/East Lansing and Grand Rapids) are right at the average, and the remaining eight (including Ann Arbor) are below.

Zwarensteyn says the study grew out of his "scientific curiosity." He commented that he had gathered some "background information to see if employers in west Michigan are getting a good deal on health care costs and to see if certain regulatory approaches had any value." He is convinced that "competition is a bankrupt philosophy in health care"; he believes there are rivalries but no true economic competition.

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Adjusted Expense Per Hospital Admission, Selected Metropolitan Areas and the United States, 1986–90

Area	1986	1987	1988	1989	1990	% of Increase 1986–90
Ann Arbor	$6,448	$7,266	$7,740	$8,220	$8,883	37.8%
Boston	5,137	5,554	6,728	6,697	6,771	31.8
Chicago	4,755	5,110	5,653	5,847	6,391	34.4
Philadelphia	4,541	5,074	5,463	5,947	6,273	38.1
Los Angeles	4,827	5,156	5,498	6,077	6,156	27.5
Detroit	4,536	4,961	5,328	5,461	5,909	30.3
Cleveland	4,608	4,871	5,210	5,543	5,663	23.1
Cincinnati	4,091	4,555	4,907	5,274	5,564	36.0
Rochester, MN	3,130	3,619	4,068	4,285	5,042	61.1
Austin, TX	2,939	3,064	3,302	3,624	4,058	38.1
United States	3,533	3,850	4,207	4,588	4,947	40.0

SOURCE: Calculated by Public Sector Consultants, Inc. from data supplied to the Alliance for Health by the American Hospital Association.