Gerald Faverman, Ph.D. • *Chairman of the Board*
Craig Ruff • *President*
December 1992

HEALTH POLICY BULLETIN

FOCUS: OPEN-HEART SURGERY

The appearance of Dennis L. Schornack, director of state policy and senior policy advisor to Governor John Engler, before the Certificate of Need (CON) Commission was an unwelcome surprise for some hospital representatives. The commission met on December 14 and 15 to take final action on the proposed new standards for open-heart surgery. On behalf of Governor Engler, Schornack testified in support of the stricter standards.

The current standards became effective in December 1988. These standards require adult open-heart surgery services to perform 200 procedures a year and pediatric services to perform 100 pediatric open-heart procedures a year. Once within a three-year period hospitals are allowed to lend their inpatient discharge data (i.e., the number of patients discharged with a particular diagnosis, for example, cardiac disease) to one or more facilities applying for a CON to perform open-heart surgery. This means that a hospital that does not have the data to prove it has enough patients in the area to support a service such as open-heart surgery may borrow the data and be granted a CON to establish an open-heart surgery service. Once granted, the CON is permanent. At present, no minimum performance requirements exist for attending surgeons, who can perform as few open-heart procedures as colleagues allow and still remain credentialed for open-heart surgery by the facility.

The proposed standards will increase the number of required adult procedures to 300 a year, allow hospitals to share inpatient discharge data with only one hospital within a seven-year period, restrict the sharing to hospitals within the applicant's planning area, prohibit hospitals that already have open heart surgery services from sharing data, require attending surgeons to perform 50 adult procedures annually, and apply the new standards to pending applications that have been submitted to the Michigan Department of Public Health (MDPH) but not yet received a final decision.

Schornack's testimony focused on three issues: the failure of market competition to control the proliferation of costly services, the application of the new standards to all applications for open-heart services that are currently awaiting decisions by the MDPH, and data lending among hospitals.

"All too often," Schornack said, "the competition for physicians and patients results in a less efficient and more costly health care system—an outcome that is contrary to prevailing economic theory." He also noted that although a CON "is not a perfect mechanism for allocating health care capital . . . neither is the market." In his view, "the commission stands as the only tool we have to assure that the costs incurred for capital investments are worth the benefits our citizens will receive from improved health care."

Schornack added, "Governor Engler . . . supports the application of the new standards to all applications, including those already in the pipeline." This would force applicants to comply with the new standards. Schornack also conveyed the governor's request for a temporary freeze on new applications until the standards are either accepted or rejected by the commission.

Schornack described data sharing among hospitals to enable an applicant to meet the CON standards for open-heart surgery or other costly services and equipment as the "perverse practice of data double-dipping." He said the practice has led to the proliferation of open-heart surgery programs in the state.

Over the protests of the Michigan Hospital Association (MHA) and some individual hospital representatives, the commission adopted the proposed standards by a 4–1 vote; the lone dissenter was Carla O'Malley. The standards had been revised following an October 19 public hearing to solicit comment. Donald Pietruk, assistant director for MHA legislative and regulatory affairs, was particularly distressed by the provision that will allow the application of new standards of review to CON applications already being reviewed by the MDPH. In his view, this will be changing the rules in the middle of the game and will constitute retroactive application of new standards, a practice, he noted, in which the MDPH has not previously engaged. Pietruk pointed out that a large body of case law seems to indicate the illegality of such a policy on the grounds of inequity. Pietruk also objected on the ground that the revision amounts to a substantive change in the proposed standard.

Larry Horwitz, executive vice-president of the Economic Alliance for Michigan, challenged Pietruk's view. Horwitz noted that when the legislature wishes to "grandfather" existing practice, it generally does so specifically. In his view, applying the new standards to CON applications already undergoing review is a legitimate exercise of state power. He dismissed as inaccurate the MHA's claim of retroactivity: "Retroactivity," he said, "is taking away something one already has. These CONs have not been decided, therefore, there is no retroactivity." Horwitz views the MDPH practice of deciding applications using the standards in effect at the time the

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Sq. • Suite 401
Lansing, MI 48933-2134 • (517) 484-4954

application is submitted as leading to confusion and inequity. An attorney was overheard to say to another observer, "This [retroactivity] will keep the lawyers busy for years."

The next most controversial aspect of the proposed CON standard is the provision allowing a hospital to lend its patient discharge data to another hospital. The new standard will allow a hospital to lend such data to only one hospital within the same planning area only once within a seven-year period; the lending hospital must neither offer open-heart surgery services nor have a CON for such services. The new standard also defines planning areas fairly strictly, dividing the state into eight areas composed of contiguous counties. For example, under the new standard, E. W. Sparrow Hospital in Lansing will not be able to borrow data—as it does in its current open-heart application—from Muskegon, Wayne, and Gratiot counties; it will be restricted to Clinton, Eaton, Hillsdale, Ingham, Jackson, and Lenawee counties; W. A. Foote Hospital in Jackson will be competing with Sparrow for the same data. It is unlikely that there would be enough patients in the area for either hospital to gain a CON for open-heart surgery services. In fact, if the new standards are found to apply, it is unlikely that any of the current applicants would be able to borrow enough data within its planning area to receive a CON, especially if an open-heart program already is operating in the area.

Five facilities currently have CON applications pending for open-heart surgery services. E. W. Sparrow Hospital's is closest to a decision (December 30) and, it is thought, will be unaffected by the proposed stricter standards, which cannot take effect until mid-to-late February. The vulnerable facilities are Crittenden (Rochester), Foote, Grace (Detroit), and St. Mary's (Grand Rapids); the decision dates on their applications fall after the new standards are expected to become effective. Also affected would be several other hospitals, including St. Joseph (Mt. Clemens), Macomb Hospital Center (Warren), and Botsford (Farmington), which have filed letters of intent.

To what extent does Governor Engler's request for stringent regulation of open-heart surgery programs signal a change in policy? The governor's position historically has been that free market competition is the most effective method for controlling the proliferation of services and the cost of health care. Schornack's testimony indicates that while the governor sometimes favors regulation, in health care—as in other areas—he likely will continue to be a pragmatist.

FOCUS: MEDICAID COVERAGE, POPULATION IN POVERTY, GREAT LAKES STATES

The accompanying table ranks selected states according to the percentage of people in the population with incomes below the federal poverty line who are covered by Medicaid. The table shows both the national rank and the rank within the eight-state Great Lakes region. Six of the eight states are above the national median (25) and five are within the first quartile. Michigan ranks 16th in the nation and 5th among the Great Lakes states.

Percentage of Population in Poverty Covered by Medicaid, FY 1990

State	Regional Rank	National Rank	Percent
Ohio	1	5	98%
New York	2	7	91
Pennsylvania	3	8	90
Wisconsin	4	12	86
Michigan	5	16	79
Minnesota	6	23	72
Illinois	7	26	68
Indiana	8	43	48

SOURCE: American Association of Retired People, *State Profiles 1991* (Washington, D.C.: The AARP, 1992). Calculations by Public Sector Consultants, Inc.

Michigan's Medicaid program enrolls 79 percent of all residents who are in poverty. The number of people who are eligible for Medicaid has increased principally because coverage of children and pregnant women has been expanded. This expansion of eligibility has contributed to Michigan's state budget crisis. Health care reform at the state and federal levels must find ways to incorporate poor people without bankrupting the system.

—Frances L. Faverman, Editor
and Peter Pratt, Consultant

Printed on recycled paper