APPENDIX J

AUTOMOBILE MANUFACTURER EMPLOYEE HEALTH COSTS

CERTIFICATE OF NEED

Endorsement By DaimlerChrysler Corporation

Health care costs represent an important ingredient in manufacturing decisions made by DaimlerChrysler Corporation (DCC). DCC may build new factories, expand or renovate facilities, or close factories based in part on the cost and quality of health care in a geographic area. Health care is DCC's largest single component cost in producing a vehicle—larger than even the cost of steel. DCC closely tracks the relative costs of health care in each of its major production areas.

In DCC's Traditional and PPO programs, the costs of health care per person are significantly less in states with Certificate of Need (CON) programs than in states without CON. What is notable is that the design of DCC's health benefit programs does not vary by geographic region and that significant differences in relative costs occur between areas even after the data is standardized for gender and age. DCC's costs for health care are considerably higher in non-CON states, such as Wisconsin and Indiana, than in CON states such as Delaware, Michigan and New York.

DCC urges the State of Michigan to continue its CON program, which is one of the better ones in the country. There are certainly areas in which it could be improved, but DCC considers keeping an effective CON program important not just for DCC, but also for the state as a whole. CON helps to ensure that a reasonable balance is maintained between resource demand and resource availability.

DCC's three lowest cost areas are in states with Certificate of Need laws in place, while the two highest cost areas are in states without CON laws. The adjusted per person costs in the Kenosha/Southeast Wisconsin area, for example, are about triple what they are in Syracuse, New York.

Location	Adjusted 2000 Cost*
Kenosha, WI	$3,519
Indiana	$2,741
Newark, DE	$2,100
Michigan	$1,839
Syracuse	$1,331

** Age, gender, and geographically adjusted. Adjusted numbers use Syracuse as a base.*

DCC believes it is important to recognize that CON not only contributes to lower health care costs but that it also helps to ensure quality. The Leapfrog Group for Patient Safety maintains that the push to open new centers may have a negative impact on quality. There is evidence that new centers may not do enough surgeries to meet the "practice makes perfect" maxim. Leapfrog recommends that, for a coronary artery bypass, for example, a minimum of 500 procedures a year should be the benchmark. Scientific literature documents significantly superior patient outcomes in hospitals with higher volumes.

DCC joins the vast majority of other health care stakeholders in Michigan in strongly urging retention of the Michigan CON program.

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Ford Motor Company

FORD MOTOR COMPANY STUDY

RELATIVE COST DATA vs. CERTIFICATE of NEED (CON) for STATES in WHICH FORD has a MAJOR PRESENCE

"Major Presence" is defined as states with more than 10,000 Ford Motor Company "members" --- active employees, retirees, or dependents --
in fee-for-service programs --traditional or PPO health benefit plans.

CONCLUSION:

IN STATES WITH MEANINGFUL CON PROGRAMS,

FORD MOTOR COMPANY HAS LOWER HEALTH COSTS

THAN IN STATES WITHOUT MEANINGFUL

CON PROGRAMS

"Meaningful" is defined as a CON program with significant application to acute care hospitals, as well as to advanced medical equipment and services.

Overview of the Study

WHY this Study was Developed:

In a few states, some legislators and health care providers have questioned the value of Certificate of Need (CON). One of the questions being raised is whether CON helps to contain health care costs.

Some academic studies examined the cost implications of CON on a macro-level, examining total health costs for the entire population in the state. But those inter-state comparisons are confounded by the intervening factors of widely differing health benefit plans (with significant variations regarding services covered, payment schedules and rules, etc.) as well as varying demographics and health status of the populations covered. **In short, lack of comparability of the data has meant that macro-inter-state comparisons of costs are very difficult to develop in a meaningful way**.

Ford Motor Company, as a multi-state company with the same benefit plan, offers the opportunity for properly examining comparable health cost data. A key part of the comparability of this study is that other key factors affecting health costs (age and gender demographics, as well as health status of the covered population) are thought to be rather similar among the individuals covered by the Ford Motor Company plan in the states in which Ford has a significant presence.

HOW this Study was Developed:

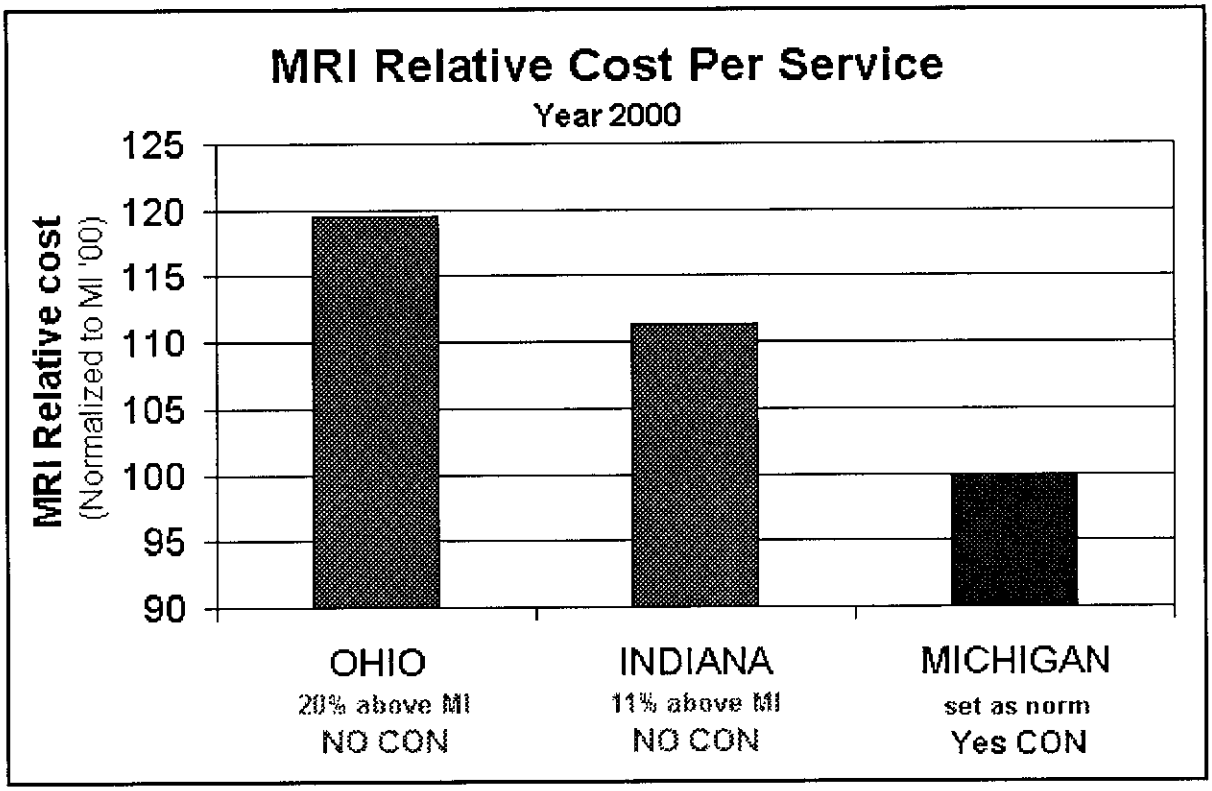
It should be emphasized that this study took many months to develop to generate this uniquely available comparative statistics. Great care was taken to assure statistical validity, by using the following data:

- Data from the five states (Michigan, Indiana, Ohio, Kentucky and Missouri) in which Ford Motor Company has at least 10,000 "members" (or covered lives), involving active and retired employees, plus dependents.
- This excludes those covered by HMOs because inter-state comparative data is not available for HMO enrollees.
- For the focused studies on CABG (coronary artery bypass graft), and MRI (magnetic resonance imaging), Missouri and Kentucky were not considered because the relatively few Ford members in those states meant that very few utilized those specialized services.
- The most recently available annual data (year 2000) was used.

CONCLUSIONS:

- **Indiana and Ohio, which eliminated CON coverage for most services, consistently had the highest relative costs.**
- **Michigan, with a CON program since 1972 covering a wide range of services, consistently had among the lowest relative costs.**
- **Kentucky and Missouri, which also have had CON programs covering a wide range of services, also had low relative costs.**
- **This consistent correlation between CON and lower costs was quite notable because the pattern was the same across a range of different services. This was true for the broad but differing categories of hospital in-patient and out-patient services, and the narrower focus on CABG (an inpatient surgical procedure) or on MRI (a diagnostic service, mostly done on an out-patient basis).**

MRI SERVICE
FOR YEAR 2000
Normalized to MI Year 2000 = 100



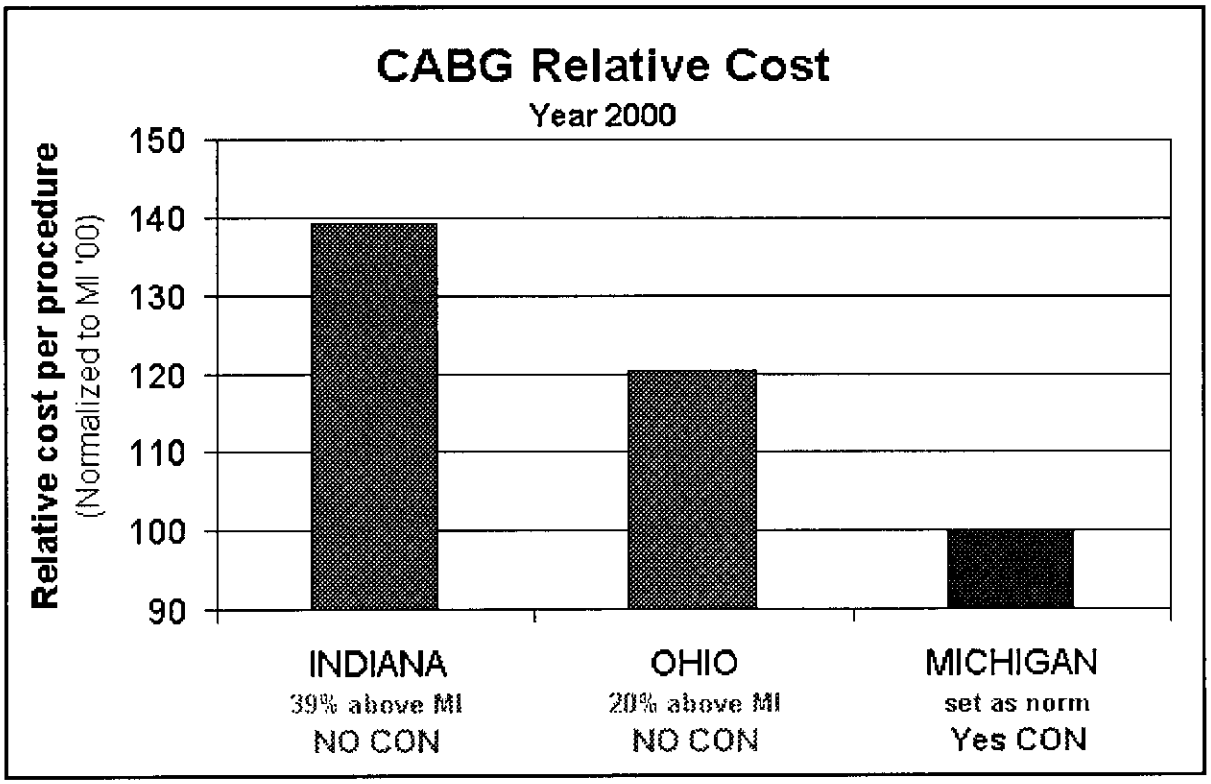
Ohio started a 3-year program in 1995 to phase out CON, including MRI services. Of the three states, it had the **highest relative costs, 20% above Michigan.**

Indiana: **NO CON covering MRI** services since the 1980s. It had the **second highest relative costs, 11% above Michigan.**

Michigan has had a full coverage CON program since 1972. Its **relative MRI costs were the lowest** among all states in which Ford Motor has a significant presence and there were a statistically significant number of MRI services performed for Ford Motor's members.

Data source: To assure statistical significance, this is Ford Motor Company data from the three states where Ford has a significant presence (at least 10,000 members-- actives, dependents, and retirees-- enrolled in PPO and traditional health-benefit plans combined) in the year 2000 and there were more than 800 MRI services statewide in year 2000 for Ford's members. These three states account for most of Ford's members in the USA.

Coronary Artery Bypass Graft (CABG)
For Year 2000
Normalized to MI Year 2000 = 100



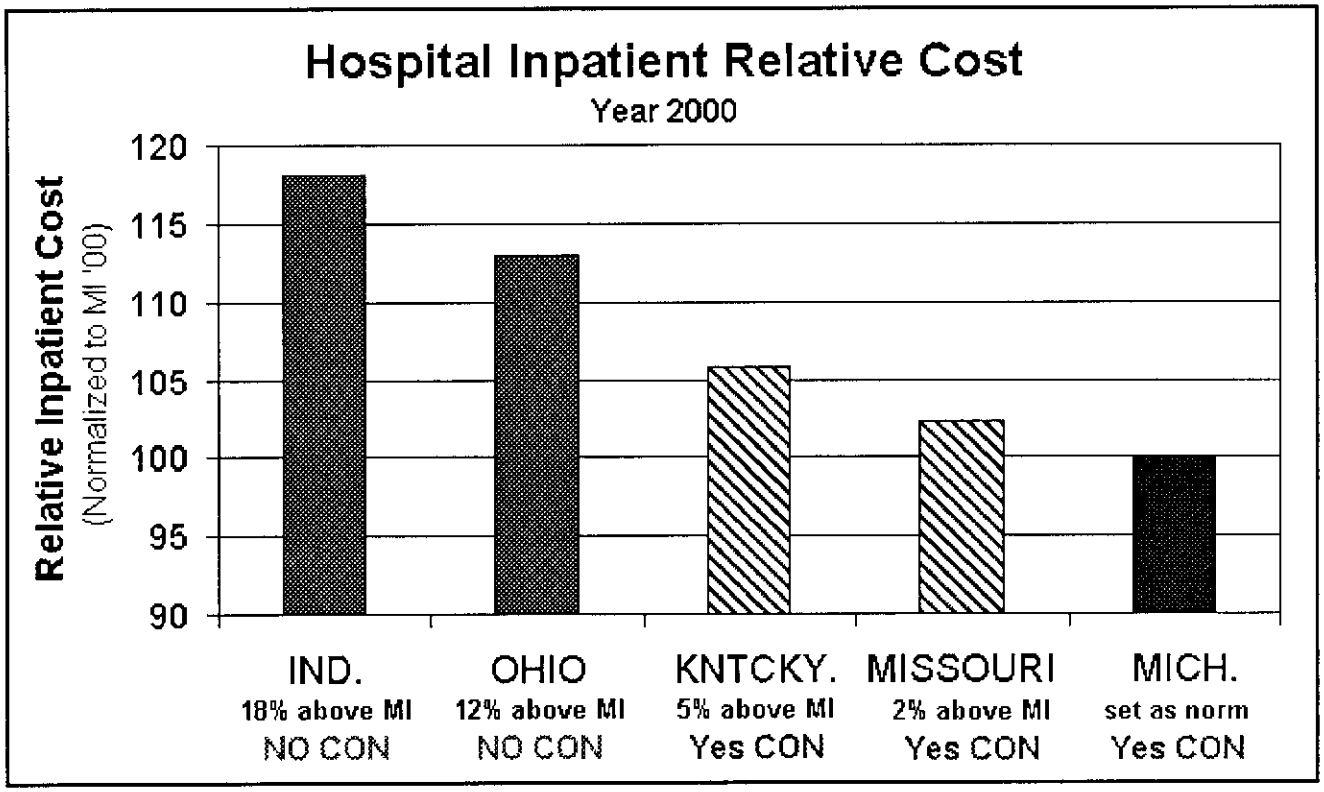
Indiana: **NO CON** program covering CABG services since the 1980s. It had the **highest relative costs, 39% above Michigan.**

Ohio started a 3-year program in 1995 to phase out CON, including deregulating CABG services. Of the three states, it had the **second highest relative costs, 20% above Michigan.**

Michigan has had a full coverage CON program since 1972. Its **relative CABG costs were the lowest** among all states in which Ford Motor has a significant presence and there were a statistically significant number of CABGs performed for Ford Motor's members.

Data source: To assure statistical significance, this is Ford Motor Company data from the three states where Ford has a significant presence (at least 10,000 members-- actives, dependents, and retirees-- enrolled in PPO and traditional health-benefit plans combined) in the year 2000 and there were more than 200 CABG cases statewide in year 2000 for Ford Motor's members. These three states account for most of Ford Motor's members in the USA.

Hospital Inpatient Relative Cost
Per Member Per Month
Normalized to MI Year 2000 = 100



Indiana: **NO CON** program covering inpatient acute care hospitals since the 1980s. It had the **highest costs, 18% above Michigan.**

Ohio started a 3-year program in 1995 to phase out CON, thus de-regulating most in-patient services. It had the **second highest costs, 12% above Michigan's.**

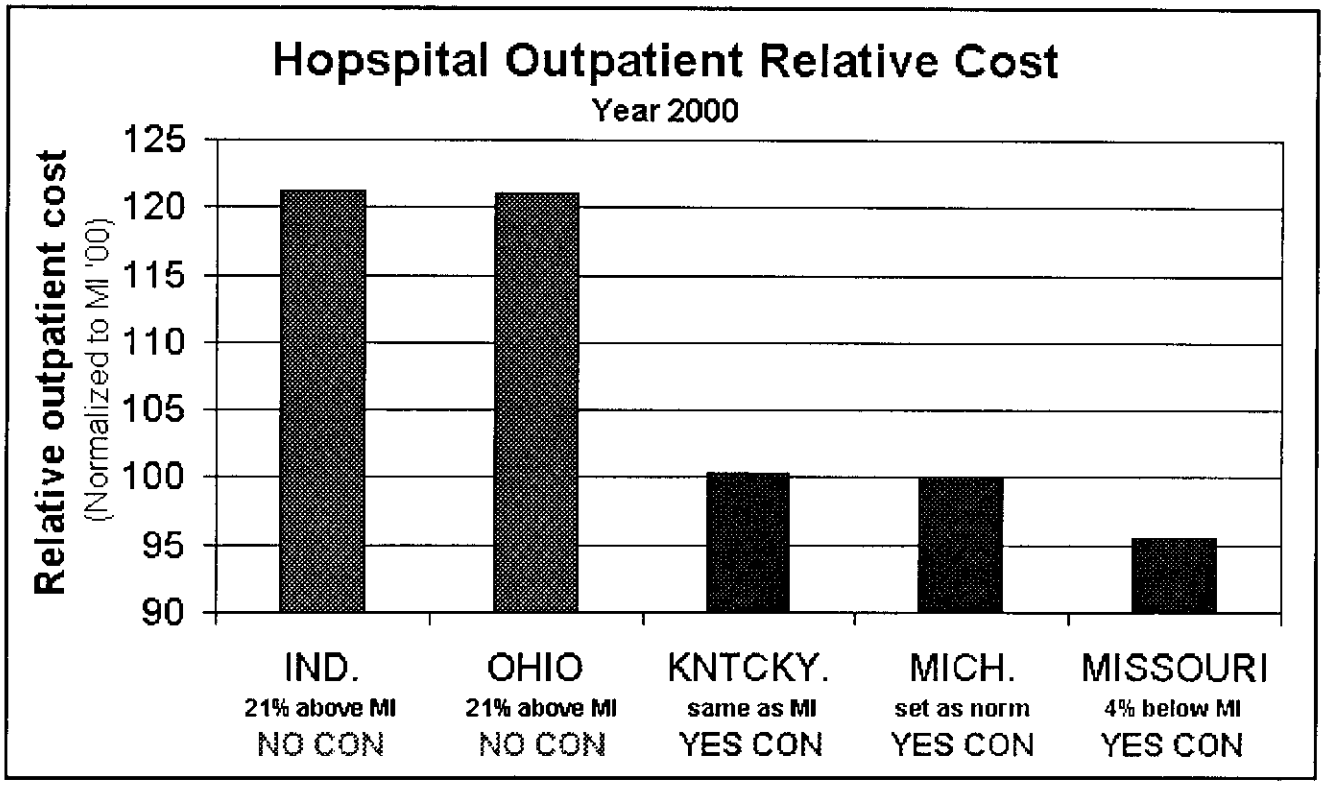
Kentucky has had a relatively extensive CON program for many years. Its **relative in-patient costs were low, just 5% above Michigan's**.

Missouri has had a full coverage CON program since 1979. It repealed the program, effective December 2001, but that was after the period covered by this data. Missouri's **relative costs were low, just 2% above Michigan's.**

Michigan has had a full coverage CON program since 1972. Its **relative inpatient hospital costs were the lowest** among all states in which Ford has a significant presence.

Data source: To assure statistical significance, this is Ford Motor Company data from the five states where Ford Motor has a significant presence (at least 10,000 members-- actives, dependents, and retirees-- enrolled in PPO and traditional health-benefit plans combined) in the year 2000. These five states account for most of Ford Motor's members in the USA.

Hospital Outpatient Relative Cost
Per Member Per Month
Normalized to MI Year 2000 = 100



Indiana: **NO CON** program covering outpatient hospital service since the 1980s. Like Ohio, Indiana had the **highest costs, 21% above Michigan.**

Ohio started a 3-year program in 1995 to phase out CON, thus de-regulating outpatient hospital services. Like Indiana, it had the **highest outpatient hospital service costs**, **21% above Michigan.**

Kentucky has had a relatively extensive CON program for many years. Its **relative outpatient hospital costs were about the same as Michigan's**.

Michigan has had a full coverage CON program since 1972. Its **relative outpatient hospital costs were among the lowest** among all states in which Ford has a significant presence.

Missouri has had a full coverage CON program since 1979. It repealed the program, effective December 2001, but that was after the period covered by this data. Missouri's **relative costs for outpatient hospital serviceswere the lowest**, at 4% below Michigan.

Data source: To assure statistical significance, this is Ford Motor Company data from the five states where Ford Motor has a significant presence (at least 10,000 members-- actives, dependents, and retirees-- enrolled in PPO and traditional health-benefit plans combined) in the year 2000. These five states account for most of Ford Motor's members in the USA.

Statement of General Motors Corporation
On the Certificate of Need (CON) Program in Michigan
Based on Testimony Given February 12, 2002

General Motors Corporation believes that Michigan's Certificate of Need (CON) Program should be retained as an important tool to ensure cost-effective, high quality health care services.

Background

General Motors is the largest private purchaser of health care in the U.S. and spends $4.2 billion a year on health care benefits for its1.2 million employees, retirees and their dependents. In Michigan, GM covers 520,000 lives and spends $1.6 billion a year.

Health care costs are growing at unacceptable rates. At GM, we believe that improving health care quality will reduce costs. It is a continual effort to balance quality, access and costs, but we believe it can be done through delivering the right services, for the right patients, at the right time. We believe improving quality means preventing overuse, underuse and misuse of the health care system by reducing unnecessary, duplicative and wasteful services. We strongly believe in fostering the same kind of continuing quality improvement efforts in the medical community that we apply to our own business. We do not believe that unbridled expansion of health care services will lead to improved quality, affordability or accessibility.

General Motors Corporation Health Expenditures in States with Large GM Populations

Some argue that deregulating health facility expansion will trigger free-market forces of supply and demand and lead to lower costs. On the contrary, General Motors has not found that to be true based on our vast experience operating in states that have varying degrees of CON regulation. In fact, the traditional supply and demand theory doesn't work in the health care industry because often consumers only pay for a fraction of health care services or don't have enough information to make choices based on quality. Therefore, demand for services remains largely provider-driven.

Our data for 1996 through 2001 in Michigan, Ohio, Indiana, and New York – four states with very significant GM populations – includes all of our self-insured hospital, surgical and medical expenses on an age-adjusted, dollars-per-life basis. We have been authorized to include Delphi Corporation data since it was a GM subsidiary during that period.

	1996	1997	1998	1999	2000	2001	CON Status
IN	$1,611	$1,629	$1,613	$1,706	$1,846	$2,008	No CON for many years
OH	$1,556	$1,559	$1,465	$1,606	$1,746	$1,834	Recently repealed CON
MI	$1,487	$1,487	$1,483	$1,560	$1,606	$1,732	Has CON
NY	$1,306	$1,228	$1,204	$1,271	$1,347	$1,501	Has stringent CON

While the GM populations served and the benefits and cost-sharing provisions are quite similar in all four states, our health care costs are highest in Indiana – a state with no CON regulation – and lowest New York – a state with stringent CON regulation. There can be multiple reasons for this trend and we are not suggesting that the differences are only a function of CON regulation, but regulation cannot be totally ruled our as a contributing factor.

Quality Concerns

It has been shown that there is a relationship between the volume of services performed and the quality of care. Typically, fewer facilities result in improved outcomes. This is true with open-heart surgery, transplant services and some cancer services. Paradoxically, the services are related to fairly common conditions and represent significant income opportunity for those who provide them. Many hospitals see it as a competitive imperative to have specialized units handling these conditions. Excess capacity leads to two significant risks. First, spreading the population over more institutions will result in lower quality at some or all of the institutions. Second, those who do not require the services may be induced to have them, exposing themselves to inappropriate risks.

General Observation

The existing CON provisions seemed to have served the state well in matching capacity to need. However, GM would caution against trying to revise the process with an emphasis on speed, as opposed to timely and efficient review. The revised CON process was intended to replace a political and sometimes arbitrary or capricious process with a deliberative one. It was intended that there be Ad Hoc Committees, with a majority of experts but also with other knowledgeable and interested parties, who could review competing interests and provide counsel to the Commission. The Commission, likewise, does not rush to judgment on the Ad Hoc Committee recommendations, but has its own process for public input and deliberation. This process is a sound one, and in our opinion, should be preserved.

APPENDIX K

STATE-LEVEL MEDICARE DATA FROM DARTMOUTH ATLAS

Table K-1. Price/Illness Adjusted Medicare Spending, by Stringency of Acute CON Regulation, 1997

		1997 Use/Cost Index		1997 Spending Index	
	Price/Illness Adjusted AAPCC, 1997	U.S. =100	Minneapolis = 100	Total Per Capita	Medicare per Enrollee
United States	5,636	100.0	120.5	100.0	100.0
All CON States (30)	5,328	92.8	114.8	105.0	95.2
Stringent CON (3)	5,164	89.9	112.5	111.3	103.1
Connecticut	4,736	81.0	105.5	123.9	107.6
Maryland	5,873	104.0	123.7	101.2	102.3
New Jersey	4,881	84.5	108.3	108.7	99.4
Moderate CON (8)	5,436	95.8	117.2	103.6	95.1
Georgia	6,080	107.3	126.3	96.0	99.3
Maine	4,886	84.7	108.4	101.7	78.6
Massechusettes	5,700	101.1	121.4	129.1	122.8
Michigan	5,080	89.1	111.9	97.6	100.4
North Carolina	5,329	94.2	116.0	95.5	85.6
Rhode Island	5,071	88.9	111.7	116.5	107.5
South Carolina	5,442	96.4	117.7	90.5	83.1
West Virginia	5,899	104.5	124.1	102.2	83.4
Limited CON (19)	5,309	92.0	114.2	104.6	94.0
Alabama	6,223	109.4	128.0	99.6	101.3
Alaska	4,690	79.8	104.5	96.9	87.0
Delaware	5,336	94.4	116.1	110.0	78.8
District of Columbia	5,669	100.6	121.0	220.0	190.5
Florida	6,985	119.3	135.9	107.2	114.9
Hawaii	4,076	61.7	90.1	103.6	60.3
Illinois	5,145	90.4	113.0	97.7	92.0
Iowa	4,711	80.4	104.9	92.2	68.4
Kentucky	5,625	99.8	120.4	96.4	87.2
Mississippi	6,127	108.0	126.9	85.6	101.9
Missouri	5,785	102.6	122.6	101.4	100.5
Nevada	5,520	97.9	118.9	85.4	98.0
New Hampshire	4,604	77.6	102.7	102.5	79.0
New York	4,944	86.0	109.4	123.9	111.9
Oregon	4,668	79.3	104.1	87.7	72.3
Tennessee	6,192	109.0	127.7	109.2	108.0
Vermont	4,814	82.9	107.0	91.0	70.4
Virginia	4,647	78.7	103.6	86.8	81.7
Washington	5,102	89.5	112.2	90.0	81.2
All States w/o Acute Care CON (21)	5,467	95.5	117.0	93.0	89.0
Dropped CON Before 10/1/86 (9)	5,456	95.3	116.8	93.4	88.9
Arizona	6,057	107.0	126.1	84.2	90.3
Idaho	4,813	82.9	107.0	73.2	67.6
Indiana	5,525	98.0	119.0	95.5	90.9
Kansas	5,935	105.0	124.5	94.8	82.0
Louisiana (L)	6,864	117.9	134.8	101.5	134.4
Minnesota	4,542	75.9	101.4	111.6	78.0
New Mexico	5,416	95.9	117.3	81.6	71.8
Texas	5,987	105.9	125.2	91.9	121.8
Utah	5,401	95.7	117.1	75.5	84.3
Dropped CON 10/1/86-1989 (7)	5,362	93.9	115.7	90.3	85.4
Arkansas (L)	6,057	107.0	126.1	88.3	81.5
California	5,130	90.1	112.7	91.1	110.3
Colorado	5,821	103.2	123.1	91.0	98.8
Oklahoma (L)	5,656	100.4	120.8	87.0	97.6
South Dakota	4,698	80.0	104.7	99.0	74.1
Wisconsin (L)	4,614	77.8	102.9	99.9	74.8
Wyoming	5,555	98.5	119.4	75.8	60.7
Dropped CON 1990 or later (5)	5,319	92.1	114.3	104.7	90.5
Nebraska (L)	4,642	78.6	103.5	95.7	77.3
North Dakota	4,603	77.6	102.7	109.9	82.7
Ohio (L)	5,833	103.4	123.2	100.4	92.5
Pennsylvania	6,198	109.1	127.8	112.8	109.5
Note	[A]	[B]	[C]		

Notes Unless otherwise indicated, all data reported in [S1] which includes all details about sources and methods. The price and illness adjusted AAPCC values for each state are weighted averages based on the number of enrollees in each HRR shown. Figures for each major CON grouping represent unweighted averages of figures shown.

[A] The price-illness adjusted average per capita cost (AAPCC) represents the expected cost of care for a typical Medicare beneficiary in a given geographic area, by eliminating differences in cost of living and differences in severity of illness of the Medicare population

[B] Figures shown indicate the percent savings per Medicare enrollee that would be achieved were the state to match the U.S. average price/illness adjusted AAPCC, i.e., achieving "average" performance.

[C] Figures shown indicate the percent savings per Medicare enrollee that would be achieved were the state to match the price/illness-adjusted AAPCC in Minneapolis ($4,478), i.e., the benchmark for "optimal" performance according to the Dartmouth Atlas.

Source:

[S1] Center for Evaluative Health Sciences. *The Dartmouth Atlas of Health Care 1998*. Estimated 1997 Average Adjusted Per Capita Costs (AAPCC) and Related Statistics for Medicare by Hospital Referral Region (in dollars). http://www.dartmouthatlas.org/tables/98table7.php (Accessed July 26, 2002).

Table K-2. Dartmouth Atlas Medicare Utilization Indicators Index (US=100), Michigan Compared to States That Dropped Acute Care CON, 1999

			States That Dropped CON Before 10/1/86										CON Dropped 10/1/86-1989								CON Dropped After 1990				
	Michigan	All States w/o CON	Average	Arizona	Idaho	Indiana	Kansas	Louisiana	Minnesota	New Mexico	Texas	Utah	Average	Arkansas	California	Colorado	Oklahoma	South Dakota	Wisconsin	Wyoming	Average	Nebraska	North Dakota	Ohio	Pennsylvania
	Index (US=100)																								
Preventative Services	**101.6**	**92.9**	**92.7**	**113.4**	**89.9**	**84.7**	**93.1**	**90.5**	**97.4**	**80.4**	**102.2**	**83.0**	**94.0**	**89.1**	**105.2**	**87.3**	**95.8**	**95.5**	**99.6**	**85.6**	**91.3**	**82.7**	**98.1**	**89.8**	**94.4**
Blood Lipid Testing in Diabetes	83.8	84.3	88.4	121.0	94.9	75.3	83.1	84.9	78.7	74.6	114.8	68.5	82.2	81.2	105.6	64.1	95.0	90.7	90.6	48.2	78.6	76.8	95.1	73.6	68.7
Eye Examination in Diabetes	99.2	96.3	97.5	104.9	94.0	88.4	98.2	95.1	100.0	97.3	99.0	100.4	95.6	87.2	106.7	100.7	88.6	97.0	95.9	93.2	94.9	93.4	93.5	98.1	94.6
HbgAlc Testing in Diabetes	70.1	104.6	109.0	119.0	134.7	98.2	119.0	90.7	119.6	99.9	110.0	89.5	109.4	99.8	101.0	107.9	103.3	128.1	125.6	100.1	86.5	55.9	134.9	87.2	67.8
Mammography in Women 65 and Olc	124.8	99.1	96.7	105.3	95.4	94.3	111.1	91.4	111.5	87.9	84.3	89.1	97.4	83.7	96.2	95.5	93.4	95.5	115.7	101.8	107.6	105.2	117.6	102.5	104.9
Colon Cancer Screeing	125.9	67.6	65.8	105.7	36.7	27.8	68.4	58.9	77.2	52.4	120.0	45.2	66.9	52.6	144.7	42.9	79.9	62.4	45.3	40.5	73.1	52.7	54.8	69.6	115.3
Vaccination: for Pneumococcal Pneum	105.9	105.4	99.0	124.5	83.5	124.2	78.5	121.8	97.6	70.2	85.2	105.1	112.6	130.2	77.0	112.7	114.7	99.5	124.5	129.8	107.1	112.0	93.0	108.0	115.3
Supply Sensitive	**100.8**	**91.5**	**88.0**	**79.7**	**70.2**	**97.8**	**87.1**	**116.5**	**89.4**	**86.4**	**96.0**	**68.7**	**92.6**	**105.3**	**91.5**	**84.2**	**95.0**	**89.6**	**85.1**	**97.5**	**97.5**	**83.1**	**94.2**	**105.3**	**107.4**
Hospitalizations for CHF	103.3	86.9	82.8	64.0	51.8	107.5	84.1	142.3	77.2	61.1	102.6	54.7	85.0	122.7	80.9	63.0	94.0	72.1	81.5	80.5	99.6	73.5	90.0	114.0	121.1
Acute Care Beds	98.8	105.8	99.0	67.9	85.7	108.3	121.4	143.9	94.0	82.1	104.3	83.3	107.3	120.0	75.7	75.0	116.7	130.4	90.6	142.9	118.5	114.3	150.0	104.3	105.6
Medical Hospitalizations	95.8	92.1	89.1	72.4	70.5	101.3	90.3	133.1	86.8	83.4	101.5	62.5	93.9	118.2	86.1	79.9	100.2	90.7	82.9	99.6	95.9	80.1	91.6	103.3	108.6
Primary Care Physicians	103.5	92.3	85.6	92.3	68.4	83.1	87.2	79.0	105.9	109.2	77.1	68.5	99.1	86.5	101.4	105.4	94.1	104.0	95.2	107.1	95.4	88.4	96.0	97.2	100.0
Medical Specialists	105.6	87.3	87.3	109.6	73.2	82.2	66.2	101.3	98.9	104.3	78.5	71.7	87.0	75.3	110.7	102.8	79.4	67.4	90.6	82.4	87.7	66.0	66.8	107.9	109.9
Death having admission to ICU	98.1	84.6	84.0	72.2	71.6	104.4	73.7	99.1	73.4	78.1	112.0	71.6	83.3	109.1	94.0	78.7	85.6	73.1	69.7	72.8	88.0	76.6	71.0	105.4	99.1
Surgery	**118.5**	**108.0**	**107.5**	**105.7**	**125.2**	**103.8**	**114.4**	**114.7**	**116.0**	**74.2**	**110.8**	**102.5**	**106.8**	**94.8**	**105.7**	**104.4**	**106.7**	**122.2**	**104.7**	**109.1**	**111.2**	**126.3**	**109.9**	**104.0**	**104.6**
CABG (coronary artery bypass graft)	110.4	101.1	95.1	88.3	93.5	110.6	94.4	116.6	94.6	51.6	118.8	87.1	99.8	113.9	100.8	77.2	95.7	114.5	98.2	98.4	117.1	127.4	108.9	115.5	116.8
Lower Extremity Bypass	89.4	75.8	74.3	73.9	106.8	92.9	65.9	85.0	78.0	45.5	88.6	31.8	69.9	69.1	86.4	68.2	59.1	50.0	83.5	72.7	89.6	88.6	67.0	102.7	100.0
Mastectomy/Lumpectomy	107.0	111.0	104.2	124.3	89.8	93.6	101.8	128.1	136.7	71.9	101.8	89.8	118.3	88.6	98.4	131.7	117.8	167.7	122.0	101.8	113.6	134.7	128.7	89.8	100.9
TURP for BHP	93.7	105.7	108.9	97.6	129.4	103.4	122.3	100.3	122.1	83.5	120.4	101.4	100.2	105.8	109.4	78.2	108.9	125.9	98.3	75.0	107.9	107.5	123.8	98.0	102.3
Knee Replacement	113.9	118.9	122.4	108.7	158.7	111.9	156.9	93.4	138.8	88.1	111.1	133.9	113.6	85.5	97.7	125.6	103.4	141.3	133.3	108.3	120.6	150.5	121.6	110.3	100.0
Back Surgery	146.5	143.4	133.9	158.1	109.7	109.7	129.0	122.6	146.8	119.4	137.0	173.1	162.4	112.3	145.6	187.6	158.1	186.1	114.9	232.3	131.6	164.5	121.8	124.8	115.4
Carotid Endarterectomy	134.5	104.7	109.4	78.7	219.1	118.0	129.4	154.1	71.6	44.1	113.1	56.9	96.6	115.9	104.8	65.5	113.7	113.2	89.3	73.5	108.5	119.1	97.1	117.4	100.4
Radical Prostatectomy	152.3	103.2	111.6	115.8	94.7	90.1	115.8	117.5	139.5	89.5	95.4	145.6	93.7	67.4	102.6	101.1	97.4	78.9	98.0	110.5	100.9	118.4	110.5	73.7	100.9
End-of-Life	**91.4**	**76.7**	**75.7**	**50.9**	**68.9**	**97.4**	**79.2**	**91.9**	**65.8**	**61.0**	**104.0**	**61.9**	**76.2**	**95.4**	**70.4**	**55.7**	**83.7**	**74.2**	**67.9**	**86.3**	**79.6**	**79.0**	**73.2**	**85.2**	**81.0**
% Deaths Occuring in Hospitals	87.5	81.1	77.5	40.9	67.6	93.8	95.3	98.4	71.4	63.3	98.1	69.0	83.6	109.3	60.0	55.6	94.8	90.9	77.7	97.3	84.5	88.8	91.9	75.7	81.6
Average Number of Days in Hospital [	107.8	89.1	83.6	48.1	69.6	104.8	105.4	115.1	73.7	60.9	113.6	61.6	90.9	119.8	66.7	60.7	109.1	94.0	82.9	103.3	98.1	97.8	101.4	93.7	99.7
Average Medicare Reimbursements f	108.1	84.8	82.9	55.0	78.5	97.2	89.3	102.4	78.4	61.7	112.2	71.6	86.3	92.7	91.8	66.3	93.4	75.7	79.8	104.6	86.4	83.7	82.1	93.4	86.3
% Admitted to ICU During Terminal H	106.6	86.2	89.1	56.2	82.7	118.4	89.7	101.1	76.2	72.0	125.7	80.0	86.3	117.2	77.5	62.2	97.1	81.7	79.1	89.3	89.5	85.3	78.7	99.5	94.6
% Admitted to ICU During L6	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1
% Spending a week of more in ICU	101.0	79.7	83.7	68.2	77.7	132.9	58.2	97.4	58.0	70.9	137.5	52.1	73.1	96.5	89.3	52.1	70.9	65.9	50.7	86.4	82.2	81.4	48.2	112.1	87.0

Note: All raw data for individual communities and U.S. averages are reported in four downloadable tables accessible through [S1]. State averages are estimated by authors using unweighted averages of raw data for all communities in that state; likewise, calculations of index values are calculated by authors using estimated statewide averages and the reported U.S. averages

Source:

[S1] Center for Evaluative Health Sciences. *The Dartmouth Atlas of Health Care 1999*. http://www dartmouthatlas.org/download.php (Accessed September 15, 2002)

Table K-3A. Dartmouth Atlas Medicare Utilization Indicators, U.S. Michigan and Michigan Communities, 1999

	United States	Mich-igan	Ann Arbor	Dear-born	De-troit	Flint	Grand Rapids	Kala-mazoo	Lan-sing	Mar-quette	Musk-egon	Pet-osky	Pontiac	Royal Oak	Sag-inaw	St Jo-seph	Tra-verse City
Preventative Services																	
Blood Lipid Testing in Diabetes	376.1	315.3	398.4	510.1	435.2	454.4	253.2	215.5	176.9	160.2	87.6	261.8	399.5	501.1	245.7	360.7	269.4
Eye Examination in Diabetes	822.5	815.8	840.1	819.2	819.0	811.0	800.0	783.3	832.5	747.3	900.5	761.4	793.4	850.9	749.7	848.5	880.8
HbgAlc Testing in Diabetes	434.1	304.1	310.2	324.3	342.9	318.5	363.9	312.5	226.1	220.0	103.3	207.7	365.1	406.7	264.9	462.9	333.1
Mammography in Women 65 and Older	436.4	544.6	567.9	520.1	524.5	569.8	483.2	512.3	552.6	541.2	583.5	517.5	544.6	597.1	548.7	605.1	500.4
Colon Cancer Screeing	79.2	99.7	104.5	99.9	124.3	145.5	98.4	67.7	117.4	78.5	57.5	101.9	92.6	133.1	71.7	99.3	103.8
Vaccination for Pneumococcal Pneumonia	57.1	60.5	56.7	51.9	57.6	61.6	60.6	58.8	56.4	52.5	59.1	61.5	80.7	68.6	68.0	55.1	58.2
Supply Sensitive																	
Hospitalizations for CHF	22.6	23.4	23.5	31.9	28.4	27.4	19.1	19.5	22.6	20.8	18.7	19.7	27.6	23.1	26.4	19.8	21.8
Acute Care Beds	2.8	2.8	2.4	3.1	3.4	3.3	2.1	2.7	2.5	3.4	2.8	2.7	2.4	2.3	3.1	2.9	2.4
Medical Hospitalizations	227.1	217.5	232.7	254.0	249.0	247.2	176.9	193.0	217.5	216.3	169.7	189.7	254.4	220.1	238.4	193.3	210.0
Primary Care Physicians	65.0	67.3	66.3	60.9	61.2	71.6	57.4	60.2	68.0	59.5	63.7	65.3	84.2	102.9	59.9	58.1	70.1
Visits to Primary Care Physicians		5.8	6.5	7.7	6.4	6.9	4.7	5.1	5.9	5.3	5.5	5.7	6.6	5.8	5.5	4.8	5.1
Medical Specialists	25.6	27.0	32.0	25.6	29.8	19.6	21.1	25.0	25.4	21.2	21.3	24.0	40.3	49.9	19.9	24.2	26.2
Visits to Medical Specialists		2.5	2.7	3.5	3.4	3.4	1.5	2.0	2.4	1.3	1.5	1.3	4.2	3.9	2.4	2.1	1.6
Death w/admission to ICU	16.9	16.6	19.4	22.1	19.0	21.8	13.7	16.1	16.0	13.3	12.5	14.4	16.0	17.3	18.1	15.6	13.3
Surgery																	
CABG (coronary artery bypass graft)	6.2	6.8	6.2	6.7	6.9	8.1	6.0	6.5	7.7	8.1	6.0	6.1	6.7	5.8	8.5	6.5	6.9
Mastectomy/Lumpectomy	1.7	1.8	1.6	1.5	1.7	2.2	1.7	1.2	1.7	3.3	2.2	1.6	1.5	1.3	1.8	1.1	2.4
TURP for BHP	7.1	6.6	6.5	6.8	6.6	8.8	5.9	6.2	6.0	4.3	5.6	4.9	7.7	7.5	8.7	6.7	7.2
Knee Replacement	5.5	6.2	6.4	4.8	5.7	6.3	6.6	6.5	7.0	6.0	6.9	6.8	5.7	5.3	7.1	5.5	6.5
Back Surgery	3.1	4.5	3.8	3.0	3.8	4.9	4.6	5.3	4.6	4.4	4.6	7.0	4.6	4.3	5.7	3.5	4.0
Cartoid Endarterectomy	3.4	4.6	3.6	4.4	4.4	4.7	3.2	5.2	4.7	2.9	6.0	4.3	4.5	4.0	5.4	4.9	6.4
Lower Extremity Bypass	2.2	2.0	1.9	2.4	2.1	1.8	1.4	2.7	1.4	1.9	1.6	1.7	3.2	1.9	2.0	2.0	1.5
Radical Prostatectomy	1.9	2.9	2.2	2.0	2.0	3.3	3.4	1.8	3.5	2.1	3.6	3.6	1.8	2.1	3.8	3.1	5.1
End-of-Life (L6=last six months of life)																	
% Deaths Occuring in Hospitals	33.0	28.9	29.0	32.6	31.7	33.1	24.2	29.4	24.6	27.8	25.9	26.0	28.0	32.8	30.3	29.5	28.2
Average Number of Days in Hospital During L6	9.2	9.9	10.5	13.8	12.7	11.5	7.5	8.6	10.1	8.2	7.7	7.2	10.8	13.4	10.5	8.0	8.3
Average Medicare Reimbursements for Inpatient Care During L6	9,616.0	10,396.1	11,495.0	13,304.0	13,682.0	12,405.0	8,227.0	10,013.0	9,998.0	8,492.0	7,778.0	7,486.0	11,935.0	14,575.0	9,278.0	8,406.0	8,868.0
% Admitted to ICU During Terminal Hospitalization	15.0	16.0	18.8	21.1	18.9	19.3	13.7	16.5	12.7	11.7	12.5	13.7	16.4	17.1	19.0	13.5	15.0
% Admitted to ICU During L6	28.9	37.1	42.8	36.3	33.0	30.1	33.3	26.3	26.3	24.9	31.6	26.9	31.6	31.1	36.6	23.9	31.2
% Spending a week of more in ICU	11.0	11.1	14.8	17.8	15.5	11.7	9.8	11.6	8.3	5.9	6.8	7.9	10.7	12.4	15.7	7.2	10.6

Note: All raw data for individual communities and U.S. averages are reported in four downloadable tables accessible through [S1]. Michigan averages are estimated by authors using unweighted averages of raw data for all communities shown. U.S. averages for visits to primary care physicians and medical specialists were not available.

Source:

[S1] Center for Evaluative Health Sciences. *The Dartmouth Atlas of Health Care 1999*. http://www.dartmouthatlas.org/download.php (Accessed September 15, 2002).

Table K-3B. Dartmouth Atlas Medicare Utilization Indicators Index (US=100), U.S. Michigan and Michigan Communities, 1999

	United States	Mich-igan	Ann Arbor	Dear-born	De-troit	Flint	Grand Rapids	Kala-mazoo	Lan-sing	Mar-quette	Musk-egon	Pet-osky	Pontiac	Royal Oak	Sag-inaw	St Jo-seph	Tra-verse City
Preventative Services		**101.6**	**106.8**	**107.7**	**112.0**	**119.2**	**98.3**	**88.4**	**95.7**	**83.2**	**77.7**	**94.2**	**111.6**	**125.9**	**92.1**	**111.0**	**100.5**
Blood Lipid Testing in Diabetes	100.0	83.8	105.9	135.6	115.7	120.8	67.3	57.3	47.0	42.6	23.3	69.6	106.2	133.2	65.3	95.9	71.6
Eye Examination in Diabetes	100.0	99.2	102.1	99.6	99.6	98.6	97.3	95.2	101.2	90.9	109.5	92.6	96.5	103.5	91.1	103.2	107.1
HbgAlc Testing in Diabetes	100.0	70.1	71.5	74.7	79.0	73.4	83.8	72.0	52.1	50.7	23.8	47.8	84.1	93.7	61.0	106.6	76.7
Mammography in Women 65 and Older	100.0	124.8	130.1	119.2	120.2	130.6	110.7	117.4	126.6	124.0	133.7	118.6	124.8	136.8	125.7	138.7	114.7
Colon Cancer Screeing	100.0	125.9	131.9	126.1	156.9	183.7	124.2	85.5	148.2	99.1	72.6	128.7	116.9	168.1	90.5	125.4	131.1
Vaccination for Pneumococcal Pneumonia	100.0	105.9	99.3	90.9	100.9	107.9	106.1	103.0	98.8	91.9	103.5	107.7	141.3	120.1	119.1	96.5	101.9
Supply Sensitive		**100.8**	**105.7**	**114.7**	**113.3**	**110.6**	**81.5**	**92.2**	**97.3**	**93.6**	**85.4**	**91.1**	**116.9**	**122.8**	**101.6**	**92.1**	**93.9**
Hospitalizations for CHF	100.0	103.3	104.0	141.2	125.7	121.2	84.5	86.3	100.0	92.0	82.7	87.2	122.1	102.2	116.8	87.6	96.5
Acute Care Beds	100.0	98.8	85.7	110.7	121.4	117.9	75.0	96.4	89.3	121.4	100.0	96.4	85.7	82.1	110.7	103.6	85.7
Medical Hospitalizations	100.0	95.8	102.5	111.8	109.6	108.9	77.9	85.0	95.8	95.2	74.7	83.5	112.0	96.9	105.0	85.1	92.5
Primary Care Physicians	100.0	103.5	102.0	93.7	94.2	110.2	88.3	92.6	104.6	91.5	98.0	100.5	129.5	158.3	92.2	89.4	107.8
Visits to Primary Care Physicians																	
Medical Specialists	100.0	105.6	125.0	100.0	116.4	76.6	82.4	97.7	99.2	82.8	83.2	93.8	157.4	194.9	77.7	94.5	102.3
Visits to Medical Specialists																	
Death w/admission to ICU	100.0	98.1	114.8	130.8	112.4	129.0	81.1	95.3	94.7	78.7	74.0	85.2	94.7	102.4	107.1	92.3	78.7
Surgery		**118.5**	**104.5**	**102.8**	**108.0**	**131.8**	**111.0**	**115.6**	**121.7**	**115.4**	**127.7**	**125.9**	**116.5**	**103.5**	**141.5**	**109.7**	**141.2**
CABG (coronary artery bypass graft)	100.0	110.4	100.0	108.1	111.3	130.6	96.8	104.8	124.2	130.6	96.8	98.4	108.1	93.5	137.1	104.8	111.3
Mastectomy/Lumpectomy	100.0	107.0	95.8	89.8	101.8	131.7	101.8	71.9	101.8	197.6	131.7	95.8	89.8	77.8	107.8	65.9	143.7
TURP for BHP	100.0	93.7	91.9	96.2	93.4	124.5	83.5	87.7	84.9	60.8	79.2	69.3	108.9	106.1	123.1	94.8	101.8
Knee Replacement	100.0	113.9	117.4	88.1	104.6	115.6	121.1	119.3	128.4	110.1	126.6	124.8	104.6	97.2	130.3	100.9	119.3
Back Surgery	100.0	146.5	122.6	96.8	122.6	158.1	148.4	171.0	148.4	141.9	148.4	225.8	148.4	138.7	183.9	112.9	129.0
Cartoid Endarterectomy	100.0	134.5	105.9	129.4	129.4	138.2	94.1	152.9	138.2	85.3	176.5	126.5	132.4	117.6	158.8	144.1	188.2
Lower Extremity Bypass	100.0	89.4	86.4	109.1	95.5	81.8	63.6	122.7	63.6	86.4	72.7	77.3	145.5	86.4	90.9	90.9	68.2
Radical Prostatectomy	100.0	152.3	115.8	105.3	105.3	173.7	178.9	94.7	184.2	110.5	189.5	189.5	94.7	110.5	200.0	163.2	268.4
End-of-Life		**91.4**	**121.6**	**135.9**	**126.2**	**115.6**	**89.3**	**98.9**	**89.9**	**79.9**	**82.9**	**81.9**	**107.1**	**121.8**	**116.4**	**83.7**	**95.4**
% Deaths Occuring in Hospitals	100.0	87.5	87.9	98.8	96.1	100.3	73.3	89.1	74.5	84.2	78.5	78.8	84.8	99.4	91.8	89.4	85.5
Average Number of Days in Hospital During L6	100.0	107.8	114.1	150.0	138.0	125.0	81.5	93.5	109.8	89.1	83.7	78.3	117.4	145.7	114.1	87.0	90.2
Average Medicare Reimbursements for Inpatient Care During L6	100.0	108.1	119.5	138.4	142.3	129.0	85.6	104.1	104.0	88.3	80.9	77.8	124.1	151.6	96.5	87.4	92.2
% Admitted to ICU During Terminal Hospitalization	100.0	106.6	125.3	140.7	126.0	128.7	91.3	110.0	84.7	78.0	83.3	91.3	109.3	114.0	126.7	90.0	100.0
% Admitted to ICU During L6	100.0	37.1	148.1	125.6	114.2	104.2	115.2	91.0	91.0	86.2	109.3	93.1	109.3	107.6	126.6	82.7	108.0
% Spending a week of more in ICU	100.0	101.0	134.5	161.8	140.9	106.4	89.1	105.5	75.5	53.6	61.8	71.8	97.3	112.7	142.7	65.5	96.4

Note: Calculations of index values are calculated by authors using estimated Michigan averages and the reported U.S. averages.

APPENDIX L

KEY INFORMANT SURVEY

KEY INFORMANT SURVEYS ON HOSPITAL CON

PURPOSE

Due to limitations on the availability of data, the updated empirical analysis of CON is restricted to all years through 1998. However, the health care market has continued to evolve substantially in the interim, in terms of growing consolidation in both the health services and health insurance markets, the continued evolution of managed care and the unrelenting pace of technological advances, including the explosion in pharmaceutical costs. Moreover, any empirical analysis is limited both by the availability of data on what plausibly can be measured and the extent to which it can take into account the fmer-grained nuances in how CON differs across states both in terms of its scope as well as its effectiveness in practice. To remedy some of these shortcomings of a purely empirical analysis, we relied on what amounts to a case study of Michigan using key informant interviews to learn more about subjective impressions of the impact of CON in actual practice, potential improvements that might be made in CON and the potential impact of dropping CON for acute care or selected technologies altogether.

SURVEY DESIGN

Areas of Focus

Our desire was to obtain a general overview of CON for hospital facilities and services and then to focus attention on three important components of CON relating to a) hospital beds; b) MRI units; and c) cardiac catheterization and open heart units. These areas were selected both because they were of particular interest to the Michigan DCH, but also in recognition that even if CON may have outlived its usefulness as a means of controlling bed supply, there might be good reasons to retain it for selected expensive technologies. Time constraints did not allow us to examine every technology now regulated by Michigan's CON program; hence the ones selected might be viewed as representative in some way of how CON works in regulating technology more generally.

Survey Respondents

Our goal was to obtain a wide variety of informed opinions about how CON worked, whether it needed to be fixed and/or whether it should be abandoned entirely. It was important to have the views of regulators, payers, providers and the general public as it was clear each group might have very different views on the merits of CON. On the other hand, CON is not necessarily well understood by even well-informed members of the public, so an effort was made to find individuals who at least had some familiarity with the process, either through personal

experience or by talking with colleagues familiar with it. Time constraints imposed a natural limit on the numbers who could be interviewed, so it was decided to identify at least 12 individuals in each of the four groups, but to have additional names to substitute in the event that a prospective respondent was unwilling or unable to participate. The goal was interview at least 10 but no more than a dozen individuals within each group. Because the consultants for this study were from outside Michigan, a small working group within DCH selected the list of names of individuals to interview. This working list was carefully vetted to ensure that it fairly represented a broad cross-section of views and was not obviously tilted in the direction of either supporting or opposing CON. Thus, the final sample was neither a purely random sample of Michigan residents nor a group whose opinion was invited by their predisposition to support or oppose either the continuation or reform of CON. Ultimately 11 individuals refused to participate and 2 others could not be reached or did not respond after a half dozen separate attempts. Substitutes were found for all but two of these.

General Hospital CON Survey. We completed a total of 9 interviews; 3 declined and 1 was unavailable after repeated contacts. The final sample included 2 representatives of government, 3 representing payers, 3 representing providers and 1 representing patients/consumers.

Hospital Beds Survey. We completed 12 interviews; 2 declined to participate. The final sample included no representatives of government, 2 representing payers, 7 representing providers and 3 representing patients/consumers.

MRI Survey. We completed 13 interviews; 2 declined to participate. The final sample included no representatives of government, 2 representing payers, 9 representing providers and 2 representing patients/consumers.

Cardiac Catheterization/Open Heart Survey. We completed 9 interviews, 4 declined to participate and 1 was unavailable. The final sample included no representatives of government, 2 representing payers, 7 representing providers and none representing patients/consumers.

Questionnaires

To minimize the burden on respondents and ensure cooperation in obtaining interviews, each questionnaire was designed to last no longer than 15-20 minutes. In addition, respondents were assured that their answers would be kept confidential. A total of 35 interviews were conducted by the Duke University consultants and the balance were conducted by Greg Cline, *Director*, Center for Collaborative Research in Health Outcomes and Policy, Michigan Public Health Institute.

Each questionnaire had three parts. The first section addressed perceptions about the impact of CON in actual practice. These questions asked for a subjective evaluation of CON in terms of

effectiveness (e.g., did/does it really affect the size or nature of the industry or number/nature of beds, MRI units etc.?), *access* (for the uninsured and other disadvantaged populations), and *quality* (patient satisfaction and technical quality of care). Respondents also were asked to judge CON in terms of *equity*, that is, whether the process in Michigan--regardless of effectiveness--is currently conducted in a manner that produces a level playing field between different players (e.g., hospital versus non-hospital outpatient, teaching hospitals vs. non-teaching hospitals, or any other comparisons deemed relevant by the respondent).

The second section focused on potential improvements in CON, asking respondents to name the single most important improvement that might be considered and then to offer any additional major improvements in CON that related to the area about which they were being queried.

The last section included questions about the potential impact of dropping CON. Respondents for the general CON and inpatient beds questions were asked to evaluate whether dropping CON has influenced/would influence the nature or pace of Medicaid cost containment efforts. A second question examined whether lack of CON has/would have a positive or negative effect on the rate at which the delivery system would change over the next 5 on 10 years. Respondents also were be asked whether the public would be better served by relying on CON or the market. Those given the technology questionnaire were asked a more focused set of questions would have any impact, positive or negative, on costs, access or quality of that particular service (those who answered affirmatively were asked to briefly explain how removal of CON might make a difference).

The final section addresses the best way to make a transition away from CON, i.e., whether this should be done all at once or phased in over time and the risks associated with one approach rather than another. For those who thought CON should be phased out, further probing was done to determine the time-frame and manner in which they thought this might be done. Note that respondents were not asked to accept the premise that dropping CON was a desirable direction to take: they were instead asked to focus on the narrower "what if" question of how it might be best to take this step if for whatever reason Michigan had elected to move in that direction.

KEY FINDINGS: GENERAL HOSPITAL CON CASE STUDY

The following summarizes the findings from this survey. Because of the small size of the sample, no effort has been made to differentiate responses by type of respondent, except whenever this could be done without compromising confidentiality of individual responses. Instead, we summarize the general tenor of responses, along with the specific issues/concerns/points raised by individual respondents.

Impact of CON in Actual Practice

Impact on Costs

Overall, 5 respondents thought that CON had a clear impact in reducing the size of the hospital industry, 2 thought that while it did not reduce the size of the industry (given the current excess supply of beds), it did have the desirable effect of constraining the movement of beds away from inner cities (which both believed would otherwise result in shortages in these areas) into suburbs where they were not necessarily needed. One noted that CON also had a positive effect on preserving a nonprofit health sector. Several acknowledged that Michigan already had excess capacity in hospital beds, but claimed that CON kept there from being even more excess capacity in beds.

In contrast, one thought CON had relatively little impact since the economics of health care in areas beyond the scope of CON were far more significant cost drivers than those regulated by CON, while another was certain CON had *no impact* on costs whatsoever (and had no clear purpose). On the contrary, this individual viewed CON as adding to costs by forcing facilities to jump through regulatory hoops while at the same time adding to patient time costs by making certain technologies such as MRI less available in physician offices, thereby forcing them to endure, for example, inconvenient appointments at 3:00 in the morning.

Impact on Access

Impact on Access to Hospital Care for Uninsured/Disadvantaged. 3 respondents thought that CON improved access to the uninsured and other disadvantaged populations since it prevented for-profit clinics or hospitals from "cream-skimming" (a term volunteered by several respondents) paying patients in low income areas. Another concurred that CON had only a moderating effect on keeping facilities from relocating outside Detroit, but noted that it was not a fair expectation that CON would promote access in any aggressive way since it cannot solicit applications for facilities to be built/located/expanded in areas of particular need for these populations. Another thought it did so only to the extent that CON makes use of comparative review (which reportedly had not been done in practice for years according to this same respondent) in which case such review would take into account Medicaid patient loads within each applicant's area). One respondent thought CON made no difference in terms of access for these populations (but certainly did not make things worse), while another was uncertain. Another conceded that this was an argument made by CON proponents, but observed that bad debts exist in any business and that it was more appropriate just to recover these by building them into charges rather than relying on CON to deal with this problem.

Impact on Geographic Access. Overall 6 expressed the view that CON had the effect of keeping hospitals from fleeing central cities, which (as indicated earlier) most viewed positively on grounds that this improved access for uninsured or other disadvantaged populations. None

took the view that CON made access worse in central cities and most who explicitly talked about suburban areas seemed to think that in the context of the large excess supply of hospital beds, the dynamic of preventing the inner city hospitals from relocating was not creating any access problems of concern. However, one respondent indicated that part of the problem of CON was that people from Detroit tended to dominate the process, making decisions for other cities such as Grand Rapids whose problems they understood less well. As a general matter, this means that smaller hospitals tend to be deterred from seeking what they need. More specifically, Metropolitan Hospital in Grand Rapids was land-locked and its neighbors refused to contemplate any expansion of its facility; consequently it kept trying repeatedly to work within the CON process to get around a rule that would not allow it to move more than two miles. Ultimately, it was able to get an exemption allowing it to move 10 miles, but only because of a threat to get rid of CON entirely.

Views regarding rural access were a bit more mixed. One respondent indicated that there would always be some geographic disparities, but that a free market system would result in more disparities than under CON, which at least ensures some baseline level of services in both central cities and rural areas. This views was supported by another who suggested that CON probably improved access in rural areas to certain services (such as radiation therapy services) by allowing only units of an economically viable size to exist. Similarly, another suggested that CON forces providers to build services according to where populations were located, not where the money is. Another thought that CON improved geographic access to some extent since its needs formulas attempted to balance access across different areas (similarly, while another indicated he was not completely certain about rural areas, he stated both that he had not heard complaints about this and that the review standards used more lenient thresholds in rural areas that had the effect of permitting greater access). A similar view was expressed by a rural respondent who noted that while there were some complaints about driving times or waiting times, overall CON did a pretty good job of ensuring a reasonably uniform level of access regardless of location.

One respondent said they were uncertain about CON's effects on rural access while another respondent would not comment since it depends on how one defined what is a "reasonable" distance to get access to various services, but noted that access in rural areas used to be far worse than it is today. Unprompted, this respondent also observed that CON had substantially reduced access to several services for all populations regardless of geography, such as MRI, principally because it is retrospective in nature and does not project needs into the future very well. As well, one of the earlier respondents who thought CON improved geographic access also noted that the process sometimes was too slow to respond to changes in needs/standards with the result that there were temporary access problems faced in all areas.

Impact on Quality

Overall, six respondents suggested that for services where quality is sensitive to high volume, (angioplasty, cardiac PCI, cardiac services generally, open heart services, radiation therapy and

transplantswere cited as illustrations by various respondents), CON improved quality by ensuring that well-qualified facilities get the volume/experience they need to ensure high quality. These individuals stated or implied that a free market would result in a proliferation of lower volume facilities, the net result of which would be lower quality overall.

Another respondent thought that hospital quality in general was eroding currently, but that this was not being driven by CON, which at best could only affect quality at the margins. Another conceded that proponents often cited the volume-quality argument, but felt that there was no justification for using CON to achieve this purpose: it would be more straightforward just to set qualification standards for all facilities (e.g.., through licensure process). This individual also had some faith in market mechanisms to weed out poor quality, suggesting that too often, physicians appeared to believe they were above the free enterprise system.

Fairness of CON Process

One respondent acknowledged there will always be some bias when humans make judgments, but in comparing across states, this respondent felt that Michigan's CON was as objective as possible in the sense that if standards are met, a CON is granted. Potentially there is some bias in the setting of standards, but this respondent further noted that Michigan had relatively few legal challenges to its standards because the involvement of many different interest groups resulted in a fairly balanced approach. Another concurred that the process was fair and that the statute allowed for variances that the Comnussion was able to use to maintain a level playing field. For example, rural areas were given less stringent volume requirements for PET and MRIs since there was less evidence that volume affects quality for these technologies. Two others also felt the process was very fair because the standards now were written in such a way that much of the subjectivity that existed in the past had been eliminated.

Others conceded that the existing process was biased towards hospitals, but felt this was justifiable: in this view, most of the complaints about unfairness came from specialists wanting to set up specialized facilities outside of hospitals that would allow them to do profitable procedures that would erode the ability of hospitals to cross-subsidize care for uninsured and Medicaid. Another respondent echoed this idea that some complaints about fairness were self-serving, citing the example of free-standing ambulatory surgical centers. Physicians and entrepreneurs have complained that the standards are not fair for them compared to hospitals, but the Commission has considered this concern and in the context of seeing sufficient overall capacity to perform outpatient procedures, sees no merit in building competing capacity right next to hospitals. Another pointed out that any services covered by CON actually apply to both hospitals and freestanding facilities and in that sense, Michigan's program is more fair than in other states where it only applies to hospitals; but this understandably annoys physicians who therefore are precluded from being able to do in Michigan what their colleagues in other states might. This respondent noted that in theory, anyone could challenge a competitor in an area, but that's not the norm in the current system. The process allows for both comparative reviews—in

which two or more applicants simultaneously have their applications for a needed service in a given area reviewed, with the more meritorious proposal "winning~~~r individual reviews. Michigan got away from comparative reviews some time ago because there were too many legal challenges to them etc.

Two expressed the view that the fairness of the process has deteriorated over time, with one claiming that fairness varied by gubernatorial administration and that the current administration is "at the low end of the scale" as some CONs have been awarded or not for political reasons. This was echoed by another who felt that recently individual hospitals have been allowed to bend the rules that were in place. Overall, this individual felt that the system gave an advantage to the larger teaching hospitals. A third respondent felt the process was completely unfair, with decisions being made by individuals based on the interests they represented (unions were cited as an example) and this individual also felt that the larger hospitals preferred CON because it allowed them to charge more for their services than if more competition existed.

Potential Improvements in CON

Our questionnaire gave respondents the opportunity to provide both the single most important improvement in CON they could recommend, but a follow-up question permitted them to add other potential program improvements worthy of consideration. Given differences in priorities/views across respondents, there obviously is some overlap in the suggestions made in each category. However, we have segregated the responses as they were originally asked so that readers can distinguish the ones view as most important from all the other suggestions rendered.

Most Important Improvements

Improve Standards/Methods. Three respondents thought the process of setting standards needed to be made more forward looking and less retroactive so that it better reflected changes in technology, standards of care and changes in population. As well, the program should avoid "always reacting to a crisis." One specifically criticized the bed need methodology and how service areas were defined, noting that it relied on 3-year-old data and therefore did not adequately account for changes in population growth in selected areas.

More Staff. Three respondents said that there needed to be an increase in the number and proficiency of CON staff, one noting as an example that all financial review positions have been eliminated. As a consequence, commitment, knowledge and awareness of CON by the current staff is low. For example, the 2000 hospital survey results have not yet been released, making it difficult to assess needs when data is absent. With more staff, the Commission would be better prepared to make decisions and the entire process could be expedited. According to several accounts, this problem is not new, going back at least a few years or more.

Standard-Setting. One respondent made a point of saying that despite under-staffing, the standards-setting process worked pretty well, another complained that minor changes to standards were way too cumbersome to develop and adopt, requiring 6 months of hearings and other procedural hurdles that are hard-wired into the current statute.

Enforcement of Standards. One respondent said that an important and valid criticism in the Auditor's Report last spring was that one a CON is approved, there is no process for confirming that the applicants actually live up to volume standards or other conditions claimed in their applications will be met. This respondent claimed that CON was beginning to look into this issue, but it is unclear what changes if any will be made. He cited the specific example of there being lots of low-volume angioplasty providers, but there is not a good public data system that would allow for informed decisions in this area. For example, now mid-sized hospitals are now seeking to do diagnostic catheterizations (PCI) without having an open heart back-up unit in the event emergency surgery were needed. New York is looking at this, but in contrast to Michigan, has an excellent data system that provides outcomes for CABG and other types of surgical procedures.

Complete Overhaul. One respondent noted that hospitals continue to be extremely inefficient despite CON, hence a complete overhaul was probably needed; a national health system may be needed to address the cost, access and quality issues CON is intended to remedy. This person felt that ending the program made more sense than trying to mend it, in part because hospitals now have to spend millions of dollars in getting approvals under the current system.

Other Potential Improvements

One respondent elected to offer no further suggestions claiming that the process works pretty well. While it unfortunately is not community-based health planning, this individual thought it was the closest thing to it since it's a mechanism allowing payers to affect overall system capacity. In the ad hoc committee structure, a majority *(51* percent) are experts, i.e., MD's and the rest represent employers, insurance carriers and consumers.

One respondent thought that streamlining/automating the process would help considerably, thereby making it easier to submit applications and obtain decisions. A related comment from another individual suggested the review process would be more effective if picayune details were given less attention. To collect data to document MRI use/need, MCDH required original signatures from physicians to be collected in blue ink and could not be faxed, but a forger easily could have used a blue pen.

One respondent cited understaffing as a more secondary consideration, but suggested that the quality of staff was down compared to five years ago (but indicated that staffing has been a problem for all state agencies, not just CON). This individual was not certain whether it was due to lack of cooperation from the hierarchy within CON and conceded that some of the problem

related to retirements, but felt that overall the process could be more efficiently and timely than it is if the staff were more experienced. CON is a difficult process and staff have to know what they're doing for it to work well. This concern was echoed by another who felt that the people on the CON Commission are not experts and have not been given the tools to do their job; consequently there is no planning.

One respondent thought it would help if there were some sort of committee whose purpose was to regulate and monitor what was actually happening in the state in terms of waiting times for services, needs and unmet needs. This would make the whole system more time sensitive. For example, lacking such an "early warning system" the state got into a situation where for over a year there was a serious access problem to MRI units because the state was not approving enough. As of July 2002, this finally was rectified. The current statute does provide for a Task Force to look at new technologies, but this has not been implemented. Along the same lines, another respondent said that a big problem in Michigan is that no real vision exists of where the system should be headed over the next 10 years, so the focus is on where to cut, not how to get to where the state needed to be. In that sense, CON is part of this broader problem since it too is backward-looking.

Finally, one observer suggested getting partisanship out of the process. The current ad hoc process relies on provider "experts" and includes input from payers/consumers; all of these groups have a vested interest in the outcome: it would be better to rely on some sort of independent body free of such interests.

Impact of Dropping CON

Impact on Medicaid Cost Containment Efforts

Because CON historically was motivated by concerns about Medicaid spending, our questionnaire gave respondents an opportunity to consider whether lifting CON would affect cost containment efforts. Several respondents noted the difficulty of seeing a direct connection, but most made efforts to speculate about the potential impact. One respondent suggested that CON removal would result in a tightening of Medicaid utilization review activities. It also could lead to access problems for two reasons. First, it would remove the current CON requirement that approved facilities participate in making their services available to Medicaid patients. Second, it likely would lead to a flight of urban hospitals into the suburbs. This latter point was echoed by 3 other respondents, one of whom claimed that up to 4-5 hospitals would make such a move. Another thought the CON removal would encourage the arrival of for-profit hospitals lessing willing to accept Medicaid patients. One respondent thought that unless Medicaid created its own CON process, the result would be more duplicative, less efficient services. But another disagreed, suggesting that the economics of reimbursement would not encourage an explosion of building facilities or buying equipment.

Impact on Health Delivery System Change

One respondent felt strongly that CON removal would have a "salubrious" effect on health system change insofar as the current system is a franchise system favoring hospitals even though health care is moving to the outpatient setting. CON removal is likely to lead to more collaboration/integration rather than less. Another felt that hospitals were combining anyway, so CON removal would not have much effect on horizontal integration; similarly another felt that in light of all the vertical integration already going on, CON removal was not likely to make much difference on such activities. Likewise, three respondents thought CON removal would have little or no effect on HMO penetration and no one offered an alternative to this judgment.

Most others were much less sanguine, speculating that there might be tremendous growth in both inpatient and outpatient facilities (predominantly the latter)—especially those that were physician-owned—with a consequent loss of profitable services in hospitals and negative impact on hospital finances. Several cited the case of Ohio, in which they say a huge increase in for-profit facilities occurred follow CON removal.

CON vs. Market Forces

When asked to consider whether on balance the public is better served by reliance on CON or on market forces to achieve the right balance between costs, quality and access to care, only one respondent indicated a preference for market forces, while 5 unequivocably favored CON. Of those favoring CON, one noted that CON has the effect of leveling what otherwise would be a very uneven playing field while another argued that markets cannot work in health care since consumers do not have enough information.

Among those with with ambivalent views, one thought that if Michigan had a highly functional CON system, the state would be better off with CON, but otherwise it's better to choose market forces; this person saw CON as most effective in slowing down technologies that would otherwise explode onto the market (such as lithotripiters) and slowing down acquisition until it's easier to see what makes sense in terms of demand and supply. Another indicated it was best to have a mix, which is what the current system represents (since CON addresses only a portion of the universe of health services). Another acknowledged that the arguments for market forces have some validity, but that currently, CON would be better than complete reliance on the market.

Transition from CON

Immediate vs. Gradual Removal of CON

Respondents were asked whether, *if* Michigan decided to eliminate CON, it would be best to do so immediately or to gradually phase out CON over time. Respondents were asked to accept this premise even if they disagreed with this as a possible policy direction, but two said either they did not know or did not have strong opinions about this. Another suggested that what

mattered more than speed was whether the state first created some sort of mechanism to protect providers who delivered unprofitable services to patients.

Only one believed removal should be done immediately, suggesting that it was hard to see operationally how it could be done gradually. Of the six using a more gradual approach, the suggested time frames ranged from 3 to 5 years or longer and most thought that some sort of monitoring system would be desirable during this period to permit a reversal if it looked as if things were getting out of hand. The rationales for gradual phaseout ranged from concerns about existing shortages of technicians that would be exacerbated if selected types of facilities exploded in number. Mechanisms for undertaking such a phaseout ranged from gradually raising dollar thresholds to examining and dropping selected services one at a time on some sort of priority basis.

Risks Associated with Immediate Removal of CON

Although some indicated they did not know whether there would be any risks, another argued that precisely because no one can accurately predict what would happen, "it can't possibly be sound public policy some of those advocating a gradual approach offered several concerns about moving faster. Some worried about the impact on quality of rapid proliferation of technologies such as ambulatory surgery, MRIs etc. while others were concerned about what the anticipated proliferation of services would to do health costs. Several respondents thought the "surge" in facilities and resultant duplication would in a few years get disciplined by the market. Still others were worried about the effects of immediate withdrawal on access to care for low income inner city residents, arguing that time was needed for the facilities now serving such patients to adjust to the new situation.

One knowledgeable observer was asked follow-up questions about Blue Cross/Blue Shield's Evidence of Necessity program (EON). EON was created in the mid-1980's prior to major legislative reforms in the Michigan program as there were concerns about CON's effectiveness during that period. If CON were no longer on the books, the company might consider resurrecting it even though it is expensive to do. BCBS now pays prices rather than uses cost-based reimbursement, so the focus and justification for such efforts would be on averting inappropriate use rather than trying to cut unit prices.

KEY FINDINGS: HOSPITAL BEDS CASE STUDY

Impact of CON in Actual Practice

Impact on Costs

Impact on Number or Types of Hospital Beds. Within the inpatient beds group, all but one believed CON had prevented proliferation of beds, but there were divergent views on how

desirable this was. For example, 1 criticized the program for not having had any impact on the sizable amount of excess capacity in beds (a different respondent claimed that Michigan had *40-50%* too many beds) since there is no CON authority/procedure to dc-bed. On the other hand, another thought that the admittedly small reduction in the number of beds that has occurred to date should be attributed to CON insofar as it is designed to force hospital systems to redirect their service lines around their existing infrastructure rather than build new facilities. Several made the point that the result of CON is that successful institutions are penalized (since they cannot expand capacity) because empty beds are held by neighboring hospitals. Another conceded that it was virtually impossible to add beds in the current system since overall occupancy rates were too low, but also indicated that from the beginning, CON had never been designed to deal with the proper distribution of beds. This view was supported by another who felt that the bed need methodology was flawed in part because it relies on old data, resulting in areas that are theoretically overbedded not getting beds that actually were needed. As an example, one hospital had to close its ER to ambulance traffic as a means of reducing demand for the limited number of beds available. Several respondents reported backlogs in admitting patients from ER's to inpatient beds.

Impact on Access

Impact on Access to Hospital Care for Uninsured/Disadvantaged. 7 respondents said CON had no effect on access to the uninsured or disadvantaged populations. One explained that federal law (EMTALA) requires all hospitals to accept any patients via their ER regardless of ability to pay, so that CON was not needed to perform this function. The other 5 thought CON did improve such access principally by preventing large urban facilities from fleeing to the suburbs. However, one who acknowledged this contribution of CON also worried about the long-term viability of these facilities since CON's two-mile rule prevented them from creating satellite facilities to meet local market conditions.

Impact on Geographic Access. Seven respondent thought CON had no effect on geographic access; 3 of these noted that since there already are too many beds everywhere, geographic access really was not an issue in the state, while another 2 thought that CON's impact on geographic distribution was limited to technologies such as MRIs but not beds. Two others thought that CON resulted in there being too many beds in urban areas and too few in suburbs, which was viewed as not helpful. None of the respondents thought that CON had an adverse effect on access in rural areas.

Among those who believed that CON had a positive effect on geographic access, 1thought that access would be worse in urban areas without CON, but that there were sufficient beds in rural areas even with CON; another had the identical view with respect to both urban and rural areas.

Impact on Quality

4 respondent thought CON for hospital beds had no impact on quality, although several of these pointed out they did believe CON potentially could improve quality for procedures where a volume-quality effect had been demonstrated. One of these skeptics noted that CON never looks retrospectively at quality anyway, so it does not make a difference especially since hospitals have an incentive to police their own quality anyway. This same individual noted, however, that self-policing may not work on outpatient side since competition there is more driven by the bottom line (in contrast to inpatient side where all the players are not-for-profit), so in theory CON could have a beneficial effect in that area.

Another 3 respondents thought CON had a positive effect on quality, but appeared implicitly to be alluding to CON review of technologies rather than beds since all of them also cited the volume-quality effect as justification for their belief. An additional respondent expressed uncertainty, but noted that some major payers such as Ford and Chrysler believe that CON has a positive effect on quality. Only 1 respondent unequivocably thought CON for hospital beds improved quality while another was equally certain CON potentially could put quality at risk by giving hospitals a franchise and shielding them from the quality-enhancing effects of competition.

Fairness of CON Process

2 respondents thought that the current CON process was fair, although one of these noted that very recently, legislature has attempted to get more involved resulting in some ad hoc decisions that raise questions about fairness. The system used to be very political, but the revised system that was based more on very explicit standards and ad hoc committees that are well balanced took decisions out of the hands of legislators: until recently, the legislature has not attempted to meddle in the CON process. 2 others felt this was hard to determine; one of these thought the rules were very complex so facilities often are uncertain of how to proceed (e.g., what's covered as a "single project" etc.), while the other characterized the old CON system as definitely a "good old boy" network and one in which persistent facilities could always win on appeal because there were no clear standards. So the state shifted to an "all numbers" approach in the mid-1980's, which worked reasonably well until the arrival of a Republican governor who did not like CON and who installed deputies who felt the same way. The result has been a return to a less level playing field in which those with political connections get what they want. The most blatant example was the situation regarding Metropolitan Hospital which was able to get an exemption to standard requirement that hospitals could not relocate more than 2 miles from their current site. Conversely, the politics of SE Michigan have unfairly prevented the expansion of Beaumont Hospital.

Another said the system was procedurally fair—i.e., decisions were made according to the clearly enunciated standards—but that those with deep pockets of necessity have an advantage because they have more wherewithal to find ways to show they meet the standards and because

they are better represented in ad hoc committee process etc. Another voiced similar sentiments noting that neophytes are at a disadvantage given the complexity of the process, but this individual also noted that small facilities often are assisted by skilled consultants so there is not a general bias in the current system that works to their disadvantage. Three others echoed this view but characterized the larger teaching hospitals as the ones who knew best how to "play the game" (one framed this as "manipulate the system") and hence had some advantage. Another thought that it was hospitals in general rather than any particular type of facility that was favored in the current process. However, this view was contradicted by another who claimed that on the outpatient side, CON served as a franchise creator, creating an interest group that prevents others from getting in later on. Echoing this, another felt that the unfairness of CON was evidenced far more for technologies such as MRI; in contrast, the issue of fairness on the inpatient side currently was irrelevant insofar as hospitals know they cannot get approval for new beds, so they do not even bother trying. However, this individual felt that in another 15 years, this would create serious problems. Since not too many hospitals replace their entire facility, current rules prevent an old urban hospital from emerging as a new suburban hospital. But eventually, the need for beds in suburbs will be so great that new facilities will be built, resulting in even more unused urban beds.

Potential Improvements in CON

Most Important Improvements

Only one respondent offered no opinion, while the suggestions of the others were disparate, ranging from making more flexible to making CON more restrictive.

Return to Old HSA System. One respondent felt that the current system permits approval of projects that should not be approved. This could be avoided if Michigan returned to a system that gave HSAs preliminary veto power over projects, thereby preventing their approval by the CON Commission.

Allow More Flexibility. Everyone concedes most areas are overbedded. A committee now is working on fixing the hospital groups that were set in the late 1970's. The system will not work if hospitals are permitted to move willy-nilly (e.g., Metropolitan Hospital), so something needs to be done about the replacement zone issue, i.e., perhaps relaxing the 2 mile requirement. This view was echoed by another respondent who thought that allowing health systems to move beds between any of their hospitals within a sub-area without approval would be an improvement (this recommendation would only inpatient-to-inpatient bed transfers, i.e., it would *not* permit conversion of inpatient beds to outpatient facilities such as ambulatory surgical centers).

Fix Bed Need Methodology. There were several suggestions for changing the bed need methodology. One characterized the current method as "horribly flawed" as it relies on use patterns from 1970's and 1980's and old technology; a companion problem is that population

data are not kept up to date. As a consequence, CON can never get the number and distribution of beds right. As an example, experts in cardiac care suggest Michigan may be making a huge overinvestment in cardiac capacity since the current methods do not adequately account for changes in utilization and technology. Another respondent noted that the current system was based entirely on licensed rather than filled beds, which inaccurately reflects currently available capacity. The system allows hospitals with many empty beds to block successful facilities with too few beds to block expansion of these latter facilities. The current rule is that licensed beds must be able to be set up within 24 hours, but it costs very little for hospitals to retain such beds on their books by, for example, being able to convert single hospital rooms into doubles, etc.

Take Excess Capacity Offline. Two respondents thought there needed to be some mechanism to de-license unused beds (one respondent noted that from the standpoint of cost savings, it would be better to close entire facilities rather than close selected beds within facilities). Current thresholds to retain a CON are set too low, allowing facilities with very low occupancies to keep their beds.

Fix Attitude of Regulators. One respondent suggested that current rules seemed arbitrary and totally inflexible; there were long delays in processing materials. This individual felt that the law itself was not that bad, but that Engler administration had let the "program go to hell" because they wanted it that way; this attitude is driving people crazy. A related suggestion by another respondent was that the ad hoc process could resolve issues more promptly if there were fuller staffing.

Make Hospital Data Available to Consumers. One respondent thought that CON eventually could be replaced by market forces only if consumers had good information. To move in that direction, Michigan should require hospitals to report mortality, complication rates, volume of procedures, prices and some sort of error reporting system such as airlines now have. Many other states have adopted such reporting systems.

Fairer Representation of Small Hospitals. One respondent thought that smaller hospitals needed to be better represented on the CON Commission and ad hoc committees.

Other Potential Improvements

When asked for further suggestions, one respondent noted that several years ago an advisory committee had reviewed what services/technologies should undergo CON review. The general conclusion was that the system might warrant occasional tweaking, but not major reform, as the current structure works pretty well. Two other respondents also could think of no additional suggestions for change.

Those who offered suggestions included some of the items cited above, such as changes to bed need methodology and stopping the "political assault" on the program. Other suggestions included:

Streamlining Process. One respondent said that the conduct of Commission proceedings was inefficient with too much talking about nothing. Another noted that the CON forms asked for duplicate information and that the process for developing new standards is too cumbersome and time-consuming due to the many steps involved. Another cited the requirement to obtain physician signatures for MRI applications, which was very time-consuming for applicants

Increase Payer Representation. One respondent said that by statute, all ad hoc committees had to have a majority of experts, which has been translated to mean providers. On a recent decision concerning PET, providers voted in a bloc to override concerns from payers and others about the decision being made.

Improve Need Standards. One respondent said that current need standards look at use rates in the local area and state and use whichever is lower. However, this does not account for higher utilization rates among the poor, for example.

Regionalize Process. Along the lines of the previous suggestion to rely on HSAs in the approval process, another respondent said that the current statewide structure of CON tends to favor facilities in SE Michigan. Regionalization would allow more flexibility, and because hospitals are major institutions, local economies should have some control over their size etc. This individual thought that such a structure could have avoided the Metropolitan Hospital situation: even though there was widespread community support for Metropolitan's moving its location, this was initially blocked due to fears that this precedent might allow Providence Hospital to build a suburban facility: the politics of this essentially revolved around concerns about a "foot in the door."

More Scientific Standards. One respondent noted that currently, the Commission relies too little on scientific data, with most of the focus being on cost data rather than anything else. Another elaborated that the program should promote better research on outcomes so that standards could be adjusted to promote higher quality care; this is especially important for higher end/more complicated services (e.g., open heart) for which there's good evidence that high volumes produce better outcomes.

Impact of Dropping CON

Impact on Medicaid Cost Containment Efforts

5 respondents thought that dropping CON would have no impact on Medicaid cost containment efforts and another thought the effects would be "minimal." 4 others thought that

lifting CON would result in beds being built in areas where Medicaid population typically does not live, resulting in a loss of access (and presumably spending); hence, it is unlikely Medicaid would see a cost explosion, so no change in cost containment policy is likely. Two others, however, cited the same flight to the suburbs, but thought this would have an adverse effect on Medicaid costs. One argued that whereas in the current system employers pay for Medicaid and the uninsured in inner city hospitals, the flight to the suburbs would result in a "firewall" that would allow suburban hospitals to serve higher income customers without their needing to cross-subsidize care for others, leaving urban hospitals forced to rely on higher Medicaid payments in order to remain viable. The other shared this view, but added that due to the resultant access barriers, costs would go up because people would not get timely care (resulting in avoidable hospitalizations) and because of higher inappropriate service use (e.g., ER use).

Impact on Health Delivery System Change

The views on how the delivery system would evolve if CON were removed varied widely. One respondent thought there would be a negative effect on the delivery system as the volume of new facility construction would go up, but capital would be diverted to only a small number of geographic areas. Another stated more specifically that there would be a proliferation of facilities in the suburbs, resulting in the closure of some hospitals elsewhere. Another thought CON removal would result in more services provided outside of hospitals and there would be more competition among the providers of these services. Likewise, another thought CON removal would accelerate the shift from inpatient to outpatient care without affecting the pace of vertical integration. However, another thought that CON removal would result in building more specialty hospitals without any impact on managed care penetration or vertical integration. Another characterized vertical integration as a joke, with no evidence that such integration results in improved efficiency; this individual also believed there would be no major impact on the rate of delivery system change resulting from CON removal. Without CON, another felt that there would be less incentive to take a systematic approach to health delivery within a community, so the shift would be to individual institutions. Another predicted no major effect of CON removal on grounds that 70 percent of patients are in managed care already; this individual thought there would be no effect on vertical integration, but speculated it would lead to more for-profit hospitals. Another also felt certain that for-profit activity would increase and that "several" new hospitals would be built in addition to a proliferation of ambulatory surgical facilities.

One respondent thought there would be no impact on the delivery system since the primary focus today is to get patients out as quickly as possible; since payers will not pay for excess use, facilities are unlikely to waste resources building duplicative capacity. Another thought the impact would be positive since it would provide the flexibility needed to account for an aging population that will have higher bed use over time. Another who viewed CON removal positively predicted that there would be an influx of outpatient surgical centers due to the pent-

up demand that CON has created; this would be beneficial to Michigan since these facilties cost less (but this individual thought this would be a positive development

CON vs. Market Forces

Nine respondents preferred CON; one of these explicitly acknowledged that the current CON system was not particularly effective, but claimed that even this was preferable to a completely free market (this was echoed by another who preferred CON "warts and all" over market forces that would encourage more for-profit activity. Another noted that if Medicaid reimbursed fairly, there might not even be a need for CON. Another said that because patients must rely on expert advice that is not always altruistically motivated, the market does not work in health care; to suppor this view, the respondent noted that GM had compared its per member costs across states with and without CON and found them lower in Michigan and New York (states with CON) compared to California and Indiana (states that dropped CON). Another pointed to the ability of hospitals to borrow at below prime rate (because they are not-for-profit) and the fact that patients do not have to pay full freight as conditions that precluded effective operation of the market.

Three respondents preferred market forces. One of these felt that "enlightened regulation" is OK at the local level to shape the direction of the delivery system, but today purchasers have taken over and largely eliminated cost-based reimbursement, so there is little danger in an explosion in inpatient services if CON were lifted.

Transition from CON

Immediate vs. Gradual Removal of CON

Two respondents could not or would not indicate whether immediate removal of CON was preferable to a phased out approach. Of those responding, 6 preferred immediate removal and 4 favored a more phased approach, typically 3 years or so. Those favoring immediate withdrawal offered several reasons: a) because it was difficult to imagine a fair way of doing so gradually; b) because the demand for services that CON has artificially suppressed has grown to acute levels in some areas; c) because the same politics that now surround the program would plague a gradual phaseout as well; d) to return to a level playing field as soon as possible.

Several of those arguing for a more gradual phaseout typically wanted a chance for decisionmakers to reverse this decision if it turned out to produce undesirable results while another said that it was better to go slow since otherwise some players would take advantage of the system. The only concrete suggestion for how such a phaseout could be done would be to do so geographically while monitoring what occurred.

Risks Associated with Immediate Removal of CON

Two respondents saw no risks associated with immediate phaseout of CON (except for long term care, which was not the focus of questioning). These individuals indicated that the market could be counted on to constrain excess growth. One acknowledged that there might be an explosion in use of certain technologies such as MRI/CT scans, but this might be justified (this individual noted that for most products, consumers are not forced to get up in the middle of the night to make use of them). Another acknowledged the risks of "land rush" development that would siphon capital away from certain areas, but was comfortable with letting this shake out in the market.

The various risks associated with immediate withdrawal were variously described by respondents as follows: a) there would be overbuilding of new facilities in the Detroit area, with subsequent adverse consequences on inner city hospitals that now are financially healthy, along with access problems for the indigent and elderly; b) there would be a proliferation of facilities (e.g., boutique open heart clinics) with questionable quality and/or unnecessary services provided (and companion reduction in volume of procedures for existing providers); c) an influx of for-profit providers who would cream-skim paying patients from facilities with high uncompensated care loads.

One respondent cautioned that if the state were to move in the direction of removing CON, it needed to be consistent in its approach to the health care market, e.g., by removing favorable state financing for hospital loans and letting them compete for capital on a level playing field and not tying the hands of the market with any-willing-provider laws and insurance mandates etc.

KEY FINDINGS: CARDIAC CATHETERIZATION/OPEN HEART CASE STUDY

Impact of CON in Actual Practice

For brevity, cardiac catheterization laboratories will be referred to throughout this section as CCL and open heart units as OHU.

Impact on Costs

Impact on Number/Nature of Cardiac Services. All respondents except one thought that CON had a clear impact in reducing the number of CCL/OHUs; the one exception thought CON had no impact on number/nature of CCLs. There appeared to be some divergence of opinion over the extent of CON's impact, with a handful indicating the impact was relatively slight and the majority appearing to believe the impact was substantial (e.g., one characterized the bar as being

set "very high" in Michigan). Similarly, most viewed these constraints positively, e.g., as contributing to greater quality, whereas others viewed them negatively, e.g., as stifling competition. Others expressed uncertainty about whether rules were constraining "good proliferation" or "bad proliferation."

Impact on Access

Impact on Access to Cardiac Services for Uninsured/Disadvantaged. Seven respondents said CON had no effect on access to the uninsured or disadvantaged populations. Two thought CON improved access, but for slightly different reasons. One thought that CON improved access in inner cities for reasons similar to those described in the general CON and hospital beds interviews. The other noted that most recipients of CON in Michigan are hospitals and since all hospitals in the state are not-for-profit, they are obliged to take all comers regardless of ability to pay.

Impact on Geographic Access. Two respondents said CON had no impact on geographic access since there was ample supply everywhere; one of these indicated that CCLs cannot be supported in any case without sufficient population, so population drives availability much more than CON. Another painted the same general picture in terms of suburbs vs. cities but was uncertain about CON's impact in rural areas.

Some viewed CON's impact on geographic access negatively, e.g., noting that most major heart hospitals were located in major cities, leaving rural areas with less access. Others noted that population growth had been in the suburbs, but CON rules have prevented facilities from following this growth, leaving suburbs at a relative disadvantage.

Others viewed CON's role more positively. For example, several observed that CON had made a tremendous effort to make CCLs more available in rural areas. Conceivably, rural areas might see better access to these technologies in the short-term without CON, but over the long term, many of these facilities inevitably would fail due to lack of sufficient demand for services. In that sense, CON provided the stability and patient base to ensure survival of the facilities approved through the process. Another indicated that people in rural areas were resigned to having to travel longer distances to get medical care and other services. In this person's experience, people often drove past a local facility to go to a larger facility in a city; thus, even though CON does limit services to some extent, people are willing to go to where such services are available. Another respondent thought that while access in urban areas was not a problem, not enough thinking and evidence has been brought to bear on access problems for rural areas. For example, if transportation barriers are an issue for some rural residents, then current CON rules may be having a negative effect, but right now, most CON decisions are made only in terms of economic considerations rather than bringing other scientific evidence to bear to better understand the problem and what the right answer might be in terms of service availability.

Impact on Quality

Six respondents thought CON had a positive impact on quality of CCL/OHU services, although one characterized the impact as minor and another noted that CON does not police units once they have gotten their CON to ensure that they actually meet the volume targets specified in their CON applications. Nearly all cited the relationship between high procedure volumes and higher quality as the reason CON contributes to better quality. However, one of these also noted that the technology is moving very rapidly, but Michigan's standards are not keeping pace. This individual acknowledged there will always be a lag in any bureaucratic system, but further noted that it took Michigan 2-1/2 years to recently change its OH standards. MDCH is understaffed, but it has always been this way (e.g., going back to the 1980's). However, the situated was aggravated when Engler combined mental health with the department of public health and then has moved the department 5-6 times over the past 4 years.

One respondent was certain CON had no impact on quality while another was "not sure" and another indicated "probably not." The individual who was not sure noted that there was a debate over what number of procedures was associated with good quality, as there was some evidence of good outcomes even in low volume facilities.

Fairness of CON Process

Two respondents thought that the current process was fair, although one qualified this response claiming not to be very knowledgeable about the politics of this issue. Both framed fairness in terms of whether facilities that met objectively set standards were given approvals. A third individual also said they were not qualified to judge. This individual used to be adamantly opposed to CON when it was a much more political process seeming to lack any objective standards and too often relying on outdated data that made it easy to reverse CON decisions in court. In contrast, the current system is a major improvement. In general, CON tends to restrict technology, but when it saw long waiting times for selected (unnamed) technologies, it re-adjusted the criteria, which this individual thought was an appropriate response. A fourth respondent was unable to comment.

Among those who viewed the current process as unfair, a variety of reasons were offered (some of which slightly contradicted one another): a) the current system is biased towards hospitals in general and teaching hospitals in particular to protect these institutions from cherry-picking that would leave them unable to cover their uncompensated care losses; b) the current system is biased towards hospitals over outpatient facilities in terms of CCL, but is neutral with respect to different types of hospitals. The system does not preclude outpatient facilties from qualifying for CON, but the system is stacked towards hospitals as only hospitals currently have CCLs right now; and c) the current system has become politicized, with special interest groups having gotten into the review process and/or those with "political pull" having more influence over the Commission.

Potential Improvements in CON

Most Important Improvements

Since some of the recommendations seemed generic and not restricted to CCL/OHUs, we have listed those related specifically to cardiac services first and more general recommendations last. Only one respondent thought that no improvements were needed.

Establish Minimum Volume Requirements per Physician. One individual thought that annual volume standards for facilities should be extended to individual physicians to ensure proficiency, i.e., 75 angioplasties and 100 CC procedures. Currently there appears to be no willingness by those involved in CON to do this.

Change Open Heart Volume Standards. The current threshold of 300 OH procedures is not very realistic because today so many stents have replaced OH. Thus, a facility performing 1200 stents and 250 OH procedures could have the same quality as a facility doing 300 OH operations. Current standards do not reflect that technology currently is headed in the direction of stents.

Increase Scientific Input into Standards-Setting. Several respondents expressed concerns that CON decisions were too dominated by considerations of what payers were willing to pay rather than on scientific evidence regarding what would be best for patient health. One respondent claimed that standards were too often set by payers wanting to limit the number of facilities, so the Commission "backed into" standards on this basis rather than basing them on latest scientific evidence.[1] One respondent recommended tapping the Michigan chapter of American College of Cardiac Care to obtain up-to-date standards of care to use in making CON decisions. Another respondent observed that the Committee on Cardiac Catheterization includes 6 experts, including cardiologists, nurses, administrators etc., but none of these was a cardiac surgeon.

Establish Quality Monitoring System. One respondent felt that CON had no teeth in terms of quality control since it has no capacity to monitor whether facilities comply with the standards needed to obtain a CON in the first place. If the Commission approves an application and the applicant fails to meet standards, it has no power to rectify this situation. A related concern is that being under MCDH makes CON more political: it might function better in a place where it has regulatory authority (including the staff to do its job).

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[1] A specific example not related to CCL/OHU was the recent battle over PET scanners. This respondent thought the Economic Alliance had undue influence over the methodology, resulting in a number that was roughly half the level that would have been reached based on scientific evidence alone. Moreover, all 3 PET scanners that were approved are located in SE Michigan reflecting the bias in favor of selected institutions rather than a consideration of what is best for population as a whole.

Permit Outpatient Facilities to do Therapeutic Cardiac Catheterization. One respondent said that Michigan's CON is antiquated in not permitting outpatient facilities to obtain CONs for therapeutic CC services (the current standards require facilities to be able to perform OH as back-up in an emergency). This results in all such units being in hospitals where costs are higher. Another echoed this sentiment, saying it also should apply to angioplasties (but further noting that Commission already is exploring this).

Create a More Regional Comprehensive Planning Process. One respondent said that the system has to have enough flexibility to account for regions that do not have multiple institutions. The goal should be to ensure good care for citizens rather than maximize economic value for hospitals and other health care providers.

Other Potential Improvements

Several of the preceding ideas were echoed among the respondent's suggestions for other improvements. Some additional ideas offered included the following.

Better Communication. Given the constant turnover in staff, it is critical that whenever MDCH changes its interpretation of a standard, this be widely communicated so that prospective applicants are not caught by surprise.

Streamline Filing Process. The MDCH already is moving in the direction of having information available on-line and permitting electronic filing of applications. This approach was strongly endorsed by several respondents.

Increase Flexibility. Echoing a suggestion made regarding CON for hospital beds, one respondent thought that health systems ought to be given the flexibility to move resources across geographic areas as needed to respond to changes in population and utilization—something that would benefit rapidly growing suburbs in particular.

Impact of Dropping CON

Impact on Costs, Quality and Access

One respondent thought that dropping CON would have no adverse impact on costs, quality or access for cardiac services; if anything, it might improve access/quality since it will allow diffusion of CCLs beyond the 31 hospitals having OHUs. This person thought there would be no risk to quality since if a patient had a cardiac event, there would always be time to transfer to a different facility to do OH if that were needed. Another thought that there might be some adverse effects in the short run resulting from a surge in building both CCLs (especially outpatient) and OHUs. This would result in better access, but at a higher cost. In the long run, however, the market would take over, resulting in higher quality at a lower cost. As "losers" shut

down, access would drop accordingly, but still would be higher than it would have been under CON; based on the experience in other states, Michigan would end up with more heart hospitals focused on delivering high quality services.

In sharp contrast, two thought that dropping CON would have negative effects on costs, quality and access with one indicating that the size of the impacts on cost and quality might be quite high. There would be higher costs since there are high fixed costs (implying that even if volume of procedures within the system remained the same, unit costs would go up). Apart from the volume-quality effect (which this respondent predicted would result in loss of life were programs begun in areas with insufficient volume), the limited supply of trained staff will mean that new programs may rob existing programs of their staff. Another respondent also thought the impact would be "catastrophic" as freestanding heart hospitals and physician-owned facilities steered patients away from existing hospitals, thereby hurting financial viability of the latter. With respect to access, however, the uninsured and other disadvantaged populations would have worse access due to lower cross-subsidies for care, but those with insurance probably would find access improved. Another respondent said that access was not the issue: hence, there would not be much difference with or without CON, but removing CON would negatively affect costs, and one could make a "weak argument" regarding a negative effect on quality. This individual pointed out that this year, for the first time, Michigan has established physician-level minimum quality requirements (75 PCI or 100 diagnostic); physicians who fall below these thresholds will be sent an advisory letter, but the CON Commission has no authority to do anything beyond this.

Another respondent thought that only 1 or 2 more programs might emerge were CON to be eliminated; hence the negative effects on costs and quality were likely to be small. Another was uncertain, but also thought the CON removal would only result in a few more OH programs; furthermore, this individual did not expect this would increase the overall volume of procedures. Instead, the current number would simply be spread across more programs. This person was less certain about the impact on CCLs. Another respondent painted a parallel picture for CC services, indicating that some marginal hospitals would enter this business without CON, resulting in higher costs and lower quality as they pulled business from existing labs.

CON vs. Market Forces

6 respondents thought CON was preferable to market forces. One of these cited an Advisory Board report on what happened in Ohio following CON removal, characterizing the resultant proliferation of facilities as "irrational exuberance." This individual also pointed out that managed care had not really taken off in northern Michigan, dimming the prospects for economic discipline. The Leapfrog Group had suggested some useful changes that might make the prospects for market forces more promising, but the issue is how to pay for these improvements in patient information related to quality. Moreover, Medicaid historically always has been a poor payer for hospitals and now Medicare (especially the 1997 Balanced Budget Act) has put a lot of hospitals in difficult financial circumstances, forcing them to lay of

employees etc. In this context, it would be unwise to aggravate their situation by getting rid of CON (leaving them with even less ability to cover their uncompensated care costs). Another of these CON proponents indicated that market forces would be preferable *if* they worked, but that until patients can better distinguish good quality hospitals/physicians from those with poor quality, CON is the most reliable means to ensure quality. An additional respondent indicated some uncertainty and would need to examine the evidence more carefully, but guessed that CON was slightly preferable.

One respondent thought unequivocably that the market was better, while another felt that in the long run, having no CON would be better for patient access; however, the resultant competition also would affect the finances of some facilities so the state would have to find a way to deal with the uncompensated care issue.

Transition from CON

Immediate vs. Gradual Removal of CON

Six respondents thought that if CON were to be removed, it should be immediate. One of these thought that dragging it out would simply reward those who were most aggressive, resulting in inequities. Another noted that without state involvement, private payers probably would be more inclined to use national guidelines and other tools to keep utilization/costs from getting out of control.

Three respondents thought that phasing out CON was preferable, with two suggesting a 5 year period in which to accomplish this. One thought this would allow the system to adjust to the arrival of more for-profit players. Another recommendation a phaseout in conjunction with effective comprehensive health planning and rigorous public reporting on quality. Consumers could drive the market if they were educated regarding the volume-quality relationship and given information on volumes for each facility (historically, hospitals have resisted reporting on quality, which this individual thought made them part of the problem). Likewise, the public needs to know how much different facilities charge for the same service.

Risks Associated with Immediate Removal of CON

Three respondents though there would be no risks associated with immediate lifting of CON. One of these thought that once CON were dropped, several cardiology groups would immediately build a physician-owned and operated heart hospital, but did not view this as a problem or risk. A fourth thought there would be no immediate risk to the general population, but that with new players coming in, the current providers would have to get better or they would lose market share.

Another thought there would be no risks except in the area of long term care (which was not a focus of this analysis) and MRIs, with too much capital investment in building too many MRIs that would be sold as screening tests. One respondent thought the chief risk of immediate CON removal would be the irrational proliferation of services based on erroneous beliefs about profitability rather than quality, need or cost-effectiveness. Another thought that the financial losses resulting from cherry-picking would pose the greatest risk. Similarly, another thought that greatest risk was the proliferation of for-profit CLS/OHS programs not affiliated with hospitals. The last respondent focused on the risk to quality, noting that without CON, no one would have to fill out the Annual Hospital Statistical report that requires facilities to provide a break-down of the volume of all CON-related services/procedures (by physician and type of procedure). So there would be less information and accountability for quality.

KEY FINDINGS: MRI CASE STUDY

Impact of CON in Actual Practice

Impact on Costs

Impact on Number/Nature of MRI Services. All respondents agreed that CON limits the number of MRI units relative to the number if CON were not in place. Some characterized CON as being "very restrictive" but noted that standards had just changed in July so it remained to be seen what impact these would have. According to another respondent, prior to this change, the Henry Ford Health System was referring patients to Toledo due to an inability to expand. Another indicated that CON forces facilities to put their machines to maximum use, thereby contributing to efficiency. However, another respondent said that most patients don't like to come for evening shifts, especially from 1:00-5:00 AM; while hospitals are configured to provide 24/7 access/staffing, this model does not work well for outpatient centers. Yet another respondent suggested that CON contributed to *inefficiency* since hospitals were not terribly efficient.

Impact on Access

Impact on Access to MRI Services for Uninsured/Disadvantaged. Three respondents said CON had no impact on access to the uninsured and other disadvantaged patients. Four respondents thought CON resulted in worse access for these populations because it limits availability for the entire population and results in inconvenience for everyone. Ten respondents thought that CON improved access, but offered varying explanations for why: a) any facility receiving a CON is required to make services available regardless of ability to pay; b) limitations on MRI lowers health costs, so more people can afford coverage than they would otherwise; c) by preventing cream-skimming, CON restrictions permit hospitals to cross-subsidize care for those who cannot fully pay for their own.

Impact on Geographic Access. Three respondents felt that the current standards resulted in a very uniform distribution of facilities across the state so that no particular areas were at a disadvantage. Four others thought that CON caused people in rural areas of the state to travel long distances to get to an MRI. One of these noted that in rural areas, mobile services are available, but the result is longer waiting periods for non-emergency studies since the mobile units are not always available; this individual acknowledged that rural hospitals generally would not have sufficient demand to run a profitable fixed unit, so an intermittently available mobile unit was preferable to an underutilized/unprofitable fixed unit. Likewise, another respondent suggested that while there inevitably were longer driving times in rural areas, the standards served to have a positive effect on MRI availability in such areas relative to what would occur otherwise. This was echoed by another respondent who said that under current standards, every hospital is permitted to have at least 1 fixed unit, so access in rural areas has been protected in this fashion. Another concurred that current standards create a level playing field since volume expectations have been handicapped to favor rural areas. One respondent said that CON had created an access problem in western Michigan, but another who identified the same problem noted that this should now disappear with the recent modifications in standards. Another said that lack of access in suburbs had gotten so bad that a group had said they would put in an MRI without a CON (thereby foregoing Medicaid and Medicare reimbursement).

Impact on Quality

One respondent said that MRI quality in Michigan in very good, but this has nothing to do with CON. This was echoed by another who said that while there was some volume-quality relationship, no one, in the absence of CON, would operate a facility with a volume so low as to endanger quality. Three others concurred that CON had no impact on MRI quality.

One respondents was certain that CON improved quality for MRIs on grounds that high volume is associated with high quality; another noted that Michigan MRIs have the highest volume per unit in the country, so that if quality were associated with volume, then CON unquestionably would have an impact. Two others said they did not know specifically of scientific evidence of this volume-quality relationship for MRIs but presumed that greater experience must affect proficiency at the individual physician level; moreover, one further noted that given a shortage of skilled staff, any expansion in numbers of units would dilute quality by spreading these staff over more units. Another acknowledged that the correlation between volume and quality was not as high for MRI as for other technologies regulated by CON, but nevertheless felt that there were measureable quality dimensions included in the Project Delivery Requirements under CON that helped ensure better quality (e.g., qualifications of MD who reads MRI results). A different respondent shared this view on grounds that Michigan had stringent requirements in terms of the qualifications of medical director, annual inspections etc. Another offered a similar view, but also pointed out that there was no policing of compliance with these requirements (even when facilities go back for a 2nd or 3rd MRI unit). Nevertheless, this

individual felt that most facilities probably do comply, as did another who pointed to these same standards as evidence that quality was improved by CON, noting that most applicants took these seriously.

Fairness of CON Process

Six respondents thought the current process was fair, with four of these noting that historically, CON had been tipped in favor of hospitals, but this was no longer true due to revisions in standards. Basically, so long as an applicant meets the numerical requirements, its application will get approved. One respondent was agnostic, saying that by its nature, the process is inherently political and self-motivated, resulting in a system that is neither completely fair or unfair. The CON requirements result in an open discussion with payers and other members of the community that has a temporizing effect on well-to-do communities. That said, power follows political contributions, so well-heeled communities have better odds than others. Nevertheless, even taking all that into account, the system is fairer than a complete free-for-all.

Of those who expressed doubts about the fairness of the current process, the reasons varied: a) one thought the process basically was fair but that unfairness arose by facilities that did not play by the rules (e.g., this individual has seen physician signatures that by all appearances are forged, but there is no enforcement/audit mechanism to preclude this, as whatever is submitted with an application is automatically accepted); b) another was disappointed to see that sometimes people serve on ad hoc committees even when they have an application under consideration; c) the current system favors teaching hospitals and other large institutions who have a voice in Lansing; d) notwithstanding changes in the standards, the system still favors hospitals over out-patient facilities since current rules do not allow outpatient facilities to rely on MRI unit-equivalents that are hospital-based; and e) the system basically is fair, but for political reasons, the process has been made longer and more cumbersome, giving the appearance of unfairness (a situation that could be remedied by proper staffing). The most negative view came from an individual who characterized the process as "arbitrary and highly politicized;" the process is slow and cumbersome and tied up by special interests. This individual thought that the Commission was not objective nor did it use objective criteria to make decisions that were in the best interests of the public.

Potential Improvements in CON

Most Important Improvements

With the exception of one respondent who thought CON should just be abolished (or, absent that, have MRI removed from the list of technologies reviewed by CON), all respondents offered suggestions for how the program could be improved.

More Staffing. Five respondents mentioned staffing as a top priority consideration. The varying accounts imply this has become a problem principally during the past 5-6 years. Two noted that the process guarantees review in 120 days (plus another 30 days is permitted for completeness review of incoming applications); it is possible to conduct reviews much faster, but it always takes the maximum amount of time because staff are so limited

Increase Flexibility. One respondent thought that the system should try to better match the level of technology with the type of purpose to which it is put. Lower technology units can work fine in outpatient settings (e.g., orthopedics).

Increase Expert Input. One respondent felt that the ad hoc committees should have fewer political appointees and more experts with backgrounds/skills in hospital management and health care cost accounting. MDCH also should provide better education to those on these committees who may not have as much expertise on the issues involved.

Delay Repetitious Filings. One respondent indicated that the current process had a "squeaky wheel" aspect encouraging applicants to make more than one attempt to secure approval for a project. An open process with defined time limits would be preferable.

Better Enforcement. One respondent said that while enforcement was not an issue for MRIs, it was for other technology (e.g., cardiac services) because MDCH does not support CON.

Improve Process of Collecting MD Signatures. One respondent said the current system was very cumbersome, requiring applicants to document a need for 6,000 adjusted referrals for MRI scans. The logistics of contacting the number of physicians needed to hit this requirement are sizable. The old method used to rely on a hospital database, but this was thought to bias applications in favor of hospitals. Michigan should consider an MRI database that would be all-inclusive. Another respondent said that an MRI facilities manager had privately acknowledged that 80% of signatures on a CON application were fraudulent; this is relatively easy to police by comparing signatures on p. 1 to those on p. 2. A solution that would address this and also make the process of collecting far less cumbersome (which appears to be a rationalization used by those who submit fraudulent signatures) would be to rely on secure electronic signatures.

Improve Needs Determination Process. One respondent suggested that in rural areas in particular, residents have to drive past a too-busy facility to get to a unit that is available. The current system tracks use, but not patient origin, hence it gives a misleading picture of where demand is coming from, resulting in a maldistribution of units. Tracking patient origin by Zip code would result in a better distribution.

Require ACR Certification. One respondent indicated that volume benchmarks really do not exist for MRI, so he would like to see CON process require all facilities meet American College of Radiology certification requirements.

Other Potential Improvements

Most respondents had no additional suggestions to make, in part because everyone was optimistic that the recent changes made in July 2002 would solve many of the problems specific to MRIs. Of those who offered suggestions, several of the preceding ideas were echoed among the respondent's suggestions for other improvements. Some additional ideas offered included the following.

Address Indigent Care Problem. One respondent thought the state should monitor indigent care levels and may have to consider tax financing of such care if it wants hospitals to survive.

Generic CON Changes. Another respondent had no further MRI-specific suggestions but thought that setting up a process to permit electronic applications and obtain updated standards and other program information through Frequently Asked Questions or similar mechanisms would help streamline the program. In addition, this person thought that some things should be removed entirely from CON consideration such as hospital renovations that do not change number or type of medical services.

Impact of Dropping CON

Impact on Costs, Quality and Access

With one exception, all respondents thought the impact of dropping CON for MRIs would be negative, although their reasons differed. The most common view was that CON removal would result in a proliferation of services, leading to excess use, excess costs and lower quality (either because of the volume-quality relationship or because the limited supply of skilled staff (e.g., radiology techs) would be spread over too many units. Other observations included the following: a) Since Medicare will not pay more for scans, any higher unit costs resulting from the same volume being spread over more facilities were likely to be borne by private patients; b) misutilization is likely to be observed in for-profit facilities where investors are likely to exert pressure to make full use of expensive equipment; this excess utilization of MRIs would not be bad for patient health but clearly would have an undesirable impact on costs; c) while access in general might improve, it probably would not improve or could get worse for the uninsured; d) in the long run, the surge in facilities is likely to lead to eventual shut-down of some of them; e) the state currently has proficiency standards for X-ray and radiation therapy but nothing equivalent for MRI: having accreditation standards may help weed out unqualified providers; f) the shortage of radiation techs is nationwide, not unique to Michigan. It is hard enough to hire such individuals for hospital-based units. A proliferation of freestanding units is likely to draw techs away from hospitals since they can work 9:00-5:00 in outpatient facilities rather than 24-hour shifts in hospitals; g) Blue Cross Blue Shield of Michigan has their own Evidence of Necessity program (EON). Up until a year ago, EON had not approved any freestanding ambulatory

surgical facilities, so the insurance commissioner was forced to make EON rely on CON. This respondent viewed this incident as evidence of collusion between BCBSM and hospitals, i.e., BCBSM is willing to assist hospitals in getting rid of their competition in exchange for favorable hospital payment rates that allow BCBSM to compete more effectively (for a long time, hospitals have had most-favored-nations status with BCBSM, meaning that they are precluded from offering a competing health plan a lower price). This individual felt that without CON, there would be a danger of this kind of activity becoming more common, with nothing to prevent it.

The one exception thought that hospitals needed to figure out their role in the evolving health system; once a technology moves to outpatient, this individual saw no good reason for hospitals to compete with MDs to provide it. This person noted that Blue Cross/Blue Shield of Michigan puts out several products, requires physicians to sign up for all and then ratchets down their fees whereas hospitals continue to get paid generously. One respondent thought that cherry-picking was a legitimate concern as more physicians opened specialty service clinics, but that such adverse effects could in theory be addressed through legislation; this individual thought that elimination of CON for MRIs would improve access and also enable hospitals to be more efficient since they could move units to locations where they were most needed. Another agreed that CON removal could improve efficiency to the extent that having too many units in hospitals was inefficient (e.g., too low capacity over weekends). Another thought that the short-term effects (as described above) would be negative but that the Indiana experience shows that some facilities will fail, which may be good.

CON vs. Market Forces

Three respondents thought that market forces were preferable to CON, with one of these conceding that removal of CON would have negative effects in the MRI market in the short run, but eventually have positive effects as market discipline took hold. Another of these thought that tighter licensing standards would be an adequate safeguard against quality being eroded by new entrants into the market. A fourth respondent thought a mix of CON and market forces was needed.

Nine respondents favored CON, with most noting that for one reason or another, markets do not work very well in health care. The chief concerns were that without CON, quality would be eroded and/or there would be more of a two-tiered system. One of these suggested that some sort of centralized planning process was essential in light of market failures in health care and that CON was preferable to the alternative that might arise were CON to be eliminated: the BCBSM EON program. Yet another noted that CON is better than a broken market, but also pointed out that if CON became a bureaucratic nightmare, this might no longer be true.

Transition from CON

Immediate vs. Gradual Removal of CON

Three respondents thought that if CON for MRI services were to be removed, it should be immediate, although one of these indicated they were not completely sure and another felt that Michigan should wait to see the impact of the latest round of CON changes before taking further action.

One of these thought a more gradual phase-out was preferable, the recommended phase-out periods ranged from 1-2 years to 50 years, with 5 years being the most commonly cited figure. There were several suggestions about how a phase-out could occur: a) first, exempt replacement units for review, then lift all restrictions; b) by gradually setting less stringent standards; c) looking to other states such as Ohio to see how they phased out their programs; d) conducting a pilot test before lifting CON statewide.

In addition, several thought it was important that CON Commission monitor the phase-out to ensure it was proceeding in an orderly fashion. Others thought that without CON, it would be essential for Michigan to establish some sort of regulations regarding standards of care.

Risks Associated with Immediate Removal of CON

Three respondents saw no risks associated with immediate removal of CON: one of these thought that on the contrary, phasing out inevitably lead to a ramping up of political debate over this issue.

Most others thought there would be a proliferation of services, culminating in lower quality and greater financial difficulties for hospitals as paying patients were diverted to for-profit outpatient facilities. Over-building of facilities would be likely to culminate in eventual closure of some and in the worst case, some hospitals might also close. Some also noted that staffing shortages would be aggravated. One of these thought that without BCBSM in the picture, it might be feasible to replacing CON with some sort of centralized process that permitted MRIs to compete head-to-head, which could have beneficial effects on quality only if consumers had information to judge quality reliably. Another felt that the cream-skimming issue has to be addressed. Part of the reason hospitals feel motivated to compete against outpatient facilities is that they see no alternative way of generating profits to cover their uncompensated care losses.