H.B. 5145 (S-1) & 5575 (S-1):
FIRST ANALYSIS

CERTIFICATE OF NEED REVISION

SFA BILL ANALYSIS

Senate Fiscal Agency • Lansing, Michigan 48909 • (517) 373-5383

House Bill 5145 (Substitute S-1 as reported)
House Bill 5575 (Substitute S-1 as reported)
Sponsor: Representative Michael J. Bennane (H.B. 5145)
Representative Wilbur J. Brotherton (H.B. 5575)
House Committee: Public Health
Senate Committee: Health Policy

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RATIONALE

Efforts aimed at gaining some control over rising costs and a rapidly expanding health care industry originated at the state level of government. Arguing that market forces had little effect on restraining rising costs, state governments established a variety of controls designed to achieve a more equitable allocation of health care resources. Community, regional, and statewide needs were factors to be considered in reviewing proposals for new health care services. Michigan's first experiment with certificate of need resulted in the enactment of Public Act 256 of 1972, which dealt with construction, conversion, or modernization of health facilities. Also in 1972, the Federal Social Security Act (Section 1122) was amended to give states the option of entering into contracts with the U.S. Department of Health, Education, and Welfare to administer more comprehensive capital expenditure reviews. These reviews had the effect in Michigan of broadening the regulatory base to include coverage of all health care institutions receiving Medicare and Medicaid funds. By the middle of the 1970s, all but four states operated either a certificate of need or Section 1122 program, or both.

Federal interest in promoting health care cost containment peaked with the passage of the National Health Planning and Resource Development Act in 1975. Under this law, a system of planning and certificate of need review was established. Michigan's response was the passage of the Michigan Health Planning and Resource Development Act (Public Act 323 of 1978), and the certificate of need component to revisions of the State's Public Health Code (Public Act 368 of 1978) followed in 1978. (The health code revisions repealed Public Act 256 of 1972.) Yet, no formal guidelines were established to govern certificate of need until February 1986 when rules were put into place. Although permanent rules were adopted in June 1987, some people argue that the process originally established to control medical costs, has become so cumbersome that it now is expensive and time consuming for health facilities to implement, which has delayed the introduction of technical advances in medicine in the State.

CONTENT

House Bill 5145 (S-1)

The bill would amend the Public Health Code to:

- Require that a certificate of need (CON) be obtained before a person could acquire or operate a new health facility; change the bed capacity of a health facility; initiate a "new service"; acquire covered medical equipment; or, make a covered capital expenditure.
- Establish a CON Standards Commission to approve, disapprove, or revise the designation of clinical services and medical equipment in addition to those services and equipment proposed in Senate Bill 64 (H-5); and to approve, disapprove, or revise CON review standards.
- Require a CON applicant to demonstrate that a proposed project would meet an unmet need in the area proposed to be served.
- Outline activities for which a health maintenance organization would have to obtain a CON.
- Specify projects that would be subject to comparative review.
- Establish time frames for the CON decision-making process.
- Require that the final decision to grant or deny a CON application be made by the Director of the Department of Public Health (DPH) and permit the applicant to appeal the decision to circuit court.
- Revise fees for CON applications, and require that a fee be returned to the applicant if time frames for approval were exceeded.
- Permit certain criteria and procedures to be waived for a CON application and permit the issuance of an emergency CON under certain conditions.
- Create a medical technology advisory committee to assist in the identification of new medical technology.
- Expand penalties for violations of the proposed CON law.
- Specify that a CON issued under the current law would have the same effect as a similar CON issued under the bill.
- Repeal current CON provisions in the Public Health Code.

House Bill 5575 (Substitute S-1)

The bill would amend the Michigan Health Planning and Resources Development Act to:

- Create a 24-member State Health Planning Council within the Executive Office, which would replace the 54-member State Health Coordinating Council.

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- **Require the Health Planning Council to prepare and implement a State health plan that would have to be approved by the Governor and the Legislative committees that have jurisdiction over public health matters.**
- **Specify requirements that the State health plan would have to meet.**
- **Require the Office of Health and Medical Affairs (OHMA) to develop the preliminary State health plan that would have to be transmitted to the State Health Planning Council for review, revision, and approval.**
- **Provide for the Department of Public Health to carry out the Council's activities if the Governor did not appoint Council members.**
- **Require that the Act be reviewed by January 1, 1994, by the Legislative standing committees that cover health matters.**
- **Repeal the Act's provisions on certain activities and powers of the State Health Coordinating Council and OHMA.**

The bills would take effect October 1, 1988. The bills are tie-barred to Senate Bill 64 and House Bill 4525 and to each other. Senate Bill 64 (H-5) would provide for the designation of regional CON review agencies, which would review applications for a CON and could submit these recommendations to the DPH. House Bill 4525 (S-1) provides that a hospital applying for a CON, which met certain criteria, including Federal "swing-bed" requirements, would have to be granted a CON for a short-term nursing care program, and require that a CON be obtained before a short-term nursing care program could be initiated. A detailed description of House Bills 5145 (S-1) and 5575 (S-1) follows.

House Bill 5145 (S-1)

Activities Requiring a Certificate of Need

A person could not do any of the following without first obtaining a certificate of need:

- Acquire or begin operation of a new "health facility". "Health facility would mean a hospital licensed under the Public Health Code; a mental hospital, psychiatric hospital, or psychiatric unit licensed under the Mental Health Code; a nursing home licensed under, or a long-term care unit as defined in the Public Health Code, or a freestanding surgical outpatient facility or health maintenance organization licensed under the Public Health Code. "Health facility" would not include: an institution conducted by and for the adherents of a church or religious denomination in order to provide facilities for the care and treatment of the sick who depend solely on spiritual means through prayer for healing; a health facility or agency located in a correctional institution; a veterans facility operated by the State or Federal government; or, a facility owned and operated by the Department of Mental Health.
- Make a change in the bed capacity of a health facility.
- "Initiate a new service". "Initiate a new service" would mean the initiation of a "covered clinical service", as defined in Senate Bill 64 (H-5), by a person if the covered clinical service had not been offered in compliance with the bill or the Public Health Code's current CON requirements (Part 221) on a regular basis by that person at the location where the covered clinical service was to be offered within the 12-month period immediately preceding the date the service was to be offered. "Initiate a new service" would include, but would not be limited to, the expansion or replacement of an existing covered clinical service or beds dedicated to a covered clinical service if authorized under the bill.
- Acquire "covered medical equipment", as defined in Senate Bill 64 (H-5).
- Make a covered "capital expenditure", as defined in Senate Bill 64 (H-5).

CON Standards Commission

The CON Standards Commission would be created in the Department of Management and Budget. The bill specifies that the Commission would have to make it a priority to review and amend or rescind, or both, the standards, policies, and guidelines set forth in the bill.

The Commission would have to be appointed within six months after the bill's effective date and would have to consist of 15 members. Nine members would be appointed by the Governor with the advice and consent of the Senate. Three members would have to be appointed by the Senate Majority Leader and three by the Speaker of the House. The bill details interests the members would have to represent, including health care provider organizations and health care purchasers, as defined in House Bill 5575 (S-1), and health care consumers. "Consumer of health care" would mean an individual who met all of the following requirements: was not a purchaser or payer of health care; was not a member of the immediate family of either a licensed health professional or a provider of health care; and, did not hold a fiduciary position with, or have a fiduciary interest in, a health facility. A health care consumer could represent an organization including, but not limited to, a labor union, senior citizen organization, or social welfare group.

In making appointments, the Governor, Senate Majority Leader, and Speaker of the House, to the extent feasible, would have to assure that membership was representative of the various geographic regions of the State. Each member would have to have knowledge or expertise relevant to health care, as demonstrated by at least five years of related experience in health care. The bill would require that nominations for members come from a wide range of sources including business and professional associations, educational institutions, consumer organizations, labor unions, provider organizations, senior groups, the Department of Public Health, and other health care-related organizations. The bill also would outline the terms of office for members, operating procedures of the Commission, reason for removal of a member, and compensation. The Department and Office of Health and Medical Affairs would be required to assign professional employees to assist the Commission in the performance of its responsibilities.

Commission Responsibilities

The Commission would be required to do all of the following:

- Upon submission by the Department and OHMA, approve, disapprove, or revise and return to these agencies: 1) the designation of covered clinical services and covered medical equipment, in addition to the covered services and equipment proposed in Senate Bill 64 (S-1); 2) the deletion or revision of those services and equipment; and 3) CON review standards that established the need, if any, for new services, covered medical equipment, new health facilities, changes in bed capacity, or covered capital expenditures, including conditions, standards, assurances, or information that would have to be met, demonstrated, or provided by a person who applied for a CON; and, proposed data reporting requirements and criteria for determining health facility viability. A CON review standard also

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could establish ongoing quality assurance requirements including any or including any or all of the requirements specified in the bill. The State Health Coordinating Council could perform these duties or approve or disapprove a standard only until all members of the Commission were appointed and confirmed or until five months after the bill's effective date, or sooner.

- Direct the Department and OHMA to prepare and submit recommendations regarding Commission duties and functions that were of interest to the Commission.
- Annually assess the operations and effectiveness of the CON program.
- Make recommendations, every four years after the bill's effective date, to Legislative standing committees with jurisdiction over public health regarding statutory changes to improve the CON program, including but not limited to threshold levels for capital expenditures, the Commission's role, CON review standards, and the need for the CON program.
- Upon submission to the Department and OHMA, approve, disapprove, or revise and return to these agencies: standards that would be used by the Department in designating a regional CON review agency, and CON review standards governing the acquisition of new technology.
- Approve, disapprove, or revise and return to the Department and OHMA proposed procedural rules for the CON program, in accordance with the bill's provisions on a CON applicant's demonstrating that a project would meet an unmet need in a proposed service area.
- Modify the 100 licensed bed limit set forth in the bill, if determined by the Commission to be consistent with the bill.
- Consider the recommendations of the Department and the Attorney General as to the administrative feasibility and legality of proposed actions concerning the designation of clinical services and equipment, CON review standards, and Commission duties.
- Consider the impact of a proposed restriction on the acquisition of equipment or availability of services on the quality, availability, and cost of health services in the State.

Before the Commission took final action on the designation of clinical services and equipment, CON review standards, proposed data reporting requirements for determining health facility viability, standards for designating a regional CON review agency, CON review standards governing the acquisition of new technology, or the modification of the 100 licensed bed limit, the Commission would be required to conduct a public hearing and submit the proposed action to the Governor and Legislative standing committees on public health matters. The Governor or Legislature could disapprove the proposed action within 30 days after it was submitted. Legislative disapproval would have to be expressed by concurrent resolution, stating specific objections, that would have to be adopted by a record roll call vote of each house of the Legislature. If the proposed action were not disapproved, it would be binding on all persons affected 30 days later or on a later date specified in the proposal.

Legislative Review

Every five years after the bill took effect, the Legislative standing committees with jurisdiction over public health matters would be required to make findings and recommendations regarding any changes in, or the continuation of, the CON program after consideration of the recommendations submitted by the Commission pursuant to the bill's requirements for a four-year review of the CON program by the Commission.

Application Fees

The bill would revise CON fees and require a base fee of $750 for each application. For a project requiring a projected capital expenditure of more than $150,000 but less than $1.5 million, an additional fee of $2,000 would be added to the base fee. For a project requiring a projected capital expenditure of $1.5 million or more, of $3,500 would be added.

If reports received from the Department indicated that the CON application fees collected had not been within 10% of one-half the cost to the Department of implementing the bill, the Commission would be required to make recommendations regarding the revision of those fees so that the CON application fees collected equaled approximately one-half of the cost to the Department for implementing the bill.

Standards

Except as otherwise provided in the bill for pending appeals, until other CON review standards were approved by the Commission pursuant to the bill, the Department could use documents specified in the bill as standards, policies, and guidelines that would affect: general acute care beds; long-term care services; cardiac services; extrarenal organ transplantion services; special diagnostic radiological procedures rooms—excluding procedure rooms used only for general radiology and fluoroscopy procedures; specialized radiation therapy services—including but not limited to linear accelerators and cobalt units; neonatal intensive care services—including special newborn nursery services; extracorporeal shock wave lithotripsy; magnetic resonance units; mobile computed tomography scanners; fixed computed tomography scanner services; psychiatric hospitals and units; and surgical facilities—including but not limited to surgical facilities in hospital or outpatient settings. The bill specifies that these standards, policies, and guidelines would not be incorporated by reference into the Public Health Code, and this provision would not affect the legal status of the standards, policies, and guidelines.

No later than six months after the confirmation of all 15 members, the Commission would be required to hold a public hearing on the standards, policies, and guidelines. Based on the public hearing and other information available to it, the Commission would be required to establish a schedule for the orderly review and revision of the standards, policies, and guidelines and to direct the Department and OHMA to adhere to the schedule in the development of proposed or revised CON review standards.

Department of Public Health Requirements

The Department would be required to do all of the following:

- Develop rules authorized in the bill in conjunction with OHMA.
- Report to the Commission at least three times each year on the performance of the Commission's duties.
- Develop, in conjunction with OHMA, proposed CON review standards for submission to the Commission.
- Administer and apply CON review standards.
- Report, annually, to the Commission on the costs to the Department of implementing the bill and the CON application fees collected in the preceding State fiscal year.

In developing a proposed CON review standard, the Department would be required to appoint an ad hoc advisory committee which would be required to assist in

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the development of the proposed standard and would have to have the opportunity to review and comment on the proposals submitted to the Commission. The ad hoc committee would have to include all of the following: experts in the subject of the proposed standard, who would have to constitute a majority of the ad hoc advisory committee; representatives of health care provider organizations concerned with licensed health facilities or licensed health professions; and, representatives of organizations concerned with health care consumers and the purchasers and payers of health care services.

CON Applications

A CON applicant would have to include as part of the application a statement addressing review criteria described below. The bill specifies that this would not apply to a CON application for a short-term nursing care program, as proposed in House Bill 4525 (S-1).

In order to be approved, a CON applicant would have to demonstrate to the Department's satisfaction that the proposed project would meet an unmet need in the area proposed to be served. The need for a proposed project would have to be demonstrated by credible documentation of compliance with the applicable CON review standards or, if none, by credible documentation that the proposed project would be accessible geographically and efficiently and appropriately utilized in the light of the type of proposed project and the existing health care system, including approved projects that were not yet operational, proposed projects under appeal from a final decision of the Department, or proposed projects that were pending final Department decision. If, and only if, these requirements were met, in order for an application to be approved, an applicant also would have to demonstrate to the reasonable satisfaction of the Department all of the following:

- With respect to the method proposed to meet the unmet need, that the project used the most efficient and effective feasible methods available to the health care industry; in the case of a project proposing physical plant expansion, that the project was the most efficient and effective expansion alternative after consideration of at least new construction, modernization, lease, or purchase; and, in the case of proposed new construction, that the project was the most appropriate construction option.
- With respect to the financial aspects of the proposed project, that: the project, in terms of capital costs, was the least costly project, in light of available alternatives; the project represented the least costly alternative of providing the health facility, service, or equipment; funds were available to meet the capital and operating needs of the project; the project used the least costly method of financing, in light of available alternatives; and, in the case of a construction project, the applicant stipulated that the applicant would bid competitively capital expenditures among qualified contractors, or alternatively, the applicant presented satisfactory evidence to the Department that the applicant was proposing an alternative to competitive bidding that would result in the least costly method for implementing the project.
- The proposed project would be delivered in compliance with applicable operating standards and quality assurance standards including one or more of the following: mechanisms for assuring appropriate use of the project, methods for evaluating its effectiveness, means of assuring its delivery by qualified personnel and in compliance with applicable safety and operating standards, evidence of the current and historical compliance with Federal and State licensing and certification requirements in this State by the applicant or the applicant's owner, or both, to the degree determined appropriate by the Commission in light of the subject of the review standard; and, other criteria approved by the Commission as appropriate to evaluate the quality of the project.
- The proposed health services would be delivered in a health facility that met the criteria, if any, established by the Commission for determining health facility viability. The criteria would have to be proposed by the Department and OHMA, and approved or disapproved by the Commission. At a minimum, the criteria would have to specify, to the extent applicable to the applicant, that an applicant would demonstrate viability by demonstrating one of the following: a minimum percentage occupancy of licensed beds, of combined uncompensated discharges and discharges under Title XIX of the Federal Social Security Act in the health facility's planning area, and, of the total discharges in the health facility's planning area; evidence that the health facility was the only provider in its planning area of a service that was considered essential by the Commission; an operating margin in an amount determined by the Commission; and, other criteria approved by the Commission as appropriate for Statewide application to determine health facility viability.
- In the case of a nonprofit health facility, the health facility was in fact governed by a body composed of a majority consumer membership broadly representative of the population served. In the case of a health facility sponsored by a religious organization, or if the nature of the nonprofit health facility was such that the legal rights of its owners or sponsors might be impaired by a requirement as to the composition of its governing body, an advisory board with majority consumer membership broadly representative of the population served could be construed by the Department to be equivalent to the governing board described in this subdivision, if the advisory board met all of the following requirements: the role assigned to the advisory board was meaningful, as determined by the Department; the board's functions were clearly prescribed; and, the board was given an opportunity to influence policy formulation by the legally recognized governing body, as determined by the Department.

Health Maintenance Organization

A health maintenance organization (HMO) would be required to obtain a CON only for one or more of the following purposes:

- The acquisition, purchase, new construction, modernization, or replacement of, or addition to, a hospital or other health facility providing inpatient services, if a covered capital expenditure were required.
- The acquisition of covered medical equipment.
- A covered capital expenditure that was proposed to be undertaken by an HMO and was not intended principally to serve the needs of the enrollees of the HMO, as determined by the Department.

In making determinations and conducting reviews for CONs for HMOs, the Department would be required to consider special needs and circumstances of HMOs, and would have to apply the following criteria: the availability of the proposed service from a health care provider other than an HMO on a long-term basis, the long-term needs of the HMO, and the long-term impact of the proposed service on health care costs in the service area.

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Comparative Review

The following proposed projects would be subject to comparative review: projects specified as subject to review in a CON review standard; projects that, when combined, exceeded the planning area's need; and new beds in a hospital or nursing home, if there were multiple applications to meet the same need for projects that, when combined, exceeded the planning area's need, as determined by applicable review standards. Replacement beds in a hospital or nursing home that were proposed for construction on the original site, on a contiguous site, or within a five-mile radius of the original site would not be subject to comparative review.

Until otherwise established in a CON review standard by the Commission, the establishment or expansion of the following services would be subject to review if applications exceeded the service area's need: open heart surgery, megavoltage specialized radiation therapy, neonatal intensive care unit or special newborn nursery unit services, extracorporeal shock wave lithotripsy services, extrarenal organ transplantation services, and air ambulance services.

CON review standards approved by the Commission could establish comparative review or an alternative procedure based on specific considerations, as outlined in the bill. If an applicant involved more than one health facility, the application would have to indicate the proposed site for the project and arrangements for the utilization and financing of the covered medical equipment or covered clinical services.

If an application under comparative review or appeal were not subject to comparative review under the proposed provisions or standard, the application could be withdrawn and resubmitted as a new application.

In evaluating applications for a health facility in a comparative review, the Department would be required to include participation in Title XIX of the Federal Social Security Act as a distinct criterion, weighted as very important, and determine the degree to which an application met this criterion based on the extent of participation in the Medicaid program.

CON Application Decisions

The decision to grant or deny a CON application would have to be made by the Director of the DPH. Failure to comply with the bill's provisions or a term, condition, or stipulation of a CON issued under these provisions, or both.

A decision would have to be proposed to the Director by a bureau within the Department designated by the Director as responsible for the CON program. A decision would have to be in writing and indicate either approval, disapproval, approval with conditions, and approval with stipulations. Conditions would have to be explicit and related to the proposed project and would have to specify a time limit—up to one year after the decision was made—for the conditions to be met. If the Department were conducting a comparative review, the Director could issue only one decision for all applications included in the comparative review.

Before a final decision was made, the bureau would have to issue a proposed decision that individually addressed each of the bill's criteria and specified the reasons and authority of the Department for the proposed decision. The Department would have to transmit a copy of the proposed decision to the applicant, who would have 60 days to file written exceptions with the bureau. The bureau would have to respond in writing to the exceptions. The Department would be required to send the applicant a copy of the bureau's response to the exceptions within 60 days after they were received by the bureau. Unless a hearing was requested, the proposed decision, exceptions, if any, and replies to exceptions would have to be submitted to the Director by the bureau on the earliest of dates specified in the bill. The Director would be required to review the proposed decision, exceptions, and replies before a final decision was rendered.

The Director would be required to issue a final decision no later than 60 days after the date of a proposed decision, exception and reply to an exception was submitted to the Director. The final decision could be appealed only by the applicant and only on the record directly to the circuit court in the county where the applicant had its principal place of business or the Ingham County Circuit Court. Judicial review would be governed by the Administrative Procedures Act.

Appeals pending or brought pursuant to an application filed under the current CON law would continue under those provisions. The CON board created under the current law would continue to perform its functions until all appeals lawfully brought under the current law were concluded.

If the Department exceeded the bill's time frames for other than good cause, as determined by the Commission, upon the applicant's written request, the Department would be required to return to the applicant all of the CON application fee paid by the applicant. If an applicant did not believe that the decision documents were adequate for the Director to make a final decision, the applicant could request a hearing to demonstrate to the Department that the application met the requirements for approval. The bill would detail the time frames for conducting a hearing.

As a condition precedent to the issuance of a CON, the Department could require a health facility to provide it with data and statistics that the Department considered necessary if that information had not already been reported to the Department.

A CON would cease to be effective if approval were based on a stipulation that the project would participate in Title XIX of the Federal Social Security Act and the project had not participated in the Medicaid program for at least 12 consecutive months within the first two years of operation.

CON Waiver

The Department could waive applicable provisions and procedural requirements and criteria for review upon the applicant's showing, by affidavit, certain circumstances as specified in the bill, including the need for temporary relief due to natural disaster and other emergency conditions, a serious adverse effect of delay, lack of substantial change in facilities or services that existed before the emergency circumstances, and the temporary nature of the construction of facilities. The Department also could issue an emergency CON, according to certain conditions specified in the bill.

New Technology

A person could not acquire new technology before the end of a new technology review period, which would be the period ending 12 months after the date of Federal Food and Drug Administration (FDA) approval of the technology for commercial use, unless one of the following occurred: the Department, with concurrence of the Commission, issued a public notice, which could apply to specific new technology or class of new technology, that the technology would not be added to the list of covered medical

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equipment during the new technology review period; the person complied with the bill's requirements on acquiring new technology before approval by the FDA; or, the Commission approved the addition of the new technology to the list of covered medical equipment and the person obtained a CON for that equipment.

To assist in the identification of new medical technology in the earliest possible stage of development, the Department and OHMA would be required to appoint a standing advisory committee, composed of representatives of health care provider organizations concerned with licensed health facilities or licensed health professions and other persons knowledgeable in medical technology.

Unless the Commission provided otherwise in a standard approved under the bill's provisions, a person could acquire new technology before it was approved by the FDA if the person notified the Department before acquiring the technology and that technology continuously met requirements specified in the bill as to operation, relation to research on its safety for use on human subjects, funding, and use. The bill would establish requirements as to the technology's deactivation and removal from service.

Compliance

The Department would be required to monitor compliance with CONs as to project costs and conditions and stipulations contained in a decision to approve an application. The Department could investigate allegations of noncompliance with a CON. The bill would outline actions the Department could take for noncompliance including revoking or suspending the CON, imposing a civil fine up to the amount of the billings for the services provided in violation of these provisions, issuing of a compliance order, and taking other enforcement actions.

A person could not recover costs for services provided or for equipment or facilities that were acquired in violation of the bill. If a person had violated these provisions, in addition to sanctions specified, the person would be required, upon request of the person from whom the charges were collected, to refund those charges.

Bed Capacity

If a hospital had a high occupancy rate, as determined by the Department, and was issued a CON for an increase in licensed bed capacity, the Department could enter into an agreement with the hospital to authorize it to lease space and operate beds in another hospital in the same planning area, if the other hospital had a low occupancy rate. The Department could enter into such an agreement only if all of the following applied: the hospital issued a CON had a documented history of high occupancy, the alternative of redistributing the beds within the hospital's licensed bed capacity did not exist, the agreement would not change the overall supply of beds within the planning area, new construction was not required, and the Department determined that the agreement was necessary to protect the public health, safety, and welfare. The Department could revoke the CON for increased bed capacity if one or more of these conditions no longer applied.

The list of subareas having excess hospital beds, specifying the appropriate hospital capacity and the number of excess hospital beds by subarea, most recently published by the Department, and the plans for reducing excess beds by subarea most recently approved, would continue in effect, except as provided by the bill. A hospital that was not in compliance with its hospital capacity reduction responsibility or that had not committed to such compliance would be required to comply as a condition for approval of a CON application. If the Department determined that the number of beds in a subarea did not exceed the number of beds specified in the current CON law, then the reduction plan would be considered by the Department to have been implemented.

Additional Provisions

Notwithstanding other remedies, the Department could request the Attorney General or prosecuting attorney of the jurisdiction where a capital expenditure was proposed or was made to bring an action to restrain or prevent a violation of the bill or rules promulgated under it. The Department, with Commission approval, could promulgate rules to implement the bill. Pursuant to the Administrative Procedures Act, rules promulgated under the current CON law would remain in effect until amended or rescinded by the Department.

The bill specifies that a CON issued under the current law would have the same effect as a similar CON issued under the bill's provisions. The holder of a CON would be subject to all of the conditions, stipulations, and agreements pertaining to the CON and to the same authority of the Department to limit, suspend, revoke, or reinstate the CON as a holder of a CON issued under the bill.

Under the bill, the Department could enter into an agreement with the Michigan State Hospital Finance Authority to review proposed bond projects related to applications for a CON and to make the determination regarding the applicablility of these provisions to such projects as required by the Hospital Finance Authority Act. The agreement would have to authorize the Department to provide information on any proposed bond project considered appropriate by the Department and would have to provide funding for the staff needed to implement this provision.

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House Bill 5575 (S-1)

State Health Planning Council

The State Health Planning Council could be created in the executive office of the Governor, and would consist of 24 voting members appointed by the Governor with the advice and consent of the Senate. The bill would delete references to the 54-member Statewide Health Coordinating Council.

Eight members of the planning Council would have to be appointed from each of the following categories: health care consumers, providers, and purchasers or payers. The bill would provide for staggered terms for the members.

State Health Planning and Health Policy Development

The Council would be required to carry out the following activities relating to State health planning and policy development:

- Prepare and approve the State health plan at least once every three years, subject to the bill's requirements for the plan. The Council could revise individual components of the plan as it considered necessary.
- Submit the proposed plan to the Governor and the standing committee in the Senate and House of Representatives with jurisdiction over public health matters. The Governor or Legislature could disapprove the plan within 60 legislative session days after submission. The bill would define "legislative session day" and outline procedures for computing this time. Legislative disapproval would have to be expressed by concurrent resolution, stating specific objections to the plan, that would have to be adopted by a record roll call vote of each legislative house. If the proposed plan

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were disapproved, the Council would be required to revise the plan based on stated objections. If not disapproved within the 60 legislative session days, the plan would be considered approved.

- Annually review program activities and budgets of State departments that were related to health and medical care to determine consistency of these activities and budgets with the State health plan. The Council would be required to report its conclusions to the Governor, appropriate legislative committees, and other affected agencies.
- Actively pursue implementation of the recommendations contained in the State health plan. An annual implementation plan would have to be prepared and submitted to the Legislature, Governor, and other interested parties.
- Provide a public forum for the discussion and identification of priority health issues.
- Make recommendations to the Governor, Legislature, and affected agencies regarding current or proposed changes in Federal and State health statutes, policies, and budgets, that took into account the State health plan.
- Cooperate with legislative committees having jurisdiction over health matters and advise in the development of a consistent and coordinated policy for State health affairs.
- Assess the policies and rules of State departments and agencies concerning the collection and application of statistics relating to health, health planning, and health policy development, and periodically make recommendations to the Governor, Legislature, and other affected agencies for improvement and coordination of the statistics. The Council would be required to report its conclusions to appropriate Legislative committees, the Governor, and affected agencies. The report would have to recommend, at a minimum, policies concerning accessibility of data, uniformity and reliability of data, independent and shared use of data, and coordination of health data systems.
- Perform other duties as specified in Part 222 (certificate of need) of the Public Health Code, as proposed in House Bill 5145 (S-1).

The bill specifies that the Council could not delegate its responsibility for the final approval of the State health plan.

State Health Plan

The State health plan would be required to do all of the following:

- Address mechanisms to promote adequate access to health care for all segments of the State's population.
- Outline initiatives designed to contain the costs of health care and improve the efficiency of service delivery.
- Address ways in which changes in individual behavior and responsibility could assist in reducing health care costs.
- Promote innovative and cost effective strategies for projecting and addressing the poplulation's future needs.
- Encourage the rational development and distribution of health care services.
- Suggest means by which the quality of health care services could be improved through changes in the delivery system.
- Promote cooperation between the public and private sectors in meeting these requirements.

Office of Health and Medical Affairs

The Office of Health and Medical Affairs, which currently is housed in the Department of Management and Budget, would be required to develop the preliminary State health plan after review and consideration of input from other public and private agencies, including, but not limited to, local health related entities. The preliminary plan would have to be transmitted to the State Health Planning Council for review, revision, and approval.

The bill would delete certain provisions currently dealing with the preparation and administration of the State administrative program, review of certain plans and policies for the development of the preliminary State health plan, and development and administration of a State medical facilities plan. The bill would retain provisions on OHMA providing administrative support for the Council, and the director serving as secretary of the Council.

In addition to the new and retained duties, OHMA would be required to do all of the following:

- Collect and publish technical and other information, if not duplicative, that would promote informed decision-making by individuals and groups related to services, financing and delivery systems, and health benefit design.
- Identify priority health issues and create strategies to address these health issues in a coordinated manner. The Office could convene appropriate groups and consult with the Council in carrying out the Office's duties.
- Develop recommendations to improve the organization, delivery, and financing of health care.
- Advise the Governor and the Legislature on the steps needed to achieve and facilitate a consistent and coordinated policy for health affairs in the State.
- Perform other duties as specified in Part 222 of the Public Health Code, as proposed in House Bill 5145 (S-1).

These duties would be in addition to duties prescribed in the Act except for those concerning the monitoring and evaluation of decisions of health systems agencies as to proposed uses of Federal funds, the provision of technical assistance to certain agencies for promoting health planning and resources development, and the making and receipt of grants as well as entering into contracts, which the bill would delete.

Transition

The bill specifies that the current Statewide Health Coordinating Council could perform the duties of the proposed State Health Planning Council until all 24 members of the Council were appointed and confirmed or five months after the bill's effective date, whichever was sooner.

If the Governor did not appoint the Council members, the Department of Public Health could carry out the activities prescribed in the bill for the Council relating to State health planning and policy development as well as other duties prescribed for the Council under the bill.

MCL 325.2001 et al.

SENATE COMMITTEE ACTION

The Senate Committee on Health Policy adopted a substitute to House Bill 5575 that would permit, but not require, the Governor to appoint the State Health Planning Council. The Committee also adopted a substitute to House Bill 5145 which removed the "incorporation by reference" of guidelines and provisions that have been used to administer the certificate of need law; increased from two miles to five miles the radius for noncomparative reviews; included provisions currently found in the Public Health Code on health maintenance organizations; and provided for a process to appeal a decision on a certificate of need application.

FISCAL IMPACT

House Bill 5145 (Substitute S-1)

House Bill 5145 and Senate Bill 64 (H-5) together would have an indeterminate impact on State expenditures. The impact would depend on the number of CON applications filed with the DPH; the extent to which existing resources could be used; the number of CON commission meetings held; and the number of exceptions to or violations of DPH CON decisions. The DPH estimates that the bills would require an additional 9.5 FTE positions and approximately $300,000. (The current CON program budget is approximately 25.0 FTEs and $1.3 million.) Based on current CON applications and decisions, the bills would have no appreciable impact on State Medicaid Program expenditures. The bills would also increase CON application fee revenues by between $200,000 and $350,000 annually. (Currently CON application fee revenues are approximately $400,000 annually).

House Bill 5575 (Substitute S-1)

The bill would result in an indeterminate reduction in expenditures related to the activities of the Statewide Health Coordinating Council (SHCC) due to the decrease in membership from 54 to 24 of the proposed State Health Planning Council. The bill would have no impact on Office of Health and Medical Affairs (OHMA) expenditures. The FY 1987-88 appropriation for OHMA, including the SHCC, is approximately $1.5 million of which more than $1.1 million is appropriated from the State General Fund.

ARGUMENTS

Supporting Argument

House Bills 5145 and 5575 along with House Bill 4525 and Senate Bill 64 comprise a package designed to reform the certificate of need process. Representatives of health care facilities, State health agencies, business, and labor reportedly have been working for about a year to develop statutory reform proposals to create a predictable, enforceable, and timely certificate of need program that could assure that needed services and medical technology would be available at reasonable cost to the State's citizens. Designed and administered properly, the CON process can play and important role in restraining health care costs, guaranteeing quality services, and assuring equitable distribution of and access to health care. The package attempts to strike a balance that would allow for the meaningful regulation of new capital expenditures and, at the same time, not discourage innovation or deny Michigan residents the benefits of new advances in medical technology.

Opposing Argument

According to a Federal Trade Commission (FTC) study of Michigan's CON program, issued in March 1988, the FTC found that: CON programs do not result in health care cost savings, but may actually increase costs; continued CON regulation is unlikely to benefit health care consumers in the State; and, CON laws, in effect, pose a "hidden tax" on all health services in the form of higher prices and lower quality. Continued CON regulation, the FTC concluded, would be contrary to the interests of Michigan's health care consumers. Ongoing changes in the health care financing system are eliminating the principal grounds that prompted CON regulation—namely, that unregulated competition would result in the construction of unnecessary facilities, unnecessary expansion of existing facilities, or unnecessary capital expenditures by health facilities. The FTC also concluded that the CON regulatory process does not appear to serve its intended purpose of controlling health care costs and actually may defeat that purpose by interfering with competitive market forces that otherwise would help contain costs. Thus, reform of the CON process may not be enough. If the process only is to be revised and not eliminated, however, then steps should be taken to reduce the negative effects of the CON system.

Response: One could argue that the FTC report actually supports the bills, which would address the very problems that may have invoked the FTC's criticism: the cumbersome and time consuming nature of the CON process and its costs to providers and consumers. Both interest groups would benefit, for example, from the proposed deadlines within the approval process, and consumers as well as the health care industry would benefit from the introduction to the State of new medical technology. Also, a 24-member health planning council could no doubt operate more effectively and efficiently than the 54-member health coordinating council.

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