

# HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Tuesday, October 12, 2004

MDCH Public Health Building #19  
North Complex Baker-Olin West (BOW)  
3423 North Martin Luther King  
Manty Conference Rooms 1B & 1C  
Lansing, MI 48906

## APPROVED MINUTES

### I. Call to Order.

Chairperson Dale Steiger called the meeting to order at 10:10 a.m.

#### a. Members Present and Organizations Represented:

Dale L. Steiger, Blue Cross Blue Shield of Michigan, Chairperson  
Robert Asmussen, Ascension Health/St. John Health System  
James F. Ball, Michigan Manufacturers Association  
Brooks F. Bock, MD, Wayne State University (Alternate)  
Greg S. Dobis, McLaren Health Care  
James B. Falahee, Jr., Bronson Healthcare Group  
Stephen Fitton, Michigan Department of Community Health (arrived at 10:10 a.m.)  
Maureen A. Halligan, Genesys Health System  
Robert Meeker, Alliance for Health  
Patrick G. O'Donovan, Beaumont Hospitals  
Vinod K. Sahney, Henry Ford Health System (arrived at 10:30 a.m.)  
Thomas Smith, Economic Alliance for Michigan  
Kenneth G. Trester, Oakwood Healthcare, Inc. (arrived at 10:15 a.m.)  
Robert Yellan, The Detroit Medical Center

#### b. Members Absent and Organizations Represented:

John D. Crissman, MD, Wayne State University, School of Medicine  
Eric Fischer, The Detroit Medical Center  
Denise Holmes, Michigan State University, College of Human Medicine  
Carol Parker Lee, Michigan Primary Care Association  
Sande MacLeod, UFCW 951  
Anne Rosewarne, Michigan Health Council

c. Staff Present:

Lakshmi Amarnath  
Jan Christensen  
Tom Freebury (arrived at 10:20 a.m.)  
Larry Horvath (arrived at 10:20 a.m.)  
John Hubinger  
Andrea Moore  
Stan Nash  
Brenda Rogers (left at 1:00 p.m.)  
Gaye Tuttle

d. General Public in Attendance:

There were approximately 25 people in attendance.

**II. Declarations of Conflicts of Interest.**

None were noted.

**III. Review of Agenda.**

Chairperson Steiger noted for the record that action would be taken on items VI, VII, and VIII. Motion by Mr. Ball, seconded by Mr. Falahee, to accept the agenda as presented. Motion Carried.

**IV. Review of Draft Minutes of August 10, 2004.**

In Section I (a) the spelling of Dr. Bock's name was corrected. Motion by Dr. Bock, seconded by Mr. Ball, to accept the minutes as adjusted. Motion Carried.

**V. Work Groups Report.**

**A. Travel Time Methodology.**

Mr. Meeker provided an overview of the workgroup's progress (Attachment A).

Dr. Richard Groop and Dr. Joe Messina provided a presentation of the maps. Discussion followed.

**B. Beds Per Population Methodology.**

Mr. Meeker provided an overview of the workgroup's progress. (Attachment A)

**C. Modification of Sub-Area Methodology.**

Mr. Meeker provided an overview of the workgroup's progress. (Attachment A)

**D. Modification of Replacement Zone for Hospital Beds.**

Mr. Meeker provided an overview of the workgroup's progress. (Attachment A)

**VI. Report to CON Commission at the September 14, 2004, Meeting.**

**A. Travel Time Methodology.**

Motion by Mr. Ball, seconded by Mr. Yellan, to create an exception to the bed need methodology to establish a new hospital (population of not less than 50,000 using the travel time methodology, utilizing slowest route according to MDOT).

Discussion followed.

Peg Reheimer, Botsford General, addressed the Committee.

Larry Horwitz, Economic Alliance, addressed the Committee.

Motion Carried.

Motion by Mr. Meeker, seconded by Mr. Asmussen, to define a qualifying hospital for purposes of the exception, as having licensed acute care hospital beds with 24-hour Emergency Room, OB and surgical services.

Discussion followed.

Mr. Larry Horwitz, Economic Alliance, addressed the Committee.

Motion Carried.

Lunch Break from 12:00 noon to 12:40 p.m.

**B. Beds Per Population Methodology.**

Motion by Mr. Smith, seconded by Mr. Yellan, that the Beds Per Population Methodology not be adopted by the Committee.

Discussion followed.

Motion Carried.

**C. Modification of Sub-Area Methodology.**

Discussion regarding the proposal.

Larry Horwitz, Economic Alliance, addressed the Committee.

Motion by Mr. Falahee, seconded by Mr. Bock, to not pursue the Modification of Sub-Area Methodology.

Discussion followed.

Motion Carried.

**VII. Bed Pool for Indigent Care.**

Mr. Christensen provided an overview of the proposed language and written Standards Comparison (Attachment B).

Discussion followed.

Motion by Mr. Yellan, seconded by Dr. Bock, that the Committee not adopt this proposal and not submit it to the Commission.

Discussion followed.

Motion Carried.

Larry Horwitz, Economic Alliance, addressed the Committee.

**VIII. Relocation of Hospital Beds.**

Ms. Joan Lowe, Pontiac Osteopathic Hospital, addressed the Committee and provided written overview of her proposal (Attachment C).

Committee discussion followed.

Motion by Mr. Meeker, seconded by Dr. Bock, to disapprove this proposal. Motion Carried.

**IX. Comparative Review Informal Workgroup.**

Mr. Steiger asked for volunteers to be on an informal workgroup to draft comparative review standards. Interested parties were to contact the Department by Thursday, October 14, 2004, at 4:00 p.m. Mr. Meeker stated that the previous TAC had worked on this issue and Mr. Meeker would forward their documentation to Mr. Steiger for this workgroups use.

**X. Workgroup – Overview of Remaining Issue.**

Mr. Meeker listed the following items to be handled by the workgroup at future meetings.

- a. Continue work with the MSU maps to determine population and bed need.
- b. Begin draft language for proposal.
- c. Rural/urban differences need to be defined.
- d. Definition of minimum or maximum size.

**XI. Future Meeting Date – October 27, 2004 and November 10, 2004.**

No changes made.

**XII. Public Comment.**

None received.

**XIII. Adjournment.**

Motion by Mr. Meeker, seconded by Mr. Ball, to adjourn the meeting at 3:10 p.m. Motion Carried.

## Hospital Access Work Group

### Report to the Hospital Bed SAC

October 12, 2004

The Hospital Access Work Group was charged with attempting to identify circumstances related to inadequate access to community hospital in the state and to objectively quantify those situations in ways that could be translated into specific exceptions to the acute care bed need methodology (ACBNM) in the CON Review Standards for Hospital Beds. In the process, the Work Group identified the type of new hospitals which would qualify for such an exception as follows: *licensed acute care hospitals with 24 hr. emergency services, obstetrical services and surgical services.*

The Work Group had an open membership and accepted participation from any interested party. A total of 33 different people attended one or more of the nine (9) Work Group meetings held between July 1 and October 4, 2004. Two additional meetings have been scheduled, if necessary. A list of the participants is attached to this report.

The Work Group considered four (4) proposals related to access to hospitals within Michigan. Following is a list of the proposals considered by the Work Group and summarized in this report:

- 1) Travel Time
- 2) Beds-per Population
- 3) Sub-Area Modification
- 4) Relocation Zone Modification

## Travel Time Methodology

Policy Issue: Michigan residents should have access to a community hospital within 30 minutes travel time from their homes.

Description: The Work Group identified this method as having the greatest potential for providing an objective approach to account for problems of access to hospitals. It is designed to identify “pockets” of Michigan’s population, which have inadequate access to basic hospital services (measured by travel time), and which represent at least a minimum critical mass of demand for inpatient acute care.

As described previously, the following decision rules are recommended to determine inadequate access to basic hospital services:

- a Basic hospital services requiring community access -- acute care beds & 24 hr. emergency services
- b Maximum acceptable average travel time to basic hospital services -- 30 minutes

Representatives of the Department of Geography from MSU have mapped a 30-minute travel time radius around all existing community hospitals meeting the above criteria. In so doing, they employed a typology of urban and rural roads developed by MDOT. Average speeds on these roads are assumed to be the posted speed limit. To counterbalance the concern about varying degrees of traffic congestion at different times of the day, the model uses the slowest route available between hospital locations and local populations. For this reason much of the work group believes that no further adjustment is warranted in the travel time model.

The final decision rule from the work group relates to the minimum population in an identified “limited access” area to require a new hospital. The Work Group suggests a minimum of 50,000 population in such an area in an urban or suburban region, although some members expressed concerns that this figure is too low to sustain a potential new hospital. Where such “limited access” areas are identified using the travel time model, the bed need methodology from the CON Review Standards is applied the population to determine the number of hospital beds needed in the area.

Using these and the previously recommended decision rules, maps of the “limited access” areas are presented.

Recommendation: This approach represents an objective population-based method of identifying and quantifying inadequate access to hospital beds in the state. It can be translated into defensible language to provide for exceptions to the ACBNM in the CON Review Standards.

## **Beds per Population Methodology**

Policy Issue: Michigan residents should have access to a sufficient number of community hospital beds within 30 minutes travel time from their homes.

Description: This approach is designed to identify “pockets” of Michigan’s population, which have inadequate access to a sufficient number of beds in facilities providing basic hospital services. Unlike the previous approach, it would answer the question: “Are there *enough* hospital beds within 30 minutes travel time of existing hospitals?”

The final method to operationalize this approach has not been determined by the Work Group. One method would identify the number of hospital beds within 30 minutes per thousand population of each zip code area. A drawback of this method is the inability to aggregate adjacent zip code areas to identify a larger ‘underserved’ area which needs a possible new hospital.

Geographers from MSU outlined a possible alternative approach to this issue, using a spatial location-allocation model. Under this approach, “use” of existing hospitals could be assigned, starting with the population in closest proximity. As hospitals are “filled up” by demand by people residing closer to them, populations located further away (even though they may be within 30 minutes travel time) could be identified as being “underserved” by the existing network of hospitals. In order for this method to be implemented, necessary decision rules would have to be determined, and the model would have to be constructed and tested. A reasonable time estimate for this project would be September 2005.

Recommendation: Determination of adequate access to a sufficient number of hospitals represents a significant expansion of the concept of hospital access. Objective investigation of this question is technically feasible; however, not in the time frame allotted the existing SAC. Implementation of this approach is contingent upon endorsement by the Commission and a SAC of the underlying policy premise.

### Modification of Sub-Area Methodology

**Policy Issue:** Hospital planning subareas should be standardized and should include no more than a maximum population base to allow equity of access to hospitals.

**Description:** The current hospital planning subareas resulting from application of the approved subarea methodology vary significantly in terms of both distance and population. It has been suggested that standardizing subarea size by limiting their population (for example: < 300,000 people) would represent an improvement in planning for the need for hospital beds.

Modification of the existing hospital planning subareas could be accomplished by a variety of methods, ranging from modifying the existing methodology with a maximum population, to use of county or other political boundaries, since the existing subareas do not have physical boundaries. The relative pros and cons of these two approaches are as follows:

Approach	PRO	CON
<i>Modify existing methodology</i>	Takes into account existing patterns of hospital use	Assumes existing patterns of hospital use are appropriate
	Takes into account out-of-area referrals	Not sensitive to population shifts
	Sensitive to changes in hospital use	Cannot be completed within legislated time limit
	Long history of use in hospital planning	
<i>Use arbitrary boundaries (e.g. Counties)</i>	Clear physical boundaries	Boundaries are arbitrary
	Easy to apply census data	Ignores out-of area referrals
		Ignores changes in hospital use

There remains a difference of opinion within the group about these two approaches.

**Recommendation:** Members of the Work Group questioned whether there is a strong technical reason to replace or substantially revise the existing subarea methodology. Furthermore, they feel that substantially changing the subarea methodology is outside of the scope of its current assignment. Implementation of this approach is contingent upon endorsement by the Commission and a SAC of the underlying policy premise. Its operationalization would require an arbitrary decision rule about the appropriate size of subareas, and a decision whether to change from a market based approach and, if so, by what criteria should arbitrary boundaries be determined.

### **Modification of Replacement Zone for Hospital Beds**

Policy Issue: Hospitals should have flexibility in relocating existing licensed hospital beds.

Description: Pontiac Osteopathic Hospital, presented a proposal to allow replacement of hospital beds outside the replacement zone under certain conditions. The work group identified fundamental issues underlying this and other proposals, including:

- 1) What constitutes the *need* for a replacement hospital outside of the existing replacement zone of two (2) miles in urban county?
- 2) What size of population shift is necessary to justify exceptions to existing bed need?
- 3) When population areas in need are identified, what applicants should be given preference?

**XIV. Recommendation: Since these are policy rather than technical questions, and since this proposal does not include any methodological considerations, the work group refers this proposal to the SAC without recommendation.**

**Attachment**  
**Attendees at meetings of the**  
**Hospital Access Work Group**

1. Lakshmi Amarnath	MDCH
2. Bob Asmussen	St. John's Health System
3. Susan Bates	Spectrum Health
4. Amy Barkholz	MHA
5. Melissa Cupp	Weiner & Associates
6. Richard Groop	MSU Dept. of Geography
7. Maureen Halligan	Genesys
8. Bill Hart	MDCH
9. Larry Horvath	MDCH
10. John Hubinger	MDCH
11. Mark Hutchinson	Saint Mary's Medical Center, Grand Rapids
12. Barbara Jackson	Economic Alliance
13. Joan Lowes	Pontiac Osteopathic Hospital
14. Bob MacKenzie	Saint Mary's Hospital, Sagniaiw
15. Mark Mailloux	University of Michigan Medical Center
16. Robert Meeker	Spectrum Health
17. Joe Messina,	MSU Dept. of Geography
18. Cheryl Miller	Trinity Health
19. Mary Beth Milliman	Munson Medical Center
20. Stan Nash	MDCH
21. Patrick O'Donovan	William Beaumont Hospital
22. Liz Palazzolo	Henry Ford Health System
23. Norah Peash	Mount Clemens General
24. Lesley Quinn	Saint Mary's Hospital, Sagniaiw
25. Peg Reihmer	Botsford Hospital
26. Vinod Sahney	Henry Ford Health System
27. Karishma Shah	Weiner & Associates
28. Ashton Shortridge	MSU Dept. of Geography
29. Kirsten Tesner	Genesys
30. Ken Trester	Oakwood Medical Center
31. Lynn Wiemeister	William Beaumont Hospital
32. Bob Zorn	MHA
33. Lody Zwarensteyn	Alliance for Health

**Meeting Dates:** July 1, July 14, July 27, Aug. 10, Aug. 27, Sept. 1, Sept. 10, Sept. 23, Oct. 4, 2004

**Future Meeting Dates** (if necessary): October 20, November 1

STANDARDS COMPARISON

Attachment B

FACTORS	HIGH OCCUPANCY STANDARD	DCH MEDICAID ADDENDUM
Acknowledgments	Admits that bed need is too restrictive	Admits that bed need is too restrictive
Limits on New Beds	No real limit (adds new beds in state that is over-bedded)	Movement of up to 2.5% of <u>existing</u> beds (no new beds)
Targeted Benefit	Benefits successful hospital systems (no required Medicaid participation level)	Benefits the highest Medicaid concentrations in state (urban access)
Rationale	Expand hospital systems that have the most patients (business rationale)	Assist urban hospitals with highest uncompensated and under compensated care
Parties Adversely Effect	All other hospitals in the sub-area  All proposed new hospitals (area becomes more over-bedded)	Potential limited increased competition in new developing areas
Parties Benefited	Large successful systems	Increased access in urban areas  Supports community hospitals  Supports increased continued participation in Medicaid  Supports increased access for primary care physicians in urban areas
Formula	Fewer than 300 beds = 80% or more occupancy for 1 year. More than 300 beds = 85 % or more occupancy for 1 year.	2.5 % of statewide existing hospital beds can be moved [highest estimated Medicaid reimbursement is 85% of cost = 15% below cost times Medicaid population (1.44 mil) divided by the state population (10.1 mil) equals 2.5%]

September 14, 2004

DRAFT

**PROPOSED CHANGES TO  
CON REVIEW STANDARDS  
FOR HOSPITAL BEDS**

**Section 2. Definitions**

- (cc) "Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone, or outside the replacement zone if the requirements of section 7a are met.

**Section 7a. Requirements for Approval - replacement beds in a hospital outside the replacement zone**

Sec. 7a. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital outside the replacement zone shall demonstrate that the new beds shall result in a hospital of at least 80 but no more than 150 beds.

(2) In order to be approved, the applicant shall propose:

(a) to replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located.

(b) that the proposed new site is within a 30 minute drive time of and is located in the same subarea as the licensed site at which the proposed replacement beds are located.

(c) that the proposed new site currently operates an emergency department providing emergency medical services to patients 24 hours a day, 7 days a week, provides at least 2 covered clinical services for CON purposes, meets standards established by the medical control authority protocols, and participates in the ongoing planning and development activities of the local medical control authority.

(d) that by action of its governing body, the county, township or other governmental unit where the applicant is located has adopted a resolution of support or submitted letters in support of the applicant's proposal for replacement beds.

(e) that the applicant will provide access to health care for the indigent, lower income, and disadvantaged through the continued operation of an acute care hospital at the existing licensed site and outpatient clinical services within 2 miles of the existing licensed site.

(3) An applicant proposing replacement beds outside the replacement zone shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the applicant meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(4) If an application is approved under this Section for fewer than 150 beds, the hospital may reapply to replace additional beds at the new licensed site. For such an application to be approved, the applicant must demonstrate that the new licensed site has operated at 80% or better occupancy for the previous consecutive 12 months based on its existing licensed hospital bed capacity as documented on the most recent reports of the "Annual Hospital Statistical Questionnaire" or more current verifiable data.

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