HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Wednesday, August 2, 2006

Capitol View Building
201 Townsend Street
MDCH Conference Room B/C
Lansing, MI 48913

APPROVED MINUTES

I. Call to Order

Chairperson Ball called the meeting to order at 9:10 a.m.

a. Members Present and Organizations Represented:

Robert Asmussen, St. John Health System (left at 10:46 a.m.)
James Ball, Michigan Manufacturers Association
Barton P. Buxton, McLaren Health Care (Arrived at 9:13 a.m.)
Wayne Cass, Michigan State AFL-CIO
Michele Ciokajlo, St. John Health System (Alternate, arrived at table at 11:02 a.m.)
Connie Cronin, H.F. Health System
James Falahee, Jr., Bronson Healthcare Group
Gary Kushner, Small Business Association of Michigan
Mark Mailloux, University of Michigan Health System (via teleconference)
Robert Meeker, Spectrum Health (Alternate)
Patrick O'Donovan, Beaumont Hospitals (via teleconference)
Patricia Richards, Health Alliance Plan
Dale Steiger, Blue Cross Blue Shield of Michigan
Mary Zuckerman, Detroit Medical Center
Lody Zwarensteyn, Alliance for Health (Alternate)

b. Members Absent and Organizations Represented:

Dr. Douglas Edema, Trinity Health
A. Michael LaPenna, Alliance for Health
William Rietscha, Spectrum Health

c. Staff Present:

Lakshmi Amarnath
Bill Hart
Joette Laseur
Irma Lopez
Jeff McManus
Andrea Moore
Taleitha Pytlowanyj

II. Conflicts of Interests

No conflicts were noted.

III. Review of Agenda and Distributed Materials

Motion by Mr. Steiger, seconded by Mr. Meeker, to approve the agenda as proposed. Motion Carried.

IV. Review of Minutes – July 18, 2006

Motion by Mr. Zwarensteyn, seconded by Ms. Zuckerman, to accept the minutes as presented. Motion Carried.

V. Workgroup Reports

Chairperson Ball sought to frame the day's discussions by providing an oral and written report (Attachment A) regarding his view of the basic concepts of the bed standards and issues/dilemmas faced by the SAC.

A. Charge Four/Six Workgroup – Replacement Zone; Multiple Site Licenses under Common Ownership.

Mr. Asmussen opened the discussion by providing a recap of the question that was presented to his Workgroup by the Committee at the last meeting. Should the current replacement zone rule, which applies to 2-mile urban, 5-mile rural, be altered or should they create an exception? Ms. Lopez provided a report from Mr. Ron Styka (Attachment B) regarding Comparative Review.

It was observed that some institutions are seeking relief, through this SAC's charge relating to "replacement", for moves that would not be considered "relocations" or "replacements" in the traditional sense. There was discussion of the possibility of framing a future charge on the possible need for "new hospitals", rather than new beds. It could be submitted to the Commission, as a recommendation, along with this SAC's report. Discussion followed.

Motion by Mr. Falahee, seconded by Mr. Asmussen, for the Charge Four/Six Workgroup to have another meeting in order to speak with Mr. Styka regarding comparative review, to draft a charge for another SAC to be recommended to the CON Commission that focuses on quality, access, and affordability, and consider the issue of the 2/5 replacement zone mileage. Motion Carried.

Public Comment:

Ken Trester, Oakwood
Larry Horwitz, Economic Alliance for Michigan
Bob Hoban, St. John Health

Break from 10:47 a.m. to 11:02 a.m.

B. Charge One Workgroup – Capacity at Existing Hospitals.

Mr. Steiger presented an oral and an interim report from M.S.U. (Attachment C). Discussion followed.

Motion by Mr. Steiger, seconded by Mr. Falahee, to cease the relationship with Michigan State on this particular issue and to conclude all the efforts of Charge One. Motion Carried.

Public Comment:

Bob Zorn, Michigan Health and Hospital Association
Larry Horwitz, Economic Alliance for Michigan

C. Charge Two/Five Workgroup – High Occupancy; Occupancy Levels and Fluctuation Over Time.

Mr. Mailloux provided a brief summary from the discussion at the last HBSAC Meeting on July 18th. Department Staff member Andrea Moore gave a brief summary of the Memorandum HBSAC Background/Research Request (Attachment D) which provided an overview of the progression of the language through the CON system of the High Occupancy language. Discussion followed.

Motion by Mr. Mailloux, seconded by Mr. Meeker, to adopt the recommendations of the Workgroup.

Motion by Mr. Kushner, seconded by Mr. Zwarensteyn, to amend the Mailloux/Meeker Motion by adding the following project delivery requirements to the Workgroup recommendation:

(I) AN APPLICANT APPROVED PURSUANT TO SECTION 6(4) MUST ACHIEVE A MINIMUM OCCUPANCY OF 75 PERCENT OVER THE LAST 12-MONTH PERIOD IN THE THREE YEARS AFTER THE NEW BEDS ARE PUT INTO OPERATION, AND FOR EACH SUBSEQUENT CALENDAR YEAR, OR THE NUMBER OF NEW LICENSED BEDS SHALL BE REDUCED TO ACHIEVE A MINIMUM OF 75 PERCENT AVERAGE ANNUAL OCCUPANCY FOR THE REVISED LICENSED BED COMPLEMENT.

(II) THE APPLICANT MUST SUBMIT DOCUMENTATION ACCEPTABLE AND REASONABLE TO THE DEPARTMENT, WITHIN 30 DAYS AFTER THE COMPLETION OF THE 3-YEAR PERIOD, TO SUBSTANTIATE THE OCCUPANCY RATE FOR THE LAST 12-MONTH PERIOD AFTER THE NEW BEDS ARE PUT INTO OPERATION AND FOR EACH SUBSEQUENT CALENDAR YEAR, WITHIN 30 DAYS AFTER THE END OF THE YEAR.

Roll Call Vote:

Ciokajlo – yes
Zwarensteyn – yes
Richards – no
Cronin – no
Meeker – yes
Steiger – yes
O'Donovan – no
Zuckerman – no
Kushner – yes
Cass – yes
Falahee – yes
Buxton – yes
Mailloux – no

Motion Carried, 8 to 5.

Back to Mailloux/Meeker motion.

To accept the Mailloux/Meeker motion with the amendment. Motion Carried.

Public Comment:

Larry Horwitz, Economic Alliance for Michigan

D. Charge Three Workgroup – Comparative Review Criteria.

Mr. Zwarensteyn gave a brief update. The Workgroup will be meeting on August 15th at 9:00 a.m. in Conference Room A of the Capitol View Building. Discussion followed.

VI. Next Step

Workgroup Four/Six will be trying to meet with Mr. Styka to discuss the issues that were brought up today and have a report to give to the Committee at the next meeting. Workgroup Three will be meeting again on August 15th. Workgroup Two/Five needs to make the necessary adjustments to their draft language that was added from today's meeting to present at the August 22nd meeting.

VII. Future Meeting:

August 22, 2006

VIII. Public Comment

None.

IX. Adjournment

Motion by Mr. Falahee, seconded by Mr. Kushner, to adjourn the meeting at 12:19 p.m. Motion Carried.

Attachment A

BASIC CONCEPTS

There is a mathematically determined "Need" for Hospital Beds within geographic areas
Sections 3, 4 and 5 (Charge 1)

Absent an unmet need, "new"/additional hospitals/beds that would exceed the needed supply should not be approved or licensed
Section 6(1)

Permitted exceptions – **(When does public policy – and not institutional self-interest - support treating new/additional hospitals/beds as not being "new" or "additional"?)**

- LTAC or Substance Abuse "hospital w/i a hospital"
  Section 6(2)
- "High Occupancy Hospital" acquiring existing beds from another hospital
  Section 6(3) (Charges 2 & 5)
- "High Occupancy Hospital" unable to acquire beds and adding limited beds to relieve high occupancy
  Section 6(4) (Charges 2 & 5)
- "Limited Access Areas"
  Section 6(5)
- "Replacement" of existing hospitals/beds w/i the replacement zone (2-mile radius for urban, 5-mile radius for rural)
  Section 7 (Charges 4 & 6)
- "Relocation" of existing beds from one existing licensed acute care hospital to another existing licensed acute care hospital in the same sub-area
  Section 8(2)(a)
- "Relocation" of existing beds from one existing licensed acute care hospital to another existing licensed acute care hospital in the same HSA, if receiving site qualifies for "High Occupancy" relief
  Section 8(2)(b)
- "Acquisitions" of existing hospitals
  Section 16

When there is determined to be an unmet need in an area, proposals to fill the need generally should be subject to comparative review and project delivery requirements
Sections 9 and 12-14 (Charge 3)

ISSUES (What makes sense from a public policy standpoint?):
To what extent should new hospitals/beds be created and allowed in areas that have no demonstrated need and/or have excess capacity? **(Charges 2, 4, 5 and 6)**

What can be done to encourage existing hospitals to de-license excess bed capacity ("mothballed", "un-staffed", unused, etc.) and remove them from the system?

What should be required of a hospital seeking special rules/exceptions? Should it be proportionate to the relief sought (e.g., the further one wants to relocate the higher the price)? What latitude do the Standards/the CON Commission have? What assurance is there that the requirements (1) are not illusory, (2) are permanent and (3) can and will be enforced?

To what extent should existing hospitals be able to "replace"/"relocate" themselves to areas they are not currently serving and/or have not served traditionally, even though there is existing excess capacity in the area where they want to move, there is no unmet need and the hospitals seeking to move may be underutilized? Wouldn't they be "new" and unneeded? **(Charges 4 & 6)**

Attachment B

Information received 8-1-06 from Ron Styka

In 1988 in Section 22229 of the Public Health Code, MCL 333.22229, the legislature dealt with the comparative review issue. (This was amended in 1993.) Under that section, the concept of comparative reviews was codified. Further, exceptions were specifically made to the requirement of comparative review for some hospital and nursing home replacement projects.

Your request for advice pertains to Section 22229(2). Under that section, replacement on site or on a contiguous site are not subject to comparative review. Similarly, nonrural replacements can occur within a 2 mile radius and rural replacements within a 5 mile radius without being subject to comparative review. You ask about the effect of adopting review standards with different radii.

The Certificate of Need Commission is free to adopt review standards for the replacement of hospital beds that differ from standards for adding additional beds. However, the Commission does not have the authority to alter the zone within which comparative review does not apply, except by changing the review standard in a way that no longer limits the overall number of acute care beds. In the context of standards based on there being a limited number of beds available to serve the public, the legislature has established the exception to the general rule of either 2 or 5 miles. Thus if, for example, the replacement zone is expanded to 10 miles for rural acute care beds and if the determination of the overall number of beds in a planning area remains limited by a generally applicable review standard, then those bed replacements occurring at further than 5 miles would still be subject to comparative review.

Attachment C

To: Michigan Department of Community Health
Interim Report, June 21, 2006

MDCH-MSU Research Program

Faculty	Doctoral Students
Joseph P. Messina Ph.D.	Mark Finn
Ashton Shortridge Ph.D.	Pariwate Varnakovida
Richard Groop Ph.D.	

After the most recent meetings of the technical sub-committee workgroup, MSU was charged with answering a series of questions. The central question revolved around he rationale for identification of demand, unmet needs, and travel behaviors. Originally, we were concerned with: capacity, time, migration, DRG, use rates of local populations, and facility categories. While all agreed that these variables were interesting and potentially relevant, concerns were raised about the need for the work and that the use of these metrics or the creation of new metrics might exceed the basic charge.

Central Questions:

1. Sub-service areas were essentially undefined. No "area" metrics existed. Solution: to create a 30-minute travel window around each sub service area (see e.g. Figure 3c). In the LAA work, every place in the state was evaluated with respect to the nearest appropriate facility. In the recent work, every place in the state is located with respect to the area bounded by all the facilities in a sub service area. This is significantly different than the original LAA and is more closely aligned with existing metrics used by MDCH and others to measure capacity and demand.
2. It is clear that people choose to travel outside their respective sub service area for health care services (the University of Michigan problem). Hence the "MIDB" for years 2001-2003 were combined and all patient visits to all facilities were identified. All patient visits to facilities outside the 30-minute sub service area were recorded. The dominant destinations of patients traveling outside their respective 30-minute sub service area were identified and mapped for select locations (the spider maps). Finally, areas in Michigan where patients travel out-of-state for treatment were identified. Commitment measures were applied where appropriate.

3,452,160 hospital discharge records for the State of Michigan (2001 – 2003) were modeled for records where patients traveled further than 30 minutes away from home for treatment based on road network density and estimated travel times from Michigan hospital clusters. This extraction was done using a combination of GIS tools and a custom database implementation. Visit totals for each Michigan zip code were mapped as a percentage of total visits (Figure 1a).

After recognizing a spatial pattern to the distribution of patient visits outside the 30 minutes travel zone, "spider" diagrams were created of two select areas in Michigan with a high percentage of patients traveling further than 30 minutes away from home for treatment to determine whether this visual pattern is representative of actual patient travel (Figures 2, and 3a, and 3b). Excluding out-of-state treatment entirely, up to this point, total out-of-state visits as a percentage of total visits were mapped (Figure 4a).

Figure 1A

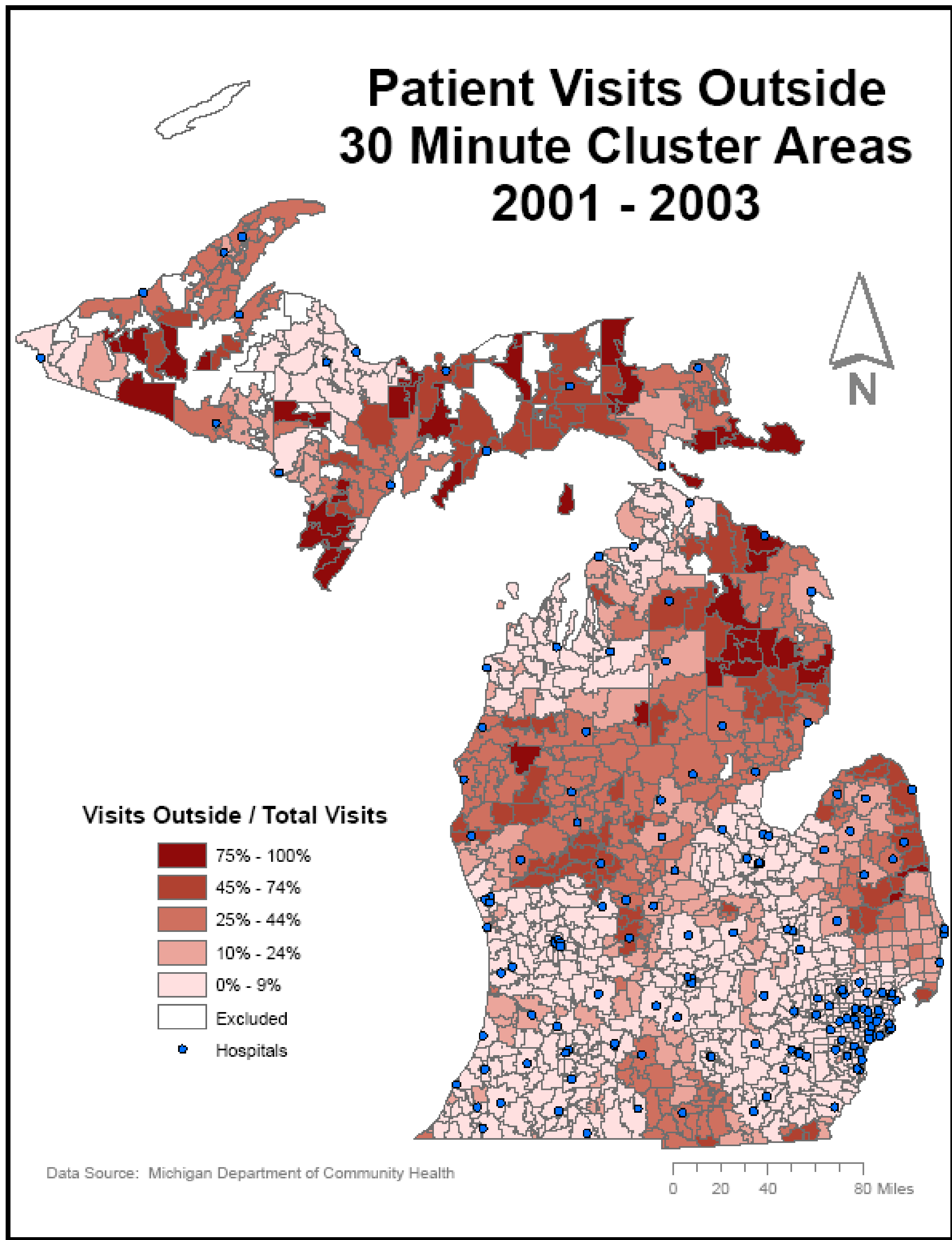
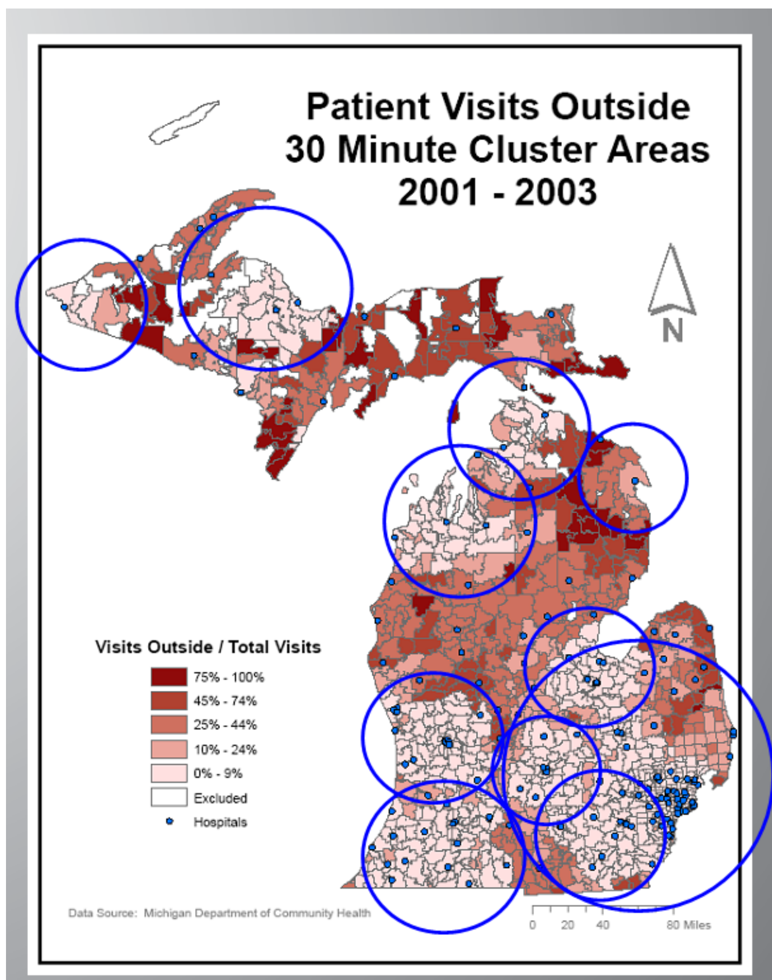


Figure 1a shows the percentage of patient from a zip code visiting hospitals falling outside the 30-minute service areas of existing Michigan hospital clusters. As expected the Upper Peninsula, northern Lower Peninsula, and Thumb of Michigan have higher percentages of patients traveling further than 30 minutes for treatment. What is unexpected is the ridge of high percentages occurring South to Southwest of the Detroit Metro and Ann Arbor areas.

What is the distribution pattern of patients in Michigan traveling further than 30 minutes away from home for treatment?

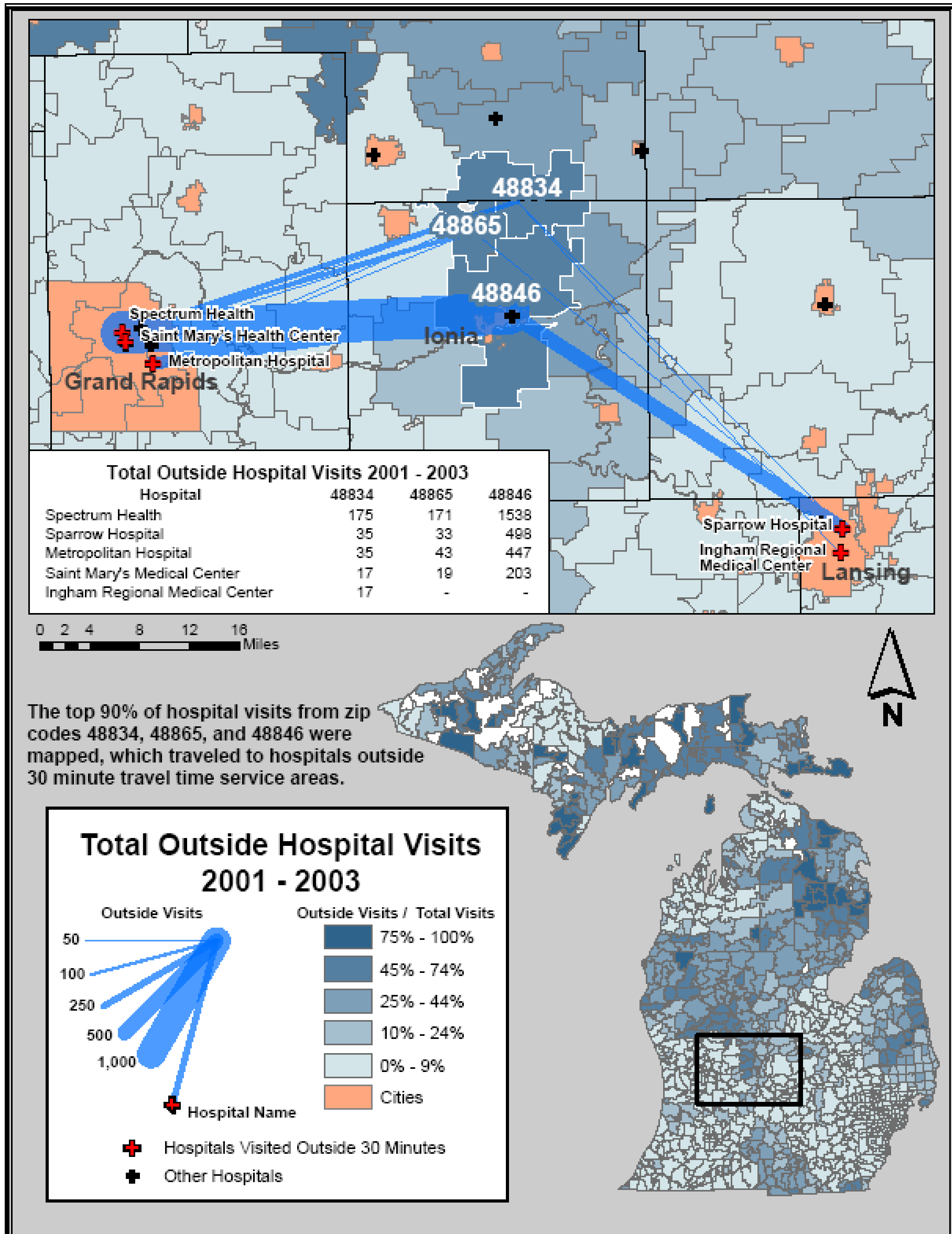
- Cities with large hospitals or groups of hospitals seem to have a visual threshold of patient commitment forming circular areas of low percentages of outside visits on the map. The size of these circular areas varies. Areas with high percentages occur on the edges of or in between these circular areas.



Circles drawn for emphasis.

Figure 1B

Figure 2



Total Outside Hospital Visits 2001 - 2003

Hospital	48834	48865	48846
Spectrum Health	175	171	1538
Sparrow Hospital	35	33	498
Metropolitan Hospital	35	43	447
Saint Mary's Medical Center	17	19	203
Ingham Regional Medical Center	17	-	-

Figure 2 is a spider diagram of the top 90% of patient visits from zip codes 48834, 48865, and 48846 traveling further than 30 minutes for treatment. This area was selected because it fell on the visual threshold edges of Lansing and Grand Rapids commitment areas.

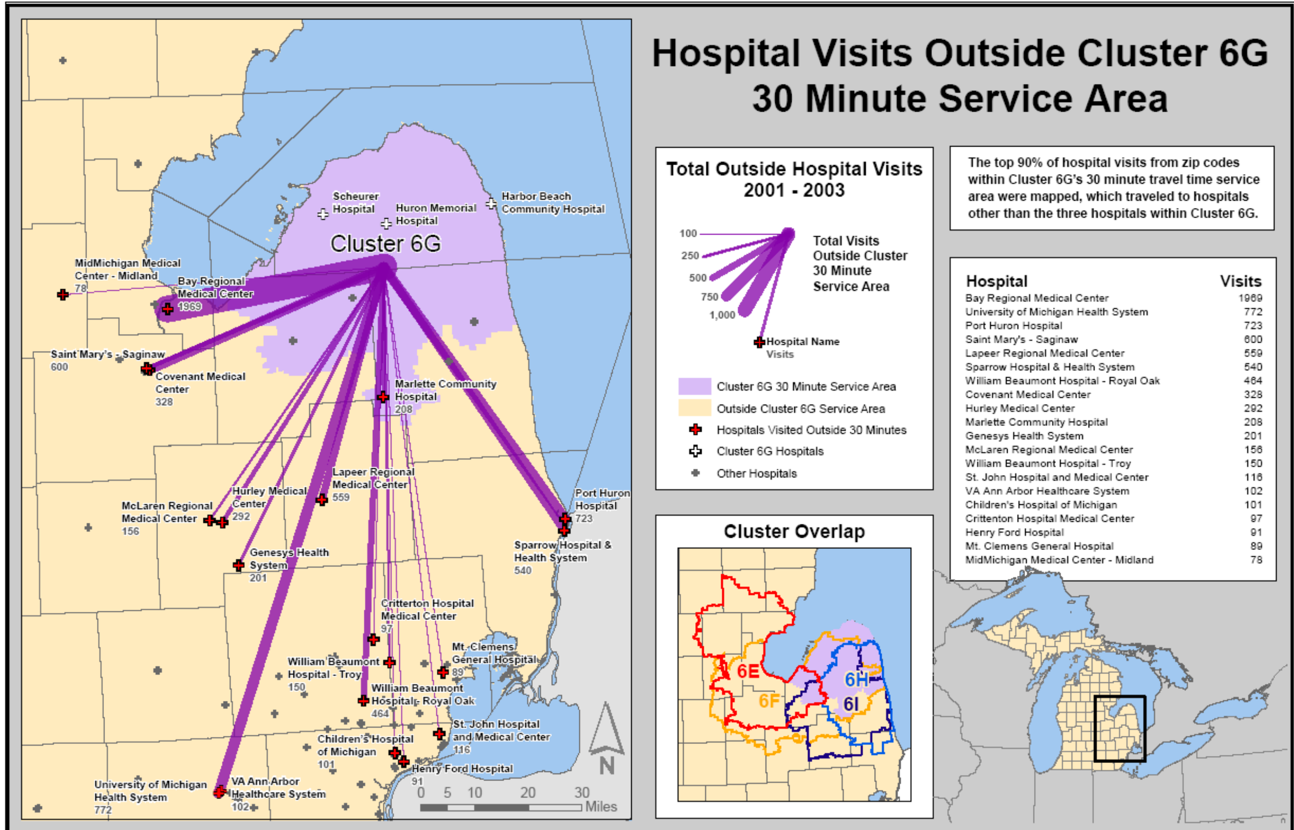
If 45% to 74% of the patients of the City of Ionia are NOT traveling to their local hospital, where are they going?

- These patients are primarily traveling to Spectrum Health in Grand Rapids.

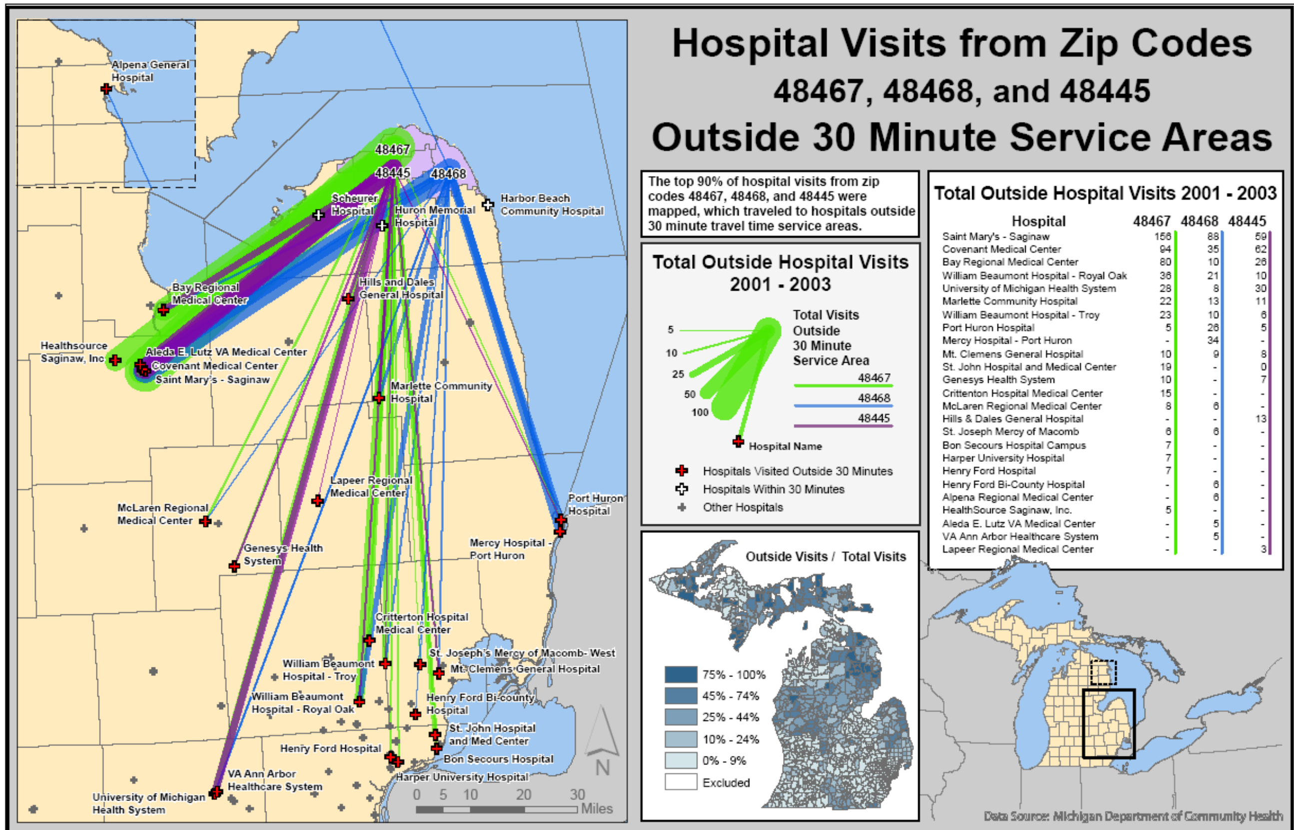
How does this map support the visual interpretation of circular thresholds around cities with large hospitals or groups of hospitals?

- This map shows that the area forming on the visual threshold edges of Lansing and Grand Rapids commitment areas are due to patient travel to Grand Rapids and Lansing and not Detroit, Ann Arbor, or any other area.

Figures 3a & 3b



Hospital	Visits
Bay Regional Medical Center	1969
University of Michigan Health System	772
Port Huron Hospital	723
Saint Mary's - Saginaw	600
Lapeer Regional Medical Center	559
Sparrow Hospital & Health System	540
William Beaumont Hospital - Royal Oak	464
Covenant Medical Center	328
Hurley Medical Center	292
Marlette Community Hospital	208
Genesys Health System	201
McLaren Regional Medical Center	156
William Beaumont Hospital - Troy	150
St. John Hospital and Medical Center	116
VA Ann Arbor Healthcare System	102
Children's Hospital of Michigan	101
Crittenton Hospital Medical Center	97
Henry Ford Hospital	91
Mt. Clemens General Hospital	89
MidMichigan Medical Center - Midland	78



Total Outside Hospital Visits 2001 - 2003

Hospital	48467	48468	48445
Saint Mary's - Saginaw	156	88	59
Covenant Medical Center	94	35	62
Bay Regional Medical Center	80	10	26
William Beaumont Hospital - Royal Oak	36	21	10
University of Michigan Health System	28	8	30
Marlette Community Hospital	22	13	11
William Beaumont Hospital - Troy	23	10	6
Port Huron Hospital	5	26	5
Mercy Hospital - Port Huron	-	34	-
Mt. Clemens General Hospital	10	9	8
St. John Hospital and Medical Center	19	-	0
Genesys Health System	10	-	7
Crittenton Hospital Medical Center	15	-	-
McLaren Regional Medical Center	8	6	-
Hills & Dales General Hospital	-	-	13
St. Joseph Mercy of Macomb	6	6	-
Bon Secours Hospital Campus	7	-	-
Harper University Hospital	7	-	-
Henry Ford Hospital	7	-	-
Henry Ford Bi-County Hospital	-	6	-
Alpena Regional Medical Center	-	6	-
HealthSource Saginaw, Inc.	5	-	-
Aleda E. Lutz VA Medical Center	-	5	-
VA Ann Arbor Healthcare System	-	5	-
Lapeer Regional Medical Center	-	-	3

Figures 3a/b are spider diagrams of the top 90% of patient visits from the Thumb of Michigan traveling further than 30 minutes for treatment. This area was selected because of its high percentage and limited access to treatment (water versus land).

Figure 3a shows a strong movement of patients to Detroit and Ann Arbor hospitals; almost equal that of Bay City and Saginaw hospitals, from the Cluster 6G service area zip codes. The Cluster Overlap map within Figure 3a shows substantial overlap of hospital service areas to cover this region except for the tip of the Thumb, which is covered exclusively by Cluster 6G (see additional map below). Figure 3b focuses on the three zip codes that make up the tip of the Thumb. Figure 3b shows more patients are traveling to Bay City / Saginaw hospitals than Detroit and Ann Arbor hospitals. This relationship was hidden in Figure 3a due to Cluster overlap into 6G.

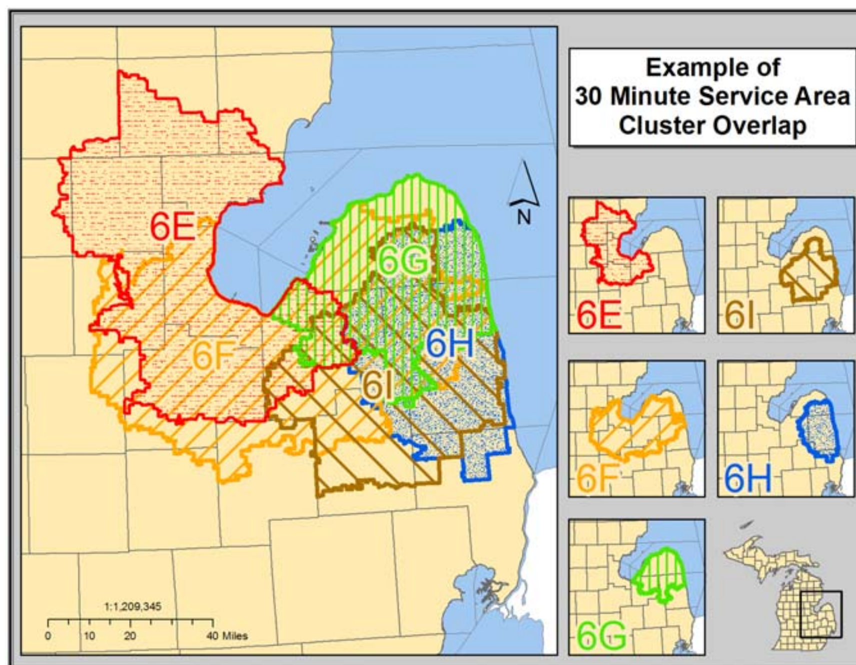


Figure 3c. Better view of Cluster Overlap with 6G

How do these maps support the visual interpretation of circular thresholds around cities with large hospitals or groups of hospitals?

- This map shows that the area forming on the visual threshold edges of the Bay City / Saginaw and Detroit / Ann Arbor commitment areas are due to patient travel to these respective hospital areas. What is interesting is the strong pull to Detroit / Ann Arbor even at greater travel time.

Figure 4a

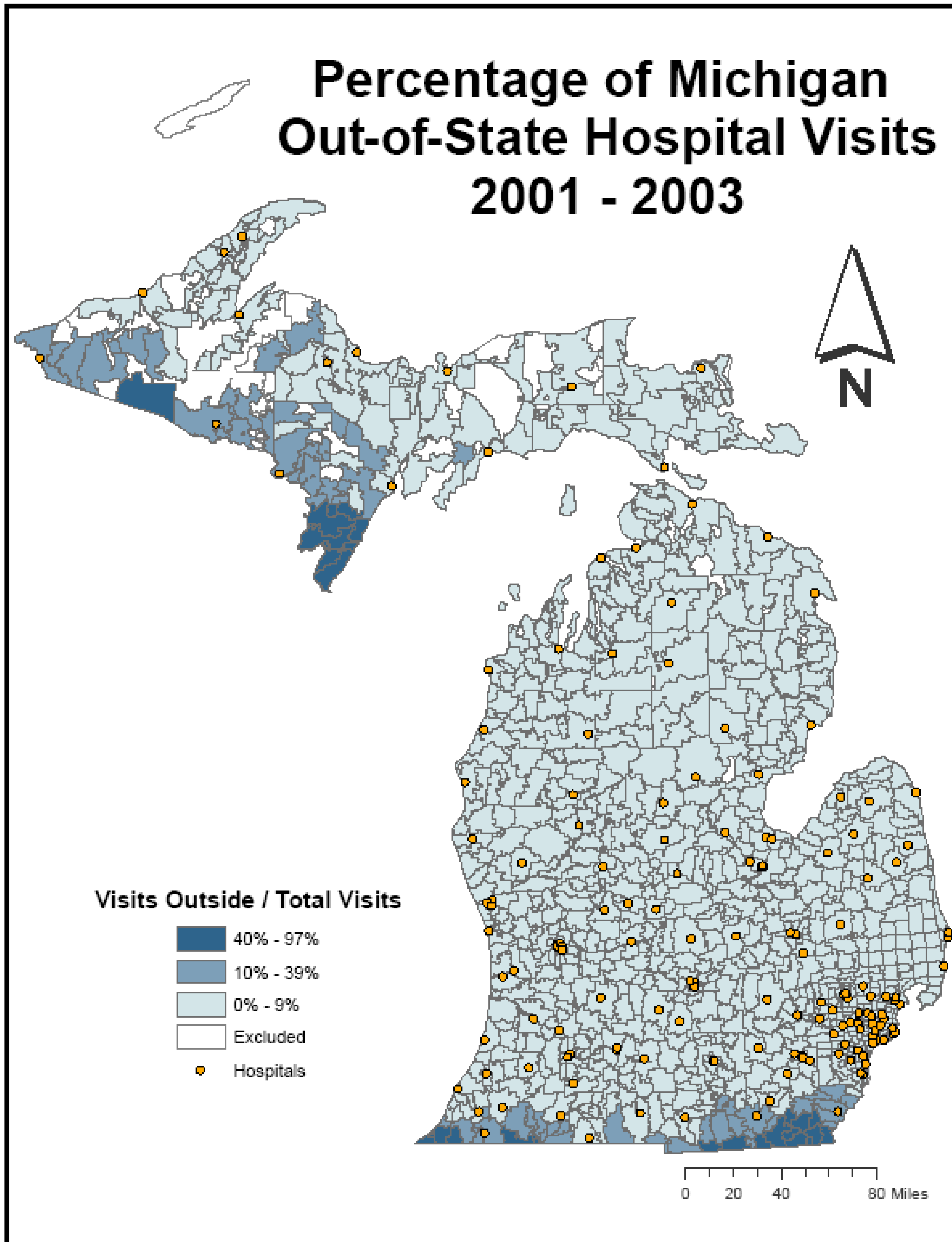


Figure 4a shows the percentage of patients from a zip code visiting hospitals outside the State of Michigan.

What are the sources of the out-of-state hospital visits?

- The out-of-state hospital visits are coming primarily from Michigan's borders with neighboring states.
- Assuming the database only reflects *transfers* to out-of-state hospitals, this may indicate doctors on the Michigan-Ohio border are sending patients out-of-state over hospitals in Detroit and Ann Arbor.

How significant are out-of-state hospital visits compared to in-state hospital visits outside 30 minute cluster service areas?

- The map below (Figure 4b) is identical to Figure 1a except it incorporates out-of-state visits. The only area where out-of-state hospital visits significantly affects the state are along Michigan's southern border with Indiana and Ohio.

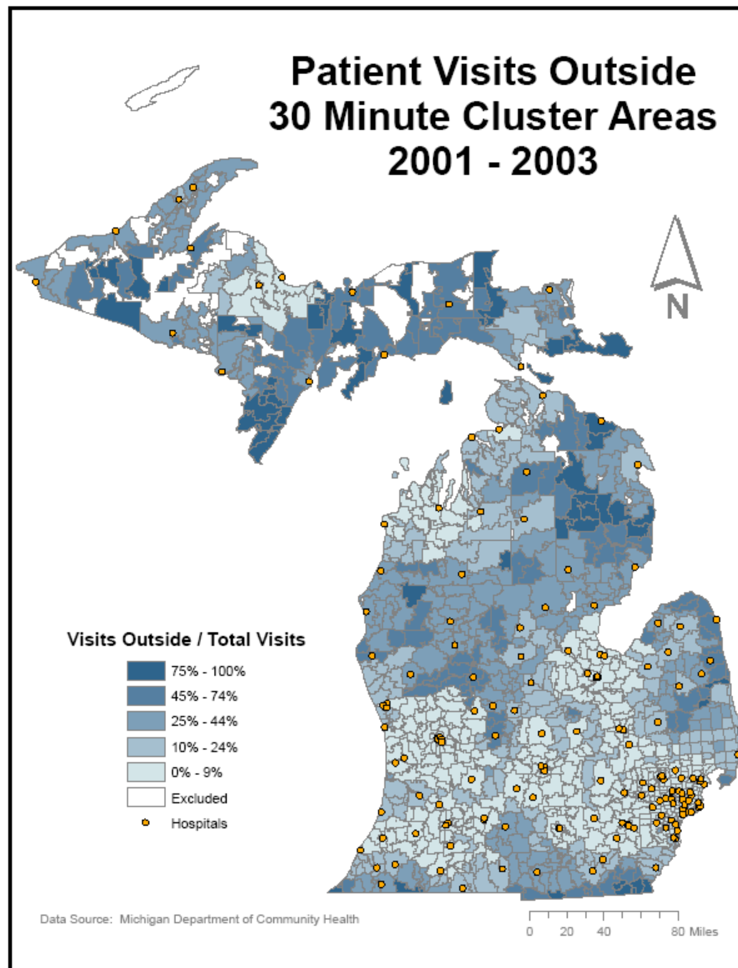


Figure 4b

Comments

Areas in Michigan where patients travel further than 30 minutes away from home for treatment fall upon the edges of circular commitment regions around cities with large hospitals or groups of hospitals. These regions vary in size and appear to have a distance decay of commitment when looking at the Thumb region of Michigan. In this case, Bay City / Saginaw hospitals have a stronger pull than the Detroit / Ann Arbor hospitals.

Using spider diagrams to map the flow of patients traveling further than 30 minutes away from home for treatment aids us in understanding where exactly patients are traveling to in relation to their immediate surrounding hospitals. These diagrams show preference but raise new questions as to why these patients are not using local hospitals. Out-of-state hospital visits occur primarily on Michigan's borders with neighboring states.

This work represents the next phase in managing health care services by focusing on the integration of consumer choice, inherent demand, and capacity. The next immediate steps are to focus on the integration of facility data with the demand data already in place, and then to expand the work to include DRGs.

Attachment D

MEMORANDUM

To: HBSAC Members

From: Andrea Moore

Date: July 28, 2006

Re: HBSAC Background/Research Request

The draft language that was referenced at the HBSAC Meeting was before the Hospital Bed Ad Hoc Advisory Committee during 2002 and early 2003. The following is an overview of the progression of the language through the CON system:

1. May 7, 2002 HB Ad Hoc Advisory Committee Meeting.

   High Occupancy language was drafted and presented to the Committee as "Department" language. High Occupancy language is in Section 6(1)(D). The requested language is located in the Project Delivery Requirement [Section 8(1)(b)(i) and (ii) see below] and is currently tied to the high occupancy language.

   SECTION 8(1)(B)(I)AN APPLICANT APPROVED PURSUANT TO SECTION 6(1)(D) MUST ACHIEVE A MINIMUM ADJUSTED OCCUPANCY OF 75 PERCENT OVER A CONSECUTIVE 12-MONTH PERIOD WITHIN THREE YEARS AFTER THE NEW BEDS ARE PUT INTO OPERATION, OR THE NUMBER OF NEW LICENSED BEDS SHALL BE REDUCED TO ACHIEVE A MINIMUM OF 75 PERCENT AVERAGE ANNUAL OCCUPANCY FOR THE REVISED LICENSED BED COMPLEMENT.
   (II) THE APPLICANT MUST SUBMIT DOCUMENTATION ACCEPTABLE AND REASONABLE TO THE DEPARTMENT, WITHIN 30 DAYS AFTER THE COMPLETION OF THE 3-YEAR PERIOD, TO SUBSTANTIATE THE OCCUPANCY RATE FOR EACH 12-MONTH PERIOD.

   Over the next several meetings, relocation language is added to the draft Standards in Section 6(3) and a new Section 8. Interestingly, the language in the Project Delivery requirement is modified and is now tied to the relocation language in Section 6(3) and the new Section 8, no longer to the High Occupancy language in Section 6(1)(D). There is no indication as to why this was done or the rationale behind it.

2. November 25, 2002 HB Ad Hoc Advisory Committee Meeting.

The Ad Hoc approves the draft language, moving the language forward for Commission action at the December 10, 2002 Meeting.

3. December 10, 2002 Commission Meeting.

The Commission made minor modifications to the draft language and moved it for Public Hearing. The Commission approved an additional Charge to the Ad Hoc Committee.

4. January 22, 2003 Public Hearing.

The High Occupancy language was moved to Section 6(4), but the project delivery requirements were still tied to the relocation language in Sections 6(3) and 8.

5. March 11, 2003 Commission Meeting.

The Commission took final action on the Standards and moved them to the Governor and Joint Legislative Committee for the 45-day review.

6. May 12, 2003 Standards became effective.

Section 9(1)(b)(i) An applicant approved pursuant to sections 6(3) and 8 must achieve a minimum occupancy of 80 percent for hospitals with licensed beds of 300 or more and 75 percent for hospitals with licensed beds of less than 300 over a consecutive 12-month period within two years after the new beds are put into operation, or the number of new licensed beds shall be delicensed to achieve a minimum of 80 percent average annual occupancy for hospitals with licensed beds of 300 or more and a minimum of 75 percent for hospitals with licensed beds of less than 300 for the revised licensed bed complement.
(ii) The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of each 12-month period, to substantiate the occupancy rate for each 12-month period.

7. August 4, 2003 new HB Standards became effective.

With the Charge approved by the Commission on December 10, 2002, the Ad Hoc Committee redrafted Section 8 and eliminated Section 9(1)(b)(i) and (ii).

The language, while starting out for High Occupancy, was approved as a project delivery requirement for relocated beds. The language was only in effect for approximately 3 months and to my knowledge was not utilized. If you have any additional questions or need further clarification, please advise.