MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Certificate of Need

ORAL TESTIMONY
PUBLIC HEARING FOR HOSPITAL BEDS AND SERVICES REVIEW STANDARDS

Wednesday, January 26, 2005
Michigan Library and Historical Center
702 West Kalamazoo
Lansing, Michigan

Approximately 15 people in attendance.

(Hearing scheduled to start at 10:00 a.m.; actual start time was 10:01)

MS. ROGERS: Good morning, my name is Brenda Rogers. I am Special Assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson Renee Turner-Bailey has asked the department to conduct today's hearing. We are here today to take testimony concerning proposed revisions to the Certificate of Need Standards for Hospital Beds. The proposed Certificate of Need Review Standards for Hospital Beds are being reviewed for the following:

1. Add criteria to the standards to allow hospitals with high occupancy to add licensed hospital beds in an overbedded subarea as an exception to the acute care bed need methodology.
2. Define and add criteria for "limited access areas" as an exception to the acute care bed need methodology.
3. Add comparative review criteria for "limited access areas."

Please be sure that you have signed the sign-in log. Packets can be found on the table. In the folder is a card to be completed if you wish to provide testimony. Please hand your card to me if you wish to speak. Additionally, if you have written testimony, please provide a copy as well. As indicated on the inside pocket of the packet, written testimony may be provided to the department through Wednesday, February 2nd, 2005 at 5:00 p.m. We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until testimony has been given, at which time we will adjourn. Today is Wednesday, January 26th, 2005, and we are now taking testimony. Mark Mailloux, University of Michigan Health System?

MR. MAILLOUX: My name is Mark Mailloux, and I am the Senior Health System Planner at the University of Michigan Health System. The Health System is here today to offer testimony on the proposed Certificate of Need Review Standards for Hospital Beds. First of all, we would like to thank the Hospital Bed Standard Advisory Committee and the Technical Work Group for the many meetings and long hours which they devoted to this effort. They certainly had to address contentious topics and did a masterful job of attempting to craft a consensus from among various disparate constituencies. Secondly, we would like to acknowledge the fact that the SAC has recommended, and the CON Commission has set forth, the high occupancy provisions found in today's draft standards. They are a welcome addition to the CON process and a good beginning to the effort to bring institutional capacity into alignment with expressed patient needs. Having said that, however, we believe that the topics -- the topic of high occupancy did not get the full and adequate consideration it requires. It was addressed late in the process. There is, of course, the statutory six-month deadline to be adhered to, and most of that time was spent on access issues. As a result, there was very limited debate on the high occupancy topic and the concomitant considerations of the special circumstances for providers with major pediatric programs. Fortunately the SAC pursued a strategy of postponement of further considerations rather than one of their outright rejections. Our interest at this juncture is to see that these facets of the topic are addressed adequately as we go forward, and done so in a timely manner. Our reasons for focusing on these considerations are clear and straightforward. Simply stated, a bed is not a bed. There is little fungibility in hospital medical surgical beds, licensure to the contrary notwithstanding. At an 800-bed hospital complex like the University of Michigan Health System, an 85 percent average occupancy does not mean that we are simply not using 120 of our beds. As time goes on and population

has increased, demand for health care services has grown, but in the midst of that two opposite factors have been at work simultaneously.

Lower intensity services have migrated to outpatient settings while technology increases have caused increases in higher intensity services. The results of the former have led to a disproportionate decrease in occupancy in many community hospital beds, while the results of the latter have fueled an increase in occupancy at tertiary care providers. This, even as overall market occupancy has declined or leveled off. Additionally, as identified by the National Association of Children's Hospitals and Related Institutions, these hospitals provide unique services which cannot be provided through traditional health care delivery methods. Consequently, a unique methodology is required to allow facilities such as UMHS to continue their commitment to quality care. Good responsible planning is a longer-term undertaking than five percent can accommodate. If high occupancy bed increases were only a case of reactivation of existing mothball capacity, then the ability to utilize five-percent increments would be appropriate. But the need to address capacity constraints for a minimum seven- to ten-year planning horizon and beyond cannot be accommodated with a one- to three-year capacity fix. Anything less than a 10 to 15 percent field of vision makes the prospect of significant structured planning for major facility modification and/or replacement untenable. Moreover, successive attempts to increase actual physical capacity by a mere five percent at a time would be grossly inefficient from both an architectural and an operational standpoint and would result in a more costly end product to the health care consumer. Right now the University of Michigan Health System is at the beginning stages of a major undertaking to replace the current C.S. Mott Children's Hospital. Current physical constraints within the existing structure severely limit the full use of our existing beds. Increasing specialization in pediatric care indicates there will continue to be potential growth in tertiary hospitalization despite the lack of any significant underlying population growth. To replace Mott and allow for future requirements necessitates a pediatric high occupancy relief valve significantly in excess of five percent, as well as one that is triggered at a lower threshold than 85 percent occupancy. It would not be fiscally responsible for UMHS to construct a facility that would need additional modifications that could only be accomplished in five percent increments. Nor would it be conscientious, from a patient care standpoint, if the facility were not able to meet growing demand. Further, the current reimbursement system does not pay for pipe dreams but rather for care delivered to patients. Allowing for adequate growth does not burden the health care system. There must be actual patient care delivered for reimbursement to take place. The institution itself is at risk for the planning portion of the equation, as well as for any poorly planned or underutilized capital improvements. It is our understanding that the CON Commission is considering the formation of a new Standards Advisory Committee to address further topics in the access arena. We would propose that from the outset any new charge to a SAC should include a more thorough examination of the high occupancy issue, and the unique circumstances surrounding pediatric high occupancy specifically, so that these important considerations might not be overlooked. Thank you for according us this opportunity to address these concerns. We stand ready to work with you and the department on this issue.

MS. ROGERS: Thank you. And as a reminder, as you approach the podium, please print your name on the sign-in sheet for the court reporter. Thank you. Patrick O'Donovan, Beaumont Hospital?

MR. O'DONOVAN: Good morning, my name is Patrick O'Donovan, Director of Planning for Beaumont Hospitals. Thank you for the opportunity to provide comment on the proposed Hospital Bed Standards. I participated as a member of the Standards Advisory Committee that developed the recommended changes to the Hospital Bed Standards, and I believe these recommendations were based on solid planning criteria that will result in improved access to hospitals and hospital beds. The only part of the proposed standards that Beaumont does not agree with are the comparative review criteria for the new "limited access area" hospitals that are heavily weighted in favor of applicants with higher proportions of uncompensated care and Medicaid. Specifically, our concern is that because payer mix represents fully 45 percent of total points available in the comparative review, that any needed hospitals will be awarded based on payer mix regardless of cost, quality, efficiency or access considerations. Health planning should be based on the health needs of patients and access to services at reasonable cost. Why should adverse payer mix be a rationale for health planning for the citizens of the state? First, all of the CON Review Standards have recently been revised to require participation in the Medicaid program. Second, state and federal policies and laws already compensate hospitals with high percentages of Medicaid and uninsured patients. Medicaid Disproportionate Share Hospital, or DSH payments, and the Quality Assurance Assessment Program, or QAAP, are the two most notable. These two payment programs specifically compensate for adverse payer

mix and already reimburse hospitals with high Medicaid and uninsured populations in excess of $160 million in extra payments annually. Third, Medicare reimbursement formulas also take into account hospitals' Medicaid involvement, resulting in vast variations in Medicare reimbursement to hospitals. This means that for the same inpatient case, Medicare pays Disproportionate Share Hospitals more than other hospitals. Because of the factors involved in determining Medicare reimbursement levels, Medicare is an adverse payer for some hospitals, including Beaumont. Yet Medicare is not included in the comparative review, only Medicaid and uninsured. CON applications in comparative review should be judged based on the applicants' abilities to bring quality care and access to the population to be served at reasonable cost. The proposed comparative review criteria don't reflect that, since 45 percent of the points are awarded based on adverse payer mix. The practical impact of these criteria is that any Detroit-based applicant will be awarded a hospital over virtually any other applicant regardless of cost, quality, efficiency or access considerations. Of additional concern is the precedent this sets. The Comparative Review Criteria Work Group that came up with the proposed criteria is recommending that this criteria be extended to all hospital bed applications subject to comparative review. To illustrate our concern, note that both Beaumont hospitals were named to Solucient's most recent list entitled "100 Top Hospitals: Benchmarks for Success." This program seeks to identify the top overall achievers in the industry. The introduction to their report states the following, quote: "Through the program, we have named only the hospitals that have set national benchmarks for overall hospital performance. To achieve results that are far-reaching and include all hospitals, Solucient began with a balanced scorecard approach, with deliberately broad criteria, gleaned from publicly available data. The result is an award that honors 100 of the nation's top performing hospitals - a group that adapts quickly to external pressures for change, provides high quality care that is delivered efficiently, all the while maintaining financial viability," end quote. In addition, Beaumont, Royal Oak set the benchmark in its peer group for expense per adjusted discharge in this Solucient report. The point in citing this research is not to single out Beaumont. Other Michigan hospitals have made this list in the past and will in the future. Rather, the point is that decisions to award new hospitals ought to be based on demonstrated ability to provide quality care at reasonable cost rather than on payer mix. For purposes of final approval of these standards, Beaumont recommends that the point categories relating to payer mix, Sections 14(3)(A) and 14(3)(B), be removed and the potential points totaling 100 be proportionately redistributed among the remaining categories. Beaumont further recommends that this comparative review issue be revisited as part of the charge to the next Hospital Beds Standards Advisory Committee. Thank you.

MS. ROGERS: Thank you. Bob Meeker, Spectrum Health?

MR. MEEKER: My name is Bob Meeker, from Spectrum Health in Grand Rapids, and I too was a member of the Standards Advisory Committee and also the Technical Work Group that worked on the access issues. Spectrum Health, in general, supports the proposed revisions to the standards and will urge the commission to approve them at their next meeting. Specifically, we feel in the area of hospital access that the identification of critical access areas provides a reasonable and justifiable exception to the acute care bed need methodology. We would urge the commission also to follow the recommendations of the SAC -- I'm sorry -- the Technical Group and the SAC to pursue further refinements to that approach in the next year as the ability to make those refinements becomes available, and to appoint a SAC to oversee that. We also support the comparative review standards as they're currently phrased, and we urge the commission, in that next SAC, to consider adopting comparative review standards that apply generally to all hospital bed applicants in the future. As far as the high occupancy standards, again, we support the standards that have been recommended for approval. But I would join my colleague, Mark Mailloux from the University of Michigan, in urging that the next SAC also be directed to look at or examine the peculiar or the unique needs of high volume pediatric hospitals and their -- the occupancy issues related to them. Finally, Spectrum Health would like to reiterate its concern that a five-year planning horizon for all the Hospital Bed Standards is too short a horizon, and we would urge the commission, as a future work plan item, to investigate ways to overcome the technical limitations in implementing a ten-year planning horizon for acute care beds.

MS. ROGERS: Thank you. All right. Any other comment for Hospital Beds? All right. Hearing none, it is 10:21 and this hearing is adjourned. Thank you.

(Hearing concluded at approximately 10:21 a.m.)