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5. Standards: Hospital Beds
6. Testimony:

Content-Length: 155932

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February 15, 2012

Mr. James Falahee, J.D.
Chairman
Certificate of Need Commission
Michigan Department of Community Health
201 Townsend Street, 7th Floor
Lansing, Michigan 48913

Dear Chairman Falahee,

On behalf of Oaklawn Hospital in Marshall, Michigan, we appreciate this opportunity to provide comments on the Hospital Bed standards up for a final vote at the March CON Commission meeting. Oaklawn Hospital is a 94-bed hospital located in Calhoun County, with more than 900 employees and 125 active staff physicians providing over 30 specialty services.

Oaklawn raised concerns at the December 2011 CON Commission meeting regarding the low occupancy provisions included in the Hospital Bed Standards Advisory Committee (SAC) recommendations. Specifically, we feel the provisions have a disproportionately negative impact on smaller, less urban facilities by limiting their ability to respond to changes in their markets and reconfigure their hospitals to meet their community's needs. We can appreciate the SAC's intentions but feel additional exemptions should be added to the provision to prevent it from having unintended consequences.

Attached please find our recommended modifications to the SAC recommendations along with some additional explanation and rationale. We appreciate your time in considering this matter and look forward to continued discussions before and during the March Commission meeting. Please feel free to contact me directly at (269) 789-3924, or Keith Crowell, our Chief Development Officer, at (269) 789-3942.

Sincerely,

Rob Covert
President and CEO



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Proposed Modification to the "Low Occupancy" Provisions

In the Hospital Bed SAC Recommendations

Background:

The Hospital Bed Standards Advisory Committee (SAC) recommended a package of changes to the Hospital Bed standards related to limiting the ability of hospitals with lower occupancy to replace, and/or relocate beds as well as to be acquired. The SAC recommendations exempt the following hospitals:

- Critical Access Hospitals
- Hospitals located in rural or micropolitan statistical area counties
- Long-term Acute Care Hospitals
- Sole Community Hospitals (CMS designated)
- Hospitals with 25 or fewer beds

As indicated at the December 2011 Commission meeting by the main proponent of this proposal, the primary intent of these provisions is to address issues in the more heavily populated areas of the state, such as southeast Michigan region where there are multiple hospitals serving the same communities.

While these exemptions address many of the issues geared toward ensuring access to inpatient acute care services in areas where the population is more rural in nature, they omit provisions necessary to protect access to care in several out state counties.

Proposal:

We propose that any hospital in a county with a population less than 200,000, and more than 10 miles from another existing hospital with at least 100 beds, also be exempted from these low occupancy provisions.

Rationale:

In areas where there are not multiple hospitals serving a community, it is that much more important for hospitals to have the ability to make modifications to meet changing community needs as patients do not have multiple options. Because these types of modifications take a great deal of planning, investment, and time, changing community needs can often result in lower occupancy until the adjustments are made. As an unintended consequence, the proposed Standards revisions could severely hinder the ability of community hospitals typical to smaller counties to have the flexibility to meet patient needs unique to each hospital. For instance, a hospital with a surplus of beds in one specialized unit could be prohibited from getting CON approval to do the construction needed to utilize those beds in other areas of the hospital where there is a shortage. It is important to remember that these SAC recommendations won't just impact hospitals based on their occupancy today, but rather will be in place indefinitely and so we must proceed with caution.

The Federal Government designates counties as rural, micropolitan, or metropolitan based on traffic patterns and commuting routes, not based on population or the type of community. A metropolitan county, as designated by the feds, no longer is an indicator of an urban area. This can be seen by looking at the differences in population for metropolitan and rural/micropolitan counties in Michigan. As an example, Allegan County with 111,408 people is considered micropolitan, but Newaygo County with 48,460 people is considered metropolitan. A county with a population of 48,460 should not be treated the same as counties with a population of 1.8 million.

In addition, it is important to note that hospitals as large as 377 beds are already exempted from these provisions because they are located in federally designated micropolitan or rural counties, but hospitals as small as 41 beds would not be exempted because they are in metropolitan counties. A great example of this is the 88 bed Pennock Hospital located in Barry County, population 59,173, is not exempted under the current SAC recommendation. However, Munson Medical Center with 377 beds in Grand Traverse County, population 86,986, is exempted.

The Commission has recognized the shortcomings of the federal designations in the past and made provisions to correct for them. For example, in trying to ensure geographically diverse access to MRI services, the Commission approved language that took into consideration distance from another existing MRI service because county designations did not adequately reflect the true nature of these regions. Another example is in the surgical services standards where the population of the city, village, or township, along with the total county population was used to define more rural areas for a lower expansion criteria.

Because the federal designations do not adequately distinguish urban from rural for these purposes, we suggest looking to the CON statute for a better distinguishing factor. Our Michigan Legislature, in MCL 333.22229(2), determined that 200,000 population adequately distinguished rural from urban areas as it pertained to hospital beds. We recommend using this same criterion of counties with less than 200,000 population, combined with distance of no less than 10 miles from another existing hospital of at least 100 beds, to ensure that the low occupancy provision does not have unintended consequences in outstate Michigan.

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6. Testimony: See attached document

Content-Length: 4125509



HEALTH CARE

Philip A. Incarnati
President and CEO

TESTIMONY IN RESPONSE TO THE PROPOSED HOSPITAL BED STANDARDS

My name is Philip Incarnati President and CEO of McLaren Health Care. I would like to provide comment for public record on the proposed changes to the Certificate of Need (CON) Hospital Bed Standards.

As a matter of business, McLaren Health Care routinely addresses the issues of balancing access to high quality health care in a cost effective manner while remaining mindful of our responsibilities to the communities we serve. We are proud that we provide access for the physical health and well being of the people we care for; and we are a major contributor to the economic health of the community as well. We believe that as a good corporate citizen, we must develop and execute comprehensive plans that ensure that our services are the best they can be, that they reflect the needs of the community today, as well as into the future and contribute to the economic stability and growth of the community.

The health care environment changes every year. These changes come to us through advances in technology, medicine, the economy, reimbursement and regulation. Health care is something we all care about and providers like McLaren are looked to for answers. In addition we serve as a major employer (one of the top 10 largest in Michigan) and our resources are depended upon for the financial viability of the areas in which we serve our patients. McLaren understands this responsibility and our strategic plan includes economic investment in the regions where we provide care.

INVESTMENT IN PONTIAC

McLaren Health Care believes a key element for success is our investment in the future of the communities we serve. This commitment allows our subsidiaries to grow and remain strong, thereby strengthening our entire organization. This is the primary reason that McLaren - Oakland (formerly POH Regional Medical Center) became a member of McLaren Health Care. Absent McLaren Health Care, the burden of uncompensated care in Pontiac would have become overwhelming for this facility and a valuable safety net asset of the community would likely have been lost.

As a result of the acquisition in 2007, McLaren has taken the following steps to reformat its pledge to Pontiac. Our commitment is based on providing the health care services that patients need and are essential to strengthen both McLaren - Oakland as a provider and McLaren Health Care as a system. There are three key components of our vision for the Pontiac community:

- I. Building a sustainable healthcare delivery model for the city of Pontiac
- II. Developing a platform for education, job training, housing, collateral development
- III. Strategically plan for the McLaren – Clarkston campus

I. BUILDING A SUSTAINABLE HEALTH CARE DELIVERY MODEL FOR THE CITY OF PONTIAC

Pontiac, along with other older industrial regions throughout Michigan, is faced with rapidly changing health and social services needs. These changes are due to advancements in medical technology, and constantly evolving public policy decisions combined with ongoing reductions in federal and state reimbursement for Medicare, Medicaid and Welfare programs. To further complicate matters, the decline in traditional manufacturing jobs has also contributed to significant economic challenges in Pontiac and the surrounding service area.

As part of an effort to respond proactively to this reality, and in keeping with our mission, vision and values, McLaren Health Care seeks to develop new models of healthcare delivery that build healthier neighborhoods, and find the right balance of services at each location to increase access to high quality, safe and affordable health care. The most successful communities will be those in which the stakeholders work collaboratively to define the blueprint for sustainable health and wellness services and the associated economic development those initiatives can bring to the community.

The Pontiac and Clarkston campuses of McLaren - Oakland are an example of this model for McLaren Health Care. McLaren will link its investments in a manner that will maintain high-paying health care jobs in downtown Pontiac. We will also create new jobs in health care delivery and health education through a partnership with local colleges, universities and school districts. McLaren Health Care has spent the last two years researching and studying this opportunity and is now in a position to implement a 3 point plan:

1. Population-based bed distribution

Dramatic shifts in population have occurred over the last three decades in the Pontiac and northern Oakland County market. Between 1970 and 2010, the City of Pontiac population decreased 30% from 85,279 to 59,515 (2010 U.S. Census). During this timeframe, the population of Independence Township has increased over 100%. Further, the growth of the seniors (65+) in the Clarkston service is expected to increase approximately 25%. A significant consideration as they consume health care resources at a much higher rate than all other population age segments.

These dramatic shifts in population demand a geographically appropriate, market based redistribution of licensed acute care beds. McLaren - Oakland maintains 308 licensed acute care hospital beds and 20 psychiatric beds at its downtown Pontiac site. The facility has recently received approval to add an additional 7 psych beds, bringing the total bed count to 335. This site typically maintains an average census of 97 admitted patients. McLaren proposes to retain 108 licensed acute care beds and the 27 psychiatric beds for a total of 135 beds at that location resulting in an average occupancy of 90%. Additionally the Pontiac hospital will continue inpatient and outpatient medical and surgical services, and remain a Level II trauma care provider.

As part of this restructuring, McLaren - Oakland will relocate 200 beds of the 335 beds to its Clarkston site. A 2011 Thompson Reuters bed-need study demonstrated that the Pontiac market will require 385 licensed beds to meet market demand in 2015. Currently there are 1,024 licensed beds serving the Pontiac market – an oversupply of 639. The same study also projected a need for 161 beds in the Clarkston market by 2015. McLaren - Oakland can

meet this demand and maintain at least 80% occupancy in Clarkston while doing its part to remove 200 beds from Pontiac. McLaren - Oakland can maximize efficiency, while not increasing the overall bed inventory in Oakland County.

2. Investment and Service Expansion in Pontiac

During 2012, McLaren - Oakland will make capital investments to support the growth and expansion of key health care services at the Pontiac Campus including, but not limited to, a nearly \$9,000,000 investment in program enhancement for Cardiovascular services, surgery, endoscopy, geriatric psychiatry, trauma, and infrastructure.

3. Primary Care Capacity Expansion

Access to basic primary care services is the cornerstone of a healthy community. McLaren - Oakland will continue to expand the primary care medicine base in the city of Pontiac by increasing the number of Family Practice physicians serving the market including increasing the size of the current Federally Qualified Health Center. McLaren - Oakland will be able to provide comprehensive services to both Pontiac and Clarkston by sharing system resources between the two campuses to benefit the patients served by both sites.

II. EDUCATION, JOB TRAINING, HOUSING, COLLATERAL DEVELOPMENT

McLaren, working in collaboration with local and regional business, education and political leaders, has invested considerable time and resources to identify and develop a realistic set of programs and initiatives designed to strengthen health care and educational resources available in and around Pontiac. These include:

- McLaren, in conjunction with a state university, will develop higher education programs and curriculum for students interested in careers in health care that will be housed in classroom space provided by McLaren at the Pontiac campus.
- McLaren will construct health care learning simulation labs dedicated for clinical learning for the health care education program.
- McLaren brokered a partnership arrangement for career ladders identified with area educational institutions including Oakland schools, Pontiac schools and a local community college.
- McLaren, through its partnerships with real estate firms, will develop student and workforce housing in downtown Pontiac. Also contemplated is recruitment of collateral retail tenants such as a cyber café, restaurant, grocery store, bookstore, fitness/wellness center, as well as a child care provider.
- The McLaren - Oakland Riley Foundation raised \$750,000 which will be designated for use as scholarships awarded to Pontiac children.
- McLaren will create educational programs for faculty development, advancement and patient teaching.

III. STRATEGIC PLAN FOR MCLAREN - CLARKSTON

McLaren - Clarkston is designed to deliver the full continuum of health care services using state of the art technologies to provide prevention, diagnosis, treatment and cure at one site. As the area's only comprehensive, one-stop health care destination, the McLaren – Clarkston campus is located on 80 acres at the corner of Sashabaw Road and Bow Pointe Drive in Clarkston. The \$500 million project is being built in two phases.

PHASE I (Completed 2009)

McLaren Health Care opened Phase I of McLaren – Clarkston in May of 2009 with an initial investment totaling \$100 million. Over 350 people are employed at this site with over 500 jobs created during the construction. The key components of Phase I are the 135,000 square foot Clarkston Medical Building and the 42,000 square foot McLaren Cancer Institute – Clarkston featuring a five acre garden of healing and renewal.

Located within the new Clarkston Medical Building is the Clarkston Medical Group (CMG). CMG is Clarkston's oldest and largest primary medicine group practice under the leadership of Dr. James O'Neill and Dr. Tim O'Neill. CMG employs 15 primary care physicians and over 125 support staff. The Clarkston Medical Building is also home to 64 physicians representing a wide range of specialty care services.

Other services in this building include a 24-hour urgent care center, a 17,000 square foot ambulatory surgery center with three operating rooms, a pharmacy, clinical laboratory services, home medical equipment, a breast care center featuring the area's only digital mammography unit, bariatric center, physical therapy, sports medicine, fitness center, diagnostic sleep clinic, wound care clinic in addition to a comprehensive diagnostic imaging center with CT, MRI and PET/CT modalities.

Also opened in May 2009 is the area's only dedicated, freestanding comprehensive cancer center. The McLaren Cancer Institute – Clarkston provides state of the art radiation therapy, advanced medical oncology, mobile PET/CT imaging, education programming, patient navigator and family support services.

The award winning five acre Garden of Healing and Renewal provides peaceful, soothing surroundings in which to focus healing energies, talk privately and build strength. The garden features an oasis of fountains and sculptures, sitting areas and beautiful paths to encourage exercise and curative reflection. The lush landscaped campus is open for the community to use and enjoy.

PHASE II

The second phase of McLaren - Clarkston will include the development of a 200 bed hospital with all of the associated essential patient care services. McLaren conducted exhaustive research to arrive at the most appropriate and economically feasible development plans for all portions of the project. Phase I far exceeded expectations, making the Clarkston campus a health care destination for outpatient services in the planning area. Further, historical health utilization data shows an unmet need for continued development of the site to include inpatient services.

INPATIENT VOLUME GENERATED FROM CLARKSTON SERVICE AREA

According to data supplied by the Michigan Health and Hospital Association, the Clarkston service area generated 23,649 admissions to an acute care hospital during the 12-month period of July 2010 to June 2011. Assuming an average of 5 days length of stay per admission, a 200 bed acute care hospital located in Clarkston would need to capture only 37% of this volume in order to operate profitably at 60% occupancy. Even operating at 80% occupancy, the proposed facility would only need to capture 49% of this volume. Further, Thomson Reuters projects this annual volume to increase to over 30,000 admissions per year by 2025 based on continued growth in population and age-related increases in utilization.

CONSUMER SUPPORT FOR CLARKSTON PROJECT

A consumer survey of Clarkston area residents was performed by Intellitrends, a Clarkston based market research firm. When asked, "How important do you feel it is to have a full-service hospital in your community?" greater than 80% of responses rated this as "important".

ECONOMIC IMPACT

McLaren estimates that the Clarkston project, when complete will have created approximately 4,000 new jobs. Every 15 new jobs results in \$3 million dollars in economic impact (Oakland County and The Federal Reserve Board) to the area in the form of wages, state and local taxes in addition to the multiplier effect of these dollars moving through the local economy. Based on this estimate, these jobs will generate \$600 - \$800 million in annual economic impact.

CON RESTRAINTS

In spite of all of the positive outcomes listed above, the Hospital Bed Standard Advisory Committee (SAC) and ultimately the CON Commission produced a set of CON Review Standards for Hospital Beds that prohibit McLaren from reducing the number of beds in Pontiac, addressing the population growth in Clarkston, moving beyond the current 2 mile limit, creating 4,000 jobs, and investing an additional \$350 million dollars into the Michigan economy.

The bed need methodology recommended by the SAC and approved by the Commission has essentially preserved the status quo. The formula is based on patient days from existing facilities and is then compared to the total number of existing beds from those facilities. This methodology will always result in excess beds. It will never show a need for new beds in a given area. It fails to account for population shifts and makes capacity a proxy for access.

In addition to the limitations outlined above, the SAC set forth an arbitrary bed reduction requirement. The bed reduction language has no statistical basis and puts communities served by aging facilities, such as McLaren – Oakland in Pontiac, at a disadvantage. The language further complicates a potential bed move that would position Pontiac with the appropriate number of beds and allow the people of Clarkston and surrounding communities to be served by an acute care hospital.

The following proposal to regulate the structure for relocating existing hospital beds was submitted by McLaren at the November 16, 2011 Hospital Bed SAC.

The proposed methodology this committee is being asked to consider captures an historical picture of where hospital beds are in the State of Michigan and relies only on hindsight over foresight.

This methodology, like previous methodologies created by previous Standards Advisory Committees, groups and protects existing hospitals instead of projecting any future shifts in health care delivery needed to meet shifts in population. In fact, it creates a hospital grouping with a "bed surplus" that includes nearly 700 beds created by the legislature and or the courts.

This lack of foresight is further complicated by the proposals for bed reduction which discourage quality improvements to aging infrastructure and undermine a number of community hospitals.

Adopting the proposed language will continue to mean that the only new hospitals ever built in the State of Michigan will be approved by the Legislature or the courts and not the CON Commission. We can all look forward to more new, overbuilt towers at existing locations because that is the only permissible construction. And we can expect that certain communities will be abandoned entirely because the cost to maintain aging infrastructures with no ability to relocate far exceeds any benefit.

This committee has an opportunity to consider a simplified hospital bed regulatory framework that addresses community need and works toward developing the right-sized hospitals as opposed to maintaining the status quo.

As a result, we support simplifying the Hospital Bed Standards to include the following provisions:

Regulatory structure for relocating existing hospital beds:

- Reduce restrictions on CON for relocating hospital beds to a new site
 - If a hospital elects to relocate beds to a new site it must demonstrate:
 - ◆ Financial viability with regard to the entire project
 - ◆ Conclusive positive community need assessment for both the proposed hospital site that is receiving the beds and the hospital giving up the beds
 - Significant community benefit with a financially viable plan for reuse of existing facility
 - Existing facilities cannot close to move to a new facility
 - ◆ No additional beds in Michigan
 - ◆ Maintain existing payer contracts for at least five years
 - ◆ Delicense at least 10% of existing facility's beds

- ◆ Proposed new hospital sites may not be approved within five miles of existing acute care hospitals, nor within the same county as single community providers

The SAC was scheduled to meet until December 20 but decided to end deliberation on the Hospital Bed Standards early and make November 16 their final meeting. There would have been an additional 30 days to fully consider the proposal. The main criticism from opponents of the proposal was that it would increase healthcare costs. As noted by Robert Cimasi in his paper, **Duped by Cries of Duplication**, "There has been no significant or empirical data that establishes that healthcare facilities or items of medical equipment actually, in and of themselves, raise either utilization or overall healthcare costs."¹ In addition, in the report prepared for Michigan Department of Community Health by Conover and Sloan, the authors conclude that "With its roots in the rapidly disappearing cost based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and/or access to care."² The McLaren proposal will indeed improve quality and, most importantly, improve access to care through improved distribution of existing hospital beds..

In summary, the SAC-proposed Hospital Bed Standards, if enacted, will continue to preserve existing franchises, continue to assure that the only new hospitals built in Michigan will be by Legislative or court action, encourage excess spending on overbuilt patient towers at existing locations, and subject aging urban communities to a separate standard of care. We can expect that certain communities will be abandoned entirely because the cost to maintain aging infrastructures instead of relocating them will far exceed any benefit. The implication further exists that restricting the growth of new facilities could become a burden on healthcare reform itself by exacerbating the growing access problem driven by the demand generated by the newly insured. It is no coincidence that, In the face of all the negative aspects of the proposed standards, the most outspoken opponents of hospital bed reform are hospitals themselves. The proposed standards allow them to have a monopoly on hospital beds in a given area.

¹ Cimasi, Robert James (April 2002). Duped by Cries of Duplication: The Failure of Certificate of Need Regulations. Health Capital Consultants, 4.

² Conover, Christopher J., Sloan, Frank A. (May 2003). Evaluation of Certificate of Need in Michigan. Volume I: Final Report. Center for Health Policy, Law and Management. Terry Sanford Institute of Public Policy. Duke University, vi.

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6. Testimony:

Content-Length: 146791

February 16, 2012

James Falahee, Chair
Certificate of Need Commission
C/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Mr. Falahee,

This letter is formal testimony by Spectrum Health about the proposed revisions to the CON Review Standards for Hospital Beds, as approved for public hearing by the CON Commission at their meeting on December 15, 2011. Spectrum Health is supportive of the proposed Standards, particularly the updated bed need and hospital grouping methodologies and the proposed provisions directed at “low occupancy” hospitals.

The Hospital Bed SAC conducted an extensive process to review and update the Hospital Beds Standards. They authorized two work groups, each of which met multiple times to complete their tasks. There was broad participation in the deliberations of the SAC and the work groups, and all viewpoints were given due consideration.

One member of the SAC presented a proposal for possible initiation of new hospitals near the end of the last SAC meeting. While some of the concepts included in this proposal may have merit, their introduction at the last minute prevented the SAC from giving them full consideration. Since the proponent of these changes was an active participant in the SAC discussions and was vice chair of one of the work groups, there was ample opportunity to introduce a new proposal in time for the SAC to consider it fully. Anyone claiming that all viewpoints were not given due consideration should be held responsible for failing to introduce new ideas in a timely manner.

Employing a methodologies work group, the SAC developed proposed changes to both the sub-area methodology (the method by which hospitals are grouped together for purposes of bed planning) and the bed need methodology. The existing subarea methodology is an artifact from the 1970's. It incorporates a cumbersome grouping method that is very difficult to replicate. With the assistance from the MSU Department of Geography, the SAC devised a new methodology which creates “hospital groups.” It is more objective, replicable, and sustainable than the old approach. The new method groups hospitals both by similarity of hospital use patterns and by geographic proximity. It results in fewer groups than the existing methodology (approximately 35 proposed

hospital groups, as opposed to 64 existing sub-areas), and only one hospital group contains a single hospital (whereas there are 32 single hospital sub-areas currently). For these reasons, the proposed new hospital grouping approach represents a substantial improvement to the existing sub-area methodology

The hospital bed need methodology contained in the existing CON Standards also is left over from the 1970's. While the approach is valid, the methods and programs employed are substantially out-of-date. The MSU Department of Geography also helped the SAC completely revamp the bed need methodology. Using current methods and programming, the proposed new methodology is more elegant, replicable and sustainable than the current approach. The new approach eliminates the use of zip codes in favor of counties, projects patient days instead of population and use rates, and combines calculations for all age groups. As a result, it is simpler to implement and reduces the number of steps and, hence, the potential for variation. All of these changes result in a more defensible process for predicting the need for hospital beds in Michigan.

The other substantial change in the Standards addresses the issue of low occupancy hospitals. Previous revisions to the Standards addressed the concerns of "high occupancy" hospitals ability to add licensed beds in areas without identified bed need. The proposed new bed need methodology predicts an excess of 6700 hospital beds in the state. Much of this excess capacity is created by hospitals which are not using their entire licensed capacity of beds. The proposed provisions define "low occupancy" as below 40%, with an adjustment for pediatric and obstetric use. If enacted, the low occupancy standards will require low occupancy hospitals to reduce their licensed capacity in order to receive CON approval for replacement, acquisition or relocation of hospital beds. The target threshold for capacity adjustments is 60% adjusted occupancy. These provisions are a reasonable complement to the existing high occupancy standards. An adjusted annual occupancy below 40% represents a very minimal threshold for low occupancy. A hospital operating at that level is not meeting optimal operating efficiency. Since these standards only effect hospitals requesting CON approval for replacement, acquisition or relocation of hospital beds, these proposed standards represent a modest approach to reducing unneeded hospital capacity.

The revised Hospital Beds Standards endorsed by the Commission represent the most thorough revision of these standards in over a decade. Spectrum Health supports these proposed revisions and encourages the CON Commission to approve these draft standards without alteration.

Sincerely,

Robert A. Meeker
Strategic Program Manager
Spectrum Health

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5. Standards: Hospital Bed
6. Testimony: The Hospital Bed Special Advisory Committee (HBSAC) was charged with a number of issues for review and Doctors' Hospital of Michigan supports the bed need methodology established by the Michigan State University (MSU) Geography Department and appreciates the extensive work and time provided by the subgroup.

However, Doctors' Hospital of Michigan oppose the provisions set forth in the bed reduction portions of the Standards and request that for-profit hospitals be excluded from the reduction as are critical access hospitals, hospitals located in rural areas, LTAC hospitals, sole community hospitals and hospitals with 25 or fewer licensed beds. There are only two (2) for-profit hospitals, at this time, in the State of Michigan. These hospitals have unique characteristics as they were purchased as an asset, which includes licensed beds. They pay income taxes, property taxes, sales taxes and other business taxes unlike non-profit hospitals in the state. To remove beds under the new standards would leave Doctors' Hospital with a near empty building without the ability to utilize the space and requiring the hospital to pay property taxes on a near empty building.

In the alternative, it is Doctors' Hospital of Michigan's position that the State of Michigan should reimburse for-profit hospitals for the fair market value of any beds that are de-licensed under the new Hospital Bed Standards as the beds were purchased as an asset

Furthermore, there are discrepancies in the MDCH Annual Survey occupancy determination. More and more patients are considered "observation" patients and are not included in the occupancy numbers. These patients take up hospital beds, but are not counted and this could be a difference of 5% or more. A hospital just under the 40% occupancy threshold would be penalized when they are, in fact, utilizing beds. There are no scientific bases for setting the formula at 40% with a cap of 60%.

Attached is a copy of the original letter from Doctors' Hospital's CEO, Sam Gizzi, objecting to the bed reduction criteria presented to the CON Commission at their December 15, 2011, meeting.

Thank you for your consideration of our requests.



**DOCTORS'
HOSPITAL**
OF MICHIGAN

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December 15, 2011

Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Certificate of Need Commission:

I am writing this letter to strongly oppose the Bed Need Standard Advisory Committee's (HBSAC) recommendation on a bed reduction methodology. Doctors' Hospital of Michigan is a privately owned hospital facility where dedicated physicians are working diligently to provide for the medical and health care needs of the residents of the Pontiac area.

Doctors' Hospital was created when a group of physicians purchased the 321 bed hospital and other assets of North Oakland Medical Center in November of 2008. Our physicians are determined to keep the hospital operational and growing. We have been in a recovery mode following the bankruptcy by the previous owners. There has been a complete change in leadership and a new plan of action for growth and community service is in place.

As Doctors Hospital recovers and grows, it will be necessary to seek CON approval under the Bed Need Standards for renovations and updates. The proposal before you will drastically diminish our ability to fully utilize the hospital facility that we have purchased. Under the 40% occupancy trigger with only the ability to utilize 60 percent of beds above the previous 3 year occupancy level will leave us with only a 61 bed hospital and a nearly empty building. The formula does not have any scientific basis and is arbitrary.

The few beds that could incrementally be added back to the hospital under the high occupancy standard are not sufficient for our expected future needs. It would require countless CON applications at a cost that is prohibitive.

Doctors Hospital is a purchased asset and under the recommendations of the HBSAC, you would be taking that asset away from us without due process and without due compensation. As a for profit hospital, we pay property taxes to the City of Pontiac. Under the proposal, Doctors' Hospital would be paying property taxes on a building and land that could not be utilized to its full potential. You would also be limiting our ability to hire additional staff during a time when every job is vital to the economic recovery of Michigan.

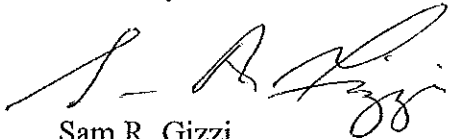
Page 2

December 15, 2011

Empty hospital beds are not a cost to healthcare. They are not a liability to the state, to purchasers of health insurance or providers. There is really no economic need for this bed reduction proposal. As a result, I strongly urge the Certificate of Need Commission to vote down the bed reduction proposal. In the alternative, I urge you to exclude for-profit-hospitals as there is a value to the purchased beds.

Your consideration of my request will be greatly appreciated.

Sincerely,

A handwritten signature in black ink, appearing to read "S. R. Gizzi". The signature is fluid and cursive, with a large initial "S" and "R".

Sam R. Gizzi
President and Chief Executive Officer