HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Wednesday, June 28, 2006

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

APPROVED MINUTES

I. Call to Order.

Chairperson Steiger called the meeting to order at 1:03 p.m.

a. Members Present and Organizations Represented:

Robert Asmussen, St. John Health System
Barton P. Buxton, McLaren Health Care
Wayne Cass, Michigan State AFL-CIO (Arrived at 1:07 p.m.)
Thomas Cragg, Michigan Manufacturers Association (Alternate)
Connie Cronin, H.F. Health System
Dr. Douglas Edema, Trinity Health (Arrived at 1:34 p.m.)
A. Michael LaPenna, Alliance for Health (Arrived at 1:05 p.m.)
Mark Mailloux, University of Michigan Health System
Robert Meeker, Spectrum Health (Alternate)
Patrick O'Donovan, Beaumont Hospitals
Dale Steiger, Blue Cross Blue Shield of Michigan
Mary Zuckerman, Detroit Medical Center

b. Members Absent and Organizations Represented:

James Ball, Michigan Manufacturers Association
James Falahee, Jr., Bronson Healthcare Group
Patricia Richards, Health Alliance Plan
Gary Kushner, Small Business Association of Michigan

c. Staff Present:

Lakshmi Amarnath
Irma Lopez
Jeff McManus
Andrea Moore
Taleitha Pytlowanyj
Brenda Rogers

II. Conflicts of Interests.

No conflicts were noted.

III. Review of Minutes – May 23, 2006.

Motion by Mr. Mailloux, seconded by Ms. Cronin, to accept the minutes as presented. Motion Carried.

IV. Review of Agenda and Distributed Materials.

Motion by Mr. Mailloux, seconded by Mr. Meeker, to accept the agenda as proposed with the addition of Review of the May 23, 2006 Minutes. Motion Carried.

V. Workgroup Reports.

A. Charge One Workgroup – Capacity at Existing Hospitals.

Mr. Steiger reported that the Workgroup had met once. They met with Michigan State and discussed some options. He had received more information from Michigan State and needs to go over the data that was given to him. The Workgroup is planning on having another Workgroup meeting soon. He is still waiting to receive the 2004 occupancy rates from the Department. The Workgroup will have a report for the Committee Members at the next Meeting. Discussion followed.

B. Charges Two/Five Workgroup – High Occupancy; Occupancy Levels and Fluctuation Over Time.

Mr. Mailloux thanked the hard work of the Workgroup. He provided a slide show presentation (Attachment A). He also provided a copy of the Workgroup's Final Report (Attachment B), Minutes from all the Workgroup's Meetings (Attachment C), and Draft Revisions to CON Standards (Attachment D). Discussion followed.

Motion by Mr. Mailloux, seconded by Mr. Meeker, for the report given by Mr. Mailloux to be accepted by the Committee for further examination. Motion Carried.

Public Comment:

Melissa Cupp, Wiener Associates
Penny Crissman, Crittenton
Bryan Broderick, Economic Alliance for Michigan

Mr. Meeker formally commended Mr. Mailloux for all his hard work and effort put into the Workgroup.

C. Charge Three Workgroup – Comparative Review Criteria.

Mr. LaPenna gave an oral report. The Workgroup has not met since the last HBSAC Meeting. He stated that the source of uncompensated care is still in question. The Workgroup will probably be meeting one more time before the next Meeting and will have a written report to present to the Committee at the next Meeting. Discussion followed.

Chairperson Steiger suggested that all Workgroups come to the July 28, 2006 HBSAC Meeting with a written report to present to the Committee.

D. Charges Four/Six Workgroup – Replacement Zone; Multiple Site Licenses Under Common Ownership.

Mr. Asmussen provided a brief overview of what the Workgroup was focusing on. He reported that the Workgroup had met two (2) times since the last HBSAC meeting. A sub-workgroup had also met two (2) times. The Workgroup does not plan on meeting any more before the next HBSAC Meeting. The Workgroup has not been able to come to a consensus. They plan on drafting two proposals for consideration by the SAC. Discussion followed.

VI. Next Step.

The SAC added August 2, 2006 to the meeting schedule.

VII. Future Meetings:

July 18, 2006
August 2, 2006
August 22, 2006

VIII. Public Comment.

None.

IX. Adjournment.

Motion by Mr. Meeker, seconded by Mr. Mailloux, to adjourn the meeting at 2:34 p.m. Motion Carried.

Final Report & Recommendations

6.28.2006

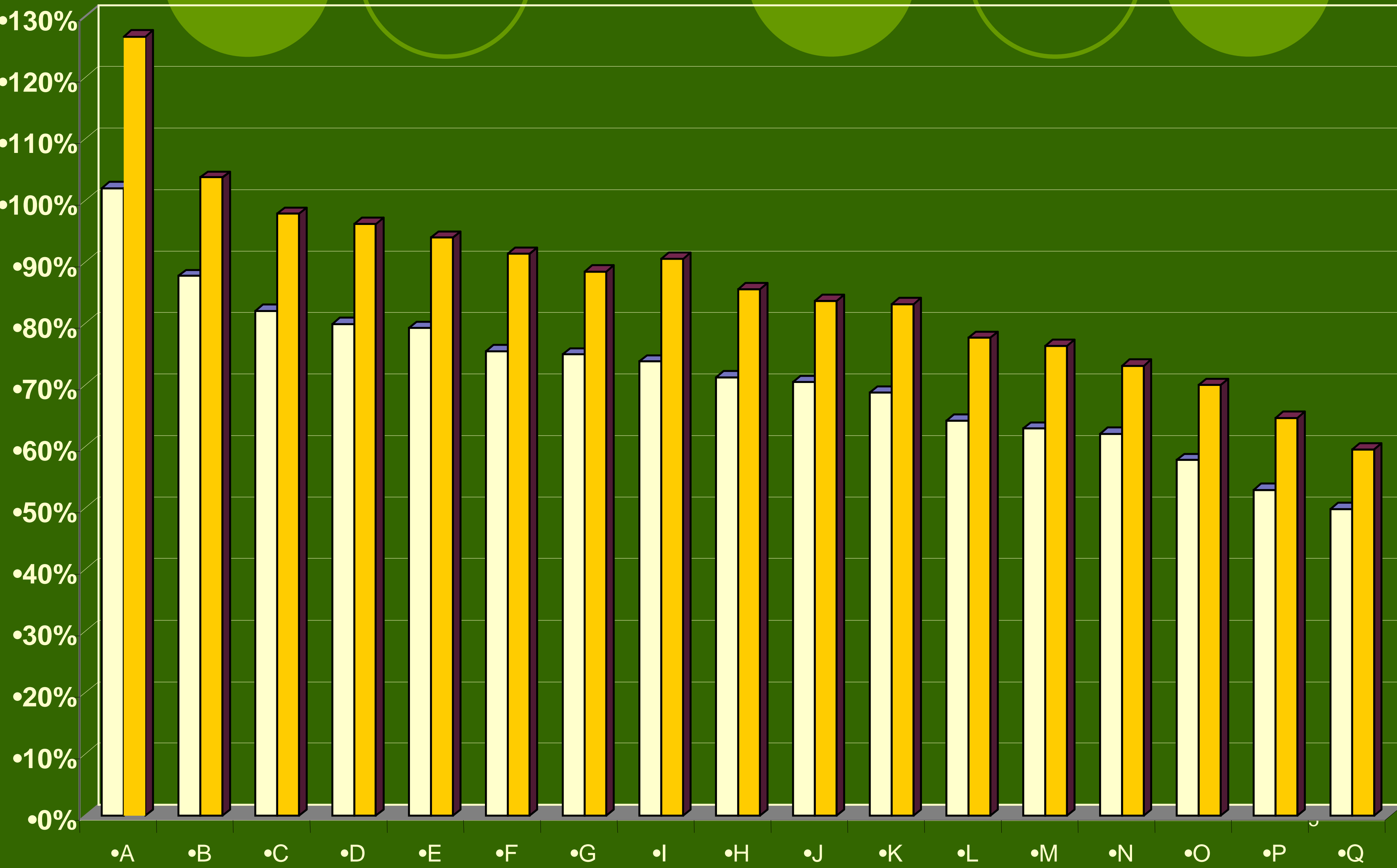
Charges 2 & 5

- 2. Review the high usage (occupancy) standards for adult, pediatric, ob/gyn and rehabilitation beds in the acute care setting.
- 5. Consider the level of occupancy and the fluctuations over time as related to the bed need methodology.

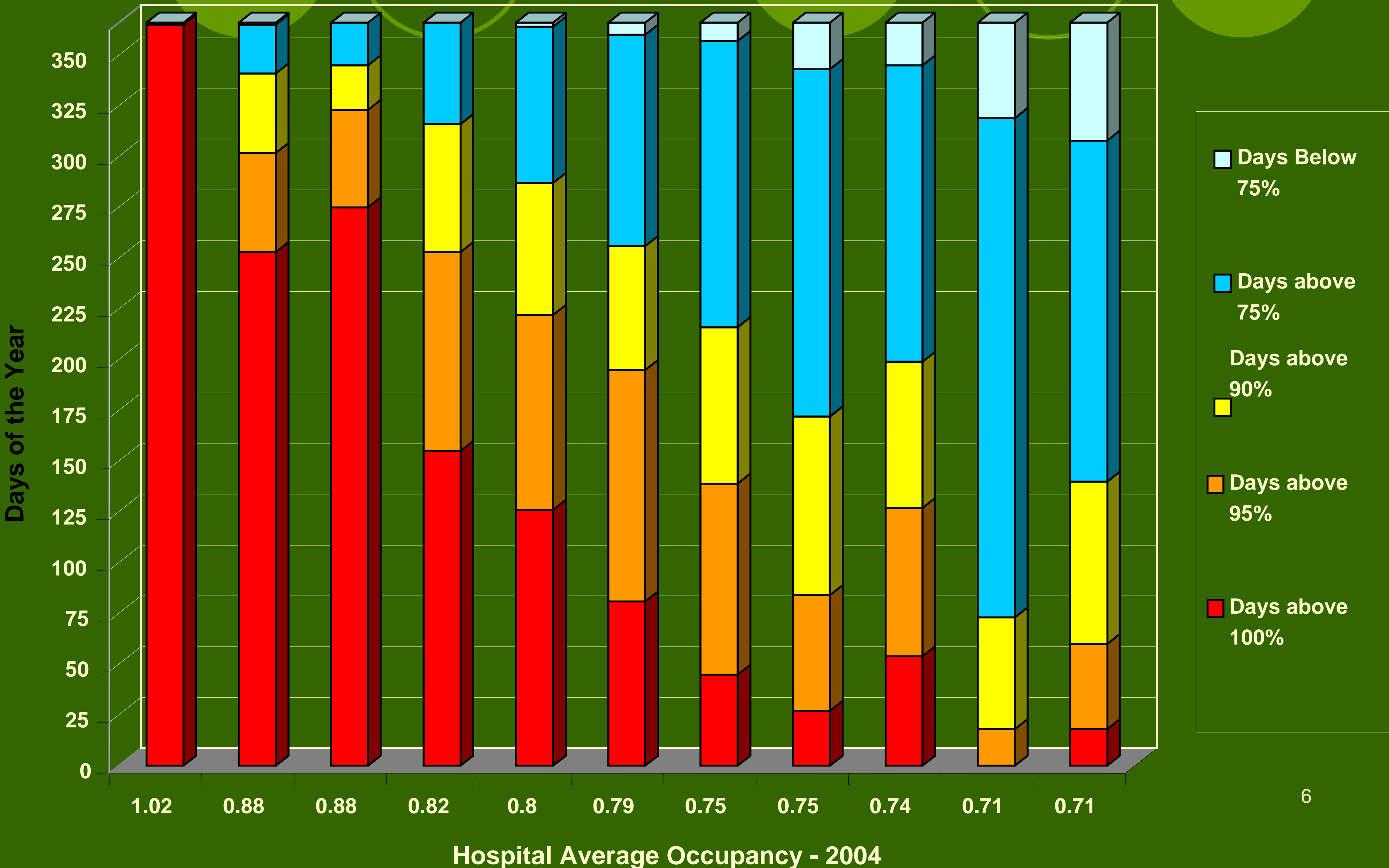
Factors of Concern:

- **“Bodies In Beds”**

Occupancy vs. ‘Bodies In Beds’ Calendar 2004



Days above Certain Occupancy Levels

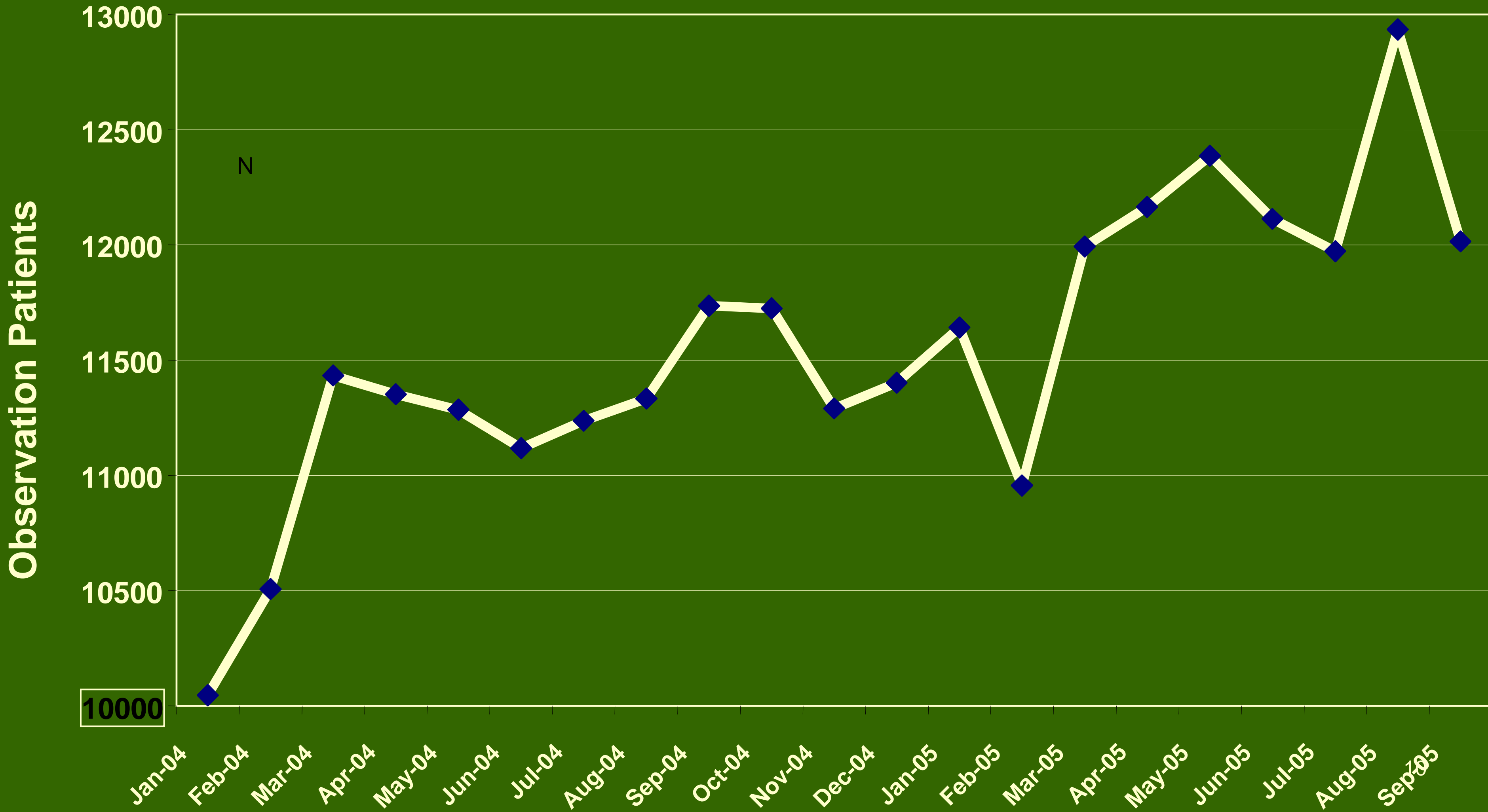


Factors of Concern:

- **“Bodies In Beds”**
- **“A Bed Is Not A Bed”**
- **Emergency Department Patients**
- **Observation Patients**

Observation Patients by Month

Jan. 2004 - Sept. 2005



Factors of Concern:

- **“Bodies In Beds”**
- **“A Bed Is Not A Bed”**
- **Emergency Department Patients**
- **Observation Patients**
- **Observation Patients in Beds**
- **PACU Patients (Post Anesthesia Care Unit)**
- **Decreasing Lengths of Stay**

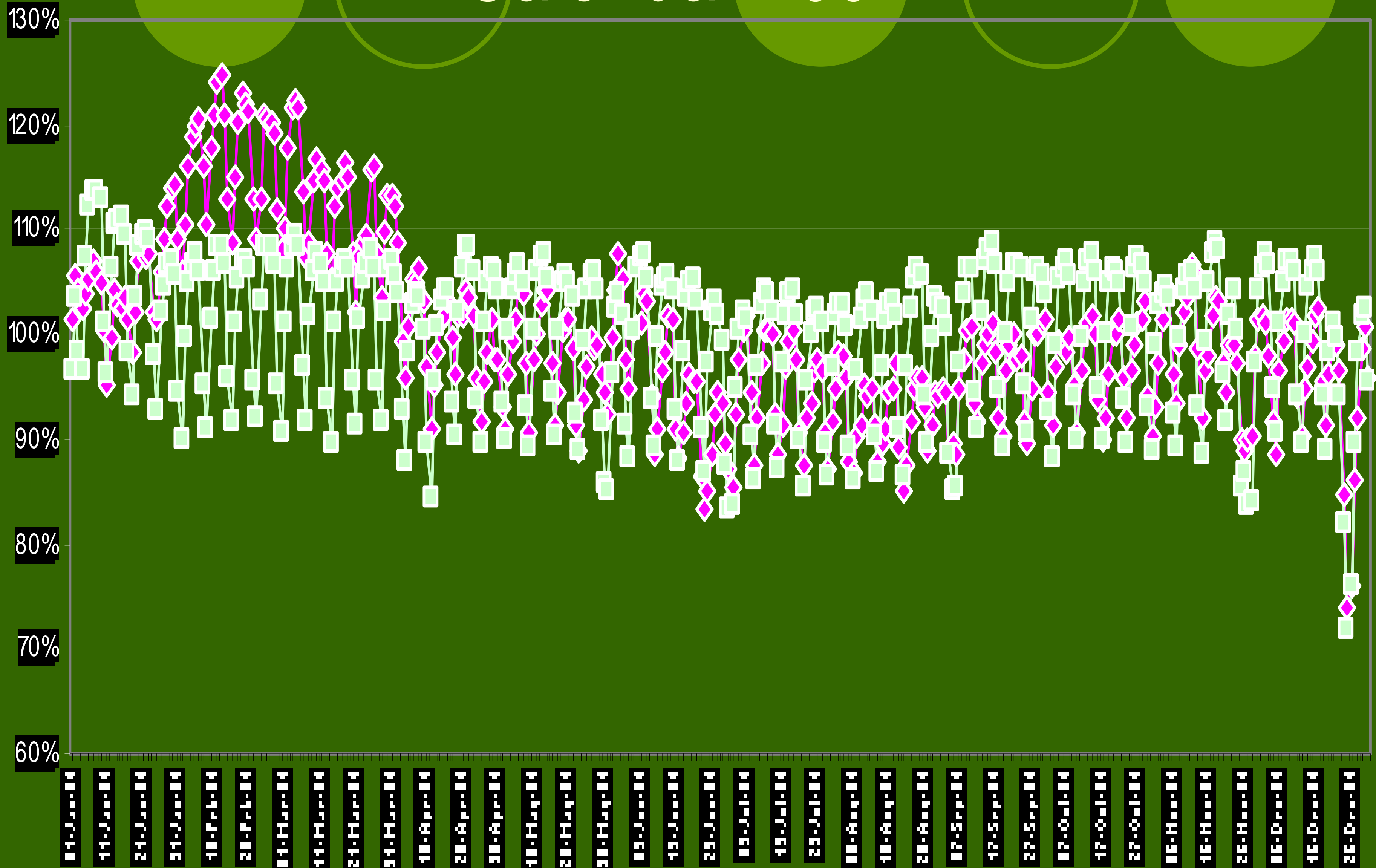
The Churn Factor
(Jan. 1 – Jan. 3)
“Bodies In Beds” vs. Occupancy

- Portions of 3 Days
- Consumption of Resources
- Exacerbated by:
  - PACU/OR Factors
  - ED Back-Up
  - Observation Status
  - Decreasing LOS
- Two-Day LOS
- Triggered by “In Bed” Status
- Point-in-Time Census Ignores Day-long Access to Resources
- Driven by Hotel Billing Methodology (Nights)

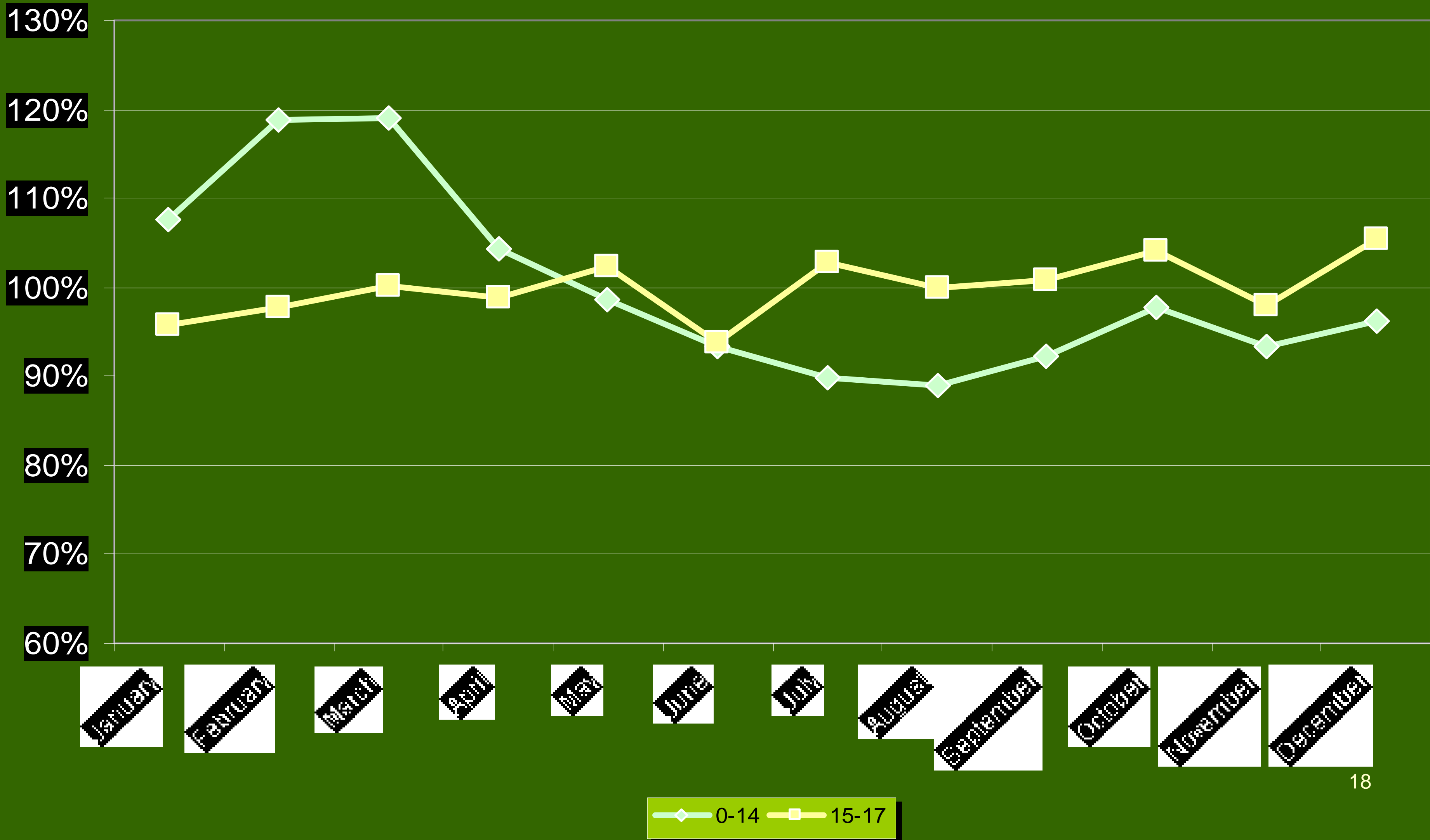
Recommendation #1:

- **Service Specific – Rehab**
- **Service Specific – Ped/OB**

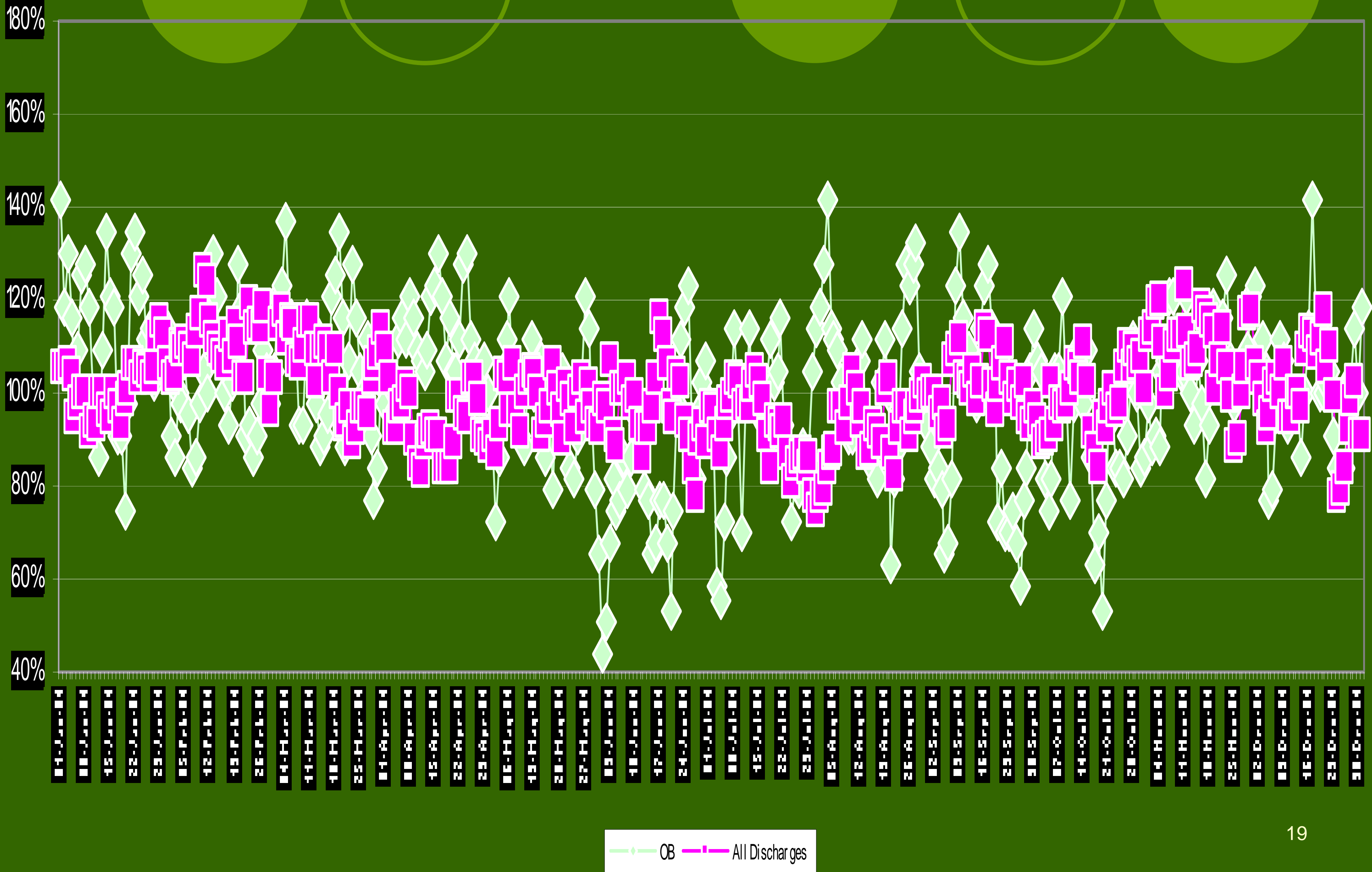
Ped (0-17) vs. Total Calendar 2004



Ped (0-14) vs. Ped (15-17) Calendar 2004



Calendar 2004
OB vs. Total



Recommendation #1:

- **Service Specific – Rehab**
- **Service Specific – Ped/OB**
- **“Level the Playing Field”**

Recommendation #1:

<u>The Pediatric Patient Days and the Obstetric Patient Days should be augmented by 10% in calculating an Adjusted High Occupancy value when applying for High Occupancy Relief</u>

Recommendation #1:

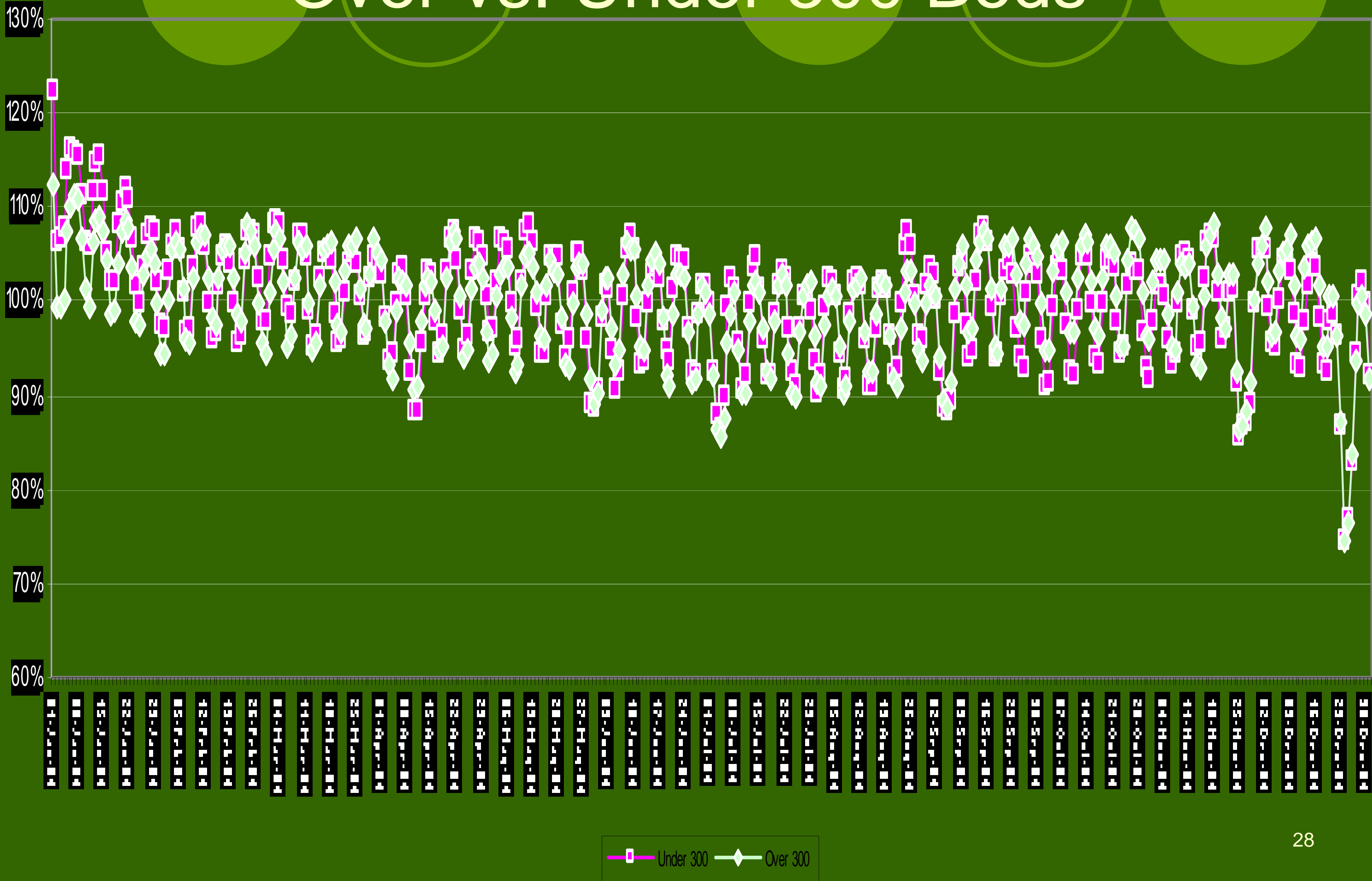
Definitions:

- ✓ **OB - All Deliveries: DRGs 370-375**
- ✓ **Ped – Patient Days Aged 0-14**

Adverse Economies of Scale:

- **Over/Under 300 Beds:**
  Intuitive vs. Formalized Position
- **Smaller Hospitals' Needs**
- **"A Bed Is Not A Bed"**
- **Large Hospital:**
  In Reality Many Small Hospitals

Calendar 2004
Over vs. Under 300 Beds



Recommendation #2:

One Single High Occupancy Threshold Should Be Applied Across-The-Board Regardless of Hospital Size.

Final Deliberations:

- ✓ **Subsequent CONs – Wait 2+ Years**

  “Should Be a Sustained Situation.”

- ✓ **Opposition to a Double Standard**
- ✓ **85% Too High for Sustained Occupancy**

  “A Bed IS Not A Bed.”

- ✓ **What About Addressing Both at Once?**
- ✓ **Cautious Compromise**

Cautious Compromise :

- ✓ Purchasers Not Eager For Lower Standard
- ✓ Providers Not Eager For Longer Threshold
- ✓ No Immediate Embrace, But The Recognition That Compromise Could Address Both Concerns at Once.

Recommendation #3:

As a Package Compromise, the High Occupancy Threshold Ought to be Set to a Uniform 80%, But with Hospitals Documenting Two Years of Sustained High Occupancy at that Level, Based on all Licensed and Approved Beds, Before Applying for High Occupancy Relief. Relief Would be the Granting of Sufficient Incremental Beds to Lower Occupancy to 75%.

Impact of Recommendations:

- **Possibility of 716 Bed Increment**
- **Reality: Fewer Than 200 Beds**

Summary:

- **Level the Playing Field:**
  - **Ped & OB By 10% each**
  - **Large vs. Small: Uniform**
- **All Hospitals High Occupancy 80%**

  But Demonstrate For 2 Years

Hospital Bed Standards Advisory Committee
Charges 2 & 5 Workgroup

Date: June 28, 2006

To: James Ball, Chair
James "Chip" Falahee, Vice Chair
Members of the Hospital Beds SAC

From: Mark Mailloux, Chair, Charges 2 & 5 Workgroup

Re: Final Report

On behalf of the Charges 2 & 5 Workgroup, I am pleased to provide you & the entire Hospital Bed Standards Advisory Committee (SAC) with this Final Report. In conjunction with the accompanying A/V presentation, it provides the Committee with a synopsis of the deliberations we have accomplished.

At the outset, let me say that the participants agreed unanimously to move these concepts forward to the SAC for your consideration, reserving the right to take a position on the proposals pending review of additional documentation, rationale and impact analyses.

The three recommendations, to be expanded in more detail in this report, are as follows:

#1 - The Pediatric Patient Days and the Obstetric Patient Days should be augmented by 10% in calculating an Adjusted High Occupancy value when applying for High Occupancy Relief.

#2 - One single High Occupancy Threshold should be applied across-the-board regardless of hospital size.

#3 - As a package compromise, the High Occupancy threshold ought to be set to a uniform 80%, but with hospitals documenting two years of sustained High Occupancy at that level, based on all licensed and approved beds, before applying for High Occupancy relief. Relief would be the granting of sufficient incremental beds to lower occupancy to 75%.

BACKGROUND NARRATIVE

This group was directed, at the initial SAC meeting on February 22, 2006, to examine the following two charges of the overall Hospital Bed Charge and report back to the SAC with our findings and/or recommendations.

Those two charges are:

2. Review the high usage (occupancy) standards for adult, pediatric, ob/gyn and rehabilitation beds in the acute care setting.

5. Consider the level of occupancy and the fluctuations over time as related to the bed need methodology.

The workgroup met seven times, and the minutes of the meetings are included as attachments to this report. Throughout these meetings, a total of 32 distinct individuals participated in and provided input to this process, either in person or by phone link, albeit not all of them at any one meeting. There was never a quorum of SAC members present at any meeting.

As we considered the two charges, it was felt that Charge 5 would be most facilitated by our examination of time series data to identify any such fluctuations. In reality, the High Occupancy (HO) considerations will often short circuit the actual bed need methodology so that the impact (if any) will be closely related to the HO considerations. Thus the workgroup decided to address these two charges by viewing service specific occupancy data and comparing it with overall occupancy data.

Early on, the workgroup identified several occupancy considerations that often go unrecognized:

- **"Bodies In Beds"**. Unlike a hotel with customary check-in and check-out times, a hospital often has more than one patient associated with a particular bed, causing scheduling and logistical complications. Under this consideration, a hospital with a nominal 75% occupancy may have a sufficient number of patients, at some time during the day, to operate as if it were well over 90% or more. A patient admitted on January 1, and discharged on January 3, will have a two-day Length of Stay (LOS). In reality, that person will have occupied a bed during portions of three separate days.
- **"A Bed is Not a Bed"**. This is related to the appropriateness of the bed which may be available. An impending OB delivery cannot be admitted to the Cardiac ICU simply because there is an available bed there at the time of delivery.

There are several additional complicating factors which affect occupancy but are not accounted for in reported occupancy statistics. The group identified and examined the following:

- **<u>Emergency Department (ED) Patients</u>**. These are patients who have been treated in the ED and determined to require inpatient admission. Until the actual bed is available, the patient isn't counted as inpatient despite already receiving care while awaiting placement.
- **<u>Observation Patients</u>**. The definition of what constitutes an observation patient is in a state of constant flux. These patients are of several types. Either they had been anticipated to return home the same day (e.g. Outpatient surgery) or perhaps presented with something like "Chest Pain." For whatever reason, it has been determined that they cannot be released, and instead are being "held for observation." Ironically, these patients may consume more resources than an admitted patient because of the heightened requirement for their actual observation. They cannot be counted in the inpatient bed census because they have not been (and perhaps will not be) admitted. For our purposes, it was sufficient to recognize that, as recorded by the Michigan Outpatient Database, the number of such cases has been steadily rising.
- **<u>Observation Patients, Occupying a Bed</u>** – These patients in essence carry a 'double whammy' in that they have been placed in an actual inpatient bed for their observation. Thus, in addition to the resource consumption implications cited above, these patients keep a licensed bed off of inpatient service while still not being counted in the inpatient bed census. Thus, that bed is not available for another pending admission.
- **<u>PACU Patients</u>**. The Post-Anesthesia Care Unit, or PACU, cares for patients who are intended to be admitted post-operatively until their respective bed is available. Like the ED patients above, they cannot be counted in census until their specific bed is available.
- **<u>Decreasing Lengths of Stay</u>**. As patients' LOS decreases, the turnover of any given bed becomes that much more frequent, thereby exacerbating what we have termed the 'Churn Factor.' This increased frequency of the admission and discharge processes has further compounded the ability to facilitate the handling of patients in the preceding categories.

Against this backdrop, the workgroup examined the first of our charges relating to service specific considerations: Pediatrics, Obstetrics, and Rehabilitation.

In order to avoid any appearance of crafting a result that was preordained to arrive at a result for any particular hospital, the group looked instead at discharge data from *<u>all</u>* Michigan hospitals, aggregated together, to ascertain the behavior of each service in general, across all facilities.

Daily discharge data for all 1.2 million discharged inpatients for an entire year were graphed to display the variation from the mean, or how much any particular

services' variability differed, if any, from the overall experience. Since, in this methodology, all values above and below the mean all averaged to zero for the entire year, the results were informative on a comparative basis. The overall discharge display was overlaid with each specific service and any additional variation, or lack of it, became immediately evident.

It should also be noted that since these data are aggregated for the entire State, these variances will be at an absolute minimum since a bed available in Alpena will not serve a patient who presents in Muskegon. Rather it displays seasonality and extremes within the data.

SERVICE SPECIFIC CONSIDERATIONS

In addressing each specific service, the following were found:

- **Pediatrics**. Corroborating conventional wisdom, the data reflected an extreme variation (at or above 30%) *above and beyond* that displayed by the total pool of discharges, during the first quarter of the calendar year. This corresponds to all of the flu and sinus related cases that plague the winter season. During the balance of the year, the data show that Pediatric patients lag somewhat behind the overall in order to balance out for the entire year.
- **Obstetrics**. No seasonality was found, but the most significant aspect was the extreme nature of the higher 'highs' and lower 'lows' throughout the entire year.
- **Rehabilitation**. No significant differences in variation from the mean were found, leading the workgroup to decide that no further action was required for this service.

Based on the foregoing, and following considerable discussion, the group developed

Recommendation #1:

The Pediatric Patient Days and the Obstetric Patient Days should be augmented by 10% in calculating an Adjusted High Occupancy value when applying for High Occupancy Relief.

Discussion had focused on the alternatives of creating a weighted average of the various beds as opposed to the re-creation of separate licensed bed categories to segment the beds for calculation purposes. Consensus developed around the weighted average approach, thereby placing relief specifically where and to the extent it was needed. Instead of calculating numerous averages however, one for each applicant, a methodology to 'operationalize' this calculation more simply put forth an 'Adjusted High Occupancy' based upon multiplying all Pediatric and Obstetric Patient Days by 1.1. This would accomplish the same result while

leaving the final high occupancy percentage identical for all applicants. The following formula was offered to help clarify:

$$\frac{(\text{OB Patient Days} * 1.1) + (\text{Ped Patient Days} * 1.1) + (\text{Remaining Pt. Days} * 1.0)}{\text{Total Possible Patient Days } \textit{or} \text{ (Lic beds + Add'l CON approved beds)} * 365}$$

For purposes of these calculations, Obstetric Patient Days are defined as all deliveries (DRGs 373 thru 375) and Pediatric Patient Days are defined as ages 0 thru 14 inclusive.

OVER/UNDER 300 BEDS CONSIDERATION

The workgroup then took up consideration of the current over/under 300 bed provision of the Standards. Data which compared variation from the mean for these two classes of hospitals showed virtually no difference between them. This could be taken as a sort of validation of the contention that while smaller and particularly rural hospitals face occupancy pressures from adverse economies of scale due to their small size, in fact larger hospitals are in reality an agglomeration of numerous, non-interchangeable small 'hospitals.' Units such as a large hospital's Cardiac ICU, Surgical ICU, Medical ICU, Neo-natal ICU, Obstetric unit and Pediatric unit face exactly the same adverse economies of scale, especially since a facility's overall occupancy will totally blur such distinctions. The workgroup then formulated

Recommendation #2:

One single High Occupancy Threshold should be applied across-the-board regardless of hospital size.

LONGER TERM & OVERALL CONSIDERATION

Finally, the workgroup took up consideration of overall longer term high occupancy concerns as indicated in Charge #5. Considerable discussion ensued surrounding the frequency with which such High Occupancy relief may be invoked. While some argued that second or subsequent applications for High Occupancy relief ought to be allowed no sooner than two years or more, others were as insistent that there be one standard for high occupancy. It is no more or no less onerous to sustain High Occupancy the first time than the second.

In addition, based upon discussion of the adverse economies of scale that larger hospitals with numerous smaller units face, it was urged that the 18% of hospitals

in Michigan currently faced with a more restrictive High Occupancy threshold be allowed to meet the 80% Standard which over 80% of the State's facilities now enjoy. It was further agreed that *all* hospital beds, licensed and approved, must be included in the calculations. This discussion generated

Recommendation #3:

As a package compromise, the High Occupancy threshold ought to be set to a uniform 80%, but with hospitals documenting two years of sustained High Occupancy at that level, based on all licensed and approved beds, before applying for High Occupancy relief. Relief would be the granting of sufficient incremental beds to lower occupancy to 75%.

It should be stressed that it is the clear sense of the workgroup that this is a non-separable package proposal in that 'two years' was only agreed to when accompanied by '80%' and vice versa. The group would *not* support removal of either of these provisions in isolation from the other.

This last recommendation alone could generate no more than 716 new beds if each and every one of the facilities over 300 beds were to qualify for high occupancy. Recent occupancy data were examined and, in reality, all of these recommendations, taken as a whole, would generate less than 200 additional beds in terms of current occupancy statistics.

SUMMARY

It should be noted again that there was not unanimity within the workgroup. Various points of view were expressed, and opposing positions were advocated, but all sides were heard: providers, regulators and consumers/payors. However, a remarkable degree of non-partisanship was exhibited. No personal agendas were espoused, and all present, at each meeting, attempted to work within the framework of the three healthcare planning principles of Cost, Quality & Access.

These recommendations, while not likely to be the last word on High Occupancy, represent an attempt to clarify and simplify the nature of High Occupancy relief in Michigan. Taken together, we believe these recommendations will level the playing field (#1 & #2) and require a sustained history of High Occupancy (Recommendation #3) in order to qualify for relief.

As always, this was a group effort. Note-taking and minutes for all of our meetings were ably provided by Cheryl Miller of Trinity Health. All data calculations were provided by Bob Zorn of the MHA who produced our graphs and charts 'blinded.' Thus, no hospital(s) that might have had an interest in any

proposal was either responsible for generating the data or even aware of the identity of 'Hospital A' when the data were displayed. Proposed language for the Standards, included as another attachment, was drafted by Melissa Cupp of Weiner Associates in conjunction with Brenda Rogers of MDCH. All participants left their respective employer's hat at the door and contr5ibuted to the good of the whole. Those efforts are heartily appreciated, and any remaining shortcomings in this report remain the responsibility of the author.

Attachment C

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes

To: Attendees: (* Indicates HBSAC Member)

* Mark Mailloux, UMHS	* Constance J. Cronin, HFHS
Barbara Jackson, EAM	* Michele Ciokajlo, SJH
* Chip Falahee, Bronson	Melissa Cupp, Wiener Assoc.
David Luick, KDA	Carrie Linderoth, KDA
Cheryl Miller, Trinity	Joette Leseur, Program CON
Eric Fisher, DMC	Mark Hutchinson, SMHC
Terry Gerald, DMC	Bob Zorn, MHA
Alex Du, HFHS	* Mary Zuckerman, DMC (phone)

From: Mark Mailloux
Date: 3/15/2006
Re: Meeting 3/09/2006

This group met on Thursday, March 9, 2006, at the offices of Kheder Davis & Associates, 201 N. Washington, Lansing, Michigan, at 9:05 AM. Thanks to Cheryl Miller for agreeing to serve as Recording Secretary.

An informal agenda of talking points concerning the two charges referred to this group by the Hospital Bed Standards Advisory Committee (HBSAC) had been circulated by the Chair prior to the meeting and additional copies were available. Wide ranging and open-ended discussion ensued surrounding both topics.

In considering Charge 2, it was mentioned that in Pediatrics, the highs are higher and the lows are lower than on Adult Med/Surg services. M. Mailloux reported that last year there was a 42% difference between the high point and the low point of the Average Daily Census (ADC) at C.S. Mott Children's Hospital.

This charge also referenced OB/Gyn beds, but there was general agreement that the real concern was for Obstetrics and not for Gynecology. The group consensus was to limit its consideration to Obstetrics alone.

Discussion arose concerning whether carve-outs should be allowed for any one service (such as Peds) or whether that would precipitate a flood of "me-too" requests for every other service. The alternative would be to investigate the option of lowering the overall high occupancy threshold (currently 85%) to a lower value to be applied across the entire facility as is currently done. No consensus was reached and the group decided to consider this topic again next time.

A prior e-Mail, received from Bob Meeker of Spectrum who was unable to be present at this meeting, suggested that the group might wish to consider first establishing some applicable definition of a Pediatric facility, which could then be applied whenever and wherever a Pediatric exception was desired such as in the current high occupancy consideration.

In addressing Charge 5, the group discussed the recently unveiled MSU Geographers' proposed new sub-areas vs. the current Acute Care Bed Need Methodology (ACBNM) sub-areas. The general consensus was that considerable clarification should be sought.

Looking forward to the next meeting, the group recognized the need for data to substantiate or refute the conventional wisdom that Peds units exhibit significantly greater variance in their ADC. Two paths would be followed:

(1) Bob Zorn volunteered to pursue the possibility of MIDB production of hospital-specific (but blinded) ADC reports, by the specific carve-outs of interest of Peds, OB, NICU and Rehab. Peds would be defined by age <18, and OB, NICU & Rehab by appropriate DRG(s). Excluded would be Critical Access Hospitals and those with ADCs below about 70% since they would not be likely to need high occupancy relief.
(2) Each of the attendees was to seek to provide their own internal data documenting the ADC variations at their institution to share with the group in case the MIDB report could not be produced.

With the next meeting having been set for Thursday, March 23, 2006 at 1:00 PM at the MHA offices, the meeting adjourned at about 11:35 AM.

Attachment C

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #2 – March 23, 2006

To: Attendees: (* Indicates HBSAC Member or alternate)

* Mark Mailloux, UMHS, Chair
Barbara Jackson, EAM
* Chip Falahee, Bronson
David Luick, KDA
Cheryl Miller, Trinity
Kirstin Tesner, Genesys
Alex Du, HFHS
Lauren Shellenberger, Dykema
Penny Crissman, Crittenton
* Michele Ciokajlo, SJH
Melissa Cupp, Wiener Assoc.
* Bob Meeker, Spectrum Health
Joette Leseur, Program CON
Bob Zorn, MHA
* Mary Zuckerman, DMC
Sean Gehle, AHM

From: Mark Mailloux
Date: 3/31/2006
Re: Meeting 3/23/2006

This group met on Friday, March 23, 2006, at the offices of the Michigan Health and Hospital Association, 6215 W. St. Joseph Hwy, Lansing, Michigan, at 1:05 pm. Thanks to Cheryl Miller for continuing to serve as Recording Secretary.

There was confirmation that there was not a quorum of the HBSAC members before the meeting began.

The discussion was divided into two components:
(1) carve out versus overall high occupancy adjustment(s);
(2) review of draft census data as compiled by Bob Zorn

The Chair, Mark Mailloux indicated that UMHS was supportive of a pediatric high occupancy provision as evidenced by the "higher highs and lower lows" experienced at C.S. Mott Children's Hospital. Although this variability was discussed at the previous workgroup meeting, Bob Meeker was able to graphically depict a similar variability being experienced at Spectrum's DeVos Children's Hospital. Specifically, while Spectrum's pediatric occupancy averaged 61% last year, the variance ranged from a low of 37% to a high of 103%. It was suggested that this variability might be limited to high volume children's hospitals such as Children's, Mott and DeVos. Chip Falahee of Bronson added that their pediatric beds accounted for over 13% of their licensed bed capacity and would like to be included for consideration in any high occupancy provision for pediatric cases. Meeker suggested that the MRI standards be reviewed to see if a definition for pediatric facilities was included and could be applied to the bed standards as well.

Concerning OB services, Mailloux asked if the historical use of a Poisson distribution for patient arrival rates could even be resurrected, especially in light of current much higher C-Section rates. Their non-random, semi-scheduled arrival rates do not observe a Poisson distribution, and were not a part of the previous OB analyses due to their much less frequent occurrence at that time and their correspondingly minimal impact on the overall random arrival rates.

Mary Zuckerman of the DMC suggested that a greater problem existed concerning observation patients, especially in the Pediatric venue, and the fact that many of them take up licensed beds and yet are not counted in the occupancy statistics. It was suggested that this payer-created situation is a significant issue for most hospitals. Bob Zorn of the MHA reminded the group that observation patients are captured in the MODB and he would check on any trends.

Zorn distributed graphs depicting licensed bed occupancy rates for hospitals (blinded) with more than 300 beds. The comparison of licensed occupancy versus the so-called "butts in beds" concept, which identifies patients in-house at some point during the day, was very illustrative. An admission on the First of the month and discharge on the Third of that same month would register as a two-day length of stay, even though that person was occupying a bed at some time during all three days: the First, Second and Third of that month.

These stacked bar charts showed the percentage of time a specific hospital would exceed its licensed bed capacity, due to patient overlap and what might be called the 'churn factor' of in- and out-processing of patients , even though the licensed bed occupancy rate would suggest that there were available beds.

Zorn was asked if he could produce similar stacked bars for selected sub-groups such as: Ped, OB, Rehab & NICU. He indicated that this would be possible, subject to resolution of some definitional issues.

Next Steps:

(1) Attendees were asked to provide Zorn with the number of licensed beds each had for Peds, Obstetrical, NICU, Rehab, Observation and Total, excluding Psych, to allow calculation of the various service-specific occupancy percentages.
(2) Attendees were encouraged to forward their meeting availability, per Mailloux's recent e-Mail request, so that the next meeting can be scheduled as soon as possible.

The meeting was adjourned at 3:15 pm.

Attachment C

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #3 – April 10, 2006

To: Attendees: (* Indicates HBSAC Member or alternate)
* Mark Mailloux, UMHS, Chair
Barbara Jackson, EAM
Melissa Cupp, Wiener Assoc.
* Bob Meeker, Spectrum Health
Cheryl Miller, Trinity
Kirstin Tesner, Genesys
* Mary Zuckerman (phone), DMC
Mark Hutchinson, Saint Mary's Healthcare
JoAnne Herman, Genesys
* Connie Cronin, HFHS
Terry Gerald, DMC
Joette Laseur, Program CON
Bob Zorn, MHA
* Wayne Cass, AFL-CIO

From: Mark Mailloux
Date: 4/17/2006
Re: Meeting 4/10/2006

This group met on Monday, April 10, 2006, at the offices of the Michigan Health and Hospital Association, 6215 W. St. Joseph Hwy, Lansing, Michigan, at 1:05 pm. Thanks to Cheryl Miller for continuing to serve as recording secretary.

There was confirmation that there was not a quorum of the HBSAC members present before the meeting began.

The discussion began by focusing on the appropriateness of 85% as the criteria if a long-term view is taken. Specifically, there was concern that there would not be sufficient "play" in the system to accommodate census "peaks and valleys". Bob Meeker provided a graphic depiction of pediatric utilization at Spectrum's DeVos Children's Hospital. The census range went from a high of 103% to a low of 37%. And, both of these extreme points occurred within the same week. Similarly, Mark Mailloux showed the variation in census at UMHS' Mott Children's Hospital. It was again suggested that this variability might be limited to high volume children's hospitals.

Continuing the discussion from the previous meeting, Bob Zorn provided two updated graphs depicting licensed bed occupancy rates for hospitals (blinded); one for hospitals with more than 300 beds and the second for hospitals with less than 300 beds, consistent with the distinction in high occupancy language in the *Hospital Bed Review Standards*. These stacked bar charts showed the percentage of time a specific hospital would exceed its licensed bed capacity, due to patient overlap and what might be called the 'churn factor' of in- and out-processing of patients, even though the licensed bed occupancy rate would

suggest that there were available beds. It was suggested that as length of stay declines, this "churn factor" would increase. Zorn suggested that this approach would explain why there was a disconnect between licensed bed occupancy rates below 100% while hospitals were still on ER diversion status.

Zorn also provided line charts showing variation in patient days by product line by month. It was clear that some of the clinical services are subject to significant seasonal variability, i.e. pulmonary medicine. He also provided a chart showing observation patients by month as reported in the Michigan Outpatient Database (MODB).

Meeker noted the methodology used in Georgia and Maryland that included an annual adjustment of licensed beds based on utilization. Mailloux formally requested that MDCH staff contact these two states (and others as necessary) to gain a better understanding of this approach. Joette Laseur agreed to transmit this request to Brenda Rogers at MDCH.

There was discussion concerning what, if anything, Mailloux should present on behalf of this workgroup at the April 19th HBSAC meeting. Given that all four workgroups are still on-going without conclusive deliverables at this point, it was suggested that the HBSAC meeting should be cancelled. Mailloux agreed to contact HBSAC Chair and Co-Chair, Jim Ball and Chip Falahee to make that suggestion.

Next Steps:

1. Attendees were still asked to provide Zorn with the number of licensed beds each had for Peds, Obstetrical, NICU, Rehab, Observation and Total, excluding Psych, to allow calculation of the various service-specific occupancy percentages.
2. MDCH will contact other states as noted above concerning annual license bed adjustments.
3. Mailloux will contact Licensure to see if someone can attend the next meeting to discuss the ramifications of separate vs. combined bed licensure for different categories (Adult, Peds, OB, etc.)
4. If completed, Mailloux will share the statistical investigation conducted by UMHS on the census variation. He anticipates that their analysis may help determine if the same high occupancy percentage level is appropriate for Peds as for Adult and, if not, what that occupancy rate should be in order to account for its "higher highs and lower lows."
5. Review percent of admissions from ED.
6. Identify how to recalculate the State of Michigan's "over-beddedness" utilizing the "bodies in beds" methodology.
7. Mailloux will send out an e-Mail to determine the next meeting date(s).

The meeting was adjourned at 3:15 pm.

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #4 – April 25, 2006

To: Attendees: (* Indicates HBSAC Member or Alternate)
* Mark Mailloux, UMHS, Chair — Amy Barkholz, MHA
Bob Zorn, MHA — Liz Palazzollo, HFHS
Melissa Cupp, Wiener Assoc. — * Bob Meeker, Spectrum Health
Cheryl Miller, Trinity Health — Penny Crissman, Crittenton
Mark Hutchinson, Saint Mary's Healthcare — * Wayne Cass, AFL-CIO
Terry Gerald, DMC — Joette Leseur, CON Program
Michael Brecht, St. John Health (by phone)

From: Mark Mailloux
Date: 5/8/2006
Re: Meeting 4/25/2006

This group met on Tuesday, April 25, 2006, at the offices of the Michigan Health and Hospital Association, 110 West Michigan Ave, Lansing, Michigan, at 9:10 am.

There was confirmation that there was not a quorum of the HBSAC members before the meeting began.

Mailloux suggested that the discussion focus on the question "Is there a categorical difference in Pediatrics or Obstetrics from the General Medical/Surgical patient base such that, whatever is decided for a general high occupancy standard, that specific service would be at a disadvantage?"

Mailloux distributed two handouts both based on the "Bodies in Beds" methodology:

1) A series of graphs/tables showing the Average Daily Census (ADC) for CY 2004 by month for all non-Psych discharges, Peds, Peds vs. Total, OB-Delivered, OB-Delivered vs. Total, Rehab, Rehab vs. Total and a summary of occupancy statistics.
2) A table with imputed occupancy factors based on Statewide 2004 occupancy data.

Following the review of the handout material prepared by Mailloux and Zorn, the group discussed the "strawman" situation. Using the current high occupancy threshold of 85% for hospitals over 300 beds, the entire State, if it were a single hospital operating at 85% occupancy, would be short about 6% of necessary Pediatric capacity on the highest day of utilization. For OB it would be short about

3.9% of capacity. At that same time, on that highest day of utilization, there would be an excess of only about 3.3% of Total capacity. In addition, this is extremely conservative since it views the entire State together, ignoring the fact that patients are not immediately transferable across the entire State as if from one hospital floor/unit to another.

Under the same scenario, at the smaller hospital 75% average annual occupancy, there would be only 6.5% Pediatric capacity available on the days of highest utilization, 8.3% OB capacity available, while the total system would have 14.7% available on the highest of those days. Clearly, the conventional misconception that "75% occupancy means 25% is unused" is inaccurate.

Mailloux suggested that this called into question the adequacy of one overall percentage to be applied particularly for Peds or OB to qualify for additional beds under the current high occupancy provisions. Their more severe occupancy 'swings' between high and low census were not consistent with the overall average exhibited in the much larger general inpatient population.

Other comments/observations/issues which were discussed:

- Is the variation around the mean the same for the "Bodies in Beds" methodology vs. the traditional occupancy calculation?
    - ✓ Since the ACBNB uses the traditional calculation, should we as well?
- Philosophically, should we have carve-outs (e.g. Peds, OB) with weighted adjustments or should the overall high occupancy requirement be adjusted?
- Should there continue to be separate thresholds for hospitals above and below 300 beds?
- Pediatric variation was very evident in the winter months.
- OB may be a bigger problem than Peds given a greater variation year-round.
- A 75% licensed bed occupancy rate does not mean that 25% of the beds are empty.
- The existence of a high occupancy standard favors existing facilities and disadvantages new entrants/new hospitals.
- Other factors of impact for consideration:
    - ✓ As LOS declines, churn factor increases
    - ✓ Seasonality (especially in Peds)
    - ✓ Increase in specialty beds/units
    - ✓ ED back up; cleared for admission but no bed available
    - ✓ Observation days: Two kinds –
        - medical (chest pain, pediatric asthma)
        - surgical (late case, longer anesthesia recovery)
    - ✓ Day of the week
    - ✓ Holding in PACU; to be admitted post-surgery but no bed available

Mailloux reported on a conversation he had with Rick Benson from MDCH Licensing concerning the categories of beds. MDCH continues to track all categories of licensed beds but that CON has aggregated everything under a single medical/surgical category.

At the next meeting, Mailloux indicated that one of the agenda items will be to prepare for his report to the SAC (May 23) concerning whether or not Peds/OB/Rehab warranted different treatment or if the overall threshold should be adjusted. At a future workgroup meeting, Benson may be asked to attend if discussion of the various categories is needed.

Next Steps and Homework Assignments:

1. Zorn will run more years of data to verify that the variations observed are not limited solely to 2004.
2. Zorn will also re-run the graphs using the traditional occupancy calculation methodology and compare with the “Bodies in Beds” approach.
3. Zorn will pull the NICU data out of Peds to verify that the ill newborns/preemies aren’t masking overall Pediatric trends.
4. Zorn will also sort the graphs so that the group can determine if the hospitals with larger Peds/OB volume have variation different that those with smaller units. Care will be given not to identify the hospital without permission. If necessary he will take the largest 12 hospitals.
5. Mailloux will ask Irma Lopez to have someone from the MDCH CON Policy Division attend the next meeting.
6. Mailloux will investigate the coefficient of variance by Service to help determine “statistically significant” variation and a possible operational method to quantify these differences in variability.
7. Identify how to recalculate the State of Michigan’s “over-beddedness” utilizing the “Bodies in Beds” methodology.

The next meeting will be May 16th at 1 pm at the MHA’s office on St. Joe Highway.

The meeting was adjourned at 11:45 am.

Attachment C

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #5 – May 16, 2006

To: Attendees: (* Indicates HBSAC Member or Alternate)

- * Mark Mailloux, UMHS, Chair
- * Connie Cronin, HFHS
- Bob Zorn, MHA
- * Michele Ciokajlo, St. John Health
- Melissa Cupp, Wiener Assoc.
- * Bob Meeker, Spectrum Health
- Cheryl Miller, Trinity Health
- Penny Crissman, Crittenton
- Mark Hutchinson, Saint Mary's Healthcare
- * Wayne Cass, AFL-CIO
- Terry Gerald, DMC
- Joette Leseur, CON Program
- Lauren Shellenberger, Dykema Gossett
- Matt Jordan, MDCH
- David Luick, Kheder-Davis
- Barbara Jackson, EAM

From: Mark Mailloux
Date: 6/1/06
Re: Meeting 5/16/2006

This group met on Tuesday, May 16, 2006, at the offices of the Michigan Health and Hospital Association, 6215 W. St. Joseph Hwy Lansing, Michigan, at 1:05 pm. Our continuing thanks to Cheryl Miller for serving as recorder for our meetings.

There was confirmation that there was not a quorum of the HBSAC members before the meeting began.

Discussion began on the service specific considerations of Ped, OB & Rehab. Zorn reported that he had looked at more than the 2004 data the group had reviewed and the aberrations were not a one year anomaly. In discussing how the application of any potential separate handling of these services apart from the overall bulk of the patient base, the terms "carve out" and "weighted average" began to circulate. For clarification purposes, Mailloux suggested that the term "carve out" be reserved to refer to a method of segregating the specific beds and/or services, while the term "weighted average" be used to describe a method of combining data into an overall average, but mathematically weighted by whatever factor(s) as might be agreed upon.

Jordan inquired as to whether the previous discussion indicated that the 85% was no longer viewed as achievable. Mailloux replied that the current focus was to create a 'level playing field' so that these services could be accommodated either by carve out or weighted average within an overall high occupancy definition.

A new handout was distributed which illustrated the effect of adjusting the Ped & OB distributions downward (by 10% & 8% respectively, for sake of discussion) so that the peak utilization would be brought within the upper bound of overall utilization. Mailloux indicated that this could be accomplished by means of a weighted average. An example to illustrate this was put on the board:

$$\left(\frac{\text{Ped Days}}{\text{Total Days}}\right) \times 0.75 + \left(\frac{\text{OB Days}}{\text{Total Days}}\right) \times 0.77 + \left(\frac{\text{Bal. of Days}}{\text{Total Days}}\right) \times 0.85 = \text{“83\%”}$$

Thus if 85% were the high occupancy threshold, and the Ped and OB adjustment were 10% & 8% respectively, then a weighted average high occupancy threshold for this hospital would be some hypothetical percentage, shown here as “83%.” Zorn posed the question of whether there still needed to be a separate calculation for facilities over vs under 300 beds.

For calculation purposes, the following simplified definitions could be utilized:

- Peds – Use Age Less Than 18 years.
- OB – Use the DRG OB Delivered
- Rehab – Use the Rehab DRG (no adjustment shown in this particular example.)

Hutchinson raised the question of other services possibly seeking similar exceptions in the future, but Zorn noted that in examining the data there were no similar seasonal variations by service with the possible exception of Gastroenterology, and that can be accommodated within almost any general Med/Surg bed.

Consensus appeared to coalesce around a weighted average approach toward Ped & OB. It was not clear as to whether the Rehab variation warranted similar adjustment. The concept of a weighted average adjustment, without any specific numerical weighting factor, would be presented to the full HBSAC for its concurrence.

In addition, the factors of ‘Bodies-in-Beds’ vs. Traditional Occupancy, ED admission back-ups, post-surgical (PACU) admission back-ups, and the increasing phenomenon of observation patients, all compounded by decreasing hospital Lengths of Stay and its accompanying ‘Churn Factor’, must be clarified, especially for the non-provider community.

Other issues in the ‘Parking Lot’ left to be handled were identified:

- What specific numerical adjustment factor(s) should be recommended?

- Should there continue to be an over/under 300 bed split for high occupancy?
- What overall high occupancy factor(s) should be utilized?
- How often should a hospital be allowed to 'Go to the Well' for high occupancy relief?
- Must high occupancy relief beds, gathered as a result of a weighted average methodology, be categorized for exclusive, service-specific use?
- How do we 'operationalize' our recommendations into CON-friendly language?

Two meetings should be scheduled by the HBSAC meeting at end of June. The dates of these meetings will be determined by the usual e-Mail poll.

The meeting was adjourned at 3:30 pm.

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #6 – June 6, 2006

To: Attendees: (* Indicates HBSAC Member or Alternate)

* Mark Mailloux, UMHS, Chair
* Michele Ciokajlo, St. John Health
Melissa Cupp, Wiener Assoc.
Cheryl Miller, Trinity Health

* Connie Cronin, HFHS
Amy Barkholz, MHA
* Bob Meeker, Spectrum Health
Penny Crissman, Crittenton

* Wayne Cass, AFL-CIO
* Mary Zuckerman, DMC
Barbara Jackson, EAM
Carol Hennessey, Consultant
Lakshmi Amarnath, CON Policy

Terry Gerald, DMC
David Luick, Kheder-Davis
Lauren Shellenberger, Dykema Gossett
Joette Leseur, CON Program
Kirstin Tesner, Genesys

From: Mark Mailloux
Date: 6/19/2006
Re: Meeting 6/6/2006

This group met on Tuesday, June 6, 2006, at the MDCH Conference Room A at the Capitol View Building, Lansing, Michigan, at 1:00 p.m.

There was confirmation that there was not a quorum of the HBSAC members before the meeting began.

Mailloux began the meeting by reviewing the previously identified "parking lot" issue of how to define pediatric. It was suggested that in previous standards, pediatrics included patients aged 14 and under. However, data analyses for this workgroup have defined pediatrics as aged 17 and under. It would appear that standards may set their own age cut-off, so this group will continue to operate under the "17 & under" determination unless otherwise directed.

The discussion then focused on the issue of whether or not Peds and OB beds should be treated the same as general Med/Surg beds. While the Pediatric utilization variation was limited to the first portion of the year, there were "higher highs" that were not random in nature. In the OB utilization, "higher highs and lower lows" were also not random and occurred through out the year. Mailloux reported on his discussion with SAC member Bart Buxton from McLaren who also happens to have considerable expertise in statistics. He indicated that the statistical profile of those services supports their being handled separately. Therefore, the question becomes whether the variations for these two services should be accounted for via a weighted average or as specific carve outs. While

neither approach is statistically "pure", each would level the playing field with the balance of general Med/Surg beds.

Mailloux highlighted one "fly in the ointment" by pointing out the difference when utilization is measured by "patients in beds" vs the traditional LOS model. The Pediatric variance is still higher with an estimated 30% adjustment needed to truly level the playing field. It was suggested that the previously suggested 10% adjustment was very conservative and justifiable. There appeared to be consensus that 10% adjustments to the high occupancy threshold would be necessary for both Peds and OB. Meeker made a motion, which was seconded by Zuckerman, to apply a 10% upward adjustment to both Peds and OB *days* in computing high occupancy and leave the high occupancy threshold constant.

During the ensuing discussion, Ciokajlo raised a previous "parking lot" item, specifically, must high occupancy relief beds, gathered as a result of a weighted average methodology, be categorized for exclusive, service-specific use. Shellenberger suggested that an applicant that qualified for only 3-5 beds, for example, might not actually operationalize such a small number of incremental beds.

Due to some confusion concerning the actual calculation that would result from the motion, the following was offered to help clarify:

$$\frac{\text{(OB Days * 1.1) + (Peds Days *1.1) + (Remaining Days *1.0)}}{\text{Total Possible Patient Days (or Lic beds + Add'l CON approved beds * 365)}}$$

This motion was passed with 7 in support, 1 opposed.

Mailloux will contact Zorn to get some blinded examples in advance of the next meeting. These examples will include CY 2004 and CY 2005 data.

A review of the May 16th meeting notes suggested that parking lot item #2 concerns the High Occupancy (HO) split between facilities above and below 300 beds. The preliminary graph handed out at the meeting seemed to indicate that there was no essential differences between these two categories of hospitals. Again, Zorn's data report at the next meeting should help answer this question.

Parking lot item # 3 (what overall HO factor(s) should be utilized) was deferred until the end of the meeting.

Parking lot item # 4 was how often should a hospital be allowed to "go to the well" for HO relief. Due to the fact that the Department has not been including previously approved HO beds when a "second helping" was applied for, the group felt strongly that this loophole had to be clearly addressed. One solution would be to limit high occupancy requests to one every 'X' years, or require

waiting 'Y' years following opening of the incremental beds. The group felt that an applicant had to clearly demonstrate the sustainability of the demand. It was suggested that PIPRs could be used to monitor any mandated timelines. Cupp offered to provide draft language for the next meeting concerning this issue. A vote on this matter will be deferred until the next meeting.

Concerning what the overall HO factor should be, the group discussed the Health Care Advisory Board's 75% "sweet spot" vs. the current 85% HO threshold vs. something in between. It was ultimately suggested that an across-the-board 80% HO level it were maintained for two years, instead of one, might be a good compromise. Under this approach, an applicant would get the number of beds needed to drop the occupancy rate from 80% to 75% but only if a continuous two-year pattern were documented. This issue will be revisited at the June 22nd meeting.

Next meeting: June 22 at 9 a.m., MHA Offices on St. Joseph Highway and June 28 in the morning before the SAC if required for any last-minute discussions. It was noted that this would conflict with the scheduled Replacement Zone workgroup meeting, so this would be only a last resort.

The meeting was adjourned at 3:00 p.m.

Attachment C

Hospital Bed SAC
Charges 2&5 Group Meeting Minutes
Meeting #7 – June 22, 2006

To: Attendees: (* Indicates HBSAC Member or Alternate)

* Mark Mailloux, UMHS, Chair
* Michele Ciokajlo, St. John Health
Melissa Cupp, Wiener Assoc.
Cheryl Miller, Trinity Health
* Wayne Cass, AFL-CIO
* Mary Zuckerman, DMC – by phone
Lauren Shellenberger, Dykema Gossett
Lakshmi Amarnath, CON Policy
* Connie Cronin, HFHS
Bob Zorn, MHA
* Bob Meeker, Spectrum Health
Penny Crissman, Crittenton
Terry Gerald, DMC
Barbara Jackson, EAM
Brenda Rogers, CON Policy
Larry Horvath, CON Program

From: Mark Mailloux
Date: 6/27/2006
Re: Meeting 6/22/2006

This group met on Thursday, June 22, 2006, at the MHA Offices on St. Joseph Highway, Lansing, Michigan, at 9:00 a.m.

There was confirmation that there was not a quorum of the HBSAC members before the meeting began.

Mailloux began the meeting by handing out material prepared by Zorn that showed the effect of increasing the number of Pediatric and OB patient days by 10%, as discussed at the previous workgroup meeting. The consensus of the group was that this adjustment had little impact except for those hospitals that may already qualify under the current high occupancy provision.

The second handout was a colored chart that depicted the total patient variation from the norm in CY04 for hospitals above 300 beds and for hospitals below 300 beds. Again, there was concurrence that similar variations were experienced by both groups of hospitals.

Mailloux provided a third handout, which outlined possible proposed changes to move forward to the HBSAC. These changes included:

1. *Pediatric Services and Obstetric Services have occupancy distributions that do not conform to the overall Medical/Surgical occupancy patterns and are thereby disadvantaged in any High Occupancy calculation.*

<u>The Pediatric Days and the Obstetric Days should be augmented by 10% in calculating an Adjusted High Occupancy value in applying for High Occupancy Relief.</u>

2. *There appears to be little justification in maintaining separate High Occupancy Standards for hospitals based upon their being above/below 300 beds.*

<u>One single High Occupancy Threshold should be applied across-the-board regardless of hospital size.</u>

3. *Hospitals ought not to be allowed to "return to the well" too frequently. High Occupancy ought to be a sustained situation that is not just a short-term aberration.*

<u>As a package compromise, the High Occupancy threshold ought to be set to a uniform 80%, but with hospitals documenting two years of sustained High Occupancy at that level, based on all licensed and approved beds, before applying for High Occupancy relief. Relief would be the granting of sufficient incremental beds to lower occupancy to 75%.</u>

After much discussion, the following clarifications/edits were suggested:

- Peds should be defined as patients 0-14, not 0-17, in order to be consistent with other CON review standards. Zorn will re-run the charts/graphs as needed to reflect this change.
- Any incremental beds received under the Peds/OB adjustment do not need to be dedicated to only Pediatric and OB beds since all beds are licensed as Medical/Surgical.
- The package compromise was clarified to state "based on all licensed and CON approved beds".

The group encouraged Mailloux to state clearly the rationale for these changes in "non-hospital lingo" in his presentation to the HBSAC on June 28th. It was also suggested that Zorn make the following revisions to assist Mailloux in clarifying this group's proposals:

- Estimate how many beds might be created by lowering the high occupancy rate to 80% for two years for those remaining hospitals currently under the 85% rule, i.e. hospitals over 300 beds.
- Simplify the stacked bar charts depicting the "Bodies In Beds" phenomena.
- Explain in the ripple effect of High Occupancy on ED diversion.

Meeker made a motion, which was seconded by Ciokajlo, that the sense of the group was to move these recommendations to the HBSAC for further discussion. All members in attendance supported this motion with the exception of three abstentions.

Mark agreed to email this draft presentation to some of the workgroup members for their input prior to the HBSAC meeting. Miller and Meeker offered to assist Mailloux in documenting the "75% sweet spot" often referenced in hospital occupancy related literature.

Finally, Cupp distributed draft high occupancy language that she had prepared. She agreed to make changes to reflect the meeting's discussion and forward to them to Rogers.

The meeting was adjourned at 11:45 a.m.

DRAFT REVISIONS TO CON STANDARDS
WORKGROUP 2/5

Section 2. Definitions

Sec. 2. (1) As used in these standards:
(a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a hospital with a valid license and which does not involve a change in bed capacity.
(b) "Alcohol and substance abuse hospital," for purposes of these standards, means a licensed hospital within a long-term (acute) care hospital that exclusively provides inpatient medical detoxification and medical stabilization and related outpatient services for persons who have a primary diagnosis of substance dependence covered by DRGs 433 - 437.
(c) "Base year" means the most recent year that final MIDB data is available to the Department unless a different year is determined to be more appropriate by the Commission.
(d) "Certificate of Need Commission" or "Commission" means the Commission created pursuant to Section 22211 of the code, being Section 333.22211 of the Michigan Compiled Laws.
(e) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et seq. of the Michigan Compiled Laws.
(f) "Department" means the Michigan Department of Community Health (MDCH).
(g) "Department inventory of beds" means the current list maintained for each hospital subarea on a continuing basis by the Department of (i) licensed hospital beds and (ii) hospital beds approved by a valid CON issued under either Part 221 or Part 222 of the Code that are not yet licensed. The term does not include hospital beds certified for long-term-care in hospital long-term care units.
(h) “Discharge relevance factor” (%R) means a mathematical computation where the numerator is the inpatient hospital discharges from a specific zip code for a specified hospital subarea and the denominator is the inpatient hospital discharges for any hospital from that same specific zip code.
(i) "Existing hospital beds" means, for a specific hospital subarea, the total of all of the following: (i) hospital beds licensed by the Department; (ii) hospital beds with valid CON approval but not yet licensed; (iii) proposed hospital beds under appeal from a final decision of the Department; and (iv) proposed hospital beds that are part of a completed application under Part 222 (other than the application under review) for which a proposed decision has been issued and which is pending final Department decision.
(j) "Health service area" OR "HSA" means the groups of counties listed in Section 18.
(k) "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.

(l) "Hospital" means a hospital as defined in Section 20106(5) of the Code being Section 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does not include a hospital or hospital unit licensed or operated by the Department of Mental Health.
(m) "Hospital long-term-care unit" or "HLTCU" means a nursing care unit, owned or operated by and as part of a hospital, licensed by the Department, and providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.
(n) "Hospital subarea" or "subarea" means a cluster or grouping of hospitals and the relevant portion of the state's population served by that cluster or grouping of hospitals. For purposes of these standards, hospital subareas and the hospitals assigned to each subarea are set forth in Appendix A.
(o) “Host hospital,” for purposes of these standards, means an existing licensed hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation.
(p) "Licensed site" means either (i) in the case of a single site hospital, the location of the facility authorized by license and listed on that licensee's certificate of licensure or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure.
(q) "Limited access area" means those geographic areas containing a population of 50,000 or more based on the planning year and not within 30 minutes drive time of an existing licensed acute care hospital with 24 hour/7 days a week emergency services utilizing the slowest route available as defined by the Michigan Department of Transportation (MDOT) and as identified in Appendix E. Limited access areas shall be redetermined when a new hospital has been approved or an existing hospital closes.
(r) "Long-term (acute) care hospital," for purposes of these standards, means a hospital has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital in accordance with 42 CFR Part 412.
(s) “Market forecast factors” (%N) means a mathematical computation where the numerator is the number of total inpatient discharges indicated by the market survey forecasts and the denominator is the base year MIDB discharges.
(t) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and1396r-8 to 1396v.
(u) "Metropolitan statistical area county” means a county located in a metropolitan statistical area as that term is defined under the “standards for defining metropolitan and micropolitan statistical areas” by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(v) "Michigan Inpatient Data Base" or "MIDB" means the data base compiled by the Michigan Health and Hospital Association or successor organization. The data base consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.
(w) "Micropolitan statistical area county" means a county located in a micropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.
(x) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation in a different subarea as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.
(y) "New hospital" means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site that is not in the same hospital subarea as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.
(Z) "OBSTETRICS PATIENT DAYS OF CARE" MEANS PATIENT IN THE APPLICANT'S MICHIGAN INPATIENT DATABASE DATA AGES 15 THROUGH 44 WITH DRGS 370 THROUGH 375 (OBSTETRICAL DISCHARGES).
(~~z~~AA) "Overbedded subarea" means a hospital subarea in which the total number of existing hospital beds in that subarea exceeds the subarea needed hospital bed supply as set forth in Appendix C.
(BB) "PEDIATRIC PATIENT DAYS OF CARE" MEANS PATIENTS IN THE APPLICANT'S MICHIGAN INPATIENT DATABASE DATA AGE 0 THROUGH 14 EXCLUDING NORMAL NEWBORNS.
(~~aa~~CC) "Planning year" means five years beyond the base year, established by the CON Commission, for which hospital bed need is developed, unless a different year is determined to be more appropriate by the Commission.
(~~bb~~DD) "Relevance index" or "market share factor" (%Z) means a mathematical computation where the numerator is the number of inpatient hospital patient days provided by a specified hospital subarea from a specific zip code and the

denominator is the total number of inpatient hospital patient days provided by all hospitals to that specific zip code using MIDB data.
(~~cc~~EE) “Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subarea or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.
(FF) “REMAINING PATIENT DAYS OF CARE” MEANS TOTAL INPATIENT DAYS OF CARE IN THE APPLICANT’S MICHIGAN INPATIENT DATABASE DATA MINUS OBSTETRICS PATIENT DAYS OF CARE AND PEDIATRIC PATIENT DAYS OF CARE.
(~~dd~~GG) "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.
(~~ee~~HH) "Replacement zone" means a proposed licensed site that is (i) in the same subarea as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.
(~~ff~~II) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.
(~~gg~~JJ) "Utilization rate" or "use rate" means the number of days of inpatient care per 1,000 population during a one-year period.
(~~hh~~KK) "Zip code population" means the latest population estimates for the base year and projections for the planning year, by zip code.
(2) The definitions in Part 222 shall apply to these standards.

Section 6. Requirements for approval -- new beds in a hospital
Sec. 6. (1) An applicant proposing new beds in a hospital, except an applicant meeting the requirements of subsection 2, 3, 4, or 5 shall demonstrate that it meets all of the following:
(a) The new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical

area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.
(b) The total number of existing hospital beds in the subarea to which the new beds will be assigned does not currently exceed the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subarea to which the beds will be assigned in accord with Section 3 of these standards.
(c) Approval of the proposed new beds in a hospital shall not result in the total number of existing hospital beds, in the subarea to which the new beds will be assigned, exceeding the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subarea to which the beds will be assigned in accord with Section 3 of these standards.

(2) An applicant proposing to begin operation as a new long-term (acute) care hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection:
(a) If the long-term (acute) care hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as a long-term (acute) care hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as a long-term (acute) care hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically.
(b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following:
(i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital.
(ii) That the proposed new beds shall be for use in space currently licensed as part of the host hospital.
(iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project delivery requirements or any other applicable requirements of these standards, the beds licensed as part of the new hospital must be disposed of by one of the following means:
(A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the long-term (acute) care hospital. In the event that the host hospital applies for a CON to acquire the long-term (acute) care hospital [including the beds leased by the host hospital to the long-term (acute) care hospital] within six months following the termination of the lease with the long-term (acute) care hospital, it shall not be required to be in compliance with the hospital bed supply set forth in Appendix C if the host hospital proposes to add the beds of the long-term (acute) care hospital to the host hospital's

medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital);
(B) Delicensure of the hospital beds; or
(C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and that entity must meet and shall stipulate to the requirements specified in Section 6(2).
(c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently, for CON approval to initiate any other CON covered clinical services; provided, however, that this section is not intended, and shall not be construed in a manner which would prevent the licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with its host hospital or any other CON approved provider of covered clinical services.
(d) The new licensed hospital shall remain within the host hospital.
(e) The new hospital shall be assigned to the same subarea as the host hospital.
(f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards.
(g) The lease will not result in an increase in the number of licensed hospital beds in the subarea.
(h) Applications proposing a new hospital under this subsection shall not be subject to comparative review.

(3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
(a) The approval of the proposed new hospital beds shall not result in an increase in the number of licensed hospital beds as follows:
(I) in the subarea, or
(ii) in the HSA pursuant to Section 8(2)(b).
(A) The receiving hospital shall meet the requirements of section 6(4)(b) of these standards.
(b) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards.
(c) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(4) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed hospital site shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
(a) The beds are being added at the existing licensed hospital site.
(b) The ~~hospital at the~~ existing licensed hospital site has operated AT AN ADJUSTED OCCUPANCY RATE OF 80% OR ABOVE~~as follows~~ for the previous, consecutive ~~12~~24 months based on its ~~existing~~ licensed AND APPROVED hospital bed capacity:~~as documented on the most recent reports of the "Annual Hospital Statistical Questionnaire" or more current verifiable data:~~
THE ADJUSTED OCCUPANCY RATE SHALL BE CALCULATED AS FOLLOWS:

~~Number of Licensed Hospital Beds~~	~~Average ADJUSTED Occupancy~~
~~Fewer than 300~~	~~80% and above~~
~~300 or more~~	~~85% and above~~

(I) COMBINE ALL PEDIATRIC PATIENT DAYS OF CARE AND OBSTETRICS PATIENT DAYS OF CARE PROVIDED DURING THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT AND MULTIPLY THAT NUMBER BY 1.1.
(II) ADD REMAINING PATIENT DAYS OF CARE PROVIDED DURING THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT TO THE NUMBER CALCULATED IN (I) ABOVE. THIS IS THE ADJUSTED PATIENT DAYS.
(III) DIVIDE THE NUMBER CALCULATED IN (II) ABOVE BY THE TOTAL POSSIBLE PATIENT DAYS [LICENSED AND APPROVED HOSPITAL BEDS MULTIPLIED BY 730 (OR 731 IF INCLUDING A LEAP YEAR)]. THIS IS THE ADJUSTED OCCUPANCY RATE.
(c) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the ADJUSTED occupancy rate for the hospital to ~~80~~75 percent ~~for hospitals with licensed beds of 300 or more, and to 75 percent for hospitals with licensed beds of fewer than 300.~~ The number of beds shall be calculated as follows:
(i) Divide the ~~actual~~ number of ADJUSTED patient days CALCULATED IN (B)(II) ABOVE ~~of care provided during the most recent, consecutive 12-month period for which verifiable data are available to the department~~ by .~~80~~75 ~~for hospitals with licensed beds of 300 or more and by .75 for hospitals with licensed beds of fewer than 300~~ to determine licensed bed days at ~~80 percent occupancy or~~ 75 percent occupancy ~~as applicable~~;
(ii) Divide the result of step (i) by ~~365~~730 (or ~~366 for~~ 731 IF INCLUDING A leap year~~s~~) and round the result up to the next whole number;

(iii) Subtract the number of licensed AND APPROVED HOSPITAL beds as documented on the "Department Inventory of Beds" from the result of step (ii) and round the result up to the next whole number to determine the maximum number of beds that may be approved pursuant to this subsection.
(d) A licensed acute care hospital that has relocated its beds, after the effective date of these standards, shall not be approved for hospital beds under this subsection for five years from the effective date of the relocation of beds.
(e) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.
(f) Applicants proposing to add new hospital beds under this subsection shall demonstrate to the Department that they have pursued a good faith effort to relocate acute care beds from other licensed acute care hospitals within the HSA. At the time an application is submitted to the Department, the applicant shall demonstrate that contact was made by one certified mail return receipt for each organization contacted.

(5) An applicant proposing a new hospital in a limited access area shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards, agrees and assures to comply with all applicable project delivery requirements, and all of the following subsections are met.
(a) The proposed new hospital, unless a critical access hospital, shall have 24 hour/7 days a week emergency services, obstetrical services, surgical services, and licensed acute care beds.
(b) The Department shall assign the proposed new hospital to an existing subarea based on the current market use patterns of existing subareas.
(c) Approval of the proposed new beds in a hospital in a limited access area shall not exceed the bed need for the limited access area as determined by the bed need methodology in Section 4 and as set forth in Appendix E.
(d) The new beds in a hospital in a limited access area shall result in a hospital of at least 100 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. If the bed need for a limited access area, as shown in Appendix E, is less, then that will be the minimum number of beds for a new hospital under this provision. If an applicant for new beds in a hospital under this provision simultaneously applies for status as a critical access hospital, the minimum hospital size shall be that number allowed under state/federal critical access hospital designation.
(e) Applicants proposing to create a new hospital under this subsection shall not be approved, for a period of five years after beginning operation of the facility, of the following covered clinical services: (i) open heart surgery, (ii) therapeutic cardiac catheterization, (iii) fixed positron emission tomography (PET) services, (iv) all transplant services, (v) neonatal intensive care services/beds, and (vi) fixed urinary extracorporeal shock wave lithotripsy (UESWL) services.

(f) Applicants proposing to add new hospital beds under this subsection shall be prohibited from relocating the new hospital beds for a period of 10 years after beginning operation of the facility.
(g) An applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital as follows:
(i) In a metropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 30 minutes drive time from the proposed new hospital.
(ii) In a rural or micropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 60 minutes drive time from the proposed new hospital.