MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
HOSPITAL BED (HB)
STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Wednesday October 19, 2011

Capitol View Building
201 Townsend Street
MDCH Conference Center
Lansing, Michigan 48913

APPROVED MINUTES

I. Call to Order

Chairperson Casalou called the meeting to order @ 9:39 a.m.

A. Members Present:

James Ball, Michigan Manufacturer's Assoc.
Ron Bieber, United Auto Workers (UAW)
Robert Casalou, Chairperson, Trinity Health
Heidi Gustine, Munson Healthcare via conference call
Patrick Lamberti, POH Medical Center
Nancy List, Covenant Healthcare
Robert Milewski, BlueCross BlueShield of Michiagn (BCBSM)
Doug Rich, Ascension Health
Jane Schelberg, Vice-Chairperson, Henry Ford
Kevin Splaine, Spectrum Health

B. Members Absent:

David Jahn, War Memorial
Conrad Mallett, DMC

C. Michigan Department of Community Health Staff present:

Natalie Kellogg
Joette Laseur
Tania Rodriguez
Brenda Rogers

II. Declaration of Conflicts of Interest

None.

III. Review of Agenda

Motion by Vice-Chairperson Schelberg and seconded by Mr. Lamberti to accept the agenda as presented. Motion carried.

IV. Review of Minutes of September 28, 2011

Motion by Mr. Ball and seconded by Mr. Rich to accept the minutes as presented. Motion carried.

V. Unused Beds Workgroup Update

Vice-Chairperson Schelberg gave an overview of the progression of the unused bed(s) workgroup (see Attachment A).

Discussion followed.

A. Public Comment:

Dennis McCafferty, Economic Alliance for Michigan (EAM)
Robert Meeker, Spectrum Health

Presentation and discussion continued.

Break @ 11:08 a.m. – 11:28 a.m.

Presentation and discussion continued.

B. Public Comment:

Dennis McCafferty, Economic Alliance for Michigan (EAM)

There was agreement to have the workgroup look at relocation and acquisition and come back to the next meeting with a recommendation.

VI. Bed Need and Subarea Methodology Workgroup Update

Mr. Milewski gave a brief overview of the progress of the subarea and bed need methodology workgroup (see Attachment B).

Discussion followed.

A. Public Comment

Robert Meeker, Spectrum Health

Motion by Mr. Milewski and seconded by Mr. Splaine to approve the new Hospital Group and bed need methodology recommendations proposed by the workgroup, subject to completion of language. Motion carried in a roll call vote : Mr. Rich – Yes; Mr. Ball – Yes; Ms. List – Yes; Mr. Splaine – Yes; Mr. Lamberti – Yes; Mr. Milewski – Yes; Mr. Bieber – Yes; Vice-Chairperson Schelberg – Yes; and Chairperson Casalou – Yes.

VII. Public Comment

None.

VIII. Next Steps & Future Agenda Items

Vice-Chairperson Schelberg will present an updated report on the Unused Bed(s) Workgroup.

IX. Future Meeting dates

A. November 16, 2011
B. December 20, 2011

XI. Adjournment

Motion by Mr. Ball and seconded by Mr. Splaine to adjourn the meeting @ 1:05 p.m. Motion Carried.

Hospital Bed SAC Workgroup Charge #6

Jane Schelberg

October 19, 2011

Workgroup Members* and Attendees

- Allen Tucker
- Andy Ball
- Nancy List*
- Jane Schelberg* (chair)
- Arlene Elliot
- Bret Jackson
- Brie Hanlon
- Carrie Linderoth
- David Jahn*
- Dennis McCafferty
- Eric Fischer
- Jennifer Sheldon
- Jim Ball*
- Jim Gilson
- Karen Kippen
- Melissa Cupp
- Monica Harrison
- Natalie Kellogg
- Paul Delamater
- Penny Crissman
- Rob Casalou
- Robert Meeker
- Sean Gehle
- Steven Szelag
- Terry Gerald
- Larry Horvath

<u>Meetings Held</u>

08/03/2011

08/31/2011

09/12/2011

09/26/2011

10/12/2011

Workgroup Charge

Consider the proper number of beds for Michigan's population given demographic (aging and health of the population) concerns and consider concepts that link occupancy to inventory thereby allowing for reduction of "excess" beds.

Example: Determine the "appropriate" occupancy and if over a defined period of time bed capacity remains below that figure, unused beds must be released.

What is the Workgroup's Objective?

- "Rightsizing" for institution and community.
  - Accurately match licensed beds with the real world.
- Curtailing the use of excess licensed beds as a commodity.

EAM Proposal Progress Report

- The EAM put forward 6 proposals for the Workgroup to review.
  - Following discussion, proposals 4, 5 and 6 were eliminated.
  - Workgroup explored proposals 1, 2 and 3 in detail in terms of cost, quality and access

Revised EAM Proposal #1

When a hospital is required to obtain a new CON for acute hospital beds, due to the **replacing** of the building that currently houses their acute hospital beds, due to obsolescence or other reasons, the number of replaced licensed acute hospital beds in the new building should not exceed x% of the hospital's average annual acute hospital bed occupancy for the prior 3-years.

"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.

Revised EAM Proposal # 2

When a hospital's **license is acquired**, **either by purchase or merger**, and the new owner must obtain a new CON, the number of licensed acute hospital beds in this re-issued CON should not exceed x% of the acquired (acquiring?) hospital's average annual acute hospital occupancy for the prior 3-years.

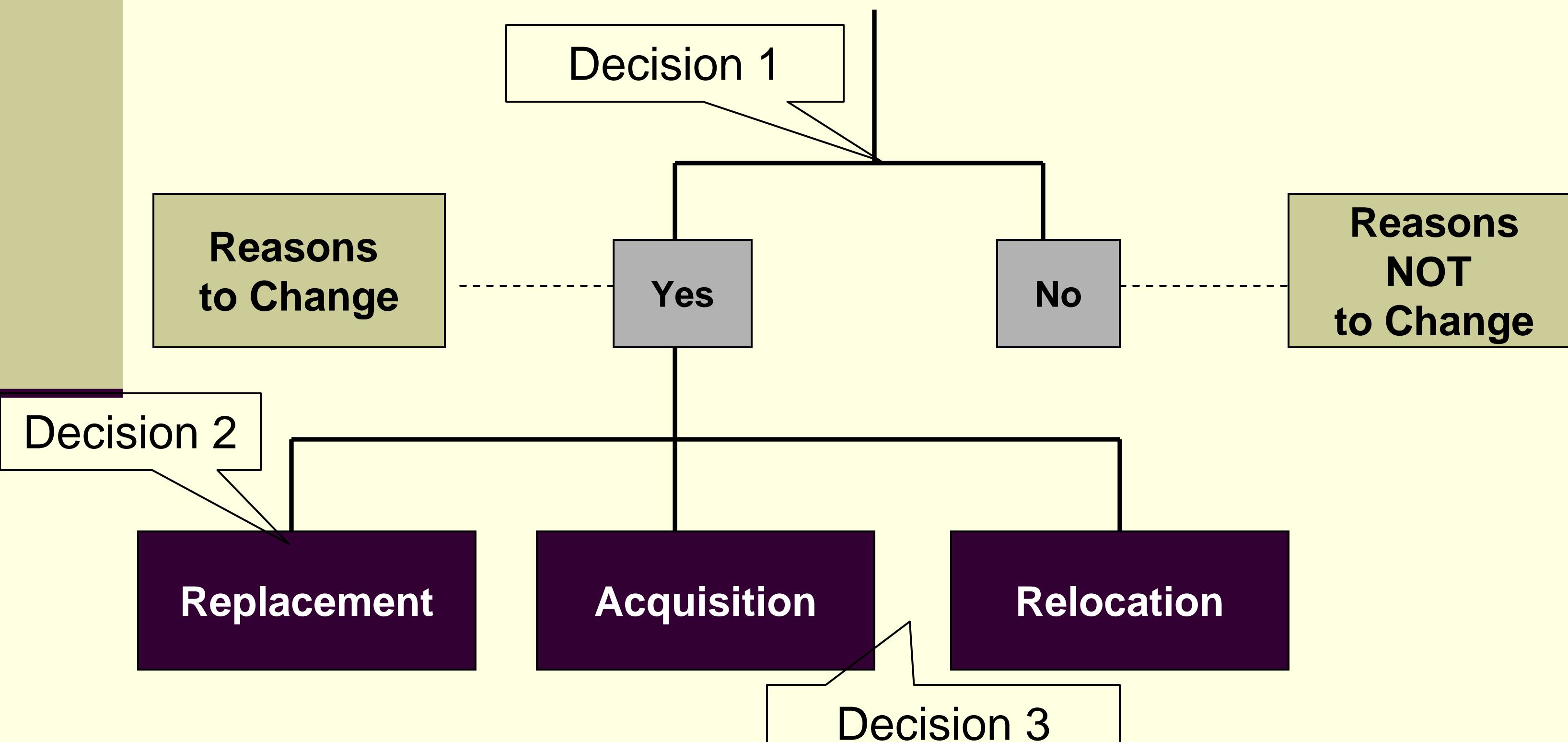
"Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity.

Revised EAM Proposal # 3

When a hospital proposes to **relocate existing licensed acute hospital beds to another existing licensed acute care hospital**, the number of licensed beds that can be relocated cannot result in the acquiring hospital having more than x% of the acquiring (acquired?) hospital's average annual acute hospital occupancy for the prior 3-years.

"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.

Decision Tree Overview



Decision 1

ATTACHMENT A

Change Hospital Bed Standards to address “excess” beds?

Yes

No consensus reached in workgroup

No

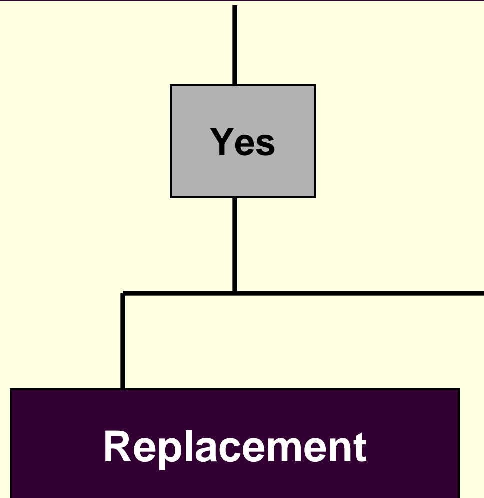
Workgroup Input: Reasons to Change

- No need to wait
  - HBSAC good opportunity
- Regardless of changes in healthcare reform and bed need methodology, there is still excess
- Proposals appropriately limited to CON events
- Limited to very low occupancy
- Balances high occupancy provisions
- Decreases the use of hospital beds as a commodity
  - a/k/a “limits shenanigans”

Workgroup Input: Reasons NOT to Change

- Not the right time
  - Healthcare reform
  - New bed need methodology
- No / limited current harm (cost)
- May result in unintended consequences
- Could have seesaw effect between low & high occupancy
- Occupancy may not be a direct correlation of need
  - Varies for many reasons (i.e.. Observation, Private Rooms, Peak vs. Avg. Occupancy, Renovation)
  - No benchmarks for efficient occupancy

Decision 2
Accept Replacement Proposal?



RATIONALE
- To avoid unintended consequences that may result from instituting a standard which reduces excess beds, this proposal would limit the pool of hospitals at risk for bed reduction to only those with a 3 year average occupancy below 40%

DESIRED OUTCOME
- Hospitals below the 40% trigger, upon submitting a CON for replacement of hospital beds, will have its total number of licensed beds reduced to result in 60% occupancy.

OCCUPANCY CALCULATION
- Adjusted occupancy rate (like current high occupancy).
- 40% and 60% based on most recent 3 year average occupancy.

EXCLUSIONS
- critical access hospitals
- rural county hospitals
- micropolitan hospitals
- long term acute care hospitals (LTACH)
- hospitals with less than 25 beds
- sole community hospitals

ADDITIONAL LIMITATION
- Standard would not allow bed reduction/right sizing to below 25 beds

Decision 3

Should workgroup refine proposals for Acquisition and/or Relocation?

Yes

Acquisition

Relocation

Unresolved Issues

- Consider a one-time pass on minimum occupancy requirement for first acquisition (similar to other standards)?
- Consider 3rd year prospective occupancy requirement in project delivery requirements versus retrospective occupancy?
- Determine if occupancy requirement applies to donating or receiving hospital?
- Could proposed changes de-value current assets of health system?
- Many scenarios - one rule may not fit all.
- May prevent acquisitions that would be good for the community.
- Unknown effects on existing Standards?
- Do not want to discourage mergers of existing hospitals.

Next Steps

- If replacement proposal is adopted, begin language development in consultation with the Department.
- If SAC requests proposals for acquisition and/or relocation, hold additional workgroup meetings.

Hospital Subarea & Bed Need Methodology Workgroup Update

Bob Milewski

October 19, 2011

Workgroup Charge and Meetings to Date

Workgroup Charge

- Review and update the subarea methodology
- Review and update bed need methodology

Workgroup Meetings

- The workgroup met on the following dates: June 28, July 12, July 14, July 20, August 8, August 25, September 12, September 28, and October 10.

Hospital Subarea Methodology

Subarea Methodology Objectives

- Objective
- Replicable
- Sustainable

Subarea Methodology Process

Use most recent 3 year MIDB data to cluster hospitals based on patient days and location.

Consider potential subarea results with peak incremental "fit" scores.

Select final number of subareas based on:

- Cap the maximum number of hospitals in a subarea to 20 or less
- Of remaining options, select the one with the fewest single-hospital subareas
- If multiple options exist with the fewest single-hospital subareas, select the option with the largest number of subareas

Subarea Methodology Decisions

All hospitals reporting in MIDB will be included, regardless of whether they have 3 full years of data.

- Rationale: Persons running the methodology in the future will not have the benefit of a workgroup to advise them of hospital changes (new, closed, expanded, downsized) that occurred during the three-year period. The impacts are anticipated to be minimal.

Hospitals not reporting in MIDB will not be assigned to a subarea.

- Rationale: If their beds are not being counted in the bed need, they should not be included in the allocation of beds; hence they do not need to be included in a subarea.
- Note: There are very few of these cases. If one of these hospitals wished to file a CON, they would have to participate in the MIDB, as required under the existing project delivery requirements.

Subarea Methodology Decisions, cont.

If feasible, MSU Geography and MDCH will work together to create a methodology which will allow an applicant to see which hospital group the facility will likely fall into. A proposed new hospital will be grouped using only the location component of the grouping methodology. The method will use minimum average road distance to each hospital in the nearest hospital groups to make such a determination. To determine their hospital group assignment, an applicant can request that the methodology be run.

- Rationale: In other standards, an applicant can determine in advance whether or not their project meets the CON Review Standards. Running the location component of the methodology would allow an applicant to see where their hospital would be placed and whether a need exists in that subarea.

Subarea Recommendations

Rename “hospital subareas” as “hospital groups” and number 1-35 based on the sum of licensed beds in each group.

- Rationale: Since the hospital clusters are not geography-based, and since many cross Health Service Area (HSA) boundaries, they are no longer "subareas" within the HSAs.

Re-run methodology at least every 5 years, or sooner at the request of MDCH, following the availability of new MIDB data.

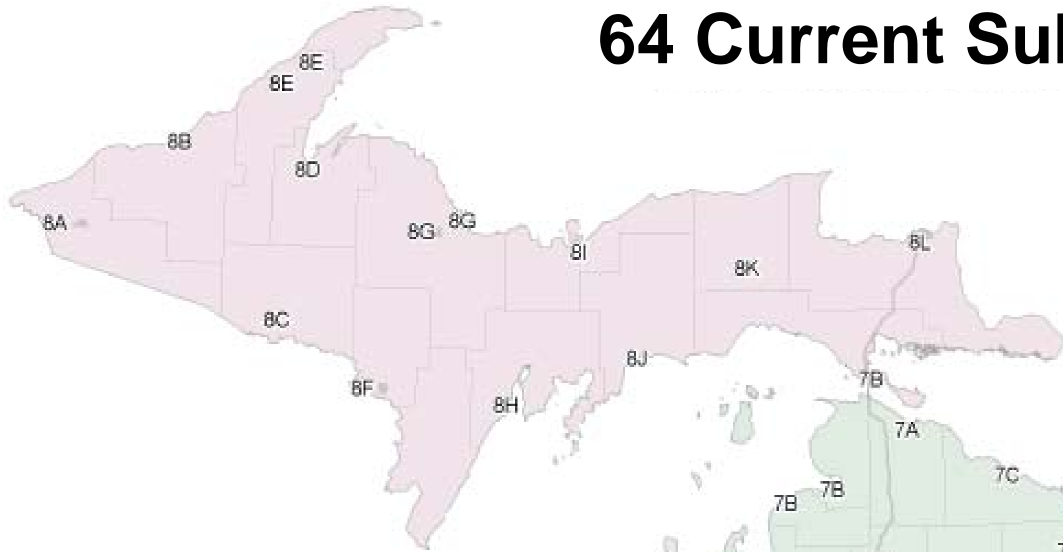
Hospital Group Impacts

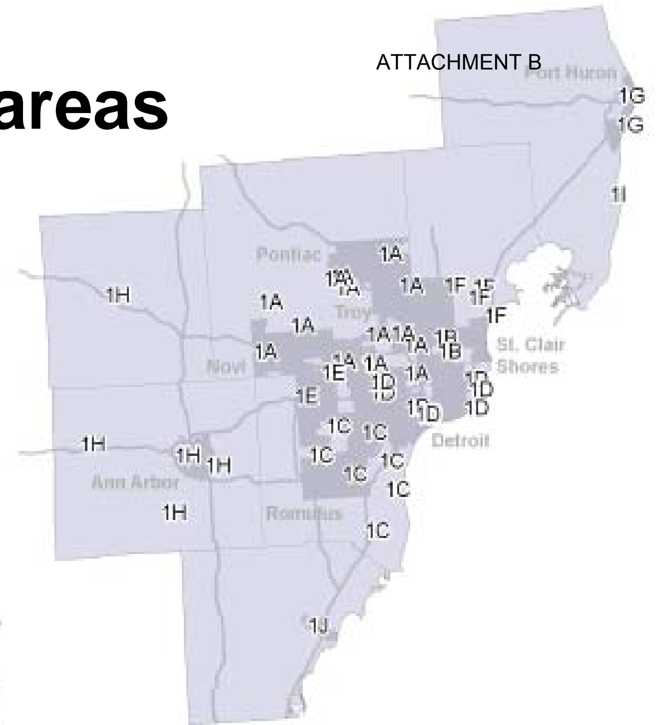
For illustrative purposes, we applied the proposed methodology to the current MIDB data.

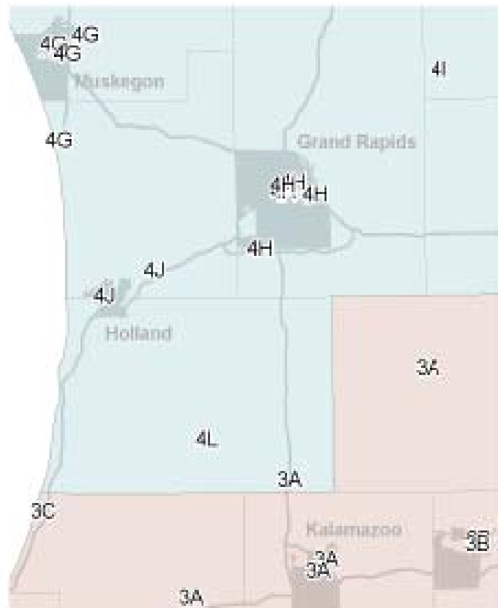
- Would reduce the number of Hospital Groups from 64 to 35
- Would reduce single-Hospital Groups from 32 to 1

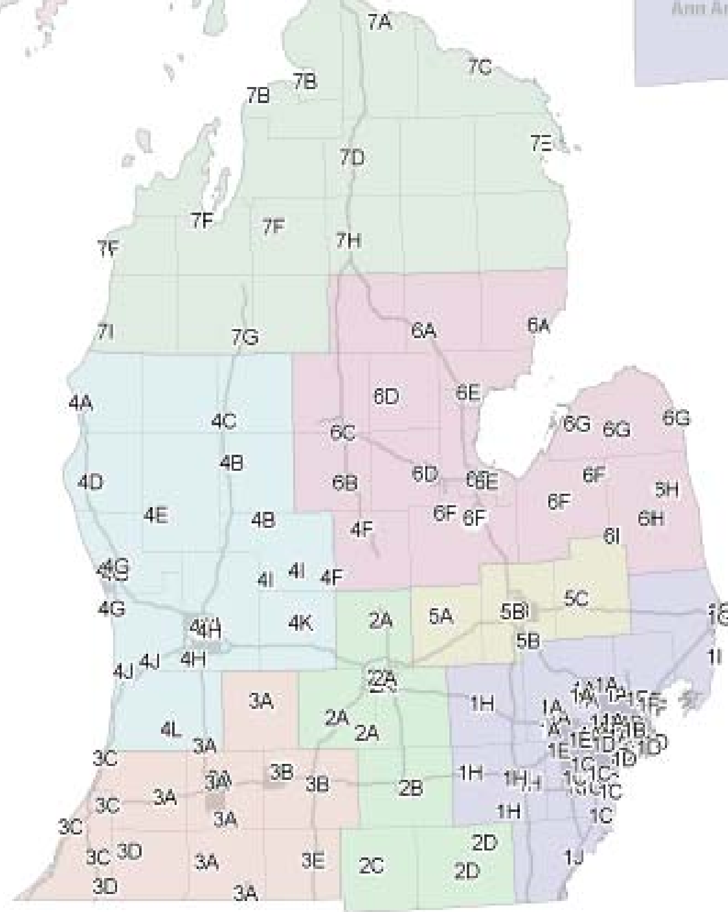
The following three slides illustrate the potential changes should the SAC adopt this methodology and apply it to the most current MIDB data.

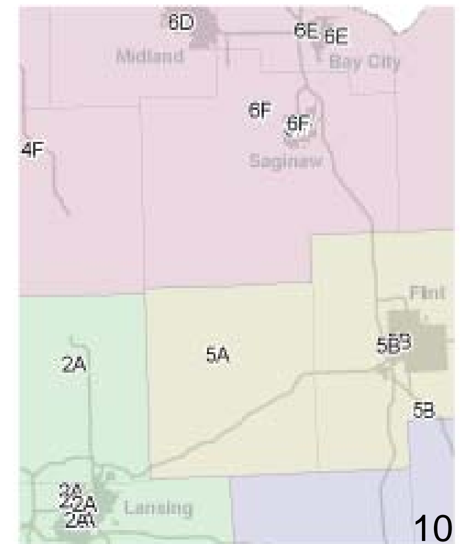
64 Current Subareas





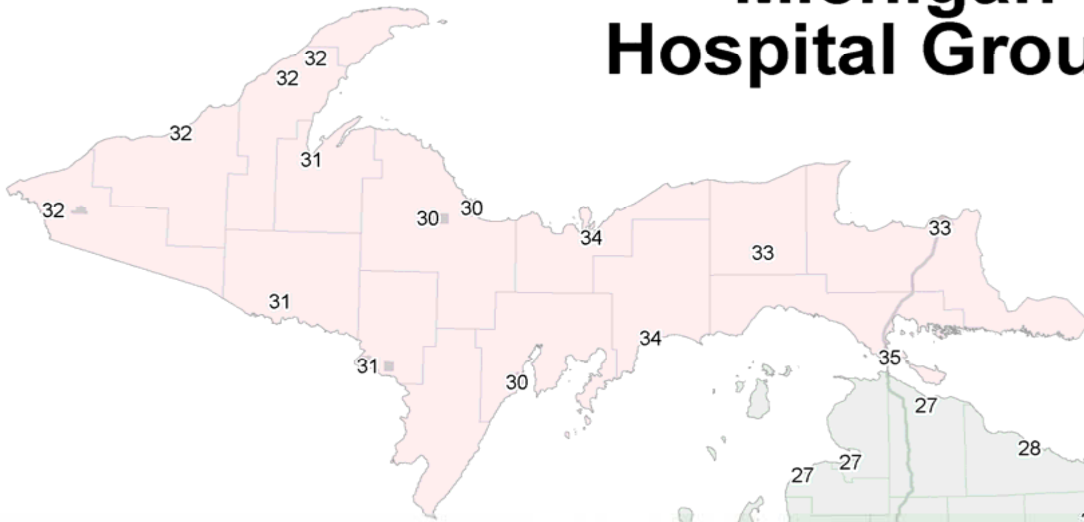


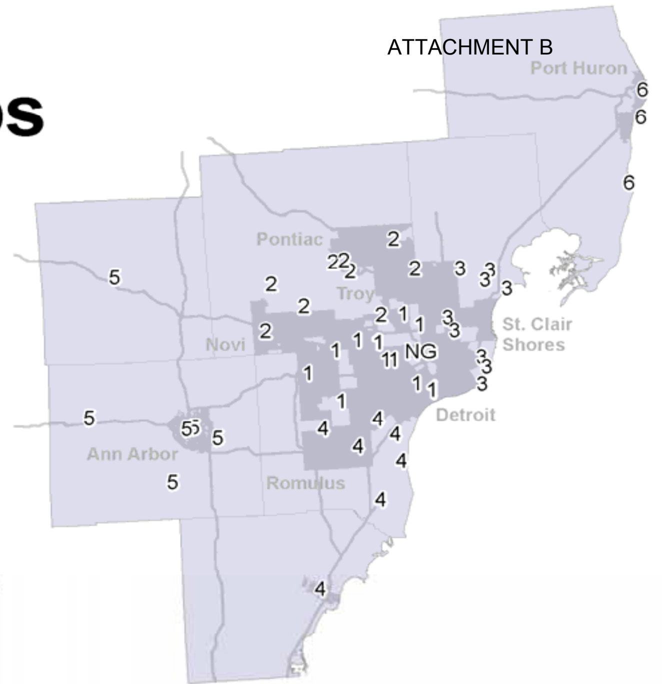


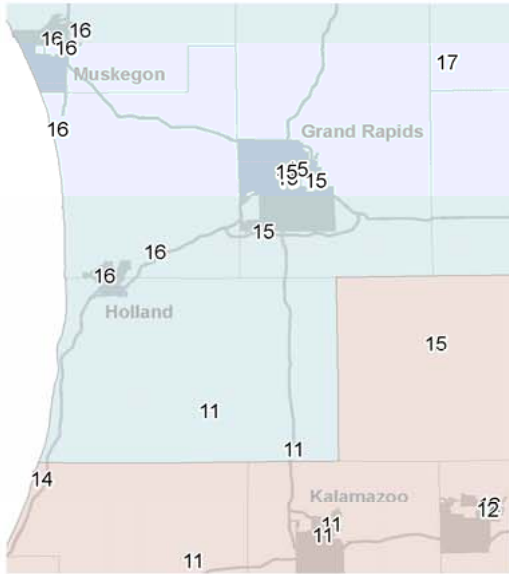


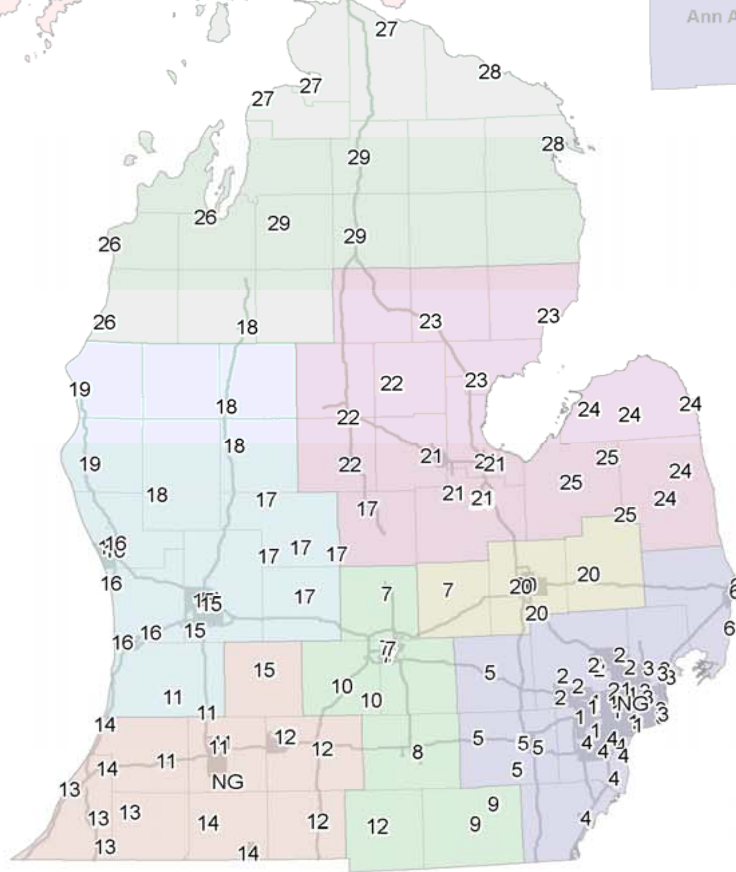
Michigan Hospital Groups

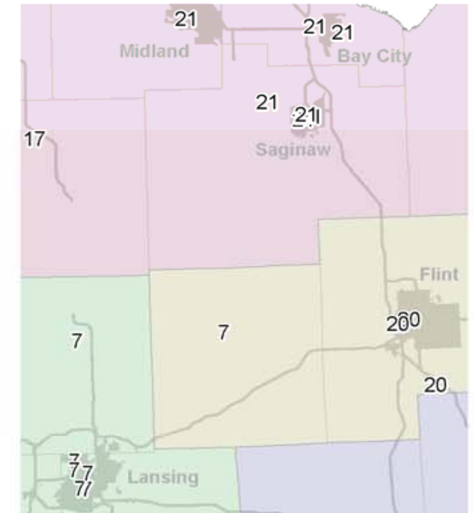
ATTACHMENT B











35 Hospital Groups

ATTACHMENT B

HG	Hospital Name
1	Sinai-Grace Hospital
1	Hutzel Women's Hospital
1	Botsford Hospital
1	Garden City Hospital
1	St. Mary Mercy Livonia Hospital
1	Rehabilitation Institute
1	Harper University Hospital
1	Straith Hospital for Special Surgery
1	Children's Hospital of Michigan
1	Oakland Regional Hospital
1	Select Specialty Hospital - NW Detroit
1	DMC Surgery Hospital
1	Karmanos Cancer Center
1	Henry Ford Hospital
1	Providence Hospital and Medical Center
1	St. John Macomb-Oakland Hosp (Oakland)
1	Detroit Receiving Hospital
2	Doctors' Hospital of Michigan
2	POH Medical Center
2	Crittenton Hospital Medical Center
2	St. Joseph Mercy Oakland Hospital
2	Huron Valley-Sinai Hospital
2	Providence Medical Center - Providence Park
2	Select Specialty Hospital - Pontiac
2	Henry Ford West Bloomfield Hospital
2	William Beaumont Hospital, Royal Oak
2	William Beaumont Hospital, Troy
3	Henry Ford Cottage Hospital
3	Mount Clemens Regional Medical Center
3	Henry Ford Macomb Hospital
3	Henry Ford Macomb Hospital - Warren Campus
3	St. John North Shores Hospital
3	William Beaumont Hospital, Grosse Pointe
3	Select Specialty Hospital - Grosse Pointe
3	St. John Macomb-Oakland Hosp (Macomb)
3	St. John Hospital & Medical Center
3	Select Specialty Hospital - Macomb
4	Oakwood Hospital And Medical Center
4	Mercy Memorial Hospital
4	Henry Ford Wyandotte Hospital
4	Oakwood Annapolis Hospital
4	Oakwood Southshore Medical Center
4	Oakwood Heritage Hospital
4	Select Specialty Hospital - Downriver
4	Vibra of Southeastern Michigan
5	St. Joseph Mercy Ann Arbor Hospital
5	St. Joseph Mercy Saline Hospital
5	Chelsea Community Hospital
5	University of Michigan Hospitals
5	St. Joseph Mercy Livingston Hospital
5	Select Specialty Hospital - Ann Arbor
6	St. John River District Hospital
6	St. Joseph Mercy Port Huron Hospital
6	Port Huron Hospital
7	Edward W Sparrow Hospital
7	Sparrow Health System - St. Lawrence Campus
7	Sparrow Specialty Hospital
7	Ingham Regional Medical Center
7	Ingham Regional Medical Center - Penn. Campus
7	Memorial Healthcare
7	Clinton Memorial Hospital
8	Carelink of Jackson
8	Allegiance Health
9	Emma L. Bixby Medical Center
9	Herrick Medical Center
10	Eaton Rapids Medical Center
10	Hayes Green Beach Memorial Hospital
11	Allegan General Hospital
11	Bronson Methodist Hospital
11	Borgess-Pipp Hospital
11	Borgess Medical Center
11	Bronson Vicksburg Hospital
11	Select Specialty Hospital - Kalamazoo
12	Battle Creek Health System
12	Community Health Center of Branch County
12	Hillsdale Community Health Center
12	Southwest Regional Rehabilitation Center
12	Oaklawn Hospital
13	Lakeland Specialty Hospital
13	Lakeland Hospital, Niles
13	Lakeland Hospital, St. Joseph
13	Borgess-Lee Memorial Hospital
14	South Haven Community Hospital
14	Sturgis Hospital
14	Three Rivers Health
14	Community Hospital Watervliet
15	Spectrum Health Blodgett Hospital
15	Spectrum Health Butterworth Hospital
15	Spectrum Health Kent Community Hospital
15	Metropolitan Hospital
15	Saint Mary's Health Care
15	Pennock Hospital
15	Mary Free Bed Rehabilitation Hospital
16	Holland Hospital
16	North Ottawa Community Hospital
16	Zeeland Community Hospital
16	Mercy Health Partners - General Campus
16	Mercy Health Partners - Mercy Campus
16	Mercy Health Partners - Hackley Campus
16	Great Lakes Specialty Hospital - Hackley
17	Sparrow Ionia Hospital
17	Spectrum Health United Memorial - Kelsey
17	Gratiot Medical Center
17	Carson City Hospital
17	Sheridan Community Hospital
17	Spectrum Health United Memorial - United
18	Mecosta County Medical Center
18	Spectrum Health Reed City Hospital
18	Gerber Memorial Hospital
18	Mercy Hospital
19	Memorial Medical Center of West Michigan
19	Mercy Health Partners, Lakeshore Campus
20	Mclaren Regional Medical Center
20	Lapeer Regional Medical Center
20	Hurley Medical Center
20	Genesys Regional Medical Center
20	Select Specialty Hospital - Flint
21	Bay Regional Medical Center
21	Bay Regional Medical Center (West Campus)
21	Midmichigan Medical Center-Midland
21	Covenant Medical Center - Cooper
21	Covenant Medical Center - Harrison
21	Covenant Medical Center - Northern Michigan
21	St. Mary's of Michigan
21	Healthsource Saginaw, Inc.
21	Bay Special Care Hospital
21	Select Specialty Hospital - Saginaw
22	Midmichigan Medical Center - Gladwin
22	Central Michigan Community Hospital
22	Midmichigan Medical Center Clare
23	St. Joseph Health System - Tawas
23	West Branch Regional Medical Center
23	St. Mary's of Michigan Standish Hospital
24	Scheurer Hospital
24	Harbor Beach Community Hospital
24	Mckenzie Memorial Hospital
24	Deckerville Community Hospital
24	Huron Memorial Hospital
25	Hills & Dales General Hospital
25	Caro Community Hospital
25	Marlette Regional Hospital
26	Paul Oliver Memorial Hospital
26	Munson Medical Center
26	West Shore Medical Center
27	Northern Michigan Regional Hospital
27	Charlevoix Area Hospital
27	Cheboygan Memorial Hospital
28	Alpena Regional Medical Center
28	Rogers City Rehabilitation Hospital
29	Mercy Hospital - Grayling
29	Otsego Memorial Hospital
29	Kalkaska Memorial Health Center
30	St. Francis Hospital
30	Bell Memorial Hospital
30	Marquette General Health System
31	Northstar Health System
31	Dickinson County Healthcare System
31	Baraga County Memorial Hospital
32	Grand View Health System
32	Aspirus Ontonagon Hospital
32	Portage Hospital
32	Aspirus Keweenaw Hospital
33	Chippewa County War Memorial Hospital
33	Helen Newberry Joy Hospital
34	Schoolcraft Memorial Hospital
34	Munising Memorial Hospital
35	Mackinac Straits Health System, Inc.
NG	Southeast Michigan Surgical Hospital
NG	Bronson Lakeview Hospital

Bed Need Methodology

Bed Need Methodology Objectives

- Objective
- Replicable
- Sustainable
- Easy to run (re-run every two years)

Bed Need Methodology: Projecting Demand

Projection of demand will be on a county-wide vs. zip code level.

- Rationale: Counties provide more robust rates and less volatility.

Projection of demand will model patient days per county directly using a 5-year regression model based on monthly data. If the regression model is not significant, a 3-year bed day average will be used.

- Rationale: This model eliminates the need for population projections, which added an additional margin for projection error. It is not advisable to use a trend model for prediction if there is no trend - the prediction is not meaningful and likely farther from the actual value than the 3-year average would be.

Bed Need Methodology: Projecting Demand, cont.

Modeling is done at the aggregate level, not by age brackets and bed type.

- Rationale: Modeling at the aggregate level produces statistically identical bed need projections as the projections done by age and type. Additionally, beds are no longer licensed separately as Med/Surg, OB, or Peds. For ease of running the model, the work group recommends eliminating this step.

Bed Need Methodology: Allocating Demand

The predicted patient days are then allocated to Hospital Groups and bed need is calculated.

- Use utilization rates from base year (most recent year of available MIDB data)
- Convert to average daily census
- Adjust using occupancy rate table

The existing occupancy adjustment tables were merged into one table, and the range was modified from 60%-85% to 60%-80%.

- Rationale: Merging the tables was appropriate since bed need projections would be made at the aggregate level, not at the bed-type level. The upper end of the range was adjusted so that bed need planning was consistent with the high-occupancy standard.

Bed Need Methodology: Allocating Demand, cont.

Hospitals that do not report in MIDB are not included in the allocation of bed need.

- Rationale: If their days are not reported in MIDB, they are not included in the bed need calculation, hence they cannot be included in the allocation of bed need.

VA and Psych Hospitals are no longer included.

- Rationale: These facilities are not subject to the CON Hospital Bed Need process so their inclusion would distort projections.

In-state residents visiting out-of-state hospitals will not be included in the methodology, however out-of-state residents visiting in-state hospitals are included.

- Rationale: This will ensure that future bed need predictions match the actual use of Michigan's hospitals.

Bed Need Recommendations

Critical access care hospitals should be included in this process, despite the fact they likely will maintain 25 licensed beds. The standards should include a provision that allows a Critical Access Hospital to add beds to reach their 25 bed maximum regardless of bed need within their hospital group.

- Rationale: Critical access hospitals address a legitimate part of the bed need within their hospital group. If other (non-critical access) hospitals within their group experience the need for additional licensed capacity, there are provisions in the high-occupancy standards that allow them to increase beds.

Re-run methodology every two years, following the availability of new MIDB data.

Bed Need Impacts

For illustrative purposes, the proposed methodology was applied to the current MIDB data.

- Does not project any areas of need within the state

The following two slides illustrate the potential changes should the SAC adopt this methodology and apply it to the most current MIDB data.

Bed Need Table Definitions

Table Columns

- HG: Hospital Group
- Base Year ADC aka ADC 2009 : (Base Year Patient Days/365) / Occupancy Rate
- PRED2014 aka Planning Year ADC: (Planning Year Patient Days/365) / Occupancy Rate
- Diff: Base Year ADC-Planning Year ADC
- PctChange: Diff/Base Year ADC
- BEDS2010: Number of Licensed Beds in 2010
- Excess Beds: Number of Excess Beds within each Hospital Group

Illustrative Bed Need Output

HG	ADC2009	PRED2014	Diff	PctChange	PRED2014	BEDS2010	BedNeed
1	3132	3192	60	1.92	3192	3906	714
2	2504	2642	138	5.51	2642	3412	770
3	1812	1885	73	4.03	1885	2452	567
4	1425	1448	23	1.61	1448	2019	571
5	1477	1490	13	0.88	1490	1707	217
6	266	260	-6	-2.26	260	350	90
7	830	862	32	3.86	862	1094	232
8	280	281	1	0.36	281	389	108
9	83	76	-7	-8.43	76	113	37
10	17	19	2	11.76	19	45	26
11	714	733	19	2.66	733	969	236
12	287	297	10	3.48	297	474	177
13	247	240	-7	-2.83	240	393	153
14	88	91	3	3.41	91	284	193
15	1343	1353	10	0.74	1353	1813	460
16	428	413	-15	-3.5	413	769	356
17	168	175	7	4.17	175	328	153
18	121	115	-6	-4.96	115	257	142
19	54	55	1	1.85	55	97	42
20	1142	1177	35	3.06	1177	1344	167
21	1175	1235	60	5.11	1235	1620	385
22	86	83	-3	-3.49	83	192	109
23	84	80	-4	-4.76	80	162	82
24	42	42	0	0	42	144	102
25	25	24	-1	-4	24	75	51
26	395	404	9	2.28	404	410	6
27	194	194	0	0	194	264	70
28	97	100	3	3.09	100	160	60
29	79	79	0	0	79	144	65
30	217	199	-18	-8.29	199	387	188
31	76	70	-6	-7.89	70	145	75
32	61	45	-16	-26.23	45	111	66
33	61	63	2	3.28	63	107	44
34	9	9	0	0	9	29	20
35	2	2	0	0	2	15	13
99	19021	19433	412	2.17	19433	26180	6747

In Summary

- When applied to current MIDB data, the proposed Hospital Group and Bed Need Methodologies do not project any areas of need within the state.
- The methodologies proposed are more replicable and are simplified, when compared to the current methodologies.
- The use of patient day projections at a county level will ensure that bed need will be responsive to the hospital needs of Michigan’s population.

Next Steps

- Based on feedback from the SAC, if the proposal is adopted, language development in consultation with the Department will begin this afternoon.
- Proposed language for the standards will be ready for discussion and approval at the November SAC meeting.