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

Wednesday July 20, 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 @ 9:34 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
David Jahn, War Memorial
Patrick Lamberti, POH Medical Center
Nancy List, Covenant Healthcare
Doug Rich, Ascension Health
Jane Schelberg, Vice-Chairperson, Henry Ford
Kevin Splaine, Spectrum Health

B. Members Absent:

Conrad Mallett, DMC
Robert Milewski, BlueCross BlueShield of Michiagn (BCBSM)

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

IV. Review of Minutes of June 23, 2011

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

V. Bed Need and Subarea Methodology Workgroup Update

Mr. Lamberti gave a verbal update of the bed need and subarea methodology workgroup and the sub-workgroup's progress (See attachment A).

Discussion followed.

A. Public Comment:

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

Break at 10:45 a.m. - 11:05 a.m.

VI. Presentation and Discussion of Project delivery Requirements

Chairperson Casalou gave a brief overview of the project delivery requirements (See attachment B).

VII. Presentation and Discussion on eliminating the Existing Addendum for HIV Infected Individuals (Written Report)

Chairperson Casalou gave a brief overview of Mr. Mallet's findings and recommendation (See attachment C).

Discussion followed.

Motion by Mr. Splaine and seconded by Mr. Rich to accept Mr. Mallett's recommendation of removing the existing addendum for HIV Infected Individuals. Motion carried.

VIII. Quality Assurance Assessment program (QAAP)/ Civil Monetary Penalties (CMP) Review and Discussion

Ms. Rogers gave a brief overview of the drafted QAAP and CMP language placement within the standards (See attachment D).

Discussion followed.

IX. Verbal Update and Discussion of Disposition of Unused Beds workgroup

Vice-Chairperson Schelberg gave a brief verbal overview of the unused beds workgroup.

X. Public Comment

None.

XI. Next Steps and Future Agenda Items

Workgroups will continue to meet and bring back updates and/or recommendations to future meetings.

XII. Future Meeting Dates

A. August 25, 2011
B. September 28, 2011
C. October 19, 2011
D. November 16, 2011
E. December 20, 2011

XIII. Adjournment

Motion by Mr. Ball and seconded by Mr. Lamberti to adjourn the meeting @ 11:25 a.m. Motion carried.

Attachment A

Hospital Subarea and Bed Need Methodology Workgroup Update

July 20, 2011

Meeting Summaries

- Full Workgroup Meetings: June 28, July 14
  - **Decided to examine hospital subarea methodology first, then move on to bed need. Depending on what changes are made to hospital subarea methodology, the bed need methodology may or may not need change.**
  - **Formed a sub-workgroup designed to examine methodologies more in-depth and report back to larger workgroup.**
- Sub-workgroup Meetings: July 12
  - **Examined methodology in-depth, developed potential alternative methodologies, and reported findings to main workgroup for additional discussion and final decision-making.**

Alternative Approaches to Hospital Subarea Methodology

- Sub-workgroup chaired by Pat Lamberti to fully understand current methodology and propose potential alternatives.

- The following four alternatives were evaluated by the sub-workgroup.

Option 1: Modify Current Methodology and Update Hospital Subareas

PROS:

- Known commodity, will provide some process consistency.
- Significant changes can be made,

  BUT 

- If you let methodology run all the way, it does work,

  BUT 

CONS:

- Reproducing current methodology is not exact because the expert panel changes.
- Large subgroups and bottom-up groupings are the least optimal format.
- Method does not help define bed need based on today's healthcare market.
- Disconnect between bed allocation method and hospital subarea method.
- Does not optimize the pretense of population-based planning-focuses on need of hospital, not need of community.

Option 2: Remove Subareas

Calculate Bed Need for Each Hospital

PROS:

- Easy from a method standpoint- no need for subarea methodology.
- Reflects fact that currently ½ of all subareas contain 1 hospital, and 1/6 of total hospitals are in a 1 hospital subarea.
- Eliminates need for comparative review process- either you get beds or you don't.

CONS:

- Non-dynamic process given market changes: assumes we have every hospital in the state that we might need.
- Does not optimize the pretense of population-based planning- focuses on need of hospital, not need of community.

Option 3: Implement Alternative Method to Cluster Hospitals

Find clusters that minimize within cluster variance and maximize between cluster variance

PROS:

- More variables could be used to cluster
- More predictable output-would be replicable
- Technically optimal
- Can use variables to sync with bed need methodology

CONS:

- Still hospital-based planning, not population planning
- Still just groups of hospitals, disconnected with geography
- Clusters will have overlapping populations

Option 4: Alternative Clustering Method Using Geographic Units

Combine regions so that those populations share a common base of hospitals

PROS:

- Population-based planning reflecting current patterns
- More predictable output-would be replicable
- A variety of variables can be used which provides flexibility (i.e. could only cluster if contiguous)

CONS:

- Still need hospital clustering if we were to use the existing bed need methodology

Full Workgroup Decisions

- MSU Geography is going to run examples of Option 3 and Option 4.
- Examining the merits of other data sources in concert with MIDB.
- Evaluating the possibility of including specialty hospitals, LTACs, etc in a different way. Currently, all are lumped together as acute care hospitals.
- Support use a multi-year average to determine a base year population calculation.

Question for the SAC

As the workgroups continue, the main question continues to be:

Should the basis for hospital planning center on populations or on facilities?

The workgroup feels this is guidance that should be provided on the SAC level.

Additional Comments or Questions?

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.

Section 7. Requirements for approval -- replacement beds in a hospital in a replacement zone

Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital in the replacement zone shall demonstrate that 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.

(2) In order to be approved, the applicant shall propose to (i) replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii) that the proposed new licensed site is in the replacement zone.

(3) An applicant proposing replacement beds in the replacement zone 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.

Section 8. Requirements for approval of an applicant proposing to relocate existing licensed hospital beds

Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(4) of these standards.

(2) Any existing licensed acute care hospital may relocate all or a portion of its beds to another existing licensed acute care hospital as follows:

(a) The licensed acute care hospitals are located within the same subarea, or

(b) the licensed acute care hospitals are located within the same HSA if the receiving hospital meets the requirements of Section 6(4)(b) of these standards.

(3) The hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

(4) The relocated beds shall be licensed to the receiving hospital and will be counted in the inventory for the applicable subarea.

(5) The relocation of beds under this section shall not be subject to a mileage limitation.

Section 9. Project delivery requirements -- terms of approval for all applicants

Sec. 9. (1) An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(a) Compliance with these standards.

(b) Compliance with applicable operating standards.

(i) An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75 percent over the last 12-month period in the three years after the new beds are put into operation, and for each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a minimum of 75 percent average annual occupancy for the revised licensed bed complement.

(ii) The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-month period after the new beds are put into operation and for each subsequent calendar year, within 30 days after the end of the year.

(c) Compliance with the following quality assurance standards:

(i) The applicant shall provide the Department with a notice stating the date the hospital beds are placed in operation and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(ii) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(iii) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information and demographic, diagnostic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site; in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(A) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(iv) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(d) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:

(i) Not deny services to any individual based on ability to pay or source of payment.

(ii) Maintain information by source of payment to indicate the volume of care from each payor and non-payor source provided annually.

(iii) Provide services to any individual based on clinical indications of need for the services.

(2) The agreements and assurances required by this section shall be in the form of a certification agreed to by the applicant or its authorized agent.

Section 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties

Sec. 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties, for purposes of these standards, are incorporated as part of these standards as Appendix B. The Department may amend Appendix B as appropriate to reflect changes by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget.

Section 11. Department inventory of beds

Sec. 11. The Department shall maintain and provide on request a listing of the Department inventory of beds for each subarea.

Hospital Bed SAC

Charge 4: Consider possible elimination of the CON review standards for Hospital Beds - Addendum for HIV infected individuals.

The hospital bed standards addendum for projects for HIV infected individuals was added several decades ago to address concerns about access to inpatient hospital care for HIV infected individuals. These provisions allow the department to approve hospital bed projects that would increase the number of beds in an over bedded subarea, if the director of the department determines that action is necessary to meet the needs of HIV infected individuals for quality, accessible and efficient care. To be approved, an applicant must demonstrate all of the following:

- The hospital will provide services only to HIV infected individuals
- The applicant has obtained an enforceable obligation from an existing licensed hospital or hospitals in any subarea to voluntarily de-license an equal number of beds
- The project will not result in more than 20 beds being approved under the addendum for the entire state

Those familiar with the history of the CON program believe these provisions were added several decades ago in response to concerns from HIV advocacy groups that fear on the part of the public, potential patients, and even some health care professionals might result in a lack of access to inpatient hospital care for HIV infected individuals. The provisions have been carried forward in each revision of the standards, but have never been used.

Recommendation: Since knowledge about HIV and the treatment and care of HIV infected individuals has advanced considerably and since these provisions have not been used in many years, it is recommended that they be deleted from the CON review standards for hospital beds.

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS - QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP)/CIVIL MONETARY PENALTIES (CMP)

Section 17. Requirements for approval for all applicants

Sec. 17. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

(2) THE APPLICANT CERTIFIES ALL OUTSTANDING DEBT OBLIGATIONS OWED TO THE STATE OF MICHIGAN FOR QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) OR CIVIL MONETARY PENALTIES (CMP) HAVE BEEN PAID IN FULL.

(3) THE APPLICANT CERTIFIES THAT THE HEALTH FACILITY FOR THE PROPOSED PROJECT HAS NOT BEEN CITED FOR A STATE OR FEDERAL CODE DEFICIENCY WITHIN THE 12 MONTHS PRIOR TO THE SUBMISSION OF THE APPLICATION. IF A CODE DEFICIENCY HAS BEEN ISSUED, THEN THE APPLICANT SHALL CERTIFY THAT A PLAN OF CORRECTION FOR CITED STATE OR FEDERAL CODE DEFICIENCIES AT THE HEALTH FACILITY HAS BEEN SUBMITTED AND APPROVED BY THE BUREAU OF HEALTH SYSTEMS WITHIN THE DEPARTMENT OR, AS APPLICABLE, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. IF CODE DEFICIENCIES INCLUDE ANY UNRESOLVED DEFICIENCIES STILL OUTSTANDING WITH THE DEPARTMENT OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THAT ARE THE BASIS FOR THE DENIAL, SUSPENSION, OR REVOCATION OF AN APPLICANT'S HEALTH FACILITY LICENSE, POSES AN IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENTS, OR MEETS A FEDERAL CONDITIONAL DEFICIENCY LEVEL, THE PROPOSED PROJECT CANNOT BE APPROVED WITHOUT APPROVAL FROM THE BUREAU OF HEALTH SYSTEMS.