

**A CASE STUDY--
CERTIFICATE OF NEED PROCESS
AND THE GENESYS HEALTH SYSTEM**

by

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INTRODUCTION

Genesys Regional Medical Center at Health Park, Grand Blanc, Michigan, is a comprehensive health care campus with over 600 MD's and DO's from four other former hospitals now working together. The Certificate of Need (CON) process administered by the State of Michigan played a role in the formation of Genesys in regard to cost containment, quality assurance and access by those served in Genesee, Shiawassee and Lapeer Counties (designated as subarea 41).

A major question that must be answered is how well did the decision making process work in formation of the new inpatient acute care hospital that evolved through the consolidation of Flint Osteopathic, Genesee Memorial, St. Joseph and Wheelock Memorial Hospitals? This question involves a multitude of issues, only a few of which this work can hope to address. The CON process, which is presumed to reflect and apply public policy, was designed and written to control cost and improve quality. It is this CON process that is at the center of the Genesys merger. The key questions are: 1) What does the CON process treat as significant issues? 2) Were those issues addressed efficiently and effectively? 3) Are there other CON related issues which need to be comprehended in future hospital consolidations?

On August 6, 1997 Young S. Suh, Genesys president and chief executive officer, who master-minded the merger of the four area hospitals into Health Park, suddenly retired. We now know he was forced out by powerful influences within Genesys Health System amid growing concern over millions of dollars in losses for fiscal year 1996-7. In addition to fiscal problems, there were other problems that were "much larger than originally anticipated," Mr. Young Suh stated. Audits now show that the fiscal problems are not that severe and some start-up losses are expected on any new hospital facility of that magnitude. The following analysis will attempt to identify some of these problems brought on by Genesys' planners and the CON process.

This analysis will proceed under the assumption that the plan to close four hospitals in the Flint area and eliminate some excess capacity in licensed beds was a sound strategy for Genesys and the community.

The 250 million dollar medical center has only been open one year so it is far too soon to determine the future of Genesys or its impact on area health.

What must now be done is to analyze the CON process in terms of what it took into account in the planning stages of Genesys, what issues it did not address and the impact all that has on subarea 41 which Genesys now serves.

PURPOSE

The purpose of this study is to determine how effective the Certificate of Need process was in this new world of managed care dealing with a vastly complex hospital merger.

PROBLEM

Was there sufficient value added by the CON process based on the issues addressed or is there need to re-focus the process based on the assumptions/expectations that underpin the CON decision process?

ASSUMPTIONS

The primary assumptions of this study are:

1. The Genesys Hospital merger was sound strategy.
2. The scope of the merger may be the most complex undertaking of its type in the nation.
3. The CON process can not be expected to address every stakeholders' concern.
4. The CON process is political.
5. Intensive managed care is changing the way individuals, business, and hospitals look at health care.

SUMMARY

The first part of this study serves to describe the CON process, the history of Genesys and the CON process and the key merger issues as perceived by Genesys and the CON staff in Lansing, Michigan. The latter part of the study addresses key questions regarding the CON process and analysis of the findings. Recommendations will conclude the study.

THE BEGINNING OF A MERGER

Michigan has had a state Certificate of Need (CON) program since the early 1970's. The CON review standards have been amended several times with the objective of ensuring access to needed health care facilities, equipment, and services at reasonable cost and in a manner that delivers quality care to the residents in the area served. A 1988 amendment significantly reduced the types of projects subject to CON review (Appendix B Figure 6). This decrease reflects the intent of the CON Reform Act--reducing unnecessary regulation (General Accounting Office, May 1992, p. 10).

The ensuing research, survey and analysis of St. Joseph Hospital CON Application No. 92-0007 will provide a description in some detail of the CON process as it evolved in "re-sizing" the St. Joseph Hospital System into Genesys Health System.

Many significant issues and questions were addressed in CON Application No. 92-0007 but several issues, raised by stakeholders in the CON process, may not have been answered effectively. The issue of how many beds to delicense in the move from Flint, Michigan to Grand Blanc, Michigan is significant yet appears to have been poorly addressed.

The process of determining what significant questions are answered effectively and which are not will provide insight into which stakeholders' interests most shape the process and whether the outcomes are in the best interest of the public who has to fund and support these CON review decisions.

RESIZING

Many hospital observers today would agree that despite the many kinds of consolidation going on in the industry, the nation still has excess inpatient hospital capacity and this is one of health care's long-standing sources of inefficiency. There is also broad consensus that we have more acute care hospitals than we need and that this overcapacity has not been as well addressed as in other prominent American industries such as steel and automobiles.

Re-sizing at General Motors Corporation started in earnest in the 1980's, in recognition that global competition was taking away both volume and profit. Health care costs have become a major player in GM's ability to compete.

GM employed over 70,000 in Genesee County in the 1970's. Buick Motor Division alone had over 29,000 workers in Flint at its peak. Today there are fewer than 40,000 GM-employed local residents. Buick City has less than 10,000 employees and no scheduled work for 1999 (GM Newsletter GLTC, May 1997).

As the economy in Flint deteriorated, local hospitals competed for the health care dollar. GM's health care cost per car is at \$1,457, reflecting its aging workforce, while transplants such as Toyota, with its younger employees, spends only \$77 per car in health-related costs (GM Comprehensive Financial Report, 1996, p. 27).

City records show that hospitals, though on a much smaller scale than GM, are Flint's second largest employer. Continual layoffs and plant closures meant fewer workers and fewer patients for those hospitals.

It was during this period of change, 1980, that Mr. Young S. Suh, who had been with Flint's St. Joseph Health System since 1965, became its president. It was the decisions and actions taken by Mr. Suh and his staff that put the Certificate of Need process into action and led to a major hospital consolidation.

The formation of the Genesys Health System was a unique opportunity to start with a green field, to design and build an ideal health facility for the people of Genesee County and the surrounding area in the 21st century.

The central focus of this analysis is to examine the Certificate of Need process (CON) as it related to closing of four hospitals in Flint and the opening of Genesys in Grand Blanc, Michigan. Key questions to be addressed will revolve around the impact the CON process had on stakeholders, benefits and disadvantages to those stakeholders, and significant questions the CON process did or did not address.

It may be years before it can be fully understood what impact the transition from Flint to Grand Blanc had on the public and particularly those directly served by Genesys Health System. The CON process played a key role in the decisions leading up to the new Genesys Hospital. The author will analyze the CON process in terms of which issues it takes into account, which it does not, and the implications of these choices for the diverse interests affected by the outcomes of the process.

From 1981, and over the ensuing years, St. Joseph Health System (423 licensed beds) was affiliated with three other hospitals: Genesee Memorial (95 licensed beds), Flint Osteopathic Hospital (359 licensed beds), and Wheelock Memorial (31 licensed beds).

The above hospitals with 908 licensed beds and affiliation with “home health and hospice, medical equipment retailers, long term health care retailers and ambulatory service centers” gave those entities economies of scale that no

one-hospital approach could offer (Journal of Healthcare Resource Management, February 1995, p. 17).

Mr. Young Suh, as president and proponent of St. Joseph Health System consolidation, believed the existing system was in need of diversification, a more complete continuum of care and a more efficient way of doing business. At that time, there was also excess licensed bed capacity in the tri-county area (subarea 41) consisting of Genesee, Lapeer and Shiawassee counties and safety issues related to hospital design at all four facilities (Mark Harris, NBBJ Healthcare, February 1994, p. 19).

Two major competitors remained in Flint to vie for patients with St. Joseph Health System: Hurley Medical Center (434 beds) and McLaren General Hospital (368 beds) (Appendix A, Sec. 6(b)).

The City of Flint had 1,871 beds to service the subarea 41's 700,000 residents. Hospitals started responding to a rise in managed care. GM was consolidating and looking for new ways to assume risk for a large population. President Young Suh of St. Joseph Health System was beginning to think strategically about new forms of integrated delivery system (IDS), managerial maneuvering and public relations know-how to rationalize capacity (Interview, Mr. Suh, April 21, 1997).

State Senator Joseph Conroy, in discussion with the writer, indicated that the State of Michigan found numerous safety items that needed correction

at all four hospitals. Among those concerns were location of exits, size of the rooms, hallways, elevator systems and structural items. St. Joseph Hospital could have been rebuilt on the eastern boundary (parking lot area) or extensive remodeling of all four hospitals was another option. The focus was not on patient convenience when the buildings were designed in 1920. Internal politics also played a role. Flint Osteopathic Hospital was a Doctor of Osteopathy institution, whereas St. Joseph was an MD hospital. To rebuild one hospital and not the other would show a preference between different cultures. McLaren Hospital refused a merger offer from Mr. Young Suh and the operating philosophy at Hurley Hospital was not acceptable to the Sisters of Mercy at St. Joseph Hospital. Since merger with the competition was no longer an option and spending 80 million dollars in additions and renovations for old buildings still left one with old buildings, the decision was made to build a new hospital-- Genesys Health Park.

Reducing the capacity in the health system was underway among top executives at St. Joseph Hospital in early 1990. Understandably, the Flint community had various entities that wanted to rally around their acute care hospitals now scheduled to be phased out.

Robert Parrish, senior vice president of Greater Area Health Council, stated to the writer that it takes a real campaign by local health providers and purchasers to prepare the public "that entire hospitals need to be taken out of

service as an economic necessity.” Cutting the number of licensed beds by over 50% (908 to 379) may not be well received by hospital staff, union, physicians or the general public, especially those whose physicians practice at the facility losing the beds.

Genesee County hospitals are keenly aware of cost containment, in part, for their own competitive survival in a managed care system and to make the service area more attractive to industry. General Motors is currently studying a one billion dollar offer from the City of Flint in incentives over ten years to keep GM jobs in the Flint area. Health care costs are a significant part of that overall ten year package.

Health care costs in 1972 were 5% of Gross National Product (GNP). Today those costs average 14% of GNP. A portion of the cost increases relates to overbuilding of hospitals in the 1970's and 1980's when hundreds of new beds and all the support facilities needed to handle the projected patients were installed. In the 1970's GM held 64% of the automotive market compared to today's 31% and the Flint area economy was vibrant (General Motors Comprehensive Annual Report, 1996, pp. 17, 34). Mr. Young Suh reflected, “The 70's and 80's were a time of bad attitudes about health care costs, overused facilities by unions and doctors, bad health habits (alcohol, tobacco, cholesterol, i.e.) and unnecessary overtime at health care facilities.”

A COMPREHENSIVE PLAN

The development of a comprehensive strategic plan for Genesys started in 1981 with the development of a “road map.” The road map to meet the needs of a new health care system and remain successful was a complex one. The process required the evaluation and recruitment of key personnel, one of whom was an accountant with outstanding credentials. Facilitators were hired to lead the new team in a four and one-half day retreat at Bay Valley. A mission or purpose was defined that was much more comprehensive than St. Joseph’s past mission of “medical treatment and education.”

Facilitators at Bay Valley stated that a health care system is not just waiting for customers from birth to death, but helping people in the community served to stay healthy. No longer would the emphasis be on acute care only but rather continual care through nursing care, community health promotion, early detection and hospice. The care would be continual and in an appropriate setting.

Deloitte and Touche, a Detroit based firm, defined the proposed Genesys Health System geographic area to be served and predicted 700,000 residents by 1995. Of that number it was decided to target 350,000 residents which would require 150 primary physicians (Strategies for Health Care Excellence, Vol. 8, January, 1995, p. 4).

The emphasis here was on reducing expenses, lowering administration cost and the average number of empty beds which helps address the excess capacity issue in Flint.

Hospital care is a highly regulated quasi-monopolistic industry with many costs built into the system even when there is a reduced need for service. A consultant was hired to forecast a year 2000 vision or outlook. The population growth (1989-2000) was projected at a 1-2% increase. (This was projected to mean approximately 700 new potential customers for Genesys.) This included looking at demographics to factor in the aging process as many GM workers were reaching the age where more frequent health care would be required (Weber, 1995 pp. 2-10).

It was during this phase that the first estimate of the number of beds (439) was made and the location (southern Genesee County) was chosen. The I-75 corridor was, and still is, a growth area and the vision was based on the next thirty years. Southern Genesee County positions Genesys in the heart of the growth area.

CERTIFICATE OF NEED (CON)

In early 1992, St. Joseph Health System began in earnest to initiate the process of applying for a Certificate of Need (CON) from the Michigan

Department of Community Health (Appendix A). This specific CON process will now be reviewed and analyzed in detail.

Michigan has had a state CON program since 1972. Today, in this time of increasing controls on the marketplace through mechanisms such as capitation and managed care, laws reflect the need to oversee the development and operation of highly specialized facilities, equipment and services without imposing unnecessary regulatory burdens. “The focus of the current law is ensuring access to needed health care facilities, equipment, and services at the lowest most reasonable cost, and in such a manner as to provide high quality care” (State of Michigan Health Department Annual Activity Report, October 1994). According to the United States General Accounting Office (GAO) in a report titled “Medicare: Excessive Payments Support the Proliferation of Costly Technology”:

Low cost and high quality are associated with high-volume providers of radiology services, and we believe those relationships also hold true for high-technology services such as MRI, which require large capital investments and a highly skilled technical staff. (GAO, May 1992, p. 10)

This GAO report cited Michigan as an example of a state which has high volume providers of MRI services. Moving existing equipment and/or buying new equipment requiring large capital investment is closely controlled by the CON regulations. Unfortunately, CON regulation was not written to accommodate mergers. According to CEO, Young Suh, the process of trying to

obtain approval to move existing equipment from the St. Joseph System to Genesys was “nightmarish.” Mr. Suh questioned whether the CON program had outlived its usefulness (Interview with Young S. Suh, April 21, 1997). Mr. Suh’s question is a difficult one but should be pursued for the sake of continuous improvement as future mergers and acquisitions take place in Michigan.

Are government attempts to cut the costs of medical care (CON regulation) resulting in poorer treatment for patients? The New England Journal of Medicine shows that in some cases there “has indeed been a correlation between strict government-mandated cost controls and poor outcomes for patients: for certain groups of patients, hospitals that imposed tight regulations had higher mortality rates than hospitals with looser regulations” (Shortell, Hughes, 1987, pp. 30-71). Variables were controlled by using Medicare system records and controlling size of hospital, case mixes and the median incomes of the counties where they were situated. The researchers found that the ratio of actual to predicted death rates of hospitals in states with stringent CON review programs was from 5 to 6 percent higher than that of hospitals with less stringent programs. “This is significant,” notes Hughes, “because it corresponds with what clinicians have been saying for years.” Correlations are not strict cause-and-effect relations but it was a first step toward looking at reducing costs and the effect on quality of care. Overall

regulatory limits and final outcomes of hospital care with a true monitoring system is something subarea 41 needs, to measure quality of care before and after a merger, based on a needs assessment and specific goals and objectives for the area served by Genesys Health System. “Assuming that some cost-control measures can be effected without harming patients, what is the threshold level at which a further reduction in cost inevitably leads to worse care?” (Epstein, Scientific American, August 1988, p. 16). This study will examine this question in relation to the extensive reduction in licensed beds following the CON process and a hospital’s desire to reduce cost under a managed care system.

The closing of the four campuses in Flint and the opening of the Genesys Health System in Grand Blanc may have been the most complex integration ever attempted involving a fundamental change in layout, operational structure, architectural aesthetics, choice of new managers in an environment that now became high-technology driven.

Not only is the CON process required to make good choices on cost but also on quality of care. The complexity of today’s managed care systems, CON regulation, the means of measuring quality, and politics all contribute to making those choices more difficult.

ST. JOSEPH HEALTH SYSTEM APPLICATION NO. 92-0007

A Certificate of Need application requires the applicant, in this case St. Joseph Health System, to respond to the following:

1. Discuss in detail what alternatives to the proposed project were considered and why the alternative choice was considered the most efficient and effective method of providing the proposed facilities/equipment/services.
2. Discuss in detail what alternatives to the proposed physical plant expansion (lease, purchase, i.e.) were considered and why the alternative chosen was considered the most efficient and effective method.
3. Discuss in detail how it was determined that the scope of the physical plant expansion (increase in square footage) was needed and why it is the most efficient and effective method of increasing the size of the physical plant.

The Certificate of Need Commission has not yet developed criteria for assessing the adequacy of alternatives to proposed projects. Consequently, the department staff “uses professional judgment in determining applicant compliance with Section 22225 of Public Act 368” (Appendix A).

The law (Public Act 368) states that a proposed project ought to be the least costly alternative. The CON Commission has the obligation to protect the

citizens of Michigan by looking at the cost per square foot of construction, infrastructure costs and CON regulations to render a judgment in the best interests of the public and to protect competing hospitals from one another.

St. Joseph Health System provided the following information to the CON analysts with respect to alternatives considered and project costs provided by an architectural engineering firm:

Renovate each of the system's hospitals and operate at current levels.

Project cost: \$137,500,000

Build a replacement hospital on an existing site.

Project cost: \$170,000,000

Build a new hospital in Grand Blanc Township

Project cost: \$145,000,000

On the surface it appears that renovation is the least expensive option but in the judgment of the departmental staff reviewing the CON, the useful life of the renovated facility was estimated to be about ten years as compared to 30 years for a new facility (Representative Emerson letter, Appendix A).

The department used the "Mean Square Foot Costs" manual which in 1992 indicated completed costs per square foot for the type structure proposed range from \$88 to \$210. St. Joseph's data, on a comparable basis with the

means manual, yielded a construction cost per square foot of \$167.10 which falls within the range of the means report.

Construction costs include new construction, fixed equipment, architect/engineering fees and contingencies. Dividing 650,000 square feet proposed into just new construction costs, \$89 million, yields \$136.92. The difference between this number and \$167.10 (\$30.18) represents fixed costs, fees and contingencies.

Based on the means report, Public Act 368 and CON historical rulings on past requests, it appears that the CON staff made a reasonable decision.

One significant cost to the Michigan taxpayer (Federal and State taxes) that was not comprehended, however, was the extensive expressway and county road work undertaken at the I-75/Holly Road exchange to better serve the increased activity in that area due to Genesys Health System.

Further investigation into costs that were not comprehended in the merger was the loss of 645,000 dollars in income tax per year (Matt Grady, Flint Budget Director) to the City of Flint which is already under fiscal stress.

St. Joseph Health System was also required to provide revenue and expense statements including two years of actual data and three years of projected data. The projections must show sufficient revenue being generated to cover operating expenses which is a condition for financial viability of the project.

Both the revenue and expense statements are reviewed by the Division of Managed Care and Health Facility Development. This division has two sections with CON responsibility: the Program Section and the Finance Section. The application review includes assessing each application for compliance with all statutory requirements and CON review standards once the Letter of Intent is approved by staff.

Having reviewed St. Joseph Health System's Application No. 92-0007 in detail, it becomes apparent that the CON Program section and Finance section activities are independent of each other and each section reviews each application separately. This was most obvious while reviewing the Michigan Department of Public Health CON records in their response to Michigan Representative Bob Emerson's queries regarding St. Joseph Health System's CON application. Notes written on page borders indicate Program section highlighted areas of Representative Emerson's questions requiring Finance section response.

It would appear to be good that more than one section reviewed such a large capital expenditure. Both Program section and Finance section rejected parts of the original data submitted in Application 92-0007 because the information was nebulous, incomplete or incorrect. Examples of these rejections and corrections are shown in Appendix A.

Timing was another area that was reviewed by the writer. By law, the CON review department must issue its proposed decision within 120 days of the date an individual substantive application is deemed complete. The review time to issue this proposed decision for a substantive application was 112 days.

St. Joseph Health System's application was incomplete as received. The CON department has 15 days to request additional information and the applicant has 15 days to respond to the department's request. It should be noted that 90% of all substantive applications filed in 1992 were incomplete. If all information is complete and meets statutory review criteria, the full 30 days for completeness review is eliminated (see Appendix C).

CON timing is mentioned in this study because there is significant concern about the time it takes for rigid application of traditional CON regulatory methods. Mr. Leo Brideau, CEO of Strong Memorial Hospital, estimated that CON requirements in New York State caused "delays that tended to inflate costs of new hospital construction by as much as \$100,000 per month for some projects" (Brennan, Berwich, New Rules, 1996, p. 323). In 1995 Governor Pataki's administration was calling for CON regulatory relief in New York State.

Although CON regulation may be uniform and convenient for some health care institutions, it has added expensive tasks that do not contribute to better care, and many health care leaders and quality advocates claim that CON regulation inhibits innovation. Mr. Chip Cadwell notes, "Hospital licensing

rules in Georgia require that respiratory therapists and pharmacists perform certain functions, yet these tasks could at times be undertaken by less highly skilled--and highly paid--employees.” Cadwell was sympathetic to the state’s concerns but asserted that the requirements simply added costs (Brennan, Berwick, New Rules, 1996, p. 324).

From the time Mr. Suh conceived of Genesys and to the time that final hospital construction took place, much had changed. It was decided to license far fewer beds than originally conceived in the early 1990’s. It became obvious the CON process was not designed to facilitate mergers involving significant bed reductions.

If time is critical, a visit to the Michigan Department of Community Health in Lansing, Michigan to clarify issues and receive direction would be well worth the applicant’s time prior to submittal. Frequently, after a proposed disapproval is issued, an applicant requests the department to reconsider its decision. This reconsideration process is an informal process which allows an applicant to submit new information in response to the area of non-compliance identified by the department’s analysis of an application and the “applicable statutory requirements” (CON Annual Activity Report, 1995).

The CON program then becomes very predictable for the applicant who can now work to meet the requirements for approval before a final decision is issued. This two-step process (proposed decision/final decision) is uniform, fair

and has resulted in far fewer administrative hearings than prior to the 1988 CON Reform Act which established the two-step process.

The CON administrative rules allow Certificate of Need amendments when a proposed change is significant enough to require a separate application. Examples requiring a new application include cost overruns that exceed the approved amount by 5% of the first one million dollars and 10% of all costs over one million dollars. Changes in the scope of the project or in financing would also require separate applications and amendment if approved.

LICENSED BEDS--SUBAREA 41

The CON process has many requirements for approval--one of which is determining if there is an appropriate number of beds in the new facility. It was determined that the new hospital would be located in subarea 41. Based on Appendix C of the Con Review Standards, subarea 41 should have a minimum of 1,241 beds. St. Joseph Hospital Application No. 92-0007 proposed a new hospital with 439 beds. At the time of proposal there were 1,710 beds in subarea 41. The CON process approved St. Joseph's request which would result in a reduction from 908 beds to 439 beds for those stakeholders whose primary care physician practice at the four hospitals to be closed.

The question to be raised here is not whether reducing excess beds in subarea 41 is the right thing to do, but rather whether the CON process

functioned in a manner beneficial to Genesys customers and the public when it allowed the St. Joseph Hospital system to reduce its total number of beds from 908 to 439 and ultimately to 379 beds at Genesys, for a total reduction of 529 beds?

Delicensing 529 beds from the service area not only violates the review standards, as the reduction drops well below the 1,241 beds required, but the full reduction comes from just one hospital system even though three hospitals are now serving the subarea. The patients of those physicians practicing under the Genesys Health Care System were not well served by the CON process.

This set up the unique situation currently ongoing at Genesys in which the hospital runs at full capacity and as Mr. Young Suh said, "Unfortunately, if your father was very ill now, we could not admit him." Decisions were made by Genesys officials to "right size" the new hospital which appears to be a good financial decision but left the stakeholders whose primary care physicians practice at Genesys, potentially waiting for a bed at Genesys. Genesys patients had no voice in the number of beds available to them at the new facility in Grand Blanc. The CON process looks at the subarea requirements for total number of beds to service subarea 41. Three hospitals now service the subarea yet one hospital was allowed to delicense 469 beds to bring subarea 41 to the minimum number of beds allowed which was 1,241. Once that was approved Genesys further reduced its number of beds by 60 which was below

the CON review standards and now obviously too few beds to properly service its own patients.

The CON process in this case did not follow its own guidelines nor was its decision in the best interests of Genesys patients who now must compete for available space at Genesys Health Facility and can not easily switch to McLaren or Hurley Hospital.

Mr. Tim Keener, St. Joseph Hospital director of planning, stated that although the CON was approved in October 1992 for 439 beds, "we decided 439 beds was still too many and voluntarily reduced the number to 379 beds to work within the community's needs."

In 1995 Mr. Keener also said, "Based on a population of 700,000, we figured that a total of about 800 beds was really the right number for the community." At that time McLaren Hospital had 368 licensed beds and Hurley Hospital had 434 licensed beds for a total of 802 licensed beds.

If Mr. Keener really believed 800 beds would serve the community's needs and his interests were those of the community he should have been asking himself if we have 802 beds now, why we need another hospital based on shrinking hospital utilization rates nationwide. This is especially true in Genesee County where General Motors jobs continue to disappear at an alarming rate and several thousand more are projected to disappear at the end of the 1999 model year.

If, on the other hand, Mr. Keener believed Appendix C of the CON review process and 1,241 beds were needed to meet the community's needs, then subtracting 802 from 1,241 dictates a new hospital with 439 beds. In further support of at least a 439 bed hospital, Deloitte and Touche (hired by Genesys) projected the Genesys Health System would serve one-half of the 700,000 residents and these 350,000 people would need 150 primary physicians. The site was chosen "along the main corridor of the 21st century--the freeway system" in a high growth area of subarea 41. All the above information lends support to a new health facility with 439 licensed beds.

The Almanac of Hospital Financial and Operating Indicators from the Center for Healthcare Industry Performance Studies (CHIPS) reports median occupancy rate at 60 percent nation-wide and that it will stabilize at about 55 percent nation-wide in the next five years. Health Systems Review, January/February 1997, indicates the ideal occupancy rate, a compromise between efficiency and the need for unexpected capacity in emergencies, in the high 70 percent range. Economists Theodore Keeler and John Ying from the University of California at Berkeley and the University of Delaware respectively believe an ideal occupancy level is about 74 percent (Review of Economics and Statistics, August 1996). Wharton School Professor Marc Pauley states,

A hospital with a low occupancy rate usually will have a higher cost per admission than a hospital with a high one. Hospitals do a pretty good job of staffing for the level of occupancy they have. The cost of the bed itself is sunk, and labor is where costs really add up.

Money is not earned so much from beds but from the pharmacy and the laboratories and the procedure suites according to CHIPS reports from consultant Jeff Goldsmith.

Hospital closure and consolidation is a recent phenomena but one that is becoming more prevalent every year. The Oakland Health System in Dearborn, Michigan is in the process of closing two of its ten hospitals in response to the rise of managed care and excess capacity. On one side of the equation are huge vested interests to maintain things as they are which is supported by labor unions, physicians, city council members, consumer groups and the media. "Jobs, health care access, city revenues and the press turn closure and consolidation into a nightmare, even if hospitals are running at 40 percent occupancy" stated CEO Gerald D. Fitzgerald of the Oakwood Health System. The St. Joseph Health System consolidation faced the same obstacles in delicensing 529 of its beds, cutting 850 jobs and merging staffs with very different cultures.

The CON process came into being when public policy truly discouraged hospitals from reducing capacity. Antitrust authorities were afraid of concentrated market power through mergers and other public policies such as

the Hill-Burton Act's subsidization of hospital construction, fee-for-service and cost-plus Medicare reimbursements that built all the overcapacity. Certificate of Need programs were designed to slow down the building trend. They were not designed for mergers and consolidations that are now becoming necessary and more frequent.

The Dartmouth Atlas of Health Care suggests that much of the nation is "awash in inpatient capacity that gets used just because it's there. Hospital beds per 1,000 population range from less than two in some parts of the country to 5.3 in others. Hospital capacity has an important, and apparently overriding, bearing on the place where death occurs" states Jon Wennberg (Health Systems Review, January/February 1997, p. 28).

CON GUIDELINES--DO THEY WORK?

Did the CON process used to consolidate four hospitals into the Genesys Health System ask the right questions on the number of licensed beds requested and did the process work in the best interests of the public who will now pay the \$629 million in loans and interest that financed the new hospital?

A review of the numbers:

Hurley	434 licensed beds
McLaren	<u>368</u> licensed beds
Subtotal	802 licensed beds
St. Joseph System	<u>708</u> licensed beds
Grand Total	1,510 licensed beds

CON regulation, per Appendix C, calls for a maximum of 1,241 beds for subarea 41. This leaves an excess of 269: 708 licensed beds minus 269 = 439 licensed beds.

This is 439 licensed beds to service the 350,000 population target area which is 1.25 beds per 1,000 population. Should the CON process which authorized the licensing of 439 beds at Genesys insist that it keep its word and license that number? Should it ever allow a hospital to request the minimum number of allowed beds on paper but then install 60 less or 80 less or more?

Some believe this "gaping hole" in the CON process should be lawfully closed. Genesys is lawful in tying up 60 beds in the service area, that could be put to use, by using the CON process against its competitors. From a Genesys business standpoint, this is an excellent position to be in. If the population shifts further south reflecting more GM plant closings, the 369 bed hospital will have been a good choice, and if growth does take place along the I-75 Grand Blanc corridor, the hospital can add the 60 beds it now has on hold from the CON process. The losers are all those who may not get into Genesys in a

timely fashion, the indigent from the Flint area who can not easily get to and from Genesys and those who in a time of crisis (plane crash, tornado, i.e.) must find room at McLaren or Hurley as Genesys is at or near capacity.

The CON process must insure that there are the right number of beds for each subarea by enforcing both maximum and minimum capacities. It is the public that the CON process should place utmost in its decision making, not the hospital lobbyists and CEO. It is the public who through taxes and service fees, pays the interest, bonds, hospital bills, insurance companies, medical providers and the CON staff.

It is the CON process that has the opportunity to help insure quality care for the public and a hospital healthy enough to pay its liabilities and service its debt.

This study leads one to believe that although the CON process has specific recommendations, there is some flexibility in the process. What is more difficult to determine is if CON staff or management influence the outcomes from a political ideology, the degree to which they are influenced by hospital lobbyists, and how much flexibility is built into CON regulation.

In 1974, Congress passed the National Health Planning and Resources Development Act (NHPDA) in an effort to bring rising costs under control. NHPDA was regulation intended to achieve a more efficient and equitable allocation of resources than the competitive market managed to produce. The

government clearly recognized that the health care market was not a true market and that regulation was required to improve it, though not necessarily by making it into a true market. State CON authorities through health system agencies followed the NHPRDA regulation guidelines. In 1974 every state in the union except West Virginia had CON programs or Section 1122 functions in place. Efforts at cooperation were not accepted by the regulated entities. By the early 1980's under the Reagan Administration which had little interest in regulation, funding for the NHPRDA dropped from 119.4 million in 1980 to 35.5 million in 1982-1983. Dozens of states dropped their CON programs in the late 1980's and early 1990's. As soon as CON programs were dropped construction accelerated massively. MIR scanners went from 38 to 72 in two years in Virginia alone (Brennan, 1996, p. 55).

The shift toward market-based approaches to health care has raised questions about the utility of Certificates of Need. The Governor in the State of Michigan can appoint those who serve on the CON Review Board. Well-funded and connected entities who have a vested interest in CON process outcomes can and do get key personnel on CON Reviews Boards to influence outcomes (Appendix B--State of Michigan CON Commission and Sec. 22211 of CON Reform Act, 1988).

METHODOLOGY

There may be no central decision more critical to the usefulness of a study such as this than the selection of a judgment sample of key individuals all of whom were intimately involved in the St. Joseph Health System hospital merger.

The personal interview was the method used to gather data on the merger. Although it was difficult to collect negative or sensitive information in part because of a lack of anonymity, leading to the individual becoming inhibited in expressing opinions. On the other hand, the method was flexible in that the writer could probe respondents for greater depth on their answers.

Telephone interviews were a good way to collect general information quickly and helped sharpen the focus.

Although a literature search did not reveal another hospital merger of the complexity of Genesys (four hospitals and a cultural clash), there was information on CONs in general.

The following people were kind enough to allow personal interviews or phone conversations to discuss the CON process at Genesys:

- * Dr. D. Bonbrisco (Director--McLaren)
- Mr. John Cherry (Michigan State Senator, Lansing, MI)
- Mr. Joe Conroy (Michigan State Senator--Flint, MI)
- Mr. Chapin Cook (Planning Commission--Genesee County)
- * Mr. Bob Emerson (Michigan State Representative, Flint, MI)
- Mrs. Sally Flanders (CON Analyst--Department of Health, Lansing, MI)
- * Mr. Matt Grady (Budget Director, City of Flint, MI)
- Mr. Dan Gustafason (Michigan State Representative, Lansing, MI)

- * Mrs. Maureen Halligan (Planner--Genesys)
- * Mr. C. Hundt (CON Staff, Lansing, MI)
- * Mr. Tim Keener (Vice President Systems Development--Genesys)
- * Mr. Carl Menard (Genesys Patient--GM Engineer)
- Mrs. Janet Olszewski (Director of Quality Improvement--Health Dept.)
- Mr. Bobby Pestok (County Health Department--Genesee County)
- * Mr. Gerald Selke (Adjunct Instructor, The University of Michigan/
Health Care Program Designer)
- * Mrs. Polly Shepherd (Executive Planner--Genesys)
- * Mr. Tony Stasunas (Regional Personnel--GM)
- * Mr. Young Suh (Executive CEO--Genesys)
- Mr. Walt Wheller (Executive CON Director--Department of Health,
Lansing, MI)
- Mrs. Raj Wiener (CON Lobbyist--Attorney and Counselor at Law)

*Personal Interview

SIGNIFICANT ISSUES AND QUESTIONS

If CON regulation continues in some form this study leads one toward having state legislatures linking new capital projects, such as the St. Joseph consolidation, to the institution's patient outcomes and objectives of the communities' master health plan.

The CON process used to regulate Mr. Young Suh and his planners may be much less relevant today than in years past. Irrespective of what the CON review staff approves in the way of capital expenditure or what the hospital implements, often today's cost and quality regulator is the PPO, HMO or BC/BS provider. If the provider decides not to pay for a certain service or to pay only under very restricted circumstances, that new hospital equipment, staff and

support facility will not be used. Is the ultimate cost controller the health maintenance organization?

Michigan Governor J. Engler believes there are enough other controls in the health system to warrant shutting the state's CON program down. He also has appointed members to the CON review boards whom one can conceive of having a similar mindset about current and proposed new regulation.

Steve Speil, associate vice president of health care systems at the Health Industry Manufacturers Association (HIMA), Washington, D.C., says, "Technology planning is an opportunity for delivering networks to do the type of rational, market-based planning that many certificate-of-need programs would impose through bureaucracy. So, if a system does it well, it would obviate a bureaucracy imposing those decisions on them" (Hospitals and Health Networks, June 5, 1993).

Mr. Y. Suh stated that CON regulation did not allow CAT-SCAN equipment to be moved from St. Joseph Hospital in Flint to Genesys in Grand Blanc but it was within regulation to buy new equipment. Genesys was concerned that the community may view a hospital that doesn't own the latest equipment or provide the range of services that it once did, as second rate. A process that does not allow transfer but does allow purchase should be corrected.

The CON process treats licensed beds and high cost equipment as very significant items to be regulated by quotas or ratios to control cost. This regulation seems to have worked fairly well in the 1970's but today multi-provider networks focus on "how we can avoid duplication, which in the past drove up costs and didn't benefit anybody" (Aldin Schultz, M.D., p. 44)

"Employees, insurers and health policy researchers armed with outcomes data, are increasingly questioning the value of certain high-tech procedures and are asking whether less-invasive, less expensive procedures would provide similar--or greater--value" (S. Hoppszallern, p. 42).

The primary intended purpose of the CON process as a regulatory tool is to reduce industry cost by preventing unnecessary duplication of facilities. That is why Genesys had to demonstrate: (1) a market demand (or "need") for its investment in Grand Blanc, (2) the inability or unwillingness of the two existing hospitals to meet that demand.

The CON process did not address the capabilities or intentions of the other existing hospitals. It did not follow its own rules; it did not ask the right questions, have a methodology to follow up its own regulation nor a means to measure any quality improvements from the regulations it mandated. If it had, Genesys would not be running at 100% capacity almost every day with beds often in the hallway while "patient" patients wait for rooms. Licensed beds was

a key issue addressed by the CON process. The regulators asked the wrong questions and the regulated gave the wrong answers to those questions.

What makes this research so fascinating to the writer is that economists have long been skeptical of the CON review process for three reasons:

(1) Private investors are likely to have vastly superior information to that held by regulators on the need for new capacity. The investors are more familiar with industry conditions than regulators and they are placing their own money at risk by entering and/or expanding. (2) Given the obvious incentive of existing firms (Hurley and McLaren) to oppose virtually any entry, expansion of capacity, or introduction of new services by competitors and the fact that this policy provides an open forum for such opposition, the likelihood that CON regulation actually serves the interest of consumers by fostering lower industry costs is remote. (3) To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left. Since most medical services are thought to exhibit inelastic demand (due to the general unavailability of substitutes and the high frequency of third party payments) the effect of such supply shifts is to raise both equilibrium price and total expenditures on the affected service, which is precisely opposite of the stated objective. (Ford and Kaserman, p. 784)

The CON process had no interest in public pronouncements from Genesys management that subarea 41 “should be well served by approximately 800 beds” (which already existed in Flint!). Genesys authorities misjudged the willingness of General Motors to sign on as a customer and miscalculated the degree to which managed care networks would drive down hospital bed demand. Hence the original request for 439 beds, presuming General Motors

would accept the soon to be operational Genesys' lower cost system of health care, which it did not. This was followed by a request for 379 beds, presuming 800 beds was sufficient for the community and health care networks would drive down bed demand.

Genesys planners have learned some very real lessons and gained much experience in designing a health care system from the ground up. In spite of years of planning and reams of data the hospital is not "right sized." The "regulated" miscalculated and the "regulators," who have even less information at their disposal, ignored their own requirements and approved 379 beds.

Genesys management publicly stated on many occasions that of the 700,000 residents in subarea 41, Genesys would target 350,000 residents. Targeting 50% of the market with 379 beds yields a licensed bed utilization rate of 1.08 per 1,000 residents. This analysis leaves us with 350,000 residents left to be served by Hurley and McLaren Hospitals with 802 beds or a utilization rate of 2.29 per 1,000 residents. This calculation leads us to a most important question. If Genesys, using their strategic planning data and the CON review board using their programmed numbers of subarea 41 agreed on a new 379 bed hospital, was that number of licensed beds in the best interest of Genesee, Lapeer and Shiawassee Counties? Did the CON review board look at Genesys in a "vacuum"?

ANALYSIS

Requirements for CON Approval:

1,241 hospital beds in subarea 41 to service 700,000 residents (see Appendix A)

Therefore the maximum authorized hospital utilization rate per 1,000 is 1,241 divided by 700 or 1.77 per 1,000

Health Systems Review indicates hospital beds per 1,000 population range from under two in some parts of the country to 5.3 in others. A 1.77 is on the extreme low end of the national average (Havighurst, 1997, pp. 25-28).

Genesys CON Application (St. Joseph Hospital System 90-0007)

Request--439 beds (July 1992)--Approved October 1992

Updated Request--379 beds (1994)

This reduction in bed numbers decided by Genesys officials did not violate the 1,241 bed maximum for subarea 41 and therefore became a non-issue for the Michigan Department of Health CON Program.

This decision now left subarea 41 with 1,181 beds which is 60 beds below the maximum 1,241 allowed and yields a new maximum utilization rate of 1.65 per 1,000 if all hospitals ran at capacity, which they are not designed to do.

Did the CON process ask the right questions when the current Genesys Health System planners asked for 439, and then, 379 licensed beds?

Did this CON approval reduce health costs below what they may have been had the CON process not been in effect in Michigan during the 1990s?

Finally, did the regulators and regulated, in this very complex merger, do what was best for the population they both serve?

Representative Bob Emerson's queries and the CON response regarding St. Joseph Health System's CON application helps indicate the rather narrow focus under which the CON regulation is designed to consider the issue of licensed beds and the population served (Appendix B--Memorandum, September 8, 1992).

Although regulation under Michigan's CON program is much more encompassing than just the licensed bed issue, this example was chosen because it is representative of the way the CON process functions.

"If you go into the literature and ask for hospital closure as a designed experience, you don't get back many examples" says Mr. Mike Guthrie, former CEO of Good Samaritan in San Jose, California (Health Systems Review, 1997, p. 28). More and more mergers are inevitable, reflecting both excessive building in earlier decades and the more recent development of integrated health care networks.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

CON laws were brought into existence, as are most laws, because of abuse in some form. Mergers were not on the minds of CON lawmakers but they did fear the scenario of the outsider who bought the hospital, increased debt and passed on the cost in increased hospital rates. Today, merger or buy out, PPO's and HMO's will not allow rate increases to be passed on.

CON laws in Michigan regarding licensed beds have a "ceiling" (1,241 for subarea 41) to help control cost but no "floor," and no methodology to improve quality.

It is obvious from this study that Genesys initially chose 439 beds, not because that was the correct number based on their current number of practicing physicians and total patients under those physicians' care, but because that was the maximum number of beds they could legally take. The application that was turned over to the state for 439 beds cost considerable money and time to process and had little to do with the community's interests. The CON process did not object to that number or the 379 bed request two years later. The CON process was designed to slow down the proliferation of hospitals and beds and to that end it has had some success.

Conclusions

What this study hopes to have shown is that it is very difficult to predict the actual number of beds needed after a complex merger. The Genesys planners had to weigh projections from Deloitte and Touche, potential commitments from General Motors, possible loss of some indigent patients, integrated health system changes, fading industrial base in Genesee County, growth in the I-75 corridor near Genesys and many other factors.

The CON process has value in that it does require the hospital to look at specific through-puts in relation to equipment, beds and facilities requested. Least cost options are always preferred and often mandated. CON laws were also written to protect the indigent. “Both hospitals and state officials fear that without CON type regulation, freestanding centers are cherry-picking patients, leaving hospitals with the poorest and sickest people to care for” (Hospitals and Health Networks, April 20, 1994, p. 45).

CON regulation was born in an era when past government regulation encouraged rapid hospital expansion with little need to justify new licensed beds. Today hospitals find themselves constantly under the watchful eye of Evidence of Necessity (EON) requirements, managed care/provider services questions, BC/BS approval process, volume thresholds and a CON regulation, to name a few.

In spite of all the hospital expertise and copious amounts of regulation from managed care Genesys Hospital System does not have enough beds to care for its patients in an efficient manner. Neither Genesys, nor any other hospital in subarea 41, is designed to run at 100% capacity on a frequent basis. There are no laws or regulations to ensure that those patients whose doctors practice at Genesys would have a licensed bed and quality care waiting for them when they arrive.

Under the title How Many Beds? the Genesys planners stated in bold type, "A hundred years ago, hospitals were built along the main street of the town. We built ours along the main corridor of the 21st century--the freeway system" (Strategies for HealthCare Excellence, January 1995, p. 3). If a 45 passenger bus rolled over on that I-75 freeway system, just outside Genesys' door tomorrow morning, the overwhelming majority of those injured passengers would have to be sent to a competitor's hospital, along the main streets of Flint, Michigan, many miles away.

The current capacity situation at Genesys is unfortunate and was unnecessary.

Recommendations

CON laws may well cause problems for integrated delivery systems by looking at a piece of equipment or the number of beds in a vacuum. The CON

staffers and analysts are only asked to look at technical factors such as the price of services or equipment or how many beds are in a given subarea.

This study leads one to suggest assessing the total number of beds in subarea 41 that are in use, on average over time, and where they are located. Having enough beds in the wrong places is neither cost or quality effective. We need to change the incentives, which are now directed toward payment for volume, to payment for value.

The Greater Detroit Area Health Council (GDAHC) and the Economic Alliance, a Detroit based coalition of business, labor, hospitals, physicians, government and consumers have the power to stop a CON in its tracks, as they did with Sparrow Hospital's application for an open-heart surgery program. They can also assist in approval, in part, because the CON process is very political. In Sparrow's case the message to deny approval was "delivered by phone, mail and directly to Governor John Engler by General Motors CEO Jack Smith" (Business and Health, September 1993, p. 68). Here is a case of the auto industry, which has little use for regulation, more than willing to help regulate the health industry to keep costs down. Sparrow Hospital is appealing the CON denial based on what it considers an illegal change midway through the CON review process and that the denial was not cost beneficial.

Hospitals look at each other as competitors and use the CON regulation to their advantage to protect their own interests, not necessarily those of the subarea they service.

The writer recommends the following to help future mergers be more efficient based on lessons learned from the St. Joseph Health System merger into Genesys:

CERTIFICATE OF NEED RECOMMENDATIONS

- (1) Certificate of Need regulations must put more emphasis on quality and CON reviewers must be taught how to think and measure quality for the hospital and the subarea.
- (2) Well-paid, well-qualified professional bureaucrats on an independent commission should manage the CON process. It is not in the best interests of the citizens of Michigan to have politically appointed volunteers who have special interests and are obligated to the Governor.
- (3) The process must be simplified. Providers spend far too much time and money on administrative and legal costs.
- (4) CON commissions should spend less time on technical factors and start thinking strategically. "They should look at the effect on specific populations and total health care costs" (Bernard, 1994, p. 44).

- (5) CON regulation needs to be deleted or refined if it can be proven that hospitals working with integrated health system networks, BC/BS contracts, economic alliances, and EONs can contain costs.

COST/QUALITY RECOMMENDATION

Data gathered from this study strongly indicates the CON process did not ask the right questions regarding the number of beds for Genesys Health System.

Genesys was designed to operate at up to 90% occupancy. The August 1996 Review of Economics and Statistics posits an ideal occupancy level of about 74%. “Most studies peg the ideal occupancy rate, a compromise between efficiency and the need for unexpected capacity in emergencies, in the high 70% range” (Health Systems Review, January/February 1997, p. 28). The following is a recommendation and discussion based on data collected for subarea 41:

Subarea 41 needs a Master Plan for the community’s health.

With appropriate leadership and cross-functional teams, a needs assessment could be done, a focus would be chosen to achieve its vision, annual targets could be developed and means developed to finalize a plan. Once implemented the

plan could be monitored for progress, reviews could take place and improvements made.

Had there been a Master Plan for the City of Flint and three counties served in 1992, leadership and cross functional teams could have given direction on what the communities needs were, what equipment might be needed and beds required. Cost and quality could be measured without a state bureaucracy giving technical factors and politics would be minimized. Providers would not be “buying” approvals and GM’s Jack Smith would not have to make personal calls on the Governor.

I am hopeful that the Greater Flint Health Coalition (GFHC) will begin to take steps in this direction. Formed in 1992 and restructured in 1995-96 the GFHC now has an executive director and a cost and planning committee. Appendix C, Exhibit 11-A-16 and pp. 144-165 show a wealth of information that was available at the time Genesys was revising its request from 439 to 379 licensed beds. The Lewin Group Survey of Genesee County, surrounding counties, the State of Michigan and many U.S. rates could have given much information toward a needs assessment including:

- Genesee County ratio of inpatient beds to residents and comparable Michigan and U.S. rates.
- Staffed and licensed beds at McLaren, Hurley and Genesys Hospitals.
- Planned bed reductions.

- % county residents treated outside the county and % outside county residents treated in Genesee County.
- Migration-adjusted utilization rates.
- Utilization rates compared to a variety of benchmarks.
- Projected utilization rates.

Conducting a needs assessment and armed with data from the Michigan Certificate of Need program, managed care networks, current surveys (Lewin Group and American Hospital Association), hospital input, and the Economic Alliance, clear direction could be given to a hospital merger and cost/quality could be measured before and after the merger.

CON staffs and business people must work together, agreeing on goals to reduce cost and meet the needs of the communities served. Then we will have a health care system that balances market forces and budget safeguard, a plan that works for Genesee County and all of subarea 41.

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APPENDIX A

1. Program Section Report
2. CON Program
3. Section 22225 of Public Act 368
4. Figure 6 - CON Activity Summary
5. Certificate of Need Review Process: Overview
6. Subarea 41 - Location

PROGRAM SECTION REPORT

Applicant: St. Joseph Health Systems

Application No.: 92-0007

Facility: St. Joseph Health Systems

Facility No.: 25-0060

Facility Type: Hospital - Section 22205(1)(a)

Facility Location: Grand Blanc Township/Genesee County/Flint Hospital Subarea (41)/GLS Region

Review Threshold: Begin Operation of a New Health Facility - Section 22209(1)(a)

Make a Change in Bed Capacity - Section 22209(1)(b)

Initiate a New Service - Section 22209(1)(c)

Acquire Covered Medical Equipment - Section 22209(1)(d)

Make a Covered Capital Expenditure - Section 22209(1)(e)

Project Summary: Construct a 439 bed hospital with 652,500 gsf of new construction, including host site for mobile UESWL unit; 18 ORs; open heart surgery services; 5 special radiological rooms, including adult diagnostic and therapeutic cardiac cath; and 1 fixed whole body CT scanner. Delicense a total of 908 beds at Flint Osteopathic Hospital (25-0020), Genesee Memorial Hospital (25-0030), St. Joseph Hospital (25-0060), and Wheelock Hospital (25-0070).

Review Type: Substantive

Analysis By: Sallie Flanders, July 10, 1992

Reviewed By: Robert Hicks, July 21, 1992

**CERTIFICATE OF NEED PROGRAM
UNDER PART 222 OF 1978 PA 368 (AS AMENDED)**

Providers must obtain a CON to:

- Acquire or begin operation of a new health facility
- Make a change in the bed capacity of a health facility
- Initiate, replace, or expand a covered clinical service
- Make a covered capital expenditure

Health Facility is:

- Hospital
- Psychiatric Hospital, Psychiatric Unit, or Partial Hospitalization Psychiatric (PHP) Program
- Nursing Home/Hospital Long-Term Care (HLTC) Unit
- Freestanding Surgical Outpatient Facility (FSOF)
- HMO (only for inpatient hospital services & covered clinical services)
- Excludes: faith healing facilities, clinic/hospital in correctional facility, V.A. facilities, MDCH facilities

Change in Bed Capacity means:

- Increase in the following bed types: Hospital, NH/HLTCU, or Psychiatric
- Change from 1 licensed use to a different licensed use
- Physical relocation of beds from a licensed site to another geographical location

Covered Capital Expenditure:

- A capital expenditure for a health facility including or involving acquisition, improvement, expansion, addition, conversion, modernization, new construction, and/or replacement
- Review Threshold for Clinical Service Areas - Project Costs > \$2,130,040
- Review Threshold for Nonclinical Service Areas - Project Costs > \$3,195,060
- Leases are included as covered capital expenditures

Covered Clinical Services:

- Initiation or expansion of:
 - Neonatal Intensive Care Services
 - Open Heart Surgery Services
 - Extrarenal Organ Transplantation
 - Specialized Psychiatric Program for Children and Adolescent Patients using licensed psychiatric beds
- Initiation, replacement, or expansion of:
 - Lithotripsy
 - Megavoltage Radiation Therapy
 - Positron Emission Tomography
 - Surgical Services
 - Cardiac Catheterization
 - Fixed or Mobile Magnetic Resonance Imager Services
 - Fixed or Mobile Computerized Tomography Scanner Services
 - Air Ambulance Services
 - Partial Hospitalization Psychiatric Program

commission shall develop proposed review standards and make the review standards available to the public not less than 30 days before conducting a hearing under subsection (3).

(b) Approve, disapprove, or revise certificate of need review standards that establish for purposes of section 22225 the need, if any, for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning the operation of a health facility, making changes in bed capacity, or making covered capital expenditures, including conditions, standards, assurances, or information that must be met, demonstrated, or provided by a person who applies for a certificate of need. A certificate of need review standard may also establish ongoing quality assurance requirements including any or all of the requirements specified in section 22225(2)(c). The statewide health coordinating council may perform the duties of the commission under this subdivision, only until all members of the commission are appointed and confirmed, or until March 1, 1989, whichever is sooner.

(c) Direct the department to prepare and submit recommendations regarding commission duties and functions that are of interest to the commission including, but not limited to, specific modifications of proposed actions considered under this section.

(d) Approve, disapprove, or revise proposed criteria for determining health facility viability under section 22225.

(e) Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission.

(f) By October 1, 1992, and every 5 years after October 1, 1992, make recommendations to the standing committees in the senate and the house that have jurisdiction over matters pertaining to public health regarding statutory changes to improve or eliminate the certificate of need program.

(g) Upon submission by the department approve, disapprove, or revise standards to be used by the department in designating a regional certificate of need review agency, pursuant to section 22226.

(h) Approve, disapprove, or revise certificate of need review standards governing the acquisition of new technology.

(i) In accordance with section 22255, approve, disapprove, or revise proposed procedural rules for the certificate of need program.

(j) Consider the recommendations of the department and the department of attorney general as to the administrative feasibility and legality of proposed actions under subdivisions (a), (b), and (c).

(k) Consider the impact of a proposed restriction on the acquisition of or availability of covered clinical services on the quality, availability, and cost of health services in this state.

(l) Appoint ad hoc advisory committees to assist in the development of proposed certificate of need review standards. An ad hoc advisory committee shall complete its duties under this subdivision and submit its recommendations to the commission within the time limit specified by the commission when an ad hoc advisory committee is appointed. The composition of the ad hoc advisory committee shall include all of the following:

(i) Experts with professional competence in the subject matter of the proposed standard, who shall constitute a majority of the ad hoc advisory committee.

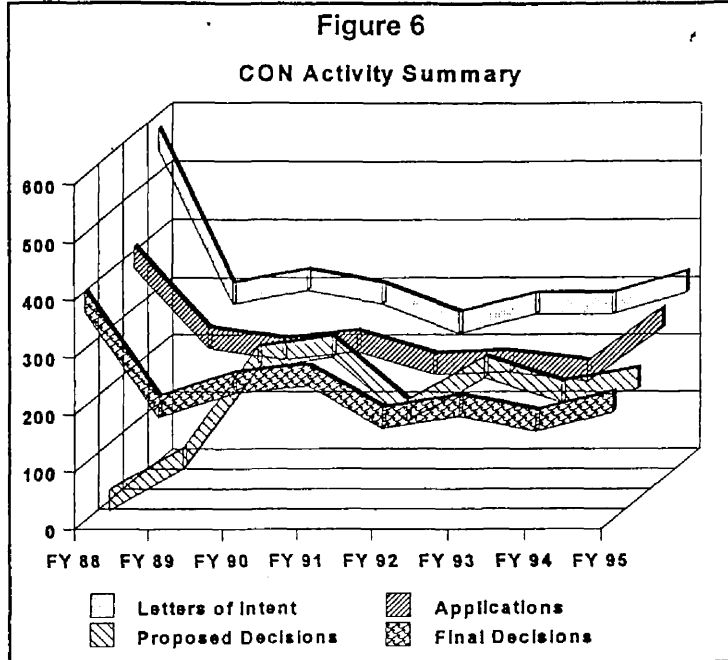
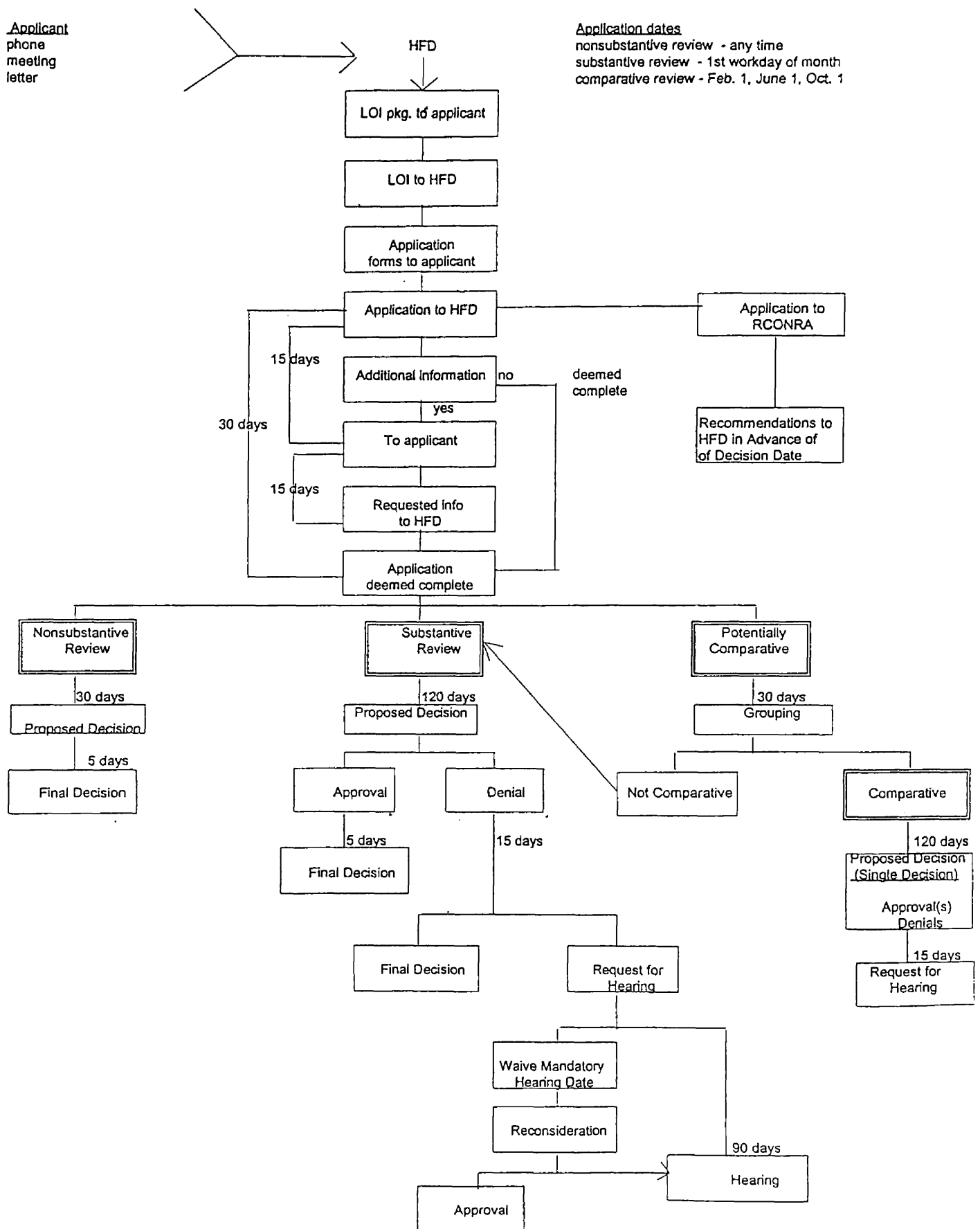


Figure 6 illustrates the impact of the 1988 CON Reform Act. Overall activity has significantly decreased from FY 88 through FY 95. Letters of Intent volumes were down by 44%, application volumes are down by 27%, and final decisions are down by 46%. Proposed decisions are down by 11% from FY 90; the Department did not issue proposed disapprovals prior to the 1988 statutory changes. Clearly, the 1988 legislative changes, including the revised standards development process, have significantly changed the CON program by reducing its scope and providing a more predictable and effective program which has reduced the number of disapprovals and associated litigation. The focus on only expensive and sophisticated services has reduced the volume of applications.

CERTIFICATE OF NEED REVIEW PROCESS: OVERVIEW

Applicant
phone
meeting
letter

Application dates
nonsubstantive review - any time
substantive review - 1st workday of month
comparative review - Feb. 1, June 1, Oct. 1



APPENDIX B

1. CON Review Standards (p. 28)
2. State of Michigan Certificate of Need Commission
3. Response to Representative Emerson's Letter
4. The Lewin Group - Genesee County Survey Hospital Data

St. Joseph Hospital
 Application No. 92-0007 (25-0060)
 Page No. 27

CON REVIEW STANDARDS - continued

Section 6. Requirements for approval -- new beds in a hospital

Sec. 6. An applicant proposing new beds in a hospital shall demonstrate that it meets all of the following:

As defined in Section 2(1)(o) of these standards, the SJHS application involves the development of "new beds in a hospital" because it involves 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 is not in the replacement zone. The proposed SJHS site in Grand Blanc Township is not in the replacement zone because it is more than 2 miles from the four licensed sites.

(a) The new beds in a hospital shall result in a hospital of at least 200 beds in a non-rural county or 50 beds in a rural 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.

The proposed project involves the development of a new hospital with 439 beds. Therefore, the application is in compliance with subsection 6(a).

(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.

As discussed under Section 3, the Department determined that the proposed new hospital should be included in subarea 41. Based on Appendix C, subarea 41 needs 1,241 hospital beds. Currently, there are 1,710 existing hospital beds in subarea 41. The chart below lists the beds. Therefore, there is an excess of 469 hospital beds in subarea 41.

<u>SA 41</u> <u>Hospitals</u>	<u>No. of</u> <u>Lic. Beds</u>
St. Joseph	423
FOH	359
Genesee Meml	95
Wheelock	31
McLaren	368
Hurley	434
Total	1,710

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M E M O R A N D U M

TO: Bob Hicks

FROM: Bob Ranger 

DATE: September 17, 1992

SUBJECT: Response to Representative Emerson's letter

- A. The least costly alternative in terms of project costs is evaluated from the applicant's response to the following:
- i. Alternatives considered
 - ii. Total project costs of each alternative
 - iii. A statement of assumptions for each alternative considered.
 - iv. Explain and give complete details and reasons as to why you believe your proposed project is the least costly project in terms of project costs and available alternatives.

The applicant provided the following three alternatives with project costs for each alternative along with a detailed discussion based on information provided by architectural engineering firms and health care construction consultants.

- Renovate each of the Systems hospitals and operate at current levels. Project cost: \$137,500,000.
- Build a replacement hospital on an existing site. Project cost: \$170,000,000.
- Build a new hospital in Grand Blanc Township. Project cost: \$145,000,000.

The professional judgment of Departmental Staff on reviewing the detailed material submitted ~~as~~ the application is that the applicant is in compliance with the criteria in Section 22225(2)(b)(i).

- B. The renovation alternative to constituting a new 439 bed hospital is not simply the renovation of 439 beds. The alternative considered by the applicant was to renovate each of the System hospitals and operate at current levels at a total project cost of \$137,500,000. Although on the surface, this cost appears lower than its alternative of building a new hospital at a total cost of \$145,000,000 the useful life of the renovated facility was estimated to be about 10 years as compared to 30 years for a new facility.

Bob Hicks
September 17, 1992
Page 2

- C. The Department uses the "Means Square Foot Costs" manual which provides a range of construction costs per square foot for a number of typical building structures. According to the 1992 Means manual, completed costs per square foot for this type of structure range from \$88.00 to \$210 per square foot. Using the data provided by the applicant on a comparable basis with the Means manual, gives a construction cost per square foot of \$167.10 which falls within the range of the Means report.

The construction costs per square foot of \$167.10 is based on new construction, fixed equipment, architect/engineering fees and contingencies.

It is not clear where the \$135.00 per square foot cost mentioned in your letter comes from. Taking just construction costs of \$89,000,000 and dividing by 650,000 square feet of area to be constructed shows a per square foot cost of \$136.92. Both cost amounts fall well within the range of costs outlined in the Means report.

- D. The treatment of debt service reserve funds varies widely depending on market conditions, the bond rating agencies, bond insurers and investors. Some debt financed projects do not require a debt service reserve fund.

The application has a letter from Kidder, Peabody and Company, the bond underwriter. They suggested a liquidity covenant in the bond documents and that St Joseph Hospital provide a debt service reserve fund only if market condition require such funding at the time of marketing the issue.

Even if conditions changed such that a reserve fund were required, the financial impact would be minimal since the funds are reinvested and third party payers require that the interest expense on the funds are offset by the interest earned for reimbursement purposes. The debt service reserve fund, if required, is equal to one year of principal and interest and is used to make the last payment on the loan.

- F. The applicant was required to provide a revenue and expense statement (copy attached) along with assumptions and rationale used for calculating the revenue and expense items for each line item. The revenue and expense statement includes two years of actual data and three years of projected data. The projections show sufficient revenue being generated to cover operating expenses which is the condition for financial viability of the project. Department audit staff reviewed the projections and assumptions in conjunction with data, projections and assumptions provided elsewhere in the application and concluded that projected revenues and expenses appear to be fairly stated.

Bob Hicks
September 17, 1992
Page 3

H. Certificate of Need Rule 415 states:

Certificate amendment for increase in construction costs.

Rule 415. Due to the difficulty in estimating, in advance, finance costs, construction delays, the need for minor construction change orders, and other similar unforeseeable events, an amendment to a certificate of need for increased capital expenditures shall not be required if the total amount of excess does not exceed the sum of 15% of the approved capital expenditure up to \$1,000,000.00 and 10% of the approved capital expenditure in excess of \$1,000,000.00

If the project costs exceed the allowable overrun, the applicant would be required to file a request for an amendment to the certificate of need or may be required to seek another substantive review.

RFR/smp

RESPONSES TO BOB EMERSON'S QUERIES
REGARDING
ST. JOSEPH HEALTH SYSTEM'S CON APPLICATION

- A. *The law (Public Act 368) states that a proposed project ought to be the least costly alternative, and I would like to know the criteria the state used to determine that this was the least costly alternative. To that end, it is my assumption that you use independent criteria, and not just the alternatives suggested by the St. Joseph Health System.*

The least costly alternative is determined on the basis of information provided by CON applicants. Applicants must respond to the following three questions:

1. Discuss in detail what alternatives to the proposed project were considered and why the alternative chosen was considered the most efficient and effective method of providing the proposed facilities/equipment/services.
2. Discuss in detail what alternatives to the proposed physical plant expansion (lease, purchase, etc.) were considered and why the alternative chosen was considered the most efficient and effective method.
3. Discuss in detail how it was determined that the scope of the physical plant expansion (increase in square footage) was needed and why it is the most efficient and effective method of increasing the size of the physical plant.

The Certificate of Need Commission has not yet developed criteria for assessing the adequacy of alternatives to proposed projects. Consequently, the Departmental staff use professional judgement in determining applicant compliance with Section 22225 (2) of Public Act 368.

- both*
- B. *It does not take a rocket scientist to figure out that building one new hospital of 439 beds will be less costly than total reconstruction of three old facilities of nearly 1,000 beds. While I question the validity of the projected costs stated by St. Joseph Health System, the cost of building a 439-bed hospital should only be compared to the cost of renovating 439 beds at their current site. Since the proposed hospital is about the same size as St. Joseph Hospital at 302 Kensington Avenue, Flint, Michigan, one would logically assume that the cost of the proposed hospital should only be compared against the cost of renovating St. Joseph Hospital or Flint Osteopathic Hospital, but not*

both.

The methodology you propose for comparing the costs of renovating against the costs of new construction at first blush appears eminently logical; however, the methodology fails to take into consideration such matters as the costs of physical plant renovations needed to bring individual hospitals up to code. You also suggest that either St. Joseph Hospital or Flint Osteopathic Hospital, but not both, be renovated.

- C. *In determining whether this is the least costly alternative, I wonder if an independent judgement was made about the accuracy of the stated construction costs. In discussing the costs of construction of a new hospital with people in the hospital construction field, I have been led to believe that \$135 per square foot construction cost grossly underestimates the costs of this project. In addition, there appears to be no consideration for the public costs, i.e. infrastructure, which I believe will be considerable. As you know, I have been most concerned about the location of the replacement hospital, and the infrastructure costs to rebuild in Flint are only a fraction of the infrastructure costs of developing the Grand Blanc site.*

Finance

\$135 not over figure

reference

*Address
infrastructure the low rules*

- D. The application does not appear to include a debt service reserve in the finance costs. Isn't that unusual? If it is, then does that not also tend to underestimate the costs of the project? I was also unable to find in the application how St. Joseph Health Systems demonstrated that "the project meets an unmet need in the area proposed to be served", as mandated by Section 2225 of the Public Health Code. You may be able to clarify this for me.

Finance

Address program

- E. Throughout the application, St. Joseph Health System makes reference to the medical mall and a regional integrated health delivery system, yet it appears that the certificate of need is only for a replacement hospital. Is that assumption correct, and if it is, will they have to apply for a certificate of need for the medical mall? Since I found the application confusing, I was unable to determine which ancillary services would be moved to the Grand Blanc site, and what new services would be added.

Program

F. Since the proposal and your conditional approval both allude to the future filing of one or more certificate of need applications, has there been an indication of the type of future filings we can expect? (Has the DEpartment conducted any investigation to ensure that the current certificate of need (92-0007) will be financially viable without the need for granting future certificates of need?

Hecks
Zalley

Finance
last sentence

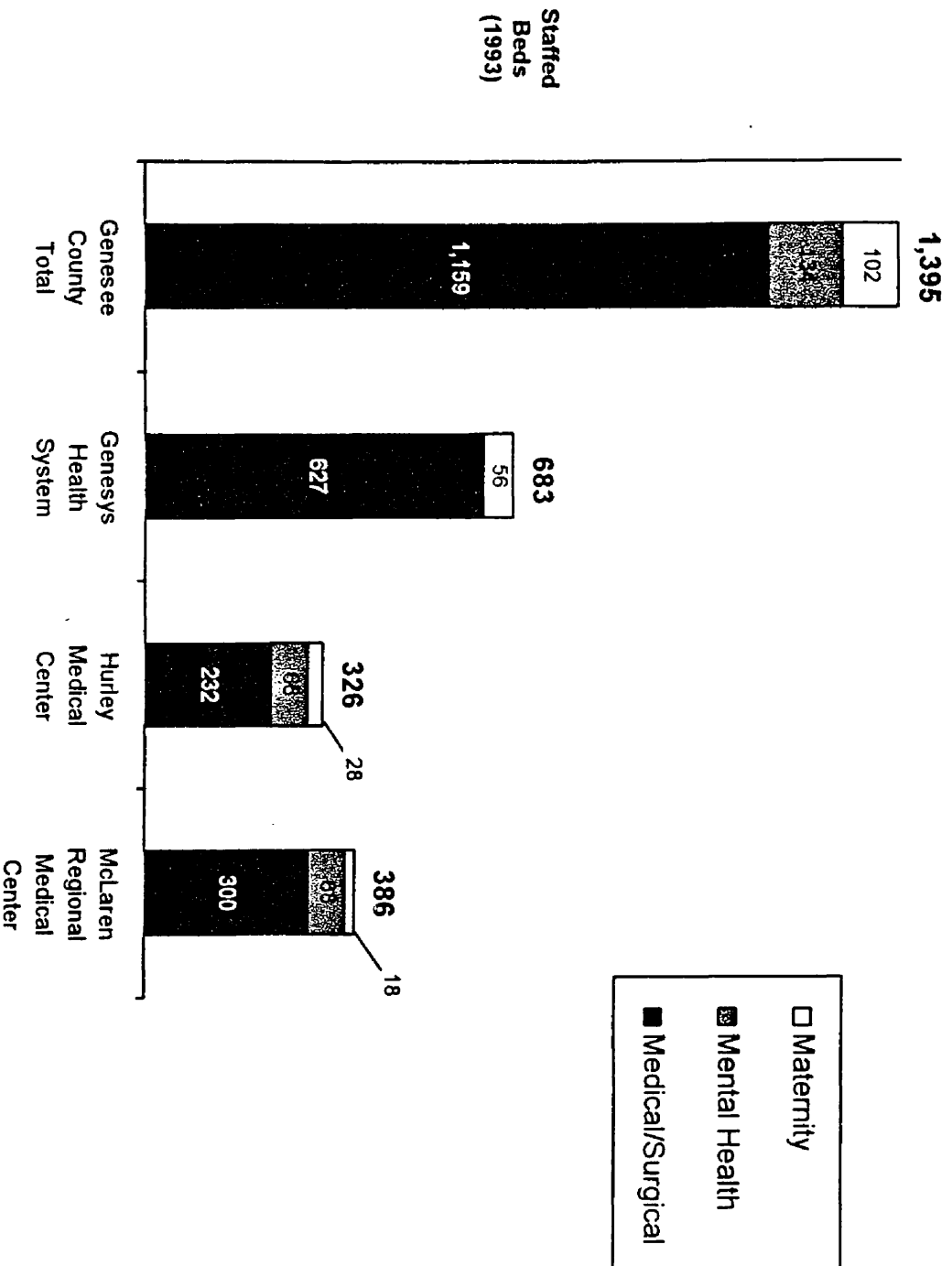
G. I would also like to know how the letter of intent, filed by Flint Osteopathic Hospital, to expand their rehabilitation beds is consistent with the certificate of need applications. Does the letter of intent actually change the scope of the project necessitating the filing of an amended petition, or do you consider it an unrelated matter?

Program

LIST OF TABLES

1. RESOURCE ASSESSMENT
 - Exhibit 11-A-2
 - Exhibit 11-A-4
 - Exhibit 11-A-8
 - Exhibit 11-A-10
 - Exhibit 11-A-12
 - Exhibit 11-A-16
2. VALUE ASSESSMENT
 - Exhibit III-B-1
 - Exhibit III-B-3
 - Exhibit III-B-5
 - Exhibit III-B-9
 - Exhibit III-B-11
 - Exhibit III-B-40
3. ANALYSIS OF CON PROGRAM FEES AND COSTS
 - Table 15, 16 and 17
4. Subarea 41Hospitals

EXHIBIT II-A-2: Genesee County providers supply 1,395 staffed beds, the majority of which (49 percent) are supplied by Genesys Health System.

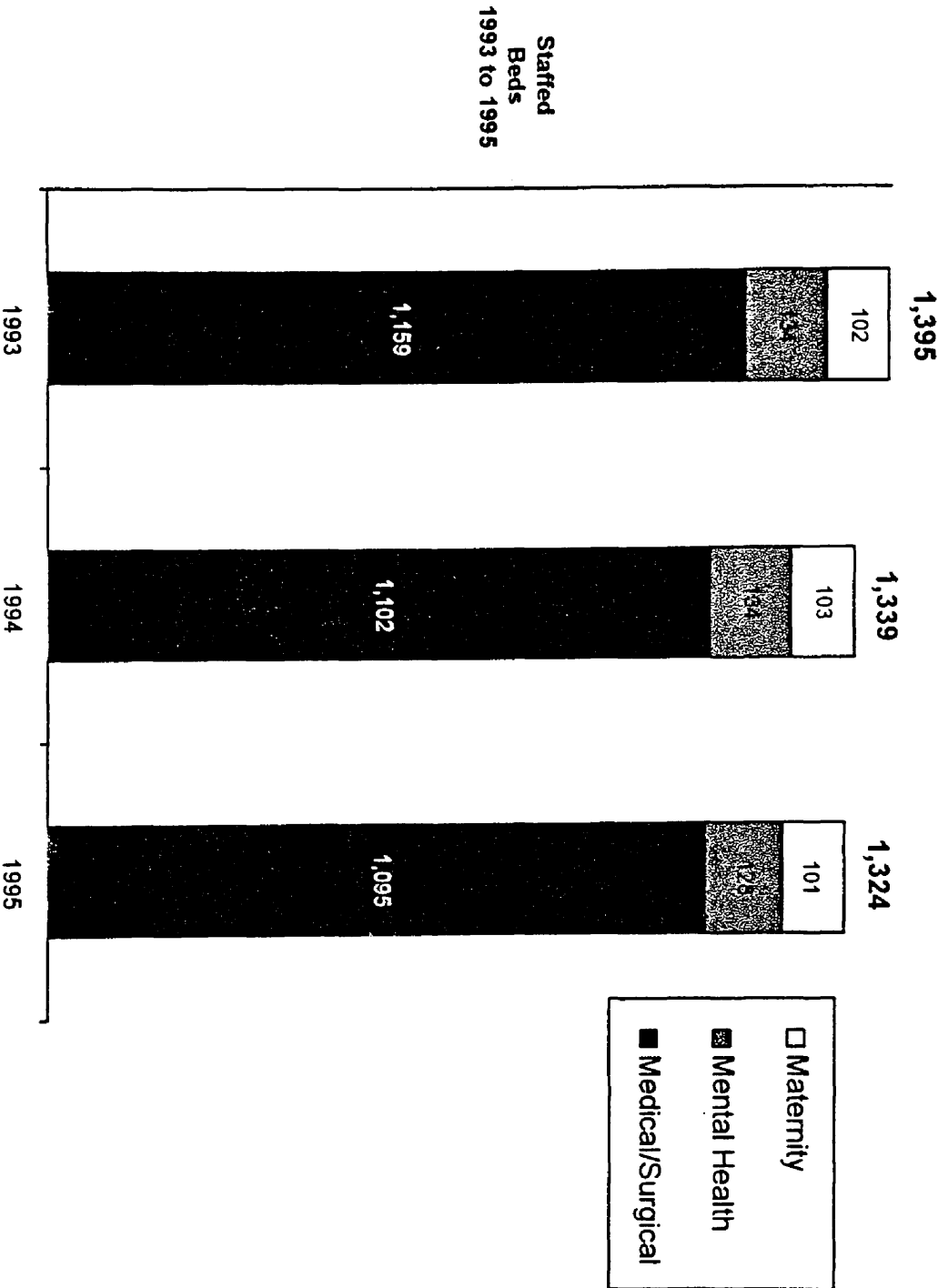


Source: The Lewin Group survey of Genesee County hospitals.
 Note: Estimates do not include long-term care beds.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Hospital	Physician	Diagnostic Services

EXHIBIT II-A-4:

Over the past several years, the number of staffed beds in Genesee County has fallen by five percent, largely through reductions in the number of staffed medical/surgical beds.



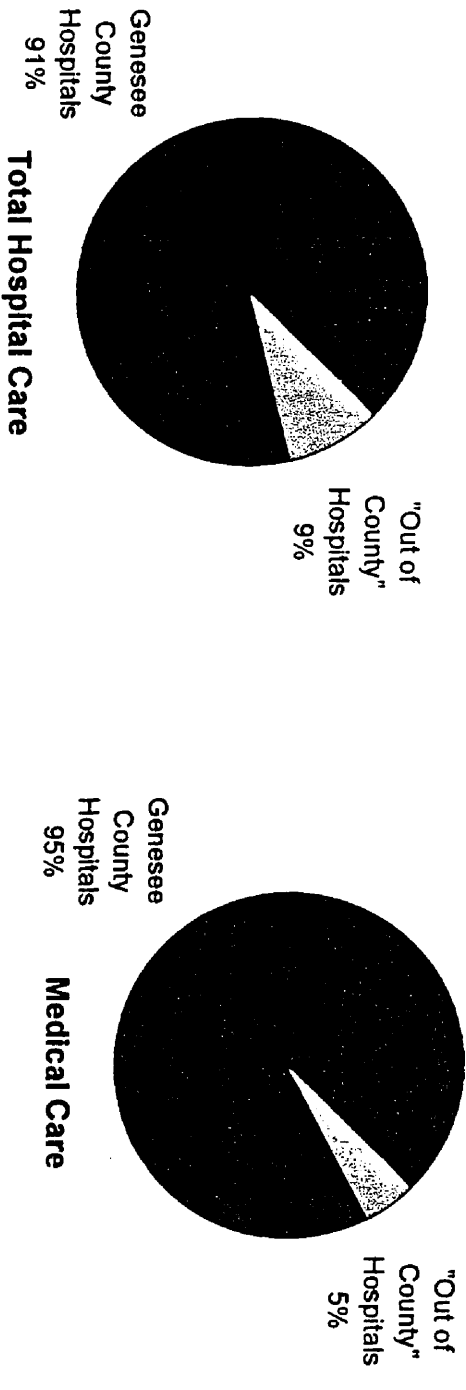
Source: The Lewin Group survey of Genesee County hospitals.

Note: Estimates do not include long-term care beds.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Hospital	Physician	Diagnostic Services

EXHIBIT II-A-8: Genesee County residents primarily rely on hospitals located within the county for inpatient services, although this varies somewhat by type of service.

**Genesee County Residents' Hospital Use
1993**



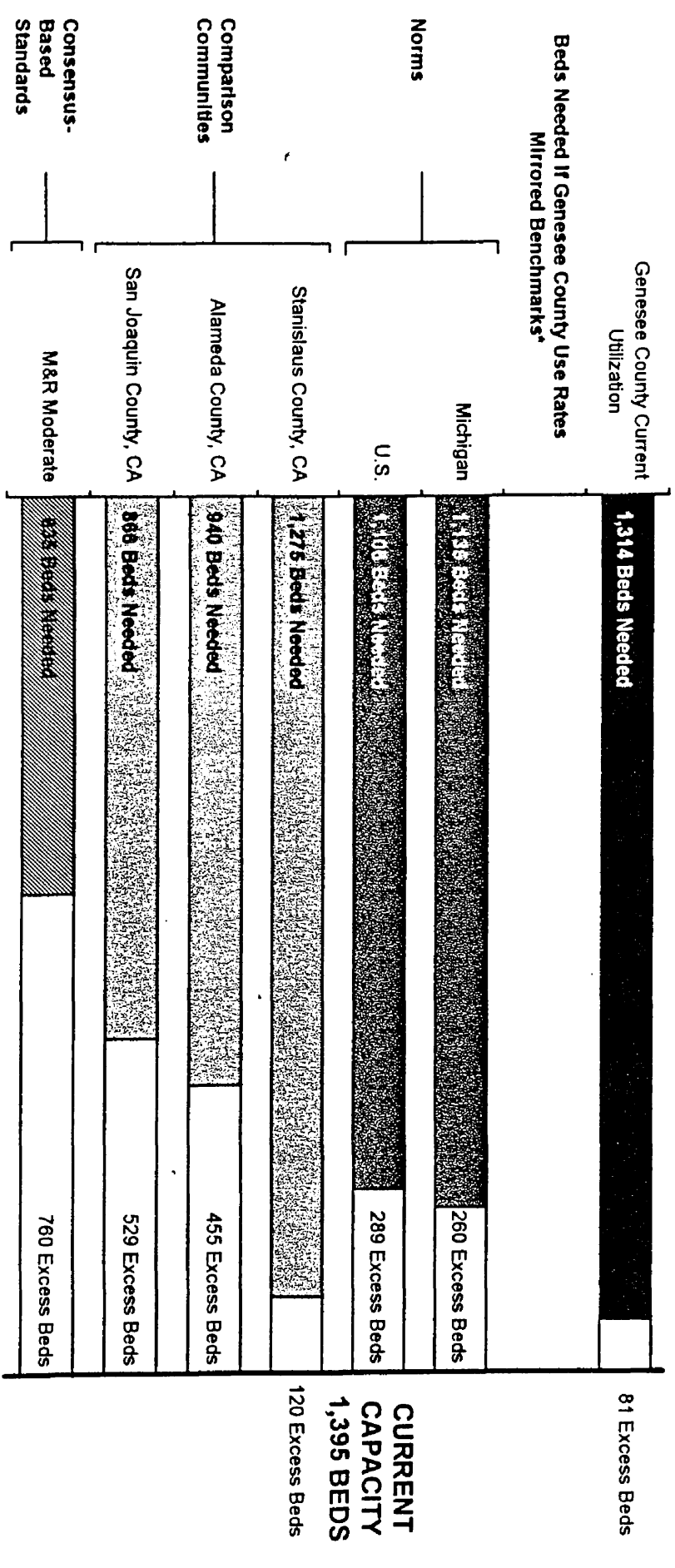
Source: Migration rates are based on sample of over 14,000 GM beneficiaries living in Genesee County during 1994. These rates were applied to 1993 hospital discharge data from the Michigan Health and Hospital Association. Information on migration patterns for mental health services was not available.

Note: Estimates are based on days of inpatient hospital care.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Hospital	Physician	Diagnostic Services

EXHIBIT II-A-10: Although Genesee County's supply of staffed beds appears appropriate under current utilization, excess capacity rises to between nine and 38 percent under most alternative utilization scenarios.

Migration-Adjusted Demand Versus Staffed Bed Supply: All Beds
1993



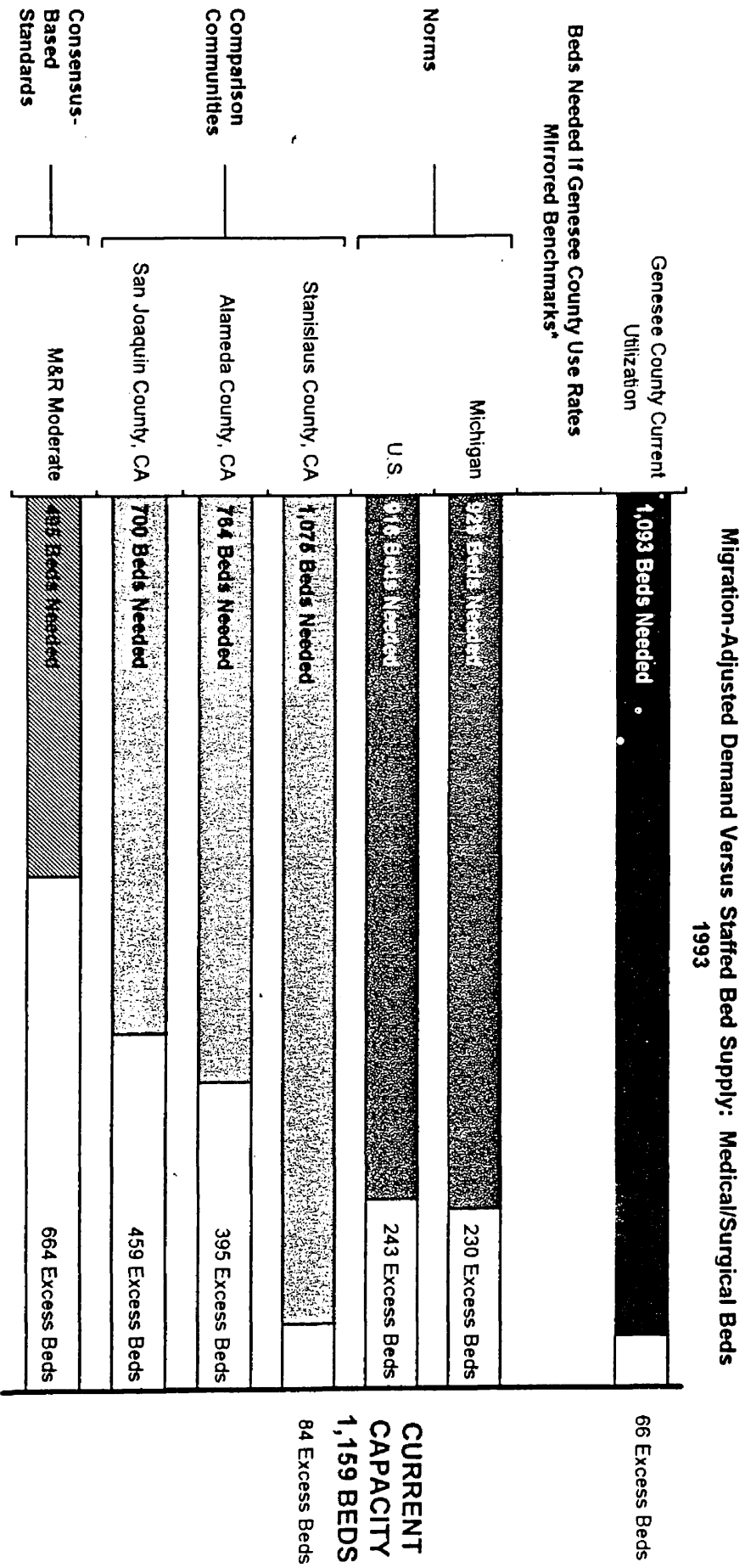
Sources: 1) The Lewin Group hospital survey; 2) Michigan Health and Hospital Association Service Corporation Interactive Data System 1993 discharge data; 3) 1992 National Hospital Discharge Survey; 4) California Office of Statewide Health Planning and Development 1993 discharge data; 5) Milliman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care). Underlying inpatient utilization estimates are adjusted to reflect the impact of migration into and out of the county. Bed capacity is based on number of staffed beds. Bed need estimates assume the following hospital occupancy levels: 80 percent for medical/surgical beds, 70 percent for maternity beds, and 95 percent for psychiatric/substance abuse beds.

* Benchmark use rates are age/sex adjusted to the Genesee County population, with the following exception: Milliman and Robertson use rates are age-adjusted only (no gender-specific utilization data were available).

HEALTH ASSESSMENT RESOURCE ASSESSMENT VALUE ASSESSMENT

Hospital Physician Diagnostic Services

EXHIBIT II-A-12: Although under current utilization Genesee County's supply of medical/surgical beds is comparable to demand, excess capacity climbs to between 16 and 40 percent under most alternative utilization scenarios.

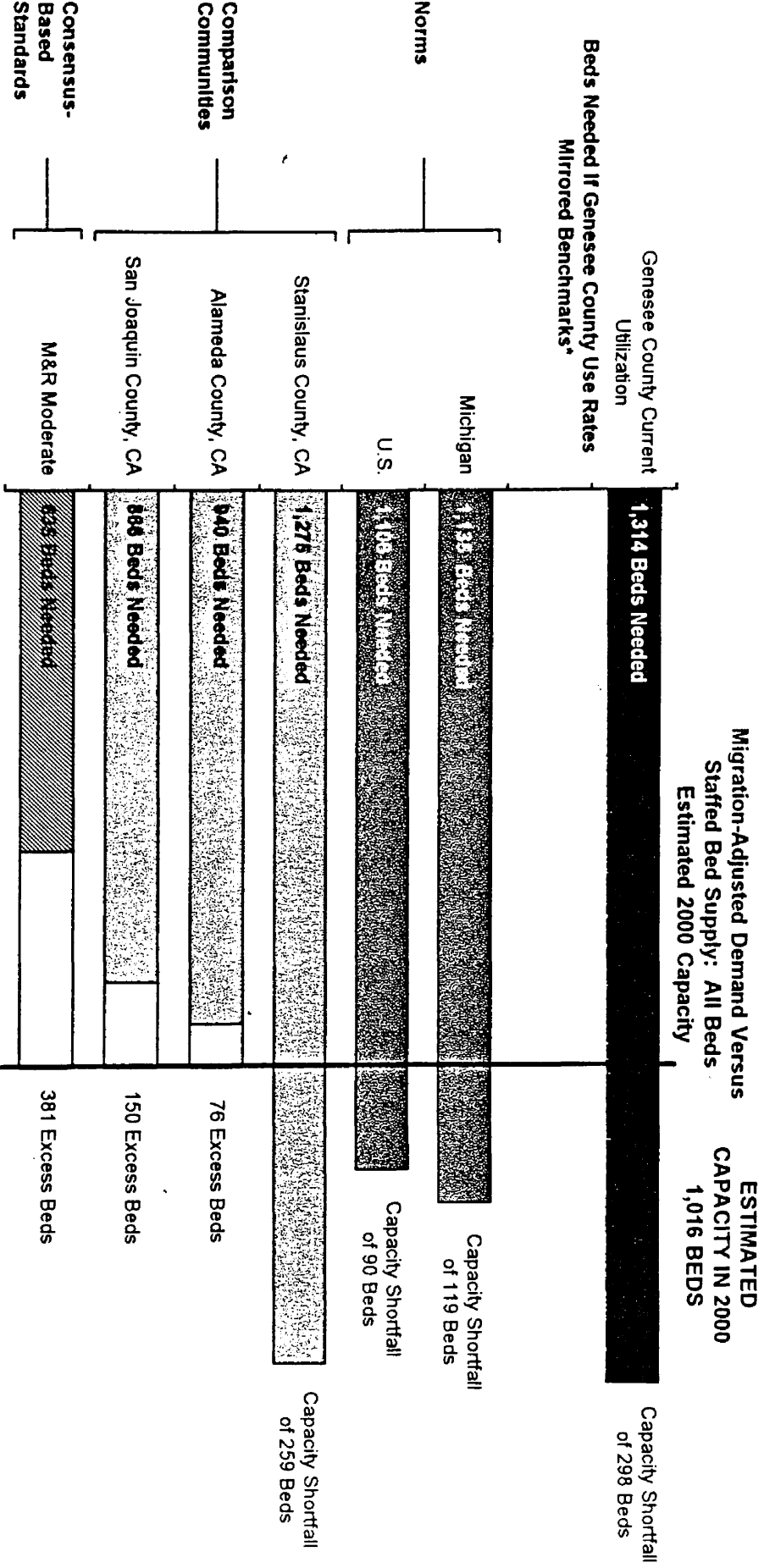


Sources: 1) The Lewin Group hospital survey; 2) Michigan Health and Hospital Association Service Corporation Interactive Data System 1993 discharge data; 3) 1992 National Hospital Discharge Survey; 4) California Office of Statewide Health Planning and Development 1993 discharge data; 5) Milliman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care). Underlying Inpatient utilization estimates are adjusted to reflect the impact of migration into and out of the county. Bed capacity is based on number of staffed beds. Bed need estimates assume 80 percent hospital occupancy.

* Benchmark use rates are age/sex adjusted to the Genesee County population, with the following exception: Milliman and Robertson use rates are age-adjusted only (no gender-specific utilization data were available).

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Hospital	Physician	Diagnostic Services

EXHIBIT II-A-16: Although planned reductions in staffed beds will eliminate excess capacity in the county under current utilization rates, significant overcapacity will remain if more disciplined utilization rates are achieved.

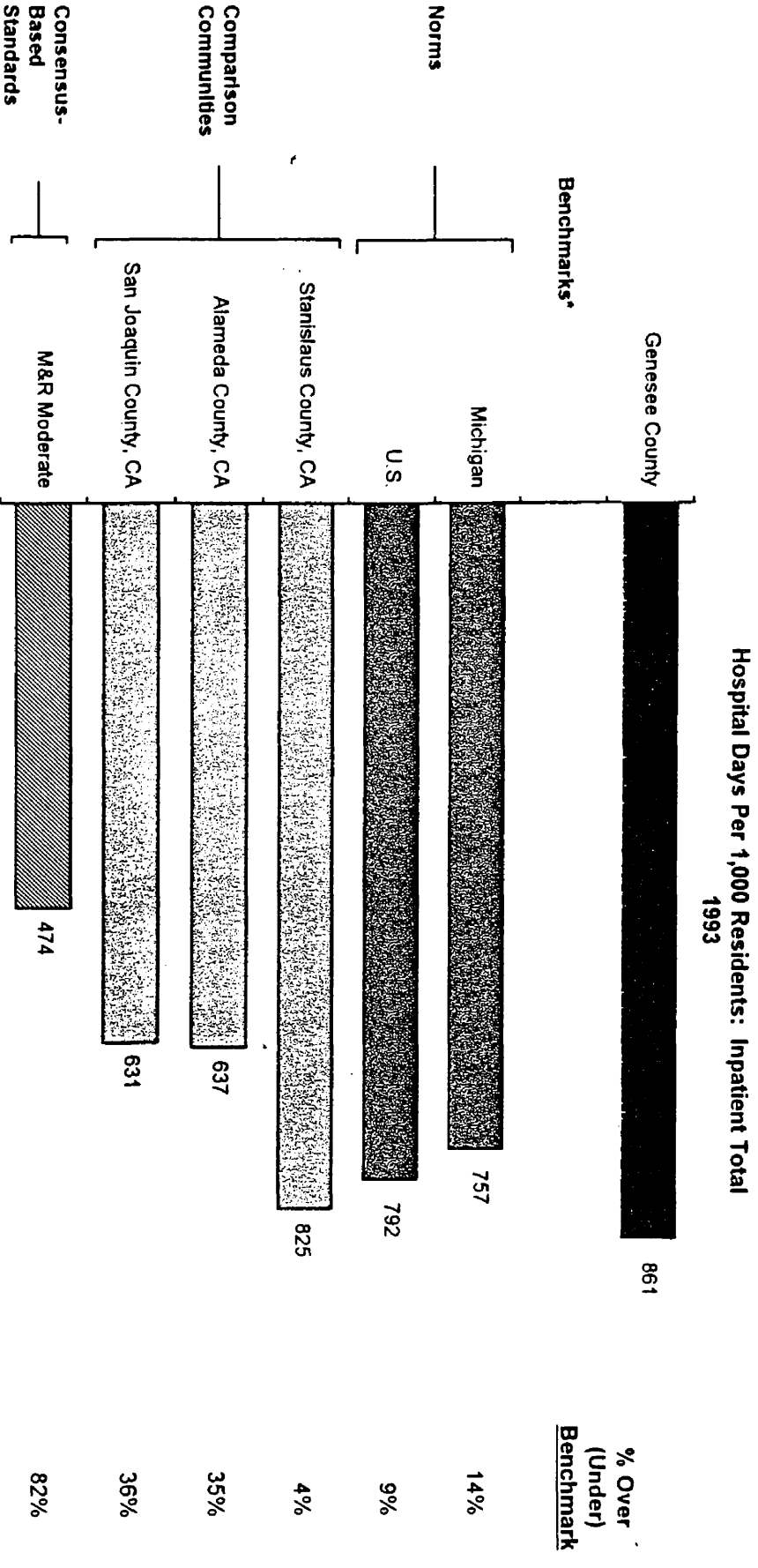


Sources: 1) The Lewin Group hospital survey; 2) Michigan Health and Hospital Association Service Corporation Interactive Data System 1993 discharge data; 3) 1992 National Hospital Discharge Survey; 4) California Office of Statewide Health Planning and Development 1993 discharge data; 5) Milliman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care). Underlying inpatient utilization estimates are adjusted to reflect the impact of migration into and out of the county. Bed need estimates assume the following hospital occupancy levels: 80 percent for medical/surgical beds, 70 percent for maternity beds, and 95 percent for psychiatric/substance abuse beds. Staffed bed projections were provided by hospital officials.

* Benchmark use rates are age/sex adjusted to the Genesee County population, with the following exceptions: 1) Michigan use rates are not age-sex adjusted, and 2) Milliman and Robertson use rates are age-adjusted only (no gender-specific utilization data were available).

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Hospital	Physician	Diagnostic Services

EXHIBIT III-B-1: Genesee County residents use hospital services at a rate which is nine to 36 percent higher than most benchmark rates.



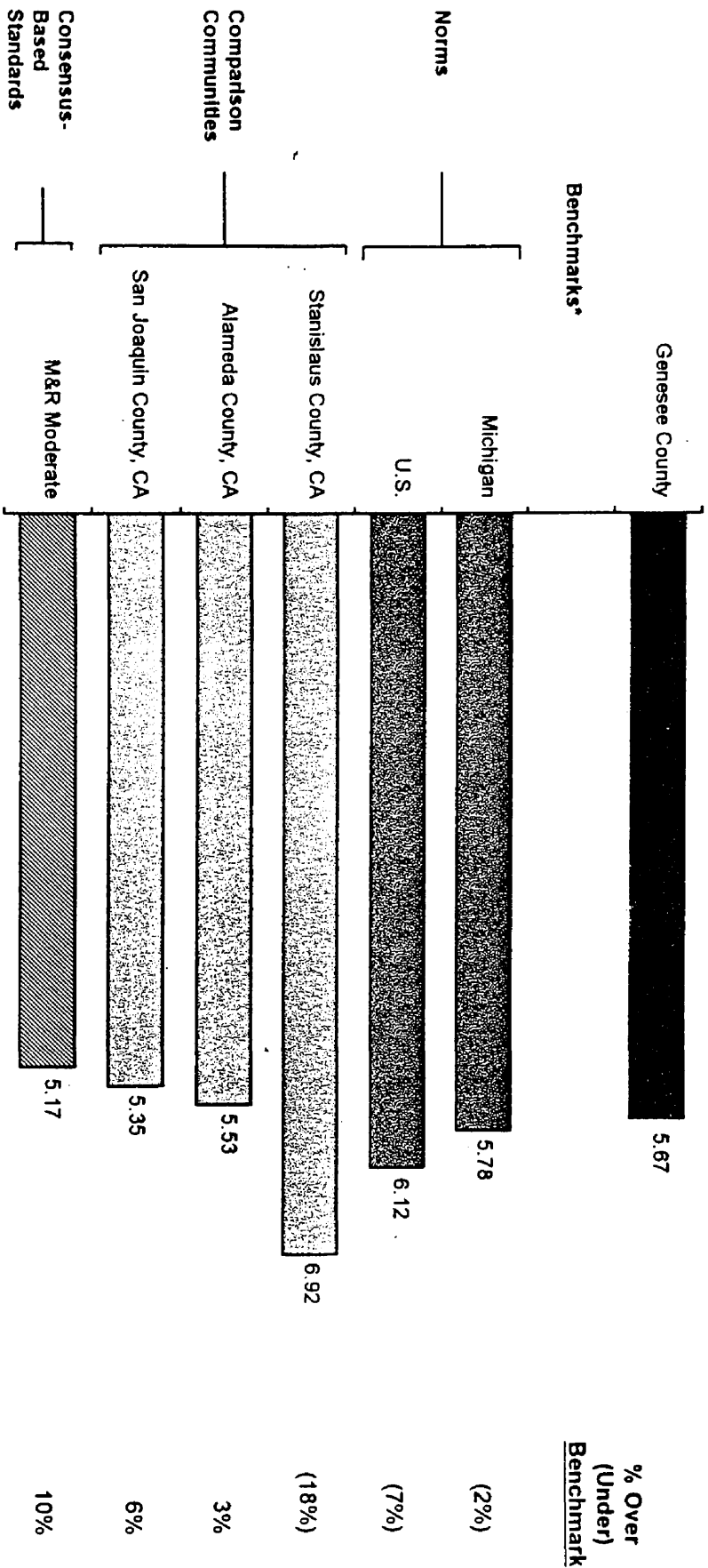
Sources: 1) Genesee County and Michigan rates are based on 1993 Michigan Health and Hospital Association hospital discharge data; 2) U.S. rates are based on 1992 National Hospital Discharge Survey data; 3) California county rates are based on California Office of Statewide Health Planning and Development 1993 hospital discharge data; and 4) M&R's moderate benchmark estimate is based on data reported in Millman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care).

* Benchmark community rates are adjusted to reflect the age and sex distribution of Genesee County's population, with the following exception: M&R rates are age-adjusted only (gender-specific utilization data were not available). Benchmark rates are also case-mix adjusted to control for differences in types of hospital admissions.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

EXHIBIT III-B-3: Genesee County residents' hospital stays are shorter than or comparable to most benchmark standards.

Average Length of Stay: Inpatient Total
1993
Data Not Severity Adjusted

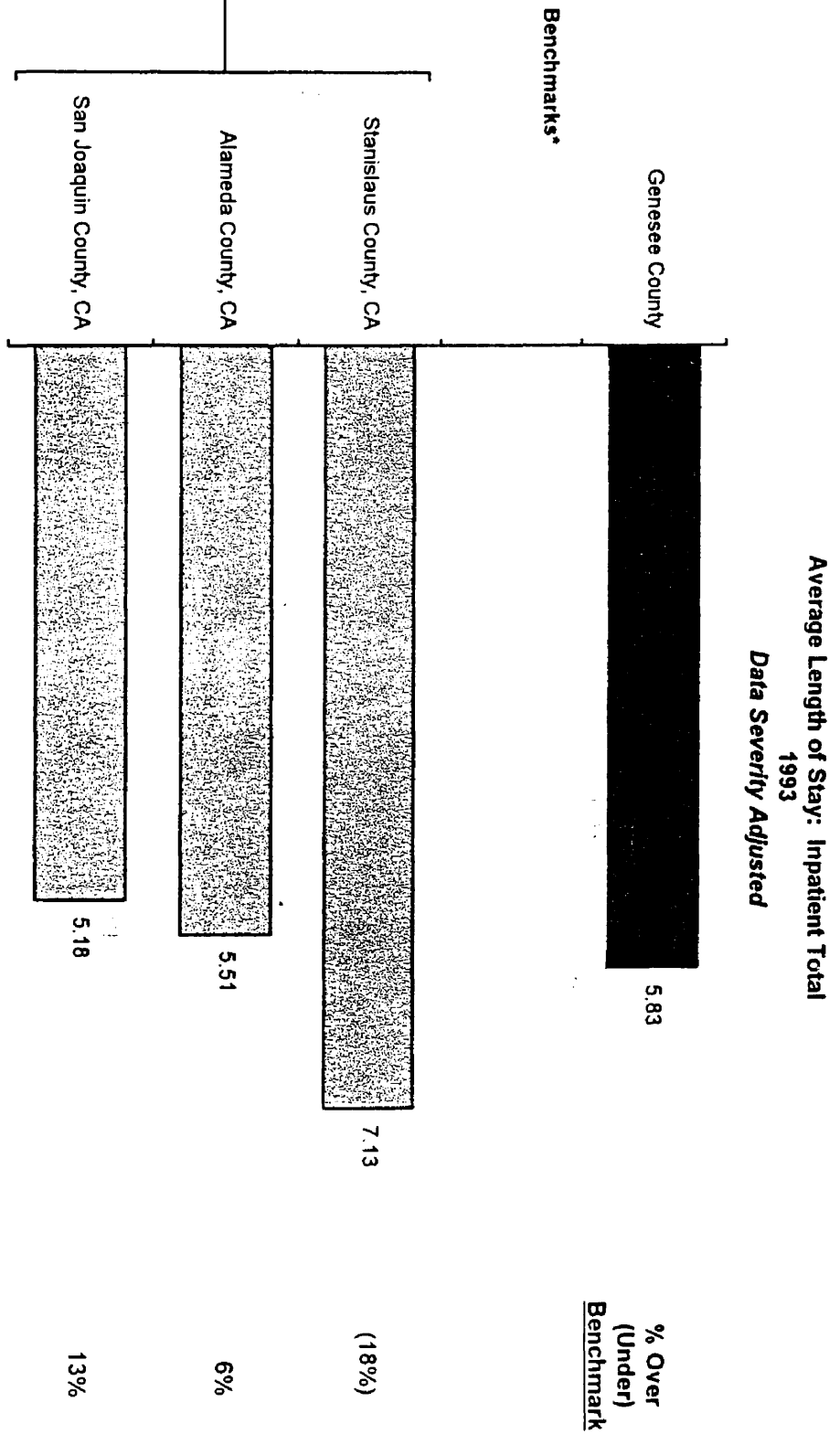


Sources: 1) Genesee County and Michigan rates are based on 1993 Michigan Health and Hospital Association hospital discharge data; 2) U.S. rates are based on 1992 National Hospital Discharge Survey data; 3) California county rates are based on California county rates reported in Milliman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care).
* Benchmark community rates are adjusted to reflect the age and sex distribution of Genesee County's population, with the following exception: M&R rates are age-adjusted only (gender-specific utilization data were not available). Benchmark rates are also case-mix adjusted to control for differences in types of hospital admissions.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

EXHIBIT III-B-5:

Because the severity mix of Genesee County's inpatient population is only slightly less severe than benchmarks, adjusting for severity has a minimal impact on the county's average length of stay performance relative to benchmarks.

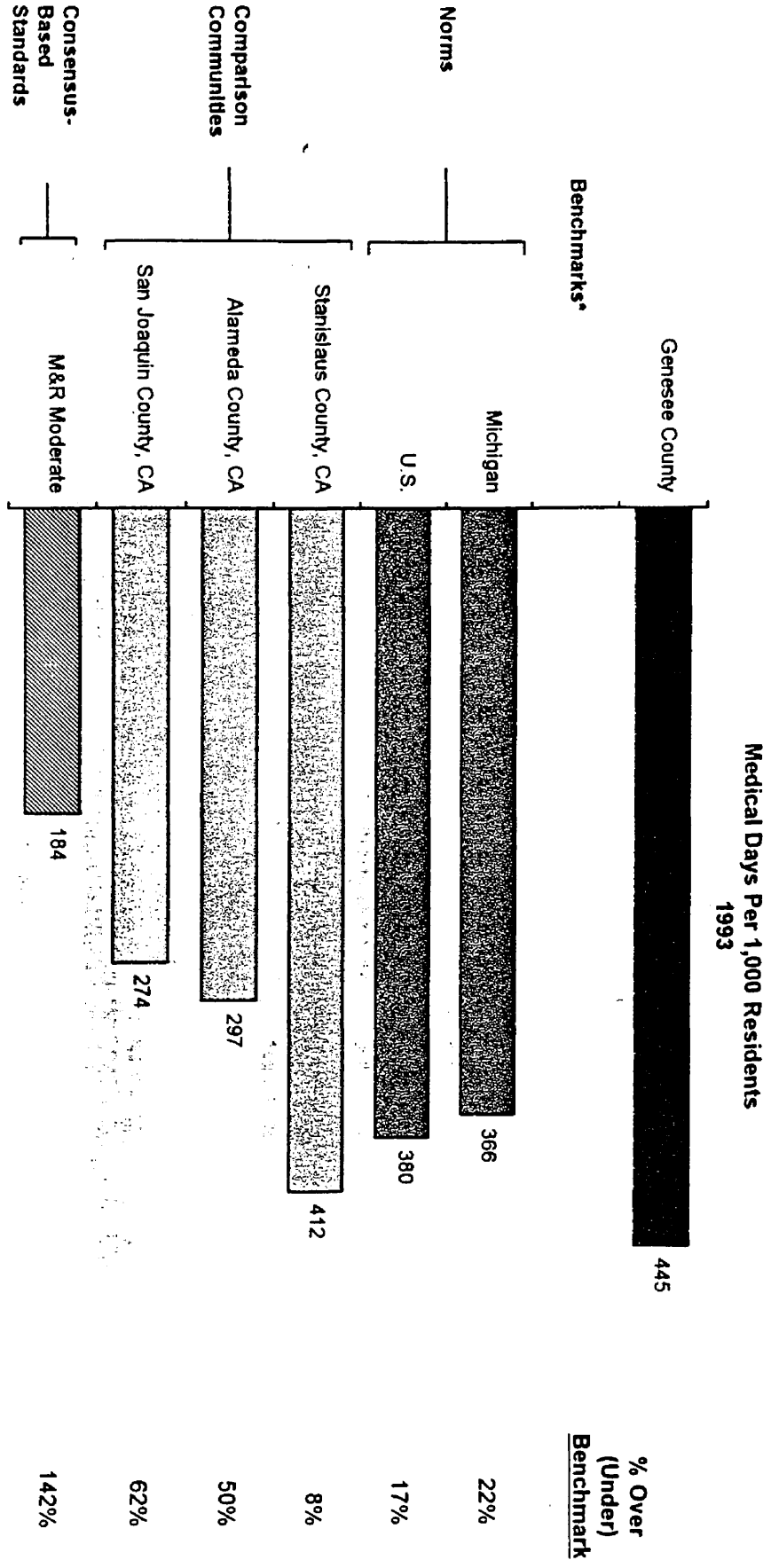


Sources: 1) Genesee County rates are based on 1993 Michigan Health and Hospital Association hospital discharge data; 2) California county rates are based on California Office of Statewide Health Planning and Development 1993 hospital discharge data;

*Data are severity adjusted using the APR-DRG disease staging method.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

EXHIBIT III-B-9: Genesee County residents use inpatient medical services at a rate which is 17 to 62 percent higher than most benchmark rates.

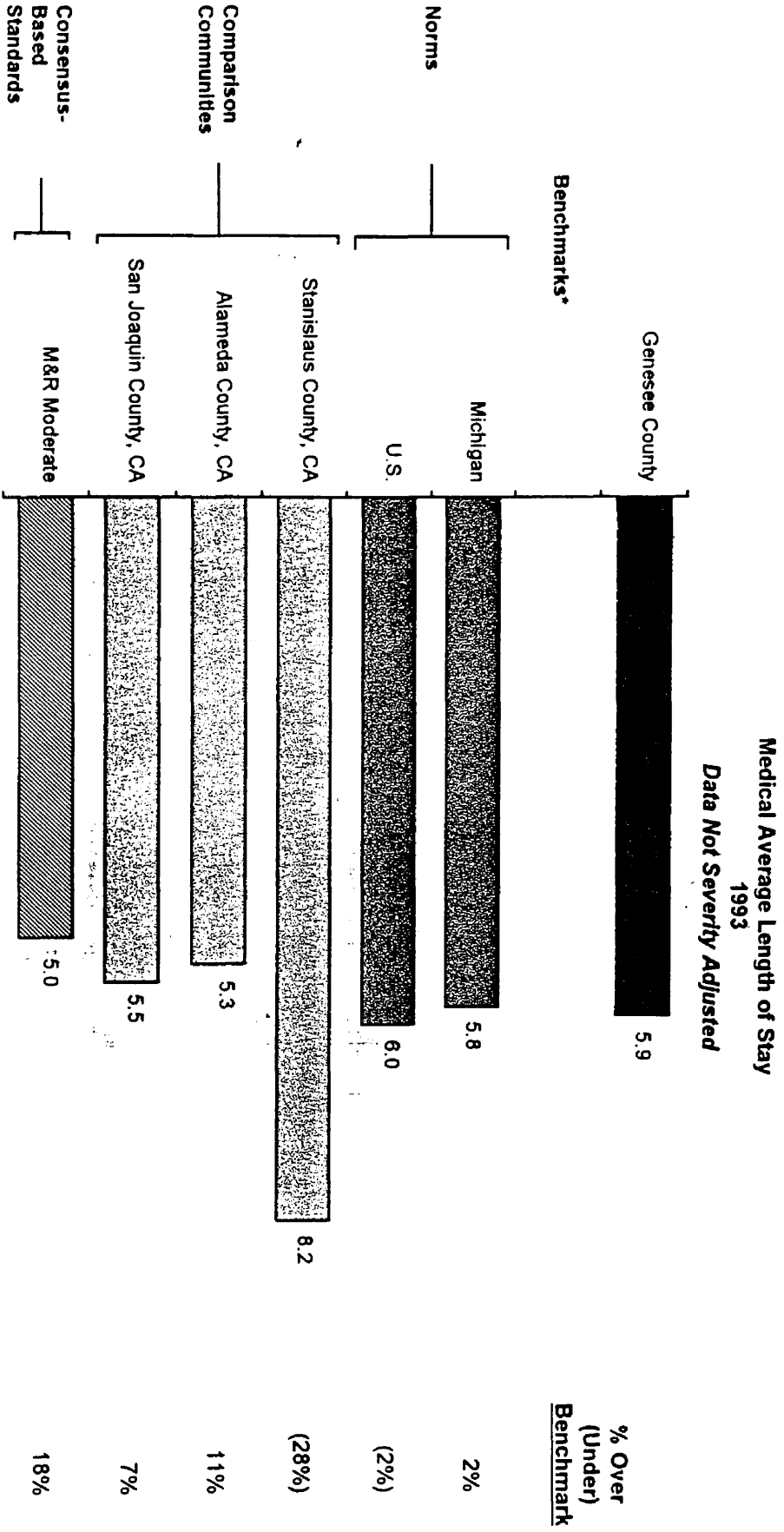


Sources: 1) Genesee County and Michigan rates are based on 1993 Michigan Health and Hospital Association hospital discharge data; 2) U.S. rates are based on 1992 National Hospital Discharge Survey data; 3) California county rates are based on California Office of Statewide Health Planning and Development 1993 hospital discharge data; and 4) M&R's moderate benchmark estimate is based on data reported in Milliman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care).

* Benchmark community rates are adjusted to reflect the age and sex distribution of Genesee County's population, with the following exception: M&R rates are age-adjusted only (gender-specific utilization data were not available). Benchmark rates are also case-mix adjusted to control for differences in types of hospital admissions.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

EXHIBIT III-B-11: Genesee County residents' average hospital stay for medical admissions is comparable to most benchmark values.



Sources: 1) Genesee County and Michigan rates are based on 1993 Michigan Health and Hospital Association hospital discharge data; 2) U.S. rates are based on 1992 National Hospital Discharge Survey data; 3) California county rates are based on California Office of Statewide Health Planning and Development 1993 hospital discharge data; and 4) M&R's moderate benchmark estimate is based on data reported in Millman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care).

* Benchmark community rates are adjusted to reflect the age and sex distribution of Genesee County's population, with the following exception: M&R rates are age-adjusted only (gender-specific utilization data were not available). Benchmark rates are also case-mix adjusted to control for differences in types of hospital admissions.

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

EXHIBIT III-B-40: Genesee County residents' admission rates are significantly higher than a majority of benchmark rates in 21 MDCs.

Major Diagnostic Category	MDC Code	Genesee County	Norms				Comparison Communities					Consensus-Based Standard		
			Michigan		U.S.		Stanislaus County, CA		Alameda County, CA		San Joaquin County, CA		M&R Moderate	
			Rate	% Var	Rate	% Var	Rate	% Var	Rate	% Var	Rate	% Var	Rate	% Var
Nervous System	1	8.5	6.6	29%	5.9	44%	5.6	52%	6.0	42%	5.4	57%	4.2	102%
Eye	2	0.8	0.6	33%	0.8	0%	0.2	300%	0.3	167%	0.2	300%	0.3	167%
Ear, Nose, Mouth, and Throat	3	2.4	1.7	41%	2.6	-8%	1.1	118%	1.6	50%	1.4	71%	1.2	100%
Respiratory System	4	13.6	11.7	16%	10.7	27%	10.3	32%	10.2	33%	9.4	45%	6.3	116%
Circulatory System	5	23.8	20.1	18%	17.1	39%	15.9	50%	15.5	54%	16.0	49%	1.7	103%
Digestive System	6	11.0	9.4	17%	10.5	5%	7.9	39%	7.9	39%	8.3	33%	7.0	57%
Hepatobiliary System and Pancreas	7	5.4	3.8	42%	3.6	50%	3.1	74%	2.9	86%	3.6	50%	2.4	125%
Musculoskeletal System	8	8.8	9.4	-6%	10.5	-16%	9.2	-4%	8.0	10%	8.4	5%	7.0	26%
Skin, Subcutaneous Tissue, and Breast	9	3.6	2.8	29%	3.3	9%	2.4	50%	2.7	33%	2.6	38%	1.7	112%
Endocrine, Nutritional, and Metabolic	10	4.3	3.3	30%	3.9	10%	2.3	87%	2.8	54%	2.5	72%	1.8	139%
Kidney and Urinary Tract	11	4.5	3.7	22%	4.2	7%	2.8	61%	3.0	50%	2.8	61%	2.4	88%
Male Reproductive System	12	1.8	1.4	29%	1.5	20%	1.1	64%	1.0	80%	0.9	100%	1.2	50%
Female Reproductive System	13	5.4	4.1	32%	4.3	26%	3.9	38%	2.8	93%	3.7	46%	3.4	59%
Pregnancy, Childbirth, and Puerperium	14	18.0	17.1	5%	18.9	-5%	20.8	-13%	17.4	3%	22.3	-19%	16.9	7%
Newborns and Neonates	15	16.6	16.4	1%	15.5	7%	16.3	2%	17.5	-5%	17.0	-2%	13.8	20%
Blood and Blood Forming Organs	16	1.3	1.1	18%	1.2	8%	0.9	44%	1.0	30%	0.9	44%	1.0	30%
Myeloproliferative Diseases	17	2.7	2.7	0%	1.4	93%	2.8	-4%	1.6	69%	1.7	59%	0.9	200%
Infectious and Parasitic Diseases	18	2.6	2.1	24%	1.8	44%	2.0	30%	2.5	4%	1.9	37%	1.3	100%
Mental Diseases and Disorders	19	8.2	6.1	34%	4.6	78%	5.8	41%	4.9	67%	5.3	55%	3.0	173%
Substance Abuse	20	3.1	1.7	82%	1.8	72%	1.4	121%	1.0	210%	0.9	244%	1.5	107%
Injuries, Poisonings, and Toxic Drugs	21	2.8	1.7	65%	1.9	47%	1.6	75%	1.4	100%	1.4	100%	1.0	180%
Burns	22	0.4	0.2	100%	0.2	100%	0.1	300%	0.1	300%	0.1	300%	0.1	300%
Factors Influencing Health Status	23	1.8	1.5	20%	1.0	80%	1.1	64%	2.1	-14%	0.6	200%	0.5	260%
Trauma	24	0.4	0.3	33%	0.2	100%	0.3	33%	0.2	100%	0.3	33%	-	-
HIV Infection	25	0.2	0.3	-33%	0.4	-50%	0.2	0%	0.7	-71%	0.3	-33%	0.4	-50%

Sources: 1) Michigan Health and Hospital Association 1993 hospital discharge data; 2) 1992 National Hospital Discharge Survey data; 3) California Office of Statewide Health Planning and Development 1993 hospital discharge data; and 4) Millman and Robertson Healthcare Management Guidelines (Volume 1: Inpatient and Surgical Care).

* Benchmark community rates are adjusted to reflect the age and sex distribution of Genesee County's population, with the following exception: M&R rates are age-adjusted only (gender-specific utilization data were not available).

HEALTH ASSESSMENT	RESOURCE ASSESSMENT	VALUE ASSESSMENT
Quality		Cost
Hospital		Professional Services

ANALYSIS OF CON PROGRAM FEES AND COSTS

Section 20161(3) sets forth the fees to be collected for CON applications. The fees are based on total project costs and are set forth in Table 15 below.

TABLE 15	
CON APPLICATION FEES	
Total Project Costs	CON Application Fee
\$0 to 150,000	\$ 750
\$150,001 to 1,500,000	\$ 2,750
\$1,500,001 and above	\$ 4,250

Table 15A analyzes the number of applications according to which fee was assessed.

TABLE 15A						
NUMBER OF CON APPLICATIONS BY FEE						
FY 90- FY 95						
CON Fee	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
\$ 750	32	76	54	54	37	48
\$2,750	86	80	76	63	69	82
\$4,250	112	88	74	91	85	115
TOTALS	230	244	204	208	191	284*

* 39 projects with "0" fees.

Table 16 provides information on CON costs and source of funds from FY 90 through FY 95.

TABLE 16						
CERTIFICATE OF NEED PROGRAM						
COMPARISON OF COST AND REVENUE SOURCES						
FY 90 - FY 95						
	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
Program Cost	\$1,675,200	\$1,539,184	NA	\$1,661,894	\$1,713,159	*
Application Fees	\$ 790,300	\$ 626,500	\$561,950	\$ 599,065	\$580,000	\$750,250
General Fund (GF)	\$ 875,300	\$ 912,684	NA	\$1,062,829		*
Fees % of Costs	48%	41%	NA	36%	34%	*
GF % of Costs	52%	59%	NA	64%	66%	*

*Not available as of September 16, 1996

St. Joseph Hospital
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(APPENDIX A continued)

Health Service Area	Sub Area	Hospital Name	City
=====			
	38	Metropolitan	Grand Rapids
	38	St. Mary's	Grand Rapids
	39	Sheridan Community	Sheridan
	39	United Memorial	Greenville
	43	Holland Community	Holland
	43	Zeeland Community	Zeeland
	44	Ionia County Memorial	Ionia
	52	Allegan General	Allegan
GLS	40	Memorial	Owosso
	41	Flint Osteopathic	Flint
	41	Genesee Memorial	Flint
	41	Hurley Medical Ctr	Flint
	41	McLaren General	Flint
	41	St. Joseph	Flint
	41	Wheelock Memorial	Goodrich
	42	Lapeer Regional	Lapeer
East	23	Tawas - St. Joseph	Tawas City
	27	Central Michigan	Mt Pleasant
	27	Clare Community	Clare
	28	Gladwin	Gladwin
	28	Mid Michigan Regional	Midland
	29	Bay Medical Ctr	Bay City
		Bay Med Ctr (d)	Bay City
		Bay Med Ctr-West (d)	Bay City
		Samaritan (d)	Bay City
	29	Standish Community	Standish