

STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED (CON)

CON COMMISSION MEETING

Tuesday, September 14, 2004
10:00AM

MDCH Public Health Building #19
North Complex Baker-Olin West (BOW)
3423 North Martin Luther King Boulevard
Manty Conference Room 1B & 1C
Lansing, Michigan 48909-2934

APPROVED TRANSCRIPT

CON COMMISSION MEMBERS PRESENT:

Renee Turner-Bailey: (Chairperson)
Norma Hagenow (Vice Chairperson)
Roger G. Andrzejewski
Bradley Cory
James K. Delaney
Dorothy Deremo
Edward G. Goldman
James Maitland
Michael Sandler, MD
Michael Young, DO

CON COMMISSION MEMBER ABSENT

Peter Ajluni, DO

DEPARTMENT OF ATTORNEY GENERAL STAFF PRESENT

Ron Styka

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF PRESENT

Jan Christensen
William J. Hart, Jr.
Larry Horvath
Brenda Rogers

GENERAL PUBLIC ATTENDANCE

There were approximately 42 people in attendance.

CHAIRPERSON RENEE TURNER-BAILEY: Good morning, everyone. I'd like to call the September 14th meeting of the Certificate of Need Commission to order. It's 10:10 am. I trust everyone had a good summer, and once again our microphone issue continues. We're in the right place I know that. We'll take just a moment to review the agenda. I'll just take a quick second to review it. At this time if there's a motion for acceptance for the agenda then I'll take it.

COMMISSIONER DELANEY: I move for the acceptance of the agenda.

COMMISSIONER SANDER: I second it.

CHAIRPERSON TURNER-BAILEY: It's been moved by Commissioner Delaney that the agenda be accepted as given. All those in favor signify by saying, aye. Opposed, (none). The next order of business is the Declaration of Conflicts of Interest. Any declarations at this time? Thank you. Item 4, Review of the minutes of the June 15th meeting of the Commission. Again, I hope you've had the opportunity to review those.

COMMISSIONER DELANEY: Just an observation, Renee, there were a significant number of typos in the minutes. Nothing that was terribly material, just a little on the sloppy side.

CHAIRPERSON TURNER-BAILEY: Thank you. Commissioner Delaney has mentioned typos in the minutes. Just to ask if we can go through and do a quick spell check just to make sure that we've caught those to the extent possible. I appreciate it. Commissioner Sandler.

COMMISSIONER SANDLER: I would like to second Jim's observation. In particular on page 25. I'm quoted as saying "no puny view published material". That's "no peer review". That's on page 25 that substantiates that position. Not that that's terribly important, but it's somewhat what I meant.

CHAIRPERSON TURNER-BAILEY: I think that's actually a little more material rather than just a regular typo so we should include that in the changes. Any other suggestions, Commissioner Young?

COMMISSIONER YOUNG: Just on the members present, I'm a DO, and not a MD.

CHAIRPERSON TURNER-BAILEY: We need to make that correction as well. Any other corrections? Is there a motion for the acceptance of the minutes with the changes that have been noted?

COMMISSIONER MAITLAND: So moved.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Maitland.

COMMISSIONER YOUNG: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Young. Discussion? All those in favor please signify by saying, aye, opposed (none). Nursing Home and Long-Term Care Unit Beds: Commissioner Cory, do you have a report that you want to give to the Commission?

COMMISSIONER CORY: Thank you. I'm pleased to report that we seem to have ironed out the majority of the problems that we had in the public comment. One thing that I would like to do is that I would like to give all the parties who participated in this process. I've never seen the spirit of cooperation that prevailed throughout this process between the for-profit Association, the non-profit Association, the County Medical Care Facility Council and the Department. It was a process that, in deed, from my perspective worked the way it should have. That concludes my comments, and from this point I'll turn it over to Jan Christensen.

MR. CHRISTENSEN: Actually I think Brenda will walk through the particular changes in the public hearing. A couple of very minor changes on substantive changes that clarify things. We did reach an agreement on the majority comments at that hearing in terms of a framework that accommodated the input that we got.

MRS. ROGERS: This is Brenda Rogers. If you look at the material that you received, what I'm going to do is make reference, just a comment portion of the standards instead of going through the variances of the standards. You should have already received these. The First Amendment that the department is proposing as indicated in these amendments are based on the public comment that was received. The first amendment would be in Section 11, Sub 1, Sub F; we are proposing that language to be stricken. When that initially was put in there, we were trying to bring it into compliance with the other standards and make it consistent. Since that time as indicated, and we've made contact regarding those valid provisions

and we followed up with the Attorney General's Office and it has been confirmed that after these formal preliminaries reviewed that many other laws supercede this provision for Nursing Homes, and therefore, we offer this as a technical amendment through this language for the review standards. The second amendment, we jump to the pilot project in the addendum. That would be Section 3, sub 3; we are proposing to strike a language to "include at least 80 percent of a single occupancy resident rooms and the remainder of the rooms shall." The reason for this is to be able to prevent the language, still it will prevent three and a quarter bed wards would remain in the existing facility and not require a specific percentage of single occupancy resident's room. The reason for this is because the extensive renovations will be able to comply with that renovation. The third amendment falls under the addendum as well. Section 3, sub 4, sub B, small I; we're adding language at the end of the sentence that states, "the proposed licensed site with replacement beds exhibiting any planning area, the language being added is not limiting three mile radius from a licensed nursing home that has a newly constructed or replaced (parenthesis) including approved projects (parenthesis), within five calendar years prior to the effective date of this addendum. This amendment would prevent a facility from placing one of these pilot projects within three miles of a newly constructed or replacement facility (parenthesis) within five years of the effective date of the addendum if the applicant is believed to be outside the replacement zone. The next amendment is Section 3, sub 7, small A and small B; we are striking "or it's parent or any subsidiary" under Sub A, and under B, we are striking, "or it's" and we are adding "amend" as a result in a STOC citation issued over the past 12 month period and any nursing home or hospital long-term care unit under its parent or any subsidiary. This basically is to clarify this language. The amendment under Section 5, sub 3, small A and small B has that same type of clarification. Then the final amendment would be under Section 4(2). We are adding language at the end of that sentence. We're adding "the inability to obtain Medicaid certification of nursing home beds due to the aggregate statewide amendment on the maximum number of Medicaid certified nursing home beds in Michigan shall not constitute grounds for the location the CON if the applicant furnishes to the department the date one year from the date of CON approval, proof of Medicaid certification or denial of Medicaid certification based upon the statewide limit, along with a signed affidavit stating willingness to certify 100 percent of the beds subject to CON approval under this pilot program when accepted by Medicaid". This amendment would prevent a facility from losing at CON because of denial of Medicaid certification based upon the statewide limit, but will require the facility to obtain Medicaid certification when it's available. For those of you who do not agree with the proposed language to move forward, I'll be happy to answer any questions.

CHAIRPERSON TURNER-BAILEY: Are there any questions? (No response) Any discussions? (No response) I do have several cards for public comment. Jack Steiner.

JACK STEINER: Good morning, my name is Jack Steiner and I'm the Executive Director of BEAM. Chairperson Renee Turner-Bailey and members of the CON Commission, my remarks will be in support of Commissioner Cory's comments. I am delighted for this opportunity to provide support for the addendum on New Design Models for Nursing Homes. That is the new design model pilot project. I am the Executive Director for BEAM, a non-profit educational organization that has represented the Eden Alternative here in Michigan for over six years. The BEAM Board of Directors, and I personally, believe the leadership of the Commission and representatives of MDCH are providing with regard to this pilot project, will substantially lead to better environments for long term care, to the benefit of both the State and the people accessing such services. I cannot emphasize strongly enough the importance of these pilot programs and the impact on the future of rebuilding the Nursing Home Infrastructure in advance of the looming Geriatric "bubble" represented by the baby boomer generation. Baby boomers will not accept Nursing Homes as we now know them, it must be different. They will accept nothing less than either home-based care or modernized smaller communities such as this proposed CON addendum offers. BEAM and I personally urge adoption of these supplemental CON provisions and are pleased for the opportunity to provide unequivocal support of your excellent work and to offer our thanks to the competent CON staff and MDCH for their hard work. Thank you very much. I have printed copies of my remarks.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response) Kevin Ganton.

KEVIN GANTON: Good morning to the Commission. Thank you for just a few moments to express some

very exciting feelings. My name is Kevin Ganton and I'm an Administrator to Arbor Manor in Spring Arbor. I am privileged to be a third generation and have followed very closely through our association, a lot of calls to Kim and Pat with regards to the proposed change. I find it very exciting. I know from a lot of contact with a lot of families that change is what they desire. I know I also work at Flint Hospital and people need to know that something is out there. The boomers that we know are coming, 76, 77 million strong and currently what's out there, folks, is not going to work. This kind of movement is so encouraging and I've seen prints and I've talked to people in other states. There are some folks down in Tupelo, Mississippi, that have new models of care. I've spoken with them a couple of times. The outcome, the satisfaction, the turnover, is all very exciting, so I applaud the Commission for this movement and encourage continued change and we're not changing folks, we're not going to go anywhere. One final little piece that I would like to read that I found in a magazine that says that the baby boomer generation has long commanded the attention of demographics, politicians, marketers, and Social Scientist. Seventy six million strong boomers represent the single largest sustained population growth in our history. The numbers alone have an enormous impact on our political culture and social structure. As you notice that the boomers who are now about 56 approach later adulthood, they are about to redefine yet another aspect of life, retirement. What that may seem like years away for some of us, it's never too early to begin for long-term care providers to start planning ahead. I think this is great and I applaud you for your vision and I'm excited about seeing this move ahead, thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions? (No response). Thank you. Jim Branscum:

JIM BRANSCUM: Good morning. Thank you, Ladies and Gentlemen. Commission, I want to applaud you for starting this de-institutionalization that we have in the state of Michigan regarding the Nursing Homes. I personally own many Nursing Homes, around 1,700 beds. So, I'm the poster child for what we should be doing. I've been blessed for doing it for 40 years as an Administrator and owner. I started out as a janitor. This is a wonderful crack in the wall to let the people in Michigan and in this country follow the leadership that you're giving here. I don't know if you even understand or feel the dynamics of it because we're out there in the streets everyday and we've been wanting to do something of this nature just to answer the question that the public perception is that they want to de-institutionalize Nursing Homes, and quite frankly we haven't been able to until now. I just want to applaud you and say thank you very much.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response) Michael Perry:

MICHAEL PERRY: Good morning, my name is Michael Perry, and I'm the Director for Operations for HCR Manor Care. We operate 300 facilities in 31 states including 26 in the great state of Michigan, with over 3,000 person facility beds. We also operate assisted living residences, home health care offices, also in the state of Michigan. As a multi-state provider, we have an opportunity to observe a variety of regulatory frameworks for Nursing Home facilities among the different states. In addition we've developed new state of the art Nursing Homes including in the state of Michigan that reflect the high level of quality care that we're know for. We reviewed the final Pilot Program language for Long-Term Care Beds in Units developed by the Long-Term Care work group. We would like to offer our comments. First we would like to commend the CON Commission, Commissioner Cory and the department and other work group participants for taking the initiative to examine regulatory and CON issues for Nursing Homes. We would like to thank the department and the Commission for the opportunity to raise our concerns and work through the process. We support the language put forth by the department that provides a three-mile zone around existing facilities. To maintain success of the Pilot Program it is necessary to allow growth but not at the expense of the existing facilities that maintain high quality services for Michigan patients as well as compliance with licensing and regulatory guidelines. Thank you for your hard work.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions? (No response) Thank you. Paul Bridgewater:

PAUL BRIDGEWATER: Good morning, I'm Paul Bridgewater and I'm the Executive Director of the Detroit Area Agency on Aging. I'm primarily responsible for seniors in the city of Detroit. There are two points

that I want to make. The first is that we're very supportive of the language and the language change of this proposed policy. I think if you look at the papers every other month you'll see Nursing Homes closing in the city of Detroit. I think it's a symptom of a problem that is talked about in eroding problem in our city. One of the issues that I'm very fortunate to do is that we just recently did a report and that report showed that in the city of Detroit that there's a premature death of elderly population. The title of our report is Dying Before Their Time. In the report we begin to identify that choices of long term care options in the city of Detroit may not exist. In most cases, we find that many of the seniors basically stay in their homes or in their community and not having the choice of quality Nursing Home facilities in the city. However, we've been very blessed in the sense of having the mayor of the city of Detroit establish a city-wide task force entitled Dying Before Their Time, looking at the options, and one of the options of those sub-committee of that task force is residential care. In that we're taking a good look at our existing Nursing Homes and other long term options, but certainly this here language certainly gives the city of Detroit hope in the sense of providing some real serious changes and options for seniors in the city of Detroit. We want to thank you for being creative in the sense of putting this type of strategy together. Again, I think if we could ----it was interesting that there was a trade magazine that just recently published cities that had the best Nursing Homes, the top ten, and it also had the top ten Nursing Homes in the United States, and in the worse Nursing Homes in the United States, Detroit was listed as number one. We have some challenges in front of us and certainly we're very pleased that at least we have some strategies that can help us develop the types of programs and services that will meet the need of the population in an urban city. Thank you for giving me the opportunity to make these comments.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response) Reg Carter:

REG CARTER: My name is Reg Carter and I'm the Executive Director of Health Care Association of Michigan. We represent 280 Nursing Homes and 220 Assisted Living Facilities; 30,000 people are being served each day through our members. I would like to thank particularly Mr. Bradley Cory, Jan Christensen, Bill Hart, as well as the Commission for considering these changes. You have heard from earlier testimony the level of support for the kind of changes that have been made and suggested here. I think the insight of these changes is that it prepares us for a definition of the best care available. We believe that you cannot have privacy and dignity without your own room. That's the heart of this particular model, is just to test that. All the regulations and all the other kind of things you can do, the best thing you can do is have your own room and have the privacy and dignity that comes along with that. So, thanks for the support and again I applaud you, as the Commissioners for considering this and we appreciate most of all the leadership. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Brenda:

CHAIRPERSON TURNER-BAILEY: If there is anyone who has spoken already and you have not signed the sheet, would you please take care of that at this time. Thank you. I don't have any further cards for comments. At this time a motion would be in order. Commissioner Sandler.

COMMISSIONER SANDLER: I move that we accept the proposed language with the technical amendments that was stated by Brenda Rogers.

CHAIRPERSON TURNER-BAILEY: It's moved by Commissioner Sandler and supported by Commissioner Hagenow that we accept the language with the technical changes suggested by the department.

MRS. ROGERS: I will forward to the joint Legislative. It's a 45-day review period.

CHAIRPERSON TURNER-BAILEY: Excellent. Any discussion? (No response) All of those in favor, and at this time I'm going to ask for your right hands. All in favor please signify by raising your right hand. I see a unanimous vote. Commissioner Cory, I would just like to take a moment to thank you for your time and efforts in getting this language on board. We have so many positive comments today and I think this is a positive step forward for the Commission as well. Thank you as well. At this time we'll take a report from the Hospital Beds Standard Advisory Committee, Bob Meeker:

BOB MEEKER: Good morning. Thank you Madame Chair and members of the Committee, the Commission. I'm substituting for Dale Steiger today, who of course is the Chair of the Hospital Bed (SAC). He sends his regrets and best wishes, but he's convalescing from knee surgery after an unfortunate accident during the Labor Day holiday. Hopefully he will be back at full swing by the time the Commission meets in December. The Hospital Bed (SAC) has met at least four times since the last meeting of the CON Commission. We have determined that the assignment that you have given us is broad and deep, and it's one of those things that the more peels of the onion you pull away, the more onion there seems to be. So, there have been two work groups that have met. We've had major presentations from four proponents who would like to see significant changes to the CON review standards for hospital beds. One of the work groups looked at the concept of capacity adjustment or reducing capacity when it's not being used. We discovered that that's a very difficult and slippery slope due to current regulations and state law. The other work group and one that I have chaired has been looking at the whole idea of geographic access to hospital beds. Most of the work of the SAC has focused on that and I'll get into that in a little more detail in just a moment. Another issue that we have spent some time discussing is the issue of high occupancy and whether or not something like the Pilot Program that the Commission approved a few years ago for high occupancy hospitals should be continued. Certainly the final recommendation of the SAC and that regard will also come at your next meeting. In the area of geographic access, the department has contracted with the Michigan State University Department of Geography to assist the work group and the SAC and their efforts to look at geographic access. The work group has actually received in various stages of specificity three different proposals to look at. One of which is a travel time proposal. That's the one that has received the most attention. It was the most well flushed out in an intermediate proposal and we're very close, I think, to a final form of that approach. Still needing of course to be translated into official language for possible amendments to the standards. The other two approaches which have been recommended and for which neither the SAC or the work group have received formal proposals, although we believe that they are forthcoming, is looking at an approach that would take into account the number of beds per population. The first approach, the travel time standard that the work group and the SAC have been dealing with is the idea that the hospital bed should be available within 30 minutes of the population. That being the standard. By that we mean a community hospital that has an emergency department that's available 24 hours. The beds per population would say well even for folks who are within a 30 minute travel time, there may be a whole lot of people and not very many beds. So, this is a proposal. As I said we have not seen a formal presentation on. We've had some very preliminary conversations with the MSU Geographers as to how we would approach that. At the next meeting of the work group, we will be looking at that in a little more detail. The final recommendation that we've had or proposal that we've had would be to look at some sort of modification to the existing sub-area methodology. Again, there's not been anything specific to that and we're looking forward into the future with that. As I said the travel time methodology has received the most attention. The Michigan State University Department of Geography has plotted the locations of all the hospitals in the state with emergency departments and using the Michigan Department of Transportation classification of roads, has determined a 30-minute travel time radius, if you will, around those to assist the work group and ultimately the SAC in identifying areas that would be outside of the 30-minute travel time. We're pursuing jointly with MSU ways to modify that methodology that would take into account variations and road congestion or traffic volume or that sort of thing. Again at our next meeting we will be discussing those modifications. That pretty much summarizes where we are. As I said it's been an enormous project and the travel time part has taken the bulk of our attention. I think that the work group in the SAC has looked into that diligently and we would expect at least for the travel time a recommendation or a proposal that we would have recommendations for this CON Commission at your next meeting.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Hagenow:

COMMISSIONER HAGENOW: I just want to comment. I think in the diligence in which you're going about this because my frustration has been around the fact that the CON itself is on the line on this issue. I think if we aren't relevant to the population and we do not have good policy around how we decide things, then there are all of these exceptions that'll continue to be there and it'll wind up with somebody in which they are already saying why do we need the CON. So, having you have rationale and be

responsive in a timely fashion and one that we all whether we like it or don't like it, due to our personal interest, is something that we can explain those rationale. I just want to commend, I guess, the Commission, and I think I through out the last time that the impression is that the SAC won't really do anything, it's kind of a sand bag from the beginning. I've been impressed just from what I've received as information that you are taking it very seriously and you recognize how much importance it has in the larger scheme of the CON in the states. That's just basically a comment and not necessarily a question. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any other comments or questions? (No response) Thank you. Item 7; CON Commission Bylaws: Mr. Styka.

MR. STYKA: Well, I'm somewhat chagrin to tell you that I did not complete my work on the bylaw proposal. I did want to brief you. We have some excellent work in the progress. We have some wonderful folks on the staff and I've been trying to bring that together, but I just continue to run into conflicts in trying to do so and I apologize for that. I will have that for the Commission within the next few weeks. You'll will have it way in advance of the meeting. I apologize. You will have a proposed draft for you that incorporates those, but I do have some other things. There is a complication there because we still do not have the written opinion (conflict of interest), we just have a copy of the motion which gives us the answer but not really the full answer. In a way we still have that but there's no reason why you couldn't have the rest of it to look at, if I only had the time to do it, so I will have it for you in a couple of weeks.

CHAIRPERSON TURNER-BAILEY: Is there any way we can follow up with the Ethics Board that you're requesting in written form?

MR. STYKA: Yes, I will also do that. I will send it on your behalf with communication to the Counsel from that board encouraging the actual issues.

CHAIRPERSON TURNER-BAILEY: And we do need to have the bylaws in hand at least 60 days prior to the Commissioner's meeting; is that correct? Thirty days. So, we have a little bit of time.

MR. STYKA: Yes, I will beat that deadline. Most of it was done by Bill and Mr. Goldman. There's just some areas like reflecting a little bit more on the New Standard Committee and also on the bylaws. I just need to get it to you.

CHAIRPERSON TURNER-BAILEY: Any questions? (No response) Any discussions? There's an item of action on here but that was in anticipation of having the bylaws in front of us.

MR. STYKA: As late as Thursday I was asked about it, and I said keep it on there.

CHAIRPERSON TURNER-BAILEY: Excellent. New Medical Technology.

MRS. ROGERS: I have nothing new to report.

CHAIRPERSON TURNER-BAILEY: Item 9, Compliance Report: Mr. Horvath:

MR. HORVATH: Per your request, what we have done for the Commission is a preliminary review of volume requirements for the open-heart programs in the state. What you'll see on the table, on the charts before you, is that we basically have three categories. We have those that have been approved under this CON standards that took effect February 13, 1999 to have a volume requirement of 300 open-heart procedures to be done. In that category as you will see that St. Joseph Mercy of Macomb, Bay Medical Center, and Sinai Grace hospital are below required volume. This is a preliminary review of the volume requirements. Prior to February 13, 1993, the second grouping of those that were approved that had a different volume requirement prior to the 1993 date of 200 per service. Out of those grouping of hospitals Lakeland, St. Joseph and Port Huron hospital are below the volume requirement. And then the last grouping of hospitals are hospitals that were either grandfathered in or had CON approval prior to a

volume requirement in effect. As you will see in the majority of those hospitals, they are running well above 200, and most of them are above the 300 requirement. This is our preliminary findings to date on the open-heart programs.

COMMISSIONER SANDLER: I have several questions. I see dashes from a number of these institutions. They haven't reported yet; is that what this means?

MR. HORVATH: That is correct. There are three remaining facilities that have yet to report for 2003 surveys. We are following up with them.

COMMISSIONER SANDLER: Thank you. The question is for those institutions failing to meet the first group will be 300 and the second group will be 200; what happens now? It's not clear to me from your comments what happens to those institutions that fail to meet this requirement? What is the policy of the department or the mechanism or the process or fill in the blank?

MR. CHRISTENSEN: This is Jan Christensen. The department has a range of options that we can undertake. I think the first thing that we're going to do is to set up some type of communication with these institutions indicating that these are the numbers and verify that the numbers are accurate. Then we have a full count. The second part is typically what we have done in most regulatory reports is some type of corrective action plan that would say to the institution that our standards are not being met and these standards are in effect, and have your client get them out. At some point we have had a couple of situations where we simply went go out to the institution and decided that they didn't want to do that because they can't meet the standards, so they voluntarily withdrawn. That's the situation for us that it's a voluntary action. On the other hand, we do have of authority under 619, and we do what's necessary to have them comply.

There are a whole bunch of other standards in addition to the numeric standards that tend to deal with our program, and all this chart does is to show the numeric standards. From a proportionate standpoint, the numeric standard of 300 procedures and 200 procedures of the Standard, and we can look at that and take a look at other additional standards that may be in effect. That's not to say that the other facilities that meet that numeric standard are necessarily meeting the other quality assurance standards. We need to do some type of inspection of entities now. We've been struggling a little bit since 619, it was passed in December of 2002, and it authorized additional FTE's. The Legislature has passed in the Senate and is being considered in the House right now. We've been working to get that infrastructure passed and then we can add the additional staff that's necessary to actually go out and do the inspection.

COMMISSIONER SANDLER: Has any possible, any institution, be there voluntary or you've given up doing cardiac bypass, open-heart surgery, or have you ever revoked the CON for that in the department, either one of those two?

MR. HORVATH: I can't answer. Stan would know because it's prior to my starting the program.

MR. NASH: The open-heart surgery program at Hurley Medical Center in Flint was terminated due to a low volume, and that was a voluntary termination on their part.

COMMISSIONER SANDLER: That's the only one that you are aware of?

MR. NASH: That I'm aware of.

COMMISSIONER SANDLER: Thank you.

COMMISSIONER HAGENOW: I just wanted to ask a role question. What is the role of the Commission in this enforcement side versus the department? When we set the standards and we put it out there but you don't necessarily-----I just want to know what is the expectation of us enrolled?

MR. STYKA: Well, the enforcement is for the department to do. Your role-----the Commission in the past

has asked for these monitoring reports from the department as to what's going on, so if you remain educated this may affect what you want to do with standards, whether you want to change them in the future, criteria. Actually the obligation is not on the Commission, it's under the department to use its powers and discretion and to enforce accordingly.

COMMISSIONER HAGENOW: The reason that I wanted to clarify that is because again I think it's a test of the value of the Commission. Now, we put the standards in, but then that plays out in terms of the hands of the department in carrying it out. If, in deed, we put these things in and there is no teeth in it, then again it's a test of the state and its validity of the CON.

COMMISSIONER MAITLAND: I think this came originally from the Auditor General's report, which specifically mentioned this. I think it had a couple of other things that it mentioned, so I think that we are responsible for making sure, or at least freeing up the attention to the department that they should enforce the standards that we have. If they're not enforceable or the times have changed, and one could change in the standards, so I think it's great that ----that's what we're supposed to do, so I think we should maybe look at those other two or three items that was mentioned in the Auditor General's report as a weakness in our compliance and proceed with looking at those two. I don't even know what they are but I know there was more than one. And in the Commission was criticized for not enforcing those rules that we have.

MR. STYKA: But statutorily that is not your role. Your role is to adopt the standards.

COMMISSIONER MAITLAND: Well the Auditor General didn't seem to think so.

MR. STYKA: Well, the Auditor General is not always correct on a lot. It looks to be correct on the numbers. It's a common that could have been given fact to the Auditor General.

MR. CHRISTENSEN: There may be some need to change some of the standards to allow them to be enforced in a more equitable way. As we get into the enforcement process, we certainly will give the need to the staff. We've actually got the resources to go out and do a fair evaluation of the programs to evaluate against those things. We may discover that there are certain standards that need to be changed or modify essentially to make them more enforceable, more clear, more objective in carrying them out. We would be bringing those recommendations back to the Commission.

CHAIRPERSON TURNER-BAILEY: But anything that we may discover in that rheum that doesn't keep us from enforcing standards that we can see by the numbers that are not being met, and you named several steps that could take place, and I guess I would ask that at least get started on those processes for these organizations who are clearly not meeting the standards as you pointed out. The volume standards are a right line standard that you can say whether you're meeting it or you're not or explain why you're not and what your corrective plan of action is get to compliance.

MR. CHRISTENSEN: Let me give you an example of the gray matter that you get into. Say for example the facility is running over 300 procedures with the standards and have done so pretty consistently for three or four years, and then one year it has 295 standards or procedures. At that point you can argue that they are no longer in compliance, but you can also argue that it was an anomaly, maybe their surgeon quit and they were looking for another cardiologist or something that would procure that out. So, if you get into a question of -----yes, you have to have 300, but what constitutes substantive compliance with the 300 standard. So, decisions like that need to be made. As we figure into that and make those recommendations, we of course would share that information with the Commission on how that gets done.

COMMISSIONER SANDLER: I'm not questioning what you have said doesn't make sense. If there is an anomaly you wouldn't want any quality institutions left to offer immediate service as a generic grant. I agree with that and I believe it. There are two points here; two points to be made. Cardiac surgery in the United States is down. It's been down for a couple of years. It has been down for two reasons; one, the biggest reason is the use of stents and angioplasty. There simply is not as great of need for that

operation. The second point is the preventive things such as the use of Statins just starting to go to the extent but has been popular for about five or six years, but what are the two most prescribed drugs in the country, I believe Lipitor and Zocor for example.

COMMISSIONER DEREMO: I agree.

COMMISSIONER SANDLER: The point of the matter is that this is a procedure that is going to be decreasing in the United States and there is peer review literature as to outcome requirements led into a minimum volume that levels off. For all of those reasons is just something that we probably do need to work at, not as a business venture necessarily, but as a patient safety issue for the population. In fact, coincidentally about two weeks ago I was at a dinner meeting at a different venue, the Alumni Association meeting with an interventional Cardiologist. This interventional Cardiologist happened to have a son who was a third year medical student at Wayne State Medical School. His comment was that the last specialty he would ever encourage his son to go into was cardiac surgery because there is going to be a significantly lower volume. Thank you.

CHAIRPERSON TURNER-BAILEY: Commissioner Cory:

COMMISSIONER CORY: I have one concern. You touched upon one of the options for corrective action for the hospital, the 200 or 300 procedures per year, and that is to get the volume up. I am concerned with that unless there is a specific quality assurance standard set up on a contract basis rather than a retrospective basis. Because there could be a number of unnecessary surgeries or pushing minimal so to speak that we can only find upon a review retrospect fully. I wonder if in the corrective action process that there is in deed a concurrent type of review to make sure the surgery is necessary.

CHAIRPERSON TURNER-BAILEY: Commissioner Andrzejewski:

COMMISSIONER ANDRZEJEWSKI: Referring to the example that Jan cited, I think you have to look beyond the anomaly factor. If you take a look, for example, Port Huron hospital. Take a look at the trends and apply a rule of reasons of the facts and circumstances, and you'll see that they dropped well below 200 in 2002. But if you back it up to the three previous years and they averaged over 200 a year. I think those kind of trends need to be taken into consideration.

CHAIRPERSON TURNER-BAILEY: Any more questions regarding the compliance report?

MR. HORVATH: This is all on Commissioner Maitland's comments. Other things that we were cited in the Auditor General's report, and I do want to report to the Commission that we have been pursuing those things. We had it back logged, one of the other in a sense of the compliance issue was a fall off of the projects that was over 100 percent complete. It was done on time within the cost that they set. When that report came out we had a backlog of over 300 cases. We are pretty much caught up now on the compliance. We were doing follow up letters back when projects that I should have mentioned completed five or seven years ago, but we are now a dedicated staff to that and we're almost getting all of the follow up letters within a year or when the CON was issued. So, we are making progress on at least making sure that the CON once approved that they are followed through within the year time frame, and then any subsequent time frame as they indicate on the project. So, we have made great strides there. Again this is a preliminary report as we proceed forward into checking the findings.

CHAIRPERSON TURNER-BAILEY: Again, I would request I think a compliance report, I would interpret to mean compliance and enforcement. So, we can understand as a Commission, what steps are being taken relative to organizations that are not meeting the standards. I have one comment. Larry Horwitz.

LARRY HORWITZ: Larry Horwitz of Economic Alliance. I wanted to applaud the department for proceeding and going forward in pursuing the compliance effort. This was something that the Auditor General particularly focused on as the department's responsibility for compliance and the Legislature tightened up the rules about compliance in the last enactment. This is an area that the Economic Alliance has long been interested in, in terms of the compliance of the generic CON thing. They have particularly

focused on open-heart surgery. We published this brochure every year or two and have since shortly after the standards were adopted in '93. That publishes for every consumer and now is on the web page, the volume of open-heart surgery for each program in the state; adult and pediatric. It is widely used and available by employers. It has links on their pages and our pages, and we have lots of employees who check this data. Unfortunately the only generally available indicator of quality we do not have but we should have the severity adjusted measures of quality which should be far better. This is a very crude proxy for quality outcome but it's the only one that you have. As with the experience of our former president indicated, sometimes this happens and you don't have a lot of time to do a lot of research even if you have the greatest coverage of healthcare in the world. In terms of the particular comments, the Alliance has worked closely with the Administration of this program under a different leadership, and we are glad to work with them. I just would emphasize that we take very seriously the idea that you should not be critiquing a program because of one particular year when they fell below. That's why in our brochure we do provide the yearly numbers but provide the three-year average, just to see where the trend is. We give them each of the three years. The statute does not require the department the discretion that Jan talked about is already built into the statute. The statute says that the department shall do one of many things, including whatever the department thinks it should do, and that was explicitly put into the statute before, so if the department finds that there is a problem; someone is at 296 and it's only temporary, or whatever else it is, they don't have to go any further than that, or they go all the way towards taking it to the CON. In other spheres, people have lost the CON. So, I think the statute does rather well on that. There is a provision in effect enforcement by the Purchaser community, which sometimes the department has occurred to happen because there is a provision in the statute that if someone operates a program in violation of Certificate of Need, you're subject to a fine by the Government of 100 percent of all the money that you ever got to that service. And a refund of 100 percent of all the money you ever got from anybody who ever paid you for doing something that you did in violation of the CON. That's a two to one hit. I just mentioned that because this program should be taken seriously. There is a lot of effort by the Commission to see to it that it's fair and equitable. That happens only if the department makes a finding that someone is in violation, and that has happened. We had an instance of a major healthcare system in the state that had to refund about a half a million dollars for operating a Cardiac Cath lab in violation of Certificate of Need. So, that does happen, but I think the statute is set up so that the department has wide discretion to operate on a rule of reason. I think that absolutely makes sense. It would be absurd to take something away from someone who was temporarily dropped below a certain number and that happened some years ago in Lakeland. They had a corrective plan and they came back. To my understanding that's the same problem that Lakeland has run into again. So, I just want to commend the department for doing that. We certainly have the support of the fee increase so that it can be done. I know that Janet Olszewski has said that this is one of her principle concerns, to maintain the integrity of the program. I think the Commission is to be applauded, and the comments from the Commissioners today for indicating great concern in terms of the profit volume included. We peaked open-heart surgery about three or four years ago in this state where they are up about four or five percent since then. I think Angioplasty is still zooming. I think one of the factors of why in 1992 your predecessors moved from 200 to 300. The American College of Cardiology recommended anything in between, it took 200 to 300 as the minimum volume. They didn't go all the way up to 700. Clearly it is leveling off. But one of the reasons that it went to 300 was that there was a concern of let's not have anymore programs unless it's a very critical need for it. As you have more programs coming in, particularly at a time of a technology that this Commission use, all you're really doing is stealing away from other established programs. That harms quality. That harms patient safety. Almost all of the programs that have come about in recent years have been in the Southeast Michigan Metropolitan area that have lots of programs already, and just added to those programs by taking volume and staff and resources away from other places with no particular net gain for quality or access. So, we applaud the fact that the standard is at 300 and applaud the department for proceeding with the proportion process. I think the statute is in order, as is your standard. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you, any questions? (No response). Legislative Report:

MRS. ROGERS: This is Brenda again. I have no Legislative report today.

CHAIRPERSON TURNER-BAILEY: No Legislative Report. Okay, Commission Work Plan.

MRS. ROGERS: This is Brenda. I'll just read you what's currently on the Commission. What we're planning, and we can forward from there. Currently we have hospital beds in an Advisory Committee. We have MRT Services, Nursing Homes, hospital long-term care to finalize, and today we have to move forward for the 45 day review period. We have surgical services standard, New Medical Technology, 619 requirements for the Commission's action. We have this semi-annual report, and I duly hope that we will have that in December. Again, I apologize that we haven't been able to bring that forward to you sooner than we have.

CHAIRPERSON TURNER-BAILEY: Are there any comments or questions about the work plan? I do have several cards for public comment. Greg Glowaez.

GREG GLOWAEZ: Good morning. My name is Greg Glowaez and I'm vice president of Ambulatory and Clinical Services for St. Mary Mercy Hospital in Livonia. I am joined by John Schwartz, who is my Director of Radiation Oncology at St. Mary Mercy Hospital. Cheryl Miller is distributing some information from our medical oncology director, Dr. Omar Majid, in regards to our situation at St. Mary Mercy hospital regarding our MRT Services. I'll be brief this morning. First of all, I just wanted to thank you for being here today, and it's my pleasure to at least speak for the first time before this Commission. Our situation at St. Mary Mercy hospital is that we have a generic accelerator that is over 13 years old. It's in need of replacement. We have been informed by the manufacturer that it is at the end of life stage and they will no longer be making parts for this in the very near future, so we are looking forward to trying to replace that piece of equipment. In that we have also had a large brachial therapy program at St. Mary Mercy hospital that we have been working on for the last four to five years. With that, the amount of brachial therapies that we do perform on an annual basis is approaching 100 as we speak. The average brachial therapy program in this state from our understanding is about 35 to 40 patients. So, we do have a very large brachial therapy program. We look at this as a cutting edge technology, which is complimentary to the MRT Services. Currently, right now, the standards do not incorporate any language that would allow for the incorporation of brachial therapy and the equivalent patient treating volumes. So, what we're asking for at this present time is that a SAC be appointed by the Commission to look at MRT issues. We are asking the Chair and the Vice Chair to appoint representatives to begin working on this SAC prior to the December CON meeting. In that, we have developed a charge for this SAC in regards to the MRT standards that are before the Commission. Any questions?

CHAIRPERSON TURNER-BAILEY: Is this hand-written charge that we received, is that the one that you're proposing?

GREG GLOWAEZ: Yes.

COMMISSIONER MAITLAND: Mr. Glowaez, we did meet prior to the meeting today and I am going to make some recommendations. I thank the gentleman for his support but we can discuss it now or we can wait until we get to the specific items on the board.

CHAIRPERSON TURNER-BAILEY: Well, I do have several more cards. Do you want to hear those first. The MRT is the first thing on the work plan.

COMMISSIONER MAITLAND: Are the MRT related items?

CHAIRPERSON TURNER-BAILEY: For the most part, yes.

COMMISSIONER MAITLAND: I think we're all in agreement. Go ahead and listen to them.

CHAIRPERSON TURNER-BAILEY: I didn't mean not to hear them. If we all agree, we can keep our comments brief, I would assume. Mark Hutchinson.

MARK HUTCHINSON: Good morning. My name is Mark Hutchinson and I work at St. Mary's hospital in Grand Rapids. So, you have two St. Mary's working together on this issue. One of our major concerns is

that the standards have not changed to keep up-to-date with technology in MRT Services as it happens, in such other areas as CT and MRI. One of the areas that we are looking at is IMRT issues. Currently there is no weighted value for IMRT procedures. According to our Radiation Oncology department there's much greater time that is needed for IMRT procedures, and so we feel that there needs to be some change in the weighted scales with IMRT procedures. We would like to thank the Commission for this opportunity and hope that they will form a SAC committee. We are willing to serve as experts on that committee. Thank you.

CHAIRPERSON TURNER-BAILEY: Okay, any questions? (No response) Peter Lai:

PETER LAI: Good morning, my name is Peter Lai. I'm Radiation Oncologist at Lakeland Hospital in St. Joseph. I agree with the first two speakers. We have a 14-year machine, and according with Siemens, they will no longer be able to service the machine after 2005. That means we need a new replacement standard for the existing machine. We are using IMRT, which is very time consuming. Just for example; for a regular patient, we tend to spend 10 to 15 minutes on the machine. On IMRT we spend anywhere from 30 to 40 minutes. That is an indication that we need to change the waiting for a IMRT. It ought to be between two and three. I will contact my colleagues in the state of Michigan. I'll contact all the Radiation Oncologist and ask them to submit to me the time that they spend on IMRT patients. I can report to the Committee in December as to the recommended waiting. Therefore, just by the first two speakers, I would like to ask the Commission to appoint a SAC Committee to look into this matter. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you, are there any other questions? Amy Barkholz.

AMY BARKHOLZ: Good afternoon. Hi, I'm Amy Barkholz from the Michigan Health and Hospital Association. I would just like to lend the Hospital Association support for the recommendation to open up the MRT standard to a Standard Advisory Committee. We would also support allowing the Chair and Vice Chair, as they have done historically, to appoint that Committee so that the Committee can hopefully get up and running prior to the December meeting to help speed this issue. We have also seen a copy of the drafted charge that's been referenced and we support the language for the SAC Committee and we look forward to that. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you, any questions? Commissioner Maitland, any comments?

COMMISSIONER MAITLAND: Yes, we did meet prior to----an informal group with some concerns about MRT met prior to the meeting today. We've reviewed the process and talked about whether they have a informal or a regular Advisory Committee process for changing and reviewing the standards for the MRT. I think the consensus was, and what I think what you're hearing is that with the six-month limit on making the decision, the formal process might be the best way to handle the MRT. At this point we have at least nine issues that have come up. Some are simple and some are going to be a little more complex. So, from that Committee, I am recommending to the Commission that we establish a Standard Advisory Committee to handle and review the changes to the MRT program with the charges that have been passed out. I can read that.

CHAIRPERSON TURNER-BAILEY: I assume when you say recommend; you're stating this as a motion?

COMMISSIONER MAITLAND: Well, yes. I so move that we establish a MRT Standard Advisory Committee with the following charge to review and recommend changes to the MRT Standard, including but not limited to the adjustments for the IMRT, Brachial Therapy, 3-D(CRT) Extra Cranial Serial Tactic procedures, Special Unit definition. We should wait and mollify our adjustments, rule out access issues and examination of the department's policy as stated in the white paper report on replacements and relocation of uninstalling MRT services.

COMMISSIONER DEREMO: Support, Deremo.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Maitland and supported by Commissioner

Deremo. Any discussion?

COMMISSIONER SANDLER: Yes. Presumably the Chair can appoint help from the department a SAC within-----

COMMISSIONER MAITLAND: Yes, I was going to make that as a separate motion once we have a charge.

COMMISSIONER SANDLER: So, whatever the issue on the criticism, but this has been on the agenda for a long time. We didn't act on it probably because of the amount of time we spent on the bed relocation issue. However, if it's possible, I would like to encourage, once the SAC has been appointed, that they have language for us at the March 8, 2005 meeting. Although that is slightly less than six months. I would like to see us aim for that as the time, otherwise, we're going to lose another three months. This is an issue that the Radiological Society feels needs to be addressed because of the patients, particularly in rural areas, not having access. Thank you.

CHAIRPERSON TURNER-BAILEY: Any other comments? (No response) All of those in favor, please signify by raising your right hand. Unanimous.

COMMISSIONER MAITLAND: And then as a follow up to that and to move this process along as quickly as possible, I move that we allow the Chair and Vice Chair to make the final approval and appoint the Chair of the SAC Committee.

COMMISSIONER DEREMO: Support, Deremo.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Maitland and supported by Commissioner Deremo to delegate the duties of choosing the Committee as well as the Chair and Vice Chair of the Commission. Any discussion? (No response) All of those in favor, please signify by raising your right hand. Unanimous. Thank you.

COMMISSIONER MAITLAND: One last thing. Because this is a Standard Advisory Committee, I think the minimum number of people that we need is 12, with the majority of those experts, so I ask everybody in the healthcare community when the public notice goes out, to make themselves available to serve on this Committee.

COMMISSIONER SANDLER: No problem. We have plenty of volunteers. Thank you.

CHAIRPERSON TURNER-BAILEY: Brenda Rogers.

MRS. ROGERS; Again this is Brenda. Just for clarification for those who were not in our meeting this morning, we have received some offers as far as sitting on whether it was a Standard Advisory Committee or a work group. I indicated that we would consider, you know put your name in with the group. What I forgot to mention to you is that we haven't received-----we're going to be sending out formal letters, so if you could respond to that, because in that letter it will tell you what you need to submit to the department and you need to identify which category you're going to be applying for on the Standard Advisory Committee. Even though we have already received some names, please when you get those letters, please re-submit it and any for summaries and you don't get the letter, please just re-submit in a formal letter with your resume which category you want to sit for on this committee so we can actually consider it along with anything else that we receive. Thank you.

CHAIRPERSON TURNER-BAILEY: We ask that you look out for the letter so that even if you respond in a timely way, so that we can seek the committee and get language for what hopefully will be less than the standard six months. The six months is an outside. That doesn't mean that it has to take six months, so I would just ask you to respond quickly.

MRS. ROGERS: One further comment to make. We will be posting that nomination letter on the website

like we handled it last time versus actually mailing them out. That seemed to work for everybody, so hopefully here within the next couple of weeks you can be watching for that. If you are on that ListServ, you will get notice that it is posting.

COMMISSIONER HAGENOW: There has been an informal work group that has met twice now, actually I think three times. Once before and the last meeting twice then in which we're trying to identify the key issues and be able to bring a revision of the current standards to the December meeting. As is true of MRT's, there has been a great change in terms of surgical services and that which was done on an in-patient basis, is now moving to an out-patient basis. So, what's the volume count if you're in-patient or if you're out-patient, and even more significant is what is the definition. The informal work group is really been about trying to get clear rationale or criteria or put that into the revisions. I'm not clear in my mind where that is you put a formal SAC group together, and when you do the informal work part. Our hope was when we started, and then I took on as facilitator as the Commissioner Facilitator, our hope was that we could be very clear in the revisions in the rationale regarding health policy basis, and then it could be revised fairly quickly because it would be so clear as to the why we said what we did in terms of the definitions. If it becomes more complicated, I would guess that after it's presented in December then it would have to go to a SAC group as well as the MRT, but that's been our rationale at the moment, is that through the informal work group we have great constituent representation from the position group. Just a broad spectrum of constituents, and so hopefully we can have good rationale and then it can be presented in an open hearing and approved. But if we need to we'll probably have to go the SAC route as well.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? I have a couple of cards. I'm not sure if they're both from the same person. I am not sure if you wanted to speak to the work plan or under the general public comment, so I'll call your name and if you want to speak now, come now, or we can wait until public comment. Joan Lowes.

JOAN LOWES: I can speak now if it's in agreement with you.

CHAIRPERSON TURNER-BAILEY: Is it relevant to the work plan at all?

JOAN LOWES: It's to the bed standard and the other comment is towards to the new matter but it could be something that could go under work plan. Good morning. My name is Joan Lowes, and I'm an attorney with Paul Render, Killian, Heath and Wyman in Troy, Michigan. And the first comment that I would like to make today is on behalf of my client, Pontiac Osteopathic Hospital. It relates to the document that I hope was passed out earlier this morning. Pontiac Osteopathic Hospital is very interested in positively impacting the process of creating a fair and equitable hospital bed standard. We have been listening to the debate surrounding this issue. We participated in the SAC meetings and so forth, and we have come up with the proposal that you have in front of you that we believe is a fair and equitable one. The proposal that you have in front of you provides for the development of a new licensed site using replacement beds currently licensed to a hospital. The two-mile replacement zone is not eliminated under this proposal. However, it is not taken into account if the hospital meets certain other requirements related to drive time and the existence of an operating base at the proposed site. This operating base must include key services such as an emergency department that is open 24/7. It also must have at least two CON services in existence at the present time. The proposal does not increase hospital beds, it simply gives the hospital the needed flexibility to draw from its existing beds in order to create a new site of up to 150 beds. The hospital could replace as few as 80 beds to start, if high occupancy can be shown over time that the hospital may add beds at the new site up to the limit of 150 beds. Thank you for considering this proposal. While we fully intend to consider to work through the process with the Standard Advisory Committee, we want you to know that we believe this issue is of sufficient importance that the Commission needs to consider a proposal such as this in addition to the work bed that's going on at the sub-committee. Thank you, do you have any questions?

CHAIRPERSON TURNER-BAILEY: Thank you, are there any questions? Dr. Sandler?

COMMISSIONER SANDLER: I'm slightly confused by this. In the process not the verbiage. You've given

us a list of a proposal which may or may not have merit by a proposal.

JOAN LOWES: It's a proposal that we want to float for the Commission's consideration.

COMMISSIONER SANDLER: To reflect upon this, but I believe Commissioner Maitland, if I'm not mistaken did have a motion at the last meeting that all proposals were to go to the SAC until the SAC gave a report.

JOAN LOWES: And I will be at that meeting next week.

COMMISSIONER SANDLER: So, what I think is true and if anyone can help me with this, we appreciate you bringing this to our attention, but we would not be able to take any action on this. This would be on a vocational thing to know what POH is thinking about, but this will have to go before the Committee, which is co-chaired by Mr. Meeker who gave a report.

JOAN LOWES: Yes, and I talked to Mr. Meeker earlier today.

COMMISSIONER SANDLER: I believe POH, in fact, correct me if I'm wrong, has given a presentation to that Committee.

JOAN LOWES: Mr. Lamb spoke in front of the Committee, that's correct, the CEO.

COMMISSIONER SANDLER: Well, then my suggestion would be that although we cannot take action, of course you would be welcome to come back and to comment on this in the future.

JOAN LOWES: Yes, we're aware of the need to go through the process and fully intend to do that, but as I said we do believe that this is of such critical importance that we don't want the Commission to lose sight of the issue as we work through the process.

CHAIRPERSON TURNER-BAILEY: Thank you, any other comments or questions? Mr. Meeker:

BOB MEEKER: I'm not sure if the speaker was done.

CHAIRPERSON TURNER-BAILEY: Yes, she has a different subject.

BOB MEEKER: I just wanted to respond very, very briefly to that comment. We did speak prior to the meeting, but I was not aware that there was going to be a proposal submitted to the Commission today. I think it's important to realize that neither the work group or the SAC have seen this proposal. Whereas, this is the onion. The more we peel away, we're running close to the end of our six-month time line and at the same time we're starting to get more and more proposals. I think that Mr. Steiger has been operating the SAC, such as he has been encouraging specific proposals to come forward. The only one that came forward initially was the travel time proposal, which is the one that we've been acting on. We have been urging formal written proposals related to beds in the population and also modification of the sub areas and now we apparently have, and I still haven't seen it but a formal proposal on this. The six month time period is getting closer and not further away. We're finding more and more onion under the peeling, but at this point the SAC has not seen this proposal. We have canceled our meeting for next week so that the work group can spend more time on their efforts. Certainly the work group can take a look at this. At this point the work group has given absolutely no thought to this proposal.

CHAIRPERSON TURNER-BAILEY: Thank you, are there any questions? Commissioner Sandler.

COMMISSIONER SANDLER: Yes, I have a comment proposal. I can't speak to the merit of it, but I can say it's a well thought out concept, whether it's appropriate is a separate issue, but certainly your Committee would be the mechanism that this should go on to first.

BOB MEEKER: Our Committee or a different SAC, if, in fact, the Commission wanted to establish another

SAC to look at this or other more narrow issues, as I indicated earlier the charge that we have been given is very, very broad and very difficult to get a handle certainly in six months. We're attempting to do that.

CHAIRPERSON TURNER-BAILEY: Commissioner Deremo:

COMMISSIONER DEREMO: Mr. Meeker, with respect to the proposals, I think there's going to need to be a fine balance, because when I can see your work is drawing to a close that you would be inundated with a number of proposals that would be used to stonewall, and I hate to say that but that is potentially an opportunity, and to continue to push this process out so that it never comes to closure. It's my understanding as a Commissioner that we really aren't expecting that there is a closure until there's a defined date. So, how that is addressed raises something that the SAC might want to make some recommendations, whether there's a cut off date for proposals related to the work plan that you have or in some way looking at those proposals in another venue so that we can continue to move forward with this process. In the meantime Michigan citizens are waiting for an answer and this also does reflect the Commission and whether we meet our task to Michigan citizens.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any further comments or questions?
Commissioner Maitland:

COMMISSIONER MAITLAND: Well, just a general question about -----I'm never quite sure what happens after six months if they don't have a final recommendation or what if we don't like their recommendation and wanted further discussion? Ron, do you have any further thoughts on that?

MR. STYKA: I'll answer that one when it actually happens. I will give it some thought though.

CHAIRPERSON TURNER-BAILEY: Mr. Christensen:

MR. CHRISTENSEN: Jan Christensen from the department. I just wanted to provide a little clarification. Mr. Meeker indicated that there has been only one proposal submitted and that was the travel time, 30-minute, an issue that the work group and the SAC have been working diligently on. There was of course the other proposals that this Committee specifically referred to the SAC, which was the department's proposal to access to care in high Medicaid areas and some ability to move a certain number of beds under that standard. In the SAC, I've consistently indicated that we were waiting and looking forward to seeing the SAC's deliberation on the travel time and then seeing if issues related to Medicaid eligibility concentrates on the Medicaid population. That could be added in the factor in that. So, those are the two major things that I think are officially on the agenda, and there were two other proposals submitted by SAC members to be considered as well, but SAC has not yet gotten to. I have to say that the SAC has been working extremely hard and you have charged a very diligent dedicated group of people to move forward on this difficult issue that Bob pointed out, but I'm confident that they will come to some conclusions. If not exactly in six months, maybe six months and two weeks or something like that.

CHAIRPERSON TURNER-BAILEY: Thank you. I have a card for Surgical Services: Mark Hutchinson:

MARK HUTCHINSON: Mark Hutchinson, St. Mary's in Grand Rapids. When is the next informal meeting for the Surgical Services work group? So, if some interested parties were interested in participating?

COMMISSIONER HAGENOW: I don't think we've set the next meeting, Brenda, in terms of the informal work group. Interested parties, we've had folks asked to come and it's been very limited, but if we could I would let them come. I think Brenda will let them come. We're not trying to be closed but we're also trying to be small enough to be a work group and get it done and not them be in the open hearing that's going to be in the process.

CHAIRPERSON TURNER-BAILEY: At this time-----I'm sorry, did your next comment refer to the work group at all.

CHAIRPERSON TURNER-BAILEY: I'm going to call that under public comment. Is there a motion on the

work plan?

COMMISSIONER SANDLER: Yes, I have a comment. The Radiation Oncology issue, the key issue should take precedent over what I'm going to say. But I'm wondering where the department stands on the technical changes and not the volume changes. There are two technical issues involving help that my guess would be that one informal work group probably could result in a mild change in the standards that would allow this to move forward. Basically this has to do with a mobile pet scanners doing what HSA, not changing volume and it's not something that would be that controversial. But there's also another one, about 85 percent rule. What does the department think? Should we wait until after the first of the year? Can you do this before the next Commission meeting? What?

MRS. ROGERS: This is Brenda. It is on the Commission's work plan. At this point and time the Commission has not really given us any guidance as far as if you want to move that up ahead of some these other issues, so at this point and time we're trying to finalize the MRT and Surgical. We have now completed the Nursing Homes and we're trying to finalize hospital beds, but again that's the Commission's choice.

CHAIRPERSON TURNER-BAILEY: We can put it on the work plan for discussion for December.

COMMISSIONER SANDLER: Well, in order to do that I would think that you would need some language that we would have to develop. I believe and I hate to say that this is not controversial, but I don't think it is. You don't have all players from both the business and from the provide community, but it's a really few issues that we can probably can resolve relatively quickly and there are some institutions unable to offer Pet Scanning because where they are on the local route outside of the HSA and will be posted. That is my concern. If we can't do it between now and December, I certainly would like to do in December and March for the work plan. We hold the work group but when can it be put on the agenda. We need to put it on the agenda. We need to have a work group in the time period between the two meetings. Either we can hold a work group between now and December 14th, or put it on for December 14th with the language or we can have it after the first of the year and put it on for the March 18th meeting.

CHAIRPERSON TURNER-BAILEY: Jan Christensen.

MR. CHRISTENSEN: I'm Jan Christensen from the department. I think it makes sense to have a small group of people to come together and have a conference call or a small meeting to figure out how deep the water is, and whether there are really significant issues or relatively minor issues. From that we can project how quickly we can reach a resolution on it. We can certainly do that between now and the next Commission meeting.

CHAIRPERSON TURNER-BAILEY: Do we need to make a change to the work plan? That's just going to show up next time. Any discussion on the work plan?

COMMISSIONER SANDLER: We may not bring it back in December, that's the feeling of the department that it's too complex if that happens.

CHAIRPERSON TURNER-BAILEY: Did you want to make a motion about the work plan? One last comment about the work plan.

BOB MEEKER: I apologize Madame Chairperson. I've only been Vice Chair of the SAC now for about three days, so you'll have to excuse me if I'm not totally up to speed although I've been on the Committee. I wanted to do two things. First of all I wanted to acknowledge Mr. Christensen's comments about the Medicaid participation proposal that was deferred from the Commission to the SAC at the last meeting. That certainly is on our agenda. It was on the agenda for the last SAC meeting to seek a specific presentation from the department, and at that point Mr. Christensen said it again this morning that it looked like we were making progress on the issues and that he would defer making a presentation until such time we either addressed the issue or there needed to be a modification. So, he expressed then as he did now of the satisfaction in which we're going. It would be very much appreciated, speaking as the

Vice Chair of the SAC, to have some direction from this Commission as to when we cut it off. If our report is due November 30th and we get a new proposal November 29th, have we not done our job. How about November 1st? Can you provide some guidance for us as to, especially given the mandate under the law, that we have to have our report within six months. As the time grows shorter and we get more now a very specific proposal and there are more proposals that we're going to be getting for the next couple of weeks. Can you provide some guidance as to cutting that off or is it just you all come in and we'll do the best we can and let you know after six months.

COMMISSIONER MAITLAND: What is your recommendation?

BOB MEEKER: My recommendation is that we need to have a cut off and it's getting very late in the process. We have less than three months out of a six month proposal.

COMMISSIONER MAITLAND: When would you like to see it cut off?

BOB MEEKER: I guess I would like October 1. The SAC does not meet between now and October 1, but the work group is meeting on the 23rd and certainly I think the work group could at least receive the proposals, but they couldn't obviously act on them, but they can receive them.

CHAIRPERSON TURNER-BAILEY: Any comments? Commissioner Deremo, you can now speak.

COMMISSIONER DEREMO: It seems to me that that's an appropriate thing to do, is to have some cut off date and it really would be between the department and the SAC as to when that would be, whether it's October 1 or October 15th. But without a cut off time, there would be so many proposals coming in at the 11th hour and 55 minutes, and it would be impossible for the Committee to give it to us.

CHAIRPERSON TURNER-BAILEY: Mr. Styka:

MR. STYKA: The Advisory Committee, there isn't a lot of structure between the statute except the timing. It seems to me that it's perfectly reasonable and rational for the Committee to set a deadline, a reasonable deadline and that could be October 1 and to adhere to it. This doesn't foreclose people from coming to the Commission with their proposals when this matter is up for discussion in front of the Commission. Obviously it's better from the perspective if the Commission gained the expertise of the Committee. It was there first. This Commission could end up listening to these proposals the same night that the Committee received it just because of the time factor. Obviously people have had much time already to provide input to the Committee, and one would hope that they would perceive in all new cases or whatever they had in mind. They need reasonable time to do it in. We're basically dealing with a reasonable considerate response. I think it's reasonable to give them until October 1 so that we can have a chance to look at it.

CHAIRPERSON TURNER-BAILEY: So, we can say that we support that in terms of a reasonable approach.

MR. STYKA: I wouldn't really go to a motion.

COMMISSIONER DELANEY: To the Commissioner's earlier comments, I see as the charge the timing runs out, that late proposals probably have more potential obstacles to progress, and I would certainly support or encourage the SAC to set a deadline.

CHAIRPERSON TURNER-BAILEY: Larry Horwitz:

LARRY HORWITZ: Larry Horwitz, Economic Alliance. Sunday was the fourth month anniversary of your authorization of the SAC. I read the statute and I can tell you that the deadline for the report is six months after the Commission established the SAC, not from when it first met. I see Mr. Styka shaking his head. Therefore, it's got a deadline of November 11th. We are now there for less than 60 days to go. I don't think that you're going to be able to have any basis for someone to consider Pontiac Osteopathic

Hospital's proposal if you also expect the SAC to consider that which is already before them. Surely no other proposal is yet to come. As I read the statute, the SAC does not have the power to limit its charge, nor does the department, only the Commission does. So, if the Commission wants to narrow its guidance and say, you know what you've been working on plan (six of them), and we want you to focus your energies on Plan 2-C and get to the other ones later. The only group that I know can do that is the Commission. You have the authority to do that. If you don't, then I think what you're setting yourself up for is the sandbag the concern that I believe, and I don't think that's what the word was, but it sort of sounded like that, but you're ending up kind of setting us up for a guaranteed failure. To me it's sort of unreasonable for the Commission on May 11th charged everybody including Pontiac Osteopathic to come forth and give them their proposal and then it shows up four months later and then to have Pontiac Osteopathic Hospital later to say that we didn't get reasonable consideration. I went to one meeting just to listen and from everything that I heard some of these proposals aren't going to be able to be assessed and analyzed for a significant amount of time. MSU talked about one thing that would take them 15 or 16 months to do, so if you don't give them prior authorization of what they already have on their plate, then you're setting yourself up for sharp critique of a lame duck session of the Legislature in which the POH already have a pending bill. You didn't hear about it in your Legislative report, but the bill has been introduced to go around the Commission and achieve for themselves by statute what they are now saying we should do by Commission action. It seems as if you want to protect the program and defend your own process, then you need to take the responsibility of establishing clear cut deadlines. If you make it October 1, you're setting this thing up for failure.

CHAIRPERSON TURNER-BAILEY: Dr. Sandler:

COMMISSIONER SANDLER: My comments are two comments. The first comment is the fact that there's a bill in the Legislature that doesn't say Pontiac Osteopathic, and I'm certain that it's not relevant to this. The Legislature has chose to introduce bills and that's not relevant to the action that the Commission should be taking anyway. Two, I don't know if this thing is worth anything, but it was presented to the Commission concerning the SAC of a timely manner, and I think that any cut off should be after this presentation was given to us. After this piece of paper was given to the SAC to include a deliberation.

CHAIRPERSON TURNER-BAILEY: Mr. Christensen:

MR. CHRISTENSEN: Jan Christensen, MDCH. I wanted to point out that the next meeting of the Commission is December 14th. So, whenever the SAC completes its work, it won't be considered by this Commission until December 14th, so that if the SAC runs over a week or two from the December 7th thing, we may have a technical violation of the law but it takes an extra week or two to get the right answers and the consensus out of the SAC that you have quality recommendations, then you can consider that there's that window there.

CHAIRPERSON TURNER-BAILEY: Any other comments or questions? Mr. Goldman:

COMMISSIONER GOLDMAN: In terms of what I would be interested in from the SAC is a report that is as complete as they can make it given the time frame. It is certainly appropriate for the SAC to use that time frame for itself if you say we will have this proposal for October 1st, and then afterwards we will not be able to do the kind of analysis that we want to do. I wouldn't be surprised at all if the report that you've submitted to us had an appendix. The following 12 protocols that we submitted on the following dates, protocols 7 through 12 were submitted one day before we went out of existence so we note them for your consideration, but did no analysis of them. That's perfectly fine. Then it is up to people to submit it in a timely fashion. It's no different than anything else in life. If your term paper is due on a specific date and it's in late, you can note that it arrived and when it arrived and you can decide what you want to do with that.

CHAIRPERSON TURNER-BAILEY: Any other comments or questions? (No response) I know it seems strange, but we still have no motion on the work plan to complete the work there, so one would be in order at this time.

COMMISSIONER GOLDMAN: Yes, I move that we accept the work plan as we have discussed.

COMMISSIONER SANDLER; I second it.

CHAIRPERSON TURNER-BAILEY: It has moved and supported to accept the work plan with the issues that we have discussed, which will show up at the end of December meeting. Commissioner Goldman made the motion and Commissioner Sandler supported it. Any discussion? (No response) All of those in favor, please raise your right hand. It's unanimous except that Commissioner Hagenow did not vote.

MR. STYKA: It appears that you're moving to public comment?

CHAIRPERSON TURNER-BAILEY: It appears we are.

MR. STYKA: Before you do that, I just want to give you a quick report because I think it's of interest and we've spent the last year and a half on it. The challenge to the Legislation Act 619 of 2002, in particular the challenge dealing with the amendments to Section 209 has allowed several hospitals including Henry Ford and St. John's Providence to move some beds to suburban locations. It was finally ruled on in July by the Circuit Court Judge who decided that, in accordance with something we had submitted. I think the challengers did not have legal standing to pursue the challenge in Court. That was both the hospital as well as individuals. Finally on August 23rd an order was entered in effect by the Circuit Court. They've been faced with that. The Claimant's file in both the Court Of Appeals, we're asking for immediate consideration of a reversal and in the Supreme Court asking them to take it on a bypass of the Court Of Appeals. We have responded to both of those within the last few weeks. The responsibility was on last Friday, and we're waiting for the Appellate Court. In the meantime there is no stay. The Circuit Court denied a stay of its opinion and decision that there was no standard freeing these challenges, so theoretically at least the hospitals could go forward within the programs. Whether they do so of course would be their own decision as to their own prudence as to whether they want to do that or hold off until they get the Appellate Court decision. That's the status. Any questions?

COMMISSIONER SANDLER: Yes, I have a question. What would you anticipate the Supreme Court will decide whether or not they wish to hear this?

MR. STYKA: There is no time frame in the rules of either Court as to how fast the decision will come in.

COMMISSIONER SANDLER: Meaning that if you submit something, they don't take it to the front of the line.

MR. STYKA: No, my reputation is not that strong.

CHAIRPERSON TURNER-BAILEY: Any questions or comments? Just as a note, prior to going to public comment for our future meeting dates. You'll want to take note of those dates: December 14, 2004 is the next meeting and the last meeting of 2004. After that we have March 8, 2005, June 22, 2005, September 13, 2005 and December 13th of 2005. I noticed that when I was looking at my calendar that the June 22nd is on a Wednesday. That's unusual because our meetings are normally on Tuesday, and you might just want to make note of that.

COMMISSIONER MAITLAND: Don't we normally make a motion to establish those as official meeting dates? Maitland moves that these be established as our meeting dates for 2005.

CHAIRPERSON TURNER-BAILEY: It's been moved by Commissioner Maitland that we accept these meeting dates. It was supported by Commissioner Delaney. Any discussion? (No response) All those in favor, please raise your hand. It's unanimous. I have one card for public comment. Joan Lowes: I also have an announcement from Kheder Davis. They are providing lunch for all who are in attendance today, so you might want to stick around for that.

JOAN LOWES: Switching gears now, thank you. Joan Lowes, and this time I'm here speaking on behalf of Hillsdale Community Health Center in Hillsdale, Michigan. The hospital recently asked me to assist it with a CON for psych beds. The hospital was proposing this course of action due to the difficulty it is currently having. Admitting patients from its emergency room into in-patient psych beds within a reasonable distance from the hospital. Despite this difficulty, information received from the department shows that there are currently no bed need in the Hillsdale, Jackson area. The hospital, therefore, has asked me to bring this matter to the Commission's attention to consider one or both of the following options: First of all review and update the current inventory numbers. The information that we have received indicates that this has not been looked at for some period of time. Second, initiate the process for reviewing and possibly revising the psych bed standards in particular with an eye toward some relief for hospitals like Hillsdale, who are in rural counties and who are experiencing difficulty placing these patients on a timely and efficient way into an in-patient bed. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Commissioner Goldman:

COMMISSIONER GOLDMAN: So, these are patients that need in-patient care on an involuntary civil commitment or voluntary civil commitment?

JOAN LOWES: We're putting together the data on the exact nature of the patient's condition and so forth. I don't have that with me today but I believe that is true. We're having difficulty placing them, those kind of patients.

COMMISSIONER GOLDMAN: The placement would then at the moment have to be uncounted?

JOAN LOWES: Foote Hospital is the closest and that is quite a distance. That is where the 40 beds in those two counties are currently located.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow:

COMMISSIONER HAGENOW: Maybe this is for you or maybe it's for the department. When last have we reviewed these standards?

COMMISSIONER SANDLER: I was a medical student.

COMMISSIONER HAGENOW: So, the request is that we review the standards?

JOAN LOWES: Yes.

CHAIRPERSON TURNER-BAILEY: We did a complete review of the standards about a year and a half ago, so I would assume that it was included.

JOAN LOWES: I was told that there has not been a psych hospital survey since 2000 and that would have provided information I suppose on occupancy rates and that kind of thing.

MRS. ROGERS: This is Brenda again. The special task force that was set up, five or six years ago. Somewhere in that time period we did take a look at all of the standards at that point and time. So, the psych has been reported since that time.

CHAIRPERSON TURNER-BAILEY: Any comments or questions?

MR. NASH: I just wanted to indicate that the annual hospital statistical questionnaire which goes out to all hospitals and free standing private psych units, the hospital part of it includes psychiatric beds, patient's age, discharges, and we do calculate occupancy ratings for those units across the state. We don't make a big deal out of it because our primary interest is with the hospital's CON covered services, but we have 2003 data that says that we're in the process of completing it's collection and editing.

JOAN LOWES: When will that be available?

MR. NASH: I would guess an honest answer would be four to six months. I might be wrong on that.

CHAIRPERSON TURNER-BAILEY: Any other questions?

COMMISSIONER YOUNG: Was the request brought before the department?

JOAN LOWES: I had an informal discussion with staff who suggested that I raise the matter.

MR. HORVATH: The last time we believed that the inventory was updated would have been in '97, as far as the Committee's calculation. The standard dictates that it has to be done every three years.

CHAIRPERSON TURNER-BAILEY: You said that it was updated in '97, but that doesn't mean that it wasn't reviewed in that. That's really the question. Maybe we should take a look at that at the next meeting. Commissioner Deremo.

COMMISSIONER DEREMO: I think this would be an issue that would need to be reviewed. There has been significant change in reimbursement for psychiatric care and in-patient care. There has been a number of hospitals mainly having those beds under inventory but actually may not be utilizing them.

MR. HORVATH: We just appointed clarification and there is a big difference in running the methodology. We continue to update the inventory based upon closing up facilities or re-licensing the beds. So, the methodology has been the number that determines that bed need for planning area by any beds that are currently in the inventory, if they are to be a licensed facility. We just went through all the psych licenses. If any of those beds that came up fine are back in the inventory, if it shows the bed need in the planning area. We maintain that. We try to do that on a monthly basis. We go back and look at the different licenses that have been re-licensed. We do that for Nursing Homes and Hospitals.

CHAIRPERSON TURNER-BAILEY: Commissioner Goldman.

COMMISSIONER GOLDMAN: Let me just ask. What's the possibility of having some information in our December meeting on in-patient psychiatric beds that could then lead us to decide whether we wanted to admit the work plan, but psychiatric in-patient beds is part of the future work plan. I don't have enough information to even make that decision. If there is a need or a perceived need that one hospital, especially a hospital that's fairly remote from the next available psych beds, I would at least like to get more facts on that and decide whether we want to add it to the work plan.

MR. HORVATH: I think Brenda has mentioned a couple of things that we can do at the December meeting, and that is to put it on our agenda to come back to the Commission with an update on when were the standards last revised substantively. When was the inventory last run based some base population. That would give you a summary of what are all the planning areas in the state showing. How many actually show a bed need methodology.

CHAIRPERSON TURNER-BAILEY: We'll ask you to do that in preparation for the December 14th meeting.

MR. HORVATH: And the other thing that Brenda is saying is that the Commission always have the option to ask for public comments at the December meeting; if anybody else have concerns or input about this besides the hospital. There might be other areas in the state that we want to hear about. We will for the December meeting bring back a report on this.

CHAIRPERSON TURNER-BAILEY: Thank you very much. I don't have any further cards, so a motion for adjournment would be in order.

MRS. ROGERS: At this time, are you suggesting amending the Commission work plan and add

psychiatric beds to the amendment or just have it as an agenda item for the December meeting?

CHAIRPERSON TURNER-BAILEY: It's what we talked about.

COMMISSIONER MAITLAND: I move for the adjournment of the meeting.

COMMISSIONER SANDLER: I second it.

CHAIRPERSON TURNER-BAILEY: We are adjourned.

(Whereupon proceedings concluded 12:14PM)