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1 STATE OF MICHIGAN
2 DEPARTMENT OF COMMUNITY HEALTH
3 HOSPITAL ADVISORY COMMISSION

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5 P U B L I C H E A R I N G

6 November 20, 2002

7 Sparrow Hospital-St. Lawrence Campus

8 1210 West Saginaw

9 Lansing, Michigan

10 Panel - DR. ARTHUR PORTER - Chairman (Detroit Medical Center)

11 JOE DAMORE - Member (Sparrow Health System)

12 ROD NELSON - Member (Mackinac Straits Hospital)

13 DON GILMER - Member Ex-Officio

14 (State Budget Director)

15 JAMES K. HAVEMAN - Member Ex-Officio

16 (Department of Community Health)

17 Recorded by - NETWORK REPORTING CORPORATION

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1 (Proceedings scheduled to start at 4:00 p.m.; actual
2 start time was 4:15 p.m.)

3 MR. DAMORE: Good afternoon. I'm Joe Damore,
4 President of Sparrow Hospital Health System, and I'd like
5 to welcome everyone to the St. Lawrence Campus of the
6 Sparrow Health System. It's a real pleasure for us to host
7 this first in a series of public hearings by the Hospital
8 Advisory Commission who is sponsoring this event today. So
9 we're really pleased to be the host for this event with the
10 Michigan Department of Community Health. We're really
11 honored to have a great team here today. And we look
12 forward to seeking the community's input.

13 The purpose of today's public hearing is really to
14 seek input and ideas from people regarding these key
15 questions facing us in health care. And so we hope that we
16 can get a lot of input from throughout the state, and that
17 we can use this input to better serve the people of the
18 State of Michigan.

19 Let me introduce our team here. First, led by our
20 chair, Dr. Arthur Porter, who is the President and Chief
21 Executive Officer of the Detroit Medical Center. It's
22 great to have you here --

23 DR. PORTER: Thank you.

24 MR. DAMORE: -- leading this effort. He'll be
25 chairing today's meeting. Next to Dr. Porter is Rod

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1 Nelson, CEO of Mackinac Straits Hospital up in the UP. And
2 it's great to have Rod down here in the lower part of the
3 state today.

4 MR. NELSON: Thank you, Joe.

5 MR. DAMORE: Next to Rod we have Mr. Jim Haveman, the
6 Director of the Michigan Department of Community Health and
7 our leader of the Department. Jim, thank you for being
8 here. And, of course, Don Gilmer, the Director of Budget
9 for the State of Michigan is also here. We're really
10 pleased Don could be here; and to my left Joe Baumann, who
11 is the assistant to the Director of the Michigan Department
12 of Community Health. So now I'd like to turn the hearing
13 over to our chair, Dr. Arthur Porter. Dr. Porter?

14 DR. PORTER: Thank you very much, Joe. And, again, it
15 is a great pleasure to be here today. And I just wanted to
16 take a moment to talk about the Hospital Advisory
17 Commission within the Michigan Department of Community
18 Health.

19 This was established by an Executive Order, 2002-15,
20 and really has the responsibility to advise the Department
21 of Community Health over a fairly wide range of issues that
22 are pertinent to health care today. And as I look around
23 the room, and I know many of you, many of these issues have
24 come up within your own forums, within the forums that we
25 serve and within our institutions.

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1 I think that it's also fair to say that health care
2 has faced many, many challenges, but some would argue that
3 as we sit right now at this time in this state, we probably
4 have some very significant issues that are before us. And
5 I think that it is good that a commission like this has
6 been established to begin to look at some of these issues.

7 And for those who have not had the opportunity to read
8 the executive order that established the Commission, we
9 look at the general purpose that frames some of its work.
10 The Committee's advisory. It assists the Department in
11 assuring hospital access to health care for the uninsured,
12 the underinsured and for the Medicaid population. It's
13 going to look at patient safety and mechanisms to reduce
14 medical errors that affect hospital patients. It is going
15 to look at some of the financing issues such as
16 disproportionate share and other federal funds that are
17 available. It is going to provide advice on the
18 development of partnerships between the State and its
19 hospitals to maximum federal funding opportunities, to make
20 recommendations for what has been a really important area,
21 and that is promoting the hiring, the retention of nurses
22 and other key health care personnel that we all know are in
23 short supply, and to look at securing other opportunities
24 to increase Michigan's share of the federal funding.

25 I think it is also -- one of the areas that it's

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1 established for is to help advise on mechanisms to allow
2 hospitals to more effectively network with life science
3 corridor research and research opportunities and to
4 recommend to the director methods for hospitals to partner
5 with the State in effective wellness and prevention
6 programs.

7 The Commission is required to provide reports within
8 one year of the development of the executive order. And
9 specifically, the Commission is required to report on any
10 of the negative effects of Medicare funding for hospitals
11 and the relationship of this funding to the Medicaid
12 programs.

13 The Commission shall report on the adverse effects of
14 rising medical malpractice premiums on the health care
15 industry and advise on mechanisms to reduce hospital
16 premiums, to reduce hospital and health care system costs
17 and liability. And the Commission shall also report on the
18 increased utilization trends for hospital services and
19 devise recommendations for reducing inappropriate
20 utilization of resources.

21 I'm privileged to have these folks with me. And just
22 to remind you of the members of the Commission, several
23 members are here, others are not here today. We have
24 Mr. Rick Breon from Spectrum Health Care who is not here
25 today; Mr. Phil Incarnati from the McLaren Health Care

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1 Corporation; Mr. Ken Matzick from the William Beaumont
2 Hospitals; and Mr. Larry Warren from the University of
3 Michigan Hospitals and Health Centers.

4 In beginning to construct a process for the Commission
5 to do its work, it was felt that it was important to seek
6 testimony across the state in terms of what folks felt that
7 mattered, what were pertinent to their organizations,
8 pertinent to their associations and pertinent to themselves
9 in terms of health care access, funding, these
10 opportunities that I described.

11 We have set an ambitious schedule to meet the date of
12 a report in a year in moving across really four locations
13 within the state and hold testimony. These are locations
14 are today in Lansing, in Ann Arbor in December, and we'll
15 be hopefully able to provide you with a date today, Grand
16 Rapids, Detroit, Pontiac, Kalamazoo, Gaylord and
17 St. Ignace. We hope that that would give an opportunity
18 for everyone to be able to really present their views, et
19 cetera.

20 We have also chosen a fairly wide and liberal time
21 frame that we will sit up here. That's from 4:00 to 7:00.
22 And the reason we did that was not that we expected to have
23 a full program of testimony, but more importantly, that
24 each and every one, each and every organization that felt
25 the need to come and say their piece would have the

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1 opportunity and would not be constrained necessarily by the
2 working day.

3 The plan today is to seek your testimony for
4 members, and I'll also be asking the members of this
5 Commission to give their thoughts on where they see their
6 organizations and their issues in testimony today.

7 Without too much further adieu, let me call on the
8 first person. And it's always brave to be the first person
9 who agrees to come up here and do this. And that allows us
10 to practice with him, and for you to practice with us. But
11 I think that one of the areas that has been very important
12 has been the Michigan Association of Health Plans. And
13 we're fortunate to have Rick Murdock, who is here and who
14 will testify on behalf of that organization. Rick.

15 MR. MURDOCK: Mr. Chairman, I appreciate the
16 opportunity to speak before the Commission. Director
17 Haveman, Director Gilmer, thanks for the opportunity to be
18 here. I'm here on behalf of Michigan Association of Health
19 Plans. My name is Rick Murdock, and I am the deputy
20 director of the association.

21 As the Michigan Hospital Advisory Commission begins
22 its series of public hearings, the Michigan Association of
23 Health Plans believes that it's important to establish
24 underlying principles for reviewing and developing
25 recommendations. And it's in that vein that we offer the

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1 following testimony.

2 Several year ago the Michigan Association of Health
3 Plans adopted a policy that established a "managed care
4 industry" philosophy of care. Among other principles
5 included in that policy was the following that we believe
6 is germane to the current discussion regarding the future
7 of health care delivery. And I'd like to quote from that
8 policy.

9 "We represent a philosophy of health care that
10 emphasizes active partnerships between patients and
11 their physicians. We believe that comprehensive
12 health care is best provided by networks of health
13 care professionals who are willing to be held
14 accountable for the quality of their services and
15 satisfaction of their patients. We are committed to
16 high standards of quality and professional ethics and
17 to the principle that patients come first."

18 That statement is our underlying principle and, as such,
19 the Association will continue to support problems that
20 emphasize the following points, and I'd like to itemize the
21 for you:

22 The first point is that future health care delivery --
23 and we were struggling with how to describe, you know, the
24 real mission of the Commission, so we viewed it as you're
25 looking towards developing recommendations for the future

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1 of health care delivery. So that's the terminology we were
2 using.

3 Future health care delivery in Michigan should
4 emphasize quality of care as the focal point for improving
5 access, providing cost-effective care and producing
6 measurable results. And then we've identified
7 characteristics under that that would include:
8 accreditation; capacity for "medical home"; the use of
9 organized data, standardized data, including HEDIS and
10 customer services that meet or exceed the requirements
11 under the Michigan Patient Bill of Rights.

12 We believe that the future of health care in Michigan
13 should emphasize accountability, perhaps now more than
14 ever. And as a hallmark of collaboration, accountability
15 would be a standard. And that would be determined through
16 public reporting, such as quarterly and annual financial
17 reporting, customer grievance reporting,
18 complaint/grievance, consumer satisfaction surveys and
19 utilization reports.

20 We believe that the future of health care delivery in
21 Michigan should be based on measures of performance as a
22 bench mark for all health care delivery. And then we've
23 identified some tools that may be used. There certainly
24 are others. That would include audited HEDIS data that has
25 national accreditation and standardized encounter data.

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1 Finally and perhaps more importantly than others is we
2 believe the future of health care in Michigan should first
3 focus on how to implement preventive health strategies.
4 That would include care coordination, disease management to
5 help citizens with chronic conditions such as diabetes, to
6 manage their condition, and customer services that focus on
7 incentives for health promotion primary prevention. It's
8 our belief that these principles and the focal points
9 identified above are consistent with the issues that you
10 are trying to raise through the Commission.

11 Many difficult moments for health care will be
12 encountered over the next several months and, indeed, over
13 the next year. We are hopeful that the discussion
14 resulting from the Commission, coupled with those in
15 forums, will provide direction to the next evolution in
16 health care delivery.

17 At this time the Association would like to respond to
18 the issues raised in the Advisory Committee's --
19 Commission's hearing notice, and raise additional questions
20 in the hope that the response can be part of that
21 evolution.

22 Under funding issues and questions: Critical funding
23 issues are now being analyzed due to the budget situation.
24 Future public hearings for the Advisory Commission,
25 including next month's in Ann Arbor, will obviously receive

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1 testimony that will include data regarding that analysis.
2 However, we believe that it is time for all interested
3 parties to support preventative health initiatives.

4 The Michigan Association of Health Plans believes that
5 the need to support prevention, health promotion and to
6 emphasize personal responsibility cannot be separated.
7 Therefore, as a challenge to all of us, the follow
8 questions are raised: What type of partnerships for
9 prevention can be established and sustained through funding
10 formulas to reach "at risk" populations? And how can we
11 maximize flexibility for all sources of funding to support
12 an agreed upon strategy? We believe this is a very
13 critical strategy as we go forward.

14 Under medical safety and security issues, as you may
15 know, the Michigan Association of Health Plans is one of
16 the founding members of the Michigan Health Safety
17 Coalition that represents a broad based coalition of
18 members who have come together to develop solutions to the
19 issue of medical errors.

20 The Association suggests that the projects and
21 initiatives of the Health and Safety Coalition could be
22 used to further statewide efforts. Current examples of
23 those have been recently reported in the media, including
24 the results of the Hospital Referral Guidelines Survey
25 regarding staffing in ICUs, which was in today's paper.

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1 Another example recently reported is the support by
2 Trinity Health System in upgrading their computer software,
3 in part to reduce medical errors. The support by Trinity
4 Health System was undertaken not only to improve the
5 outcome of patient care, but also expected to result in
6 economic savings. We anticipate that there will be more
7 examples in this area as a result of state and national
8 emphasis in patient safety and partnerships that have been
9 established to implement these recommendations.

10 In a recent report prepared for the American
11 Association of Health Plans by PriceWaterhouse Coopers, the
12 following factors were identified as contributing to the
13 13.7 percent increase in health care costs that took place
14 in 2001: Drugs, medical devices and other medical advances
15 accounted for 22 percent of the increase; rising provider
16 expenses, 18 percent; general inflation, 18 percent;
17 increased demand, 15 percent; government mandates and
18 regulations, 15 percent; impact of litigation, 7 percent;
19 and fraud, abuse and other cost drivers, 5 percent.

20 As noted in this report, 22 percent of every new
21 health care dollar is driven by litigation and mandates
22 alone, and that should be sufficient evidence to address
23 these items as priorities. On a national basis, the added
24 spending resulting from litigation, mandates and fraud and
25 abuse, which is estimated to be \$18 billion, could have

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1 insured 6.8 million more Americans. These are sobering
2 statistics.

3 Under the future of health care, we believe that the
4 need for coordinated care is growing rapidly as it relates
5 to the increasing number of chronic illness occurring in
6 today's society. Chronic illness requires coordination and
7 communication. According to the Robert Wood Johnson
8 Foundation, over 45 percent of today's US Health Care
9 Spending is related to chronic disease, and by the year
10 2020, that percent is projected to be 80 percent.

11 Future initiatives in health care must address this
12 statistic and support cost effective interventions. Again,
13 as we have noted in this testimony, prevention would be a
14 cornerstone of chronic care management. As noted in a
15 report to the Medicare program, providers in the current
16 system do provide some care coordination services; however,
17 they generally do not offer the breadth or depth of
18 services found in model programs, which would be
19 comprehensive multidimensional assessments of medical,
20 functional and psychosocial needs, arrangements of
21 community services, coordination across providers,
22 intensive health education and support for lifestyle
23 modifications and a methodical tracking of the patient's
24 progress between office visits.

25 As an association, we are certain that the components

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1 for a comprehensive health care coordination are available.
2 What is necessary is this systematic method of integrating
3 such services.

4 These are just our preliminary thoughts as we are
5 looking towards interacting with this Commission over the
6 next series of meetings. We'd like to thank you for
7 providing the opportunity to make these comments. And as I
8 indicated, we will provide subsequent testimony regarding
9 more specific issues at future meetings, but we believe
10 this is a very important setting and an important agenda
11 you have in front of you. We thank you very much.

12 DR. PORTER: Thank you very much, Mr. Murdock. Maybe,
13 if you'd be prepared to take some questions from the
14 Commission, Joe, any comments?

15 MR. DAMORE: Sure. Rick, thank you very much. That
16 was very thoughtful. Any thoughts about how we can further
17 enhance the Medicaid managed care program that you might
18 comment on today?

19 MR. MURDOCK: Well, to judge by the phone calls I get
20 in our office, I think we have an overriding issue, and
21 that's central to your issues too as a hospital commission,
22 and that's the funding, the funding for the Medicaid
23 program.

24 We certainly are relying to a large degree over
25 different sources of financing. I think we're all very

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1 much aware of the State budget situation and are looking
2 towards federal relief where we can get it. We are
3 certainly trying to get an affirmative response to the
4 Quality Assurance Assessment Program that was passed back
5 in May. We understand discussions have taken place as late
6 as this week and we're hopeful that there will be a
7 positive outcome of that. But beyond that, if we can
8 obtain that source of financing, then we're going to have
9 some serious situations, I believe, over the next year.

10 DR. PORTER: You talk about the concept of wellness
11 programs. Do you feel that currently the incentives are
12 aligned appropriately for wellness programs to be put on
13 the front burner as opposed to, perhaps, more
14 sickness-based programs?

15 MR. MURDOCK: No.

16 DR. PORTER: And how would you sort of see the health
17 plans perhaps participating in if there was needed to be a
18 change in direction?

19 MR. MURDOCK: I think part of the -- the answer to --
20 direct answer to your question is no. I don't believe we
21 have appropriate incentives yet. I think we're moving in
22 that direction, and that is through accountability and
23 performance standards. What we need to arrive at, I
24 believe, is more standards, performance standards, whether
25 they're in contracts or whether they're in a variety of

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1 arrangements between the State or other payers and
2 providers.

3 Then we'd first and foremost look at the performance
4 of that particular provider entity, system, whatever, HMO,
5 in terms of how well they organize and deliver preventative
6 services. I think we need to focus on that and build it
7 into our contracts and arrangements. We've started that.
8 In a general way we've looked at some of the, I think,
9 typical preventative measures; immunizations, well child
10 visits, things of that nature. But I think we need to take
11 it to the next level, and I think that will give more of an
12 appropriate emphasis.

13 DR. PORTER: Rod?

14 MR. NELSON: Mr. Murdock, you've mentioned government
15 mandates and regulations are 15 percent of the increase.

16 MR. MURDOCK: Yes.

17 MR. NELSON: Regarding instances such as surveys and
18 accrediting bodies coming in, from a very small hospital
19 standpoint, we obviously have very limited resources. And
20 when surveyors or accrediting bodies come in, sometimes
21 that relationship is not necessarily -- well, let me put it
22 this way: Sometimes it's adversarial, which results in
23 many funds being used for consultants to fix the survey
24 process. Is there any thought on looking at that issue?

25 MR. MURDOCK: I don't know if I can speak directly to

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1 the surveys that take place in hospitals. Maybe we can
2 look at the examples taking place with managed care. We
3 have both national accreditation requirements, either
4 National Committee of Quality Assurance or the Joint
5 Commission on Accreditation of Health Care Organizations,
6 as a requirement. We also have the surveys that take place
7 by the state government through the Department of Community
8 Health as well as the Office of Financial Assurance
9 Services. What seems to be, if I may, problematic is the
10 difficulty it takes in terms of coordinating those visits,
11 so the State -- as the State is having a visit, the
12 recognition of the results of the survey can be used either
13 for deemed status for qualifications in other areas, so
14 there's some meaning to actually having the surveys take
15 place.

16 I think there can be a better working relationship and
17 understanding between the regulating agencies and the
18 agencies that are being regulated in terms of what the
19 standards are and how best to meet them without going
20 through consultants. I believe there's room for that
21 opportunity. And certainly within the State there's been
22 movement in that area. I'm not aware of that taking place
23 at the national level. And, in fact, I believe it's going
24 in the opposite way, where you just about have to have
25 consultants because of all the changes, and they're

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1 changing again as we speak.

2 But certainly where we have control and discretion, we
3 should consolidate or coordinate those type of reviews and
4 use them for deemed status purposes. I think that would be
5 a good step forward.

6 DR. PORTER: Jim, any questions?

7 MR. HAVEMAN: Thanks, Rick, for coming in today.

8 Maybe you can comment on a couple things. One is, you
9 know, there's a bill that, I think, Representative Hart
10 floated around about HMOs being owned by hospitals. And is
11 your organization taking a position on that? And secondly,
12 you know, we've had the agreement with hospitals in regards
13 to the contractual arrangement with HMOs, and is that
14 working like it should? Do you think we have some
15 challenges with it and some opportunities dealing with
16 access? Have you had some thoughts on how we might address
17 that as a Commission in the years ahead?

18 MR. MURDOCK: In response to the first question,
19 Representative Hart's legislation, I believe and, although
20 you might have to correct me, I believe that we've taken a
21 position in opposition to that piece of legislation. As
22 it's written, we don't believe it will accomplish anything
23 related to its objective. And we're not quite certain of
24 the basis for pushing that legislation. We don't believe
25 that there are difficulties in the current relationships

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1 now.

2 The second issue I believe is more important because
3 it does speak to the direct issue of access, particularly
4 for our members who have Medicaid contracts. We
5 certainly -- the issue of having access to hospital
6 services is an important issue. Everyone emphasizes the
7 need to have contracts because that spells out the details
8 of all the relationships, the referrals, the discharge
9 planning, the care and coordination that can best take
10 place. We believe that's -- contracts are our first and
11 foremost, you know, where everyone needs to be. However,
12 there are instances where contracts aren't possible. Then
13 the question then is an issue.

14 And this really is a question for this body as well as
15 others: If you are a provider of a service that's only
16 available in a certain location, can you deny access to
17 that service regardless of the source of payment for that
18 service? You know, it's an issue that remains outstanding.
19 And I think the access agreements that the Department
20 worked on with the Hospital Association and the Association
21 of Health Plans a year and a half ago took a step in the
22 right direction to articulate the ground rules in the
23 absence of a contract. I believe that's a vehicle that can
24 be used. We would hope that folks would go in contract
25 rather than using it though.

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1 You may want to spend some time looking at that access
2 agreement to see how it could be improved or updated. I
3 think I would advise that. But it's there. And I think as
4 long as we can guarantee access to the Medicaid
5 beneficiaries, either through a contract or through the
6 access agreement, that's an important statement of the
7 State to have in place.

8 MR. HAVEMAN: Thanks.

9 DR. PORTER: Any further questions?

10 MR. DAMORE: Rick, has the Association taken a
11 position related to the Certificate of Need program in
12 Michigan? I was just curious more than anything if you
13 have a formalized position that you care to --

14 MR. MURDOCK: Yeah, we haven't established a formal
15 position. We're still studying the position -- or the
16 current statute that's out there, yes.

17 MR. HAVEMAN: All right. Well, Rick, as we travel
18 around the state in the locals that we're at, some of your
19 members could come and testify and give us some kind of
20 practical real-life experiences they've had in their HMOs
21 and interactions with hospitals, the things that are
22 working and also some of the barriers, particularly in
23 access arena that they think we should address. And if you
24 have ideas too, I'm sure the Commission would want --

25 MR. MURDOCK: I think that we will, certainly, at each

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1 of the hearings, make sure that the members in those areas
2 will attend and do exactly that. The first hearing was a
3 little short notice, so we thought we'd start off with just
4 more of an overriding principle, but those issues are near
5 and dear to the members, so I'm quite certain they'll be
6 there.

7 MR. HAVEMAN: Thanks.

8 DR. PORTER: Thank you very much, and thank you for
9 agreeing to kick this off.

10 MR. MURDOCK: My pleasure.

11 DR. PORTER: What we're going to do, while we wait for
12 individuals to give testimony, some of us prepared, too, to
13 address the Commission. And I'm going to turn over the
14 chair of the Commission to Joe Damore, our host. And I
15 would like to describe and discuss some of the issues
16 associated with the Detroit Medical Center as one of the
17 largest, if not the largest Medicaid provider, so --

18 MR. DAMORE: Thank you, Arthur. Many of you know the
19 Detroit Medical Center is really -- does the yeoman's share
20 of care to the poor in the Inner City of Detroit, and
21 Arthur faces a tremendous challenge to be able to provide
22 care in the City of Detroit. And so, Arthur, we appreciate
23 your perspective from your testimony here today, so thank
24 you.

25 DR. PORTER: I'm joined by John Kelley, our head of

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1 Government Affairs, Senior Vice President of Government
2 Affairs and our General Counsel of the Detroit Medical
3 Center.

4 Many of you know the Detroit Medical Center. We don't
5 seem to manage to keep ourselves necessarily out of the
6 news in many forums. But we are a very complex
7 organization. We are an organization that consists of 10
8 hospitals and institutes, 3,000 physicians, associated with
9 a medical school, Wayne State University School of
10 Medicine, spreading over a tri-county area through Macomb,
11 Oakland and Wayne County, and providing approximately or
12 utilizing approximately 25 percent of the state's Medicaid
13 budget. We are the largest private employer in the City of
14 Detroit and also act as an economic engine for the City.

15 If you look at our demographics, our institutions span
16 an inner-city environment, an urban environment but also a
17 suburban environment and, thus, is a sort of microcosm of
18 health care. We have had the opportunity to see many of
19 the challenges that affect health care today within that
20 environment. And I think that over the last three and a
21 half years or so that I have had the helm of the Detroit
22 Medical Center, but also as a still practicing physician,
23 many of the issues that are germane today can be seen at
24 the Medical Center.

25 Firstly, our population and our payer mix -- and

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1 frankly, as many of you know, the financial relationship of
2 a medical center have been extremely challenged over the
3 last few years from three and a half years ago where we
4 lost nearly \$140 million.

5 We're the largest carrier of uncompensated care. And
6 if you take our uncompensated care burden and you subtract
7 from that burden those funds that we get from state,
8 federal, Blue Cross and other entities such as
9 disproportionate share, the amount the Detroit Medical
10 Center still contributes is in excess of \$130 million.

11 At the same time, we carry a second public mission,
12 and that is as an academic provider actually providing, in
13 collaboration with Wayne State, about three quarters of the
14 physicians that currently practice within the state. That
15 is also a contribution, a contribution both in terms of
16 dollars received, GME dollars, IME dollars, but
17 approximately \$80 million a year.

18 At the same time we have found that over the last
19 three years as we have moved towards solvency and even
20 profitability at some of our institutions, there are still
21 some fundamental issues. And there are some steps that we
22 have taken which are fundamentally challenging.

23 We see a continued expansion of technology. And we
24 ask ourselves, as an organization, can we keep up? In
25 fact, if you look at the capitalization or the capital

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1 funding for Detroit Medical Center and its institutions
2 year by year, we, in fact, have deferred a considerable
3 amount. This can only lead to an eventual stretch of that
4 rubber band which will not be sustainable.

5 We have seen, too, the need to expand our organization
6 out into more suburban environments that, frankly, are
7 supported by a different payer mix. But is that the
8 appropriate thing to do when one is supporting an urban and
9 primarily urban mission?

10 We have had to look at efficiencies and efficiencies
11 that probably most hospitals within the state have not had
12 to be challenged in terms of our staff ratios, in terms of
13 our efficiency and even in terms of our outpatient clinics
14 and access points.

15 If you look at some of the most worrisome areas -- and
16 often I'm asked what keeps me up at night -- is trauma
17 care. Detroit Medical Center has the two largest trauma
18 facilities in the City of Detroit: Detroit Receiving
19 Hospital and Sinai Grace Hospital. Currently the Detroit
20 Receiving Hospital is the only Trauma One Level certified
21 institution within that city, yet for the first six months
22 of the year 2002, we took in or had approximately \$50
23 million of charity care.

24 My concern lies on several fundamentals: Can we
25 continue to sustain the large access points in terms of

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1 trauma care without looking at novel funding mechanisms?
2 Can we continue to provide the right obstetrical services
3 and care for newborns without the right funding streams?
4 Can we continue to take an uncompensated burden and if as a
5 private institution we move away from that mission, whose
6 responsibility is it? And finally, is it the time that we
7 look for opportunities to rationalize and share more across
8 systems? Should we have three cancer centers or one great
9 cancer center?

10 And I think both from this position of giving
11 testimony but also from the other venues that I sit on, I
12 think that it is not a time for incrementalism when we look
13 at our issues, but probably more radical and innovative and
14 out-of-the-box ideas. And so, therefore, I present this
15 testimony and ask John Kelley if he wishes to add anything
16 to what I have said currently.

17 MR. KELLEY: Thank you, Dr. Porter. Members of the
18 Commission, it is a pleasure to be here. I have spent the
19 last 25 years of my life in both public service and had the
20 opportunity to serve with Representative Gilmore and also
21 to speak with Jim Haveman, having been one of the people
22 who was responsible for his advise and consent in assuming
23 a very important position in state government. And so
24 we're well acquainted over the years in the elected forum
25 with a number of the issues that this Commission is charged

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1 with dealing with.

2 I am also a member of the Board of Governors of Wayne
3 State University and have watched very closely what has
4 happened in terms of academic medicine and the role that it
5 plays, the very vital role that it plays in the delivery
6 continuum that we have established here in the state.

7 My constituency was mostly in Detroit, and I have
8 watched over the years and was an advocate when I was in
9 the legislature for DSH dollars and all of the programs
10 that came in. And particularly the Medicaid funding
11 programs, I was there to fight for those as a legislator
12 and continue to fight for those as a person who is
13 dedicated to improving the health care services that we
14 have in this state.

15 Unfortunately we've watched -- as Dr. Porter has
16 pointed out, we've watched that deficit grow and grow, and
17 we have not built a public hospital infrastructure in this
18 state or a public funding stream in this state that can
19 allow the privatized system that we have created to
20 actually fully deliver health care services to provide the
21 accessibility, to provide the affordability, to provide the
22 quality that people of this state so richly deserve.

23 The Detroit Medical Center is a pleasure to work for
24 because it continues my own personal mission, and I think
25 what has shown in almost all polls that have been done on

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1 the part of the public before the last 12 election cycles
2 that I've participated in, that the public is concerned
3 about what's happening in the area of health care.

4 Unfortunately it's such a complex subject, it is a
5 subject which has, for the most part, eluded many members
6 of the legislature and many members of the public in
7 understanding how it's delivered that it requires very
8 strong leadership on the part of the people in state
9 government to be an advocate for those goals, to help
10 people understand what we are trying to achieve and to
11 create the architecture for delivery of those services, not
12 just in the urban areas that I come from, but also in the
13 rural communities across the state where I've watched the
14 erosion of health care services as well.

15 I had the pleasure in 1983 of introducing a bill to
16 create a universal health care system. And it was
17 interesting to see the reaction. All across the country --
18 not in Michigan, but all across the country I had
19 invitations for people to come and speak. They too are
20 grappling with this question. And I follow in terms of the
21 industry publications and the journals that are coming out
22 now that all across this great nation from California to
23 New York to all the states in between, people are trying to
24 figure out, how do we deal with this question of delivering
25 to the people what is a -- I believe a constitutional

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1 commitment for people to have access to health care, and
2 what our obligations are as a democratic society to provide
3 those.

4 So it's not just the polls, but it's also the fact
5 that many hospital systems, many state governments have
6 been looking for ways to deal with this question, some in a
7 draconian way, closing down emergency rooms, some saying
8 we're going to limit the access to service for only
9 particular ranges of things that we will do for people who
10 come walking through the door, but also, I think, there is
11 a growing recognition that there is reliance on public
12 funding. There is -- 34 percent of the revenue that flows
13 into hospital systems to pay for this uncompensated care
14 comes from tax resources. And, quite frankly, this state,
15 ever since 1978 and the adoption of the Headlee Amendment,
16 has not made that a high priority, has not made that
17 something that this legislature, these legislatures have
18 been able to tackle or the state government has been able
19 to tackle without having to offset it with some other
20 thing.

21 So I believe that what we need to do in this
22 Commission, I believe what the task is for the next group
23 of people who are coming into leadership, is to find those
24 novel ways to approach what our obligations are, to fulfill
25 our constitutional commitment, our moral, our ethical

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1 commitment to the people of Michigan.

2 It's incumbent upon the hospitals who have been doing
3 creative -- you know, pursuing creative ways of taking care
4 of compensated care, and the physicians who are often left
5 out as being the individuals who have to bear a great share
6 of this burden as well, looking at the ways that are
7 possible for us to construct this financial system in such
8 a way that we can give the people the quality that they
9 deserve and we can fulfill our commitment to the people of
10 Michigan. So thank you for the opportunity of being able
11 to testify today.

12 DR. PORTER: And we are more than happy to answer any
13 questions on the Medical Center, Joe.

14 MR. DAMORE: Are there any questions for Dr. Porter?

15 MR. HAVEMAN: If you could just off the top of your
16 head do six things differently if you were looking at
17 reimbursement, and, you know, Detroit Medical Center is a
18 non-profit hospital; hospitals in this state don't pay 1.2
19 billion dollars in state and federal taxes. I think people
20 have a right to expect some uncompensated care. I think
21 that's a given, it's part of a mission as non-profits. But
22 if you could change five, six things, what would they be?

23 And part of what we're all talking about here is an
24 underlying redefinment of what a health care delivery
25 system should look like because the one we have right now

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1 is -- 'cause there's not going to be the billions of new
2 dollars just to pay full charges. And so what are some of
3 your thoughts futuristically, out of the box?

4 DR. PORTER: You know, I've never been accused of
5 really thinking inside the box, so I'm not sure exactly
6 where the box is. But I think that -- I agree with you
7 there is unlikely to be -- this is not a problem that can
8 be fixed by throwing more money at it. I mean, even if we
9 had the money to throw at it, it might not be the wisest
10 use of that money.

11 I think there are a number of issues that we need to
12 look at. I think the first one is how we do business, and
13 in what business are we? And I thought I began to begin to
14 talk a little bit about sort of rationalized delivery of
15 health care. Do we need every center to do everything? Do
16 we need to look at one great cancer center as opposed to
17 four or five not so strong cancer centers? Do we need to
18 look at more strategic partnerships? Do we need to have
19 a -- the opportunities to begin to develop creative
20 partnerships with our physician colleagues?

21 Oftentimes I find myself in the hospital world at
22 cross purposes or with perverse incentives between our
23 physicians and myself as a physician and myself as an
24 administrator. For example, in the hospital world, we
25 necessarily want to have a patient move through the system

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1 very rapidly. As a physician, I need necessarily -- would
2 perhaps have the patient stay a little longer. So there
3 are these conflicts that are at cross purposes, which I
4 think to some extent would align our systems better.

5 I think the last testimony that we heard on wellness
6 and prevention strategies I think is something that we can
7 take heart to because, again, this is more as a sort of
8 national perspective. We tend to be an illness-driven
9 health care system than a wellness-driven system. I recall
10 many times saying, "The flu season didn't hit," in a sort
11 of sad tone, or, "We're not having as many high-risk
12 pregnancies." So to some extent, there are those
13 incentives that perhaps need to be modified.

14 I think we have to look carefully at our appetite for
15 high tech equipment and to look at opportunities to share
16 and to work in collaborative partnerships across the health
17 care industry. After all, we are not for profit. And in
18 fact, more strategic partnerships between organizations,
19 suburban, urban, academic, et cetera, would be of better
20 benefit.

21 We need to look more creatively at our links with
22 industry. One of the opportunities is perhaps moving our
23 health care systems towards greater disease state
24 management, looking at our pharmacy formularies, looking at
25 how we spend our dollar and doing those things in a much

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1 more standardized and accepted manner. And I think as an
2 academic health care system, that is something we should
3 strive to take a leadership role in.

4 As you can see, there is no one answer, and even
5 though at some stage we will have to look for a certain
6 public funding commitment, there still are many areas that
7 I think we can look at how we work within the hospital
8 environment and between the hospital environment and other
9 health care providers.

10 I think then you have to look at another side that is
11 a funding side, and that is how we deal with truly
12 uncompensated care and how we deal with those things that
13 would, in many other areas, be considered part of the
14 public mission.

15 Many cities in the United States have a public
16 hospital; for example, Cook County, the Grady System and
17 others. We have chosen not to have a public hospital
18 system, but we still have a public mission. And to some
19 extent, I think that we may need in those instances to
20 begin to look for streams of funding that support a public
21 mission both within our large urban environments, but also
22 within those environments that perhaps are not urban, like
23 our rural environments as well, but are committed to
24 uncompensated care. These are just but a few examples of
25 where I think the Detroit Medical Center and other

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1 institutions like us could play a role.

2 MR. DAMORE: Thank you. Any other questions or
3 comments? Thank you very much.

4 DR. PORTER: Thank you.

5 MR. DAMORE: Is there anyone else that would like to
6 testify before the Commission today, anyone else in the
7 audience thus far?

8 DR. PORTER: I'm also told that our host institution,
9 Sparrow Hospital, would like to give testimony to this
10 Commission and get -- President, CEO of the Sparrow Health
11 Care System, Joe Damore. Again, before you start, let's
12 start off by thanking you for your hospitality for allowing
13 us to use your institution today and for you being our host
14 here. Joe?

15 MR. DAMORE: Thank you, Dr. Porter, Mr. Haveman and
16 Rod, the entire group, it's great to have you here today at
17 the St. Lawrence Campus of the Sparrow Health System.

18 And I think Dr. Porter did an excellent job of
19 articulating many of the challenges that we're all facing
20 in health care today. And I'd like to take a few minutes
21 and first talk about the environment here, which is in many
22 respects similar to Detroit but also has some differences,
23 and then second talk a little bit about the health care
24 challenges and what we see maybe as some of the issues that
25 can be addressed by the Commission and the Michigan

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1 Department of Community Health in the coming months.

2 Sparrow is a comprehensive health system that includes
3 several hospitals: Sparrow Hospital over on the east side
4 of Lansing; of course, St. Lawrence here at this campus;
5 Clinton Memorial Hospital up in St. Johns, Michigan; Carson
6 City Hospital up in Carson, Michigan; and then affiliate,
7 Central Michigan Community Hospital in Mt. Pleasant.

8 Sparrow Hospital two miles east of here is a Level One
9 Trauma Center certified by the American College of Surgeons
10 for the middle part of Michigan and is a comprehensive
11 regional referral center for the mid part of the state
12 serving about a 50-mile radius.

13 Sparrow also includes a nursing home, the Dimondale
14 Nursing Facility, large home care companies, and then, of
15 course, our wellness and athletic club with over 8,000
16 members in that program, and then our physician group, a
17 network of both primary care physicians and some
18 specialists providing care.

19 And we are also a major teaching hospital affiliated
20 with two medical schools, both the Michigan State
21 University College of Osteopathic Medicine and the College
22 of Human Medicine. We have 14 residency and fellowship
23 programs with 150 fellows in residence in those programs
24 and another 50 medical students at Sparrow on a daily
25 basis.

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1 Sparrow has been recognized throughout the country for
2 many quality programs and is recognized in this community
3 as the leader in health care services because of the high
4 quality physicians and staff that work at Sparrow.

5 The challenges are great right now in health care. I
6 recently attended a national seminar this past week, and
7 one of the things that I found striking is the fact that as
8 our population ages, we're going to continue to be
9 stretched in health care.

10 A remarkable number that I heard was 10,000 people a
11 day in the United States are turning the age of 50; 10,000
12 people a day. There are 80 million Americans that are
13 between the age of 37 and 56 in the baby boomer group. As
14 that group matures -- you know, and I'm one of those --
15 above the age of 50, they will utilize health care services
16 at a rate of 7 times as great as someone under the age of
17 50.

18 So the demand for health care in America and in
19 Michigan is going to continue to dramatically increase,
20 which I think is going to stretch all of our resources in
21 Michigan. And that brings us to the challenge of adequate
22 funding.

23 Ever since 1997 when the Balanced Budget Act was
24 passed, Medicare cuts have really stretched our hospitals
25 in Michigan and throughout the country. And we need to do

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1 all we can to ensure that we have adequate Medicaid funding
2 also. And I'm really thrilled with the efforts to try to
3 maximize the federal contributions to the Medicaid program
4 through the quality assurance assessment for hospitals, for
5 HMOs and for nursing homes. I think that's a very positive
6 step that the State of Michigan has taken to maximize
7 Medicaid funding at the federal level because, I don't know
8 if everyone understands, but for every dollar that's
9 generated here in Michigan, the federal government matches
10 it at about \$1.10. And so it brings in a substantial
11 amount of funds into the state that wouldn't be here
12 without that effort.

13 I think there's a challenge of aligning incentives.
14 We have many reimbursement issues that face health care.
15 Health care is so complicated because there are so many
16 individual fiefdoms, if you will, rather than a real
17 organized delivery system. And one that I was going to
18 mention is one that Dr. Porter mentioned, and that's trauma
19 care.

20 The challenge that we face is that many physicians are
21 not adequately paid to take care of trauma patients. If we
22 think about trauma, it's one of the most difficult types of
23 injuries to take care of because a physician must come in
24 in the middle of the night usually and take care of a
25 person they've never met before, that they don't have a

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1 history. Yet reimbursement to care for those patients is
2 substantially below what a physician could generate in
3 their office taking care of elective patients in many
4 fields, general surgery, orthopedic surgery, neurosurgery.
5 So that reimbursement to take care of the sickest of the
6 sick patients at the most inopportune times is lower than
7 it is to take care of the routine patients on a daily
8 basis. And I think that's something that's wrong with our
9 reimbursement system for physicians.

10 Another area, of course, is aligning reimbursement in
11 certain specialties. In surgery we have alignment in
12 reimbursement because the surgeon is paid on a per case
13 basis, so there's alignment with the hospital. But in the
14 area of internal medicine there's a great challenge because
15 the internist is not paid in an aligned manner. The
16 hospital is paid on a DRG usually, and the internist would
17 be paid or the family physician on a per diem basis. So
18 there is a lack of consistent incentives to manage length
19 of stay in a economic way that needs to change.

20 I think we have a great challenge of recruitment and
21 retention of health care professionals. Today our greatest
22 shortage is nursing. We have to be more creative in
23 encouraging young people to enter the nursing profession at
24 a young age, and I think we have to create scholarship
25 opportunities to help fund their education so that they

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1 will stay in Michigan and care for the patients here in our
2 state.

3 I think we're facing some other shortages right around
4 the corner similar to nursing. Pharmacy has been one area,
5 I think some physician specialties are going to be -- we're
6 going to experience shortage here in the next few years
7 that we need to think through in advance that they're going
8 to occur.

9 Another challenge is, how do we create incentives for
10 efficiency? You know, we really believe that we need to
11 look at the most efficient organizations and bench mark
12 against those organizations and then share that information
13 with similar organizations in the state. So a bench
14 marking effort maybe that could be done by the Department
15 to help hospitals, nursing homes, insurers, might be
16 another method that we can -- where we can spread
17 successful efforts to become more efficient throughout the
18 state.

19 Pharmacy costs, another key area: Pharmacy costs for
20 us have been rising at 15 to 18 percent per year. That's a
21 real challenge when reimbursement is going up at 3 percent
22 or going down at 3 percent. It really stretches our
23 organization. And I have a frustration with the -- a
24 personal frustration with the pharmaceutical industry, you
25 know. It is the only unregulated portion, from a price

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1 perspective, of the health care industry. And I think we
2 really need to look at pricing in the pharmaceutical
3 industry.

4 I don't know if you've seen the advertisements
5 recently in our newspapers, but Canadian firms are
6 advertising in our local newspaper, encouraging people to
7 have their prescriptions sent to Canada, filled in Canada,
8 and the drugs mailed back here to the United States because
9 the cost of the exact same drug is 20, 30 and 40 percent
10 lower in Canada than it is in the United States. There's
11 something awfully wrong in our country when we see this
12 happening.

13 And these are just some of the significant challenges
14 that we at Sparrow are facing and I think hospitals
15 throughout the state and the country are facing. And I'm
16 really worried about the future because, as we age as a
17 nation, health care costs are not going to decline.

18 You know, remember that number, you know, 10,000
19 people a day turning the age of 50; people over 50 use
20 health care resources at a ratio of 7 times greater than a
21 person under 50. I think we're going to be faced with a
22 tremendous challenge in our country. And I think, as
23 Arthur said, it's time for some break-through thinking.

24 You know, tweaking things at the edges are not going
25 to resolve the tremendous cost issues that are going to be

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1 facing us in the next five to ten years. And I think we
2 need to try to get ahead of the curve. So I hope that's
3 helpful, and I'd be pleased to answer any questions.

4 DR. PORTER: Thank you very much, Joe, and maybe I can
5 turn to -- any questions, Jim or Rod?

6 MR. HAVEMAN: (Shaking head negatively)

7 DR. PORTER: I have a couple of questions. Probably a
8 huge nut is the sort of pharmaceutical costs that we all
9 face. Have you any thoughts on how we can get it down or
10 what steps have you as an organization taken to attempt?

11 MR. DAMORE: Well, the -- you know, the most
12 traditional attempts have been done to maximize the use of
13 generic equivalents, of course, and then second, large
14 group purchasing. And I believe that the Department of
15 Health has also taken steps in those directions, and maybe
16 Mr. Haveman would like to comment on that. But those are
17 two kind of traditional steps.

18 You know, I happen to think we need to go further
19 because I think if you look at the current laws, the
20 current laws in this country related to pharmaceuticals, we
21 actually -- our government actually allows pharmaceutical
22 firms to create monopolies for specific drugs. And I think
23 we need to look at the whole patent law system in the
24 pharmaceutical industry.

25 But that's really a national issue, not a state issue.

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1 And that's just my personal opinion as an area that we need
2 to look at. I don't know. Jim, would you have any
3 comments about the State's efforts to control
4 pharmaceutical companies?

5 MR. HAVEMAN: It seems to me that if you read the
6 literature, the whole discussion, the debate of
7 pharmaceuticals has overtaken the discussions of health
8 care reform. And it's not only a major issue at the
9 federal government -- for instance, in Michigan if the
10 federal government would pay the pharmaceuticals for the
11 dually eligible, which is costing the state \$191 million in
12 General Fund dollars, that could go a long ways to giving
13 some financial relief to the states. And these are people
14 who are on Medicare that we, you know, provide Medicaid
15 services to through -- so they get the pharmaceutical
16 benefit.

17 When we went into the pharmaceutical drug list, PDL,
18 and had the P&T Committee pick that best drug in class or
19 those best two and then did a reference point, a reference
20 price, we are currently saving -- experiencing savings of
21 \$650,000 a week. And we not only have been able to absorb
22 the 10,000 new Medicaid recipients that have come in every
23 month in the last several months, but have done this in a
24 way that people are still getting their pharmaceutical
25 benefit. And right now about 80 percent of the drugs being

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1 used are not being preauthorized because people have moved
2 to that list.

3 I think one of the issues I would find interesting --
4 you know, we've been sued twice on this now, one in the
5 local courts here and one at the federal level by PHRMA,
6 trying to stop this, because if they can stop it here in
7 Michigan, they feel that they can stop it throughout the
8 country.

9 But it would be very interesting to put together a PDL
10 that almost all of us could begin using in common so that
11 we can begin negotiating accordingly, because what happens
12 in this state is, HMOs have a different formulary,
13 hospitals have different, and drug reps are everywhere.
14 And some hospitals in the state have banned drug reps from
15 campus, but other ways are found.

16 But it's certainly a challenge, and it's not unique to
17 Michigan. It's something that the Canadians are
18 experiencing. In fact, in Canada right now the premieres
19 have all agreed to move to one formulary for the Universal
20 Health Care of Canada. So even the provinces will not have
21 different ones.

22 The piece that has excited me the most and one of the
23 upcoming sessions, maybe the next one, I can talk more much
24 like Arthur and Joe have, but is the whole evidence-base
25 approach to health care. I'm really excited about -- and I

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1 hope the Commission -- we can spend some time and maybe
2 bring some people in, we have the ability to do that, to
3 talk about evidence and the evidence-based centers that are
4 around the country who are beginning to look at best health
5 practice in a non-biased way, so that we can then -- to get
6 some bench marks of some treatment techniques and outcomes
7 so we can begin doing some measuring and some holding
8 people accountable.

9 But it's hard to build incentives when you don't have
10 those bench marks. And I think evidence-based approach to
11 health care makes a lot of sense. They're beginning now to
12 look at the pharmaceuticals, and at -- these evidence-based
13 centers, which are about 12 around the country, can look at
14 what is the best drug, you know, Vioxx over against an
15 over-the-counter drug, and produce that evidence. It's
16 done because the evidence which physicians and others are
17 getting are what the pharmaceutical companies want to hear.
18 So I think that is an area that we really should spend some
19 time and talk about as a Commission.

20 MR. DAMORE: That's a great idea. We have a professor
21 from Michigan State, Jim, who would be really excellent,
22 who leads the evidence-based medicine program at Michigan
23 State, Dr. Henry Barry. He's a nationally recognized
24 family physician who leads their institution on
25 evidence-based medicine. I'm sure Dr. Barry would love to

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1 share with us a little bit about what they're doing.

2 MR. HAVEMAN: Maybe we do that at our next meeting.

3 DR. PORTER: Perhaps at the next meeting, --

4 MR. DAMORE: Uh-huh (affirmative). Sure.

5 DR. PORTER: -- we can have him present. Are there

6 other questions for Joe Damore?

7 MR. DAMORE: Thank you.

8 DR. PORTER: Again, Joe, thank you very much for your

9 testimony.

10 MR. DAMORE: A real pleasure.

11 DR. PORTER: What I'd like to do now is ask for maybe

12 a ten-minute break unless there's somebody who wants to

13 come to the -- if there's not, that will give me an

14 opportunity. And then maybe, Jim, we'll start off with you

15 and hear from the director, from Director Haveman. Just a

16 ten-minute break, and we'll be back with you at 25 to 6:00.

17 (Off the record)

18 DR. PORTER: Maybe we can start the session, move the

19 session along, and the first person who will give testimony

20 is Mr. Timothy Codd, who is the Chief Executive Officer of

21 Youngsoft, Incorporated and also the President of Michigan

22 Orthopedic Services. Tim? Mr. Codd?

23 MR. CODD: Thank you very much, Chairman, members of

24 the Commission, Director. As board member of the Detroit

25 Medical Center, as owner of Michigan Orthopedic Services,

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1 as owner of Youngsoft H2H Solutions, as citizen of the UP,
2 I guess I have an interesting perspective sitting before
3 you as a -- not only a patient but a provider and a
4 taxpayer. You always hear the negatives. And it kind of
5 frustrates me to only read the press that says doom and
6 gloom, the problems with this and the problems with that
7 and the financial issues here and the financial issues
8 there.

9 The comments that I've observed and have heard aren't
10 just in this room, but I think it's been commonplace and
11 consistent for the last few years, again due to unforeseen
12 circumstances, I think. But I think also it's -- all of us
13 in this room have inherited situations that we really
14 weren't a part of.

15 So as a provider, Michigan Orthopedic Services has
16 approximately 50 employees providing services from Midland
17 all the way down into Detroit. We have grown approximately
18 12 to 15 percent each and every year. H2H Solutions
19 Youngsoft ranked 43rd in the Inc 500 fastest growing
20 privately held firms doing business in 27 states and 3
21 countries. It's really not, for me, as bad as it is for
22 you. And that's what I'm hearing. As a board member,
23 that's an interesting position to be in these days.

24 One of the most -- I should say one of the consistent
25 observations that I've made sitting on a board and boards

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1 have been the lack of participation of the members. They
2 feel privileged, they've earned this seat or have been
3 given this seat. But when there are issues that have to do
4 with the viability of the hospital or their performance, I
5 really don't see a whole lot of solution or participation.

6 So I observe my hospital that I sit on and some of the
7 decisions that have had to be made, and I applaud it
8 because they're not easy. You know, if you look at the
9 last three years, closing two hospitals, putting a ball to
10 one, restructuring the administration, moving corporate
11 headquarters, I applaud that. But unfortunately, it's not
12 as newsworthy as the losses or the financial challenges
13 that seem to make front page.

14 I think it's the responsibility of all of us to try
15 and work not only with our board members, but the community
16 at large. And when you say "community," you know, really
17 what is it? Is it your hospital? Is it your school
18 system? Is it your municipality? Is it the employers?
19 It's all of it. And if you don't have a successful health
20 care system in your community, you really have a challenged
21 community.

22 So my comments for today are, there are some real
23 leaders out here, and it's impressive for the ones that are
24 truly making the hard decisions. You read all these
25 comments about, you know, "This is so bad," and, "We're not

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1 getting paid enough." Well, what are your solutions?

2 We at Michigan Orthopedics, before we even went to the
3 market, one of the things that we did -- and again, this
4 comes from just, I think, good old UP upbringing, is that
5 you've got to prove it. Talk is cheap and things are made
6 on a handshake. And that's one of the things we did.

7 We talk about evidence-based results and outcome. We
8 put a scientific survey in place so that we measure certain
9 types of patients randomly, via the mail, via the phone,
10 and it's impressive that the results come back in the high
11 90's. And we've been doing this for five years; therefore,
12 there's a 12 to 15 to 20 percent growth. The old "Field of
13 Dreams." "If you build it they will come." And I think
14 it's a challenge for all of us to start producing results.

15 Coming from the Upper Peninsula, it's comforting to
16 see we have a representative from the UP. Almost like
17 Forest Gump, what am I doing here? I applaud that, your
18 commitment to this opportunity, Rod, 'cause living in
19 Ontonagon County -- and I'm sure not a lot of us know where
20 that is -- it's a population 35 on a holiday, and it's
21 challenged. We've got a rural health care clinic that's
22 five miles away, and the physicians are usually on a
23 rotation with the local community support. But the local
24 hospital is only but an urgent care basically. That's it.

25 Rod, I know you are thinking out of the box. You are

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1 doing things that I would hope more would do, and that is
2 try to bring resources to you in an economical way.

3 So I sit before you to say, it's really not so bad
4 because I think we're all very bright people. We've
5 inherited situations that I think we're capable of fixing.
6 It takes leadership like what the DMC is doing. It takes
7 individuals like us, fellow board members, to get more
8 active.

9 And then I want to state an example that sits with my
10 company and the experiences that I've had with the Michigan
11 Department of Community Health. And again, it's amazing to
12 me that we have so many challenges and it is so wrong that
13 we're suffering and suffering. But if you look at the
14 budget, where it was 12 years ago and where it is today,
15 it's impressive.

16 Director Haveman met -- he and I met five, six years
17 ago. And I was a humble little company. I think I had
18 nine employees. And he asked me what was -- "Do you have
19 any issues with Medicaid?" And I said, "Yes, I do." And
20 he said, "You do?" I said, "Yes, but versus talking about
21 it here, I invite you to my place." And true to Haveman
22 form, he scheduled it and came to my facility.

23 And we walked through, and he saw -- actually saw an
24 amputee. He saw a leg being made. He saw the whole
25 manufacturing process. And he said, "What's your problem?"

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1 And I showed him a shelf. And again true to Haveman form,
2 "What's with that shelf?"

3 We had about 48 patients under the Medicaid system
4 that were waiting for authorization. So I didn't complain.
5 I said, "There are the 48 patients." But interesting, I
6 put a business case before him and said that, "True to
7 form, 97 percent of those patients will be authorized for
8 services, but we're waiting six to eight weeks." And the
9 average case happened to be between four and fifteen. I'm
10 not here to share the expertise clinically, but it's a
11 challenge. It's painful.

12 Of the three percent that were denied authorization,
13 they were overturned on appeal. So we had a 100 percent
14 approval. True to Haveman form, he called up his director
15 on his mobile, and everybody knows where he keeps his
16 mobile, and he said, "I want a meeting right away. I want
17 this to be resolved."

18 Within five weeks he changed policy on muscular
19 dystrophy and cerebral palsy. He eliminated the
20 authorization process on behalf of Medicaid because it was
21 consistent. We had a business case. All the procedures
22 were consistent. You can't deny the codes. And with that
23 example, there was no press release. There were no
24 banners. There wasn't a forum like this.

25 So I sit before you as an entrepreneur being pressed

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1 into action. And I look at all of you as kind of like the
2 same way. You've got to come up with solutions. The
3 challenges are many, and they're going to get worse, and I
4 think there's room for improvement. And it's not to be
5 resolved today, but it's interesting that, you know, when
6 you do talk to the major payers out there, including the
7 Michigan Association of Health Plans, they're all very
8 bright. They're all living with a system that is coming
9 and going. What I think is needed is this type of forum.

10 It's amazing to me that when someone's on the other
11 line trying to give us authorization on prosthetics or
12 orthotics, they really don't have the specialty. There's
13 areas I think that we can improve on. We'd love to sit at
14 the table and talk about it.

15 Now, the second issue that I want to talk about or at
16 least address is technology. I reference, and it's not a
17 forum for me to share with you the attributes of my
18 company, it's interesting that we've created solutions that
19 have made the systems more efficient. And it's amazing to
20 me that we're succeeding, not because we have the biggest
21 and the best and were publically traded, but we have
22 results. And we come in with our sleeves rolled up, and we
23 come in looking for performance evidence and risk.

24 You know, you see all the warranties in performance
25 contracts and et cetera, and it's amazing to me. I walked

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1 into one managed care plan, and I said, "We're willing to
2 go at risk on this. If it doesn't work, you don't pay for
3 it." They said, "You can't do that. This is health care."

4 It kind of shocked me. You know, it happens in my --
5 when I buy a car or when I buy a product. If I don't -- if
6 it doesn't work on the technical side or the appliance
7 side, these are hard metals, we can take risk. We can
8 warranty our appliances.

9 So I stand before you or sit before you to say that
10 we're succeeding, and there's good news out here. And I
11 welcome the opportunity to share it and be a part of it.
12 So with that, I'm here to take your questions.

13 DR. PORTER: Thank you, Mr. Codd. You do have a
14 number of different views from the UP to the manufacturing,
15 entrepreneurial side. You've also had the opportunity to
16 look at health care organizations as we -- as they go
17 through this little morass of changes.

18 Perhaps I'll paraphrase one of the questions that were
19 put to me. If you could look for a few instant magic wand
20 changes, what would be on your list that you say, "Let's
21 change this?" because clearly the director of the
22 Department solved an issue that was related to timeliness
23 of authorization for you and perhaps a process improvement.
24 Can you think -- have you considered other areas that might
25 benefit the whole health care chain?

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1 MR. CODD: Yeah. Gosh, I think that's why I'm an
2 entrepreneur because I think so much. And half of what I
3 do works, but, hey, the half that does is pretty good.

4 We have in the State of Michigan probably the largest
5 purchaser of benefits in the country. You have the
6 automotives. You have organized labor. And for a little
7 old company like me to fight up the food chain to get to
8 them to provide results to say I'm worthy of being a
9 participant in what they called back then a very closed
10 panel because it made sense financially to close the panel,
11 they listened. I'm not here to take away the credit and
12 hard work of special interests, but sometimes special
13 interests is just that. It's very special to an
14 individual's agenda. I look at the purchaser to get closer
15 to the results.

16 It's amazing that I -- I sit on a rehab board, and all
17 of the work-related and trauma injuries, a lot of the care
18 is going to Chicago and Denver. And I think there's
19 something wrong with that.

20 The other issue is the pharmaceuticals. And I don't
21 know if anybody has really quantified the total purchase of
22 pharmaceuticals in the State of Michigan. But it's got to
23 be very, very generous, given the largest purchasers are
24 here. So what percentage are we getting in order to help
25 fund our challenges? You see a lot of the dollars going

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1 elsewhere. So I would look towards getting closer to where
2 the dollars go.

3 And technology, I think -- you know, Director Haveman
4 and I have had this conversation before, and I've had it
5 with a number of purchasers. There's a huge data
6 disconnect. The duplication of services and the redundancy
7 is overwhelming.

8 You look at the automotive companies and the major two
9 suppliers, and you've got the State of Michigan and its
10 employees, but they're all on their own systems. They're
11 all separate. And I know this isn't an issue we'll solve
12 today or tomorrow, but hopefully we can have discussions,
13 and who knows what can happen from there, but there's got
14 to be a way that we can cooperate on data because the
15 economy that we have from a purchasing power, I think we
16 can reward the systems that produce the results that I
17 would choose to go to.

18 DR. PORTER: Questions? Thank you, Mr. Codd. Thank
19 you.

20 MR. CODD: Thank you.

21 MR. HAVEMAN: Let me share a few words.

22 DR. PORTER: Yeah. Director Haveman has asked that he
23 come on the record and share a few words about his views of
24 this, and I'm delighted that you felt able to do this at
25 this time.

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1 MR. HAVEMAN: As you know, this is an area that we all
2 really appreciate talking about, and I appreciate the
3 opportunity. And it's nice to be on a Commission with
4 people like Mr. Damore and Dr. Porter and Rod Nelson and
5 others.

6 I was preparing for a talk the other day, and I added
7 up, in 1991 when some of us arrived here in Lansing the
8 budgets of all the departments that are now are part of the
9 Department of Community Health was just short of, I think,
10 about \$5 billion, maybe about 4.7, 4.9. Today it's \$9.2
11 billion. The Medicaid office -- department I think has
12 done an extraordinary job of finding additional resources
13 that we could bring into the state, and if Don Gilmer would
14 be here, he'd certainly acknowledge Paul Reinhart and his
15 creativity to bring in federal dollars to Michigan. And I
16 think the work that has gone on recently with the
17 assessment with the legislature and the Department and DMB
18 and the governor certainly points it out as well.

19 Only about 7 percent of hospital revenue in this state
20 is from Medicaid. It amazes me the debate that goes around
21 from the hospital groups at times over Medicaid. It's an
22 important part of revenue. It's a significant part of
23 revenue for some -- some more than others, but many of the
24 issues -- and I think Mr. Damore referenced it -- are
25 taking place at the federal level. And one of the

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1 challenges I think that was built into the executive order
2 of this commission is to begin addressing some of the
3 federal issues, not only the balanced budget, but also the
4 issues related to the recent cut backs in Medicare which
5 have not been reinstated and also with the effect on the
6 nursing homes. And the list just goes on.

7 And as you know, right now Congress is pretty well
8 fixated and not moving on a lot of issues, including some
9 of them which we've been advocating for for some time, and
10 I think we're going to have to wait 'til the new Congress
11 gets in place before some of these are addressed. But
12 revenue at the federal level is certainly down, as it is at
13 the state level.

14 We're preparing recommendations for an executive order
15 this week because the revenue of the state isn't what it
16 should be or what it was projected to be when this -- when
17 the '03 budget went together.

18 Medicaid has 80,000 pages of rules. Medicare has
19 120,000 pages of rules; two completely different functional
20 systems. And out there then you also have the VA. And
21 Dr. Porter well knows there's a VA Hospital right in the
22 middle of his campus which is significantly empty and low
23 in bed utilization. But there's not a huge connection at
24 times between VAs and it's something that currently even
25 some legislation is being looked at in the Michigan

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1 legislature with hospitals and VA and even, to see how
2 controversial the amendment can be, it points out some of
3 the challenges.

4 I've already talked about the dually eligible. But if
5 we would have Medicaid block granted to states with some
6 annual inflation similar to what was done with TANIF with
7 Social Services or Family Independence Agency, we could be
8 very creative and kind of redesign what could be done.

9 You know, 5, 6 billion dollars is a significant amount
10 of money, but at times it's just orchestrated in the wrong
11 way or in the wrong place, and it's tough to move it from A
12 to B to C, because not only the politics but also tradition
13 and how it's always been and how the reimbursement
14 structures have been.

15 Tim pointed out a situation that -- Mr. Codd, that he
16 experienced, and basically what that came down to was two
17 people who were employed to do prior authorization, and
18 nobody ever asked, "Well, how many actually get
19 preauthorized?" And if you're almost at 100 percent, why
20 do you preauthorize it? You can always do a back audit if
21 need be, and that's what we did.

22 100,000 people a year die in hospitals. One of the
23 situations I thought about recently when I was flying back
24 from a meeting was, why, when we issue a CON, don't we
25 require a hospital to have a certain standard of technology

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1 and medical records and automation and be addressing some
2 of the issues related to medical errors?

3 The technology has been proven to cut down
4 significantly -- particularly in the laboratory, the
5 automation and the use of swipe cards and bar codes and the
6 like, maybe we should consider that. You know, we
7 currently don't, and I don't see that happening real soon.
8 But it's a thought I think we should think about.

9 Uncompensated care, people think, well, it's great.
10 Let's go to the fair qualified health centers and establish
11 them. Well, what people often forget, we reimburse fairly
12 qualified health centers about 100 percent of charges,
13 so -- and that comes out of the Medicaid budget. And
14 there's some talk that there's a separate pool in
15 Washington that could be funneled into some of these
16 centers, as the president has suggested. And I do happen
17 to think that those comprehensive health centers are a
18 great way to provide some level of uncompensated care.

19 You know, we have about a million people without
20 insurance in Michigan. But about 600,000 are kind of
21 between jobs, and, you know, it's kind of a changing number
22 all the time, but there's still a core group of people.
23 And we don't think very creatively on how to keep some of
24 the core group of people out of ER rooms and where we just
25 provide services.

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1 And even one time we went to a two-tier system for ER
2 rooms so that we could get more reimbursement for
3 physicians, because a lot of -- some areas of the state
4 they were providing urgent care centers through the use of
5 nurse practitioners. As soon as we provided more funding
6 for the ER rooms for the physicians, they shut down the
7 urgent care centers so that they could get their
8 reimbursements through the ER room. So I had unintended
9 consequences to what I thought was a good idea.

10 And so this is kind of the changing behavior of health
11 care. And I do not see -- and many of you go to
12 conferences as I do and you hear the futurists, and you
13 know, I get just as nervous and sleepless night as Joe when
14 you hear the statistics of people turning 50. But this
15 is -- this is going to continue for some time. And what I
16 think that we have to start really looking at is what we
17 can do to address issues that are driving it. Malpractice,
18 there are cities in this country, in Montana, where there
19 are no OB docs for hundreds of miles because of liability
20 issues and malpractice issues.

21 Scope of practice, we have to address it. We have to
22 talk about it. There are many uses of extenders in health
23 care. Sparrow Hospital uses a lot of them, CRNAs,
24 physician assistants, nurse practitioners, as does DMC, and
25 others. But there are some places in the state where that

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1 might not be accepted. And it's because of some particular
2 belief of a physician community or whatever. But there's
3 much to that scope of practice. Whenever it comes in front
4 of the Michigan legislature it is a hotly debated
5 situation, as many of you know.

6 I saw -- there's a lot of studies going on, and I have
7 access to some more recent studies on health work force
8 issues, and I'll share them with the Commission. But it's
9 something that needs to be addressed. And I was at a --
10 talked to some people last week. For instance, Michigan
11 has 100,000 nurses in it. Not all of them are practicing
12 nursing. Once they did a survey of where there are nurses.
13 The largest amount of nurses that had an RN background were
14 selling real estate; totally got out of it.

15 So, you know, what we should begin addressing -- I
16 think it would be interesting for the Commission to do
17 it -- is really spend some time asking the question, "Why
18 are people getting out of health care?" And sometimes it's
19 the way nurses have been treated -- some of the surveys --
20 by physicians in hospitals. Some is the long hours. And
21 many hospitals, as you know, have tried to be fairly
22 creative to go back to kind of positional work force time
23 and to kind of pay attention and bring nurses much more
24 into the decision-making process. And they've been able to
25 retain them. And I think we have to look at that. If

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1 there's models out there that are working, then I think we
2 should take a look at it.

3 And the other degree of interest is, when do we start
4 intriguing people about health care? You know, the debate
5 we just had on Proposal 4, it doesn't do anything to
6 attract people to health care. They just look at it and
7 say, "Why?" I mean, these are the people themselves who
8 are kind of driving this. I mean, we have to go back to
9 that this is an exciting field for people to work in. It's
10 something that junior high kids and high school kids have
11 to get engaged in early, to identify, to be proud to be a
12 physician, proud to be a nurse, proud to be an
13 administrator in this field. And if you talk about many of
14 the students, why they're not going into health care, many
15 of them who had planned to, they just don't want the
16 hassles. And I think we have to do some creative ways to
17 try to reverse that.

18 I think the life sciences corridor, you know, which
19 some of the Tobacco money goes to, has done really some
20 amazing research. But I think we should tie the hospitals
21 and the health care community, whether it be HMOs and
22 others, to really challenge them with some of the research
23 that we need for what we're going to be doing in the
24 future. And part of the health sciences money is to be
25 focused on health care research, whether it be aging or

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1 whatever. And I think that there are some, certainly,
2 opportunities there.

3 And I'm not going to talk about the duplication. I
4 think we're falling behind in technology. I think Mr. Codd
5 talked about that; both of you talked about that, but most
6 industry is spending between 13 to 17 percent. I think
7 hospitals and others are spending about 8 or 9. And it's
8 something that we have to bring up.

9 You know, we're just now going to be putting out end
10 of this month, end of December, swipe cards for Medicaid.
11 We still mail 800,000 paper Medicaid cards to people every
12 month. And it's taken me four years finally to get the
13 systems geared up so at least we can have a swipe card that
14 we can mail out to consumers, and then the swipe card will
15 determine their eligibility so we don't have to keep
16 sending out these cards.

17 The challenge has been to get the physician community,
18 as you know, to adopt the swipe card and the technology
19 that's there that can certainly make their life easier.
20 But we are going to move ahead. And what we have found out
21 sometime, that you've just got to go ahead with the
22 product, and they'll bring the technology on board. And
23 we've been doing a lot of training, and quite honestly,
24 people have been very cooperative with that.

25 Michigan is very creative in the use of waivers, but I

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1 think we have to go further in disease management,
2 particularly in diabetes and obesity. You know, we started
3 some initiatives with the Department, but we really need a
4 statewide effort. And that's where it goes back to the
5 evidence-based treatment. I mean, we are treating diseases
6 many different ways and many different plans and many
7 different hospitals, and some of it, quite honestly, is
8 based on historical, "This is what I learned in medical
9 school or nursing school 30 years ago." And I think to
10 really put some time to bring people up into the current
11 thinking and futuristic thinking in disease management --
12 because we are going backwards in many states in this
13 country on issues related to obesity and diabetes and all
14 of the different diseases that we do measure on a regular
15 basis.

16 I think we have to ask the question sometime, "What's
17 the incentive for people to stay healthy?" I've always
18 liked the idea of medical savings accounts. I never quite
19 figured out how to do it. I like the idea of people having
20 some definite amount of money to spend, and if they can not
21 utilize some of those dollars, that they have some benefit
22 to them personally.

23 The use of a card has got way too easy for people.
24 They don't even think about maybe I shouldn't do this.
25 They just assume that, "I have the card and somebody will

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1 pay for it."

2 End of life issues, we still spend -- I think we need
3 to address that. We spend way too much of our health care
4 dollars in the last 12 weeks of life. Don Gilmer and Joe
5 Damore just were part of the mortgage burning of the
6 hospice which is right next door, which is great. It
7 served how many people last year?

8 MR. DAMORE: Well, since its inception 1100 people.

9 MR. HAVEMAN: 1100 people?

10 MR. DAMORE: Since 1996.

11 MR. HAVEMAN: Only 25 percent of the people in
12 Michigan who are terminally ill die in a hospice program.
13 They don't know about it. They know the option -- the
14 alternative. The stay in hospice in Michigan is probably
15 less than 17 days, even though they have a six-month
16 benefit.

17 We should talk about palliative care, about earlier on
18 engaging people. And we have some of the hospitals in this
19 state who are addressing that earlier on, helping people
20 think through those end-of-life issues. And people have, I
21 think, a great ability to make decisions about end-of-life
22 issues if people are honest with them and tell them the
23 truth, and rather than do extra-ordinary things which many
24 people don't want.

25 I don't think we can duck the issue of what the

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1 Governor raised in not only the State of the State, but
2 the -- over the whole Blue Cross/Blue Shield issue. Blue
3 Cross/Blue Shield is still 75 percent of the benefit for
4 health care in the state. It's huge. It's having some
5 challenges.

6 We don't have a lot of competition in health care. If
7 you just take a look at the Blues and Medicaid and
8 Medicare, you've kind of got the population. There are
9 some who would like to come into this state but feel
10 anxious about coming into Michigan. How do we make this a
11 more insurance-friendly state so people would feel more
12 comfortable competing in this state or even have an even
13 ground to compete, I think is something we've got to
14 continue to look at.

15 I'm not going to talk about the pharmaceutical issue,
16 but we've tried to address it from the state, and quite
17 honestly many states are looking at this issue. I think
18 Michigan is the only state who has actually put in
19 something that's bringing in some savings. Maine is hung
20 up in courts. Multi-state purchasing groups haven't
21 worked. It's been very difficult to do. States who have
22 tried to set up their own distribution system have found it
23 frustrating because the pharmaceutical companies won't sell
24 it to them.

25 So I think -- so this is something that I think we can

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1 address and really speak to that might benefit the whole
2 state. So let me just stop right there and -- but I'll
3 share some of the work force papers with you.

4 Medicaid, by the way, is currently about 26 percent of
5 the General Fund budget. 1980 it probably was less than 8
6 percent. How large can Medicaid be as part of this budget?
7 We currently have about 1.2 million people on it. I think
8 it was very smart to the state to move 750,000 people to
9 the managed care -- fine managed care programs in this city
10 and elsewhere.

11 Our HEDIS scores continue to improve. Customer
12 satisfaction is certainly significantly better than it was
13 when the providers owned Medicaid. And I often say that
14 because I think until we begin to aggressively manage the
15 dollar and act like a purchaser, the providers had
16 increases of 10, 13, 15 percent a year, and we couldn't
17 sustain that. There's no way you could sustain that for
18 now and into the future.

19 I think once the Geno projects are completed and that
20 whole dynamic becomes involved in health care, those baby
21 boomers are going to be demanding 15 times what people
22 under 30 are asking for, and we have to get prepared for
23 it.

24 DR. PORTER: Thank you very much, Director Haveman.
25 Are there questions for Jim?

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1 MR. DAMORE: Jim, would you be willing to comment on
2 the status of the Quality Assessment Program in the state
3 for hospitals?

4 MR. HAVEMAN: There were three parts of Quality
5 Assessment: one dealing with nursing homes, one dealing
6 with HMOs and one dealing with hospitals. The HMO one has
7 run into some -- with CMS you can get a clock that ticks,
8 and if they ask questions the clock stops. And they're
9 currently asking some questions. We're hopefully
10 addressing those. And we're cautiously optimistic that we
11 can correct some of their concerns, and a couple of their
12 concerns are legitimate concerns that we need to address
13 and fix here in Michigan.

14 The hospital assessment will bring \$140 million over
15 the next couple years for hospitals. There is no reason
16 why -- we did some at the state plan amendment right away.
17 We are getting no indication that there's any difficulty
18 with that. We believe that we'll soon receive the approval
19 so we can distribute those dollars.

20 And, you know, this is something that people work
21 together on, and I think that's the way it should be, to
22 bring to additional dollars, to particularly try to address
23 some of the issues which both Dr. Porter and Mr. Damore
24 commented on.

25 DR. PORTER: Jim, you sort of had the opportunity of

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1 asking me about the six things, the six things that one
2 would want to change if one could. And I'm sure, as you
3 sort of look back -- and to some extent, I know that
4 already you've touched on many, but if you could do six new
5 things, I mean, if there was six things that could be -- or
6 five or whatever, what are the sort of things that you'd
7 say, "These are things that I would implement or I would
8 pass on as things that we'd do"?

9 MR. HAVEMAN: Yeah, I think those are fair questions.
10 I would ask some tough questions about how many hospitals
11 do we need in Michigan? How many beds do we really need,
12 and where should those beds be located? I think what we
13 did in the rural community -- and Mr. Nelson is part of
14 those with the critical access rural hospitals where if
15 they limited the beds to under 20, there's 100 percent
16 reimbursement. I think all of us were pleasantly surprised
17 the number of hospitals that chose to do that which took
18 significant beds off line.

19 I think we're not spending enough time talking about
20 the hospital of the future. I get a little nervous
21 sometimes when I continue to see the large construction
22 that's going on and wonder if that's really what we should
23 be building for the next 30 years or are there other models
24 or more decentralized systems? Particularly as I see the
25 technology and the people's use of the Internet, I don't

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1 think we've addressed the reimbursement issues as it
2 relates to the Internet, hospitals and physicians offering
3 consultation, scheduling appointments. And how do we shift
4 the dollars to do that? Because Medicaid's such a rigidly
5 run system.

6 I get very anxious with cancer centers that go up four
7 blocks from each other situation; Grand Rapids where that's
8 happening now. It goes on in Detroit and elsewhere, huge,
9 huge buildings, you know, 30-, \$40 million expenditures.

10 I would welcome automated medical files, people would
11 really come to grips with the use of technology. I think
12 it's unfortunate where somebody in Michigan is in one city
13 and gets in an accident in another city, and there's no
14 ability either in a swipe card or a driver's license -- or
15 maybe not so much a driver's license, a medical card or an
16 ability to go to a central file to access that information.
17 I think consumers would welcome that, and I think you could
18 do that and the consumers would support that. And I know
19 there's HIPPA issues, but I think it's something that could
20 be addressed.

21 Evidence-based medicine I think is something we all
22 have to really understand as to what are the best
23 strategies for the treatment of particular disease and that
24 we all accept it and we'll all do it.

25 I think sometimes the fear of doing it is people

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1 really don't want to be rated. I'm amazed that the
2 consumers don't have more information about procedures and
3 hospitals. I think we have a tremendous job ahead to
4 educate consumers, particularly so that they can make more
5 choices about their own personal care, but also to gain and
6 understand that if they drink for 30 years, that they're
7 going to have a liver problem, and if they smoke or if they
8 do some of the other things or stay overweight for a
9 particular period of time, chances are they're going to
10 have diabetes. And then I think we've got to step back and
11 say -- and kind of redesign a basic health care benefit
12 that offers basic care. And if people want to add on to it
13 a kind of definitive health care plan, they can do that.
14 How to do that within the current debate both in Congress
15 and in states is very difficult to do, but I think we have
16 to go that direction.

17 MR. NELSON: Director Haveman, the issue of block
18 grants, is it possible to pilot that initiative and
19 obviously being from the Upper Peninsula, we only have one
20 plan up there, the UP Health Plan. What are your thoughts
21 on that?

22 MR. HAVEMAN: I've said publically in speeches that I
23 think the UP has probably done a better job in kind of
24 putting together a uniform unique identifier for people who
25 come through the Upper Peninsula Health Plan. And if I

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1 could ever just send one check to the UP and let them kind
2 of manage health care in the UP, it would kind of be an
3 interesting pilot. To do that might be a challenge because
4 of all the infighting that still goes on and the silo
5 thinking in health care. But we tried to make a run on
6 block grants three or four years ago, the governor did.
7 There's little or no support in Washington to block grant
8 Medicaid dollars to states.

9 The whole issue of federalism is still a debate that
10 takes place, states' rights over against the federal
11 government. And it's something that's just not going to go
12 away, although we could -- you know, I've always been
13 interested in -- you know, we spend 2.5 billion dollars of
14 Department of Community Health money in Wayne County.
15 That's a lot of money. If we could all sit down -- and I
16 offered this to the Chamber four years ago. I said, "Let's
17 all get in the room, all the health care providers in Wayne
18 County, and say, 'Is there a different way to spend this
19 which might do some of the wellness, prevention up front
20 and spend some time in technology and put together some
21 uniform indicators and evidence-base that we could all kind
22 of really champion who really were" -- you know -- "gains
23 from these monies, which is consumers, let's do that.'"
24 And there's never been an offer, other than Dr. Porter, of
25 a willingness to do that. And I think that's unfortunate.

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1 I think those are missed opportunities. And it's 'cause I
2 think the system -- I don't know how much the system itself
3 wants to change. And I think that's the challenge, which I
4 think we can address.

5 DR. PORTER: Thank you very much, Director Haveman.
6 Thank you. I think we want to have -- Rod Nelson also
7 wants to speak to the group. And I really respect the
8 members of the Commission who have chosen also on this
9 first day of giving their testimony because I think it puts
10 us almost on the same group, that we're all members of the
11 Commission in a way, that we're all interested in what
12 eventually comes out as health care.

13 Rod Nelson is CEO at Mackinaw Straits Hospital and has
14 a completely different environment shared only by Mr. Codd.
15 But, please, go ahead.

16 MR. NELSON: Thank you, Dr. Porter. Mackinac Straits
17 Hospital is a 15 bed critical access designated facility
18 with 99 long-term care beds. We also operate three
19 clinics, which is not unusual for small hospitals to have
20 outlying clinics; however, two of our clinics reside on
21 Boblo Island -- on the map it's spelled Bois Blanc, but
22 Boblo Island and then Mackinac Island, which gives a
23 different perspective to recruiting, finding nurses willing
24 to live on an island, physicians, et cetera.

25 It's amazing that there are similarities between the

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1 large hospital systems, as far as issues, and the small
2 rural. We both have very similar issues; for instance, the
3 work force shortage. Obviously, nursing, radiology techs,
4 pharmacy are an issue, but to put it into perspective, we
5 have two people in our radiology department, and we have
6 one pharmacist in our pharmacy department, and that's for
7 24/7.

8 Part of the challenges of recruiting to a rural area,
9 obviously you have to recruit the family as well as the
10 individual you're trying to recruit. It's a unique person
11 that can work in rural health care because you have to do
12 so much, and you have to be so flexible.

13 When you're working, such as our x-ray people, when
14 you're on call for two or three straight days, and all of a
15 sudden there's an illness, all of a sudden the rest of your
16 week is dedicated to the facility.

17 We obviously are trying to recruit, and we engage
18 different sorts of companies to assist us, but that is
19 always an ongoing challenge. The financial resources, we
20 obviously are always looking to bring in resources, capital
21 improvements.

22 Part of our issue in the next coming year, we are
23 beneficiaries of inter-governmental transfer monies. That
24 program is leaving in 2006. Those monies are equivalent to
25 about \$400,000 a year to a facility that generates about 13

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1 and a half million dollars, so it's pretty substantial.

2 Physician recruiting is always an issue. We are
3 fortunate in that we have four and a half physicians which
4 we employ. We have three ER physicians which we employ.
5 When you're only seeing 4,000 visits a year, obviously we
6 have to subsidize our physicians, and that presents a
7 challenge.

8 But it's not all bleak. I mean, we've had great
9 opportunities Up North. And I think I'd like to share that
10 with the Commission also. It's not all doom and gloom. A
11 lot of relationships that we've developed with our local
12 facilities have proven to be very beneficial. And we are
13 continuing to explore that with our friends in the Upper
14 Peninsula and with our friends in the Lower Peninsula.

15 We're also looking at working with our school system
16 on identifying those students who would be interested in
17 pursuing a career in health care and offering scholarships.
18 So we have students coming in throughout the year working
19 with our x-ray people, our lab people, our nursing people,
20 et cetera.

21 We are very fortunate that we've been the recipients
22 of a number of grants and grant opportunities. And, in
23 fact, one of the grants helped fund the clinic on Boblo
24 Island, when we send the nurse practitioner over to an
25 island populated, believe it or not, by about 100 people in

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1 the winter, and that probably grows to about 2,- to 3,000
2 people in the summer.

3 We've been very successful in obtaining grants that
4 have, for instance, provided air conditioning for our
5 long-term care residents, which has been tremendously
6 beneficial. We've worked with Center for Rural Health, and
7 we've worked with Director Haveman's department.

8 So even though we have tremendous challenges, I still
9 think that if we work together and if we network and if we
10 don't take on the adversarial relationship that sometimes
11 we as hospitals do with the Department, et cetera, I think
12 we can do a lot of great things.

13 And so I think I'm here from a rural hospital
14 perspective, and even though I'll have a sleepless night
15 probably tonight about something that's coming up tomorrow,
16 I think our -- still our future is bright and we'll work
17 very hard to make that happen. So thank you.

18 DR. PORTER: Thank you very much, Rod. Are there
19 questions?

20 MR. DAMORE: Rod, I'm just curious about things like
21 teleradiology, telemedicine. Do you see that in the future
22 for your facility and facilities like you throughout the
23 UP?

24 MR. NELSON: Absolutely.

25 MR. DAMORE: And are you using any right now?

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1 MR. NELSON: Currently, Joe, we have to courier our
2 films 25 miles away every day over the Mackinac Bridge to
3 the radiologist. We are in the process of instituting a
4 teleradiology program, and that also will include Mackinac
5 Island because during the summertime the population of that
6 island explodes to include about, I think, 900,000 visitors
7 a year. And if you've been on the island -- and I know
8 many of you have -- there are a lot of bike accidents, and
9 there are a lot of heads that hit the pavement and x-rays
10 taken.

11 So we anticipate in the next 6 to 18 months we'll have
12 a teleradiology program in place. And most of that program
13 was funded through an innovative grant that we certainly
14 appreciate from the Department.

15 DR. PORTER: Again, if you wanted to see some things
16 changed and you had your opportunity to change a few
17 things, would there be things that would come to mind that
18 you would like to see changed, even though things are near
19 perfect?

20 MR. NELSON: You know, I can use some recent examples
21 in our facility. You know, oftentimes, particularly when
22 you have a nursing home attached, you're subject to annual
23 reviews. And we welcome that because we look at that as an
24 opportunity to improve. But I think somewhere the process
25 may have gotten off track a little bit because I think

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1 there should be a mechanism where when the reviewers come
2 in to look at you, it shouldn't be adversarial; it should
3 be helpful. And the main objective ought to be improving
4 quality.

5 And as you know, CMS has just released, I think, the
6 quality indicators for 16,000 nursing homes. I think that
7 should be the focus because, unfortunately, when you're in
8 a small facility and you need resources and you have to
9 bring people in, you're talking about spending 5 to 7
10 percent of your annual budget. It's 4 hours away to bring
11 people up from downstate or to fly them in. That would be
12 one area.

13 I think secondly, I mentioned that before, I think --
14 and I think we're doing a pretty good job of it, the
15 networking and the relationship aspect has to be enhanced.
16 We're pretty fortunate in that the local hospitals to St.
17 Ignace -- and when I talk "local," I mean 50 and 65 miles
18 away -- we actually bring our boards together once a year
19 to look at our little triangle up in the UP to see where
20 we're headed, what initiatives we can work with. So there
21 has to be a better working relationship with providers.

22 And again, I just think, as long as it's quality
23 driven, and that's the right objective, I think you'll see
24 health care costs come down. I think that's a given. So
25 just those couple of things, Dr. Porter.

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1 DR. PORTER: Any further questions? Thank you.

2 MR. NELSON: Thank you.

3 DR. PORTER: Thank you very much, Rod. At this time
4 do we have any other individuals or groups that would like
5 to present testimony at today's meeting?

6 Hearing none, what I would like to do at this -- I
7 know we have officially another half hour that we could
8 spend, but I think that this has given the group here a
9 flavor of what we want to do and what we want to discuss.

10 Our next meeting is going to be in Ann Arbor. The
11 place will be determined, but it's, again, a 4:00 to 7:00
12 p.m. meeting, Monday, December 16th. Mr. Larry Warren,
13 director at the University of Michigan, will be our host
14 for that meeting. We will at that meeting take some of
15 your thoughts from today's meeting, synthesize them,
16 present a short overview of where we have come so that we
17 continue to build on what we have.

18 There have been a couple of suggestions for
19 presentations. For example, a presentation on the disease
20 state management and its impact on costs, et cetera, and
21 best practices. And we will have those scheduled for that
22 or future meetings. And, again, we will take testimony as
23 we build the case for identifying priorities in all these
24 areas of health care.

25 So, again, I just also want to say that, as you know,

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1 there will be other forums. There will be a Medicaid forum
2 tomorrow held by the governor-elect and the team. There
3 will be other forums over the next little while. But I
4 think that rather than look at this as being divisive or
5 problematic, I look at it as being very constructive
6 because I think that health care is now getting a very
7 enlightened position that we're all recognizing that
8 something new and something different has to be done. What
9 exactly it will turn out to be we're all not sure at the
10 present time, but if we focus in those directions, I think
11 that -- and work together -- and I think, Rod, you said it
12 well, in non-adversarial ways, we will be able to find
13 solutions which will be truly win/win.

14 So hopefully I will see some of you on the 16th of
15 December. And hearing no further interest in testimony, I
16 would like to call this meeting adjourned.

17 (Proceedings concluded at approximately 6:30 p.m.)

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