STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED

PUBLIC HEARING

REVIEW STANDARDS FOR UESWL SERVICES/UNITS, PB AND SERVICES, CC SERVICES AND OHS SERVICES

BEFORE ANDREA MOORE, DEPARTMENT TECHNICIAN TO CON COMMISSION

201 Townsend Street, Lansing, Michigan

Wednesday, October 31, 2007, 9:00 a.m.

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Lansing, Michigan

Wednesday, October 31, 2007 - 9:01 a.m.

MS. MOORE: Good morning. As many of you know, I am Andrea Moore, Department Tech to the Certificate of Need Commission from the Certificate of Need Policy Section of the Department of Community Health. Chairperson Norma Hagenow has directed the Department to conduct today's hearing.

Please be sure that you have completed the sign-in log. Copies of the Standards and comment cards can be found on the back table with the sign-in log. A comment card needs to be completed if you wish to provide testimony.

The proposed CON Review Standards for Litho Services and Units are being reviewed and modified to include, but not limited to the following:

1. Additional language to allow for acquisition of units or services.
2. Added language to allow for relocation of a unit or a service.
3. Developed separate definitions for "replace" and "upgrade."
4. Clarifying language to reflect that only MIDB data can be used for projections in initiation.
5. Additional language for initiation of a mobile litho service to require that 100 procedures must

be projected in each region in which the proposed mobile service is proposed to operate.

6. Elimination of the comprehensive kidney stone treatment center and all references as it is no longer necessary.

7. And additional technical changes.

The proposed CON Review Standards for Psychiatric Beds and Services are being reviewed and modified to include but not limited to:

1. Bed Need Methodology will be maintained and calculated every two years to determine the overall planning area need with an adjustment for low occupancy facilities.

2. The adult planning areas have been modified from the Community Mental Health borders to the health service area boundaries.

3. Modification of the minimum average annual occupancy rate within the project delivery requirements for adult beds from 85 to 60 percent. If a facility's average occupancy falls below 60 percent, the facility must decrease the number of beds, not to be less than 10 beds, to bring its annual average occupancy to 60 percent.

4. Modification of the minimum annual average occupancy rate with the project delivery

requirement for child/adolescent beds from 75 percent to 40 percent. If a facility's average occupancy falls below 40 percent, the facility must decrease its number of beds, not to be less than 10 beds, to bring its annual average occupancy to 40 percent.

5. There was the addition of a high occupancy provision that will allow expansion outside of the bed need.

6. The replacement zone was increased to 15 miles within the planning area.

7. The minimum number of beds in a psychiatric unit will be 10 beds.

8. The 1 bed for 20 rule will be changed to 1 bed for 10 rule if the bed need is 9 beds or less in a planning area.

9. To increase beds at a facility utilizing beds in the inventory, the facility shall have at least 70 percent average occupancy for the previous two years.

10. And additional technical changes and updates.

The proposed CON Review Standards for Cardiac Cath Services are being reviewed and modified to include but limited to:

1. Facilities providing Cardiac Cath Services in Michigan will be required to participate in the

American College of Cardiology National Cardiovascular Data Registry.

2. Elimination of physician volume requirements for adult diagnostic cardiac cath services.

3. Institutional volumes shall be minimum of 600 procedure equivalents in the category of pediatric cardiac caths to be performed annually.

4. Modifications in computing cardiac cath equivalents, procedures and weights.

5. Cardiac permanent pacemaker/ICD device implantations will be performed in diagnostic cardiac cath laboratories in hospitals that do not provide therapeutic cardiac cath services.

6. There was a revision to the definition of "replace" and "upgrade."

7. The requirement for facilities proposing to initiate a pediatric cardiac cath service must meet the guidelines of American Academy of Pediatrics for Pediatric Cardiovascular Centers, March of 2002.

8. The definition of "Intra-Vascular Catheterization" within Section 11, Methodology for Computing Equivalents, Procedures and Weights.

9. And additional technical changes.

The proposed Review Standards for Open Heart Services are

being reviewed and modified to include but not limited to the following:

1. Facilities providing open heart surgery services in Michigan will be required to participate in the Society of Thoracic Surgeons, STS, database and the program's statewide auditing.
2. The ICD-9 Code groups and weights have been updated.
3. Replaced the word "procedure" with the word "cases" for count purposes, as any given case could possibly involve multiple procedures.
4. Each physician credentialed by an applicant hospital to perform adult open heart surgery cases shall perform a minimum of 75 adult open heart surgery cases per year. This is a revision from 50.
5. Consulting hospitals will be required to perform a minimum of 400 cases per year for at least three consecutive years. This was an increase from 350.
6. Once MIDB has been committed to support a CON application for open heart surgery services, it shall not be recommitted. After seven years, only the incremental increase in the MIDB data could be committed to support a CON application for open heart surgery services. Additionally, if the

hospital committing data have experienced growth in their own program and wish to initiate an open heart service program, the hospital may use all of its MIDB data, including previously committed data, to support their own CON application and meet initiation volume requirements.

7. Clarification of the adult and pediatric open heart surgery definitions.

8. And additional technical changes.

In addition to the draft language, the Department and the CON Commission is soliciting public comment on:

9. The geographic implications of the proposed language.

10. The potential increase in programs as a result of the methodology.

11. The implications of Sections 6(1)(b) and 6(2)(b) in terms of the potential for double counting of data.

12. And finally the proposed methodology which proposes separate weights for both principal and non-principal diagnostic codes.

If you wish to speak today on proposed Litho, Psychiatric Beds, Cardiac Cath or Open Heart Surgery Standards, please turn in a comment card to me. Additionally, if you have written testimony, please provide a copy as well. Just as a

reminder, all cell phones and pagers need to be turned off or set to vibrate during this hearing.

As indicated on the Notice of Public Hearing, written testimony may be provided to the Department via our Web site at www.michigan.gov/con through Wednesday, November 7, 2007 at 5:00 p.m.

Today is Wednesday, October 31st, and we will begin the hearing by taking testimony on Litho, then Psychiatric Beds, then Cardiac Cath and finally Open Heart Surgery. And if I have anybody that's interested in providing testimony, I'd take your cards at this point.

Just by a show of hands, do I have anybody interested in providing testimony this morning? Then at this point I show it is 9 minutes after 9:00, and we will go ahead and recess. And unless somebody comes in before 10:30 to provide testimony, I will start the second hearing at 10:30.

MR. McCAFFERTY: Dennis McCafferty, Economic Alliance.

MS. MOORE: Okay. And you are going to provide testimony on?

MR. McCAFFERTY: On Open Heart Surgery and Cardiac Cath.

MS. MOORE: Okay.

MR. McCAFFERTY: My name is Dennis McCafferty.

I'm from the Economic Alliance of Michigan, a statewide business and labor coalition. A couple of issues we'd like to comment on: First of all, the proposed methodology change for Open Heart Surgery Standards. We strongly believe that there is not a need for additional open heart surgery programs in Michigan. Adding more programs, especially when utilization of open heart surgery is steadily declining, would be a bad outcome in producing lower quality and higher costs. We wish that the refined methodology would not allow additional programs; however, given the extensive time and effort with this Standard, our Health Group concluded -- that is, the Health Group of the Economic Alliance concluded -- that we would support this change in the methodology, this revision in the methodology.

The refinement to the methodology for projecting the need for additional programs proposed by the staff -- the Michigan Department of Community Health staff -- was developed pursuant to the strong request of the SAC and the Commission. Those refinements have made the process much simpler and have gone a long way to improve its predictability. The staff members involved with developing refinements in the methodology for projecting the need of new programs should be commended for their efforts and knowledge in producing this refinement.

In our detailed review of this we did identify a

few minor errors not yet in the final Impact sheet, and we believe these are minor corrections. The Impact will eventually have to be corrected to reflect these.

One of these is -- and it's pursuant to Section 6 of the Standards that have long provided that CON-approved or operational Open Heart Surgery programs cannot provide data for the potential of new programs; however, this section would require that the recognition of Mid-Michigan and Foote Hospital, their data is included in there, and it doesn't be. It makes really no -- it's a moot point for their regions, the numbers are so low anywhere -- anyways.

We also did a very thorough review of the data that was produced for HSA 1. And we believe that the numbers in this projection chart are understated by about 50. So we think that instead of being 555, it's probably approximately 605. But again, the impacts of those are relatively minor, and we did want to point them out.

The Economic Alliance has been following this process very closely, and we put together our own little summary of how this process of revising the methodology came about, the background behind it and the things that have happened through the process and how it has been resolved. We'll make available copies of this on the back counter.

As far as the other Standards that were reviewed, first of all, Cardiac Cath Standards. Our Economic Alliance

members supported the recommended changes to the CON Standards for Catheterization. Of particular note were the following: We particularly support the idea that requiring facilities providing cardiac cath in Michigan being required to participate in American College of Cardiology, the National Cardiovascular Data Registry and the CAT PCI Registry. I think that's a great idea. Requiring a facility proposing to initiate a pediatric cardiac service to meet certain guidelines of the American Academy of Pediatrics also a fine idea we support. And maintaining limitations to -- maintain the provision that CON for elective angioplasty should only be done with on-site open heart surgery; that only facilities that have on-site open heart surgery are able to do elective angioplasty. We strongly support that. Our members strongly support that.

Some general comments on the rest of the Open Heart Surgical Center Standards: The EAM, our members, support the recommended changes in the Standards for Open Heart, in particular these following ones: Facilities providing open heart surgery in Michigan will be required to participate in the Society of Thoracic Surgery database and the program's statewide auditing. We think that's a fine idea. Collecting data and providing feedback to the physicians is always a positive move. Maintaining a minimum of 300 per year, we strongly endorse that. Increasing the

minimum volume for attending physicians from 50 to 75, we strongly support that.

Consulting hospitals will be required to perform a minimum of 400 cases per year for at least three consecutive years, again we support that idea. Limiting hospitals' ability to commit their data to only the data that they previously committed; that they cannot recommit data thereby limiting the ability to recycle their data every seven years.

Refinements in the methodology projecting the need for new programs; however, at the September Commission meeting there was a point raised by the Attorney General's office that did require the validity of the proposed Standards to allow hospitals to use their own data previously committed for starting their own program. The Attorney General raised a question about that, and we believe that has to be yet further followed up by staff. We believe that the Attorney General's opinion will require striking of the Section 6(1)(b), lines 154 and 158 of the proposed Standards. This will allow for equal application of the regulations for every provider.

On both of these issues, Open Heart Surgery and Cardiac Cath, our members have expressed that they were going to be providing additional written comment within the time frame here. Mr. Wayne Cass is a business

representative of the International Union of Operating Engineers, Local 547, and Marsha Manning, Manager of Southeast Michigan Health Care Initiatives for General Motors Corporation, both of these folks have expressed interest in submitting -- they were unable to make it today, but submitting written comments in conjunction with these. That's all.

MS. MOORE: Thank you, Dennis. Do I have anybody else that's interested in providing testimony on any of the Standards this morning, Litho, Psych Beds, Cardiac Cath or Open Heart Services? With that, we will recess until 10:30 when we well take public testimony on the 2003 Review Standards. Thank you for your time today.

(Proceedings concluded at 9:20 a.m.)

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