PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, December 20, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Paul J. Cote, Jr., Commissioner, Department of Public Health, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr. Albert Sherman, Ms. Janet Slemenda, and Dr. Martin Williams. Ms.Phyllis Cudmore, Dr. Thomas Sterne, and Mr.Gaylord Thayer, Jr. absent. Also in attendance was Atty. Donna Levin, General Counsel.

Commissioner Cote, Chair, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Ms. Sally Fogerty, Associate Commissioner, Center for Community Health Services; Ms. Joan Gorga, Acting Director, Mr. Jere Page, Senior Analyst, Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF AUGUST 23, 2005, SEPTEMBER 27, 2005 AND OCTOBER 18, 2005:

Records of the Public Health Council meetings of August 23, 2005, September 27, 2005 and October 18, 2005 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Records of August 23, 2005, September 27, 2005, and October 18, 2005, as presented.

PERSONNEL ACTION:

In a letter dated December 12, 2005, Mr. Mitt Romney, Governor of Massachusetts, and Dr. Ellen Nelson, Associate Commissioner for Clinical Laboratory Services, Department of Public Health, recommended approval of the appointment of Patrick T. Noonan, Jr., M.D. to the Massachusetts Hospital School Board of Trustees. Dr. Noonan completed a remarkable career as a physician in the Naval Medical Corps. Retiring from the Navy in 2004, he is presently practicing medicine in the radiology department at the Lahey Clinic in Burlington, Massachusetts. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) that in accordance with recommendations of the Governor of Massachusetts and Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, under the authority of M.G.L.c.111,s.3A, the appointment of Patrick T. Noonan, Jr., M.D. to the Board of Trustees of the Massachusetts Hospital School, be approved.

STATE REPRESENTATIVE TURKINGTON ADDRESSED THE COUNCIL ON PROJECT APPLICATION NO. 5-3A83 OF MARTHA'S VINEYARD, INC.:

State Representative Eric Turkington of the District of Barnstable, Dukes and Nantucket Counties addressed the Council, accompanied by Legislative Liaison Russell Smith. Representative Turkington asked the Council to support the Project Application No. 5-3A83 of Martha's Vineyard

Hospital. He said in part, "As you know, the Island Hospital has had ups and downs in terms of its annual financing, but I think all along there has been a commitment from the State that there has to be a hospital on Martha's Vineyard, not just because of the Presidents'of the United States and everyone else who goes there in the summer, but because of 14,000 people whose lives literally depend on there being a hospital. The Commonwealth's commitment has been steady and we appreciate that very much, in good times and in bad. Good times are now back on the Vineyard, in terms of health care. The hospital is running in the black and the support in the community for a new facility is as unanimous as anything ever gets on Martha's Vineyard. The people are willing to put their own money, in great numbers, in great dollar signs into this proposal…The idea of a new hospital structure is no longer a controversy. It is a necessity. We very much appreciate your anticipated support of this measure, and thank you for your time this morning."

REGULATIONS:

REQUEST FOR FINAL PROMULATION OF AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS – 105 CMR 130.000, MATERNAL AND NEWBORN SERVICES:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, together with Ms. Sally Fogerty, Associate Commissioner, Center for Community Health, presented the maternal and newborn licensure regulations.

Dr. Dreyer noted in part, "We have been working on these regulations for almost two years, through a number of committees, to bring the regulations up to date. They were last amended in a major way in 1989, and a number of changes have occurred in the field that have warranted our taking a new look at the regulations and bringing them up to the current clinical practices and standards."

Dr. Dreyer addressed three major issues: the level of care structure that the regulations create, volume requirements for the levels of care, gestational age, and data collecting and reporting. Ms. Fogerty addressed family-centered care.

Dr. Dreyer explained, "The regulations currently recognize Level I, Level II and Level III maternity services. Level I maternity services are community hospitals. Level II services are special care nurseries that take care of moderately sick infants, and Level III nurseries are NICUs (Neonatal Intensive Care Units). The new regulations create two new levels. They break level two into levels II A and II B, and they maintain the current Level I and IB structure. One of the major controversial issues in these regulations concerns what can be done in a level II B, and the issue has revolved around short-term mechanical ventilation, which is a procedure that is typically performed in a NICU."

Dr. Dreyer further noted, "We had an extraordinarily vigorous debate in the committee and at the public hearing between advocates for performing short-term mechanical ventilation in Level II Bs and for those who thought the procedure should be restricted to NICUs. The argument in favor of the II Bs is it keeps the mother and child together. The argument is that often times, mildly sick infants, who need mechanical ventilation for 24 hours, can be kept successfully. The disease will resolve itself with medication and ventilation and the family will stay together. Counter argument is

that, in Level II Bs, this is a relatively rare occurrence. Mechanical ventilation is a technique that requires skilled therapists, neonatologists, nurses, and respiratory therapists, and that it is most safely performed in a Level III NICU, where they do many of them and there is lots of experience."

Dr. Dreyer continued, "This is a very difficult issue for us to address. There is not a great deal of literature that supports either position but in the end, what we came down on is the side of safety. If we are going to err on one side or the other, we felt we should choose safety, and that means maintaining mechanical ventilation as a NICU procedure. In Level II Bs we are allowing what is called CPAP, which is Continuous Positive Airway Pressure, which is a less invasive technique, but not mechanical ventilation…We will entertain short-term mechanical ventilation on a special project basis but we are not proposing that it be adopted in the regulation for certain hospitals that do high volumes that can come to us and demonstrate that they can do this procedure safely and effectively and that there are good reasons for them to do it."

With regard to volume requirements, Dr. Dreyer noted in part, "We want to maintain the current volume minimum for Level II A at 1500 births, and for II B at 2,000 births, but we are going to allow facilities that can demonstrate that they can provide the services with adequate staffing, and safely and effectively, the opportunity to make that demonstration if they can't make the volume requirements. For Level III, we put in a volume minimum and this is new but we have allowed facilities to show us if they take care of large numbers of very low birth weight infants, that they can substitute that experience for the volume minimum."

"We added a new provision for gestational age", noted Dr. Dreyer, "and this essentially affects the proposed level II A facilities. We have said that they cannot, as a routine matter, accept for delivery, mothers who have delivered less than thirty-four weeks. This affects mostly 32 and 33 week infants. This is a change. We had some concern from commenters that this might affect bottom line numbers of deliveries negatively. We looked at the data and found that it is actually very small numbers of Level IIs that deliver infants in these age ranges, it is less than one percent of deliveries…Seven percent have been in these age ranges. So, out of 80,000 births, it is less than a couple of hundred that might be affected by this change. We also found that infants at this age range, who happen to deliver in Level IIIs often receive CPAP or mechanical ventilation. So, if we allowed Level II As which by definition cannot provide either of these modalities, to deliver 32 or 33 weekers, they will be delivering infants who need this level of respiratory support, and it won't be available. They will have to be transferred. It seems sensible to maintain this gestational age." It was noted that CPAP is a mask on the face with nasal canula and is not invasive however, mechanical ventilation requires intubation.

"Finally", said Dr. Dreyer, "With respect to data collection and reporting, we are putting in a new requirement that NICUs use what is called the Vermont Oxford Network Very Low Risk Database system for reporting birth outcomes and we have agreed to develop a data collection system for other levels, but that is going to have to be worked out at our Perinatal Advisory Committee because we don't have a data system in place for those hospitals."

Ms. Sally Fogerty, Associate Commissioner, Center for Community Health Services, addressed the Council. Ms. Fogerty noted in part, "The regulations also address family-centered care. We focused on improving, assuring and maintaining quality of care. We really have focused on strengthening

the family through these regulations. There is a very clear recognition of a combination of labor, delivery and postpartum room, or some combination in which the infant remains with the mother for the majority of the time instead of the mother being moved from a labor room to a delivery room to a postpartum room."

Ms. Fogerty noted further that the regulations also encourage hospitals to develop comprehensive programs which will address issues such as depression and shaken baby. The major change is supporting breast feeding…We are requiring hospitals to develop a comprehensive policy around breast feeding support, to have lactation consultants available and to have nursing staff have increasing skills and expertise in that area…We are prohibiting the marketing of formula to mothers, and the provisions of coupons to mothers. If the mother, in discussing this with a physician or the nursing staff, decides that this is appropriate for her, she can still obtain formula and coupons but it is not to be given routinely…"

Council Member Sherman noted his concern about poor women having the access to the free formula and coupons. He said in part, "Infant formula is one of the largest shoplifted items in Massachusetts today…" Associate Commissioner Fogerty noted that if a woman can't afford formula it is always available and that WIC Information is part of the regulations. It was further noted that WIC provides lactation consultants. Council Member Sherman made a motion for approval of the regulations.

After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Request for Final Promulgation on Amendments to Hospital Licensure Regulations – 105 CMR 130.000, Maternal and Newborn Services**; that the final amendments be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,837**.

REQUEST FOR EMERGENCY PROMULGATION OF AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS – 105 CMR 130.000, REPORTING OF EMERGENCY CONTRACEPTION PROVIDED TO RAPE VICTIMS:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented emergency amendments to the hospital licensure regulations to the Council. These amendments implement certain provisions set forth in Chapter 91 of the Acts of 2005, An Act Providing Timely Access to Emergency Contraception, which took effect on December 14, 2005. Section 4 of Chapter 91 requires the following of facilities as defined in M.G.L.c.111, §70E:

- Facilities must require all persons who provide care to victims of sexual assault to be provided with medically and factually accurate written information prepared by the Commissioner of Public Health about emergency contraception.

- Facilities must promptly provide medically and factually accurate written information about emergency contraception prepared by the Commissioner of Public Health to every female rape victim of childbearing age who presents at a facility after a rape.

- Facilities that provide emergency care must promptly offer emergency contraception at the facility to each female rape victim of childbearing age, and must initiate emergency contraception upon her request.

- Facilities must report annually to the Department of Public Health the number of times that emergency contraception is provided to victims of rape.

Staff further noted:

"Section 4 additionally requires the Department to promulgate regulations to carry out this annual reporting requirement. The Department is proposing these emergency amendments to comply with this requirement. In the meantime, the Department has already issued a circular letter to hospitals to advise them of their obligations and to provide the necessary forms. The Department is interpreting 'facilities that provide emergency care' to be those hospitals licensed to provide emergency services, i.e., hospitals with emergency departments. Thus, every hospital with an emergency department, without exception, must offer emergency contraception to rape victims and must report the number of times it does so to the Department, as well as distribute the necessary information to staff and patients.

As noted in the proposed amendments, a hospital is already required to complete a Provider Sexual Crime Report ("PSCR") pursuant to M.G.L.c.112, §12A ½ each time it treats a victim of sexual assault and submit the PSCR to the Executive Office of Public Safety ("EOPS"). The Department worked with EOPS staff, who revised the PCSR to add a new question 36 under section F, to capture information about emergency contraception. EOPS will transmit the information about emergency contraception on an annual basis to the Department; thus, completion of the PSCR, including question 36, will satisfy the above-noted reporting requirement in a manner that does not require any additional record-keeping by the hospital."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Request for Emergency Promulgation of Amendments to Hospital Licensure Regulations – 105 CMR 130.000, Reporting of Emergency Contraception Provided to Rape Victims**; that the emergency amendments be forwarded to the Secretary of the Commonwealth; and that a copy of the amendments be attached and made a part of this record as **Exhibit No. 14,838.** The Department intends to file the amendments with the Secretary of the Commonwealth immediately so that they can go into effect today. The Department will hold a public hearing on these amendments on January 23, 2006. After the hearing, staff will return to the Council with public comments and any needed revisions and seek final approval of the amendments.

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 248 CMR 1.00-10:00: THE STATE PLUMBING CODE AND FUEL GAS CODE REGULATIONS:

Attorney Robert Horacek, Counsel for the Board of Plumbers and Gas Fitters, presented the request for final promulgation of amendments to 248 CMR 1.00-10.00: The State Plumbing Code and Fuel Gas Code Regulations to the Council. Atty. Horacek and Mr. Howard Wensley's memorandum to the Council noted the following:

"The intent of the regulations is to prevent the possibility of carbon monoxide poisoning in residential buildings that will have an installation of gas combustion equipment that exhausts through a vent on the exterior of the building that could be blocked by snow or otherwise obstructed. The emergency regulations had required the installation of a carbon monoxide detector within the living area as well as on the same level as the combustion equipment in circumstances where the exhaust vent is less than seven (7) feet above the outside grade. The Department offered comment that the regulations should explicitly apply to such exhaust vents that are less than seven feet above a deck or porch and not just ground level to address circumstances where snow or other obstructions on decks or porches can block the exhaust vent.

These regulations were developed in conjunction with the State Fire Marshal following the death of a child last winter as a result of the blockage of the carbon monoxide exhaust by snow accumulation. The regulations will meet an important need until the State Fire Marshall promulgates regulations in March implementing the recently signed "Nicole's Law", which requires the installation of carbon monoxide detectors in all residences. Other provisions of the regulations include:

- Requiring an identification plate to be permanently mounted on the exterior of the building at a minimum height of eight (8) feet above grade directly in line with the exhaust vent terminal. This plate shall state, "GAS VENT DIRECTLY BELOW, KEEP CLEAR OF ALL OBSTRUCTIONS".

- Requiring the manufacturer of a side wall horizontally vented gas fueled equipment to provide detailed instructions for the installation of the venting system or venting system components.

After consideration, upon motion made and duly seconded, it was voted unanimously [Council Member Sherman not present at the time of the vote and therefore he did not vote] to approve the **Request for Approval of Final Amendments to 248 CMR 1.00-10:00: The State Plumbing Code and Fuel Gas Code Regulations;** that the final amendments be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,839.**

DETERMINATION OF NEED PROGRAM:

CATEGORY 1 APPLICATION: PROJECT APPLICATION NO. 5-3A83 OF MARTHA'S VINEYARD HOSPITAL, INC. FOR NEW CONSTRUCTION AND RENOVATION OF EXISTING FACILITY TO REPLACE AND EXPAND INPATIENT, OUTPATIENT AND SUPPORT SERVICES AND INCREASE ADULT MEDICAL/SURGICAL BED CAPACITY FROM 11 TO 18 BEDS:

Note: see page one for State Representative Eric Turkington's remarks to the Council on this application.

Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program, presented the Martha's Vineyard Hospital application to the Council. He stated, "…Martha's Vineyard Hospital,

the Applicant, seeks the Council's approval today for substantial capital expenditure to expand and update the hospital's facilities located at One Hospital Road in Oak Bluffs. Martha's Vineyard is a geographically isolated, sole hospital service provider, serving a population of 15,000 year round residents, plus an additional 90,000 summer residents and visitors. The proposed project scope encompasses 91,478 gsf of new construction, and 12,123 gsf of renovation to two existing buildings. A planned two-story wing would accommodate all inpatient rooms, surgery, imaging, outpatient services, and the emergency department. The hospital also seeks to increase its licensed bed capacity from 19 to 25 acute care beds. That's the net of a seven bed increase in medical/surgical beds, from 11 to 18, and a one bed decrease in obstetric beds, from 4 to 3. The proposed and recommended maximum capital expenditure of the project is 44,248,575 July 2004 dollars."

Mr. Plovnick cited population statistics showing that population growth and aging of the population are major factors in the hospital's need to expand its inpatient services. Duke's County, which comprises the hospital's primary service area, has a projected population growth of 26% for the period of 2000 to 2010. By contrast, for the same decade, Massachusetts' rate is 6% and the USA is expected to be 9%.

Mr. Plovnick noted further the following:

- Currently, patients are held in ER while they wait for a bed;
- The allocation of space for new construction is reasonable when compared to previously approved DoN projects;
- The proposed incremental operating costs of 2.8 million dollars are reasonable;
- The project is financially feasible and within the Applicant's financial capacity.
- The project will be financed with an equity contribution of 66% and with a 15 million dollar mortgage from a local bank;
- The hospital's recently audited financial statements, and key financial ratios demonstrate that the hospital's financial position is sound;
- The Applicant has committed to provide 2 million dollars in community initatives, over five years, to support local community health initiatives in the areas of behavioral health, preventive care, and primary care.

In closing, Mr. Plovnick said, "The recommendation of staff is approval with five conditions…" The Applicant was present but was not requested to address the Council. Council Member Mr. George, Jr. moved for approval.

After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 5-3A83 of Martha's Vineyard Hospital, Inc.,** based on staff findings, with a maximum capital expenditure of $44,248,575 (July 2004 dollars), and first year (in FY2009) incremental operating costs of $2,817,236 dollars. A staff summary is attached and made a part of this record as **Exhibit No. 14,840**. As approved, this application provides for substantial capital expenditure: a new 91,478 gsf addition that will accommodate all inpatient rooms, surgery, imaging, outpatient services, and the emergency department as well as 12,123 gsf of renovations to two existing buildings. The project, as approved, also

provides for an increase of seven adult medical/surgical beds to the Hospital's licensed bed capacity. This Determination is subject to the following conditions:

1. Martha's Vineyard shall accept the maximum capital expenditure of $44,248,575 (July 2004 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. The total gross square feet (gsf) for this project shall be 91,478 gsf of new construction and 12,123 gsf of renovations to existing space.

3. Martha's Vineyard Hospital shall contribute 66% in equity ($29,248,575 in July 2004 dollars) toward the final approved MCE.

4. With regards to its Medical Interpreter Service, Martha's Vineyard shall provide the following:

   - Capacity to provide interpreter services beyond telephonic interpretation.
   - Capacity to track all interpreting sessions, inclusive of those performed by employee interpreters.
   - Formal training of all bilingual employees who may be in a position to function as interpreters.
   - Signage posted at all critical entry points as required by 105 CMR 130.1104.
   - A Plan for outreach to the agencies and natural support groups of Limited English Proficient ("LEP") communities to ensure dissemination to their members of current information about Martha's Vineyard Hospital programs and the availability of interpreter services.
   - Provision to the Department's Office of Multicultural Health ("OMH") of a copy of the annual language needs assessment, as required by 105 CMR 130.1103 (A).

   Martha's Vineyard shall submit a written improvement plan addressing the above items to OMH no later than 120 days following DoN approval. In addition, the Hospital shall submit annual progress reports to OMH on the anniversary date of the DoN approval and shall notify OMH of any significant changes to its interpreter services program.

5. Martha's Vineyard Hospital shall provide $400,000 per year, or a total of $2,000,000 (July 2004 dollars) over a five-year period, to fund community health service initiatives in its service area in the following manner:

   - $400,000 over five years to fund initiatives in mental health and substance abuse services.
   - $575,000 over five years to fund an island-wide health promotion and disease prevention program.
   - $925,000 over five years to fund primary care physician recruitment and retention efforts.

- $100,000 over five years to fund innovative approaches for existing or new health priorities

Funding support shall begin within 30 days following DoN approval. In its allocation and expenditure of these funds, the Applicant shall adhere to the processes described in its revised Factor 9 submission dated December 2, 2005 and referenced in the DoN staff summary. Martha's Vineyard shall submit an annual report to the Office for Healthy Communities describing the programs established and supported through this funding, the level of funding support for each, and a measure of program impact, as indicated by process or outcome measures.

Staff's recommendation was based on the following findings:

1. Martha's Vineyard Hospital, Inc. has proposed construction of a new, 2-story addition to its existing facility that will incorporate all inpatient rooms, surgery, imaging, outpatient services, and the emergency department and renovations to existing facilities for administrative and support departments. The Hospital has proposed the addition of seven adult medical/surgical beds.

2. The health planning process for the project is satisfactory.

3. The proposed increase of seven adult medical/surgical beds (net increase of six beds) is well substantiated and consistent with DoN Regulations.

4. The proposed new construction and renovation is supported by current and projected acute care utilization, as discussed under the Health Care Requirements factor of the Staff Summary.

5. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

6. The project, with adherence to a certain condition, meets the standard compliance factor of the DoN Regulations.

7. The recommended maximum capital expenditure of $44,248,575 (July 2004 dollars) is reasonable compared to similar, previously approved projects.

8. The recommended operating costs of $2,817,236 (July 2004 dollars) are reasonable compared to similar, previously approved projects.

9. The project is financially feasible and within the financial capability of the Applicant.

10. The project meets the relative merit requirements of the DoN Regulations.

11. The proposed community health service initiatives, with adherence to a certain condition, are consistent with the DoN Regulations.

ALTERNATIVE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATIONS:

PROJECT APPLICATION NO. 4-3B06 of KINDRED HEALTHCARE, INC. – Request for transfer of ownership and original licensure of Braintree Hospital, LLC, d/b/a Northeast Specialty Hospital and its satellite locations, Northeast Specialty Hospital, Natick, Northeast Specialty Hospital, Stoughton, and Northeast Specialty Hospital – Sterling Medical Center, Waltham, resulting from the acquisition of the Hospital and satellites by Kindred Healthcare, Inc. through its wholly owned subsidiary Kindred Braintree Hospital, LLC.:

PROJECT APPLICATION NO. 1-3B07 OF KINDRED HEALTHCARE, INC. – Request for transfer of ownership and original licensure of Park View Specialty Hospital of Central Massachusetts- Leicester, resulting from the acquisition of the Hospital and satellite by Kindred Healthcare, Inc. through its wholly owned subsidiary Springfield Park View Hospital, LLC.:

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented application No. 4-3B06 to the Council. Ms. Gorga noted that Kindred currently owns and operates two hospital facilities and thirty skilled nursing facilities in Massachusetts. Ms. Gorga said, "Based on the review of the Kindred application, Staff has determined that the Applicant satisfies the following five standards set forth under the DoN regulations regarding hospital change of ownership:

1. Individuals residing in the hospital service area will comprise the majority of the individuals responsible for decisions concerning borrowings, changes in services, and capital and operating budgets.

2. The Applicant and staff consulted with MassHealth concerning the access of medical services to Medicaid recipients at the hospital and the satellites. Comments from MassHealth officials indicate that it anticipates that the proposed transaction would have no effect on access to services for Medicaid recipients at the hospital and at the satellites primary service areas.

3. The Department's Division of Health Care Quality found that the Applicant and any healthcare affiliates have not engaged in a pattern of practice in violation of the provisions of Massachusetts General Laws relative to discrimination against Medicare recipients in discharge planning.

4. The Department has determined that the Applicant is not subject to a condition of approval to maintain or increase its level of free care as defined in M.G.L.c.118G because it is not an acute care hospital.

5. The Applicant is an affiliate of Kindred Hospital, Boston and Kindred Hospital, North Shore, which are both licensed by the Department of Public Health."

Ms. Gorga said in regard to standard #2 above, "Medicaid did have a concern about the continued availability of neuro-behavioral services currently available at Braintree Hospital and, based on MassHealth's recommendation, Staff attached a condition regarding the continuity of these services."

Ms. Gorga noted, "That a public hearing was held on November 29, 2005 in Braintree. All commenters at the public hearing were in support of the hospital and the satellite's proposed acquisition by Kindred. The comments of Lester Schindel, President of New England Sinai, presented at the hearing, and the written comments of the Rehabilitation Hospital's Interested Party urged the Department to attach conditions to the approval relating to the Applicant's level of participation in the Medicaid Program. The recommended conditions would require Kindred to maintain a Medicaid utilization rate that is no less than the average Medicaid days provided by Braintree from 2002 to 2004, require Kindred to report its actual Medicaid utilization to the Department on a biannual basis, and require Kindred to specify a commitment to provide a certain level of free care at the hospital."

Ms. Gorga stated further, "In addressing the concerns about Medicaid access expressed by the Interested Party, staff notes that Kindred, as a condition of approval, has agreed to make its best efforts to maintain current medical programs, payer access, and provider contracts at Braintree and the satellites without discrimination based on Medicaid status, and will prepare and expedite applications and contracts to appropriate payers, including Medicaid. Staff further notes that comments from MassHealth anticipate no access problems for Medicaid recipients. A condition requiring Kindred to maintain a specific utilization rate would be inappropriate as neither the approval of the Medicaid contract, nor the maintenance of a specific utilization rate, would be within the control of Kindred."

Ms. Gorga continued, "Requiring Kindred to report Medicaid utilization is unnecessary because payor mix data are regularly reported to the Division of Healthcare Finance and Policy, and are available to Medicaid through the Medicaid Management Information System. Regarding a condition which would require Kindred to provide a certain level of free care at Braintree, Staff notes that Kindred is not subject to a condition of approval to maintain or increase its level of free care because it is not an acute care hospital…Kindred is prohibited from discriminating in its admissions, based on an individual source of payment, and that such discrimination violates both State and Federal law and regulations. Therefore, staff continues to recommend approval of this application with the conditions attached on pages 5 and 6 of the staff summary."

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented **Project Application No. 1-3B07 of Kindred Healthcare, Inc**. to the Council. Mr. Page stated that this application mirrors the one above presented by Ms. Gorga, and that Kindred satisfies, the five standards noted above for the previous application, however, for this particular application MassHealth had no concerns for there is no specialty unit involved here.

MassHealth indicated that this transfer would have no effect on access to services for Medicaid recipients. A public hearing was held on December 1, 2005 in Springfield.

Mr. Page said, "All commenters at the hearing were in support of the hospital and satellites proposed acquisition by Kindred. Both the Baystate Visiting Nurse Association and Baystate Health,Inc., the parent of Baystate Medical Center, noted the current level of services to Medicaid recipients at the hospital was significant and expressed concern about the continuing access to that facility for indigent patients in the area, once the transfer to Kindred had occurred and, as a result, they had recommended the same three conditions that Joan just described for the Braintree area. In order to address the concerns of the Interested party, Kindred, as a condition of approval, has agreed to make its best efforts to maintain current clinical programs, payor access and provider contracts at Park View and its satellite without discrimination based on Medicaid status, and will prepare and expedite applications and contracts to appropriate payers, including Medicaid and the Department of Mental Health… We continue to recommend approval of this application with the two conditions on pages 5 and 6 of the staff summary."

Mr. Paul J. Diaz, President/CEO of Kindred Healthcare testified before the Council. He said in part, "…I want to assure the Council of our intent to stand behind the conditions and our commitment. We know it is an item of concern with respect to the Medicaid population and access, not only to continue that access to these applicant hospitals, I hope to extend that in our other hospitals locally, as well." Mr. Diaz spoke about the company, its values and how they look at the business. "We view ourselves as an organization of people, and we have a simple philosophy in terms of how we look at healthcare. We view that our nurses, our therapists, our physicians, our people, are really the principal drivers of quality and that quality and service are the principal drivers of our business." Mr. Diaz further noted that they updated their facilities across the country with modern equipment and that their electronic medical records were available for their patients who had to be relocated to other states due to Hurricane Katrina. With regard to their employees, he said, "The employees are the key for patient satisfaction and what the employees of the Commonwealth facilities will see is greater benefits, and great flexibility in terms of their benefit choices. They also shared a Medicaid settlement with their employees to thank them for their contributions to the Company."

In closing, Mr. Diaz said, "I give you those examples of the actions that we have taken to stand behind our words and our commitments, and again want to assure you that, with respect to the access of the Medicaid population, there are many states where we serve actually greater percentages of Medicaid patients in our hospitals. It varies from state to state, based on practice patterns, and different things, but in Illinois it is forty percent, and in Kentucky it is 29%; in Georgia 18%; Arizona 16%, and we are very committed to make sure that access is maintained here for the patients in the Commonwealth of Massachusetts."

Lester Schindel, CEO/President of New England Sinai Hospital, Stoughton, an Interested Party, testified before the Council, stating that they support Staff's recommendation but believe the conditions should be strengthened. He stated in part, "Kindred's history across the nation has not supported a high use of Medicaid patients in these long term care hospitals

because they differentiate upon admission who would be eventually eligible for Medicaid…We would like to suggest that in an initial report back, within nine months of license transfer, show that they are in compliance. In addition, in their recent press releases, they have indicated the desire to redeploy 95 beds that are currently not being used in the Northeast Specialty Licenses. Upon redeployment of those beds, they must ask the Council for a Site Application Transfer, Site Relocation Application Transfer. We would like another condition, being that they have to demonstrate compliance with these conditions upon use of those redeployed beds."

Attorney Edward Kalman of Behar and Kalman addressed the Council. He said in part, "What we would suggest is they come within nine months, that you just require them to report on proforma Medicaid cost reports, our RSC-41 Cost Reports, on a six month basis thereafter, how they are doing, and then, since they have issued a press release saying that they intend, or desire, to move 95 of these beds, which is a big piece of these beds, to different locations, these are currently assets which are available and used by the Medicaid population. I will say the medically indigent population and percentages, you move beds, you move them to where they are going to do the best for you because of the utilization and payor status. We think it is imperative that you require that it is a condition of any move that they demonstrate to the DoN staff that they have, I want to say it correctly, that they have extended reasonable efforts to maintain Medicaid efforts. It is reasonable, and we are not requiring, or asking to require any fixed percentage."

Council Member Maureen Pompeo, added, "To paraphrase you, that sounds a bit ambiguous as well. I would be more concerned with what the Division of Medical Assistance says about this issue than any particular individual hospital. I don't know how many other non-acute hospitals there are in the system, but it seems unfair to just focus on this group if, indeed, there is Medicaid access. So, if there is a report, I would say that it should be a statewide report."

Lester Shindel, CEO/President of New England Sinai Hospital replied, "We do not believe there is currently a Medicaid access issue. Our concern is, upon transfer, if the levels of Medicaid usage is not maintained in the system, there will be a Medicaid access issue because we cannot accept every Medicaid patient in Southeast Massachusetts."

Dr. Dreyer, Associate Commissioner, Center for Quality Assurance and Control, noted that any request for a transfer for any of these beds would automatically come back to the Council for a whole discussion, and any appropriate conditions could be imposed at that time."

Attorney Daria Niewenhous of Mintz, Levin, Cohen, Ferris, Glousky and Popeo, representing Kindred HealthCare, testified. She said, "…I totally agree with Ms. Pompeo's analysis. To impose a condition where we have to come back and have some sort of a percentage stated doesn't account for changes in the marketplace in the hospital industry generally. To single out Kindred based on what, frankly, is a rather distorted analysis of its practices in other states, without taking into consideration circumstances in those other states, I don't believe is helpful to this Council. Nor do I believe that a condition that really is a condition on some future Determination of Need, that Kindred may or may not file with

respect to transfer of site of these beds, is what is before the Council here, and that is, in effect, what Mr. Kalman's condition would be."

Attorney Niewenhous continued, "As Ms. Pompeo mentioned, Kindred would more than welcome a Medicaid contract at Kindred Hospital, Boston and Kindred Hospital North Shore and would be happy to apply for those contracts. We have heard from DoN staff that they do not believe that a percentage report is necessary or appropriate. Frankly, I don't know that it is their role to monitor that. We have heard from the Department, Division of Medical Assistance, they don't believe there is an access problem here."

Atty. Niewenhous noted that Kindred presently has 34 long term care facilities and two hospitals in Massachusetts and have for many years, "We ask that you judge us on our record here in Massachusetts on our stated intent that you let the laws and regulations that are in place, which would include any future DoN, a review of our practices, and include a law against discrimation against Medicaid participants, and I could assure you that the Division of Medical Assistance would be on us in a nanosecond, would we try to do that, and it is not just with respect to admission but how you treat Medicaid patients post admission as well."

Dr. Dreyer responded, "With respect to any future transfer of beds, those certainly would come back to the Council in a separate action. I would agree with the last comment, that it doesn't make sense to address that now. That will be addressed in whatever future action might happen. I think we have also made the point that we agree that it doesn't make sense to look at a fixed percentage of Medicaid utilization because that is not in the control of the Applicant and things can change and it is very hard to understand what those numbers might mean. With respect to coming back and reporting to the Council about best efforts, my own view is this is a condition that is often imposed in acute care transactions, it hasn't been imposed on these kinds of transactions. If the Council thought that would be reasonable, I don't think staff would object to that. It would be a matter of the kind of showing we have when acute care providers come back and report on progress they have made with respect to complying with conditions."

Council Member Manthala George made a motion to approve staff recommendation of Project Application No. 4-3B06, with an added condition that the Applicant report back to the Council in nine (9) months.

After consideration, upon motion made and duly seconded, it was voted: (Chair Cote, Mr. George, Ms. Slemenda and Dr. Williams in favor; Ms. Pompeo opposed; Mr. Sherman abstaining (MGL.268A) to approve the application of **Project Application No. 4-3B06 of Kindred Healthcare, Inc. (Kindred Braintree Hospital, LLC)** and that a copy of the staff summary be attached and made a part of this record as **Exhibit No. 14,841.** This approval provides for the transfer of ownership and original licensure of Braintree Hospital, LLC, d/b/a Northeast Specialty Hospital and its satellite locations, Northeast Specialty Hospital, Natick, Northeast Specialty Hospital, Stoughton, and Northeast Specialty Hospital, Sterling Medical Center, Waltham, resulting from the acquisition of the Hospital and satellites by Kindred Healthcare, Inc. through its wholly owned subsidiary Kindred Braintree Hospital,

LLC. This Determination is subject to the following conditions:

1. The Applicant shall, through its best efforts, endeavor to maintain current clinical programs, payer acess, and providers contracts at Braintree Hospital d/b/a Northeast Specialty Hospital and its three satellite locations, Northeast Specialty Hospital-Natick, Northeast Specialty Hospital-Stoughton and Northeast Specialty Hospital-Sterling Medical Center-Waltham without discrimination based on Medicaid status, and will prepare and expedite applications and contracts to appropriate payers, including Medicaid.

2. With regards to its interpreter service, the Applicant shall:

   - Develop a reliable and valid system for the collection of self-reported race and ethnicity information from patients.

   - Translate patient education documents and signage into the most commonly spoken languages in the service area as needed.

   - Submit an Annual Language Needs Assessment utilizing internal and external data and involve community-based organizations in the Annual Needs Assessment.

   A plan to address these interpreter service elements shall be submitted to the Office of Multicultural Health ("OMH") within 120 days of the DoN approval, and the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in HealthCare. In addition, the Applicant will provide annual progress reports to OMH on the anniversary date of the DoN approval.

   Staff's recommendation was based upon review of the application as submitted, and clarification of issues by the Applicant, staff found that the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. and 100.602, A and B.

   After consideration, upon motion made and duly seconded, it was voted: (Chair Cote, Mr. George, Ms. Slemenda and Dr. Williams in favor; Ms. Pompeo opposed; Mr. Sherman abstaining (MGL.268A) to approve the application of **Project Application No. 1-3B07 of Kindred Healthcare, Inc. (Springfield Parkview Hospital, LLC)** and that a copy of the staff summary be attached and made a part of this record as **Exhibit No. 14,842.** This approval provides for the transfer of ownership and original licensure of Park View Specialty Hospital, LLC in Springfield and its satellite location, Park View Specialty Hospital of Central Massachusetts in Leicester, resulting from the acquisition of the Hospital and Satellite by Springfield Park View Hospital, LLC. This Determination is subject to the following conditions:

1. The Applicant shall, through its best efforts, endeavor to maintain current clinical programs, payer access, and provider contracts at Park View Specialty Hospital and Park View Specialty Hospital of Central Massachusetts without discrimination based on Medicaid status, and will prepare and expedite applications and contracts to appropriate payers, including Medicaid and the Department of Mental Health.

2. With regards to its interpreter service, the Applicant shall:

    - Develop a reliable and valid system for the collection of self-reported race and ethnicity information from patients.

    - Develop a formal plan and provide the necessary systemic support to conduct outreach to non-English speaking communities through out HSA I.

    - Translate patient education documents and signage into the most commonly spoken languages in the service area as needed.

    - Submit an Annual Language Needs Assessment utilizing internal and external data, and involve community-based organizations in the Annual Needs Assessment.

A plan to address these interpreter service elements shall be submitted to the Office of Multicultural Health (OMH) within 120 days of the DoN approval, and the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. In addition, the Applicant will provide annual progress reports to OMH on the anniversary date of the DoN approval.

Staff's recommendation was based upon review of the application as submitted, and clarification of issues by the Applicant, staff found that the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. and 100.602, A and B.

Note: Council Member Maureen Pompeo noted for the record, that she did not vote against the Kindred Applications but against the extra condition that the Applicant return in 9 months to the Council. Ms. Pompeo stated that she thought that it was unfair to place the condition on these applications when to her knowledge it had not been required of other specialty hospitals.

The meeting adjourned at 11:15 a.m.

_____
Paul J. Cote, Jr., Chair

LMH/lmh
PHC 12/20/2005