Bob MacKenzie
Oral Testimony

Comments submitted to the
Certificate of Need Commission
January 9, 2007

St. Mary's of Michigan offers the following comments regarding the current Air Ambulance standards. These comments are submitted to urge the Commission to improve the access, quality and reasonable cost of air ambulance availability for the residents of the State of Michigan.

Expansion of existing services

Current standards permit new services to enter a service area much easier than allowing an established service to expand. Volume requirements for new services present a threshold that is much easier than those for an existing program. Based on the current volume methodology in the standards, expansion of services is much more prohibitive than new programs. This type of barrier limits economies of scale that expanding programs can offer. By creating this type of limitation, high quality established programs cannot make adjustments to the demand for their services that are responsive to the population needs.

Consideration should be given to single aircraft programs to include flights refused due to the aircraft already on a mission, and flights refused due to mechanical downtime as part of the ongoing demand for the service. With a single aircraft program, there is no back up support to manage multiple calls. The refused flights would not occur if that back up were to exist. By only recognizing refused flights as part of the projection for additional aircraft, the standard, as now defined, is blind to actual demand that the program would be servicing if there were multiple aircraft available.

Geographic service area consideration for current programs should be added to the standards. Currently, multiple programs can be developed in the same geographic region. For programs such as air ambulance, this creates challenges to maintain qualified flight crews and maintain a seasoned, expert staff. When a program has been established to service a defined, geographic area, additional program requests should not be considered without taking the existing service ability to offer coverage into consideration.

Coverage Area

Definitions within the standard for service area are currently vague and difficult to demonstrate in clear terms. Clarification on current primary and secondary service area definitions should be made with regards to scene and transfer definitions. The current definitions create great overlap in service areas as they are currently defined.

Steven Szelag
Oral Testimony

University of Michigan
Health System

University of Michigan Hospitals and Health Centers
1500 East Medical Center Drive
Ann Arbor, MI 48109

Public Testimony
Certificate of Need (CON) Review Standards for Air Ambulance Services
January 9, 2007

My name is Steven Szelag and I am a Senior Health System Planner at the University of Michigan Health System. The Health System is here today to offer initial comments on the Certificate of Need review standards for Air Ambulance Services. The comments that we are offering today pertain to the quantitative requirements for expanding and replacing an Air Ambulance Service.

Section 4 outlines the requirements to expand a program. Item 4(b) contains the requirements for expanding a program, requiring that 1,400 flights be completed in months 7 through 18 after beginning operation of a third aircraft. This number is arrived at by using the calculations enumerated in section 9. In short, air ambulance service data from the previous year is used to project 1,400 flights following expansion to three aircraft.

Section 5 outlines the requirements to replace a helicopter(s) (or renew a lease) in an existing program. Item 5(b) references section 4(b) to determine how many flights are necessary to replace 2 helicopters, stating that the same number of flights needed to expand a program (1,400) must have been completed in the previous 12 months. It should be noted that in order to replace 2 helicopters, the program must have flown enough patients to meet the expansion requirements for three helicopters. It should also be noted that a program operating a single helicopter only requires 275 flights to replace one helicopter, but 1,400 to replace two helicopters.

Another problem exists in the verbiage of section 5. It states that "either" of four listed criteria "as applicable" must be met. What does the word "either" mean? Does it mean only one of the criteria?

The University of Michigan recommends that a Workgroup or Standards Advisory Committee evaluate and analyze the numeric logic of replacing and expanding an Air Ambulance service. Thank you for according us this opportunity to address these concerns. We stand ready to work with you and with the Department on these issues.

Steven Szelag - 2

University of Michigan
Health System

University of Michigan Hospitals and Health Centers
1500 East Medical Center Drive
Ann Arbor, MI 48109

Public Testimony
Certificate of Need (CON) Review Standards for CT Services
January 9, 2007

My name is Steven Szelag and I am a Senior Health System Planner at the University of Michigan Health System. The Health System is here today to offer initial comments on the Certificate of Need review standards for CT Services. The comments that we are offering today pertain to the requirements for initiating and expanding a Mini CT Scanner service.

It is clear that the continued evolution of diagnostic imaging and its application to clinical practice offers clinicians the enhanced ability to detect and diagnose diseases. Applications of these imagining tools are broad but require regulation in order to maintain the integrity of health care provision within the State of Michigan.

It is important, therefore, to develop a separate set of Standards tailored to the specific characteristics of these new and emerging technologies, such as the Mini CT. There is an urgent and immediate need for the review and implementation of a set of Standards for the Mini CT Scanner. The relative low cost and current availability of the unit may cause a "rush" of purchases, flooding the State with Mini CT Scanners and compromising health care provision. Appropriate Standards will successfully protect and promote the efficient and economical delivery of health care services.

The University of Michigan recommends that a Workgroup or Standards Advisory Committee analyze and evaluate the quantitative and other potential requirements for initiating or expanding a Mini CT Scanner service. Thank you for according us this opportunity to address these concerns. We stand ready to work with you and with the Department on these issues.

Mary Turner

AARP Michigan

The power to make it better.™

January 9, 2007

Michigan Certificate of Need Commission
Michigan Department of Community Health

RE: AARP MICHIGAN TESTIMONY FOR THE APPOINTMENT OF A STANDARDS ADVISORY COMMITTEE ("SAC") TO REVIEW AND DEVELOP NEW LONG TERM CARE CERTIFICATE OF NEED POLICY

AARP's 1.5 million members living and working in the state of Michigan are deeply concerned about the issues and direction of long term care. Many of them currently utilize its services in every community, in facilities and in their own homes, and many others have elders, spouses and other family members of their own who seek choices or struggle with the choices they have already made – or were forced to by systems which for most currently offer little alternative. One estimate of the economic impact of informal caregiving alone in this state tops the figure of **$9 billion annually**. Our members demand change, more choices as well as better quality and the Michigan Department of Community Health's Certificate of Need Commission wields important authorities to bring about the types of reform our consumer members desire.

AARP Michigan therefore calls on the Michigan Certificate of Need Commission to appoint in 2007 a Standards Advisory Committee charged with responsibilities to include but are not limited to revisions of nursing home and hospital long term care units beds, definitions and methodologies.

Michigan's long term care landscape has entered a historic time of rapid and profound change, driven by unprecedented, major demographic and market forces and spurred by the 2005 Governor's Medicaid Long Term Care Task Force Final Report, which names those forces: calling for important, fundamental changes and improvement in the way the business of delivering long term care services is conceived and conducted in this state. Our current CoN definitions, methodologies and standards related to long term care in total are found badly outmoded by these trends and we thus have an opportunity with this process to bring the CoN system into alignment with those trends.

The most important change occurring in long term care is the shift away from nursing homes and "beds" themselves as a workable concept defining what might be the center of long term care delivery; the shift already well underway across the United States and in Michigan is toward no such center at all but to an "array" of facility and community based long term care "supports and services" in which nursing home beds are just one delivery mode and choice.

»

Indeed, the Choice overwhelmingly preferred by consumers across the entire market of elderly and persons with disabilities is home and community based services -- not nursing homes, though many still would like to make that choice too -- and we therefore need a new paradigm for establishing and projecting Need itself, one not hidebound to one "choice," the least popular and least cost efficient one at that -- as is currently the case, illustrated by the category of testimony outwardly limited here to "Nursing Home and HLTCU Beds."

So AARP Michigan calls on the Commission to appoint a SAC charged with:

-- developing recommendations for changing definitions, methodologies and standards from "Nursing Home and HLTCU Beds" to those which describe and encompass ALL long term care supports and services, from institutional to 'assisted living' to in-home supports and services, for all populations using and seeking such services from the entire array of delivery options.

-- develop policy recommendations to reform existing nursing home bed standards to award future Certificate changes only to those owners with successful, operation-wide track records of regulatory and quality success.

-- other CoN issues may need to be raised in light of the 2005 Governor's Medicaid Long Term Care Task Force Report which call for additional policy development by the SAC.

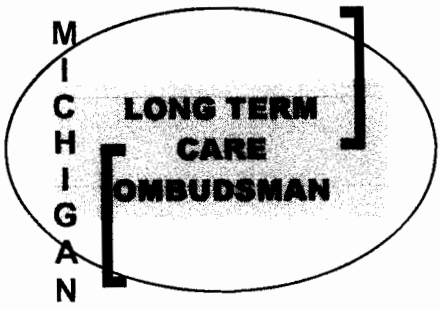
-- the Commission must make every effort to assure the 2007 SAC it appoints for these purposes is broadly and heavily comprised of consumer representation reflecting the geographic, generational and cultural diversity the emerging long term care market already serves and anticipates in the coming years.

We are very grateful for this opportunity to provide Testimony to the Department of Community Health and its Certificate of Need Commission and look forward to partnering with the success of its work in 2007 and beyond.

Sincerely,

Andrew Farmer
Associate State Director
Health & Supportive Services
AARP Michigan

(517)267-8921
afarmer@aarp.org



Testimony of Bradley Geller, Assistant Michigan State Long Term Care Ombudsman
Michigan Department of Community Health CON Commission
January 9, 2006

The Michigan State Long Term Care Ombudsman Program is a federally and state mandated program charged with advocating for the highest quality of care and quality of life for the 100,000 Michigan citizens in licensed, long term care facilities. Approximately 45,000 of those individuals are residents of nursing homes.

The CON Commission can play a critical role in ensuring both quality care and access to care. We request -

1. The Commission act expeditiously to establish the Standards Advisory Committee (SAC) for nursing home standards, and appoint consumer advocates, including the State Long Term Care Ombudsman, to the committee.

2. Standards adopted by the Commission must include quality standards for providers to adhere to before being allowed to build, buy or make major renovations or expansions to nursing facilities.

3. The Commission should only consider approving such requests if the owner or prospective owner has a proven track record.

4. Quality standards are never a replacement for strong, consistent and effective nursing home enforcement for existing and new facilities alike.

5. Standards should be expanded to in-home, long-term care services, such as home health and HCBW services, so we ensure consumers a continuum of quality services in an integrated, uniformly excellent system.

7109 West Saginaw Highway PO Box 30676 Lansing, MI 48909-8176
(517) 335-1560

6. To ensure better access services, as a condition of receiving a certificate of need, a nursing should be required to have all beds in the facility dually certified for Medicare and Medicaid.

7. The Commission should work to ensure currently licensed nursing homes obey Michigan law in seeking Medicaid certification for each bed certified for Medicare.

8. No long term care service provider should be permitted to discriminate among applicants or recipients based on the individual's source of payment.

Thank you very much for the opportunity to express the views of the State Long Term Care Ombudsman Program.

-

University of Michigan
Health System

Mark Mailloux
Senior Health System Planner

University of Michigan Hospitals and Health Centers
300 N. Ingalls, 4E16
Ann Arbor, MI 48109-0443

(734) 764-1505
(734) 763-5311 fax

mmaillous@umich.edu

January 9, 2007

Ladies & Gentlemen of the Commission:

My name is Mark Mailloux and I am a Senior Health System Planner at The University of Michigan Health System. The U-M Health System wishes to take this opportunity to comment on the upcoming 2007 cycle of CON Standards to be reviewed. Specifically, we believe that the Nursing Home Standards need some work to enhance the threefold goal of the Certificate of Need process itself, namely Cost, Quality and Access.

At the outset let me say that U-M Health System has no direct standing in regard to these Standards since we have no Nursing Home Beds. Nonetheless, the specifics of these Standards will have considerable, if indirect, impact on us as I suspect it will on every other hospital provider.

In that regard, the Access issue focuses on making available those resources which the patients themselves require. The ability of our hospital to secure Nursing Home placement for those patients who are unable to return home but no longer require acute care hospitalization is the number one hurdle to be overcome by our Discharge Planning staff.

Clinical acuity is different from one facility to the next, despite being classified as "Skilled." This means that placement often depends upon the particular patient morbidity involved. Issues such as Traumatic Brain Injury (TBI), Ventilator-Dependency, Kidney Dialysis, Alzheimer's, etc. radically limit the selection options which are available at placement time. Some facilities accept one condition but not another or vice-versa. It would be helpful to have a requirement that a certain minimal clinical skill set should be required for classification as "Skilled" so that a skilled

nursing placement would not be as extremely facility-dependent as it currently is. Perhaps additional certification could be awarded (and therefore advertised by the facilities) for the most severe of these issues such as a TBI care or an Alzheimer's unit.

With the 'graying' of America, Geriatrics will only continue to increase in importance in Nursing Home care. That inexorable population demographic will demand ever more beds in a market that is already overtaxed and under-funded. Sooner or later honest evaluation must begin on setting an appropriate bed supply, as well as enhancing viable, less-comprehensive alternatives such as home-care, respite care and assisted living. Moreover, there is, at present, no uniformity in the on-site presence of such personnel as a Geriatric Physician or a Geriatric Pharmacist, as well as appropriately trained OT and PT staff. Minimum standards here would improve Geriatric care as well as the quality of the facility across-the-board.

It will come as no surprise that there are Cost issues in addition to the Quality and Access concerns addressed above. Among the payment issues, not surprisingly, Medicaid surfaces as the number one concern on two counts: in terms of difficulty finding patient placements and difficulty in securing Medicaid coverage.

It is well established that Medicaid is one of the poorest, if not the poorest of payors. As a result, Medicaid beds are difficult to secure. Over and above this, however, many Nursing Homes are reluctant to accept Medicaid-*pendin*g patients because of the risk they incur if the Medicaid coverage does not materialize. There are instances wherein patients have been transferred to Ohio because of their differing Medicaid eligibility requirements and there are cases wherein U-M Health System has *itself* paid for Nursing Home placement for some patients because a further inpatient stay was not required, but the inpatient bed was in demand.

In addition, if documented levels of difficulty can be established for such conditions as TBI or Alzheimer's units, then an appropriate surcharge ought to be available for the care of those patients.

Thank you for this opportunity to address the standard setting process and to these standards in particular. The University of Michigan Health System wholeheartedly supports them and stands ready to assist your efforts in this regard.

Alison Hirschel

MICHIGAN POVERTY LAW PROGRAM

■MPLP-SUPPORT
611 CHURCH ST
SUITE 4A
ANN ARBOR, MI
48104-3000

■PHONE:
(734) 998-6100

■FAX:
(734) 998-9125

■WEB:
www.mplp.o rg

Testimony of Alison Hirschel of the Michigan Poverty Law Program and the Michigan Campaign for Quality Care before the Certificate of Need Commission

January 9. 2007

Good morning. I am Alison Hirschel, the elder law attorney at the Michigan Poverty Law Program (MPLP). MPLP serves as the statewide back-up center for legal services staff across the state who provide free legal services to low income consumers. I am also counsel to the Michigan Campaign for Quality Care, a statewide, nonpartisan group of hundreds of consumers who seek better care, better quality of life, and better choices for Michigan's long term care consumers. I appreciate the opportunity to testify today on behalf of both organizations.

It is no exaggeration to say that Michigan is on the brink of dramatic long term care reform. The reopening of the MiChoice home and community based waiver program, the thoughtful work and recommendations of the Governor's Medicaid Long Term Care Task Force, the creation of the Office of Long Term Care Supports and Services in the Department of Community Health, the development of four Single Point of Entry demonstration projects, and the enactment last week of the Single Point of Entry legislation to create one stop shopping for long term care consumers all

presage significant changes in Michigan's fractured long term care system.

The Governor's Task Force recommendations and the advocacy and consumer groups I represent all support three major goals in long term care reform: quality, access, and choice. These goals are completely consistent with this Commission's mandate: "to promote and assure....[t]he availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in this state." MCL §333.22215(o)(2). As the state begins to embrace a coordinated, efficient, collaborative long term care system, it is essential that this Commission act in support of these crucial goals and in concert with the Department's important efforts.

I therefore **ask that the Commission promptly establish a Standards Advisory Committee (SAC) for nursing home standards and appoint consumer advocates to serve on that committee**. Doing so is permitted by the CON statute and will be consistent with the Governor's policy of inclusiveness and the Department's efforts to ensure all stakeholders have a voice in long term care reform.

To reflect the changing landscape of long term care, **I ask that the Commission abandon its practice of looking only at nursing home and hospital long term care unit beds and consider instead the whole array of long term care supports and services on which consumers rely**. Wise planning simply is not possible if the Commission evaluates only the availability of nursing facility beds without considering the other long term care services

which many consumers prefer and are already utilizing. Moreover, as the long term care population burgeons, the state will no longer be able to afford its current practice of serving the vast majority of long term care consumers in the most costly long term care setting.

To promote quality and to be consistent with the Department's efforts to reward and encourage better performance, **I ask that the Commission revise existing standards to ensure that providers can build, buy, renovate, or expand facilities only if they can demonstrate adherence to appropriate quality standards across all the facilities they own or manage**.

To ensure access and to be consistent with the Department's goals, **I ask that the revised standards require, as a condition of receiving a certificate of need, that all nursing facilities be dually certified. Moreover, I request that facilities accept applicants on a first come, first served basis and do not discriminate based on the applicant's source of payment.** Facilities in a number of other states are required to accept applicants in this manner and it is time Michigan's nursing home consumers enjoy the same rights to be served in the facility of their choice.

Finally, **I ask that the Commission work closely with the Medical Services Administration, the Office of Long Term Care Supports and Services, the Office of Services to the Aging, and, when appropriate, the Department of Human Services, to ensure that all long term care developments in the state are part of a thoughtful, consistent, coordinated plan**.

Thank you again for the opportunity to testify. If I can be of any assistance to the Commission, please feel free to contact me at my MPLP East Lansing office: (517) 324-5754 or by email at hirschel@umich.edu.