STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED

PUBLIC HEARING
REVIEW STANDARDS FOR
AIR AMBULANCE (AA) SERVICES
COMPUTER TOMOGRAPHY (CT) SCANNER SERVICES
NEONATAL INTENSIVE CARE (NICE) SERVICES/BEDS
NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS
URINARY EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (UESWL)
SERVICES/UNITS

BEFORE ANDREA MOORE, DEPARTMENT TECHNICIAN TO CON COMMISSION

201 Townsend Street, Lansing, Michigan
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Lansing, Michigan
Tuesday, January 9, 2007 - 9:00 a.m.

MS. MOORE: Good morning. I am Andrea Moore, and I am the Department Technician to the Certificate of Need Commission from the Certificate of Need Policy Section from the Department of Community Health. Chairperson, Norma Hagenow has directed the Department to conduct today's hearing. Copies of the review standards can be found on the back table along with comment cards which you need to complete if you wish to provide public testimony. Please be sure that you have signed the sign-in log. This is the annual public hearing held each January to determine if any changes need to be made to the standards scheduled for review. Air Ambulance Services, CT Scanner Services, Neonatal Intensive Care Services, Nursing Home and Hospital Long-Term Care Unit Beds, and Lithotripsy Services Standards are scheduled for Commission review in
2007. The 3-year review schedule for all standards is listed on the second page of the Commission Work Plan located on the Department's website at www.michigan.gov/con. If you wish to speak on any of the scheduled standards, please turn in your comment card to me. Additionally, if you have written testimony, if you could, please provide a copy, as well. Just a reminder, please turn all cellular telephones and pagers off or set them to vibrate during this hearing. As indicated on the Notice of Public Hearing, written testimony may be provided to the Department via our website at www.michigan.gov/con through Tuesday, January 16th, 2007 at 5:00 p.m. Today is Tuesday, January 9th, 2007. We will begin the hearing taking testimony in the following order: Air Ambulance, CT, Nursing Home, NICU and finally, Litho. The hearing will continue until all testimony has been given, at which time we will adjourn. And we'll start the morning with Bob Meeker from Spectrum Health.

MR. MEEKER: Good morning. I'm Bob Meeker from Spectrum Health in Grand Rapids. For this and the rest of my testimony in other areas I will have written comments by next Tuesday. There are several areas that we wish to comment on related to air ambulance. In no particular order they are in the "definition" section, the requirements for air medical personnel includes, "at least two members, one of which must be a licensed paramedic in the State of Michigan." We would submit that if, in fact, a physician trained in emergency medicine were accompanying the flight, that that could be substituted for a paramedic; that could be an either/or requirement, and we'd like to make that suggestion. Within the air ambulance industry it is common -- well, I guess most air ambulances operate on a 12-hour schedule. And when expanding capacity it's common to start with perhaps a 12-hour helicopter; in other words, running 1-1/2 helicopters. And we would suggest that the Commission 4 look into the possibility of allowing a 12-hour helicopter as an alternative to expanding from one full helicopter to two. The expansion section of the air ambulance standards is different than the expansion sections in some of the standards, and we would like to suggest

perhaps making a little bit of consistency. Right now the requirement is that there be 600 flights actually performed in the most recent year per air ambulance and that you project an additional 200 using the methodology in the standards. There are other standards that have basically just a threshold. When you get to a certain number, then you qualify for a second; for instance, in the case of MRI Services. And so we would suggest that perhaps that number be established and that the projection number not be included. In the area related to replacement, there is a cross-reference in the volume requirements between the replacement section and the expansion which, in the very least, is confusing. And it really implies, if read literally, that if you had 2 air ambulances, you would have to be doing 600 for each air ambulance plus an additional 200 in order to replace either one of them. I don't think that was the intention. I would suggest that the cross-reference be eliminated and the actual intention just be spelled out in the replacement standards. That's pretty much the sum of my comments related to air ambulance.

MS. MOORE: Thank you. Bob MacKenzie from St. Mary's.

MR. MACKENZIE: Good morning. I'm Bob MacKenzie from St. Mary's of Michigan. And I have submitted written testimony for the Commission and for the review. I'll paraphrase this to go through it. St. Mary's of Michigan offers our comments to urge the Commission to improve the access, quality and reasonableness of the standards that are currently in existence for air ambulance. We have two major areas where we have major concern right now. One is in the same area as Mr. Meeker has discussed, and that's expansion of existing services. The 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 the existing program. If you look at the current volume methodology, expansion is much more prohibitive than new programs. This type of barrier limits economies of scale for a program to expand. As we all know, it's readily evident air ambulances services do start with a large base cost that, as they expand, can be distributed amongst multiple aircraft. By creating this type of limitation, really high quality established programs cannot make adjustments for the demand of their services as easily as creating a new service in the same area. Secondly, consideration should be given to single aircraft programs to include the flights that were refused due to the aircraft already on a mission as well as mechanical down time. If you are a single -- if you have a single-server program, once you're in the air, you're in the air for a mission, and those other calls that come in you're unable to service. That's actual business demand that at this point is only considered as a projection and not part of the demand for the existing service. We feel that those numbers should be included as part of the existing volume for the business. Another consideration under expansion is the geographic area of consideration. The way that the standard is developed right now, another carrier coming into an area only has to notify the existing program that they intend to come into the program -- into that area. There is no comparative review; there is no consideration that there's already an air ambulance in that area. This creates -- although it's a competitive situation, it also creates a situation where the individual programs may become – may reduce the individual volumes, and therefore their quality

of service goes down. We feel that there should be some better definition for and consideration for the geographic coverage that existing programs have once they are established.
In the "definitions" area we feel that "coverage area of existing programs" needs to be tightened up. The definitions for -- we feel that the definitions in the standards are somewhat vague. Clarification on primary and secondary service areas should be made with regards to scene and transfer definitions. As we've attempted to do this a number of times, if you look at the way that secondary definition is -- secondary market definition is defined right now, most air ambulance systems in the state would define the vast portion of the Lower Peninsula as their secondary service area. That needs to be – those definitions need to be cleaned up. We also feel the definitions create great overlap, and there should be -- through improvement in the definitions, that should be cleaned up. That concludes my comments for today.

MS. MOORE: Thank you, Bob. Steve Szelag from the University of Michigan.

MR. SZELAG: Good morning. My name is Steven Szelag. 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 requirements for expanding a program, requiring that 1400 flights be completed in months 7 through 8 after beginning operation of a third aircraft. This number is arrived at using the calculations enumerated in Section 9. In sort, air ambulance service from the previous year is used to project 1400 flights following the expansion of three aircraft. Section 5 outlines the requirements to replace a helicopter or helicopters 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 -- 1400 -- 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 1 helicopter with 1400 to replace 2. 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 work group or standards advisory committee evaluate and analyze the numerical 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 the Department on these issues.

MS. MOORE: Wonderful. Thank you, Steve. Are there any additional comments on air ambulance services? Hearing none, we will continue on to CT services. Bob Meeker, Spectrum Health? Oh, yes. Can we change that? We're going to let Steve Szelag from University of Michigan go.

MR. SZELAG: Good morning again. My name is Steve Szelag. I'm 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 practices offers clinicians the enhanced ability to detect and diagnose diseases. Applications of these imaging tools are broad but require regulation in order to maintain the integrity of health care provisions 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 of Michigan with Mini CT Scanners and compromising healthcare provisions. Appropriate standards will successfully protect and promote the efficient and economical delivery of health care services. The University of Michigan recommends that a work group 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 with you and the Department on these issues.

MS. MOORE: Thank you. Bob Meeker from Spectrum Health.

MR. MEEKER: I'm Bob Meeker from Spectrum Health, and we have several areas that we wish to comment on related to the CT scanning C.O.N. review standards. Again in no particular order of importance, the requirements for relocation currently are stated as "relocation of existing CT scanner service." Unlike other standards, this implies, if not states directly, that you can only replace -- you can only relocate the entire CT service, not one or more of the units of that service. Recent changes approved to the MRI standards specifically allow the relocation of individual units, and we think that similar modifications should be made to the relocation requirements in the CT standards. An additional requirement of the relocation standards specifies that the unit to be relocated needs to have performed 7500 CT equivalents in the most recent year. I think it's safe to say that at least many times the relocation of a unit may be motivated by the fact that its current location is not a good one and it's being underutilized. So to have standards that would prohibit the relocation of an underutilized unit due to mislocation I think should be modified, and the volume requirement for relocation should either be eliminated or substantially reduced. Finally in the relocation standards, the unit to be relocated needs to have been in operation for 36 months. You know, we certainly acknowledge that we're talking about relocating an established unit, not just sort of, you know, bounce and move, but our -- we consider that the 36 months is too long and perhaps that should be reduced to 24. In talking about the replacement of CT -- and we'll be making this comment for several of the areas -- the definition of "replacement" basically could cover something as little as changing a switch or replacing minor wiring or whatever. For many of the other standards, again, MRI being an example, there is a

dollar amount that is specified for MRI. If you expend more than $750,000 on upgrades over the course of a 24-month period, that constitutes a replacement and requires C.O.N. Although CT technology is less costly than MRI, a similar approach would be appropriate and with a dollar level perhaps something less than 750,000 over a 2-year period of time. Regarding CT services for pediatric patients, many of the C.O.N. review standards include allowances for the needs of pediatric patients. Some of them even go so far as to have special requirements for dedicated pediatric units. We would not contend that the CT concerns arise to the level of requiring specific pediatric units, but nevertheless a lot the considerations, for instance, sedation or special needs patients, also apply to CT. We think that there should be some allowance in the weighting of the CT units to account for pediatric patients, and we would suggest a simple way to do that might be to just add a .25 to each procedure involving a patient under 15 years of age. Similar to Steve Szelag's comments about Mini CT's, I think that there are going to be increasing numbers of special use CT scanners. One that has come to our attention is a xenon CT scanner which is used in Level I trauma centers for seriously brain injured patients. These would be portable units that actually be brought to the bedside in an intensive care unit. Such a specialized unit would never be expected to arise to the utilization level of 7500 CT equivalents each year. I think that the Commission needs to take into account some of these special use CT scanners and carefully develop specific criteria to evaluate their use. Certainly these are not things that we feel should have broad availability across the state, much as the concern raised by Steve, but rather there need to be an acknowledgment of these units and standards appropriate to these units. That pretty much concludes my comments on CT scanning.

MS. MOORE: Thank you. Are there any additional comments on CT standards? Hearing none, we will move on to nursing home and hospital long-term care unit beds. Bob Meeker from Spectrum Health?

MR. MEEKER: I'm Bob Meeker from Spectrum Health and you're not. We have numerous comments on the nursing home standards that I'll summarize. In the "definitions" area, the definition of "replacement zone," which has had attention in the past, is currently set at a three-mile radius in a metropolitan area, and we would respectfully suggest that that replacement zone needs to be reexamined, perhaps even by a SAC; that that would be too restrictive in metropolitan areas. Under the "need" discussion, there is and has been for quite some time, a high occupancy provision for nursing home beds which certainly in the current environment is extremely, extremely severe, and I would doubt that anybody could meet it. It currently not only requires a 97 percent occupancy for three years, but also requires that all the nursing home beds in your planning area
are -- nursing home facilities in the planning area have been operating at 97 percent for 3 years. We would suggest that this standard needs to be modified and made closer to the high occupancy standard for hospital beds, dropping the requirement of the other facilities in the area and perhaps lowering the high occupancy level for the applicant facility to something closer to 90 percent for 2 years. The standards identify numerous special population groups, and we would suggest the addition of a new population group, that being patients with psychiatric diagnoses. With the closing of the state

psychiatric facilities for some time now and the reduction in residential psychiatric capacity statewide, many of these patients are finding their ways into nursing homes. And their unique needs perhaps should be acknowledged in the standards. Finally, in the requirements for the new design pilot programs, new design pilot programs are required to have at least 80 percent single occupancy residency rooms with adjoining bathrooms, and there's a longer requirement there both in the newly either constructed or renovated area and in the remaining part of the nursing home. For facilities that are only proposing to use the new design pilot in a portion of their facility, we would suggest that the high percentage of single occupancy rooms not need to be applied to the remaining part of the facility which is not being designed as the new design pilot project. That concludes our comments on long-term care.

MS. MOORE: Thank you. Alison Herschel from Michigan Poverty Law Program.

MS. HIRSCHEL: Thank you. I'm with the Michigan Poverty Law Program and the Michigan Campaign for Quality Care. The Michigan Poverty Law Program is the statewide backup center for legal services programs that provide free legal services to low income consumers. And the Michigan Campaign for Quality Care is a statewide grassroots group of consumers who seek better care, better quality of life and better choices for Michigan's long-term care consumers. Michigan is now on the brink of dramatic long-term care reform. And I appreciate the opportunity to testify today about changes we believe are necessary to the standards governing long-term care -- governing nursing home and hospital unit long-term care beds. The reopening of the MiChoice Program, the thoughtful work and recommendations of the Governor's Task Force, the creation of the Office of Long-Term Supports and Services and the Department of Community Health, the development of Single Points of Entry and other steps 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. And these goals are completely consistent with the Commission's mandate to promote and assure the availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in this state. As the State begins to embrace coordinated, efficient, collaborative long-term care, it's essential that this commission act in support of these crucial goals and in concert with the Department's important efforts. And for those reasons, I would ask several things: First, I ask that the Commission promptly establish a standards advisory committee for nursing home standards and appoint consumer advocates to serve on that committee. Including consumers will be consistent with the Governor's long-standing policy of inclusiveness and with the Department's effort to ensure that 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 isn't possible if the Commission evaluates only the availability of nursing facility beds without considering the other long-term care services on which many consumers rely and which many consumers prefer. Moreover, as long-term care population

burgeons, the state will no long be able to afford its current practice of serving the vast majority of long-term care consumers in nursing homes, which are the most costly long-term care setting. To promote quality and 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 demonstrate adherence to appropriate quality standards across all facilities that they own or manage. To ensure access and 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 duly certified. Moreover, I request that facilities accept applicants on a first-come, first-served basis and don't 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's time Michigan nursing home consumers enjoy the same rights to be served in a facility of their choice. Finally I ask that the Commission work closely with 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 very much.

MS. MOORE: Thank you, Alison. Next we'll have Andy Farmer from AARP.

MR. FARMER: Good morning. I'm glad Alison preceded me with Michigan Poverty Law Program and the Campaign for Quality Care. I'm merely going to copy her answers. We have already submitted testimony electronically to the Department and I'm not going to karaoke-style repeat it here. I just want to say it a little bit differently from how we submit it to the Department but basically cover the same points. And, again, I'm resonating a great deal of what Alison said. AARP of Michigan has a membership of 1-1/2 million members in this state. That doesn't really account for all of the family members that they are concerned with also who are in any number of long-term care supports and services across the state, some of which are in nursing homes and adult foster care and homes for the aged. Others are trying to get community-based care through the waiver or other types of informal services. And, in fact, it is informal care that is the largest sector of long-term care in the state. The last estimate from the Family Caregivers Alliance nationally places Michigan value of economic impact at well over 9 billion dollars every year in informal care giving that families and friends are trying to deliver every day. So we are calling for attention to be brought to the very paradigm of this Certificate of Need process in definitions, methodologies and how it even looks at need when applying to long-term care, not just nursing homes and hospital long-term bed care units. And the metaphor that I think I can offer you to try to illustrate that differently from our testimony is to say that we have essentially a situation where we are operating a fully modern airport facility with runways able and capable of taking all manner of different type of aircraft. But with Certificate of Need process and structure the way it's set up, that airport is certified, if you will, to provide services only for zeppelin travel. And that's got to change. So the first and foremost thing we're looking for is the appointment of a standards advisory committee to start looking at changing the very paradigm of how the Certificate of Need even thinks about and looks at long-term care, defines it, constructs methodologies and even thinks about need

because this airport is providing services for all kinds of people all over the map and off the grid who show up occasionally, and not just Medicaid services, but this is about Medicaid services also, and that informal care impact having a massive potential impact and rightfully should be having an impact on how the state spends it public dollars also. All that should be integrated into one place. And it's time Certificate of Need came into line with that. Now, I don't have anything against nursing homes, and I like -- I thought zeppelins were pretty cool. I thought I'd like to travel on one myself, but that would take my metaphor and turn it into the Hindenburg because I don't want to live in a nursing home personally. That doesn't mean other people shouldn't want to. And even that is beside the point because my point is about the future. Nursing homes themselves are changing. They are becoming smaller. They will become smaller. They will become more truly homelike in the future just because that's what the market demands and what the technology and understanding of how long-term care delivered understands it can be done that way. Certificate of Need, again, methodologies, definitions and constructs even on -- narrowly just on nursing homes don't fit with what the future of that industry is going to look like. And the point there being that the future of that industry will render it looking not too much different from any other sort of array of services that are community based. So we need a standards advisory committee to get to the work of shifting the paradigm of the definitions and methodology away from nursing home beds only and hospital long-term care beds and units only to long-term care need and long-term care methodologies and predictions. So the other three recommendations are in the testimony already. We also would like to see it limited just to current nursing home methodologies and changes in certificates. We do like the idea of changing the process by which only nursing home chains, operators, owners are granted changes and increases in their certification and capacity based on them having successful track records of quality and regulatory compliance. The Department already had a highly developed policy template for such a policy change. We like it. We think a standard advisory committee should look at it, and it's time for it to make a formal recommendation on it. Thirdly, there may be a range of issues identified in the 2005 Governor's Medicaid Long-Term Care Task Force Report that do pertain to Certificate of Need that are not described in these remarks or others that really should be given a careful look at. Again, think about the airport that is already being used, but we have a Certificate of Need that's only working with zeppelins right now. And lastly and indeed as such a committee is formed – standard advisory committee is formed, we urgently call upon it that it be highly comprised of -- not just consumer representation, but that consumer representation reflect the differentiation and diversity of what long-term care consumers have already been for many years, which is not just seniors. It’s persons with disabilities; it’s persons from all over the state from rural to isolated to urban settings, different racial backgrounds, different cultural backgrounds. We need a Certificate of Need advisory committee that's able to reflect the future that's already in existence now around long-term care in order to craft policy that will be effective and bring this whole structure with important authorities into line with that future. So thank you.

MS. MOORE: Thank you, Andy. Pat Anderson from HCAM.

MS. ANDERSON: Good morning. I'm Pat Anderson, Vice President of Reimbursement for the Health Care Association of Michigan. On behalf of HCAM I would like to address the C.O.N. review standards for the nursing home and the hospital long-term care unit beds. HCAM is a statewide association that represents over 250 nursing facilities. Our membership includes facilities across the state as well as a spectrum of proprietary and nonproprietary county owned and hospital long-term care units. We actively encourage and support our members in providing the highest quality of care for those residents residing in our facilities. The Certificate of Need standards are designed to foster quality care to maximize the utilization of the limited health care dollars. The HCAM believes both of these values can be accomplished by responding to the customers who need our members services. In this regard the CON standards should reflect the desires of the customers. This is clearly demonstrated in the CON nursing home and hospital long-term care standards addendum, the new design model pilot program. HCAM proudly helped created this standard's addendum. HCAM member Tendercare of Leelanau located in Suttons Bay was the first new model pilot program opened this past September. Many more HCAM members are in the process of building or remodeling existing facilities under these standards. The customers ask for our facilities to be built to provide them with greater privacy and dignity, and that is what we are doing. The addendum for the new design model pilot program section 3, "Statewide Pilot" items number 1, limits the pilot for four years from the effective date of the addendum. The addendum was approved by the CON Commission on December 3rd, 2004 which means the pilot would end in December 2008. When originally written, four years seemed like a very long time, but in the construction business, it is a very short time. Many projects are still in the planning phases securing local code approvals and appropriate financing. HCAM would like this item to be reviewed and the pilot extended at least another four years. HCAM hopes when the Commission establishes the standards advisory committee and makes the overriding charge of the group to further the desires of the customers. The CON standards can be the driving force to change the long-term care landscape to address consumer needs. We encourage the SAC to keep this forward-movement emphasis in the review of the standards. HCAM looks forward to working with the SAC when appointed and working together to make Michigan the leader in the nation in creating the facilities for the future. Michigan has taken the first steps in the new pilot addendum. Let's just keep it moving. Thank you.

MS. MOORE: Thank you, Pat. Mark Mailloux from the University of Michigan.

MR. MAILLOUX: Addressing the ladies and gentlemen of the Commission, my name is Mark Mailloux. I am Senior Health System Planner at the University of Michigan Health System. U of 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; cost, quality and access. At the outset let me say that U of M Health System has no direct standing in regard to these standards since we have no nursing home beds; nevertheless the specifics of these standards will have considerable, if indirect, impact on us, as I suspect it will every other hospital provider. In that regard, access issues focuses on making available these 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, or TBI, ventilator dependency, kidney dialysis, Alzheimer's, et cetera, 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 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 TBI 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 over taxed 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 on the onsite 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 I addressed above. Among the payment issues, not surprisingly Medicaid surfaces as the number one concern on two counts: in terms of difficulty finding patient placement and difficulty in securing Medicaid coverage. It is well established that Medicaid is one of the poorest, if not the poorest, of payers. As a result Medicaid beds are difficult to secure. Over and above this, however, many nursing homes are reluctant to accept Medicaid pending 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 of 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 such 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 standards setting process and to these standards in particular. University of Michigan Health System wholeheartedly supports them and stands ready to assist your efforts in this regard. Thank you.

MS. MOORE: Thank you, Mark. Are there any additional comments on nursing home beds?

MR. VERLEE: Thank you. I just arrived and I wasn't necessarily prepared to speak, but on the other hand, listening to some of the comments --

MS. MOORE: Can I have your name and your facility?

MR. VERLEE: Yes. Paul Verlee, V-e-r-l-e-e, and I'm from Fair Acres Care Community in Armada, Michigan. Just in responding to some of the comments that were just mentioned, I've heard the discussions from the AARP in the past also relative to looking at the future. And I agree with much of what was said of the gentleman from AARP that nursing homes are changing, becoming more homelike and looking at meeting the needs and the culture changes that we're seeing today. The only comment I want to put into that is that in the past when this was addressed we talked of it in terms of funding or the lack of funding, and the thought was that we could take people that are currently in nursing homes today needing 24-hour skilled care and put them into a homelike setting less costly than is provided in the nursing home. And I would challenge that line of thought. I think if you're going to look at opening up funding under Medicaid to assisted living, home health care and things of this nature, then I think you're going to be looking at opening up a whole lot -- sorts of additional funding that would be necessary to accommodate that. They would not be transferring people out of the nursing homes that are needing 24-hour care into a home setting and providing that for $130 a day. So basically that was my comment.

MS. MOORE: Thank you, Paul. Hearing no additional comments, we continue on to NICU Services. We have Bob Meeker from Spectrum Health.

MR. MEEKER: I'm Bob Meeker from Spectrum Health in Grand Rapids. We have several comments related to the current NICU standards. One of the most fundamental is the entire basis for the existing bed need methodology which essentially contends that the need for nursing home beds in the State of Michigan should be 4-1/2 NICU beds for 1,000 live births. Those numbers are adjusted in regional areas based on the percentages of births less than 1500 grams. The validity of this need ratio may need to be reevaluated. It's been in existence for quite some time, and there have been a lot of changes in the entirety of care for very tiny, very premature babies. The rate of premature births has increased. The survival rate of those premature babies has also increased, and so this ratio may be out of date and should be reevaluated. The existing standards allow an exception to the bed need methodology for NICU's that receive a disproportionate number of referrals from other NICU's. There is a formula that's involved, but this exception is capped at five additional NICU beds per facility. We think this is a good idea to make this adjustment, but we don't think necessarily that the cap makes sense, and so -- if the cap were eliminated and the formula were allowed to determine the number of additional beds a particular referral NICU needed to take care of the referrals from other NICU's. Furthermore, since those referrals from other NICU's really are beyond the normal neonatal need in the region by definition, then we'd contend that the acute care beds used for those services for those patients from other NICU's also could be considered as being outside the calculated acute care bed need in the planning area. And we would suggest or we would request that the Commission examine looking at, for the beds awarded based on this exception, that they be not only outside the NICU bed need methodology but also in addition to the acute care bed need methodology. Finally, in the area of the project delivery requirements, there are a number of medical subspecialties for which onsite and consultation provisions must be

made by the operator of NICU services, but we feel that there is a glaring omission in that none of these specialties are identified as required to be pediatric specialties -- subspecialties. We think that the requirements should be specified to pediatrics such that there's a requirement for a pediatric cardiologist, a pediatric ophthalmologist, a pediatric surgeon and so forth. With that, that concludes our comments.

MS. MOORE: Thank you, Bob. We're going to back to nursing home and hospital long-term care services, and I have Brad Geller, State Long-Term Care Ombudsman Program.

MR. GELLER: Thank you for the opportunity to make some comments today. I'm here on behalf of the Michigan State Long-Term Care Ombudsman Program which is a federally and state mandated program charged with advocating for quality of care and quality of life for the 100,000 individuals in Michigan who are residents of licensed long-term care facilities. About half of those individuals are residents of nursing homes. I believe that the CON Commission plays a critical role in ensuring both quality of care and access to care, and we request the following: First, that the Commission act expeditiously to establish the standard advisory committee for nursing home standards and appoint consumer advocates including State Long-Term Care Ombudsman Committee; second, that standards adopted by the Commission must include quality standards for providers to adhere before being permitted to build, buy or make major renovations or expansions to nursing facilities. Third, the Commission should only consider approving such requests if the owner or prospective owner had a proven track record. Fourth, quality standards are never a replacement for strong, consistent and effective nursing home enforcement for existing and new facilities alike. Fifth, standards should be expanded to in-home, long-term care services such as home health and HCBW services so we can ensure consumers a continuum of quality services in an integrated, uniformly excellent system. Sixth, to ensure better access to services. As a condition of receiving a Certificate of Need a nursing home should be required to have all beds in the facility duly certified for Medicare and Medicaid. Seventh, the Commission should work to ensure currently licensed nursing homes obey Michigan law in seeking Medicaid certification for each bed certified for Medicare. Eighth, no long-term care provider should be permitted to discriminate among applicants or recipients based on the individual's source of payment. And finally, we would like a C.O.N. for the Big Ten Football Programs to have competitive football teams. Thank you.

MS. MOORE: Thank you. Are there any additional comments on NICU or nursing home services? Hearing none, we will continue on to lithotripsy. I have Bob Meeker from Spectrum Health.

MR. MEEKER: I'm Bob Meeker representing Spectrum Health. We have several comments related to the standards -- the CON review standards for lithotripsy services. One of them -- sets of comments reflects the now, not only predominance, but basically the fact that all lithotripsy services in the State of Michigan are mobile services. This is a trend that has been nationwide and has happened here in Michigan. And, you know -- so I think as a result of that there are changes in the existing standards that would be

appropriate. Specific to some of the requirements for mobile services themselves, I think that with the availability now of multiple mobile lithotripsy routes, that access to this service at appropriate ambulatory care centers or ambulatory surgical centers makes increasing sense, but some of the requirements may be more difficult -- may not be necessary and may be more difficult for ambulatory centers to meet; for instance, the requirement for a 23-hour holding unit. You know, we would just suggest that these requirements be reassessed. In a similar vein, there are some requirements that may have applied to earlier versions or earlier generations of mobile lithotriptors but certainly don't apply now because the mobile units are so compact as to be able to be wheeled right into existing operating rooms. So the requirement in Section 11(1)(e) for a properly prepared parking pad for the mobile unit and a waiting area for patients and a means for patients to enter the vehicle just simply doesn't apply. In Section 4 there are a number of subsections related to replacing existing fixed lithotripsy machines with new mobile machines. Since there are no fixed machines anymore, I think most of Section 4(3) could be eliminated in its entirety as could subsection 4(6), and we would suggest that the Commission may want to look at that. Our main comment relates to the expansion of existing lithotripsy services. The current requirement for expansion is 1800 procedures per unit in a service -- and this is an extremely high bar to meet, especially for a mobile route which has to travel substantial differences and requires a lot of time on the road – substantial distances -- we would request that the Commission reexamine this requirement, and this may, in fact, require an advisory committee to do that. The need methodology for lithotripsy depends on an adjustment factor which is found in Appendix A of the standards. This adjustment factor is the ratio of lithotripsy procedures performed in the state to the number of kidney stone-related discharges for Michigan hospitals. We would suggest that this ratio probably needs to be recalculated because there is a prevalence of lithotripsy services in the state and, I think, a corresponding decrease in the number of lithotripsy discharges that perhaps the ratio, need methodology adjustment factor needs to be recalculated. Finally, in the area of replacement, similar to the comments I made earlier on CT scanning, the definition of "replacement" is very vague and could constitute almost any minor change in an existing machine. Similar to the standards for MRI and other areas, if there was a dollar amount, you know, several hundred thousand dollars to be sure, a dollar amount that could be spent on routine upgrading and maintenance of an existing machine over a couple of year period of time that would not require CON coverage, I think that that would clarify the intent of the standards and exempt providers who are just doing routine upgrading of their machines from having to file a CON every year. With that, that concludes my comments on lithotripsy on behalf of Spectrum Health.

MS. MOORE: You can just stay there and continue.

MR. MEEKER: Good morning. My name is Bob Meeker and I'm representing Greater Michigan Lithotripsy. Greater Michigan Lithotripsy is a joint venture involving several hospitals and urologists across the state and operates or is involved in at least three mobile lithotripsy routes. We are affiliated with a nationwide company called American Kidney Stone Management who operates over 50 mobile lithotripsy and fixed-site services all across the country. Their experience has been that the volume

requirements for expansion of existing routes in the CON review standards are excessively high and far exceed their sort of planning levels that they use for operating mobile lithotripsy routes in other areas. Really their experience is that anything more than 1200 cases on a single mobile lithotripsy is excessive, and beyond that, service to the local host sites diminishes. You know, patients either have delays in -- unnecessary delays in services or may even have invasive procedures as an alternative to lithotripsy so that, you know, a level of 1,000 or 1200 cases per mobile unit really is an upper level as far as the capacity of the machine; therefore, Greater Michigan Lithotripsy recommends that the volume requirement for expansion of existing mobile services be reevaluated and lowered.

MS. MOORE: Thank you. Are there any additional comments on any of the five services that we were covering today? Seeing none, we will conclude the hearing. I want to thank everybody for their time for coming in and your testimony.

(Proceedings concluded at 10:01 a.m.)
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