STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED

PUBLIC HEARING
REVIEW STANDARDS FOR CT SCANNER SERVICES
and
NH/HLTCU UNIT BEDS

BEFORE ANDREA MOORE, DEPARTMENT TECHNICIAN TO CON COMMISSION
201 Townsend Street, Lansing, Michigan
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MS. MOORE: Good morning, I am Andrea Moore; Department Tech to the Certificate of Need Commission for Certificate of Need Policy Section in the Department of Community Health. Chairperson Norma Hagenow has directed the Department to conduct today's hearing. Please be sure that you have completed the sign-in log. And copies of the standards and comment cards can be found on the back table with the sign-in sheet. A comment card needs to be completed and provided to me, if you wish to provide testimony today.

The proposed CON Review Standards for CT Services are being reviewed and modified to include, but not limited to, the following points: Added language that would allow for the relocation of a unit or a service. Modified replacement/upgrade definition. Upgrade is proposed to be removed and replaced and that would be defined as an equipment change in the existing scanner which requires a change in the Radiation Safety Certificate. Added language that would allow for replacement of a scanner currently operating below minimum volume requirement of 7500 CT equivalents to receive a one-time exemption if the following conditions are satisfied: The existing scanner is performing at least 5000 CT equivalents in the preceding 12-month period. The existing CT scanner at one point met the volume requirements. The existing scanner is fully depreciated.

The addition of language that would allow for replacement of a scanner currently operating below minimum requirements on an academic medical center campus to receive a one-time exemption if the scanner is fully depreciated. Modified language that would require projection of physician referral commitments for initiation of service to be based on actual physician referrals for the most recent 12-months of verified data. Further, the use of referrals from an existing facility cannot drop the facility below the minimum volume requirement. Added geographic boundaries for referral commitments, 75-mile radius for rural and micropolitan statistical area counties and 20-mile radius for metropolitan statistical area counties. Added language that would establish a Pilot Program to implement hospital-based portable CT scanners in a limited number of facilities. The requirements include certification of a Level I or Level II Trauma Facility. Qualified facilities could obtain up to two scanners of their choice. Added language that provides for expansion, replacement, relocation and acquisition of Dental CT scanners. The recommended volume threshold for expansion is 300 dental examinations per year. The recommended volume threshold for replacement, relocation, and acquisition is 200 dental examinations per year. Added language that would establish criteria for a dedicated Pediatric CT scanner. An additional .25 conversion factor for pediatric patients to the existing weights. Added language to clarify the definition of a "billable procedure" by adding the CT

procedure to be “performed in Michigan.” Addition of an exclusion to the definition of “CT scanner” for clarification purposes: “CT simulators used solely for the treatment planning purposes in conjunction with an MRT unit.” And then technical changes.

The proposed CON Review Standards for Nursing Home/Hospital Long Term Care Unit beds are being reviewed and modified to include the following: The addition of quality measures which would apply to the applicant facility and all Nursing Homes and Hospital Long Term Care Units under common ownership or control in Michigan and out-of-state. The total number of facilities which meet the criteria could not exceed 14 per cent or up to five of its facilities. The quality measure criteria’s apply differently depending upon the CON activity. The measures are as follows: A state enforcement action resulting in license revocation, reduced license capacity, or receivership, filing for bankruptcy, termination of medical assistance provider enrollment and trading partner agreement, a number of citations at level D or above, excluding life code safety citations on the scope and severity grid of two consecutive standard surveys that exceed twice the statewide average in the state in which the Nursing Home/Hospital Long Term Care Unit is located. Outstanding debt obligation to the State of Michigan for Quality Assurance Assessment payment or Civil Monetary Penalties. Two state rule violations showing failure to comply with the state minimum staffing requirement, repeat citations at the harm or substandard quality of care level issued within the last three years.

Additionally, when a home with quality issues is acquired, it must participate in a quality improvement program, such as My Innerview, Advancing Excellence, or another comparable program for five years and provide an annual report to the Michigan State Long Term Care Ombudsman, the Bureau of Health Systems, and the annual report shall be posted in the facility that is acquired. Additionally, the elimination of Alzheimer’s Disease, Rural beds and Religious beds from the Addendum for Special Population Groups. These categories will no longer be eligible for additional beds. However, the current programs can be acquired, but if the facility de-licenses any of these beds, those beds will be removed from the pool.

Addition of a rural high occupancy provision has been provided with the following criteria: The planning area must have a population density of less than 28 individuals per square mile. The facility must have an average occupancy rate of 92% for the most recent 24 months. Hospice and Ventilator Dependent beds would be maintained within the special populations criteria. Behavioral Patients and Traumatic Brain Injury/Spinal Cord Injury Patients would be additions to the addendum.

The New Design Model has been made regular criteria within the Standards and is no longer an addendum. Additionally the language has been modified to require that the Department recalculate the use rate and the bed need on a biennial basis utilizing the most recent data available.

Criteria for comparative review has been modified

to include: Percentage of Medicaid days during the most recent 12 months. Percentage of Medicaid licensed beds at the facility during the most recent 12 months. Percentage of Medicare participation during the most recent 12 months. Deduction of points for non-renewal or revocation of license or non-renewal or termination of Medicare or Medicaid certification. Participation in a culture model. Percentage of applicant cash. Facility in which it is fully equipped with sprinklers and percentage of private rooms.

Additionally you'll find multiple technical changes within those standards. Also today, the Department and the Commission is soliciting public comment on potential amendments to the proposed Nursing Home language which you'll find on the back table. This document is labeled "For CON Commission Public Hearing on February 6, 2008, with Proposed Amendments." The modifications between the two documents are as follows: Within the quality measures, you'll see that the removal of the criteria for two state rule violations showing failure to comply with the state minimum staffing requirement and the criteria for repeat citations at the harm or substandard quality level of care have been removed. Additional changes included for the criteria that looks at the number of citations at level D or above would be calculated on a rolling year. So the quarter in which the standard survey was completed would start the 12-month time clock.

Common ownership and control will apply to out-of-state nursing homes only when an applicant has fewer than 10 Michigan nursing homes. Thus, if the applicant has 10 Michigan nursing homes, then only Michigan nursing homes would be looked at when applying the quality measures. And then additionally, non-compliance with the quality measures will be calculated at 14 per cent of the total nursing homes, but not more than five nursing homes.

If you wish to speak today on proposed CT or Nursing Home Standards, please turn in your comment card to me. Additionally, if you have written testimony, please provide a copy of that as well. Just as a reminder, please have all cell phones and pagers turned off or set to vibrate during the 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 Wednesday, February 13, 2008 at 5:00 p.m.

Today is Wednesday, February 6, 2008. We will begin taking hearing testimony on CT then will follow up with Nursing Home and we will continue until the point that all testimony has been heard today. Starting with CT, I have Matt Jordan from Xoran Technologies.

MR. JORDAN: Good morning. My name is Matt Jordan, and I am testifying on behalf of Xoran Technologies regarding the proposed Michigan Certificate of Need changes to the computer tomography standards. I appreciate the opportunity to testify before you today. Xoran Technologies, based in Ann Arbor, Michigan, is a world-class developer of specialty-use CT scanners primarily used by ear, nose and throat physicians. Our main product is the "Mini-CAT," a low-dose, low-radiation -- a low-cost, low-

radiation dose specialty CT scanner designed for in-office use. It's the combination of this lower cost and in-office use of these specialty CT scanners that sets our products apart from traditional CT scanners. By bringing a $230,000 limited use specialty CT scanner to ENT physicians in their office, patients and physicians have an opportunity to achieve better, faster and safer diagnostic imaging that is vital to treatment. And yet despite the promise of this technology and its availability in 47 other states without the requirements of a Certificate of Need application, Michigan remains just one of three states that effectively prohibit this in-office specialty CT due to restrictive CON regulations. Simply put, the requirements that all CT CON applicants, of the type of equipment demonstrate 7500 equivalent CT scans in order to achieve CON approval effectively prohibits any ENT physician and most hospitals from acquiring a low-dose, low-cost specialty CT scanner. Both the current and proposed CON CT standards do not consider this emerging technology and use, and we ask that the CON Commission reconsider this vital use of specialty CT scanners.

We believe that the approach that 47 other states have taken towards exempting low-cost, low-dose specialty CT scanners is the most effective and least restrictive manner to achieving a balance of cost, quality and access when it comes to this diagnostic equipment. Of the states that retain CON regulations, the majority exempt low-cost, low-dose specialty CT scanners from CON regulations by setting a dollar threshold related to the equipment. These states exempt CT scanners -- excuse me. These states exempt CT scanners from CON by stating that CT scanners and medical equipment costing -- for example, below $750,000 in North Carolina, do not have to file a CON application. Recently West Virginia went further by approving new CON CT regulations in January 2008 that specifically exempt a low-dose CT scanner from CON that costs below $2 million and has either a radiation dose output of less than 1.0 millisievert or a power output below 5 kilowatts. Xoran believes that this is the best manner to achieve the goals of the CON program and yet still adapt regulations to the ever-changing advances in health care.

Xoran urges the CON Commission to make a change to the proposed CON CT standards now before the Commission. In the definition of a CT scanner in Section 2 (I), the following language should be added, quote:

"The term (CT scanner) does not include CT scanner systems that both generate a peak power of 5 kilowatts or less and costs less than $500,000."

We believe that this change will remove CON regulations from low-dose, low-cost specialty CT scanners just as most of the rest of the nation has chosen to do so, while still allowing Michigan to apply CON regulations to the health care additions that matter: Large capital expenditures and procedure-intensive equipment. Michigan has already chosen to not regulate other low-cost medical equipment used in-office, most notably ultrasound, kidney dialysis equipment and digital, two-dimensional x-ray

machines. Specialty CT scanners used in-office more closely align with the purpose and cost of these unregulated equipment via CON and thus should be treated in the same manner in excluding from CON regulations.

We appreciate both the CT Standard Advisory Committee and the CON Commission in permitting Xoran to testify in the past six months about this important and emerging technology. However, we feel that all the factors surrounding in-office specialty use CT scanners have not been fully discussed. The CT SAC did not inquire into the benefits of limited use CT scanning for in-office applications, but instead chose to vote against the concept with little discussion. The end result is that ENT physicians in Michigan are prohibited from acquiring these specialty CT scanners for their offices; patients are blocked from access to lower radiation dose CT scanning despite national calls to limit x-ray exposure; and a Michigan company, Xoran, is unable to sell its equipment in its own home state.

What is particularly difficult for Xoran to understand is that despite being granted over $7,000,000 from the Michigan Economic Development Corporation and being named one of the "50 companies to watch" by Governor Granholm, Xoran is effectively unable to sell its MiniCAT in-office CT scanner in Michigan. We feel that these factors must be considered -- we feel that all these factors must be considered by the CON Commission when deciding on proposed CT standards, and that the right choice for our State would be to exempt low-cost, low-dose specialty CT scanners from the CON process with the language presented above. The benefits in allowing in-office CT scanning far outweigh any risks, and would improve the State's health care environment for physicians, patients, employers and employees across the board.

Additionally, other methods of controlling the proper use of CT scanners will still remain, as CT scanners used in-office will still have to achieve the requirements of the Michigan Radiation Safety Section, must still be approved by insurance companies via prior authorization for the individual scans, and must meet the accreditation requirements developed and rolled out nationally by both the American College of Radiology and the Intersocietal Accreditation Committee. We, again, urge the CON Commission to make this necessary change to the proposed CT CON standards now before you and permit in-office CT scanning by ENT physicians.

Thank you for allowing me to testify before you today, and I look forward to any questions and comments you may have on this matter.

MS. MOORE: Thank you. And just noting for the record, I have received testimony from written Dennis McCafferty from Economic Alliance, and that will just be placed on the record.

MS. MOORE: Thank you. Do I have any further comments on CT scanners?

ALL: (No verbal response)

MS. MOORE: Hearing none, we will go ahead and

move on to Nursing Home and Hospital Long Term Care Unit beds. We'll start this morning with Andy Farmer from AARP.

MR. FARMER: Thank you. AARP supports the compromised SAC standards that are before us today. We -- AARP also supported the original SAC recommendations that were presented to the Commission. And I thought today I'd just quickly say that we would offer, in fact, a interactive testimony this morning, in the sense that's saying that this has been at least the second compromise. The first standards we endorsed, but weren't enthusiastic about because they were already a compromise from what we felt should have been stronger standards that show that nursing homes that perform well ought to be rewarded in the market. And we still believe that principle.

The interactive part, I guess, is that the SAC chair, Doug Chalgian, reported the process. He thought it was fair, open, and that it was without controversy. And I strongly urge the Commission to review the audio transcript of his remarks if today this hearing witnesses more testimony seeking furthering watering down and compromising of the SAC standards. If that happens, then I think what the Commission has is living evidence of what Doug Chalgian talked about that might be disingenuous from some stakeholders, wanting this to be accountable to the Commission process of compromise and unanimity. If that happens, then the interactive feature is this: AARP's position reverts to we support the original SAC recommendations instead of these further compromised ones today. And we would invite the Commission to revert its own position and adopt those original SAC standards also, because we'll see this evidenced, if we see more attacking of this further compromise, that there is a disingenuous element and participation by stakeholders in adopting this process. We urge that decision by the Commission. And I'll close by saying not just because it's the right thing, but because it would be an opportunity for the Commission to show the State of Michigan that it's willing to stand up for its own self. Thank you.

MS. MOORE: Thank you. Lacey, from Citizens for Better Care?

MS. CHARBONEAU: Hello. My name is Lacey Charboneau. I am a local long term care ombudsman with Citizens for Better Care. As a long term care consumer advocate, I have seen many frail people suffer because of poor care. All too often these residents are living in nursing homes that have extensive histories of providing substandard care. Some of these homes are owned by large corporations who continue to open new facilities while neglecting some of their existing facility problems, such as low staffing, abuse and neglect.

I'm here today to ask for support of the consensus option for quality standards. These standards are a necessary step towards protecting long term care consumers, as well as improving the quality of care provided by long term care facilities. Thank you.

MS. MOORE: Thank you. Renee Beniak, from Michigan County Medical Care Facilities Council?

MS. BENIAK: Good morning, Renee Beniak from the Michigan County Medical Care Facilities Council. I would first like to start off with that we do support the amended quality measures that were changed by the most recent workgroup convened by the Department following the nursing home SAC's recommendations.

Secondly, we would like to address the issue of the high occupancy standard and request that some further changes be made in that area. For example, for one county medical care facility up in the northern Michigan area, they consistently run a 97 percent to 98 percent occupancy and have run that for the 12 most recent continuous quarters. But however due to the further requirement of having that same high occupancy in their planning area, they are unable to seek and apply for additional beds. And this poses a problem at least in their community because they have a waiting list of 40 to 50 people in general who sometimes have to choose a nursing home of second or third choice, maybe 50 miles or so farther away while they wait to get into the county medical care facility. So we would like to see something severed in terms of the link to the planning area which would allow facilities that really are the provider of choice in their community be allowed to expand and not be penalized because another nursing home in their area has lower occupancy. We feel that this is in the best interest of the community who want them to be able to provide these services and expand and allow people to remain and choose a nursing home that is much closer to them and providing high quality care, high staffing ratios in a patient-centered care environment. Thank you.

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

MS. ANDERSON: Good morning. I'm Pat Anderson, representing the Health Care Association of Michigan. HCAM is a statewide trade association, representing 240 skilled nursing and rehabilitation facilities, caring for nearly 24,000 of Michigan's frail, elderly and disabled adults. HCAM represents both proprietary, non-proprietary, county medical care facilities and hospital long term care units. Our memberships employs over 30,000 dedicated caregivers providing quality care every day of the year.

HCAM has participated in the Nursing Home and Hospital Long Term Care Unit's standards advisory committee, reviewing the Certificate of Need review standards for nursing homes and hospital attached units. We also participated in the quality measure workgroup that was formed by the CON Commission at their December meeting. HCAM appreciated the Commission's efforts to establish the workgroup to provide us additional time to come to a consensus on an amendment to the SAC-proposed quality measures.

HCAM is supportive of the quality measures crafted by the workgroup at their January 2008 meetings. The HCAM Board of Directors at their January meeting expressed support of these measures as a starting point for addressing quality in the CON process. HCAM continues to have concerns about relying heavily on the survey process as the primary indicator of quality of care. The survey process was

designed to address regulatory compliance issues and not as a measure of quality. HCAM continues to support the customer and their satisfaction as the best indicator of quality of care. To reiterate, HCAM is supporting the proposed CON Nursing Home and Hospital Long Term Care Units review standards, labeled "With Proposed Amendments."

HCAM does have a few technical clarifications and consistency issues that need to be addressed. Our concerns are presented by each section. The first three sections, we didn't have any comment. On Section 4, which is on the bed need, item 4 of that section refers to the effective date of the newly computed bed needs based on the updated 2006 cohorts (sic) and the population projections from 2010. HCAM is concerned about when the new bed need is effective, its impact on current CON applications, and those CONS that are under appeal. We're not sure. What the question would be, is how will the effective date take into account these issues?

HCAM would propose that it seems reasonable to have an effective date to be 6 to 9 months in the future, to allow for any existing appeals or other issues to be resolved before implementation of the new bed need. Just as a side comment, the new bed need utilized the projection population data for the year 2010. It is interesting to note that in Macomb County if the bed need was set on the 2005 data -- actual data, which I think is a projection from the 2000 census -- it would show 463 fewer beds. This would indicate a tremendous increase in the aged population in this particular county in a five-year time span. HCAM would like to know how the projections were developed.

Section 5, the modification of the age specific use rates, we didn't have any comments. Section 6, these were -- the quality measure standards are in there. We just had a few -- a couple technical changes. It's the requirements for approval to increase the beds, that section. Part 1 (B), line 336, requires an applicant at the time of application to have certified that the minimum design standards for health facilities will be met when the construction plans are submitted for review and approval by the Department. This seems unnecessary because the applicant must comply with the design standards under the licensure provisions of the Public Health Code. HCAM would like to request that the item 1 (B) be removed due to the redundancy of requiring it twice and add a timing issue. At the time of application, the architectural plans typically have not been approved by the Department at that time. The plans will be approved prior to licensure, which is the appropriate time during the construction.

Part 1 ©), line 341, addresses the need for the Plan of Correction for any deficiencies resulting from a survey. HCAM is concerned with the timing of when a facility is notified by the Bureau of Health Systems regarding survey deficiencies, when a POC is due, and when the Bureau is able to approve the POC. We would suggest some minor changes to maintain the intent of this part, while overcoming some timing delays that are occurring with the processing of the survey results. HCAM would suggest

the following wording: 1 ©) should be worded to just -- to change a written Plan of Correction for cited State or Federal code deficiencies at the health facility, if due for submission, it would come in at -- it says at the time of application:

> "A written plan of correction for cited State or Federal code deficiencies at the health facility, if due for submission, has been submitted to the Bureau of Health Systems within the Department. Code deficiencies include any unresolved deficiencies still outstanding within the Department."

We also have a question with Part 2 ©), line 454. It was changed from single occupancy rooms to beds. HCAM requests that this be changed back to rooms to be consistent with the similar language contained in the comparative review criteria, the table on line 886. HCAM is also requesting that at least -- that at the "at least 80 percent single occupancy room requirement" be changed to "at least 50 percent single occupancy rooms." The lowering of the percentage will substantially reduce the cost of construction. This cost reduction will allow those facilities that serve a higher Medicaid resident population to access sufficient capital that is closer to the Medicaid reimbursement limits. HCAM would suggest the following wording:

> "The proposed project shall include at least 50 percent of the rooms to be single occupancy resident rooms with an adjoining bathroom serving no more than two residents in both the central support inpatient facility and any supported small resident housing units."

Section 7, it's requirements to approve to relocate existing beds. Part 1 (D) provides a limitation on the frequency of beds that can be relocated under this standard. HCAM supports this change in the standards to accommodate changing population by being able to allow to relocate beds within a planning area, but feel the seven-year limitation is overly restrictive. HCAM would propose a modification to the standard to permit bed relocations every two years. The Michigan Medicaid program has a policy that allows a facility to takes beds offline. It's titled, "Beds Out of Service Policy." This policy contains a two-year limit to the length of time the beds can be removed out of service. Once -- then they must be either put back into service, removed from the facility or the facility suffers the consequences of being impacted by the 85 percent minimum occupancy standard. It would be consistent to align the relocation bed standards with this policy. We would suggest the wording to be:

> "The Nursing Home/Hospital Long Term Care Unit from which the beds are being relocated has not relocated any beds within the last two years."

Also in Section 7, Part 2 (B), line 521, make reference to the submission of the POC. I think it's just for consistency that what was referenced about the change in the POC in Section 6 would follow through in Section 7.

In Section 8, which is requirements for approval

to replace beds, there's some consistency changes. Our comments from Section 6 should carry over also to Section 8. In Section 9, requirements for approval to acquire an existing nursing home or renew a lease, there is a carryover from Section 6 that would also apply to Section 9.

And then for Section 10 is the review standards for comparative review. The changes in this section tend to provide a level playing field for both the existing facility and a proposed new construction. The one exception to the level playing field occurs when the standards references utilizing the most recent 12 months of facility history. A new construction cannot meet this requirement because they do not have a history. This does not allow them a reasonable opportunity to succeed in the review process. HCAM would request that the language be added to include a certification or written commitment by the facility of their willingness to participate in the Medicaid and Medicare Program, including the percent of participation. The language would need to be added to lines 803, 829, and 832. Also in Section 10, Part 8, the table on the facility design should be changed to be consistent with -- if there is any changes to Section 6, to the percent of single occupancy rooms. Also, we had a question: What is an "adjacent private changing room"? I think maybe there needs to be a definition of that. Is this another room? Or is this a private space for changing?

We didn't have any comments on Sections 11, 12, 13, or 14. On Section 15, which is the effect on prior the CON review standards, Part 2 (B), it references replacing existing Nursing Home and Hospital Long Term Care Units within two miles of the existing nursing home. HCAM requests that the two-mile limit be changed to the "planning area." We didn't have any comments on the special population addendum, and support the moving of the new pilot addendum into the regular standards.

Thank you for the opportunity to comment on these standards. Our Michigan citizens who receive care in these facilities need to be remembered, and each change should be carefully evaluated based on the resident's quality life and quality of care. Thank you.

MS. MOORE: Next we're going to have Pat Anderson reading in testimony from David Stobb from Ciena Health, who is out due to weather conditions today.

MS. ANDERSON: This is testimony from David Stobb, who is general counsel of Ciena Health Care Management, Inc. Ciena is a Southfield-based management company that provides management services to 32 nursing homes throughout Michigan. They care for over 3500 long term care, skilled care residents in the state and employs nearly 4,000 employees in Michigan. David says:

"I have been a frequent speaker at opportunities for public comment at the various meetings of the Hospital Long Term Care Unit standards" -- "Nursing Home and Hospital Long Term Care unit standards SAC, reviewing the Certificate of Need review standards for Nursing Homes and Hospital Long Term Care Units. I also attended and provided comments to the quality

measure workgroup that was formed by the CON Commission at their December meeting, and participated as a member of the public in the quality measure workgroup formed by the SAC.

"Obviously quality measures for nursing homes CON were the focal point of the SAC and the committee and rightfully so, as the quality measure proposals marked a significant departure from Michigan CON regulations that have not been materially changed in 15 years or so. We appreciate the wisdom of the Commission to send the quality measures back -- quality measures" -- let's see; sorry about that. "We appreciate the wisdom of the Commission to send the quality measures back to a balanced representative workgroup for refinement. The workgroup worked hard on developing a quality measure and thankfully was able to reach consensus on a proposal.

"Ciena is generally supportive of this consensus proposal reflected in the document now labeled 'With Proposed Amendments.' Although Ciena continues to oppose the use of overall survey results by chain organization to determine eligibility for individual CON's, workgroup recommendations are an acceptable compromise and the first step in developing a quality measure in the CON process for nursing homes. If adopted, we strongly recommend these measures be reviewed in three years, timed by the next Standards Advisory Committee for long term care to determine the impact of these measures and to explore other quality measures to consider for CON purposes. Unlike the current process, we hope the next time these measures are reviewed, more time is given to evaluate the quality standards and a better representation for all long term care interests are selected for the SAC.

"There are two concerns regarding the proposed CON standards that I will raise today. First, Ciena has concern regarding the application of the proposed quality measures as recommended by the workgroup. I've spoken several times about fairness in the application of the standards. Once they become effective, a fair application of the quality measures from the standpoint of providers, perhaps even the Department who must administrate the standards, is to apply them on a rolling forward basis. Assume the standards became effective May 1st, 2008. Accordingly, if a provider filed a CON application on the June 1st batch date for comparative review applications, survey history from May 1st through 2008" -- "through June 1st, 2008, would be reviewed. If an application was filed on the June 1st, 2009, batch date, quality information from May of 2008 through June of 2009 would be considered. Eventually there would be a three-year look-back, but not until three years after the effective date. In the interim, the standards would be effective, but survey history would be only counted from the May 1st -- the effective date of the standards. This application of the standards would ease the administrative burden for

the Department of implementing these standards by gradually implementing them and then allow providers to be on notice of the CON impact of the future survey results.

"Second, Ciena is concerned about a technical change that was made in Section 15, line 1066 through 1070 that injects uncertainty into the formerly straightforward process to replace an existing nursing home. Section 15 requires projects that involve a change in bed capacity to be subject to comparative review except for the four exceptions listed in Section 15, 2 (A) through (D). Section 15 (B) created an exception to the comparative review for a facility in a metropolitan statistical area replaced within two miles of the existing nursing home. The replacement zone for a metropolitan statistical area is defined in Section 2, (GG), lines 189 to 194, as within the same planning area and within a three-mile radius of the existing facility. The existing standard in place today is that any nursing home replaced in the three-mile replacement zone is not subject to comparative review. In other words, today you can replace a facility within a three-mile radius of your existing facility as long as it's within the replacement zone and you don't need to be concerned with the comparative review. This makes perfect sense. The proposed change before the Commission in line 1069 creates a much different scenario. Although a facility can be replaced anywhere in the three-mile replacement zone, only those replaced within a two-mile radius of the existing facility will avoid comparative review. Those replaced within a radius between two and three miles will be subject to comparative review. This change will greatly limit replacement of old facilities. No provider is going to subject a replacement facility to comparative review, in fear of losing the CON beds. How would this even be administered? Would a provider lose their existing beds to a competing CON application? Will providers continually file strategic CON's in given planning areas to block competitors from building new, more desirable replacement facilities? The answer is I don't know. Providers will not risk CON beds within two miles of existing facilities. The impact is that providers' abilities to find suitable property will be significantly limited to a smaller area and providers will be further restrained from locating replacement facilities where the population wants them. A two-mile radius is not a suitable standard. This is just bad policy change. A better policy is to forget two- or three-mile replacement zones and allow replacement facilities within the wider planning area without comparative review. This allows the market to better dictate the location of facilities where they are actually needed and desired by our changing long term care population. The CON Commission has the authority to allow replacement within the planning area. For example, the new design model facilities can do this:

Allow a replacement facility that meets the minimum design standards to be replaced within the planning area. Allow the market to work and replace old and aging facilities with new ones for our residents. The proposed two-mile radius change simply is a shift in the wrong direction for Michigan. Ciena therefore strongly urges the issue to be re-examined and drafted before adoption.

"Thank you for the opportunity to comment on these proposed standards. Consider all of these proposed changes very carefully, for they greatly impact the delivery of care to the current and future long term care residents of our state. Respectfully submitted by David Stobb."

MS. MOORE: Thank you. I have Paul Verlee from Fair Acres Care Center.

MR. VERLEE: My name is Paul Verlee; I'm from Fair Acres Care Center. That's a nursing home in Macomb County. I didn't come prepared with written commentary, but I did want to make a comment on the bed need -- proposed bed need revisions. Echoing in part what Pat Anderson said at one point relative to the surprising results relative to the Macomb County bed need, as a provider I wanted to give you my personal perspective on that.

Briefly, I guess summarizing my initial surprise, is I looked at the bed need. Overall there is a net drop in beds across the State of 526 as part of these proposed revisions. We have 526 fewer beds in the state if my calculations are correct. Roughly, though, if you take all the counties that gained beds without considering those that dropped beds, there were a gain of 703 beds across various counties in the state -- I'm sorry -- 1236 beds gained across the state; 144 in Livingston, 167 in Ottawa being the next two highest, and then in Macomb County, there's 532. So I was curious as to -- as Pat said, wondering how those numbers were reached. As a Macomb County provider, I looked up in conferring with HCAM, apparently there's 87 percent average occupancy in nursing homes in Macomb County today. Based upon that, if you look at an additional 532 beds coming into the county along with additional home and community-based care alternatives, assisted living, independent living with assistance, and other options in the county, I think you can forecast a very good likelihood of a over-bedding situation, if indeed, people were to proceed with building an additional 532 beds, which is roughly -- currently there's only 3600 beds in the county now. So adding another 532 is a very significant proportion. Comparing that to what were projected in other areas of the state, I'm just very concerned that we would end up with an over-bedding situation that not only would be a hardship on providers, but -- of course, one of the major concepts of Certificate of Need planning is to make sure we have accurate supply, not only as it relates enough beds but not too many beds relative to the over-bedding creating economic hardships not only on the provider, but on the State and the taxpayers. So just questioning -- you know, definitely questioning how those numbers were arrived at and would like

to see how those are calculated and hear the rationale behind it. Thank you for your time for hearing my testimony today.

MS. MOORE: Thank you. Clifton Porter from Manor Care?

MR. PORTER: Good morning. My name is Clifton Porter. I'm here to testify on behalf of HCR ManorCare. These comments are in support of the amendments that are proposed today, and HCR ManorCare through its subsidiaries and affiliates operate more than 275 licensed nursing homes nationwide, including 20 nursing facilities here in the State of Michigan. It's one of the largest long term care providers in Michigan. We appreciate this opportunity to provide public comment on the proposed revisions to the Certificate of Need review standards for Nursing Home and Hospital Long Term Care Unit beds.

The CON Commission took proposed action to approve revised CON standards at its meeting on December 17th of 2007. We commend the Commission for taking action at its December meeting to require the Michigan Department of Community Health to hold workgroup meetings prior to today's public hearing, given there were widespread material concerns from the long term care provider community as to the proposed standards. HCR ManorCare participated in this workgroup and meetings -- I'm sorry -- participated in these workgroup meetings and had an opportunity, along with other providers, to express our concerns as to the many proposed revisions.

HCR ManorCare supports the delivery of quality services by all nursing homes. Although HCR ManorCare continues to have reservations as to whether CON standards based on survey outcomes will result in the most qualified CON applicants, the compromise proposal on the quality measures developed by the workgroup represents a substantial improvement to the proposed standards approved by the Commission at the December 2007 meeting. Thus, despite some ongoing concerns with this approach, HCR ManorCare supports the compromised proposal with the assumption that the CON Commission will revisit the standards if this approach has unintended consequences or irrational outcomes. In our experience, good public policy is developed through positive incremental change. We are pleased that the compromise proposal represents a more incremental approach.

Unfortunately, though, the Commission's work on these standards is not complete. Because the proposed quality measures monopolized much of the SAC's time, regrettably, many other critical issues in the proposed standards received very little attention. Some of these issues will implement potentially harmful policies or materially and adversely impact the fairness of the Michigan CON process. Also, in many instances, these additional issues may prevent the most qualified applicant from attaining -- obtaining, rather, additional nursing home beds. These issues must be addressed before the standards are finalized. These concerns are briefly outlined in my subsequent comments. Please note that these references below as to line numbers correspond to the amended version of the proposed standards posted by the Department for

today's public hearing.

The first point deals with the "Comparative Review Criteria," which are lines 791 through 920. The draft comparative review criteria/scoring materially favor an existing applicant or operator over a new legal entity. We are not aware of any rational basis for this approach, as it is a common legal structure in the health care arena to establish a separate business entity for each licensed facility. Unless corrected, these criteria will favor expansion of existing buildings and materially disfavor the development and construction of new facilities. Over the past 10 years the trend in nursing home construction has been away mega buildings, or extremely large facilities, towards more residential buildings within the 125-bed range, such as the new design model projects. In addition, the construction of new nursing homes improves the infrastructure of the Michigan nursing home inventory. We are unclear why the Commission or Department would support language that will restore the trend towards "super-sized" nursing homes thereby discouraging construction of new and innovative nursing home design.

The second point, "Approved Plan of Correction," these are line 341 through 344, 521 through 524, 577 through 580, 726 through 729, and 786 through 789. Language in the CON standards would require an applicant to demonstrate that it has Department-approved plan of corrections for any cited deficiencies, regardless of the scope and severity level, at the time the CON application is filed. This criterion ignores the normal compliance schedule and framework for licensed and certified nursing homes. In many instances, a plan of correction may not even be due prior to the CON filing date. Alternatively, the provider could submit the plan of correction early, only to have a delay in the processing of the plan of correction by the Department, preclude the applicant from being able to submit a CON application. We also note that the new design model projects appear to be exempt from this general quality assurance requirement, although we do not see any compelling reason for that decision.

The next point deals with "Certification as to Compliance with Minimum Design Standards." These are line 336 through 340, 572 through 576, and 621 through 625. We see no reason for an applicant to certify the minimum design standards for health facilities {health facility construction/construction permit requirements) will be met "when the architectural plans are submitted for review and approval by the Department." Clearly the minimum design standards must be met for a CON-approved project to obtain a health facility construction permit. However, frequently the plans are not 100-percent compliant with the Department's interpretation and application of the minimum design standards upon initial submission of the architectural plans, even when prepared by an experienced and qualified architect. Rather, the health facility construction plan approval process involves some "give and take" with the Department before full compliance is achieved. There is no need to tie this requirement to the

CON standards as it already is legally required under Part 201 of the Public Health Code. Alternatively, if the CON Commission retains this requirement, the standards should simply say that the CON-approved applicant will demonstrate compliance with the minimum design standards prior to initiating construction, not upon initial submission of the blueprints.

The next point, "New Design Model Language." These are lines 454 through 457, and 656 through 662. It is our understanding that the intent of the SAC was to move the language from the addendum for the pilot program for new design models to the body of the standards. In this process, the requirement as to private accommodations was modified from 80 percent private rooms to 80 percent private beds. This is a materially more difficult and burdensome standard that we believe will discourage providers from constructing new design model facilities. Testimony at the SAC suggested that construction costs for a new design model nursing home may run up from 60,000 to 80,000 more per bed than traditional nursing home construction. This is due in part to the requirement for private rooms. Given the CON Commission, by statute, must consider cost as well as quality and access, we believe that the 80 percent private bed requirement is unduly restrictive, cost prohibitive in many instances and likely to discourage construction of new design model facilities.

The fourth point, dealing with relocation of nursing home beds, and this is line 489 to 525. HCR ManorCare supports the addition of language to allow relocation of some nursing home beds from one existing facility to another existing facility within the same planning area. In our view, relocation may help even out small problems with the allocation of nursing home beds within a planning area. However, we suggest a cap on the number of beds that can be relocated, in addition to the limit on relocation of up to 50 percent of a facility's unoccupied beds. If a maximum of 40 existing beds, for example, no more than two 20-bed units could be relocated, this would provide some ability to even out allocation of nursing home beds in the planning area but not allow for establishment of entirely new nursing home facilities outside of the bed need and comparative review process.

The last point deals with the "Implementation of the New Quality Measures." The new quality measures clearly constitute a significant departure from the existing CON standards, and signal a new approach for awarding CON approvals in Michigan. However, because this system is materially so innovative, it would be reasonable to implement the new criteria on a rolling basis as follows: Assume the standards become effective May 1st, 2008. If a provider filed a CON application on the June 1st batch date for comparative review applications, quality history from May 1st through June 1st of 2008 could be reviewed. If they filed an application on the June 1st, 2009, batch date, quality information from May 1st, 2008, through June 1st, 2009, would be considered. Eventually there would be a three-year look-back, but not until three years after the

effective date. In the interim, the standards would be effective but quality history would only count from the May 1st, 2008, date forward. This approach would give providers an opportunity to become familiar with the new requirements, reduce the likelihood of litigation in comparative review applications and potentially ease the administrative burden for the Department in implementing these new standards. We expect the CON forms will need to be revised to address these criteria and that a number of questions will arise once the documents -- I'm sorry -- once the Department starts receiving CON applications under the new standards. This approach would allow for the gradual transition from the existing system to the new requirements.

Thank you very much.

MS. MOORE: Thank you. Next we'll have Jonathan Neagle from Extendicare Health Services.

MR. NEAGLE: Good morning, and thank you for allowing me to be here today. Hello, my name is Jonathan Neagle and I am here today representing Tendercare, Michigan, Inc. I am the area vice president of Tendercare, Michigan, Incorporated, and Extendicare Health Services, Inc. I personally wish to thank you for the opportunity to express our opinions today about the proposed Certificate of Review standards.

Tendercare, Michigan, Inc., is a statewide provider of long term care through our skilled nursing facilities and our inpatient rehabilitation hospital here in Michigan. Combined, we provide quality, clinically-based services to over 3341 residents in the State of Michigan. Nationally, through our parent corporation of Extendicare Health Services and its affiliates and subsidiaries, we provide on a daily basis care to over 19,145 residents in our 165 facilities across the United States. Extendicare Health Services, with its acquisition of Tendercare, Michigan, in October of 2007, is pleased to have a presence in the State of Michigan and looks forward to many years of continuing to provide optimal care to the residents of the State of Michigan.

As the Commission moves forward with an examination of the proposed standards, we urge that the goal remain focused on improving the quality of life and care for our residents. It is important to remember that such improvements can come about not only by implementation of stringent restrictions but also by initiatives that help foster, encourage and provide incentives for providers to engage in needed improvements; whether by relocations, renovations, or replacement of facility infrastructure. It is the delicate balance of both the positive initiatives and the restrictions that provide, often, the best outcomes. Tendercare cites the FIDS program as an excellent example of a program that provided such a balance.

Tendercare had a representative in attendance at the January 2008 workgroup on quality measures, and wishes to express our support of the quality measures that resulted from that 2008 meeting. Nonetheless, while we are supportive of the proposal that came forth from the workgroup, we still remain concerned and dismayed at the

stringent use of the survey process as a measure of quality. In addition, we still believe that the best type of changes to a process, those that have the most benefit and success, are those implemented in slow and incremental ways. We continue to assert that the standards developed to date proceed in a manner that implements new criteria in a way that is not indicative of a slow and incremental process at all. With that said, we still wish to reiterate that we do support the standards for quality measures, as was brought forth from the January 2008, meeting of the workgroup.

In addition, while we support the workgroup proposal that was brought forth, there does clearly and definitively exist a number of issues in the proposed standards that Tendercare asserts to be in need of further revision, clarification and/or alteration.

As I take a moment to outline our concerns and comment, I will be referring to sections and line numbers as contained in the CON review standards for Nursing Home and HLTCU beds with proposed amendments.

Minimum Design Standards for Health Facilities: In Section 6, line 336-340, (Section 6, 1 (B), page 7); Section 8, line 572 to 576, (Section 8, 1 (D), page 12); and Section 8, lines 621 through 625, (Section 8, 2 (D), page 13), a CON applicant will be required to certify compliance with the minimum design standards for health facilities in the initial plans. The minimum design standards are required to be met already under the licensure provision of the Public Health Code. Inserting them in a CON standard is not only redundant, but inconsistent with the flow of construction projects and the timing of submission of architectural plans and revisions. The resulting effect would be an applicant who certifies that they are in compliance but later determined not to be in compliance by the Department at the time of the submission of the architectural plan. This could occur, for example, at the time the construction permit is being issued. Further, this could occur at a time significantly after the date the CON is issued. As a result, a CON applicant who now has a approved CON could be deemed to be out of CON compliance. If the intent of this section was to try to make sure the minimum design standards are complied with, the Public Health Code Part 201 more than adequately addresses this, due to the fact that no facility can obtain a license without compliance. We ask how can somebody certify something in advance of the time it is required to be submitted and approved? The most one can certify is that they will attempt to meet the standards at the time of submission. In any event, prior to opening a facility's doors to residents the design standards are met, or else the facility would not be able to obtain a license. Thus, we request the deletion of this section as it does not belong in the CON standards, and already provided for at the appropriate time during the construction project under the Public Health Code.

Plan of Correction Requirements: In Section 6, line 341, (Section 6, 1, C, page 7); Section 7, line 321 to 324 (Section 7, 2, B, page 11); Section 8, lines 577 through

580, (Section 8, 1, E, page 12), Section 8, lines 626 through 629, (Section 8, 2, E, page 13); Section 9, lines 726 to 729 (Section 9, 1, E, page 15), Section 9, lines 786 to 789 (Section 9, 3, C, 3, page 16), the standards would require both the submission and approval of a plan of correction, POC, for survey deficiencies at the time a CON application is made. Unfortunately, the realities of the survey process do not fit with this requirement as currently worded. Often there is lag time between the survey and the notice of deficiency, as well as a lag time in processing the survey and approval of a POC. Also, there could be a situation in which an applicant is surveyed close to the time of the intended submission of a CON application, the batch date, whereby a potential applicant would be prohibited from making a CON application merely by the timing of a survey. We therefore support a wording change such that the plan of correction submission only stand as a requirement if the POC is actually due prior to the date of the CON application; and further request that the requirement for approval of a POC be struck from the standards.

Single Occupancy Rooms: In Section 6, lines 454 to 457 (Section 6, 2, C, page 9) and Section 8, lines 656 to 662 (Section 8, 3, B, page 13), each contain a requirement for 80 percent of the beds to be single occupancy resident rooms. It is important to note that the original pilot new design projects percentage were based on the numbers of rooms that were single occupancy, not the number of the beds in the facility. This switch from "rooms" to "beds" is not an insignificant change and results in a far stricter requirement and a much more expensive project. In addition, it could result in less projects being undertaken on the part of providers to incorporate the new design standards. It is our understanding that the State of Michigan wishes to encourage the proliferation more facilities, either renovating or constructing, using the new design standards. We therefore request that the wording be switched back to "rooms" to reflect the requirements of the original new design standards. This change would also bring consistency to the comparative review criteria in Section 10, line 866 (Section 10, 8, page 19) that correctly uses the criteria based upon the number of rooms that are single occupancy and not the number of beds.

In addition, we strongly assert that the 80-percent requirement in both Section 6, 2 ©), and the comparative review criteria in Section 10, line 886, would similarly increase the cost of construction such that the facilities with a large Medicaid population would be unable to implement design and renovation or replacement changes. The reality of the amount of reimbursement as provided for under the Medicaid program, would not allow a facility who has made the commitment to serve the Medicaid population, to entertain facility construction projects, were the level of single occupancy rooms to remain at an 80 percent level. We therefore request that the percentage be brought down to 50 percent of the rooms. This percentage will more readily allow all facilities, regardless of the payor mix, to make

needed improvements and changes to a facility for the benefit of its residents.

Relocation Restriction Limited to Seven Years: Further in Section 7, line 504 to -5, (Section 7, 1, D, page 10) a relocation of beds could only be accomplished once in seven years. This provision limits the frequency in which beds can be relocated. Under the Michigan Medicaid program, beds are permitted to be taken out of service for a period not to exceed two years without being impacted by a minimum occupancy policy. We feel that the Medicaid standard of two years more closely aligns with the reality of the market and the ability of facilities to predict occupancy and future financial constraints. Extendicare asserts that the seven year limitation for relocation is unduly restrictive and would require facilities to forecast population changes and other factors seven years into the future. Tendercare supports and recommends that the seven-year limit be reduced to a two-year limitation.

Comparative Review Standards: Section 10 sets out the comparative review standards. It would appear that as currently written the comparative review criteria sets up a system that favors those providers/applicants who are already operating facilities over a newly created facility or legal entity. As a result, new development of facilities by way of new construction would be materially disadvantaged under the proposed criteria. Under the criteria, it will be easier to prevail on an application for expansion over one for a new building. The FIDS program was an effort to stimulate innovative design initiatives and culture change. Many times such changes are not feasible within an existing facility footprint. Thus if the State of Michigan truly wishes to foster such innovation, it is important to recognize at times new construction by operators who have the capital to finance such projects is needed. Therefore it makes little sense to implement criteria that squelches the chances of new and potentially innovative facilities. Therefore we recommend that Section 10, lines 800 to 850, (Section 10, Part 2 and 3, page 16 and 17) the language which awards points based upon a 12-month facility history to be altered to allow for points to be awarded for a commitment to participate in Medicaid. Such an addition will provide for an even assessment between the existing facility applicant and the new applicant.

Section 10 in the comparative review criteria makes reference to facility design that would include a space designated "adjacent private changing room." There does not appear to be any defining criteria as to what this space actually must be. Clarification as to how one would meet the definition of "adjacent private room" would be helpful. As this criteria is part of an assessment of a central shower configuration, we request that the language be changed such that it read "adjacent private changing area."

Lastly, and of significance, Tendercare's concern about the set of quality standards that will be implemented in such a way that the survey criteria in the quality measures get effectively applied retroactively. This

concern is even heightened by the stringent criteria that look at Level D and above citations on the scope and severity grid. Most, providers when receiving survey citations, make a calculated cost benefit analysis as to whether or not to contest a citation. It is clearly and very possible that the cost benefit analysis equation under the proposed quality measures would have a different than -- would have been different than without those measure. This would be particularly true of citations at a Level D or above on the scope and severity grid. Therefore Tendercare respectfully submits that some form of progressive introduction of the standards be introduced upon the effective date of the standards. Such an approach would be consistent with a slow and incremental change approach that Tendercare favors and advocates.

Thus we would request for consideration that the quality history is assessed from the effective date of the standards going forward, such that eventually look-back of quality history data would begin to be assessed, although not immediately, upon implementation. However, the actual point that the review approximates a look-back of data history is then phased in. In the event that this phase-in is not accepted as an approach, then the only alternative and fair approach would be to alter the Level D and above citation criteria to Level E and above criteria. This would have the effect of mitigating some of the impact of the retroactive look-back approach in the implementation of the quality measures.

Thank you for your patience and time in allowing us the opportunity to provide our comments regarding these standards. As we move forward in the years to come, we hope that everyone involved in the development and implementation of these new standards will be able to look at the changes they have brought about and see effects that are positive for those who entrust us with their health care needs. Thank you.

MS. MOORE: Thank you. Next we'll have Sarah Slocum, State Long Term Care Ombudsman.

MS. SLOCUM: Good morning. Thank you for the opportunity to comment on these proposed Certificate of Need Standards for Nursing Homes and Hospital Long Term Care Units. As the State Long Term Care Ombudsman, I am the -- charged with being an advocate of residents who live in long term care facilities. And in that role I have served as both a member of the Nursing Home Standard Advisory Committee, the SAC, and the workgroup assembled in 200- -- January 2008, to review some parts of the quality standards that were proposed. I feel that this effort has created a true consensus document which you have before you today. I deeply appreciate the CON Commission's action in December 2007, accepting the majority of the recommendations from the Nursing Home SAC. And I continue to support the implementation of the proposed standards which were presented in December.

I strongly support Certificate of Need Commission approval and Department implementation of the revised quality standards as presented by the workgroup. Several

changes were made to deal with concerns from various interested parties, including:

-- Out of State providers who also have a significant Michigan presence were relieved of the burden of producing lengthy reports of their track records in other states.

-- The simplification of some of the quality standards by removing two of the less serious infractions from the list of incidents that restrict CON activity (the repeat harm citations and repeat staffing citations.)

-- Adjusting and clarifying the time period under review for survey-based measures to make the measure more real time, so that the survey data that is being looked at in terms of the statewide average is based on the average at the time of the survey being examined.

I really appreciated my provider colleagues' participation and their earnest efforts to reach a consensus, which we did in January. And I hope that they will continue to support these efforts.

In some previous testimony we've heard that -- from Ciena Corporation, that it would be a good idea to reexamine these standards after they've been put in use, and we'll have about a two and a half year or less time period to look at what actually happens once these standards are put in place. I would suggest that the idea of a rolling date of implementation or some time period where we would only in fact be looking at a few months' performance is a substantive change to the consensus document that we worked on and agreed to in January. And I would object to the Commission changing the implementation process and timing.

The survey process, which has been discussed at great length in both the SAC and at smaller workgroups, is not a surprise to any of the providers. So any provider who's been operating in Michigan for some time period not only has Certificate of Need as a motivating factor to meeting and achieving and maintaining compliance, but they have all manner of other enforcement mechanisms that prompt them to want to be in compliance with the State rules. I think implying that this is an unknown and new process that should only be used on a rolled-out basis is not really accurate, and I would object to changing the implementation timing.

So with that said, I will close by saying that I'm truly impressed with the level of cooperation and sincere dedication to problem solving that's been shown by both provider representatives and consumer representatives in the workgroup. And I thank all who participated, and I hope for swift adoption of this consensus proposal on quality by the CON Commission. Thank you.

MS. MOORE: Thank you. Next we'll have Ian Engle.

MR. ENGLE: I thank you for allowing me to come up and to speak. I would like to just offer a little bit of testimony on behalf of the residents and the consumers who are in nursing homes. I've spent a lot of time -- and I just want to make clear that as a person who has gone into nursing homes and an advocate who has had to investigate

abuse and neglect and monitor facilities that are really below compliance and really terrible, to remind everyone that these kind of facilities are out there and that these minimum standards are important so that facilities like that are not -- the companies that own facilities like that aren't allowed to go out and invest money in new facilities before they clean up what's going on in the problem areas. And to say that there are already all these mechanisms for making sure that certain standards are met and that the Certificate of Need standards are redundant, doesn't make sense to me either, because that would only be confirmation of a thing that we need, which is good quality standards. And I appreciate people talking about the need to create a good quality of life and quality of service for the residents and the consumers in these facilities, because that is what this is really all about.

And the other couple things I wanted to mention was that restriction of the construction of new facilities is, I think, important in the areas where people should be investing that money into making sure that the facilities that are already being run, are being run up to standard before they go investing into creating new facilities. I don't think it would restrict innovative -- you know, the ability for people who are doing a good job to then go out and create innovative and new facilities.

It sounds like so much of a business to me and I'm not familiar with that end of it, you know, with all the financial restraints and the reality of the market and this kind of thing. And I just want to really bring it back to the fact that I, as an advocate and a consumer, really appreciate the work of the Committee and the workgroup to put together these standards which I feel are a long time coming and just basically a minimum bar that needs to be met to make sure that the consumers do receive good quality care. And for those of you folks who are providing this good quality care, I don't think it should be a problem because I don't think you should have a problem meeting these standards. And that's not to say that some of these small little details can't be worked out. But I just want to bring it back to the very important point that I'm sure we all agree upon, which is the focus of quality of care and the benefit to residents, and the ability to start providing some kind of choice for residents so that the people who provide the best quality facilities then have consumers and families coming to them, wanting to be in that facility, and let that drive the market -- competition drive the market.

That is basically it, other than I really, once again, just want to thank the Committee and the workgroup and everyone involved for putting the Certificate of Need standards in place, because I think that it is a good first step in improving the services that are going to be provided to consumers, which is really what this is all about. Thank you very much.

MS. MOORE: Thank you. Next we'll have Frank Wrowski, from MediLodge.

MR. WROWSKI: Good morning. My name is Frank Wrowski. I'm the president of the MediLodge Group. We have

several thousand nursing home beds in southeast Michigan. And I would like to thank the Commission and all of the committee work that was done. And I appreciate all of the work and all of the compromises that had to be made. And I only have a couple items. I would certainly echo everything that has been said in the room already. I would like to follow up on a couple things. Number one is the bed need methodology, which I think is probably a fairly old formula that I used to work with, I know back in the 1970's. It currently does not take into account all of the new alternatives -- assisted living, home health care, adult foster care, home for the aged, and the like.

That's significant because over the past few years, nursing home occupancy ratios have actually come down rather than gone up. And when looking at the proposed adopted bed need, there is some increase in some counties, like Macomb County, for example, where we think the addition of enormous amounts of beds might destabilize the existing facilities and the existing population. So we would like to have the Commission examine both the formula and the methodology.

The other thing I wanted to mention is that should the Commission adopt the new bed need as proposed, that the implementation date be stretched out and put into a format that fair and just comparative reviews can be examined. The only other thing I want to mention is that the requirement under the new design model requires an 80-percent either private rooms or private beds. We think that's an arbitrary number and it should be at least -- be justified by some market studies and be determined by what's available in the market. More importantly we think that that will drive additional -- significant additional costs. And if we have to have a standard, we would propose a 50-percent standard of private rooms.

So those are my comments and I will wrap it up with that. Thank you.

MS. MOORE: Thank you. And I just want to note for the record that Kim Ringlever has provided written testimony on behalf of MAHSA for today. And is there anybody else that is interested in providing testimony today for either sets of standards that we're looking at; CT or Nursing Home?

ALL: (No verbal response)

MS. MOORE: Seeing no comments, we'll go ahead and adjourn for today. I do want to remind everyone that if you do have additional public testimony, please provide that through the Department's electronic link. You'll find that out on our website. Thank you for your time today.

(Meeting concluded at 10:34 a.m.)

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