

**STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED**

NURSING HOME & HLTC UNIT BEDS PUBLIC HEARING

Friday, July 16, 2004
Lake Ontario Room - Library
702 West Kalamazoo Street
Lansing, Michigan

ORAL TESTIMONY

(Proceedings scheduled to start at 10:00 a.m.; actual start time was 10:00 a.m.)

MS. ROGERS: Good morning. My name is Brenda Rogers. I am Special Assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson, Renee Turner-Bailey, has asked the Department to conduct today's hearing.

We are here today to take testimony concerning proposed revisions to the review standards for nursing home and hospital long-term care unit beds. The proposed certificate of need review standards for nursing home and hospital long-term care unit beds are being reviewed and modified to establish a statewide pilot program to study the potential benefit of new designs in the new construction, renovation and/or replacement of existing nursing home and hospital long-term care facilities throughout Michigan.

Pilot projects shall be within the current bed need methodology. Further, it will allow for projects that will enhance the privacy, promote greater dignity and increase the quality of life for residents.

Please be sure that you have signed the sign-in log. Packets can be found on the table. In the folder is a card to be completed if you wish to speak. Please hand your card to me if you wish to speak. Additionally, if you have written testimony, please provide a copy as well. As indicated on the inside pocket of the packet, written testimony may be provided to the Department through July 23rd, 2004, at 5:00 p.m. We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until all testimony has been given, at which time we will adjourn. Today is Friday, July 16th, 2004, and we are now taking testimony. First up I have Reginald Carter from HCAM.

MR. CARTER: The Health Care Association of Michigan represents 270 nursing facilities across the state, and would like to thank the Certificate of Need Commission, and specifically Commissioner Brad Cory, for taking a progressive stand to begin the rebuilding of the aged nursing home facilities.

The average age of Michigan nursing homes is at least 30 years old, with many of those structures being originally constructed for other purposes. The proposed changes allow a more flexible design to accommodate the consumer needs, along with providing the highest quality of care.

As much as CAM supports and participated in the language for the Certificate of Need changes, there are a few things still being debated by us that we would like additional time to be able to resolve. So the major point -- and we will be submitting the written testimony -- is the concept of financing of these new facilities. The current reimbursement structure for the Medicaid program is setting the current asset value at \$43,500, and our review of the structures that have been built in the last eight years is that it's closer to 90,000. So we need to work out that small but important issue with the Department, and we are in the process of doing that. We would hope to be able to resolve that before the September time frame, before the next meeting of the Certificate of Need, but failing that, we would ask the Commission to consider making a final decision 'til December. I think that's really our major point, without going into all of the

detail which is supplied in our testimony. So, Brenda, I think you have a copy of that, and that's our testimony. Thank you.

MS. ROGERS: Thank you. David Herbel, MAHSA.

MR. HERBEL: Good morning. My name is Dave Herbel, and I represent the Michigan Association of Homes and Services to the Aging. I'd like to thank you for the opportunity today to present to you our position on the Certificate of Need language, "pilot projects," as we're calling it.

Having participated in the work group, we'd certainly like to thank the Department and the Commission for its innovative and creative thinking in allowing the nursing home profession to begin to redesign its future and the existing facilities in the State of Michigan. MAHSA represents about 180 organizations in the State of Michigan. We are the not-for-profit organizations within the state, and we are in support of the project and would encourage the Commission not to delay the process at this point.

We, too, have concerns relative to the reimbursement issues and some of the regulatory issues that face us, as we would try to implement these new pilots, but we think it's more important to move the process forward, and we are encouraged that the subcommittee work group that created this language could also continue to work on these reimbursement and regulatory issues in the spirit which has brought us here today. So that is our primary testimony. I will be sending you a more detailed list of our concerns. But, again, we would encourage the continued momentum. Thank you.

MS. ROGERS: Thank you. Forgive me if I mispronounce this. Steve Bandstra from Community Care Group?

MR. BANDSTRA: Close enough.

MS. ROGERS: Okay.

MR. BANDSTRA: Good morning. Community Care Group is a provider of quality skilled nursing and assisted living to 1200 Michigan residents at 20 locations throughout our state. We also wish to thank the CON Commission for addressing the need to improve the physical environment of skilled nursing facilities. We generally agree and support the body of the Commission's CON changes. Some of the proposed standards we don't agree with. Our testimony today will only really focus on one aspect of that. Much of the change that is envisioned by the Commission with the proposed pilot we think is happening now and is being driven by local market forces. Most Michigan providers clearly understand the need to significantly improve or replace their structures, and many have moved forward successfully. We now urge the Commission to carefully study recent projects throughout the state before it acts on a pilot. CCG urges the Commission to engage in a series of broad-based funding and public policy discussions before moving forward with this model. We really doubt that most of our private paying residents could afford the real costs of the model as it is currently proposed. When Medicaid is asked to provide special funding for this model, we think taxpayers and legislators should essentially be asked if they wish to fund a Ritz-Carlton experience for welfare recipients in a discriminating manner. We would urge the Commission to step back from strictly defining physical plant standards. The developers and architects of these 21st century facilities we believe will require much greater flexibility to promote individual, unique and localized solutions that will benefit the patient. The more you attempt to legislate it, the less creativity and innovation will be fostered. Many in the skilled nursing profession will argue that Medicaid reimbursement is inadequate to support the level of change that we all agree is necessary. CCG supports our colleagues' arguments on the operating cost side of Medicaid, yet on the capital cost side, we disagree and believe that Medicaid dollars reimbursed and spent differently would be a strong incentive for significant new construction or renovation. We know from our firsthand experience that non-Medicaid revenue streams are significantly improved as a result of these types of projects, and this new revenue alone could make new construction financially feasible. We believe that minor regulatory and reimbursement fixes, combined with the real demand for this improved product will be the catalyst for the skilled nursing physical environment improvement that everyone wants to see happening. CCG respectfully requests that the Commission reconsider the statewide skilled nursing pilot. Again, we

commend the Commission for addressing many of these fixes, and thank you for the opportunity to testify.

MS. ROGERS: Thank you. Okay. I have to apologize, because I cannot read the writing. Michael -- I'm not sure -- and I can't even tell who it's representing.

MR. PERRY: Michael Perry, HCR Manor Care.

MS. ROGERS: Thank you.

MR. PERRY: Good morning. As noted, Michael Perry, HCR Manor Care. I'm director of operations for Michigan. HCR Manor Care operates 300 nursing facilities in 31 states, including 26 nursing facilities in Michigan, with a total of 3,000 nursing facility beds. We also operate assisted living facilities, home health care offices in locations in Michigan and around the country. As a multi-state provider, HCR Manor Care has the opportunity to observe a variety of regulatory frameworks for nursing home facilities among the different states. In addition, we continue to develop new state-of-the-art nursing buildings, including in Michigan, that reflect a high level of quality, as well as a high level of acuity services that have become an HCR Manor Care trademark. We've reviewed the draft pilot program language for long-term care beds and units developed by the long-term work care group. We'd like to offer our comments today. To begin, I'd like to commend the CON Commission, Commissioner Corey, the Department and other work group participants for taking the initiative and time to examine nursing home regulatory and CON issues. It has been a number of years since there have been modifications to the current CON standards. Thus examination of the standards in the current regulatory climate, we believe to be appropriate. Second, we support greater flexibility in the CON standards for construction or replacement of nursing home facilities. The draft pilot program language recognizes the need for more options in care delivery and would appropriately permit operators to construct nursing home facilities in Michigan that reflect innovations in nursing home care. Additionally, we support the quality of care as an important objective for all nursing homes in Michigan. A regulatory framework that rewards high quality of care, and penalizes those operators with a consistent record of substandard care is good for the long-term care industry in Michigan, and good for the citizens of this great state. We wholeheartedly support the underlying premise behind the proposed program to ensure the quality and access for Michigan residents to state of the art nursing facility services. At the same time, however, we want to ensure that changes are not made to the CON regulations at the expense of existing quality Michigan providers, including providers who have invested significant capital during recent years to develop innovative nursing facility designs that are vastly improved over older, outdated nursing facilities, and have proceeded with these new construction projects through the existing Certificate of Need process and regulations. These recent construction projects, in fact, demonstrate new design standards that respond to clinical and resident comfort needs for Michigan residents. In addition, we have concerns as to whether the impact of the four-year window for an unlimited number of pilot program projects has been sufficiently considered. This has the potential to significantly alter the location of nursing homes in multiple planning areas, especially those planning areas that are otherwise subject to the three-mile replacement zone restriction. This potential unlimited development of new nursing homes outside of the standard CON parameters could have a severe negative impact on existing nursing homes, including quality providers, newly constructed nursing facilities and new facilities under development, developments which already represent a significant financial commitment to improve the nursing facility inventory in Michigan under the current CON rules. We are concerned as to whether there has been adequate study of the potential impact of this unlimited development and its impact on replacement zones, particularly as it relates to the availability of nursing home beds in certain areas of the state. Under the proposed language, a nursing home operator could readily replace existing beds from a less economically desirable service area within the planning area to more upscale areas. The proposed language does not address the demographics of service areas within urban planning areas or the need for replacement. We have concerns that the pilot program language has the potential to leave certain areas of Michigan without sufficient nursing home beds, and to potentially reduce the quality of the available nursing home beds in those areas. With this in mind, we propose that the CON commission consider the following modifications to improve -- to the proposed pilot program language. Number one, limit the quantity of pilot program nursing facilities. To be consistent to the premise behind the pilot program, we believe it makes sense to approve a specified

number of pilot program nursing facilities, then analyze their experience and recommend changes based on that experience to ensure that innovative and successful pilot program concepts are maximized. The alternative, to approve an unlimited number of pilot program facilities, does not make sense, as it would not permit innovative concepts to be studied and modified for the long-term benefit of the residents in Michigan. We therefore propose that the Commission consider a wide geographic distribution of pilot program facilities that limits pilot program projects to a maximum of one per health planning area, no more than one to be approved to each corporate-affiliated provider. Number two, limit geography replacement zone. We recommend that the commission consider limiting the replacement zone to a maximum of five miles from the existing licensed bed -- licensed site, instead of expanding a replacement zone to the total planning area. Limiting the replacement zone to five miles would maintain access and would ensure that the existing nursing facility beds continue to serve at least some of the residents' communities that are currently being served by those beds. In fact, by expanding the current three-mile replacement zone to the total planning area would appear to be counter to the goal of improving quality and access of nursing facility care for those individuals who currently depend on ready access to those beds. Number three, total Medicare/Medicaid dual certification. We commend the Commission for requiring total dual certification for pilot program beds in order to maximize access for those residents -- for all residents. We recommend that the Commission consider adding clarification language to ensure that dual Medicare/Medicaid certification would still be required even if the pre-moratorium Medicaid bed caps have been reached. For your convenience, we have incorporated these recommended changes into the draft pilot program language. We support the pilot program language that requires a specific percentage of private occupancy rooms, currently identified at 80 percent in the draft language, and a maximum size for new construction pilot program facilities, currently identified at 100 beds. It makes sense to create specific parameters for approval of pilot program nursing facilities to ensure that innovative design models are created under the pilot program that are significantly different from the existing inventory of Michigan nursing facilities. The alternative, to permit pilot program nursing facilities to be customized for each market without a specific definition, would not ensure development of a project that meets the Commission's intended goals. In summary, we commend the CON Commission for considering strategies to improve quality and access for Michigan residents to quality nursing facility services. We hope that the Commission will consider our recommended changes to the pilot program language, as we believe that these changes would better accomplish the stated goals, while at the same time protecting the investment of many Michigan nursing facility providers to improve the nursing facility infrastructure using the current CON standards and rules. Thank you.

MS. ROGERS: Thank you. Something I forgot to mention up front. Once this hearing's over, for those of you that spoke, if you could please print your name on the sheet at the podium and your organization, if you didn't do that, just for the benefit of the court reporter. Thank you. Those are all of the cards that I have. Is there anybody else who wishes to provide testimony? Thank you. Jon Reardon. Is it Hoyt Nursing and Rehab?

MR. REARDON: Yes, ma'am.

MS. ROGERS: Thank you.

MR. REARDON: Again, my name is Jon Reardon. I'm the owner of Hoyt Nursing and Rehab Centre in Saginaw, Michigan. Today's testimony, we're hearing from many stakeholders in our state regarding this innovative movement by the government to make a change in the infrastructure and the physical plants of our nursing homes in Michigan. As an individual owner -- and I also want to speak today with no authorization from all the other individual owners, but in keeping them in mind that this will have great ramifications, whatever we do, whatever we end up with, on their abilities to be involved in this project to upgrade their facilities after many years of ownership. My family has owned Hoyt Nursing Home since its inception and its building in 1963, at which time it was a 69-bed facility. I was fortunate to get a CON to add nursing beds, 59 to my facility, and completed construction and renovation in December of 2002. We've heard testimony and some issues and questions regarding how is the Medicaid program going to cover costs and the importance of that as it relates to any CON changes. And just to give you an idea of that and the cost of construction and renovation of my facility, under the current CAV and reimbursement standards, I'm currently over the CAV by approximately 20- -- a little over \$20,000 a bed by doing this

project, which results in an interest disallowance of \$158,000 a year. We are able to, at this time, manage it based upon other revenue sources and being able to keep a fully occupied facility, because it is more new and renovated. But that is going to be a serious issue as we move forward, particularly if there is going to be additional funding provided to these pilot projects, that individuals like myself that invested in the future are still going to be sitting on the outside of this without any additional help like new facilities might receive in this program. You've heard a lot of testimony today, again, from serious stakeholders. There are some serious questions. I think our profession was really taken aback by the expediency that this has come forward. We applaud it. Without a doubt, that something needs to be done, and the government's willingness to be involved, but it has really happened too quick, I think, for everyone to have some serious studies done, be really understanding what we're trying to do, because these decisions will last into decades into the future. I encourage the Commission to withhold any decisions on this, again, until December, to where I think some more meetings of everybody can be put together, heads together, and see if the decisions that are going to be made are going to be appropriate. Quickly, the 80 percent private room, although we did hear some testimony in support of that, I have some questions of whether or not 80 percent is appropriate. There is no study that says that is. I think if we understand the nature of our residents today, whose medical care needs are more, their physical limitations are more, that a lot of the times, having a roommate is a very good benefit to stimulation and human contact, and helps with the isolation problems. I really think that the driving force for private rooms are the sons and daughters of the residents, in today's society, wanting this. Having more private rooms than our profession has now is certainly more appropriate, and I would agree we need more for special circumstances and individual wishes, but it's not for everybody. And I think that that needs a more serious look. Obviously, the more private rooms we have, the more square footage, the more cost. And, again, with the limited resources of our Medicaid program and the continuing strain on the budget, those are serious issues that do need to be taken into consideration in regard to an appropriate quality environment for a reasonable, appropriate cost. And maybe 80 percent will turn out to be right. There's just not enough time that we've had to have everybody's minds together, and I would just encourage the Commission to withhold on any decisions, again, until December, when more work and information can be provided. Thank you for allowing me to testify.

MS. ROGERS: Thank you. Is there any further testimony? Laura Hamann.

MS. HAMANN: Good morning, and thank you for the opportunity to testify. I will be brief, and I want to speak mainly to the issue of the private rooms. I represent a single facility owned by a hospital organization. It has 120 beds. And my facility was built in 1972. I think it's a design that represents many facilities across the state. We currently have two private rooms, and we're in the planning stages of doing a significant addition, replacement of many of our beds. What we would like to be able to do -- and I think many facilities would across the state -- is to do an addition that would allow to build new semi-private rooms that are very large and provide dignity to the residents, and then be able to convert the semi-private rooms to private rooms, and this model does not allow for that. So please consider that in your final decisions. Thank you.

MS. ROGERS: Thank you. Any further testimony? Okay. Seeing and hearing no further testimony, this hearing is adjourned. It is 10:27. Thank you.

(Proceedings concluded at approximately 10:27 a.m.)