From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 9:51 AM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Jean Aldrich, CMPE
2. Organization: Association of Otolaryngology Administrators, Private Practice: Eye & ENT Specialists
3. Phone: 269.945.3888
4. Email: jaldrich@eyeentmds.com
5. Standards: CT
6. Testimony:

Thank you for accepting this written testimony regarding the proposed Michigan Certificate of Need (CON) changes to the CT Standards. My past experience as the President of the national Association of Otolaryngology Administrators, past President of Michigan Medical Group Management, and my position as Administrator of Eye & ENT Specialists in Hastings, MI has provided me with knowledge at the national, state, practice, and patient level specific to CT in a physician office setting.

I had the opportunity to attend three of the CT Standard Advisory Committee (CTSAC) hearings. I testified to the impact of patient care, patient satisfaction, over utilization and cost concerns under the current regulation of CT in ENT physician offices. At these events, it was my feeling that my testimony was falling on deaf ears. My experience demonstrated that the CTSAC was like a fox guarding the hen house. The commission was heavily represented by facilities, hospital-based physicians, and others that had little interest in debating the issue with an open mind.

My point on over utilization and cost concern is that CON is not the place to try to regulate these issues. Utilization and costs are regulated by insurance companies in today's physician office, even if we're ordering a CT to be done at a hospital-owned facility. Insurance companies either require pre-authorization of the service before being performed or reject payment of the benefit as not medically-necessary. This results in neither the hospital or the provide being paid for the service, and under contract we are not allowed to bill the patient. From my research regulating the availability of a service has not resulted in decreased cost or utilization.

When deciding public or private healthcare policies, the patient care and satisfaction must be the guiding principles on any decision. Providing an opportunity for patients to receive care and treatment in a more timely fashion increases compliance, improves outcomes, and results in patient's trust and satisfaction in the health care system. Requiring patients to schedule two, three, or four appointments to get a test done because CON restricts access is no longer acceptable.

If we provided private citizens in Michigan with knowledge of the current CON process, the opportunity to provide quicker access, and the information that Michigan is one of 3 states with such a strict regulation on CT technology, I trust that the public would be in support of the physicians position of changing the CON language to be much less restrictive, if restricted at all.

Lastly, as a private citizen, I am appalled that we have provided a Michigan-based company with opportunities to grow their business foundation in Ann Arbor, however we have not allowed them complete access to the Michigan market due to CON regulations.

Thank you for this opportunity to provide written testimony. I look forward to any questions or comments you may have for me.

Respectfully,

Jean Aldrich, CMPE
Administrator, Eye & ENT Specialists

From: Irma Lopez
To: abarkholz@mha.org
Date: Mon, Feb 11, 2008 4:19 PM
Subject: Fwd: CT Public Comments

CC: Ateequi, Umbrin; Hart, Jr., William J.; Moore, Andrea; Rogers, Brenda

Thanks, Amy. We'll get these on the record.

>>> "Amy Barkholz" <abarkholz@mha.org> 2/11/2008 4:11 PM >>>
Dear Brenda and Irma:

Attached please find the MHA's written comments on the CT Standards. If you are not the correct recipients please forward them for inclusion in the public testimony to the CON Commission. I was not able to attach my PDF file via the website and it's MHAs policy to put all written communications on our association letterhead.

Thanks!
Amy

Amy Barkholz *Senior Director, Advocacy
Michigan Health & Hospital Association
110 West Michigan Ave * Suite 1200
Lansing, Michigan 48933
Ph. 517-703-8616 * Fx. 517-703-8620
E-mail: abarkholz@mha.org

<<2-08 O-arm Public Hearing Doc.pdf>>

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

Certificate of Need Review Standards for CT Services
Public Comments
February 11, 2008

The Michigan Health & Hospital Association supports the testimony of the University of Michigan Health System (UMHS) regarding the classification of a piece of surgical equipment known as an O-arm, which is used solely for intraoperative image guided surgery. **The MHA asks that the Michigan Department of Community Health act quickly to determine whether or not this machine falls within the CT standards. If the department determines it is within the CT standards, the MHA asks the CON Commission to approve additional language in the CT standards currently before the Commission to accommodate the use of this specialized equipment.**

The O-arm is a specialized machine designed to allow a surgeon to see where screws are being placed during certain complex orthopedic or neurosurgical procedures. At this time, the UMHS is the only facility utilizing this piece of equipment. There is currently a question about whether or not this machine should be considered a CT scanner. During the radiation safety registration process, the Michigan Department of Community Health decided to treat the O-arm as a CT scanner, requiring a CON. The Food and Drug Administration does not consider the O-arm to be a CT scanner and the UMHS has presented some good evidence that it should be classified otherwise.

Regardless of how it is classified, it is not feasible for the O-arm to be regulated in the same way as a CT scanner. It can only be used for guidance during specific surgical procedures and cannot be used as a diagnostic CT scanner. Physicians at the UMHS estimate that it will be used about 200-300 times per year, so it is not practical to subject it to the same volume standards as a CT scanner because to do so would diminish a facility's ability to provide full access to CT services and O-arm technology.

The MHA just learned of the use of this technology by the UMHS during its testimony at the Commission's recent January 2008 meeting. We believe the O-arm is a valuable surgical tool and it is incumbent upon the MDCH and the CON Commission to resolve the outstanding questions about whether and how it should be regulated as soon as possible so as not to impede the public's access to high-quality health care.

Thank you for the opportunity to provide comments on this important issue. Please contact Amy Barkholz at (517) 703-8615 or abarkholz@mha.org if you have any questions.

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 12, 2008 9:55 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Jesse Bernstein
2. Organization: Ann Arbor Area Chamber of Commerce
3. Phone: 734.665.4433
4. Email: Jesse @annarborchamber.org
5. Standards: CT
6. Testimony:

The Ann Arbor Area Chamber of Commerce Board of Directors urges the Michigan Certificate of Need (CON) Commission to review current thresholds as applied to todayÆs fast growing medical technologies. Further, we share with you our opposition to CON regulation of medical equipment valued below $500,000. Now, more than ever, we need to encourage growth in our most promising sectors. Healthcare generally and its technologies especially are crucial to the transformation of our economy.

The Ann Arbor Area Chamber of Commerce recently learned of an issue under review involving Xoran Technologies, Inc. and regulations applied to low cost specialty-use CT scanners. Following analysis of the CON threshold applied to certain low cost scanners, such as XoranÆs MiniCAT, we realize how regulation can impede our growth in the healthcare industry and the service our physicians can provide their patients.

Though the issue came to our attention through interest in a company located in Ann Arbor, our concerns regarding the applicable process and regulation extend beyond Xoran. With healthcare so vital to our economic transformation it is critical that we review our current regulations, maintain processes that foster growth and revise or abolish processes and regulation which impede growth.

We strongly encourage your careful review of the regulations applied to this category of medical equipment. Michigan must find a way to provide our physicians with the latest available technologies critical to the care they offer their patients. We find it puzzling that Michigan maintains a regulation on low cost specialty-use CT scanners that 47 other states either donÆt implement or have abolished altogether.

On behalf of the Ann Arbor area business community we appreciate your thoughtful review of this issue. We look forward to working with you on this matter and can be available if further information is needed.

Sincerely,

Jesse Bernstein
President and CEO

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 5, 2008 9:25 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Dennis I Bojrab, MD
2. Organization: Michigan Otolaryngology Society
3. Phone: 248-865-4444
4. Email: dibojrab@comcast.net
5. Standards: CT
6. Testimony: Dear CON Commission members,

As a practicing Otologist physician in Michigan, I urge you to reconsider the proposed CON CT Standards now before the CON Commission. The proposed language fails to consider the important and necessary use of low-dose, low-cost specialty CT scanners designed specifically for use by ENT physicians in their own office. The failure of our state to consider these limited use CT scanners has placed Michigan behind 47 other states in being able to provide lower cost, high quality imaging, and better access to our patients. Furthermore, it is creating a professional gap between ENT physicians in Michigan and those within the rest of the nation.

Accordingly, I encourage you to exempt specialty use CT scanners from the CON process adding the following language to the Section 2(i) definitions of the proposed CT Standards: "For purposes of these standards, the (CT scanner) term does not include a CT scanner system that both generates a peak power output of 5 Kilowatts or less and costs less than $500,000".

This definition change will place Michigan in the same category as the 47 other states that do not regulate these specialty use CT scanners and will give ENT physicians the ability to choose to acquire this much needed technology. This is the least restrictive way of lowering cost, providing quality, and improving access healthcare in the state and the best way for ENT physicians to ensure that our patients and citizens get the necessary care they deserve.

Sincerely,

Dennis I Bojrab, MD
Michigan Ear Institute
Immediate Past President of the Michigan
Otolaryngologic Society

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 12, 2008 3:30 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Aaron Duberstein
2. Organization: M.D.
3. Phone: 713-385-1329
4. Email: aduberstein@hotmail.com
5. Standards: CT
6. Testimony:

Dear CON Commission Members,

As a graduating resident in otolaryngology (ENT) I urge the CON Commission to NOT adopt the proposed language for CT scanners. Given the current economic climate and the fact that Michigan faces a physician shortage, restrictions on in-office specialty CT scanners is a negative incentive for retaining residents for future practice in this state, even residents such as my colleagues and I who have chosen to train here. I encourage you to exempt specialty use CT scanners from the CON process adding the following language to the Section 2(i) definitions of the proposed CT Standards:

For purposes of these standards, the (CT scanner) term does not include a CT scanner system that both generates a peak power output of 5 Kilowatts or less and costs less than $500,000. Thank you.

Sincerely,

Aaron Duberstein, M.D.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 6:57 AM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Michael S. Fozo
2. Organization: Lakeshore Ear Nose and Throat PC
3. Phone: 586 779-7610
4. Email: mfozo@aol.com
5. Standards: CT
6. Testimony:

Dear CON Commission members,

As a practicing ENT physician in Michigan, I urge you to reconsider the proposed CON CT Standards now before the CON Commission. The proposed language fails to consider the important and necessary use of low-dose, low-cost specialty CT scanners designed specifically for use by ENT physicians in their own office. The failure of our state to consider these limited use CT scanners has placed Michigan behind 47 other states in being able to provide lower cost, high quality imaging, and better access to our patients. Furthermore, it is creating a professional gap between ENT physicians in Michigan and those within the rest of the nation.

Accordingly, I encourage you to exempt specialty use CT scanners from the CON process adding the following language to the Section 2(i) definitions of the proposed CT Standards: "For purposes of these standards, the (CT scanner) term does not include a CT scanner system that both generates a peak power output of 5 Kilowatts or less and costs less than $500,000".

This definition change will place Michigan in the same category as the 47 other states that do not regulate these specialty use CT scanners and will give ENT physicians the ability to choose to acquire this much needed technology. This is the least restrictive way of lowering cost, providing quality, and improving access healthcare in the state and the best way for ENT physicians to ensure that our patients and citizens get the necessary care they deserve.

Sincerely,

Michael S. Fozo, MD

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Sat, Feb 9, 2008 11:44 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: James E Heisel, M.D.
2. Organization: Foote Hospital Radiology Dept., Jackson MI
3. Phone: 517 788-4911
4. Email: jheisel@pol.net
5. Standards: CT
6. Testimony:

The certificate of need requirement currently in place is a valuable asset to the state of Michigan and to the patients of our state. It effectively prevents the oversupply of CT scanners and MRI machines and by doing so, it reduces the over utilization of the expensive tests performed by them. If the regulations were changed to allow the purchase of these smaller CT scanners for in-office use, the number of tests would increase, with the high likelihood that the extra tests would be medically unnecessary. It is well known and also well documented in health care literature that self referral of testing procedures is a major cause of excess health care costs. The Michigan economy cannot afford higher health care costs at a time when we need badly to lower health care costs to improve the business climate. The desire for this change is purely economic, designed to create a business opportunity for the Xoran Company and to allow ENT physicians or other office based practitioners to begin to create new sources of revenue for their practices. There is no patient benefit of substance. Current full capability CT scanners are perfectly capable of dose adjustment to allow for the optimization of images at the lowest practical dose. The miniCAT by design will produce inferior images to the ones on a regular scanner with a potential for misdiagnosis. The argument for point of service care in the office fails to take into account the fact that the most important factor in any imaging test might be missing: the expert review and interpretation of the test by a qualified radiologist. Unless such an interpretation is made available at the time of service and consultation, patient care would not be well served. Admittedly, teleradiology could be a potential remedy for this issue. If in-office use of this technology were to move forward, it would be important for patient protection that regulations also require that payment for professional component be made only to radiologists and not to ENT surgeons or others with no formal training in such interpretation. It would also be important for patient safety that only sinus scans be performed and not diagnostic head scans for which the technology would be more significantly inferior to the fully capable machines. I have difficulty understanding why we would want to facilitate a move to lower quality imaging of patients in order to create a business opportunity that is not in the patient's best interest.

James Heisel M.D. staff radiologist

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 6, 2008 5:18 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Paul Theodore Hoff
2. Organization: Michigan Otolaryngology Surgery Associates
3. Phone: 734 434-0082
4. Email: pthoff@hotmail.com
5. Standards: CT
6. Testimony:

I have been practicing in Michigan for 9 years and have been frustrated by my inability to offer my patients convenient, cutting edge in-office CT scanning. What is most ironic is that the technology of low dose office scanning was developed right here in Michigan (Xoran.) We are currently recruiting a new partner, but he is concerned about our lack of office imaging. Clearly, Michigan needs to adopt the guidelines followed by nearly every other state, and allow for low dose office CT scanners for ENT practices.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Fri, Feb 8, 2008 3:05 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: John Jacobs MD
2. Organization: none
3. Phone: 313 745 4336
4. Email: jjacobs@med.wayne.edu
5. Standards: CT
6. Testimony:

Picture yourself as a patient requiring a CT scan for a sinus problem You have already taken time off from work to see the doctor. Do you really want to take more time from work to get a hospital CT scan knowing that it exposes you to unnecessary levels of radiation exposure and that you are in competition with hospitalized patients for the same resource Joining the other 47 states that allow office CT scans is improved appropriate care efficiently delivered.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 6, 2008 2:51 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Dennis McCafferty
2. Organization: The Economic Alliance for Michigan
3. Phone: (248) 596-1006
4. Email: dennismccafferty@eamonline.org
5. Standards: CT
6. Testimony: The Economic Alliance for Michigan

CON Commission Public Hearing
February 6, 2008
Dennis McCafferty, Health Policy Director

CT scanner Services:

We strongly agree with the position recommended by the Special Advisory Committee and accepted by the Commission at their December 2007 quarterly meeting that all CT Scanners should continue to be subject to CON.

We also support and endorse the many other improvements in the CT Scanner CON standards proposed by the SAC and accepted by the Commission, including:

- The minimum annual volume number of scan equivalents is unchanged at 7500.
- Replacement for existing CT Scanners can only be done if current machine has met this minimum annual volume at some time since its inception AND now is providing at least 5,000 CT equivalents.
- Projecting the need for new CT scanner sites based on actual, historically referrals volumes that can be verified by MDCH through its annual survey. (We consider this a Major improvement over existing standards.)
- That projection of need for new CT scanners cannot use referrals that would result in lowering an existing CT scanner below its minimum CON volume requirements. (We consider this to also be a Major improvement over existing standards.)
- Approval of a Demonstration Project for Special Use Portable CTÆs, limited to major trauma centers that have experienced staff on site to maintain, operate and interpret the results. The scans on these special use units will not be counted as part of the hospitalsÆ other CT scanner equivalent scan totals. (Reasonable constraint of this new technology, limiting use to existing high-volume imaging centers that will enable qualified providers to evaluate what value these portable CT units may provide the patients and treating physicians.)
- Continued CON regulation of dental office CT at the same annual minimum volume and services approved by the Commission in 2006.

The members of The Economic Alliance for Michigan oppose efforts by some to exempt Specialty Use CT units from CON regulations. This issue was dealt with by the SAC. The manufacturer of these machines was given ample opportunity to present its reasons for exempting these units. Absent clinical evidence that this new technology will provide value to the patients by improving access, lowering cost or improving quality of care, we see no reason for exempting these specialty use CT units from the CON standards. We support the CommissionÆs decision to accept the recommendations of the CT-SAC to continue the regulation of all CT units under CON.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 3:07 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Robert Meeker
2. Organization: Spectrum Health
3. Phone: (616) 391-2779
4. Email: robert.meeker@spectrum-health.org
5. Standards: CT
6. Testimony:

Spectrum Health appreciates the hard work of the CT SAC in confronting difficult issues in the review of the CON Review Standards for Computed Tomography (CT) Scanners. We support the recommended changes to the CT Standards. In particular, Spectrum Health supports the following recommendations of the CT SAC:

61656; Continued CON coverage of CT
61656; Continuation of the minimum volume requirement of 7,500 CTEs
61656; Revisions to the Relocation criteria which allow relocation of a either an entire CT service or a single CT unit
61656; Revision to the definition of Replace an Existing CT Scanner to include only projects requiring a change in the radiation safety certificate
61656; Revisions to the data Commitment process
- That: Assure that:
- The applicant must be able to document that the CT referrals committed actually occurred, and
- The CT referrals committed, if actually referred to the new CT service, would not result in the existing CT service(s) falling below their minimum volume requirements. Do not create an undue burden on CT providers by replicating the existing MRI data base.

61656; Provisions for Level I & II Trauma Centers to obtain special use CT scanners without meeting the minimum volume requirement
61656; Provisions for dedicated pediatric CT scanners and additional weights for pediatric scans performed on general purpose CT scanners, with special attention to limiting radiation exposure for pediatric patients.

Spectrum Health appreciates the opportunity to comment on the proposed CON Review Standards for CT, and we urge the CON Commission to approve them in final form at the meeting on March 11, 2008.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 3:45 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Michael Nosanov, M.D.
2. Organization: Eye & ENT Specialists, PLC
3. Phone: 269-945-3888
4. Email: mnosanov@eyeentmds.com
5. Standards: CT
6. Testimony:

I feel the inability to provide our patients with the most up to date care not only has the potential to delay diagnosis and treatment of my patient with sinus and other Head & Neck disorders, but can effect outcomes, cause delay in return to work and increase the overall health care costs. I also believe that the lack of this service will impair our ability to recruit and retain qualified providers in our state. The issue of the potential for over utilization is really unfounded. I believe that we tend to under utilize this type of exam as it would be too inconvenient, costly, and may have higher radiation exposure risks. In reality, it would be appropriately used to provide the most efficient and timely care.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 3:31 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Stephen Rapundalo, PhD
2. Organization: MichBio
3. Phone: 734 527-9144
4. Email: srapundalo@michbio.org
5. Standards: CT
6. Testimony: February 13, 2008

Norma Hagenow
Chairperson, CON Commission
c/o Brenda Rogers, CON Policy Section
Michigan Department of Community Health
201 Townsend Street
MDCH 7th Floor, Capitol View Building
Lansing, MI 48913

Dear Chairperson Hagenow:

I am writing to encourage the Certificate of Need (CON) Commission to consider changes to the proposed CON CT Standards now before the Commission. In this regard we support the long-standing position of Xoran Technologies, a MichBio member, in their quest to seek relief from current regulatory restrictions that prohibit the sale of specialty CT scanners in the state.

We ask the CON Commission to adopt language similar to that recently approved by West Virginia that specifically exempts low-dose, low-cost CT scanners from CON regulations. Regulations should not include CT scanner systems that generate 8804;5 KW of peak power and cost less than $500,000.

Opponents to easing restrictions or exempting low-cost, low-dose specialty CT scanners from current CON rules claim that doing so would lead to physician overuse and increased health care costs. Yet no empirical data exists to support such a contention from the 47 other states that do not require a CON for this technology. To the contrary, allowing access to low-cost, low-dose CT scanners should provide a more efficient, safe and cost-effective delivery of quality healthcare.

Furthermore, there appears to be no rationale for separating specialty CT scanners from other low-cost medical equipment used in-office that are currently not regulated under CON. Specialty CT scanners should be treated similarly as they more closely align with the purpose and cost of those unregulated instruments. The CT Standards currently in place are inflexible in light of todayÆs emerging technologies.

Restrictions on access to new and innovative technologies like the specialty CT scanner place not only physicians and patients at a disadvantage, but hinder MichiganÆs ability to recruit and retain life science and biotechnology companies such as Xoran Technologies. The potential negative economic impact to companies directly and the state overall must be considered when revisions are made to the regulatory environment. The fact that a highly-successful company like Xoran cannot sell its own products in the state speaks loudly to the outside business world. This is not a message that should be allowed to persist.

MichBio, as the statewide life sciences and biotechnology industry association, supports measures that will strengthen MichiganÆs competitiveness and maximizes the marketplace for our companies. We believe that recognizing the value of innovative, emerging technologies like low-cost, low-dose specialty CT scanners and exempting them from CON regulations is in the best interests of manufacturers, physicians and patients.

Sincerely,

Stephen Rapundalo, PhD
Executive Director
MichBio
330 E. Liberty
Ann Arbor, MI
48107
www.michbio.org

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Mon, Feb 11, 2008 4:49 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Caroline Ruddell
2. Organization: Michigan Dental Association
3. Phone: 517-346-9423
4. Email: cruddell@michigandental.org
5. Standards: CT
6. Testimony: February 11, 2008

Ms. Norma Hagenow
Chairperson
Certificate of Need Commission
Michigan Department of Community Health
Certificate of Need Policy Section
201 Townsend Street, 7th Floor
Lansing, Michigan 48913

Dear Chairwomen Hagenow,

The Michigan Dental Association (MDA) would like to respectfully request that dental CT be exempted form CT standards. The MDA is comprised of 5,980 members whose mission is to encourage the improvement of the oral health of the public; to enhance members' ability to provide ethical care to the public through education, training and service; and to promote the science of dentistry.

As you are aware, the MDA has been involved in the CON Commission to process to regulate dental CT. We supported the current standards because we felt it gave our members the option utilize this important technology if they did not want to wait until the review of the CT standards was complete. However, current CON regulations are certainly hindering Michigan citizensÆ access to this advancement in dental technology.

The MDA recognizes the role of the CON commission is to regulate cost, quality and access to healthcare in Michigan. However, the cost of a dental CT is very different then medical CT and at roughly $200,000 they are less then many unregulated pieces of medical equipment and cost far less then medical CT. CON does not regulate any other piece of medical equipment that is so inexpensive. In addition, CON does not regulate the digital panorex, which is the same price, provides the same type of images, and is nearly interchangeable with a Dental CT.

Thank you for reexamining the CT standards and taking the opinions of the MDA and its members into consideration. As the process moves forward we look forward to continue working together.

Sincerely,

Caroline M. Ruddell
Director of Legislative and Insurance
Advocacy
Michigan Dental Association

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Fri, Feb 8, 2008 3:01 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Steven Szelag
2. Organization: University of Michigan Health System
3. Phone: 734.647.1163
4. Email: sszelag@umich.edu
5. Standards: CT
6. Testimony:

My name is Steven Szelag and I am a Senior Health System Planner at the University of Michigan Health System (UMHS). UMHS wishes to take this opportunity today to offer comments on a very limited issue relating to the Certificate of Need (CON) review standards for Computed Tomography (CT) services. The comments being offered today pertain to the Michigan Department of Community Health (MDCH) classification of the O-arm which is used solely for intraoperative image guided surgery.

UMHS acquired the first surgical O-arm in the State of Michigan in October, 2007. It is a machine designed to allow a surgeon to see where screws are being placed during certain complex orthopedic or neurosurgical procedures. It is used only a few times a week. Indeed, our physicians estimate that it will only be used 200-300 times per year. It is not a diagnostic technology but is only used for guidance during specific surgical procedures.

During the radiation safety registration process, the MDCH decided to treat this piece of equipment as a CT scanner, requiring a CON. This was a surprise to hospital administration as it was our understanding, based on analysis from the Food and Drug Administration that this piece of equipment is not a CT scanner, but rather a mobile x-ray system. Specifically, this is an intra-operative navigation tool being added to an already existing image guided surgery configuration which is not covered under CON regulations. This equipment is not, and could not, be used as a diagnostic CT scanner; the low contrast imaging quality is well below the diagnostic quality requirements of a CT scanner.

We understand that the Standards Advisory Committee for CT services have recently completed their 6-month review of the standards and have presented their final report to the CON Commission. We do not wish to re-open the CT review process. However, the University of Michigan recommends further refinement of the definition of a CT scanner so that technology like the C-arm and the O-arm, can be similarly excluded like other imaging modalities used for treatment planning. Thank you for according us this opportunity to address this concern. We stand ready to work with you and with the Department on this issue.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Thu, Feb 7, 2008 9:43 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Jeffrey S. Weingarten, MD
2. Organization: physician
3. Phone: 248 569 5985
4. Email: jsweing@comcast.net
5. Standards: CT
6. Testimony: "Dear CON Commission members,

As a practicing ENT physician in Michigan, I urge you to reconsider the proposed CON CT Standards now before the CON Commission. The proposed language fails to consider the important and necessary use of low-dose, low-cost specialty CT scanners designed specifically for use by ENT physicians in their own office. The failure of our state to consider these limited use CT scanners has placed Michigan behind 47 other states in being able to provide lower cost, high quality imaging, and better access to our patients. Furthermore, it is creating a professional gap between ENT physicians in Michigan and those within the rest of the nation. By denying this technology to smaller facilities makes those facilities deny care to patients and forces those patients to get higher dose radiation tests!!

Accordingly, I encourage you to exempt specialty use CT scanners from the CON process adding the following language to the Section 2(i) definitions of the proposed CT Standards: "For purposes of these standards, the (CT scanner) term does not include a CT scanner system that both generates a peak power output of 5 Kilowatts or less and costs less than $300,000". MSMS supports the loss of the CON requirement for the miniCAT technology.

This definition change will place Michigan in the same category as the 47 other states that do not regulate these specialty use CT scanners and will give ENT physicians the ability to choose to acquire this much needed technology. This is the least restrictive way of lowering cost, providing quality, and improving access healthcare in the state and the best way for ENT physicians to ensure that our patients and citizens get the necessary care they deserve.

The legislature must examine the makeup of the decision makers for CON and decide why they would deny Michigan citizens access to a technology that 47 other states have allowed!!! The Detroit newspapers and Crain's Business have begun this examination.

Sincerely,
Jeffrey S. Weingarten, MD
Southfield Novi Livonia St Clair Shores
248 569 5985

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 5, 2008 2:58 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Howard Yerman, MD
2. Organization:
3. Phone: 248-360-5881
4. Email: hyerman@comcast.net
5. Standards: CT
6. Testimony: Dear CON Commission members,

As a practicing ENT physician in Michigan, I urge you to reconsider the proposed CON CT Standards now before the CON Commission. The proposed language fails to consider the important and necessary use of low-dose, low-cost specialty CT scanners designed specifically for use by ENT physicians in their own office. The failure of our state to consider these limited use CT scanners has placed Michigan behind 47 other states in being able to provide lower cost, high quality imaging, and better access to our patients. Furthermore, it is creating a professional gap between ENT physicians in Michigan and those within the rest of the nation.

Accordingly, I encourage you to exempt specialty use CT scanners from the CON process adding the following language to the Section 2(i) definitions of the proposed CT Standards: "For purposes of these standards, the (CT scanner) term does not include a CT scanner system that both generates a peak power output of 5 Kilowatts or less and costs less than $500,000".

This definition change will place Michigan in the same category as the 47other states that do not regulate these specialty use CT scanners and will give ENT physicians the ability to choose to acquire this much needed technology. This is the least restrictive way of lowering cost, providing quality, and improving access healthcare in the state and the best way for ENT physicians to ensure that our patients and citizens get the necessary care they deserve.

***** In addition to the information noted above, please consider the fact that use of low-dose in office sinus CT imaging will likely reduce use of older imaging modalities (plain sinus x-rays), and thus allow more expeditious, cost effective, quality care.****

Sincerely,

Howard Yerman, MD

From: "Adams, Phyllis" <PDAdams@dykema.com>
To: "Andrea Moore" <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 4:52 PM
Subject: Supplemental Testimony on Proposed Nursing Home Standards

CC: "Porter, Cliff" <CPorter@hcr-manorcare.com>, "Rosenthal, Lisa" <LROSENTHAL@hcr-manorcare.com>, <dwood@hcr-manorcare.com>, "Heather Scott" heather@kheder.com

Greetings Andrea,

I am contacting you on behalf of HCR ManorCare, Inc., which submitted supplemental testimony on the proposed Nursing Home Standards earlier today in electronic format via the link on the MDCH website. However, one section of the testimony includes a short table and I am not confident that the formatting of the table will come through in the electronic/link version. Thus, I've also attached a PDF of the testimony for consideration by the Department and Commission.

If you have any questions regarding this email or the attached material, please feel free to contact me.

Kind regards,
Phyllis

<<HCR MANOR CARE - Supplemental Testimony re Proposed Nursing Home Standards 2-13-08.pdf>>

SUPPLEMENTAL TESTIMONY ON
PROPOSED CON STANDARDS FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS
FOR PUBLIC HEARING ON FEBRUARY 6, 2008

Submitted by HCR ManorCare, Inc. via MDCH Internet Link on 2/13/08

HCR ManorCare, Inc., through its subsidiaries and affiliates ("HCR ManorCare"), operates more than 275 licensed nursing homes nationwide, including twenty-eight nursing home facilities in Michigan. As one of the largest long-term care providers in Michigan, we appreciate this opportunity to provide additional public comment on proposed revisions to the Certificate of Need ("CON") Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds. This testimony supplements testimony presented by Mr. Cliff Porter on behalf of HCR ManorCare at the Public Hearing on the proposed CON Standards, including the amendments developed through the Michigan Department of Community Health ("Department") workgroup process.

In addition to those comments presented at the Public Hearing, HCR ManorCare believes that appropriate policies for the distribution of nursing home beds in Michigan would be furthered by the following additional considerations/modifications to the proposed Standards:

- Language Changes Proposed by Health Care Association of Michigan ("HCAM") (Lines 336; 341; 454). At the Public Hearing, HCAM provided testimony as to various sections of the proposed CON Standards that was consistent with testimony by HCR ManorCare. In these supplemental comments, we wish to make clear that HCR ManorCare supports the actual language changes proposed by HCAM in its testimony with respect to Lines 336, 341, and 454. We believe that these additional technical changes are essential to appropriate implementation of the new Standards and that these modifications could, and should be made directly by the CON Commission, at the request and recommendation of the Department, at the March CON Commission meeting. However, HCR ManorCare does *not* support a change in the percentage of single occupancy resident rooms under the new design model language from 80% to 50%. HCR ManorCare believes that this would be a substantive change from the current version of the new model design criteria and dilute the intention of that program.

- Implementation of the New Bed Need Numbers. HCR ManorCare supports testimony by HCAM as to Section 4 of the proposed Standards as to a fair and reasonable effective date for the new bed need numbers. To give applicants a fair and equal opportunity for new beds, existing applications and appeals should be cleared off by the Department prior to the effective date of the new bed need calculations. Thus, we urge the Commission to adopt an effective date for the proposed bed need calculations, for example on October 1, 2008 or shortly thereafter. This would give applicants sufficient time to address the new bed need and would coincide with a comparative review batch date, as well as time for the Department to develop necessary CON forms to implement the new Standards and to clear off prior applications. HCR ManorCare would like to commend the Commission for updating the bed need projections with current data and we support the Department's calculations as proposed.
- Proposed Scoring under the Comparative Review Criteria in Section 10 (Lines 831 – 851). There was testimony at the Department public hearing in January 2007, prior to appointment of the Standard Advisory Committee, from hospitals and health care systems as to the difficulty in placement of certain patients in long-term care beds due to a lack of "stratification" of nursing homes to meet needs of high acuity patients. Certainly, in today's health care continuum, there is a increasing need for long-term care facilities that operate "sub-acute" units for post-hospital discharge patients in need of a skilled level of care typically covered by the Medicare Part A benefit. These types of units are essential for prompt discharge of hospital patients to the long-term care setting. However, the comparative review criteria fail to adequately reward providers that seek to meet this important need. Given the changes in the points awarded for other criteria, HCR ManorCare concludes that it would be appropriate to change the number of points awarded for Medicare participation to encourage development of a sufficient number of sub-acute beds and to increase access to vital post-acute nursing home services as follows:

Participation	Points Awarded In Draft Standards	Proposed Change by Commission
No Medicare	0	0
Medicare certification of at least one bed	1	6
Medicare of 100% of 100% of beds	2	12

- Comparative Review Requirements, Section 15 (Lines 1063-1072). We appreciate that the Department added language to Section 15 of the proposed Standards to reflect an interpretation of the comparative review requirements under Part 222 of the Public Health Code. However, in practice, we have many questions as to how this would actually work if comparative review is required for replacement of beds beyond the 2-mile radius for new design model projects in a non-rural county, as follows:

  (1) Would an applicant for replacement of beds under the new design model criteria for a site within the planning area but beyond the 2-mile replacement zone need to demonstrate a need for beds in the planning area under the bed need methodology in order to qualify for replacement of beds as a new design model project?

  (2) If an applicant for a new design model project is subject to comparative review, are the beds that the applicant proposes to replace to the new site within the planning area "up for grabs" by the other applicants in the comparative review group?

  (3) If an applicant for a new design model project is subject to comparative review, is that application only comparatively reviewed against other new design model projects seeking to replace beds beyond the statutory 2-mile radius or would their replacement bed application be reviewed against applicants seeking beds from the bed pool?

  These questions are fundamental to the application of the comparative review language in Section 15. We have concerns that the confusing policy on this issue will chill the development of any additional new design model facilities until these uncertainties are addressed.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 5, 2008 4:36 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Kevin W. Evans, NHA, CEA
2. Organization: Grandvue Medical Care Facility
3. Phone: 231.536.2286
4. Email: kevans@grandvue.org
5. Standards: NH
6. Testimony: To whom it may concern:

Grandvue has an over 98 percent occupancy rate since I have became administrator (over two years ago), and turn away local residents who often must travel out of county for care. If choice is truly intended, why not allow Charlevoix County the ability to acquire unused beds to meet a local need? We are a high quality facility, with strong community support, and the elders who have supported us over the years are crestfallen when we tell them there is no availability. The planning area requirement does not make sense.

Next - The recommended policy to relocate beds without having to satisfy quality guidelines doesn't make sense. I recommend you either make the recipient satisfy the quality measures, or remove the new relocation policy.

Lastly, why remove the staffing level requirement? Facilities or chains that use a minimum standard mentality for care, rather than investing in staff for caring, should not be rewarded with more facilities. Please keep the staffing level quality check in the CON.

Thank you for your thoughtful consideration.

Kevin W. Evans, NHA, CEA
Administrator
Grandvue Medical Care Facility

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 1:43 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Alison Hirschel
2. Organization: Michigan Poverty Law Program
3. Phone: 517-324-5754
4. Email: hirschel@umich.edu
5. Standards: NH
6. Testimony:

Thank you for the opportunity to submit these comments. As a member of both the Nursing Home Standards Advisory Committee and the Quality Measure Workgroup, I urge the Commission to adopt the Workgroup's revised Quality Measure. This document reflects a true consensus of Workgroup members. Although it sets a low bar, it is a starting point for ensuring that the privilege of obtaining a certificate of need is not available to providers who have demonstrated a very troubling inability to meet basic health and safety standards. Moreover, the revised language addresses a number of provider concerns with the original Quality Measure adopted by the SAC.

During public comment on February 6th, several speakers stated that although they supported the revised standard, they recommended a slow and gradual implementation of it with regard to the use of survey data. I urge the Commission to disregard this request and implement the measure promptly and fully. When provider and consumer representatives reached consensus on the language of the Quality Measure on January 15, no one proposed a delayed or gradual implementation. Since the consumer representatives made numerous other concessions and compromises to reach consensus with providers, I do not believe any of us would have agreed to the further watering down of the standard that a gradual implementation represents. Survey data is the only universal and independent measure of nursing facility performance available; there is no reason to delay considering it as a primary indicator of quality in the CON process.

Finally, many of those who provided comments on February 6 suggested altering other portions of the SAC's proposed Nursing Home and Hospital Long-Term Care Unit Beds standards. It was my understanding that the Commission in its December meeting accepted the majority of the SAC recommendations but sought further discussion only of the Quality Measure. There has been no further opportunity to discuss or reach agreement on the other provisions. All stakeholders will have an opportunity to address these concerns again when a new Standards Advisory Committee is appointed in 2010; in the intervening two years, we will have an opportunity to observe whether the new standards achieve their intended purposes or require further revisions.

I therefore urge the Commission to adopt the revised Quality Measure and all other provisions as set forth in the SAC recommendation.

Thank you again for the opportunity to participate in this important process.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Tue, Feb 12, 2008 4:53 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Albert D. Kaul
2. Organization: Lutheran Homes of Michigan, Inc.
3. Phone: 989-652-3470
4. Email: akaul@lhminc.org
5. Standards: NH
6. Testimony:

I am opposed to some of the proposed changes to the Certificate of Need Standards for Nursing Homes.

Regarding the High Occupancy Standard, currently, a nursing home that maintains 97 percent occupancy for 3 years cannot expand unless all other nursing homes in its entire planning area have had the same experience. The NHSAC has chosen not to revise this standard that, so far, not one nursing home in the state can meet.

Forcing seniors into empty beds rather than allow nursing homes with waiting lists to expand is not only poor public policy it is contrary to the principles of consumer choice.

Of MichiganÆs 433 nursing homes, 10 meet the 97 percent occupancy requirement for 12 quarters, but not one meets the planning area criteria. Thus, not one nursing home is eligible for expansion under the existing high occupancy standard.

Seniors should not be forced to find care at their second and third choice when the facility that is their first choice has the resources and the will to expand to meet the consumerÆs needs.

A provider should not be limited in his or her ability to provide care simply because a provider down the road has an occupancy problem. Occupancy problems and poor quality sometimes go hand and hand.

I urge you to REVISE THE HIGH OCCUPANCY RULE BY REMOVING THE PLANNING AREA REQUIREMENT.

Regarding the New Policy to Relocate Existing Beds, generally Nursing Homes are not allowed to split and sell portions of a license between providers. Traditionally, the provider who has extra beds returns them to the statewide pool at no cost.

Neither the donor nor the recipient facility would need to satisfy the new quality measures to be eligible for the relocation of beds.

The existing language will only promote the expansion of existing facilities vs. the development of new and smaller innovative design models, because it only allows the relocation of beds to currently-licensed sites.

I urge you to REMOVE THIS SECTION.

Promoting, not limiting, consumer choice will ultimately force poor performers to improve or get out of the business. It will also cause good performers to continuously improve products and services to the seniors of Michigan.

Thank you for your attention.

Sincerely,

Albert D. Kaul
Vice President for Service Excellence
Lutheran Homes of Michigan, Inc.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 3:46 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Robert Meeker
2. Organization: Spectrum Health
3. Phone: (616) 391-2779
4. Email: robert.meeker@spectrum-health.org
5. Standards: NH
6. Testimony:

Spectrum Health appreciates the hard work of the Nursing Home Standards Advisory Committee (NHSAC) and the subsequent quality work groups. However, we still have substantial concerns about several provisions in the proposed standards, including those designed to address quality concerns in the care of nursing home patients.

Quality:
Spectrum Health continues to advocate strongly for the provision of quality healthcare and supports developing appropriate ways to measure quality in the nursing home and long-term care environment. We believe that patient safety and quality care are of paramount importance for long-term care services. However, it is our opinion that the proposed quality standards included in the draft CON Review Standards submitted to the Commission in December do not include true measures of quality in long-term care. Along with others, at the December meeting, we expressed our concerns to the Commission, which directed MDCH staff to convene a work group broadly representative of organizations interested in long-term care in Michigan. The work group met and achieved a compromise, which, admittedly, is an improvement over the original proposal. However, the work group avoided serious discussion of the single issue which received the most criticism in December. That controversial issue involves the use of citations, at level D and above, on State licensure surveys as a limiting factor on the ability of CON applicants to receive approval for proposed projects. As we testified in December, use of State survey results is not an appropriate mechanism for measuring the quality in the Certificate of Need (CON) application process. As they are currently conducted, the state surveys too often include subjective and inconsistent citations. This is particularly true of level D citations, which can include a gamut of violations, some trivial, others more serious. Since the work group did not seriously address the use of State survey results, Spectrum Health recommends that the Commission approve neither the original draft of the Standards nor the compromise proposal. We continue to believe that State survey results should not be used as an indicator of quality nursing home care in the CON Review Standards. However at the very least, we respectfully suggest that the reference to Level D citations and above be removed from the Review Standards and replaced with Level E citations and above. This modification would at least insure that long-term care facilities that have been cited for isolated incidents not causing widespread harm to their residents will not be penalized in the State CON process. Rather, only facilities with more serious indications of sub standard care would be denied approval of proposed CON projects. In addition to the proposed quality standards, there are other provisions of the proposed CON Review Standards which we believe require further attention and modification.

Common Ownership:
If one facility fails to qualify for CON approval under the proposed quality thresholds, all facilities under common ownership similarly could be disqualified from CON approval for initiation, acquisition, expansion or replacement of nursing home beds. The compromise recommendation modifies this requirement by allowing up to 14% of homes under common ownership (to a maximum of five) to be in violation of the quality requirements without jeopardizing potential CON approvals for other facilities in the chain. However, the effect is the same, particularly for systems with a small number of long-term care facilities. For example, Spectrum Health currently operates four (4) long-term care facilities. In our case, poor performance at one (1) facility on the quality provisions would prevent the other three (3) facilities from undertaking major improvement projects. Spectrum Health believes that operators of systems of healthcare facilities have the responsibility of insuring consistent quality across all service locations. However, we think that the common ownership provisions are overly restrictive, as proposed. We believe that the common ownership requirements the compromise proposal need to be reconsidered. In order to make this provision less restrictive, we suggest that the percentage of poor performing facilities affecting CON eligibility of others with common ownership should be increased above the 14% currently proposed. In this way, long-term care chains would be held accountable for the performance of all their facilities, but aberrant performance of one or a relatively small number of sites, particularly in systems with few long-term care facilities, would not prohibit others in the system from expanding or replacing licensed beds.

High Occupancy:
The original charge to the Long-Term Care SAC included a directive that the high occupancy provisions of the Standards be reviewed. The SAC concluded that no change is necessary. However, the existing provisions for high occupancy are essentially unattainable. As a direct parallel to the high occupancy provisions in the Hospital Beds CON Standards, Spectrum Health reiterates our recommendation that the high occupancy standard be applied only to the applicant facility, rather than all long-term care facilities in the planning area. We support a high occupancy requirement of 90% for two (2) years, instead of the current requirement of 97% for three (3) years. We believe that this change to the high occupancy standard will enable successful long-term care facilities to better serve their communities by being able to increase their capacity in the face of high demand for care.

Spectrum Health fully supports the process of reviewing and updating CON Review Standards and appreciates the opportunity to present our views on the proposed changes to the standards for nursing home beds. We applaud the CommissionÆs efforts to interject quality measures in the Standards, and we embrace the opportunity to develop fair and objective quality of care provisions in these and other CON Review Standards.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 4:38 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: Lisa Rosenthal
2. Organization: HCR Manor Care, Inc.
3. Phone: 240-453-8569
4. Email: lrosenthal@hcr-manorcare.com
5. Standards: NH
6. Testimony:

SUPPLEMENTAL TESTIMONY ON PROPOSED CON STANDARDS FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS FOR PUBLIC HEARING ON FEBRUARY 6, 2008

Submitted by HCR ManorCare, Inc. via MDCH Internet Link on 2/13/08

HCR ManorCare, Inc., through its subsidiaries and affiliates (HCR ManorCare), operates more than 275 licensed nursing homes nationwide, including twenty-eight nursing home facilities in Michigan. As one of the largest long-term care providers in Michigan, we appreciate this opportunity to provide additional public comment on proposed revisions to the Certificate of Need (CON) Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds. This testimony supplements testimony presented by Mr. Cliff Porter on behalf of HCR ManorCare at the Public Hearing on the proposed CON Standards, including the amendments developed through the Michigan Department of Community Health (Department) workgroup process. In addition to those comments presented at the Public Hearing, HCR ManorCare believes that appropriate policies for the distribution of nursing home beds in Michigan would be furthered by the following additional considerations/modifications to the proposed Standards:

Language Changes Proposed by Health Care Association of Michigan (HCAM) (Lines 336; 341; 454). At the Public Hearing, HCAM provided testimony as to various sections of the proposed CON Standards that was consistent with testimony by HCR ManorCare. In these supplemental comments, we wish to make clear that HCR ManorCare supports the actual language changes proposed by HCAM in its testimony with respect to Lines 336, 341, and 454. We believe that these additional technical changes are essential to appropriate implementation of the new Standards and that these modifications could, and should be made directly by the CON Commission, at the request and recommendation of the Department, at the March CON Commission meeting. However, HCR ManorCare does not support a change in the percentage of single occupancy resident rooms under the new design model language from 80% to 50%. HCR ManorCare believes that this would be a substantive change from the current version of the new model design criteria and dilute the intention of that program.

Implementation of the New Bed Need Numbers. HCR ManorCare supports testimony by HCAM as to Section 4 of the proposed Standards as to a fair and reasonable effective date for the new bed need numbers. To give applicants a fair and equal opportunity for new beds, existing applications and appeals should be cleared off by the Department prior to the effective date of the new bed need calculations. Thus, we urge the Commission to adopt an effective date for the proposed bed need calculations, for example on October 1, 2008 or shortly thereafter. This would give applicants sufficient time to address the new bed need and would coincide with a comparative review batch date, as well as time for the Department to develop necessary CON forms to implement the new Standards and to clear off prior applications. HCR ManorCare would like to commend the Commission for updating the bed need projections with current data and we support the DepartmentÆs calculations as proposed.

Proposed Scoring under the Comparative Review Criteria in Section 10 (Lines 831 û 851). There was testimony at the Department public hearing in January 2007, prior to appointment of the Standard Advisory Committee, from hospitals and health care systems as to the difficulty in placement of certain patients in long-term care beds due to a lack of stratification of nursing homes to meet needs of high acuity patients. Certainly, in todayÆs health care continuum, there is a increasing need for long-term care facilities that operate sub-acute units for post-hospital discharge patients in need of a skilled level of care typically covered by the Medicare Part A benefit. These types of units are essential for prompt discharge of hospital patients to the long-term care setting. However, the comparative review criteria fail to adequately reward providers that seek to meet this important need. Given the changes in the points awarded for other criteria, HCR ManorCare concludes that it would be appropriate to change the number of points awarded for Medicare participation to encourage development of a sufficient number of sub-acute beds and to increase access to vital post-acute nursing home services as follows:

Standards	Participation Points Awarded by Commission		Proposed Change In Draft
No Medicare			0
		0	
Medicare certification of at least one bed		1 6	
Medicare of 100% of of beds	100%		2
		12	

Comparative Review Requirements, Section 15 (Lines 1063-1072). We appreciate that the Department added language to Section 15 of the proposed Standards to reflect an interpretation of the comparative review requirements under Part 222 of the Public Health Code. However, in practice, we have many questions as to how this would actually work if comparative review is required for replacement of beds beyond the 2-mile radius for new design model projects in a non-rural county, as follows:

(1) Would an applicant for replacement of beds under the new design model criteria for a site within the planning area but beyond the 2-mile replacement zone need to demonstrate a need for beds in the planning area under the bed need methodology in order to qualify for replacement of beds as a new design model project?

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(3) If an applicant for a new design model project is subject to comparative review, is that application only comparatively reviewed against other new design model projects seeking to replace beds beyond the statutory 2-mile radius or would their replacement bed application be reviewed against applicants seeking beds from the bed pool?

These questions are fundamental to the application of the comparative review language in Section 15. We have concerns that the confusing policy on this issue will chill the development of any additional new design model facilities until these uncertainties are addressed.

From: <DoNotReply@michigan.gov>
To: <moorean@michigan.gov>
Date: Wed, Feb 13, 2008 4:04 PM
Subject: February 6, 2008 Written Testimony (ContentID - 147062)

1. Name: John Tembreull
2. Organization: Baraga County Memorial Hosp. LTCU
3. Phone: 906-524-3321
4. Email: jtembreull@bcmh.org
5. Standards: NH
6. Testimony:

Baraga County Memorial Hospital currently has plans to transfer 28 hospital based HLTCU beds to a wholly owned subsidiary freestanding nursing home, which currently has 59 beds. Our concern is that Sec. 8(1)(F), Line 595, and Sec. 8(2)(F),Line 651, of the proposed standards, may prohibit the transfer of the beds, even when it is recognized that the transferred beds will no longer be HLTCU classified beds. Clarification allowing the transfer of HLTCU beds to the freestanding nursing home classification should be specifically permitted. Thank you for the opportunity to comment.