MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED (CON) COMMISSION MEETING

Tuesday, June 9, 2009

Capitol View Building
201 Townsend Street
MDCH Conference Center
Lansing, Michigan 48913

APPROVED MINUTES

I. Call To Order

Chairperson Goldman called the meeting to order at 9:08 a.m.

A. Members Present:

Edward B. Goldman, Chairperson (Left at 11:38 a.m.)
Norma Hagenow, Vice-Chairperson
Peter Ajluni, DO
Dorothy E. Deremo (Arrived at 9:11 a.m.)
Marc Keshishian, MD
Michael A. Sandler, MD
Thomas M. Smith
Michael W. Young, DO
Bradley Cory

B. Members Absent:

Adam Miller
Vicky Schroeder

C. Department of Attorney General Staff:

Ronald J. Styka

D. Michigan Department of Community Health Staff Present:

Jessica Austin
Michael Berrios
William Hart
Irma Lopez
Kasi Kelley
Joette Laseur
Tulika Bhattacharya
Nick Lyon
Andrea Moore
Tania Rodriquez
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Young, seconded by Commissioner Ajluni, to accept the agenda as presented. Motion Carried.

III. Declaration of Conflicts of Interest

Commission Sandler noted that he had a potential conflict with Pancreas Transplantation Services, Item VI, as Henry Ford is a provider of this service. Chairperson Goldman noted that he had a potential conflict with Pancreas Transplantation Services, as University of Michigan is a provider of these services.

IV. Review of Minutes – March 26, 2009

Motion by Vice-Chairperson Hagenow, seconded by Commissioner Smith, to approve the minutes as presented. Motion Carried.

V. Public Comment

Commissioner Deremo noted that she had a potential conflict with Magnetic Resonance Imaging (MRI), as Oakwood Health System is a provider of this service.

A. On Public Comment:

On Pancreas Transplantation Services:

Sean Gehle (for Darla Granger), St. John Health
Barbara Jackson, Blue Cross Blue Shield of Michigan (Attachment A)
Dennis McCafferty, Economic Alliance of Michigan (Attachment B)

On Magnetic Resonance Imaging (MRI) Services:

Penny Chrissman, Crittenton Hospital

On Pancreas Transplantation Services:

Amy Olszewski, Gift of Life Michigan (Attachment C)

MRI Services:

Janelle Spann, Michigan Resonance Imaging
Mark Mailloux, University of Michigan Health System
Alec Allen, Oaklawn Hospital (Attachment D)
Monica Harrison, Oakwood Hospital (Attachment E)
Dennis McCafferty, Economic Alliance of Michigan
Yahya Basha, M.D., Basha Diagnostics
Sean Gehle, Asension Health of Michigan
David Kondas, Alliance Health
Patrick O'Donovan, Beaumont Hospital
Barbara Jackson, Blue Cross Blue Shield of Michigan

On Open Heart Surgery (OHS) Services:

Michael Keller, Michigan State AFL-CIO
David Porteaus, Metropolitan Hospital (Attachment F)

On Open Heart Continued:
Paul Kovack, D.O., West Michigan Heart
Michael Vredenburg, D.O, West Michigan Heart (read by Chairperson Goldman) (AttachmentG)
Walter Christopherson, Michigan Building Trades
Cheryl Miller, Trinity Health (Attachment H)
John Mosley, Spectrum Health
Meg Tipton, Spectrum Health
John Burns, Spectrum Health
Dennis McCafferty, Economic Alliance of Michigan
William Merhi, West Michigan Cardiology

Break from 11:38 a.m. to 11:52 a.m. (Vice-Chairperson Hagenow assumed direction of meeting.)

Vice-Chairperson Hagenow read statement from Chariperson Goldman regarding OHS. Discussion followed.

VI. Open Heart

Vice-Chairperson Hagenow provided that the Commission did not feel there was compelling data to require opening the Open Heart Standards. Should data be provided, this could be opened before their next scheduled review.

VII. Pancreas Transplantation Services

Ms. Rogers gave an overview of the proposed language for Pancreas Transplantation Services (Attachment I). Discussion followed.

Motion by Commissioner Keshishian, seconded by Commissioner Deremo, to approve the proposed language and move forward for Public Hearing and Joint Legislative Committee (JLC) review, with the specific request to evaluate the recommendation of every two years verses the consecutive twenty four months to be reported back at the next Commission meeting. Yes – 7, No – 0, Abstention – 1. Motion Carried.

VIII. Psychiatric Beds and Services

Ms. Rogers gave an overview of proposed language for Psychiatric Beds and Services. (Attachment J)

Motion by Commissioner Deremo, seconded by Commissioner Young, to approve the proposed suggested changes to the language for Psychiatric Beds and Services and move forward for Public Hearing and JLC review. Yes – 8, No – 0, Abstention – 0. Motion Carried.

IX. Magnetic Resonance Imaging (MRI) Services – Workgroup Report & Commission Discussion

Commissioner Sandler provided a summary of the MRI Workgroup report (Attachment K).

Ms. Rogers has provided a summary on the technical language changes that the Department of Community Health has suggested for the Commissions proposed action (Attachment L). She also summarized the language modifications the MRI Workgroup would like to propose to the Commission.

Mr. Lyons gave a brief explanation of the Department's concerns with the MRI Workgroup's recommendations for proposed language. He would like the MRI Workgroup to re-analyze the language proposal and make any necessary corrections before presenting the language for Public Hearing.

Magnetic Resonance Imaging (MRI) Services – Workgroup Report & Commission Discussion Continued.

Motion by Commissioner Sandler, seconded by Commissioner Ajluni, to move forward the Department's technical language changes, MRI Work Group simulation language, and the emergency department volume based methodology for Public Hearing and JLC review. Yes – 7, No – 1, Abstention – 0. Motion Carried.

Motion by Commissioner Ajluni, seconded by Commissioner Young, to move the charity care language to a Workgroup. Yes – 5, No – 3, Abstention – 0. Motion Failed.

Motion by Commissioner Sandler, seconded by Commissioner Deremo, to forward the charity care language to a Workgroup. Yes – 8, No – 0, Abstention – 0. Motion Carried.

X. Bone Marrow Transplantation (BMT) Services – Standard Advisory Committee (SAC) Status Report

Chairperson VeCasey gave brief overview of the BMTSACs activity.

XI. Heart/Lung, and Liver (HLL) Services –SAC Status Report

Chairperson Ball gave brief overview of the HLLSACs activity.

XII. Standing New Medical Technology Advisory Committee (NEWTAC) - Report

Commissioner Keshishian gave a brief update of the NEWTAC activity.

XIII. Legislative Report

Mr. Lyon gave overview of the legislative report.

XIV. Compliance Report

Mr. Lyon gave a brief overview of the compliance report. (Attachment M)

XV. Administrative Update

Mr. Hart gave an administrative overview of the compliance report.

XVI. CON Program Update

Mr. Horvath gave an overview of the following:

A. Quarterly Performance Measures
B. Web CON Application System Update/Demo
C. Web CON Annual Survey Update/Demo
D. MDCH Health Facility Atlas Update
E. Administrative Rules Update
F. 2009 CON Seminar – October 27, 2009

XVI. Legal Activity Report

Mr. Styka gave an overview of the Legal Activity Report (Attachment N)

XVII. Future Meeting Dates –

September 10, 2009
December 9, 2009

XVIII. Public Comment

There were no other public comments.

XIX. Review of Commission Work Plan

Ms. Rogers gave an overview of the Work Plan (Attachment O). Discussion followed.

Motion by Commissioner Smith, seconded by Commissioner Cory, to approve the Work Plan as presented. Motion Carried.

XX. Adjournment

Motion by Commissioner Deremo, seconded by Commissioner Ajunli, to adjourn the meeting at 1:42 p.m. Motion Carried.

Attachment A

Blue Cross
Blue Shield
Of Michigan

600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

Testimony
Blue Cross Blue Shield of Michigan/Blue Care Network
CON Commission Meeting
June 9, 2009

Thank you for allowing me to provide testimony on behalf of Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN). BCBSM and BCN continue to actively support the Certificate of Need (CON) program, designed to ensure the delivery of cost-effective, high quality health care to Michigan residents. This role has become even more significant due to the current turbulent economy.

Proposed Pancreas Transplant Standards

As indicated in prior testimony, over the past several months BCBSM/BCN administrative and clinical staff members have met with many of the organizations interested in modifying the Pancreas Transplant CON review standards. We have also been active participants in the MDCH Pancreas Transplant Work Group.

As a result of these meetings and work group discussions, where additional information was shared, BCBSM/BCN supports the proposed language, both independently and as member of the Economic Alliance for Michigan. We believe that this proposed language captures the comparability of these services. Specifically the proposed language links the ability to perform pancreas transplants to programs with high volume annual kidney transplant thresholds, generating quality-driven programs. In addition, these proposed standards help to retain the comprehensive role of Gift of Life as a Michigan-based organ procurement program. Thus, we urge the Commission to move this language forward for proposed action.

MDCH MRI Work Group

I would also like to convey concerns about the MRI work group, at which Dr. Robert Goodman of BCBSM and I attended and actively participated. The issues pertaining to the MRI CON review standards require additional information and discussion prior to the development of proposed language. This is an evolving process, particularly since many key groups were unable to attend the first meeting. The process needs to be transparent with as many engaged parties as possible to deliberate these issues.

The initial meeting on May 6th was very informational, however, there is still more work to be done prior to development of proposed language. We think the proposed language brought forward for action at today's meeting is premature and recommend additional work group meetings to complete these deliberations and develop consensus. Only following this process, would we support MDCH-developed language to be brought forward for Commission action.

Again, BCBSM/BCN continues to support the review of CON standards in terms of cost, quality and/or access concerns. We applaud the CON Commission and MDCH staff as they continue to facilitate an objective review process, by eliciting in-depth clinical expertise as well as input from consumers, purchasers, and payors. BCBSM/BCN will continue to be an open-minded, active participant in these endeavors. As always, BCBSM/BCN commends the CON Commissioners and MDCH staff for their diligent efforts in maintaining CON as a strong, vibrant program to help ensure the delivery of high quality, safe and effective care to patients across the state.

THE ECONOMIC ALLIANCE FOR MICHIGAN
PUBLIC TESTIMONY FOR JUNE 9, 2009 MEETING OF CON COMMISSION
Dennis McCafferty, EAM Health Policy Director

Pancreas Transplants: EAM supports recommendations of Pancreas Workgroup:

- The minimum annual volume to be reduced from 12 to 2.
- Both to secure and retain a Pancreas Transplant CON, a hospital has to have done at least 80 Kidney/Pancreas transplants in the last two years.

MRI: Three issues involving the CON standards were reviewed by the MRI workgroup that met on May 6th.

- Exempting MRI units that are only used for MRT Simulation
- Lowering minimum annual volume of adjusted MRI scans to initiate a fixed MRI for hospitals with mobile MRI host sites, from 6,000 to 3,000,(16 to 8 scans per day) if they have 20,000 or more annual emergency room visits
- Lowering minimum annual volume of adjusted MRI scans to initiate a fixed MRI for freestanding MRI centers with mobile MRI host sites from 6,000 to 2,000 (from 16 to 5.3 scans per day) when at least 25% of their patients covered by Medicaid or are uninsured.

This May 6th workgroup meeting was not well attended. The only "experts" in the room were representing those wishing to amend the standards. Much of the details regarding the different proposals were not shared prior to the meeting and therefore many of the organizations that may have had a different perspective on these issues were not aware that these issues were being addressed by the workgroup and therefore did not attend.

EAM also has some concerns regarding the merits of the proposed changes.

- Does every provider of MRT services need a MRI for simulations?
- Does every emergency room with more than 8 MRI scans per day need to replace their mobile MRI with a Fixed MRI?
- Does the MRI standard need a special exception for free-standing imaging centers with high volume of Medicaid patients that have language difficulties? Should the Standards allow the replacement of mobile MRI units with a fixed MRI when the facility is providing only 5.3 scans per day? Why couldn't this special situation be handled within the existing standards by adjusting the weights for scans for these unique patients with language and other special challenges?

Due to our concerns that these issues were not given adequate venting by all impacted parties and because of our own unanswered questions, EAM is recommending that the Commission not take any action at the today's meeting and that the workgroup be asked to continue to review these proposals.

Second Open Heart Surgical Program in Kent County: On May 27th, at the request of some of our member organizations, EAM members met with Metropolitan Hospital and other health systems in Kent County to discuss their different perspectives on this question. Our members reviewed the information provided by Metropolitan Hospital and other hospitals from Kent County opposing this change in the Standards, related to Cost, Quality and Access of advance cardiac service in Kent County. Each organization was also given additional opportunity to provide responses to our member specific follow-up questions.

Unanimous Conclusion Reached by our members:

- No one has suggested that the current Quality of advanced cardiac services being provided to the citizens of Kent County is a concern.
    - Spectrum's risk-adjusted outcomes are far better than the regional averages.
    - We would question the ability of a second OHS program ever being able to reach and annual volume of 300, the CON Standard minimum for quality.
- There was no documented information provided indicating that current Access to these services is a concern.
    - The 2008 statewide volume for OHS has dropped 25% and the average number of procedures per Michigan OHS program has dropped by 39% since 2000.
    - Adding any additional OHS program capacity is not in the community's best interest.
- The information provided regarding current cost of these services suggests that a smaller, community hospital may be able to provide these service at a lower cost than a large, advanced services, regional hospital with significant number of residency programs.
    - This is the same reason that U of M indicates why its prices are so much higher.
    - Our most optimistic projections of the saving from shifting volume Spectrum to a second, community OHS program in Kent County are $500- $750,000/year.

The long-held position of The Economic Alliance for Michigan has been that the burden of proof for opening a Standard needs to be on the side of the party or parties requesting this change.

- We feel that it should not be the responsibility of the Commission or MDCH to find reasons why the CON Standards need to be modified.

- Based upon the information provided to our members, we are recommending that the Standards should not be re-opened for review at this time.

- Metropolitan and/or St Mary's hospital can always come back to the Commission at a later date if and when they are able to provide information that indicates that there is an urgent problems related to the cost, quality or access for these services in Kent County.

Attachment C

GIFT OF LIFE℠

MICHIGAN ORGAN & TISSUE DONATION PROGRAM

DONATE LIFE

A Donate Life Organization

COMMENTS REGARDING THE PANCREAS TRANSPLANT SERVICES STANDARDS

Gift of Life Michigan supports the pancreas transplant standards as presented today. We feel that the main thrust of the rewritten standards, that of patient access to care, taking into consideration cost and quality issues, will increase the number of transplants that occur in our state. We thank the Commission for bringing these standards forward for review.

There is one place where language, as used in the standards, is open to misinterpretation. This section, page 4, line 164 (Section 4(c)i.II), pertains to the number of kidney and pancreas transplants a center shall perform. Line 164 reads that procedures are to be performed, "biennially (every two years)". Gift of Life Michigan asks that the Commission recognize the unique reporting and quality control mechanisms that exist for transplant data. The federal reporting mechanisms for transplant centers do not operate on a calendar year. We request the Commission to change the wording which appears in parentheses, "biennially (every two years)" to "biennially (a consecutive 24-month period)". This will permit flexibility to allow for the different reporting and accounting systems that exist between the federal and state regulatory agencies.

Finally, in the interest of transplanting more pancreata in our state, we ask the Commission to create an administrative "fast-track" for those programs inactive under UNOS regulations due to the current CON requirements. These programs voluntarily surrendered their state certificate for pancreas transplants and have been inactive for more than a year. They would now qualify to reopen under the new standards. The entire process for standards approval will take us into the Fall of this year. Gift of Life Michigan respectfully asks that the Commission charge staff to create a process by which these programs can begin to list and transplant patients as quickly as possible, to the benefit of Michigan residents.

Thank you again for taking up this important issue and thank you to the staff of MDCH for their willingness to understand donation and transplantation and their assistance over the past year.

June 9, 2009

Richard Pietroski, Executive Director

rpietroski@giftoflifemichigan.org

Attachment D

FACILITY ID	FACILITY NAME	2007 ED Visits - Adult	2007 ED Visits - Peds	2007 ED Visits - TOTAL	Current Service	Adjusted MRI Procedures	2006 ED Visits	Notes
410040	Spectrum Health Butterworth Campus	99,923	29,513	129436	Fixed			
410040	Spectrum Health Blodgett Campus	99,923	29,513	129436	Fixed			
830420	St. John Hospital & Medical Center	77211	16645	93856	Fixed			
830500	Detroit Receiving Hospital	93594	75	93669	Fixed			
830190	Henry Ford Hospital	83317	8825	92142	Fixed			
830080	Children's Hospital of Michigan	9,792	80,595	90387	Fixed			
810030	St. Joseph Mercy Hospital	71859	17087	88946	Fixed			
830450	Sinai-Grace Hospital	73,423	11,355	84778	Fixed			
820120	Oakwood Hospital and Medical Center	69688	14030	83718	Fixed			
390020	Bronson Methodist Hospital	65428	13421	78849	Fixed			
250040	Hurley Medical Center	75458	0	75458	Off-Site Fixed			Still need to address the freestanding/consortium issue
630160	William Beaumont Hospital, Troy	58647	10215	68862	Fixed			
820230	Henry Ford Wyandotte Hospital	58661	9918	68579	Fixed			
250072	Genesys Regional Medical Center	54228	8519	62747	Freestanding Fixed			Still need to address the Freestanding issue
630130	Providence Hospital and Medical Center	56115	6428	62543	Fixed			
610010	Hackley Hospital	48,858	12799	61657	Mobile	4594		w/in 10 miles of Mercy General Health Partners
380010	W.A. Foote Memorial Hospital	49505	10867	60372	Fixed			
630050	Botsford Hospital	49744	8990	58734	Mobile	7204		w/in 10 miles of St. Mary's Livonia
500060	Mount Clemens Regional Medical Center	46645	9285	55930	None			w/in 10 miles of St. John Macomb
500110	St. Joseph's Medical Center	47040	8394	55434	Fixed			
500070	St. John Macomb Hospital	47593	6527	54120	Fixed			
390010	Borgess Medical Center	45104	6798	51902	Freestanding Fixed			w/in 10 miles of Bronson
330010	Ingham Regional Medical Center	42712	6064	48776	Fixed			
130031	Battle Creek Health System	40946	7470	48416	Fixed			
820010	Oakwood Annapolis Hospital	39,046	7883	46929	Fixed			
630140	St. Joseph Mercy Oakland	37880	7319	45199	Fixed			
250050	McLaren Regional Medical Center	41519	3604	45123	Off-Site Fixed			Still need to address the freestanding/consortium issue
820190	St. Mary Mercy Hospital	37720	4444	42164	Fixed			
700020	Holland Hospital	32,822	9,270	42092	Fixed			
280010	Munson Medical Center	36547	5391	41938	Fixed			
610020	Mercy General Health Partners - Mercy Campus	34903	6786	41689	Fixed			
110050	Lakeland Regional Medical Center, St. Joseph	34,184	7,429	41,613	Fixed			
580030	Mercy Memorial Hospital	32815	7740	40555	Fixed			
090050	Bay Regional Medical Center	34570	5715	40285	Fixed			
740020	Port Huron Hospital	31437	7599	39036	On-Site Freestanding Fixed			MRI Center - Port Huron is at the same location and has 1 fixed
630014	Huron Valley-Sinai Hospital	28,129	7,044	35173	Fixed			
560020	MidMichigan Medical Center-Midland	28493	6263	34756	Fixed			
410010	Spectrum Health Blodgett Campus	31,345	2,084	33429	Fixed			
830220	Harper University Hospital	32,911	59	32970	Fixed			
630080	St. John Oakland Hospital	29008	3440	32448	On-Site Freestanding Fixed			MRI Center Oakland is at the same location and has 1 fixed unit
470020	Saint Joseph Mercy Livingston Hospital	26039	6212	32251	Fixed			
630120	POH Medical Center	28973	3218	32191	On-Site Freestanding Fixed			w/in 10 miles of St. Joseph Mercy Oakland
820250	Oakwood Heritage Hospital	26,553	4675	31228	Mobile	4110		w/in 10 miles of HF Wyandotte
820030	Bon Secours Hospital	25948	3109	29057	Fixed			
630177	Providence Medical Center-Providence Park	22,573	6386	28959	Fixed			
520050	Marquette General Health System	24,927	4005	28932	Fixed			
500020	Henry Ford Bi-County Hospital	23887	3841	27728	Mobile	3999		w/in 10 miles of St. John Hospital & MC
630070	Crittenton Hospital Medical Center	23,020	4500	27520	Freestanding Fixed			w/in 10 miles of Beaumont Troy
120010	Community Health Center of Branch County	21,387	4,949	26336	Fixed			
040010	Alpena General Hospital	21,113	4,585	25,698	Fixed			
780010	Memorial Healthcare	20,690	4923	25613	Fixed			
820170	Oakwood Southshore Medical Center	22185	3316	25501	Mobile	5639		w/in 10 miles of HF Wyandotte
460020	Emma L. Bixby Medical Center	19273	5024	24297	Fixed			
730050	St. Mary's of Michigan	22117	1,186	23303	Fixed			
590060	Spectrum Health United Memorial-United Campus	17920	5228	23148	Mobile	8561		65 acute care/40 HLTCU Are these combined with Kelsey ED visits?
630030	William Beaumont Hospital, Royal Oak	3274	19382	22656	Fixed			
630176	Henry Ford West Bloomfield Hospital	20,064	2,210	22274	Fixed			
370010	Central Michigan Community Hospital	18530	3728	22258	Fixed			
240030	Northern Michigan Hospital	18362	3860	22222	Fixed			
740010	Mercy Hospital	18886	3322	22208	Off-Site Consortium Fixed			w/in 10 miles of Port Huron Hospital
440010	Lapeer Regional Medical Center	16452	4761	21213	Fixed			
110070	Lakeland Community Hospital, Niles	16,370	4,529	20899	Mobile	2525		
530010	Memorial Medical Center of West Michigan	15927	4538	20465	Fixed			
830230	St. John Northeast Community Hospital	16253	4124	20377	None			w/in 10 miles of St. John Hospital & MC

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410070	Mary Free Bed Rehabilitation Hospital	0	0	0				
412510	Forest View Psychiatric Hospital	0	0	0				
412530	Pine Rest Christian Mental Health Services	0	0	0				
412619	Saint Mary's Mercy Medical Center - Pine Rest	0	0	0				
500010	Southeast Michigan Surgical Hospital	0	0	0				
500080	St. Joseph's Specialty Hospital	0	0	0				
500111	Select Specialty Hospital - Macomb	0	0	0				
502530	Harbor Oaks Hospital	0	0	0				
610051	Select Specialty Hospital of Western Michigan	0	0	0				
610052	LifeCare Hospitals of Western MI	0	0	0				
630150	Straith Hospital for Special Surgery	0	0	0				
630172	SSH - Pontiac	0	0	0				
632200	Henry Ford Kingswood Hospital	0	0	0				
632530	Havenwyck Hospital	0	0	0				
730060	HealthSource Saginaw, Inc.	0	0	0				
730062	SSH - Saginaw	0	0	0				
810010	Forest Health Medical Center	0	0	0				
810081	Select Specialty Hospital - Ann Arbor	0	0	0				
820130	Kindred Hospital Detroit	0	0	0				
820272	SSH - Downriver (Wyandotte)	0	0	0				
820276	Select Specialty Hospital - Grosse Pointe	0	0	0				
830410	Rehabilitation Institute of Michigan	0	0	0				
830520	Karmanos Cancer Institute	0	0	0				
830521	SCCI Hospital-Detroit	0	0	0				
830523	Select Specialty Hospital - NW Detroit	0	0	0				
832633	Circle of Life	0	0	0				
790032	Caro Community Hospital	no info	yet	N/A	None		6284	
590030	Sheridan Community Hospital	no info	yet	N/A	None			w/in 10 miles of Spectrum Health United Campus
790030	Hills & Dales General Hospital	no info	yet	N/A	None		5111	
130100	Southwest Regional Rehabilitation Center	no info	yet	N/A	None			w/in 10 miles of BCHS
390040	HEART CENTER FOR EXCELLENCE	no info	yet	N/A	None		0	No ED?
450020	Leelanau Memorial Hospital	no info	yet	N/A	None		0	
710030	Rogers City Rehabilitation Hospital	no info	yet	N/A	None		0	No ED?
730030	Covenant HealthCare Systems	no info	yet	N/A	None			w/in 10 miles of St. Mary's
822020	Hawthorn Center	no info	yet	N/A	None			w/in 10 miles of St. Mary's Livonia
750010	Sturgis Hospital	no info	yet	N/A	Mobile	1107	19595	
700030	Zeeland Community Hospital	no info	yet	N/A	Mobile	1377		w/in 10 miles of Holland Community Hospital
750020	Three Rivers Health	no info	yet	N/A	Mobile	2930	14454	
340020	Ionia County Memorial Hospital	no info	yet	N/A	Mobile	1539	14254	
800020	South Haven Community Hospital	no info	yet	N/A	Mobile	1168	13991	
230010	Eaton Rapids Medical Center	no info	yet	N/A	Mobile	1074		w/in 10 miles of Hayes Green Beach
030030	Borgess-Pipp Hospital	no info	yet	N/A	Mobile	1468	11744	
230020	Hayes Green Beach Memorial Hospital	no info	yet	N/A	Mobile	2909		w/in 10 miles of Eaton Rapids Medical Center?
190011	Clinton Memorial Hospital	no info	yet	N/A	Mobile	3144	9178	
360020	IRON COUNTY COMMUNITY HOSPITAL	no info	yet	N/A	Mobile	931	8681	
150020	Charlevoix Area Hospital	no info	yet	N/A	Mobile	1131	8619	
520010	Bell Memorial Hospital	no info	yet	N/A	Mobile	1518	7678	
810601	University of Michigan Hospitals & Health Centers	no info	yet	N/A	Fixed			
330060	Sparrow Edward W Hospital	no info	yet	N/A	Fixed			
730040	Covenant Medical Center - Cooper	no info	yet	N/A	Fixed			
730061	Covenant HealthCare Systems	no info	yet	N/A	Fixed			
410080	Saint Mary's Health Care	no info	yet	N/A	Fixed			
410060	Metro Hospital	no info	yet	N/A	Fixed			
820070	Garden City Hospital	no info	yet	N/A	Fixed			
330050	Sparrow Health System - St. Lawrence Campus	no info	yet	N/A	Fixed			
300010	Hillsdale Community Health Center	no info	yet	N/A	Fixed			
840010	Mercy Hospital	no info	yet	N/A	Fixed			
540030	Mecosta County Medical Center	no info	yet	N/A	Fixed			
080010	Pennock Hospital	no info	yet	N/A	Fixed			
200020	Mercy Hospital - Grayling	no info	yet	N/A	Fixed			
310020	Portage Hospital	no info	yet	N/A	Fixed			

Public Testimony Regarding MRI Standards
Presented at CON Commission Meeting – June 9, 2009
By: Oakwood Healthcare, Inc.

Oakwood Healthcare, Inc., located in Dearborn, Michigan, operates four licensed hospitals with 1281 inpatient hospital beds in west and southwest Wayne County and offers an array of hospital outpatient, diagnostic, physician, and other medical services, including inpatient psychiatric services.

Oakwood supports the Workgroup MRI proposal developed by representatives of Oaklawn Hospital. Specifically, this proposal states that to convert a mobile MRI to fixed unit, the applicant must demonstrate at least 20,000 emergency department visits in the previous 12 months, as well as show that they are currently a mobile MRI host site with an historical volume of at least 3000 adjusted MRI procedures in 12 months.

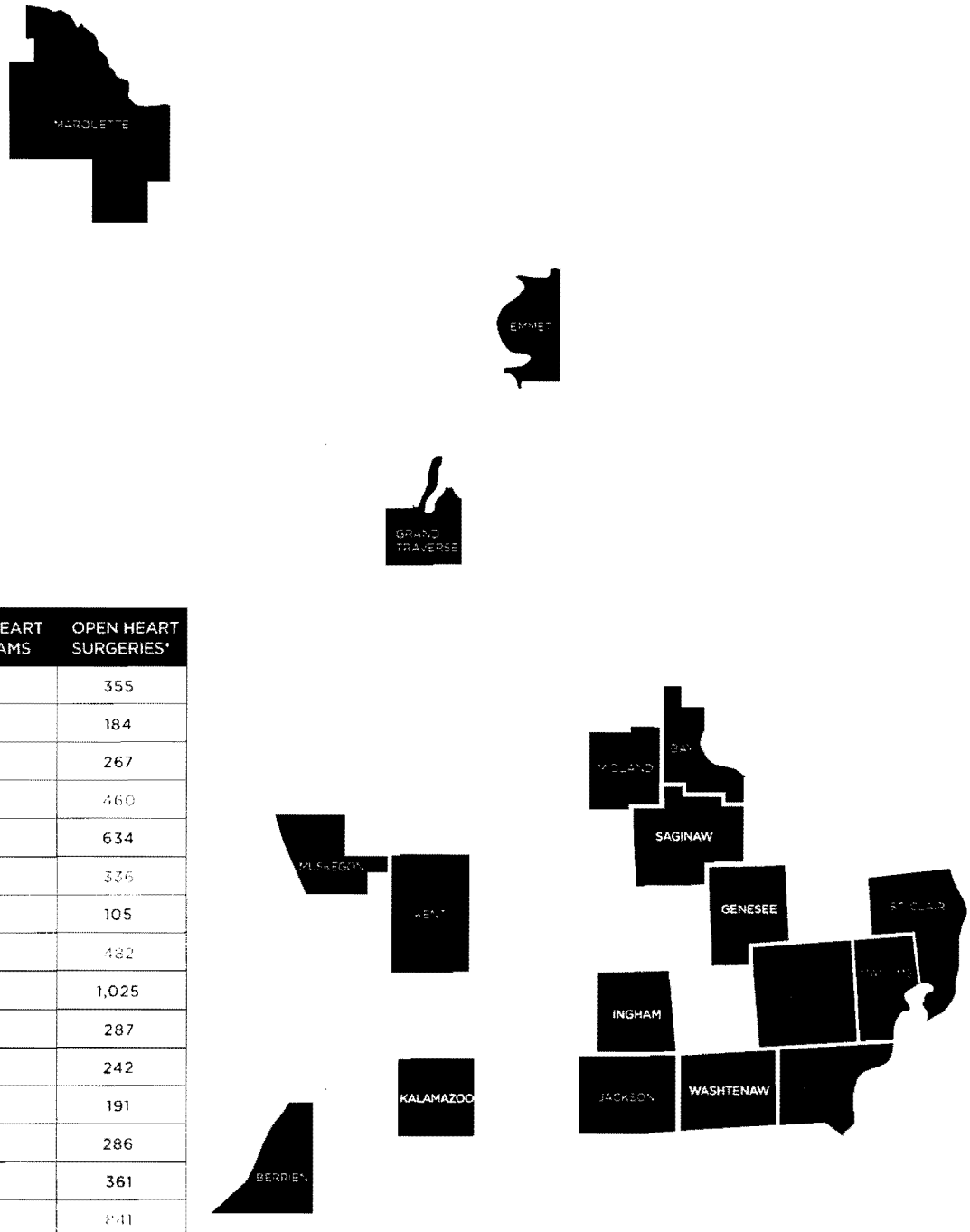
Mobile MRI service is currently provided at two of Oakwood's hospital facilities: Oakwood Heritage Hospital and Oakwood Southshore Medical Center. In the last several years, MRI has become an important component of quality patient care. Now mainstream, MRI is a vital service for all hospitals and the communities they serve. The cost of providing mobile service is significantly more expensive than those associated with a fixed scanner.

MRI capabilities have also evolved rapidly over the last five years. Increasingly, MRI is becoming the modality of choice for emergent cases, in particular cardiac MRI. Cardiology volumes have steadily increased at our Southshore facility with the onset of the emergency PCI program. Also, as a trauma center designation, the need for emergent MRI for neurology is an absolute. Also, as a teaching hospital, Southshore could provide enhanced teaching capabilities with the 24-hour availability of a fixed MRI.

We feel the proposed change in the MRI standards would allow us the opportunity to save lives and better serve our patients and community.

Thank you for the opportunity to provide these comments.

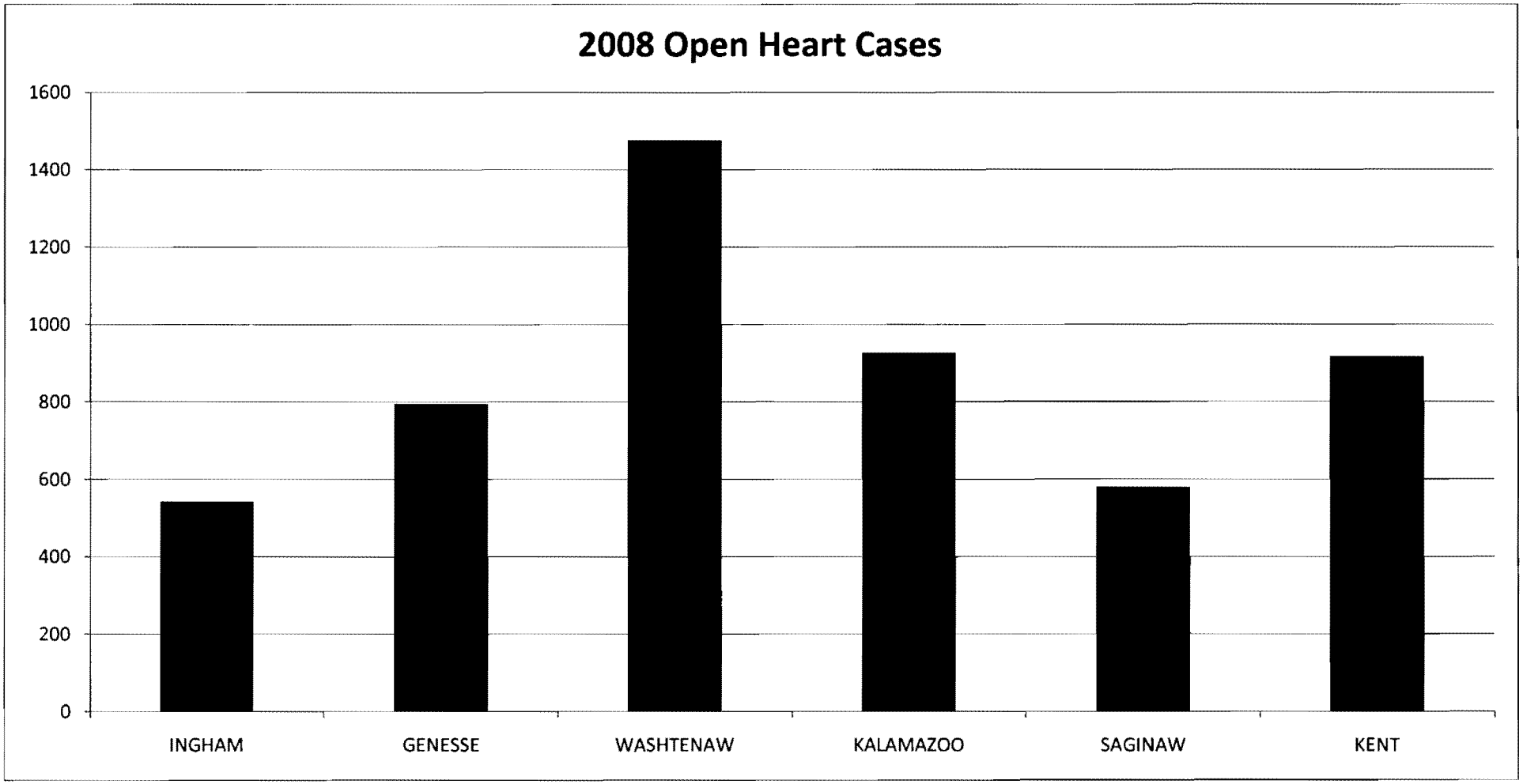
open heart programs in MICHIGAN



COUNTY	POPULATION	OPEN HEART PROGRAMS	OPEN HEART SURGERIES*
Bay	107,495	1	355
Berrien	159,481	1	184
Emmet	33,535	1	267
Genesee	428,790	2	460
Grand Traverse	86,071	1	634
Ingham	277,528	2	336
Jackson	160,180	1	105
Kalamazoo	245,912	2	482
Kent	605,213	1	1,025
Macomb	830,663	3	287
Marquette	65,492	1	242
Midland	129,494	1	191
Muskegon	174,344	1	286
Oakland	1,202,174	5	361
Saginaw	200,745	2	241
St. Clair	168,894	1	181
Washtenaw	347,376	2	761
Wayne	1,949,929	5	414

* Average annual open heart surgeries 2005 - 2008

Source: U.S. Census Bureau, Population Division (July 2008)
Source of Heart Surgeries Data: Michigan Department of Community Health



County	*Hospital(s)*	*Total open heart cases*	*Number of cardiologists*	*Average cases per cardiologist*
INGHAM	Ingham Regional Medical Center Edward W. Sparrow Hospital	542	25	22
GENESSE	McLaren Regional Medical Center Genesys Regional Medical Center	795	22	36
WASHTENAW	University of Michigan St. Joseph Mercy Hospital	1476	65	23
KALAMAZOO	Bronson Medical Center Borgess Medical Center	926	30	31
SAGINAW	St. Mary's Medical Center Covenant Medical Center	580	18	32

WEST MICHIGAN HEART
LEADERS IN CARDIAC CARE

Dennis G. Besley, M.D.
John D. Calli Jr., M.D.
Nagib T. Chalfoun, M.D.
L. Stewart Collins, M.D.
Lynn J. Cronin, M.D.
Robert C. Davidson, M.D.
Michael G. Dickinson, M.D.
Dennis W. Dunning, M.D.
Darryl A. Elmoutchi, M.D.
Bohuslav Finta, M.D.
William A. Frazenheim, M.D.
Timothy D. Fritz, M.D.
Andre J. Gauri, M.D.
J. Robert Grove, M.D.
Mark Jacoby, M.D.
David B. Johnson, M.D.
John A. Key, D.O.
Paul L. Kovack, D.O.
David E. Langholz, M.D.
Michael A. Lojek, M.D.
Richard F. McNamara, M.D.
Roger D. Miller, M.D.
L. Craig Mulligan, D.O.
Jihad A. Mustapha, M.D.
Maurice J. Norman, M.D.
Raymond A. Roden, M.D.
Matthew W. Sevensma, D.O.
Helayne L. Sherman, M.D., Ph.D.
Michael C. Vredenburg, D.O.
Eric T. Walchak, D.O.
Alan K. Woelfel, M.D.
David Wohns, M.D.
Kevin G. Wolschleger, M.D.

June 9, 2009

Edward B. Goldman, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Chairman Goldman,

I have become aware that you have received letters supporting Metro Hospital's pursuit of an Open Heart Surgery program. Please be advised that the letters received by your office regarding such a program, including the contemplation of examining the Certificate of Need Standards, should not be construed as support from West Michigan Heart in its entirety. The letters that you have received represent the explicit views of those physicians who authored the letters.

Sincerely,

Michael Vredenburg, D.O.
Managing Partner

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Fax (616) 885 5020

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Fax (616) 452-0767

Holland
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Holland, MI 49423
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Fax (616) 392-3570

Greenville
709 S. Greenville West Drive
Greenville, MI 48838
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Fax (616) 754-8941

Other Locations
Allegan, Big Rapids, Fremont, Hastings, Ionia, Reed City, Sheridan, Stanwood, Zeeland

www.wmheart.com

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June 9, 2009

Edward B. Goldman, J.D, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building
201 Townsend Street
Lansing, Michigan 48913

RE: Metropolitan Hospital's Request for Changes to the Open Heart Surgery Standards

Dear Mr. Goldman,

On behalf of Trinity Health's 15 Michigan hospitals, which include Saint Mary's Health Care in Grand Rapids and Mercy Health Partners in Muskegon, we would like to support Metropolitan Hospital's request to have the current CON standards for Open Heart Surgery reviewed.

Trinity Health has a long history of supporting a strong CON program in Michigan and that support certainly continues today. With hospitals in 7 states, 3 with CON programs and 4 without, we see the positive impact that CON programs can have on promoting appropriate competition while maintaining lower costs and the efficient use of costly technology.

Michigan's CON process ensures that a thorough review of the issues is conducted with ample opportunity for provider, payer and public input. Trinity has been an active participant in the review of many standards over the years and believes that the current review process serves our state well.

Trinity Health also has a solid track record of collaborative initiatives with other health care providers in Michigan (Michigan Stroke Network, Mercy Cancer Network, Partners at Heart in Port Huron and others). Trinity Health is supportive of the opportunity for a competitive open-heart surgery program in Kent County that demonstrates a focus on quality, improved access and value.

Thank you for this opportunity to provide comment.

Sincerely,

Joseph R. Swedish
President and CEO

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR PANCREAS TRANSPLANTATION SERVICES

(By authority conferred on the CON Commission by Section 22215 of Act No. 368 of the Public Acts of 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being sections 333.22215, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. (1) These standards are requirements for the approval and delivery of services for all projects approved and Certificates of Need issued under Part 222 of the Code which involve pancreas transplantation services.

(2) Pancreas transplantation is a covered clinical service for purposes of Part 222 of the Code.

(3) The Department shall use sections 3 and 5, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.

(4) The Department shall use Section 4, as applicable, in applying Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

Sec. 2. (1) As used in these standards:

(a) "Certificate of Need Commission" or "CON Commission" means the Commission created pursuant to Section 22211 of the Code, being Section 333.22211 of the Michigan Compiled Laws.

(b) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et seq. of the Michigan Compiled Laws.

(c) "Department" means the Michigan Department of Community Health (MDCH).

~~(d) "Implementation plan" means a plan that documents how a proposed pancreas transplantation service will be initiated within the time period specified in these standards or the CON rules. At a minimum, the implementation plan shall identify: (i) each component or activity necessary to begin performing the proposed pancreas transplantation service including but not limited to the development of physical plant requirements such as an intensive care unit capable of treating immuno-suppressed patients, equipment acquisition(s), and recruitment and employment of all physician and support staff; (ii) the time table for completing each component or activity specified in subsection (i); and (iii) if the applicant has previously been approved for a pancreas transplantation service where either the CON expired or the service did not perform a transplant procedure during any consecutive 12-month period, what changes have or will be made to ensure that the proposed service can be initiated and provided on a regular basis.~~

(~~e~~D) "Initiate" or "implement" ~~for purposes of these standards,~~ means the performance of the first transplant procedure. ~~If the CON rules do not authorize a CON review standard to define the term of the certificate, the term shall be as provided in Rule 325.9403(1) and (2). If the CON rules do authorize a standard to define the term of a certificate, t~~The term shall be 18 months or the extended period established by Rule 325.9403(2)~~, if authorized~~.

(~~f~~E) "Licensed site" means ~~either (i) in the case of a single site hospital,~~ the location of the facility authorized by license and listed on that licensee's certificate of licensure ~~or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure~~.

(~~g~~F) " Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and1396r-8 to 1396v.

(~~h~~G) "OPO" or "Organ Procurement Organization" means an organ procurement organization as defined by Title 42, Part 486.302.

(~~i~~H) "OPTN" or "Organ Procurement and Transplantation Network" means the organization contracted by the federal Department of Health and Human Services to operate the organ procurement and transplantation network.

(~~j~~I) "Survival rate" means, ~~for purposes of these standards,~~ the rate calculated using the Kaplan-Meier technique and the following: (i) the date of transplantation (or, if more than one transplant is performed, the date of the first transplant) must be the starting date for calculation of the survival rate; (ii) for those dead, the date of death is used, if known. If the date of death is unknown, it must be assumed as 1 day after the date of the last ascertained survival; (iii) for those who have been ascertained as surviving within 60 days before the fiducial date (the point in time when the facility's survival rates are calculated and its experience is reported), survival is considered to be the date of the last ascertained survival, except for patients described in subsection (v); (iv) any patient who is not known to be dead but whose survival cannot be ascertained to a date that is within 60 days before the fiducial date, must be considered as "lost to follow up" for the purposes of the survival rate calculation; (v) any patient transplanted between 61 and 120 days before the fiducial date must be considered as "lost to follow up" if he or she is not known to be dead and his or her survival has not been ascertained for at least 60 days before the fiducial date. Any patient transplanted within 60 days before the fiducial date must be considered as "lost to follow up" if he or she is not known to be dead and his or her survival has not been ascertained on the fiducial date; and (vi) the survival analyses must use the assumption that each patient in the "lost to follow up" category died 1 day after the last date of ascertained survival. However, an applicant may submit additional analyses that reflect each patient in the "lost to follow up" category as alive at the date of the last ascertained survival.

(2) The definitions of Part 222 shall apply to these standards.

Section 3. Requirements for approval -- all applicants

Sec. 3. (1) An applicant proposing to perform a pancreas transplantation service shall demonstrate that it offers all of the following services or programs on site:

(a) operating rooms;

(b) anesthesiology;

(c) microbiology and virology laboratory;

(d) continuous availability, either on-site or on-call, of diagnostic imaging services including: (i) CT scanning, (ii) magnetic resonance imaging, and (iii) nuclear medicine;

(e) continuous availability, either on-site or on-call, of a broad range of sub-specialty consultants, adult and pediatric, as appropriate, in both medical and surgical specialties including but not limited to: pulmonary medicine with respiratory therapy support; cardiology; gastroenterology; pediatrics, as appropriate; nephrology; and immunology;

(f) dialysis;

(g) infectious disease;

(h) inpatient-outpatient social work;

(i) inpatient-outpatient psychiatry/psychology;

(j) clinical research;

(k) a histocompatibility laboratory that meets the standards of the American Society for Histocompatibility and Immunogenetics or an equivalent organization, either on-site or through written agreement;

(l) other support services, as necessary, such as physical therapy and rehabilitation medicine;

(m) continuous availability of anatomic and clinical pathology and laboratory services including clinical chemistry, immuno-suppressive drug monitoring, and tissue typing;

(n) continuous availability of red cells, platelets, and other blood components;

(o) an established organ donation protocol, with brain death protocol, consistent with applicable Michigan law; and

(p) a written agreement with Michigan's federally designated organ procurement organization (OPO) to promote organ donation at the applicant hospital(s).

(2) An applicant must provide~~, at the time the CON application is submitted,~~ an implementation plan for the proposed pancreas transplantation service. IMPLEMENTATION PLAN MEANS A PLAN THAT DOCUMENTS HOW A PROPOSED PANCREAS TRANSPLANTATION SERVICE WILL BE INITIATED WITHIN THE TIME PERIOD SPECIFIED IN THESE STANDARDS OR THE CON RULES. AT A MINIMUM, THE IMPLEMENTATION PLAN SHALL IDENTIFY:

(A) EACH COMPONENT OR ACTIVITY NECESSARY TO BEGIN PERFORMING THE PROPOSED PANCREAS TRANSPLANTATION SERVICE INCLUDING BUT NOT LIMITED TO THE DEVELOPMENT OF PHYSICAL PLANT REQUIREMENTS SUCH AS AN INTENSIVE CARE UNIT CAPABLE OF TREATING IMMUNO-SUPPRESSED PATIENTS, EQUIPMENT ACQUISITION(S), AND RECRUITMENT AND EMPLOYMENT OF ALL PHYSICIAN AND SUPPORT STAFF;

(B) THE TIME TABLE FOR COMPLETING EACH COMPONENT OR ACTIVITY SPECIFIED IN SUBSECTION (A); AND

(C) IF THE APPLICANT HAS PREVIOUSLY BEEN APPROVED FOR A PANCREAS TRANSPLANTATION SERVICE WHERE EITHER THE CON EXPIRED OR THE SERVICE DID NOT PERFORM A TRANSPLANT PROCEDURE DURING ANY CONSECUTIVE 12-MONTH PERIOD, WHAT CHANGES HAVE OR WILL BE MADE TO ENSURE THAT THE PROPOSED SERVICE CAN BE INITIATED AND PROVIDED ON A REGULAR BASIS.

(3) An applicant for a pancreas transplantation service shall project a minimum of ~~1~~2 pancreas transplantation procedures annually in the second 12 months of operation following the date on which the first pancreas transplant procedure is performed~~ and annually thereafter~~.

(4) An applicant proposing to provide a pancreas transplantation service shall demonstrate that it offers all of the following services or programs:

(a) continuous availability, either on-site or on-call, of angiography;

(b) an intensive care unit with 24 hour per day on-site physician coverage;

(c) an on-site renal transplant service that has performed a minimum of 80 kidney transplants in the 2 most recent 12 month periods for which verifiable data are available; and

(d) ophthalmology retinal eye service availability, either on site or on call.

(5) An applicant shall provide verification of Medicaid participation~~ at the time the application is submitted to the Department~~. AN APPLICANT THAT IS A NEW PROVIDER NOT CURRENTLY ENROLLED IN MEDICAID SHALL CERTIFY THAT PROOF OF MEDICAID PARTICIPATION WILL BE PROVIDED TO THE DEPARTMENT WITHIN SIX (6) MONTHS FROM THE OFFERING OF SERVICES IF A CON IS APPROVED. ~~If the required documentation is not submitted with the application on the designated application date, the application will be deemed filed on the first applicable designated application date after all required documentation is received by the Department.~~

Section 4. Project delivery requirements -- terms of approval for all applicants

Sec. 4. (1) An applicant shall agree that, if approved, the services shall be delivered in compliance with the following terms of CON approval:

(a) Compliance with these standards. An applicant shall immediately report to the Department any changes in key staff or other aspects of the pancreas transplantation service that may affect its ability to comply with these standards.

(b) Compliance with applicable safety and operating standards.

(c) Compliance with the following quality assurance standards, as applicable:

(i) The applicant shall perform A MINIMUM OF 2 PANCREAS TRANSPLANTATION PROCEDURES ANNUALLY IN THE SECOND 12 MONTHS OF OPERATION FOLLOWING THE DATE

ON WHICH THE FIRST PANCREAS TRANSPLANT PROCEDURE IS PERFORMED~~the applicable required volumes within the time periods specified in these standards,~~ and annually thereafter.

(II) THE APPLICANT SHALL PERFORM A MINIMUM OF 80 KIDNEY TRANSPLANTS AND/OR PANCREAS TRANSPLANTATION PROCEDURES IN THE SECOND 12 MONTHS OF OPERATION FOLLOWING THE DATE ON WHICH THE FIRST PANCREAS TRANSPLANT PROCEDURE IS PERFORMED AND BIENNIALLY (EVERY TWO YEARS) THEREAFTER.

(ii~~i~~) The applicant shall comply with applicable OPTN and Medicare requirements.

(~~iii~~iV) The applicant shall have patient management plans and protocols that include the following: (A) therapeutic and evaluative procedures for the acute and long-term management of a patient; (B) patient management and evaluation during the waiting, in-hospital and immediate post-discharge phases of the service; and (C) long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least five (5) years.

(~~i~~v) The applicant shall implement a program of education and training for nurses, technicians, service personnel, and other hospital staff.

(vI) An applicant shall actively participate in the education of the general public and the medical community with regard to pancreas transplantation, and will make organ donation literature available in public areas of the institution.

(viI) The applicant shall establish and maintain an active, formal multi-disciplinary research program related to the proposed pancreas transplantation service.

(viiI) The applicant's education and research program related to pancreas transplantation shall be subject to external peer review.

(~~viii~~X) The applicant shall maintain an organized institutional transplant registry for recording ongoing information on its patients being evaluated for transplant and on its transplant recipients and shall participate in state and national transplantation registries applicable to the pancreas transplantation service.

(~~i~~x) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information, operating schedules, through-put schedules, demographic and diagnostic information, patient survival rates at both 12 and 24 months following the transplant procedure, primary and secondary diagnoses, whether the transplant procedure was a first or repeat transplant procedure, length of stay, the volume of care provided to patients from all payor sources, and other data requested by the Department and approved by the CON Commission. The applicant shall provide the required data on an individual basis for each designated licensed site, in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(xI) The applicant, to assure that the pancreas transplantation service will be utilized by all segments of the Michigan population, shall:

(A) not deny the services to any individual based on ability to pay or source of payment;

(B) provide the services to all individuals in accordance with the patient selection criteria developed by appropriate medical professionals, and approved by the Department; and

(C) maintain information by payor and non-paying sources to indicate the volume of care from each source provided annually.

Compliance with selective contracting requirements shall not be construed as a violation of this term.

(xiI) The applicant shall provide the Department with a notice stating the date on which the first transplant procedure is performed and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(xiiI) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(d) An applicant shall agree to establish and maintain all of the following:

(i) a written agreement with the federally approved organ procurement organization whose designated service area includes the location of the proposed pancreas transplantation service;

(ii) organ preservation capability;

(iii) an organized 24-hour transport system for transportation of organs, donors, and blood serum;

(iv) an organized 24-hour communication service capable of serving the transplant team and others, as appropriate;
(v) a laboratory with immunosuppression assay results available on the same day, as appropriate;
(vi) an immunologic monitoring laboratory;
(vii) a specialized inpatient pancreas transplantation unit or a combined inpatient renal and extrarenal transplantation unit;
(viii) a medical staff and governing board policy that provides for the selection of candidates for organ transplantation procedures in accordance with the patient selection criteria approved by the Department;
(ix) an ethics committee or human use committee to review and approve the institution's protocols related to organ transplantation, including protocols involving the selection of donors and recipients;
(x) a multi-disciplinary transplant recipient evaluation committee;
(xi) a histocompatibility laboratory that meets the standards of the American Society for Histocompatibility and Immunogenetics or an equivalent organization, either operated on-site or through written agreement;
(xii) insulin, C-peptide, glycosylated hemoglobin assays;
(xiii) glucometer glucose assay availability; and
(xiv) electromyography.
(e) An applicant shall agree that the pancreas transplantation service shall be staffed and provided by at least the following:
(i) a transplant team leader and coordinator;
(ii) transplant surgeons and physicians experienced with renal transplantation in diabetics;
(iii) surgeons with demonstrated proficiency in major pancreatic surgery;
(iv) both adult and pediatric surgeons, as appropriate;
(v) qualified adult and pediatric, as appropriate, transplant surgeon(s) and transplant physician(s). For purposes of evaluating subsection (v), the Department shall consider it prima facie evidence as to the qualifications of the surgeon(s) and physician(s) if both the kidney and pancreas transplantation programs are approved by and a member in good standing of the OPTN;
(vi) a pathologist capable of diagnosing pancreatic rejection; and
(vii) nurses with specialized training assigned to operating room(s) and intensive care unit(s) used in conjunction with the transplantation service, trained in the hemodynamic support of transplant patients, and managing immuno-suppressed patients.
(f) Compliance with the REVISED Uniform Anatomical Gift Law~~, Act No. 186 of the Public Acts of 1986, being~~ pursuant to MCL Section 333.10101 et seq. of the Michigan Compiled Laws.

(2) An applicant must demonstrate pancreatic graft survival rates at one year and two years after transplantation of no less than the national average survival rate for the most recent year for which data is published by the OPTN.

(3) The agreements and assurances required by this section~~, as applicable,~~ shall be in the form of a certification ~~authorized by the governing body of~~AGREED TO BY the applicant or its authorized agent.

Section 5. Documentation of projections

Sec. 5. An applicant required to project volumes of service under Section 3 shall specify how the volume projections were developed. This specification of projections shall include a description of the data source(s) used, assessments of the accuracy of these data, and the statistical method used to make the projections. Based on this documentation, the Department shall determine if the projections are reasonable.

Section 6. Effect on prior CON review standards; comparative reviews

Sec. 6. (1) These CON review standards supersede and replace the CON Review Standards for Pancreas Transplantation Services approved by the CON Commission on ~~September 26, 2002~~MARCH 9, 2004 and effective on ~~December 23, 2002~~JUNE 4, 2004.

(2) Projects reviewed under these standards shall not be subject to comparative review.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR PSYCHIATRIC BEDS AND SERVICES

(By authority conferred on the CON Commission by Section 22215 of Act No. 368 of the Public Acts of 1978, as amended, and Sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being Sections 333.22215, 24.207 and 24.208 of the Michigan Compiled Laws).

Section 1. Applicability

Sec. 1. (1) These standards are requirements for the approval and delivery of services for all projects approved and Certificates of Need issued under Part 222 of the Code which involve psychiatric beds and services.

(2) A psychiatric hospital or unit is a covered health facility for purposes of Part 222 of the Code.

(3) An increase in licensed psychiatric beds or the physical relocation from a licensed site to another geographic location is a change in bed capacity for purposes of Part 222 of the Code.

(4) The Department shall use sections 3, 4, 5, 6, 7, 8, 9, and 10, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.

(5) The Department shall use Sections 12 and 13, as applicable, in applying Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

(6) The Department shall use Section 11 in applying Section 22215(1)(b) of the Code, being Section 333.22215(1)(b) of the Michigan Compiled Laws

Section 2. Definitions

Sec. 2. (1) For purposes of these standards:

(a) "Acquisition of a psychiatric hospital or unit" means the issuance of a new license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangement) of an existing licensed psychiatric hospital or unit and which does not involve a change in the number of licensed psychiatric beds at that health facility.

(b) “Adult” means any individual aged 18 years or older.

(c) "Base year" means 1992 or the most recent year for which verifiable data are collected by the Department and are available separately for the population age cohorts of 0 to 17 and 18 and older.

(d) "Certificate of Need Commission" or "Commission" means the Commission created pursuant to Section 22211 of the Code, being Section 333.22211 of the Michigan Compiled Laws.

(e) "Child/adolescent" means any individual less than 18 years of age.

(f) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et seq. of the Michigan Compiled Laws.

(g) "Community mental health board" or "board" or "CMH" means the board of a county(s) community mental health board as referenced in the provisions of MCL 330.1200 to 330.1246.

(h) "Comparative group" means the applications which have been grouped for the same type of project in the same planning area and are being reviewed comparatively in accordance with the CON rules.

(i) "Department" means the Michigan Department of Community Health (MDCH).

(j) "Department inventory of beds" means the current list maintained by the Department which includes:

(i) licensed adult and child/adolescent psychiatric beds; and
(ii) adult and child/adolescent psychiatric beds approved by a valid CON, which are not yet licensed.
A separate inventory will be maintained for child/adolescent beds and adult beds.
(k) "Existing adult inpatient psychiatric beds" or "existing adult beds" means:
(i) all adult beds in psychiatric hospitals or units licensed by the Department pursuant to the Mental Health Code;
(ii) all adult beds approved by a valid CON, which are not yet licensed;
(iii) proposed adult beds under appeal from a final Department decision, or pending a hearing from a proposed decision; and
(iv) proposed adult beds that are part of a completed application (other than the application or applications in the comparative group under review) which are pending final Department decision.
(l) "Existing child/adolescent inpatient psychiatric beds" or "existing child/adolescent beds" means:
(i) all child/adolescent beds in psychiatric hospitals or units licensed by the Department pursuant to the Mental Health Code;
(ii) all child/adolescent beds approved by a valid CON, which are not yet licensed;
(iii) proposed child/adolescent beds under appeal from a final Department decision, or pending a hearing from a proposed decision; and
(iv) proposed child/adolescent beds that are part of a completed application (other than the application or applications in the comparative group under review) which are pending final Department decision.
(m) "Initiation of service" means the establishment of an inpatient psychiatric unit with a specified number of beds at a site not currently providing psychiatric services.
(n) "Involuntary commitment status" means a hospital admission effected pursuant to the provisions of MCL 330.1423 to 330.1429.
(o) "Licensed site" means either:
(i) in the case of a single site hospital, the location of the facility authorized by license and listed on that licensee's certificate of licensure; or
(ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure.
(p) "Medicaid" means title XIX of the Social Security Act, chapter 531, 49 Stat. 620, 1396r-6 and1396r-8 to 1396v.
(q) "Mental Health Code" means Act 258 of the Public Acts of 1974, as amended, being Sections 330.1001 to 330.2106 of the Michigan Compiled Laws.
(r) "Mental health professional" means an individual who is trained and experienced in the area of mental illness or developmental disabilities and who is any 1 of the following:
(i) a physician who is licensed to practice medicine or osteopathic medicine and surgery in Michigan and who has had substantial experience with mentally ill, mentally retarded, or developmentally disabled clients for 1 year immediately preceding his or her involvement with a client under administrative rules promulgated pursuant to the Mental Health Code;
(ii) a psychologist who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;
(iii) a licensed master's social worker licensed in Michigan Pursuant to the provisions of MCL 333.16101 to 333.18838;
(iv) a registered nurse who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;
(v) a licensed professional counsel or licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;
(vi) a marriage and family therapist licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;
(vii) a professional person, other than those defined in the administrative rules promulgated pursuant to the Mental Health Code, who is designated by the Director of the Department or a director of a facility operated by the Department in written policies and procedures. This mental health professional shall have a degree in his or her profession and shall be recognized by his or her respective professional

association as being trained and experienced in the field of mental health. The term does not include non-clinical staff, such as clerical, fiscal or administrative personnel.

(s) "Mental health service" means the provision of mental health care in a protective environment with mental illness or mental retardation, including, but not limited to, chemotherapy and individual and group therapies pursuant to MCL 330.2001.

(t) "Non-renewal or revocation of license" means the Department did not renew or revoked the psychiatric hospital's or unit's license based on the hospital's or unit's failure to comply with state licensing standards.

(u) "Non-renewal or termination of certification" means the psychiatric hospital's or unit's Medicare and/or Medicaid certification was terminated or not renewed based on the hospital's or unit's failure to comply with Medicare and/or Medicaid participation requirements.

(v) "Offer" means to provide inpatient psychiatric services to patients.

(w) "Physician" means an individual licensed in Michigan to engage in the practice of medicine or osteopathic medicine and surgery pursuant to MCL 333.16101 to 333.18838.

(x) "Planning area" means the geographic boundaries of the groups of counties shown in Section 15.

(y) "Planning year" means 1990 or a year in the future, at least 3 years but no more than 7 years, established by the CON Commission for which inpatient psychiatric bed needs are developed. The planning year shall be a year for which official population projections from the Department of Management and Budget are available.

(z) "Psychiatric hospital" means an inpatient program operated by the Department for the treatment of individuals with serious mental illness or serious emotional disturbance or a psychiatric hospital or psychiatric unit licensed under Section 137, pursuant to MCL 330.1100.

(aa) "Psychiatrist" means 1 or more of the following, pursuant to MCL 330.1100:

(i) a physician who has completed a residency program in psychiatry approved by the Accreditation Council for Graduate Medical Education or The American Osteopathic Association, or who has completed 12 months of psychiatric rotation and is enrolled in an approved residency program;

(ii) a psychiatrist employed by or under contract with the Department or a community health services program on March 28, 1996;

(iii) a physician who devotes a substantial portion of his or her time to the practice of psychiatry and is approved by the Director.

(bb) "Psychiatric unit" means a unit of a general hospital that provides inpatient services for individuals with serious mental illness or serious emotional disturbances pursuant to MCL 330.1100.

(cc) "Psychologist" means an individual licensed to engage in the practice of psychology, who devotes a substantial portion of his or her time to the diagnosis and treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability, pursuant to MCL 333.16101 to 333.18838.

(dd) "Public patient" means an individual approved for mental health services by a CMH or an individual who is admitted as a patient under Section 423, 429, or 438 of the Mental Health Code, Act No. 258 of the Public Acts of 1974, being Sections 330.1423, 330.1429, and 330.1438 of the Michigan Compiled Laws.

(ee) "Qualifying project" means each application in a comparative group which has been reviewed individually and has been determined by the Department to have satisfied all of the requirements of Section 22225 of the Code, being Section 333.22225 of the Michigan Compiled Laws, and all other applicable requirements for approval in the Code and these standards.

(ff) "Registered professional nurse" or "R.N." means an individual licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838.

(gg) "Replacement beds" means beds in a psychiatric hospital or unit which meet all of the following conditions:

(i) an equal or greater number of beds are currently licensed to the applicant at the current licensed site;

(ii) the beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, or other comparable arrangement); and

(iii) the beds to be replaced will be located in the replacement zone.

(hh) "Replacement zone" means a proposed licensed site which is:

(i) in the same planning area as the existing licensed site; and

(ii) on the same site, on a contiguous site, or on a site within 15 miles of the existing licensed site.

(ii) "Social worker" means an individual registered in Michigan to engage in social work under the provisions of MCL 333.18501.

(2) The terms defined in the Code have the same meanings when used in these standards.

Section 3. Determination of needed inpatient psychiatric bed supply

Sec. 3. (1) Until changed by the Commission in accordance with Section 4(3) and Section 5, the use rate for the base year for the population age 0-17 is set forth in Appendix D.

(2) The number of child/adolescent inpatient psychiatric beds needed in a planning area shall be determined by the following formula:

(a) Determine the population for the planning year for each separate planning area for the population age 0-17.

(b) Multiply the population by the use rate established in Appendix D. The resultant figure is the total patient days.

(c) Divide the total patient days obtained in subsection (b) by 365 (or 366 for leap years) to obtain the projected average daily census (ADC).

(d) Divide the ADC by 0.75.

(e) For each planning area, all psychiatric hospitals or units with an average occupancy of 60% or less for the previous 24 months will have the ADC, for the previous 24 months, multiplied by 1.7. The net decrease from the current licensed beds will give the number to be added to the bed need.

(f) The adjusted bed need for the planning area is the sum of the results of subsections (d) and (e).

(3) The number of needed adult inpatient psychiatric beds shall be determined by multiplying the population aged 18 years and older for the planning year for each planning area by either:

(a) The ratio of adult beds per 10,000 adult population set forth in Appendix C; or

(b) The statewide ratio of adult beds per 10,000 adult population set forth in Appendix C, whichever is lower; and dividing the result by 10,000. If the ratio set forth in Appendix C for a specific planning area is "0", the statewide ratio of adult beds per 10,000 adult population shall be used to determine the number of needed adult inpatient psychiatric beds.

(c) For each planning area, an addition to the bed need will be made for low occupancy facilities. All psychiatric hospitals or units with an average occupancy of 60% or less for the previous 24 months will have the ADC, for the previous 24 months, multiplied by 1.5. The net decrease from the current licensed beds will give the number to be added to the bed need.

(d) The adjusted bed need for the planning area is the sum of the results of subsections (b) and (c).

Section 4. Bed need for inpatient psychiatric beds

Sec. 4. (1) For purposes of these standards, until otherwise changed by the Commission, the bed need numbers determined pursuant to Section 3, incorporated as part of these standards as Appendices A and B, as applicable, shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise.

(2) The Department shall apply the bed need methodologies in Section 3 on a biennial basis.

(3) The Commission shall designate the planning year, and, for child/adolescent beds, the base year, which shall be utilized in applying the bed need methodologies pursuant to subsection (2).

(4) The effective date of the bed need numbers shall be established by the Commission.

(5) New bed need numbers established by subsections (2) and (3) shall supercede the bed need numbers shown in Appendices A and B and shall be included as amended appendices to these standards.

(6) Modifications made by the Commission pursuant to this Section shall not require Standard Advisory Committee action, a public hearing, or submittal of the standard to the Legislature and the Governor in order to become effective.

Section 5. Modification of the child/adolescent use rate by changing the base year

Sec. 5. (1) The Commission may modify the base year based on data obtained from the Department and presented to the Commission. The Department shall calculate the use rate for the population age 0-17 and biennially present the revised use rate based on the most recent base year information available biennially to the CON Commission.

(2) The Commission shall establish the effective date of the modifications made pursuant to subsection (1).

(3) Modifications made by the Commission pursuant to subsection (1) shall not require Standard Advisory Committee action, a public hearing, or submittal of the standard to the Legislature and the Governor in order to become effective.

Section 6. Requirements for approval to initiate service

Sec. 6. An applicant proposing the initiation of an adult or child/adolescent psychiatric service shall demonstrate or provide the following:

(1) The number of beds proposed in the CON application cannot result in the number of existing adult or child/adolescent psychiatric beds, as applicable, in the planning area exceeding the bed need set forth in Appendix A or B, as applicable. However, an applicant may request and be approved for up to a maximum of 10 beds if, when the total number of existing adult beds or existing child/adolescent beds is subtracted from the bed need for the planning area set forth in Appendix A or B, the difference is equal to or more than 1 or less than 10.

(2) A written recommendation, from the Department or the CMH that serves the county in which the proposed beds or service will be located, which shall include an agreement to enter into a contract to meet the needs of the public patient. At a minimum, the letter of agreement shall specify the number of beds to be allocated to the public patient and the applicant's intention to serve patients with an involuntary commitment status.

(3) The number of beds proposed in the CON application to be allocated for use by public patients shall not be less than 50% of the beds proposed in the CON application. Applications proposed in direct response to a Department plan pursuant to subsection (5) shall allocate not less than 80% of the beds proposed in the CON application.

(4) The minimum number of beds in a psychiatric unit shall be at least 10 beds. If a psychiatric unit has or proposes to operate both adult and child/adolescent beds, each unit shall have a minimum of 10 beds. The Department may approve an application for a unit of less than 10 beds, if the applicant demonstrates to the satisfaction of the Department, that travel time to existing units would significantly limit access to care.

(5) An applicant shall not be required to be in compliance with subsection (1) if the applicant demonstrates that the application meets both of the following:

(a) The Director of the Department determines that an exception to subsection (1) should be made and certifies in writing that the proposed project is a direct response to a Department plan for reducing the use of public institutions for acute mental health care through the closure of a state-owned psychiatric hospital; and

(b) The proposed beds will be located in the area currently served by the public institution that will be closed, as determined by the Department.

Section 7. Requirements for approval to increase beds

Sec. 7 An applicant proposing an increase in the number of adult or child/adolescent beds shall demonstrate or provide the following:

(1) The number of beds proposed in the CON application will not result in the number of existing adult or child/adolescent psychiatric beds, as applicable, in the planning area exceeding the bed need set forth in Appendix A or B, as applicable. However, an applicant may request and be approved for up to a maximum of 10 beds if, when the total number of existing adult beds or existing child/adolescent beds is subtracted from the bed need for the planning area set forth in Appendix A or B, the difference is equal to or more than 1 or less than 10.

(2) The average occupancy rate for the applicant's facility, where the proposed beds are to be located, was at least 70% for adult or child/adolescent beds, as applicable, during the most recent, consecutive 24 month period, as of the date of the submission of the application, for which verifiable data are available to the Department.

(3) Subsections (1) and (2) shall not apply if the ~~applicant meets the~~ following ARE MET:

(A) THE NUMBER OF EXISTING ADULT OR CHILD/ADOLESCENT PSYCHIATRIC BEDS IN THE PLANNING AREA IS EQUAL TO OR EXCEEDS THE BED NEED SET FORTH IN APPENDIX A OR B, AS APPLICABLE;

(~~a~~B) the beds are being added at the existing licensed site;

(~~b~~C) the average occupancy rate for the applicant's facility was at least 75% for facilities with 19 beds or less and 80% for facilities with 20 beds or more, as applicable, during the most recent, consecutive 24 month period, as of the date of the submission of the application, for which verifiable data are available to the Department;

(~~c~~D) the number of beds being added shall not exceed the results of the following formula: the facility's average daily census for the most recent, consecutive 24 month period, as of the date of the submission of the application, for which verifiable data are available to the Department multiplied by 1.5 for adult beds and 1.7 for child/adolescent beds.

(4) Proof of current contract or documentation of contract renewal, if current contract is under negotiation, with at least one CMH or its designee that serves the planning area in which the proposed beds or service will be located.

(5) Previously made commitments, if any, to the Department or CMH to serve public patients have been fulfilled.

(6) The number of beds proposed in the CON application to be allocated for use by public patients shall not be less than 50% of the beds proposed in the CON application. Applications proposed in direct response to a Department plan pursuant to subsection (9) shall allocate not less than 80% of the beds proposed in the CON application.

(7) The minimum number of beds in a psychiatric unit shall be at least 10 beds. If a psychiatric unit has or proposes to operate both adult and child/adolescent beds, then each unit shall have a minimum of 10 beds. The Department may approve an application for a unit of less than 10 beds, if the applicant demonstrates, to the satisfaction of the Department, that travel time to existing units would significantly impair access to care.

(8) Subsection (2) shall not apply if the Director of the Department has certified in writing that the proposed project is a direct response to a Department plan for reducing the use of public institutions for acute mental health care through the closure of a state-owned psychiatric hospital.

(9) An applicant shall not be required to be in compliance with subsection (1) if the applicant demonstrates that the application meets both of the following:

(a) The Director of the Department determines that an exception to subsection (1) should be made and certifies in writing that the proposed project is a direct response to a Department plan for reducing the use of public institutions for acute mental health care through the closure of a state-owned psychiatric hospital; and

(b) The proposed beds will be located in the area currently served by the public institution that will be closed as determined by the Department.

Section 8. Requirements for approval for replacement beds

Sec. 8. An applicant proposing replacement beds shall not be required to be in compliance with the needed bed supply set forth in Appendix A or B, as applicable, if the applicant demonstrates all of the following:

(1) The project proposes to replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently located.

(2) The proposed licensed site is in the replacement zone.

~~(3) The applicant meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.~~

(~~4~~3) Not less than 50% of the beds proposed to be replaced shall be allocated for use by public patients.

(~~5~~4) Previously made commitments, if any, to the Department or CMH to serve public patients have been fulfilled.

(~~6~~5) Proof of current contract or documentation of contract renewal, if current contract is under negotiation, with the CMH or its designee that serves the planning area in which the proposed beds or service will be located.

Section 9. Requirements for approval for acquisition of a psychiatric hospital or unit

Sec. 9. An applicant proposing to acquire a psychiatric hospital or unit shall not be required to be in compliance with the needed bed supply set forth in Appendix A or B, as applicable, for the planning area in which the psychiatric hospital or unit subject to the proposed acquisition is located, if the applicant demonstrates that all of the following are met:

(1) The acquisition will not result in a change in the number of licensed beds or beds designated for a child/adolescent specialized psychiatric program.

(2) The licensed site does not change as a result of the acquisition.

Section 10. Additional requirements for applications included in comparative review

Sec. 10. (1) Any application subject to comparative review under Section 22229 of the Code being Section 333.22229 of the Michigan Compiled Laws or these standards shall be grouped and reviewed with other applications in accordance with the CON rules applicable to comparative review.

(2) Each application in a comparative group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code being Section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these standards. If the Department determines that two or more competing applications satisfy all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1) of the Code, and which have the highest number of points when the results of subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects which, when taken together, do not exceed the need, in the order in which the applications were received by the Department, based on the date and time stamp placed on the applications by the Department in accordance with rule 325.9123.

(3)(a) A qualifying project application will be awarded 5 points if, within six months of beginning operation and annually thereafter, 100% of the licensed psychiatric beds (both existing and proposed) at the facility will be Medicaid certified.

(b) A qualifying project will have 4 points deducted if, on or after November 26, 1995, the records maintained by the Department document that the applicant was required to enter into a contract with either the Department or a CMH to serve the public patient and did not do so.

(c) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records maintained by the Department document that the applicant entered into a contract with MDCH or CMH but never admitted any public patients referred pursuant to that contract.

(d) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records maintained by the Department document that an applicant agreed to serve patients with an involuntary commitment status but has not admitted any patients referred with an involuntary commitment status.

(e) A qualifying project will be awarded 3 points if the applicant presents, in its application, a plan, acceptable to the Department, for the treatment of patients requiring long-term treatment. For purposes of this subsection, long-term treatment is defined to mean an inpatient length of stay in excess of 45 days.

(f) A qualifying project will be awarded 3 points if the applicant currently provides a partial hospitalization psychiatric program, outpatient psychiatric services, or psychiatric aftercare services, or the applicant includes any of these services as part of their proposed project, as demonstrated by site plans and service contracts.

(g) A qualifying project will have 4 points deducted if the Department has issued, within three years prior to the date on which the CON application was deemed submitted, a temporary permit or provisional license due to a pattern of licensure deficiencies at any psychiatric hospital or unit owned or operated by the applicant in this state.

(h) A qualifying project will have points awarded based on the percentage of the hospital's indigent volume as set forth in the following table.

Hospital Indigent Volume	Points Awarded
0 - <6%	1
6 - <11%	2
11 - <16%	3

16 - <21%	4
21 - <26%	5
26 - <31%	6
31 - <36%	7
36 - <41%	8
41 - <46%	9
46% +	10

For purposes of this subsection, indigent volume means the ratio of a hospital's indigent charges to its total charges expressed as a percentage as determined by the Department pursuant to Chapter VIII of the Medical Assistance Program manual. The indigent volume data being used for rates in effect at the time the application is deemed submitted will be used by the Department in determining the number of points awarded to each qualifying project.

(i) A qualifying project will have points deducted based on the applicant's record of compliance with applicable safety and operating standards for any psychiatric hospital or unit owned and/or operated by the applicant in this state. Points shall be deducted in accordance with the following schedule if, on or after November 26, 1995, the Department records document any non-renewal or revocation of license for cause or non-renewal or termination of certification for cause of any psychiatric hospital or unit owned or operated by the applicant in this state.

Psychiatric Hospital/Unit Compliance Action	Points Deducted
Non-renewal or revocation of license	4
Non-renewal or termination of:	
Certification - Medicare	4
Certification - Medicaid	4

(4) The minimum number of points will be awarded to an applicant under the individual subsections of this Section for conflicting information presented in this Section and related information provided in other Sections of the CON application.

Section 11. Requirements for approval for all applicants

Sec. 11. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

(2) THE APPLICANT CERTIFIES ALL OUTSTANDING DEBT OBLIGATIONS OWED TO THE STATE OF MICHIGAN FOR QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) OR CIVIL MONETARY PENALTIES (CMP)HAVE BEEN PAID IN FULL.

(3) THE APPLICANT CERTIFIES THAT THE HEALTH FACILITY FOR THE PROPOSED PROJECT HAS NOT BEEN CITED FOR A STATE OR FEDERAL CODE DEFICIENCY WITHIN THE 12 MONTHS PRIOR TO THE SUBMISSION OF THE APPLICATION. IF A CODE DEFICIENCY HAS BEEN ISSUED, THEN THE APPLICANT SHALL CERTIFY THAT A PLAN OF CORRECTION FOR CITED STATE OR FEDERAL CODE DEFICIENCIES AT THE HEALTH FACILITY HAS BEEN SUBMITTED AND APPROVED BY THE BUREAU OF HEALTH SYSTEMS WITHIN THE DEPARTMENT OR AS APPLICABLE, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. IF CODE DEFICIENCIES INCLUDE ANY UNRESOLVED DEFICIENCIES STILL OUTSTANDING WITH THE DEPARTMENT OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THAT ARE THE BASIS FOR THE

DENIAL, SUSPENSION, OR REVOCATION OF AN APPLICANT'S HEALTH FACILITY LICENSE, POSES AN IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENT, OR MEETS A FEDERAL CONDITIONAL DEFICIENCY LEVEL, THE PROPOSED PROJECT CANNOT BE APPROVED WITHOUT APPROVAL FROM THE BUREAU OF HEALTH SYSTEMS.

Section 12. Project delivery requirements - terms of approval for all applicants

Sec. 12. (1) An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(a) Compliance with these standards.

(b) Compliance with applicable operating standards in the Mental Health Code or the administrative rules promulgated there under.

(c) Compliance with the following applicable quality assurance standards:

(i) The average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at least 60 percent (%) for adult beds and 40 percent (%) for child/adolescent beds for the second 12 months of operation, and annually thereafter. After the second 12 months of operation, if the average occupancy rate is below 60% for adult beds or 40% for child/adolescent beds, the number of beds shall be reduced to achieve a minimum of 60% average annual occupancy for adult beds or 40% annual average occupancy for child/adolescent beds for the revised licensed bed complement. However, the psychiatric hospital or unit shall not be reduced to less than 10 beds.

(ii) The proposed licensed psychiatric beds shall be operated in a manner that is appropriate for a population with the ethnic, socioeconomic, and demographic characteristics including the developmental stage of the population to be served.

(iii) The applicant shall establish procedures to care for patients who are disruptive, combative, or suicidal and for those awaiting commitment hearings, and the applicant shall establish a procedure for obtaining physician certification necessary to seek an order for involuntary treatment for those persons that, in the judgment of the professional staff, meet the Mental Health Code criteria for involuntary treatment.

(iv) The applicant shall develop a standard procedure for determining, at the time the patient first presents himself or herself for admission or within 24 hours after admission, whether an alternative to inpatient psychiatric treatment is appropriate.

(v) The inpatient psychiatric hospital or unit shall provide clinical, administrative, and support services that will be at a level sufficient to accommodate patient needs and volume, and will be provided seven days a week to assure continuity of services and the capacity to deal with emergency admissions.

(vi) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to: annual budget and cost information, operating schedules, and demographic, diagnostic, morbidity and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site; in a format established by the Department; and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(vii) The applicant shall provide the Department with a notice stating the date the beds or services are placed in operation and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(viii) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:

(A) Not deny acute inpatient mental health services to any individual based on ability to pay, source of payment, age, race, handicap, national origin, religion, gender, sexual orientation or commitment status;

(B) Provide acute inpatient mental health services to any individual based on clinical indications of need for the services;

(C) Maintain information by payor and non-paying sources to indicate the volume of care from each source provided annually.

Compliance with selective contracting requirements shall not be construed as a violation of this term.

(ix) An applicant required to enter into a contract with a CMH(s) or the Department pursuant to these standards shall have in place, at the time the approved beds or services become operational, a signed contract to serve the public patient. The contract must address a single entry and exit system including discharge planning for each public patient. The contract shall specify that at least 50% or 80% of the approved beds, as required by the applicable sections of these standards, shall be allocated to the public patient, and shall specify the hospital's or unit's willingness to admit patients with an involuntary commitment status. The contract need not be funded.

(x) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(2) Compliance with this Section shall be determined by the Department based on a report submitted by the applicant and/or other information available to the Department.

(3) The agreements and assurances required by this Section shall be in the form of a certification agreed to by the applicant or its authorized agent.

Section 13. Project delivery requirements - additional terms of approval for child/adolescent service

Sec. 13. (1) In addition to the provisions of Section 12, an applicant for a child/adolescent service shall agree to operate the program in compliance with the following terms of CON approval, as applicable:

(a) There shall be at least the following child and adolescent mental health professionals employed, either directly or by contract, by the hospital or unit, each of whom must have been involved in the delivery of child/adolescent mental health services for at least 2 years within the most recent 5 years:

(i) a child/adolescent psychiatrist;

(ii) a child psychologist;

(iii) a psychiatric nurse;

(iv) a psychiatric social worker;

(v) an occupational therapist or recreational therapist; and

(b) There shall be a recipient rights officer employed by the hospital or the program.

(c) The applicant shall identify a staff member(s) whose assigned responsibilities include discharge planning and liaison activities with the home school district(s).

(d) There shall be the following minimum staff employed either on a full time basis or on a consulting basis:

(i) a pediatrician;

(ii) a child neurologist;

(iii) a neuropsychologist;

(iv) a speech and language therapist;

(v) an audiologist; and

(vi) a dietician.

(e) A child/adolescent service shall have the capability to determine that each inpatient admission is the appropriate treatment alternative consistent with Section 498e of the Mental Health Code, being Section 330.1498e of the Michigan Compiled Laws.

(f) The child/adolescent service shall develop and maintain a coordinated relationship with the home school district of any patient to ensure that all public education requirements are met.

(g) The applicant shall demonstrate that the child/adolescent service is integrated within the continuum of mental health services available in its planning area by establishing a formal agreement with the CMH(s) serving the planning area in which the child/adolescent specialized psychiatric program is located. The agreement shall address admission and discharge planning issues which include, at a minimum, specific procedures for referrals for appropriate community services and for the exchange of information with the CMH(s), the probate court(s), the home school district, the Michigan Department of Human Services, the parent(s) or legal guardian(s) and/or the patient's attending physician.

(2) Compliance with this Section shall be determined by the Department based on a report submitted by the program and/or other information available to the Department.

(3) The agreements and assurances required by this Section shall be in the form of a certification agreed to by the applicant or its authorized agent.

Section 14. Department inventory of beds

Sec. 14. The Department shall maintain, and provide on request, a listing of the Department Inventory of Beds for each adult and child/adolescent planning area.

Section 15. Planning areas

Sec. 15. The planning areas for inpatient psychiatric beds are the geographic boundaries of the groups of counties as follows.

Planning Areas	Counties
1	Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, Wayne
2	Clinton, Eaton, Hillsdale, Ingham, Jackson, Lenawee
3	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
4	Allegan, Ionia, Kent, Lake, Mason, Montcalm, Muskegon, Newaygo, Oceana, Ottawa
5	Genesee, Lapeer, Shiawassee
6	Arenac, Bay, Clare, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Mecosta, Ogemaw, Osceola, Oscoda, Saginaw, Sanilac, Tuscola
7	Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Roscommon, Wexford
8	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

Section 16. Effect on prior CON review standards; comparative reviews

Sec. 16. (1) These CON review standards supercede and replace the CON Review Standards for Psychiatric Beds and Services, approved by the CON Commission on ~~June 22, 2005~~ DECEMBER 11, 2007 and effective on ~~October 17, 2005~~ FEBRUARY 25, 2008.

(2) Projects involving replacement beds or an increase in beds, approved pursuant to Section 7(3), are reviewed under these standards and shall not be subject to comparative review.

(3) Projects involving initiation of services or an increase in beds, approved pursuant to Section 7(1), are reviewed under these standards and shall be subject to comparative review.

APPENDIX A

CON REVIEW STANDARDS FOR CHILD/ADOLESCENT PSYCHIATRIC BEDS

The bed need numbers, for purposes of these standards until otherwise changed by the Commission, are as follows:

Planning Area	Bed Need
1	~~109~~ 113
2	12
3	~~20~~ 22
4	~~40~~ 26
5	~~20~~ 11
6	~~17~~ 14
7	~~8~~ 7
8	5
TOTAL	~~231~~ 210

APPENDIX B

CON REVIEW STANDARDS FOR ADULT PSYCHIATRIC BEDS

The bed need numbers, for purposes of these standards until otherwise changed by the Commission, are as follows:

PLANNING AREA	BED NEED
1	~~1011~~ 967
2	~~170~~ 179
3	186
4	~~282~~ 283
5	~~172~~ 153
6	~~101~~ 96
7	~~51~~ 52
8	~~37~~ 38
TOTAL	~~2010~~ 1,954

APPENDIX C

RATIO OF ADULT INPATIENT PSYCHIATRIC BEDS PER 10,000 ADULT POPULATION

THE RATIO PER 10,000 ADULT POPULATION, FOR PURPOSES OF THESE STANDARDS, UNTIL OTHERWISE CHANGED BY THE COMMISSION, IS AS FOLLOWS:

PLANNING AREA	ADULT BEDS PER 10,000 ADULT POPULATION
1	~~2.9521~~ 2.8516
2	~~2.3372~~ 2.3906
3	~~2.4239~~ 2.3950
4	~~2.4423~~ 2.4095
5	~~2.9853~~ 3.2442
6	~~1.3419~~ 1.3483
7	~~1.2070~~ 1.1977
8	~~1.4938~~ 1.4781
STATE	~~2.5342~~ 2.4903

APPENDIX D

CON REVIEW STANDARDS FOR CHILD/ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The use rate per 1000 population age 0-17, for purposes of these standards, until otherwise changed by the Commission, is ~~18.53~~ 20.8898.

MRI Workgroup Summary
Commissioner Michael Sandler, MD
Presented to Certificate of Need (CON) Commission on June 9, 2009

MRI Workgroup Issues

1. **MRI used for MRT Simulation**
   MRI is emerging as a modality for use in radiation therapy treatment planning, as an alternative to CT. Not only can MRI more definitively pinpoint the exact area to be treated for certain anatomical areas of the body (i.e., brain, spine, prostate), it does so without exposing the patient to unnecessary radiation from a CT scanner (the alternative method of treatment planning) when they are already being treated for cancer. The CT standards already contain an exception for CT simulators and the request presented to the CON Commission is to create an identical exception for MRI units to be used exclusively for MRT simulation. Not only is likely that any PBT service would want to have MRI available for simulation, but in addition, non-PBT centers will want to use it for iMRT and Stereotactic Radiosurgery. Cancer Centers in other states are already using this mode of simulation, such as Fox Chase Cancer Center in Philadelphia.

2. **ED Volume Based Need Methodology**
   Currently the MRI standards define need for a new fixed MRI service in three different ways. The first and original methodology requires the commitment of MRI referrals totaling 6,000 adjusted MRI procedures from within a 20 mile radius of the proposed service. The second requires the applicant to already be a mobile MRI host site and to show historical volume of 6,000 adjusted MRI procedures in the previous 12 months. The third, requires the applicant to also be an existing mobile MRI host site, but only requires an historical volume of 4,000 adjusted MRI procedures if the proposed service is more than 15 miles for the nearest fixed MRI and located in a county that does not already have fixed MRI service.

   Oaklawn Hospital is requesting that another methodology for determining need be included in the standards, recognizing the evolution of diagnostic tools being utilized in Emergency Departments. The methodology they are proposing would require an applicant to show at least 20,000 emergency department visits in the previous 12 months, as well as show that they are currently a mobile MRI host site with an historical volume of at least 3,000 adjusted MRI procedures in 12 months.

   Oaklawn is a hospital that currently utilizes mobile MRI services 5 days per week. Due to the volume of patients they see in their ER, they feel that having MRI service available 24 hours per day, 7 days per week is necessary to provide the most appropriate care for their patients. Although Mobile MRI service could be available 7 days per week, it is only available 12 hours per day, therefore increasing mobile service is not an option that they feel solves their problem. Currently, patients who are seen in the ER and require MRI diagnosis, during times that the mobile MRI service is not available (65% of the time), either have to wait until the mobile service is available (if that is clinically an option) or have

to be transferred to another facility with fixed MRI service. For those that require transfer, the transfer adds cost and delay.

3. **Charity Care Volume Based Need Methodology**
   Basha Diagnostics is requesting a need methodology that encourages the provision of services to Medicaid and uninsured patients. The proposed methodology would require the applicant to currently provide MRI services as an MRI host site that had a volume of at least 2,000 adjusted MRI procedures in the previous 12 months and at least 25% of its MRI visits in the previous 12 months were provided to patients who were covered by Medicaid or had no insurance and were not charged for the service. The proposed methodology would require continued quarterly reporting of payer mix and would require services approved under this methodology to continue to provide at least 25% of visits to Medicaid patients and/or at no charge to the uninsured.

   Basha Diagnostics prepared a report detailing the payer mix of all MRI services in the State of Michigan, which showed that the three Basha Diagnostics MRI host sites were amongst the highest percentages of care to this underserved population. With the Medicaid roles increasing by 17,000 residents per month, Dr. Basha would like to provide more care to these patients, but cannot afford to add more mobile service time. He feels he would be able to provide more service at lower cost if he could control his fixed overhead costs by installing a fixed MRI unit.

MRI Workgroup Proposed Language
Commissioner Michael Sandler, MD
Presented to Certificate of Need (CON) Commission on June 9, 2009

MRI Workgroup Language

Section 2. Definitions

(dd) "Magnetic resonance imaging unit" or "MRI unit" means the magnetic resonance system consisting of an integrated set of machines and related equipment necessary to produce the images and/or spectroscopic quantitative data from scans. **THE TERM DOES NOT INCLUDE MRI SIMULATORS USED SOLELY FOR TREATMENT PLANNING PURPOSES IN CONJUNCTION WITH AN MRT UNIT.**

Section 3. Requirements for approval of applicants proposing to initiate an MRI service or mobile MRI host site

Sec. 3. (1) An applicant proposing to initiate a fixed MRI service shall demonstrate that 6,000 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, per proposed unit result from application of the methodology in Section 15 of these standards.

(2)(a) An applicant proposing to initiate a mobile MRI service that involves beginning operation of a mobile MRI unit shall demonstrate that a minimum of 5,500 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, per proposed unit result from application of the methodology in Section 15 of these standards.
(b) The applicant, whether the central service coordinator or the host site, must demonstrate that a minimum of 600 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, result from the application of the methodology in Section 15 of these standards, for each proposed host site that
(i) is not located in a rural or micropolitan statistical area county and
(ii) has not received any mobile MRI service within the most recent 12-month period as of the date an application is submitted to the Department.
(c) The applicant, whether the central service coordinator or the host site, must demonstrate that a minimum of 400 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, result from the application of the methodology in Section 15 of these standards for each proposed host site that
(i) is located in a rural or micropolitan statistical area county and
(ii) has not received any mobile MRI service within the most recent 12-month period as of the date an application is submitted to the Department.

(3)(a) An applicant, whether the central service coordinator or a proposed host site, proposing to initiate a mobile MRI host site not in a rural or micropolitan statistical area county, that is to be part of an existing mobile MRI service, must demonstrate that at least 600 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, result from the application of the methodology in Section 15 of these standards for that host site.
(b) An applicant, whether the central service coordinator or a proposed host site, proposing to initiate a mobile MRI host site in a rural or micropolitan statistical area county, that is to be part of an existing mobile MRI service, must demonstrate that at least 400 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, result from the application of the methodology in Section 15 of these standards for that host site.

(4) An applicant that meets all of the following requirements shall not be required to be in compliance with subsection (1):
(a) The applicant is proposing to initiate a fixed MRI service.
(b) The applicant is currently a host site being served by one or more mobile MRI units.
(c) The applicant has received, in aggregate, the following:

(i) at least 6,000 MRI adjusted procedures within the most recent 12-month period for which data, verifiable by the Department, are available or
(ii) at least 4,000 MRI adjusted procedures within the most recent 12-month period for which data, verifiable by the Department, are available, and the applicant meets all of the following:
(A) is located in a county that has no fixed MRI machines that are pending, approved by the Department, or operational at the time the application is deemed submitted;
(B) the nearest fixed MRI machine is located more than 15 radius miles from the application site;
(C) the applicant is a nonprofit licensed hospital site;
(D) the applicant certifies in its CON application, by providing a governing body resolution, that the board of trustees of the facility has performed a due diligence investigation and has determined that the fixed MRI service will be economically viable to ensure provision of safe and appropriate patient access within the community hospital setting; **OR**
(III) AT LEAST 3,000 MRI ADJUSTED PROCEDURES WITHIN THE MOST RECENT 12-MONTH PERIOD FOR WHICH DATA, VERIFIABLE BY THE DEPARTMENT, ARE AVAILABLE, AND THE APPLICANT MEETS ALL OF THE FOLLOWING:
(A) THE PROPOSED SITE IS A HOSPITAL LICENSED UNDER PART 215 OF THE CODE; AND
(B) THE APPLICANT HOSPITAL OPERATES AN EMERGENCY ROOM THAT PROVIDES 24-HOUR EMERGENCY CARE SERVICES AND AT LEAST 20,000 VISITS WITHIN THE MOST RECENT 12-MONTH PERIOD FOR WHICH DATA, VERIFIABLE BY THE DEPARTMENT, IS AVAILABLE; OR
(IV) AT LEAST 2,000 MRI ADJUSTED PROCEDURES WITHIN THE MOST RECENT 12-MONTH PERIOD FOR WHICH DATA, VERIFIABLE BY THE DEPARTMENT, ARE AVAILABLE, AND THE APPLICANT MEETS ALL OF THE FOLLOWING:
(A) AT LEAST 25% OF TOTAL MRI VISITS WITH A PAYER SOURCE OF (1) MEDICAID AND (2) NO CHARGE, WITHIN THE MOST RECENT 12-MONTH PERIOD FOR WHICH DATA, VERIFIABLE BY THE DEPARTMENT, ARE AVAILABLE; AND
(B) THE APPLICANT IS A FOR-PROFIT, FREESTANDING FACILITY.
(d) All of the MRI adjusted procedures provided at the applicant's approved site in the most recent 12-month period, referenced in (c) above, by each mobile MRI service/units from which any of the MRI adjusted procedures are being utilized to meet the minimum 6,000 or 4,000 MRI adjusted procedures shall be utilized to meet the requirements of (c). [For example: If mobile network 19 provided 4,000 adjusted procedures, network 21 provided 2,100, and network 18 provided 1,000, all of the adjusted procedures from network 19 and 21 must be used (i.e., 6,100) but the 1,000 adjusted procedures from network 18 do not need to be used to meet the 6,000 minimum.]
(e) The applicant shall install the fixed MRI unit at the same site as the existing approved host site or **WITHIN 2 MILES OF THE EXISTING SITE, OR** at the applicant's licensed hospital site as defined in these standards.

(5) Initiation of a mobile MRI host site does not include the provision of mobile MRI services at a host site if the applicant, whether the host site or the central service coordinator, demonstrates or provides each of the following, as applicable:
(a) The host site has received mobile MRI services from an existing mobile MRI unit within the most recent 12-month period as of the date an application is submitted to the Department.
(b) The addition of a host site to a mobile MRI unit will not increase the number of MRI units operated by the central service coordinator or by any other person.
(c) Notification to the Department of the addition of a host site prior to the provision of MRI services by that mobile MRI unit in accordance with (d).
(d) A signed certification, on a form provided by the Department, whereby each host site for each mobile MRI unit has agreed and assured that it will provide MRI services in accordance with the terms for approval set forth in Section 12 of these standards, as applicable. The central service coordinator also shall identify all current host sites, on this form, that are served by the mobile route as of the date of the signed certification or are committed in writing to be served by the mobile route.

(e) The central service coordinator requires, as a condition of any contract with a host site, compliance with the requirements of these standards by that host site, and the central service coordinator assures compliance, by that host site, as a condition of the CON issued to the central service coordinator.

Section 8. Requirements for approval of an applicant proposing to acquire an existing MRI service or an existing MRI unit(s)

(1)(F) FOR ANY APPLICATION PROPOSING TO ACQUIRE AN EXISTING FIXED MRI SERVICE AND ITS UNIT(S) THAT WAS INITIATED UNDER SECTION 3(4)(C)(IV) OF THESE STANDARDS, THE APPLICANT ALSO MUST MEET THE REQUIREMENTS OF SECTION 3(4)(C)(IV)(A) AND (B).

(2)(D) FOR ANY APPLICATION PROPOSING TO ACQUIRE AN EXISTING FIXED MRI SERVICE AND ITS UNIT(S) THAT WAS INITIATED UNDER SECTION 3(4)(C)(IV) OF THESE STANDARDS, THE APPLICANT ALSO MUST MEET THE REQUIREMENTS OF SECTION 3(4)(C)(IV)(A) AND (B).

Section 13. Project delivery requirements – terms of approval

(5)AN APPLICANT FOR AN MRI UNIT APPROVED UNDER SECTION 3(4)(C)(IV) OF THESE STANDARDS SHALL AGREE TO CONTINUE TO PROVIDE AT LEAST 25% OF MRI VISITS WITH A PAYER SOURCE OF MEDICAID AND/OR NO CHARGE DURING THE FIRST 12 MONTHS OF OPERATIONS AND EVERY YEAR FOLLOWING FOR AT LEAST 3 YEARS.

CERTIFICATE OF NEED

Quarterly Compliance Activity Report to the CON Commission

January 1, 2009 through March 31, 2009 (FY 2009)

This quarterly report is designed to update the Commission on the Department's activity in monitoring compliance with all Certificates of Need issued as required by Section 22247 of the Public Health Code.

MCL 333.22247

(1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.

(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:
(a) Revoke or suspend the certificate of need.
(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.
(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.
(d) Request enforcement action under section 22253.
(e) Take any other enforcement action authorized by this code.
(f) Publicize or report the violation or enforcement action, or both, to any person.
(g) Take any other action as determined appropriate by the department.

(3) A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill.

Activity Report

Follow Up: In accordance with Administrative Rules 325.9403 and 325.9417, the Department performs follow up checks on approved CONs to determine if proposed projects have been implemented in accordance with Part 222 of the Code. For the reporting quarter, the following actions have occurred:

Activity	Recent Quarter	Year-to-Date
Letters mailed to verify progress approved projects	426	736
Projects deemed 100% complete and operational	143	239
CON approvals expired due to noncompliance with Part 222	45	89

Compliance: In accordance with MCL 333.22247, the Department has initiated several statewide compliance checks, including a check on primary percutaneous coronary intervention (PCI) programs without onsite open heart surgical services and mobile magnetic resonance imaging (MRI) services. In addition, the Department throughout the summer months will be conducting random volume checks from the recently released 2008 survey data. The results of these compliance checks will be reported at the next regularly scheduled commission meeting.

CERTIFICATE OF NEED LEGAL ACTION

(5/26/09)

Case Name	***Date Opened***	***Case Description***	***Status***
Brighton Senior Care & Rehab Center Heartland Healthcare Center Livingston II Livingston Health Campus Livingston Care Center, LLC Medilodge of Howell, Inc. Admin Tribunal Docket No.: 2009-5815, 5819, 6457, 6458 CON	12/30/08	Comparative review of 1) Brighton Senior Care & Rehab Center, 2) Heartland Healthcare Center Livingston II, 3) Livingston Care Center, LLC, 4) Medilodge of Howell, Inc.	Filed Motion for Summary Disposition. Response due 5/29, Reply due 6/26/09. Heartland also has filed a motion to dismiss Medilodge and Livingston Care Center. Oral argument for all motions scheduled for 7/21.
Macomb County – Comparative Review Includes: FountainBleu-Shelby Township CON #08-0223 Utica Health Campus - CON #08-0187	4/30/09	Comparative Review of nursing home beds: 1) FountainBleu-Shelby Township CON #08-0223 2) Utica Health Campus – CON #08-0187 Have not appealed as of 5/26/09: 3) Windmere Park Nusing Center - CON #08-0218; 4) MediLodge of Richmond - CON #08-0176 5) MediLodge of Sterling Heights, Inc. - CON #08-0177 5) MediLodge of Washington - CON #08-0178 7) Heartland Health Care Center Macomb 1 - CON #08-0201	Hearing set for 6/30/09. Documents have been received and will be reviewed.
Maple Manor Rehabilitation Center Admin Tribunal Docket No: 2008-17098 CON CON Application No: 08-0018	5/28/08	Appeal of Proposed Decision of Disapproval dated 4/16/08. Proposed project to acquire an 82 bed nursing home and replace 22 beds disapproved.	Final Order entered 5/07/09. DCH's Motion for Summary Disposition GRANTED.; DCH's April 16, 2008 proposed Decision AFFIRMED.

CERTIFICATE OF NEED LEGAL ACTION

(5/26/09)

Case Name	***Date Opened***	***Case Description***	***Status***
Medilodge of Howell (CON) Macomb Cty Circuit Ct Docket No: 08-4125 CZ AG#20083027936	9/22/08	Medilodge of Howell seeks an injunction to prohibit Defendant from proceeding with a comparative, competitive review of applications to add additional nursing home beds in Livingston County, unless and until Medilodge of Howell is included in that review.	Court issued a Writ of Mandamus ordering the Department to accept and review the applications. The Department has reviewed the applications in a comparative review and denied the applications. Applicant has appealed. (See Brighton Senior Care and Rehab Center.) On 4/13/09 the Court denied Plaintiff's motion to amend its complaint.
Medilodge of Richmond (CON) Macomb Cty Circuit Ct Docket No: 08-4123 CZ	9/22/08	Medilodge of Richmond seeks an injunction to prohibit Defendant from proceeding with a comparative, competitive review of applications to add additional nursing home beds in Livingston County, unless and until Medilodge of Richmond is included in that review.	Court issued a Writ of Mandamus ordering the Department to accept and review the applications. The Department has reviewed the applications in a comparative review and denied the applications. On 4/13/09 the Court denied Plaintiff's motion to amend its complaint. Did not appeal.

CERTIFICATE OF NEED LEGAL ACTION

(5/26/09)

Case Name	***Date Opened***	***Case Description***	***Status***
Medilodge of Sterling Heights (CON) Macomb Cty Circuit Ct No:	9/22/08	Medilodge of Sterling Heights seeks an injunction to prohibit Defendant from proceeding with a comparative, competitive review of applications to add additional nursing home beds in Livingston County, unless and until Medilodge of Sterling Heights is included in that review.	Court issued a Writ of Mandamus ordering the Department to accept and review the applications. The Department has reviewed the applications in a comparative review and denied the applications. On 4/13/09 the Court denied Plaintiff's motion to amend its complaint.
Medilodge of Washington (CON) Macomb Cty Circuit Ct No:	9/22/08	Medilodge of Washington seeks an injunction to prohibit Defendant from proceeding with a comparative, competitive review of applications to add additional nursing home beds in Livingston County, unless and until Medilodge of Washington is included in that review.	Court issued a Writ of Mandamus ordering the Department to accept and review the applications. The Department has reviewed the applications in a comparative review and denied the applications. On 4/13/09 the Court denied Plaintiff's motion to amend its complaint.

CERTIFICATE OF NEED LEGAL ACTION

(5/26/09)

Case Name	***Date Opened***	***Case Description***	***Status***
Oakland County-Comparative Review	4/30/09	Comparative review of nursing home beds. Manor of Farmington Hills - CON #08-0032 Bloomfield Orchard Villa - CON #08-0036 Woodward at Bloomfield Hills Health Center - CON #07-0572 Waltonwood at Main - Phase 2 - CON #08-0027 Waltonwood at Twelve Oaks - Phase 3 - CON #08-0026 McAuley Center - CON #08-0010	Hearing set for 7/7/09. Documents have been received and will be reviewed.
Ottawa County-Comparative Review Includes: Waterford Rehab Park Place	04/27/09	Comparative review of nursing home beds.	Awaiting hearing date.
Spectrum Health United Memorial Admin Tribunal Docket No: 2009-5809 CON CON Application No: 07-0474.	12/23/08	Appeal of Proposed Decision disapproving CON Application 07-0474.	Pre-Hearing conference rescheduled from 5/06/09 to 7/21/09.

CERTIFICATE OF NEED LEGAL ACTION

(5/26/09)

Case Name	***Date Opened***	***Case Description***	***Status***
Woodcare X (Caretel) v MDCH Genesee County Cir Docket No.: 08-89784 CZ	10/13/08	Complaint for Mandamus	Court issued Order of Mandamus on 4/29/09. On 5/14/09, we filed an Application for Leave to Appeal in the Court of Appeals. We have also filed a Motion for Stay of the Order which is scheduled to be heard on 5/26/09. Circuit Court denied our Motion. We are in the process of filing similar motion in Court of Appeals. In the meantime we are engaged in heavy discovery.
Woodcare X (Caretel) v MDCH Court of Claims Docket No.: 08-132-MK	12/03/08	Filed for damages and specific performance of a settlement agreement reached 20 years ago.	This case is consolidated with the Mandamus action. We are in discovery. We will file a Motion for Summary Disposition within the next 10 days.
Woodcare X (Caretel) v MDCH	5/04/09	Filed Application for Leave to Appeal	See above.

s: chd; assign control; special; CON Leg Action; report 3/17/09

Note: New or revised standards may include the provision that make the standard applicable, as of its effective date, to all CON applications for which a final decision has not been issued.

Attachment O

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2008												2009										
	J	F	M*	A	M	J*	J	A	S*	O	N	D*	J*	F	M*	A	M	J*	J	A	S*	O	N	D*
Air Ambulance Services																					F			
Bone Marrow Transplantation (BMT) Services						• —	• P	•	• ▲ F	PH •	•	•	• R	•	• R	•	•	▮	▮	▮	▮	▮	▮	• —
Heart/Lung and Liver Transplantation Services										PH •	•	•	• R	•	•	▮	▮	▮	▮	▮	▮	▮	•	• —
Magnetic Resonance Imaging (MRI) Services	•	•	• R	•	•	• —	• P	•	• ▲ F	PH •	•	•	• R	•	•	•	•	•	•	•	• —	• P	•	• ▲ F
Pancreas Transplantation Services										PH •	•	•	• R	•	•	•	•	• —	• P	•	• ▲ F			
Psychiatric Beds and Services										PH •	•	•	• R	•	•	•	•	• —	• P	•	• ▲ F			
New Medical Technology Standing Committee	• M	• M	• M R	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M	• M
Commission & Department Responsibilities			M			M			M			M R			M			M			M			M
Administrative Rules													•	•	• R			• R			• R D			

KEY

— - Receipt of proposed standards/documents, proposed Commission action
* - Commission meeting
▮ - Staff work/Standard advisory committee meetings
▲ - Consider Public/Legislative comment
** - Current in-process standard advisory committee or Informal Workgroup
• Staff work/Informal Workgroup/Commission Liaison Work/Standing Committee Work

A - Commission Action
C - Consider proposed action to delete service from list of covered clinical services requiring CON approval
D - Discussion
F - Final Commission action, Transmittal to Governor/Legislature for 45-day review period
M - Monitor service or new technology for changes
P - Commission public hearing/Legislative comment period
PH - Public Hearing for initial comments on review standards
R - Receipt of report
S - Solicit nominations for standard advisory committee or standing committee membership

For Approval June 9, 2009

Updated June 3, 2009

The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings, contact the Michigan Department of Community Health, Health Policy, Regulation & Professions Administration, CON Policy Section, 7th Floor Capitol View Bldg., 201 Townsend St., Lansing, MI 48913, 517-335-6708, www.michigan.gov/con.

SCHEDULE FOR UPDATING CERTIFICATE OF NEED (CON) STANDARDS EVERY THREE YEARS*

Standards	Effective Date	Next Scheduled Update**
Air Ambulance Services	June 4, 2004	2010
Bone Marrow Transplantation Services	November 13, 2008	2012
Cardiac Catheterization Services	February 25, 2008	2011
Computed Tomography (CT) Scanner Services	June 20, 2008	2010
Heart/Lung and Liver Transplantation Services	June 4, 2004	2012
Hospital Beds and Addendum for HIV Infected Individuals	March 8, 2007	2011
Magnetic Resonance Imaging (MRI) Services	November 13, 2008	2012
Megavoltage Radiation Therapy (MRT) Services/Units	November 13, 2008	2011
Neonatal Intensive Care Services/Beds (NICU)	November 13, 2007	2010
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	June 20, 2008	2010
Open Heart Surgery Services	February 25, 2008	2011
Pancreas Transplantation Services	June 4, 2004	2012
Positron Emission Tomography (PET) Scanner Services	March 8, 2007	2011
Psychiatric Beds and Services	February 25, 2008	2012
Surgical Services	June 20, 2008	2011
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	February 25, 2008	2010

*Pursuant to MCL 333.22215 (1)(m): "In addition to subdivision (b), review and, if necessary, revise each set of certificate of need review standards at least every 3 years."

**A Public Hearing will be held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. If it is determined that changes are necessary, then the standards can be deferred to a standard advisory committee (SAC), workgroup, or the Department for further review and recommendation to the CON Commission. If no changes are determined, then the standards are scheduled for review in another three years.