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

Thursday December 11, 2014

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

FINAL MINUTES

I. Call to Order & Introductions

Chairperson Keshishian called the meeting to order at 9:33 a.m.

A. Members Present:

Denise Brooks-Williams
Gail J. Clarkson, RN
Kathleen Cowling, DO
James B. Falahee, Jr., JD
Marc Keshishian, MD, Chairperson
Charles Gayney
Robert Hughes
Jessica Kochin
Gay L. Landstrom, RN in at 9:49 a.m.
Suresh Mukherji, MD, Vice-Chairperson
Luis Tomatis, MD

B. Members Absent

Robert Hughes

C. Department of Attorney General Staff:

Joseph Potchen

D. Michigan Department of Community Health Staff Present:

Tulika Bhattacharya
Scott Blakeney
Elizabeth Hertel
Natalie Kellogg
Beth Nagel
Tania Rodriguez
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Brooks-Williams, seconded by Commissioner Tomatis, to approve the agenda as presented. Motion Carried with a vote of 9 – Yes, 0 – No and 0 - Abstained.

III. Declaration of Conflicts of Interests

No conflicts were declared.

IV. Review of Minutes of September 25, 2014

Motion by Commissioner Falahee, seconded by Commissioner Clarkson, to approve the minutes of September 25, 2014 as presented. Motion Carried.

V. Hospital Beds – October 23, 2014 Public Hearing Summary & Report

Ms. Rogers gave a background and overview of the public hearing summary and report on the Hospital Beds standards (see Attachment A).

A. Public comment

Barbara Bressack, Henry Ford Health System

B. Commission Discussion

No discussion.

C. Commission Final Action

Motion by Commissioner Cowling, seconded by Commissioner Tomatis, take final action to approve and move the Hospital Bed standards (see Attachment B) forward to the Joint Legislative Committee (JLC) and Governor for the 45-day review period. Motion Carried in a vote of 9 - Yes, 0 - No, and 0 - Abstained.

VI. Nursing Home and Hospital Long-Term Unit (NH-HLTCU) Beds – October 23, 2014 Public Hearing Summary & Report

Ms. Rogers gave background and overview of the public hearing summary and report (see Attachment C).

A. Public Comment

Pat Anderson, HCAM (see Attachment D)

B. Commission Discussion

Discussion followed.

C. Commission Final Action

Motion by Commissioner Falahee, seconded by Commissioner Clarkson, take final action to approve the language as presented (see Attachment E) with the technical amendment to change “and” to “if” in Section 8(1) and (2), 7(1) and (3), 9(1) and (3) and any other applicable section, forward to the JLC and Governor for the 45-day review period. Motion Carried in a vote of 9 - Yes, 0 - No, and 0 - Abstained.

VII. Cardiac Catheterization (CC) Standard Advisory Committee (SAC) Update (Written Only)

Chairperson Keshishian advised Commission members that the written report was included in the electronic binder that was sent out prior to the meeting (see Attachment F).

VIII. Megavoltage Radiation Therapy (MRT) Standard Advisory Committee (SAC) Update (Written Only)

Chairperson Keshishian advised Commission members that the written report was included in the electronic binder that was sent out prior to the meeting (see Attachment G).

IX. CON Commission Bylaws Article VII (B) (3) (d) - SAC Provisions

Chairperson Keshishian gave a brief overview of the change to the Bylaws (see Attachment H).

A. Commission Discussion

None.

B. Commission Final Action

Motion by Commissioner Cowling, and seconded by Commissioner Falahee to remove item VII (B) (3) (d) from the bylaws. Motion Carried in a vote of 10 - Yes, 0 - No, and 0 - Abstained.

X. Biennial JLC Report

Chairperson Keshishian and Ms. Rogers gave the overview of the report (see Attachment I); and reminded the Commission the report is due January 1, 2015.

Discussion followed.

Motion by Chairperson Keshishian, seconded by Commissioner Tomatis to ask the Department to find data on Indiana and Ohio, based on the cardiovascular angioplasty and to find out what percent of people are going to units that are not doing the appropriate volume as defined by the American College of Cardiology and the American Heart Association compared to Michigan. Also, research what percentages of MRT units are being used in other states that are not certified by certain organizations. Motion Carried in a vote of 10- Yes, 0- No, and 0- Abstained.

Motion by Commissioner Falahee, and seconded by Commissioner Cowling to approve the report as amended and direct the Department to submit the report to the JLC on the Commission's behalf. Motion Carried in a vote of 10 - Yes, 0 - No, and 0 - Abstained.

XI. Legislative Report

Ms. Hertel gave an update on Michigan Senate Bill 1073.

XII. Administrative Update

A. Planning and Access to Care

Ms. Nagel asked for the Commission's consideration in delegating to the Department an evaluation of the PET standards instead of formation of a workgroup.

Motion by Commissioner Gayney, and seconded by Commissioner Tomatis to move from a workgroup to an evaluation by the Department and to bring language back to the March meeting. Motion Carried in a vote of 10- Yes, 0 - No, and 0 - Abstained.

B. CON Evaluation Section Update

1. Compliance Report (Written Report & Compliance Update see Attachment J)

   Ms. Bhattacharya gave a summary of the compliance report.

2. Quarterly Performance Measures (Written Report see Attachment K)

   Ms. Bhattacharya gave a summary of the quarterly performance report.

3. FY2014 CON Annual Report (Written Report see Attachment L)

XIII. Legal Activity Report

Mr. Potchen gave an overview of the current legal activity report (see Attachment M).

XIV. Future Meeting Dates – January 28, 2015, March 18, 2015, June 11, 2015, September 24, 2015, and December 10, 2015

XV. Public Comment

None.

XVI. Review of Commission Work Plan

Ms. Rogers gave an overview of the Work Plan (see Attachment N) including today's actions.

A. Commission Discussion

None.

B. Commission Action

Motion by Commissioner Cowling, seconded by Commissioner Mukherji, to accept the work plan as presented. Motion Carried in a vote of 10 - Yes, 0 - No, and 0 - Abstained.

XVII. Adjournment

Motion by Commissioner Cowling, seconded by Commissioner Landstrom, to adjourn the meeting at 10:41 a.m. Motion Carried in a vote of 10 - Yes, 0 - No, and 0 - Abstained.

Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date: December 11, 2014

TO: The Certificate of Need (CON) Commission

FROM: Beth Nagel, Manager, Planning and Access to Care Section, Michigan Department of Community Health (MDCH)

RE: Summary of Public Hearing Comments on Hospital Bed (HB) and Nursing Home- Hospital Long Term Care Unit (NH-HLTCU) Beds Standards

---

Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the HB and NH-HLTCU Beds Standards at its September 25, 2014 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed HB and NH-HLTCU Beds Standards on October 23, 2014. Written testimony was accepted for an additional seven days after the hearing via an electronic link on the Commission's website. Testimony was received from three (3) organizations.

Hospital Bed Testimony:

1.) Robert G. Riney, Henry Ford Health Systems

- Supports viewing hospitals more as campuses and less as single solitary buildings which will save money by removing the requirement that all buildings be physically connected, if operations do not necessitate it.
- Recommends specific language changes to the Standards as highlighted and states that these changes in no way allow for the building to be any further away from the hospital:
  - Section (2)(1)(kk): "Replace beds" means a change in the location of the licensed hospital, or the replacement of a portion of the licensed beds at the same licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26….
  - Section 7(2): The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, or to replace a portion of the

licensed beds at the existing licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26.

Department Recommendations re: Hospital Beds

The Department supports the language as presented at the September 25, 2014 CON Commission meeting with the technical edits to include "(s)" at the end of "Highway" and "Street" in the inserted language in Section (2)(1)(kk) and Section 7(2) as noted in the public comment that was received.

Nursing Home-Hospital Long-term Care Unit Testimony:

1.) Pat Anderson, Health Care Association of Michigan (HCAM)

- Supports all changes to the standards with the exception to the definition of "proposed licensed site."
- Proposes that the "250 yards" be changed to 3 miles similar to the allowance provided in the definition of replacement zone.
- Suggests that if the replacement zone three mile radius is used it should be adequate to address problems with the site and still ensure that services are provided to the original population it was intended to serve.

2.) David Stobb, Ciena Healthcare

- Supports all changes to the standards with the exception to the definition of "proposed licensed site."
- Recommends the adoption of a 3 mile radius instead of the 250 yard radius.
- States that the adoption of the 250 yards from the federal EMTALA statute is not appropriate and is not relevant in any way to nursing homes.

Department Recommendations re: Nursing Home-Hospital Long-Term Care Unit

The Department supports the language that was presented at the September 25, 2014 CON Commission meeting without any further modifications.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS

(By authority conferred on the CON Commission by sections 22215 and 22217 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, 333.22217, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. (1) These standards are requirements for approval under Part 222 of the Code that involve (a) beginning operation of a new hospital or (b) replacing beds in a hospital or physically relocating hospital beds from one licensed site to another geographic location or (c) increasing licensed beds in a hospital licensed under Part 215 or (d) acquiring a hospital . Pursuant to Part 222 of the Code, a hospital licensed under Part 215 is a covered health facility. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

(2) An increase in licensed hospital beds is a change in bed capacity for purposes of Part 222 of the Code.

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

(4) An increase in hospital beds certified for long-term care is a change in bed capacity for purposes of Part 222 of the Code and shall be subject to and reviewed under the CON Review Standards for Long-Term-Care Services.

Section 2. Definitions

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

(a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity.

(b) "Adjusted patient days" means the number of patient days when calculated as follows:

(i) Combine all pediatric patient days of care and obstetrics patient days of care provided during the period of time under consideration and multiply that number by 1.1.

(ii) Add the number of non-pediatric and non-obstetric patient days of care, excluding psychiatric patient days, provided during the same period of time to the product obtained in (i) above. This is the number of adjusted patient days for the applicable period.

(c) "Alcohol and substance abuse hospital" means a licensed hospital within a long-term (acute) care (LTAC) hospital that exclusively provides inpatient medical detoxification and medical stabilization and related outpatient services for persons who have a primary diagnosis of substance dependence covered by DRGs 433 - 437.

(d) "Average adjusted occupancy rate" shall be calculated as follows:

(i) Calculate the number of adjusted patient days during the most recent, consecutive 36-month period, as of the date of the application, for which verifiable data are available to the Department.

(ii) Calculate the total licensed bed days for the same 36-month period as in (i) above by multiplying the total licensed beds by the number of days they were licensed.

(iii) Divide the number of adjusted patient days calculated in (i) above by the total licensed bed days calculated in (ii) above, then multiply the result by 100.

(d) "Base year" means the most recent year that final MIDB data is available to the Department ~~unless a different year is determined to be more appropriate by the Commission~~.

(e) "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.

(f) "Close a hospital" means an applicant will demonstrate to the satisfaction of the Department that a hospital licensed under Part 215, and whose licensed capacity for the most recent 24 months prior to submission of the application was at least 80 percent for acute care beds, will close and surrender its acute care hospital license upon completion of the proposed project.

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

(h) "Common ownership or control" means a hospital that is owned by, is under common control of, or has a common parent as the applicant hospital.

(i) "Compare group" means the applications that have been grouped for the same type of project in the same hospital group and are being reviewed comparatively in accordance with the CON rules.

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

(k) "Department inventory of beds" means the current list maintained for each hospital group on a continuing basis by the Department of (i) licensed hospital beds and (ii) hospital beds approved by a valid CON issued under either Part 221 or Part 222 of the Code that are not yet licensed. The term does not include hospital beds certified for long-term-care in hospital long-term care units.

(l) "Disproportionate share hospital payments" means the most recent payments to hospitals in the special pool for non-state government-owned or operated hospitals to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs as calculated by the Medical Services Administration within the Department.

(m) "Excluded hospitals" means hospitals in the following categories:

(i) Critical access hospitals designated by CMS pursuant to 42 CFR 485.606

(ii) Hospitals located in rural or micropolitan statistical area counties

(iii) LTAC AND INPATIENT REHABILITATION FACILITY hospitals

(iv) Sole community hospitals designated by CMS pursuant to 42 CFR 412.92

(v) Hospitals with 25 or fewer licensed beds

(n) "Existing hospital beds" means, for a specific hospital group, the total of all of the following: (i) hospital beds licensed by the Department of Licensing and Regulatory Affairs or its successor; (ii) hospital beds with valid CON approval but not yet licensed; (iii) proposed hospital beds under appeal from a final decision of the Department; and (iv) proposed hospital beds that are part of a completed application under Part 222 (other than the application under review) for which a proposed decision has been issued and which is pending final Department decision.

(o) "Gross hospital revenues" means the hospital's revenues as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(p) "Health service area" OR "HSA" means the groups of counties listed in Appendix A.

(q) "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.

(r) "Hospital" means a hospital as defined in Section 20106(5) of the Code being Section 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does not include a hospital or hospital unit licensed or operated by the Department of Mental Health.

(s) "Hospital group" means a cluster or grouping of hospitals based on geographic proximity and hospital utilization patterns. The list of hospital groups and the hospitals assigned to each hospital group will be posted on the State OF Michigan CON web site and will be updated pursuant to Section 3.

(t) "Hospital long-term-care unit" or "HLTCU" means a nursing care unit, owned or operated by and as part of a hospital, licensed by the Department, and providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

(u) "Host hospital" means a licensed and operating hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow an LTAC hospital, INPATIENT REHABILITATION FACILITY HOSPITAL, or alcohol and substance abuse hospital, to begin operation.

(v) "INPATIENT REHABILITATION FACILITY HOSPITAL" OR "IRF HOSPITAL" MEANS A HOSPITAL THAT HAS BEEN APPROVED TO PARTICIPATE IN THE TITLE XVIII (MEDICARE)

PROGRAM AS A PROSPECTIVE PAYMENT SYSTEM (PPS) EXEMPT INPATIENT REHABILITATION HOSPITAL IN ACCORDANCE WITH 42 CFR PART 412 SUBPART P.

(v) "Licensed site" means the location of the facility authorized by license and listed on that licensee's certificate of licensure.

(w) "Limited access area" means those underserved areas with a patient day demand that meets or exceeds the state-wide average of patient days used per 50,000 residents in the base year and as identified in Appendix D. Limited access areas shall be redetermined when a new hospital has been approved or an existing hospital closes.

(x) "Long-term (acute) care hospital" or "LTAC hospital" means a hospital has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital in accordance with 42 CFR Part 412 SUBPART O.

(y) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396 to 1396g and 1396i to 1396u.

(z) "Medicaid volume" means the number of Medicaid recipients served at the hospital as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(aa) "Michigan Inpatient Data Base" or "MIDB" means the data base compiled by the Michigan Health and Hospital Association or successor organization. The data base consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.

(bb) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation in a different hospital group as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation to another geographic site which is in the same hospital group as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.

(cc) "New hospital" means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site that is not in the same hospital group as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation to another geographic site which is in the same hospital group as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.

(dd) "Obstetrics patient days of care" means inpatient days of care for patients in the applicant's Michigan Inpatient Data Base data ages 15 through 44 with ~~drgs~~ DRGs 370 through 375 (obstetrical discharges).

(ee) "Overbedded hospital group" means a hospital group in which the total number of existing hospital beds in that hospital group exceeds the hospital group needed hospital bed supply.

(ff) "Pediatric patient days of care" means inpatient days of care for patients in the applicant's Michigan Inpatient Data Base data ages 0 through 14 excluding normal newborns.

(gg) "Planning year" means five years beyond the base year~~, established by the CON Commission,~~ for which hospital bed need is developed~~, unless a different year is determined to be more appropriate by the Commission~~.

(hh) "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 or these Standards.

(ii) "Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital group or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.

(jj) "Remaining patient days of care" means total inpatient days of care in the applicant's Michigan Inpatient Data Base data minus obstetrics patient days of care and pediatric patient days of care.

(kk) "Replace beds" means a change in the location of the licensed hospital, ~~or~~ the replacement of a portion of the licensed beds at the same licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26. The hospital beds will be in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.) within the replacement zone.

(ll) "Replacement zone" means a proposed licensed site that is (i) in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

(mm) "Uncompensated care volume" means the hospital's uncompensated care volume as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(nn) "Underserved area" means those geographic areas not within 30 minute drive time of an existing licensed acute care hospital with 24 hour/7 days a week emergency room services utilizing the most direct route using the lowest speed limits posted as defined by the Michigan Department of Transportation (MDOT).

(oo) "Use rate" means the number of days of inpatient care per 1,000 population during a one-year period.

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

Section 3. Hospital groups

Sec. 3. Each existing hospital is assigned to a hospital group pursuant to subsection (1).

(1) These hospital groups and the assignments of hospitals to hospital groups shall be updated by the Department every five years or at the direction of the Commission. The methodology described in "New Methodology for Defining Hospital Groups" by Paul l. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 shall be used as follows:

(a) For each hospital, calculate the patient day commitment index (%C – a mathematical computation where the numerator is the number of inpatient hospital days from a specific geographic area provided by a specified hospital and the denominator is the total number of patient days provided by the specified hospital using MIDB data) for all Michigan zip codes using the summed patient days from the most recent three years of MIDB data. Include only those zip codes found in each year of the most recent three years of MIDB data. Arrange observations in an origin-destination table such that each hospital is an origin (row) and each zip code is a destination (column) and include only hospitals with inpatient records in the MIDB.

(b) For each hospital, calculate the road distance to all other hospitals. Arrange observations in an origin-destination table such that each hospital is an origin (row) and each hospital is also a destination (column).

(c) Rescale the road distance origin-destination table by dividing every entry in the road distance origin-destination table by the maximum distance between any two hospitals.

(d) Append the road distance origin-destination table to the %C origin-destination table (by hospital) to create the input data matrix for the clustering algorithm.

(e) Group hospitals into clusters using the k-means clustering algorithm with initial cluster centers provided by a wards hierarchical clustering method. Iterate over all cluster solutions from 2 to the number of hospitals (*n*) minus 1.

(i) For each cluster solution, record the group membership of each hospital, the cluster center location for each of the clusters, the r^2 value for the overall cluster solution, the number of single hospital clusters, and the maximum number of hospitals in any cluster.

(ii) "k-means clustering algorithm" means a method for partitioning observations into a user-specified number of groups. It is a standard algorithm with a long history of use in academic and applied research. The approach identifies groups of observations such that the sum of squares from points to the assigned cluster centers is minimized, i.e., observations in a cluster are more similar to one another than they are to other clusters. Several k-means implementations have been proposed; the bed need methodology uses the widely-adopted Hartigan-Wong algorithm. Any clustering or data mining text will discuss k-means; one example is B.S. Everitt, S. Landau, M. Leese, & D. Stahl (2011) Cluster Analysis, 5th Edition. Wiley, 346 p.

(iii) "Wards hierarchical clustering method" means a method for clustering observations into groups. This method uses a binary tree structure to sequentially group data observations into clusters, seeking to minimize overall within-group variance. In the bed need methodology, this method is used to identify the starting cluster locations for k-means. Any clustering text will discuss hierarchical cluster analyis, including Ward's method; one example is: G. Gan, C. Ma, & J. Wu (2007) Data Clustering: Theory, Algorithms, and Applications (Asa-Siam Series on Statistics and Applied Probability). Society for Industrial and Applied Mathematics (Siam), 466 p.

(f) Calculate the incremental F score (F_{inc}) for each cluster solution (i) between 3 and n-1 letting:

r^2_i = r^2 of solution i

r^2_{i-1} = r^2 of solution i-1

k_i = number of clusters in solution i

k_{i-1} = number of clusters in solution i-1

n = total number of hospitals

where: $$F_{inc,i} = \frac{\left(\frac{r_i^2 - r_{i-1}^2}{k_i - k_{i-1}}\right)}{\left(\frac{1 - r_i^2}{n - (k_i - 1)}\right)}$$

(g) Select candidate solutions by finding those with peak values in f_{inc} scores such that $f_{inc,\,i}$ is greater than both $f_{inc,\,i-1}$ and $f_{inc,\,i+1}$.

(h) Remove all candidate solutions in which the largest single cluster contains more than 20 hospitals.

(i) Identify the minimum number of single hospital clusters from the remaining candidate solutions. Remove all candidate solutions containing a greater number of single hospital clusters than the identified minimum.

(j) From the remaining candidate solutions, choose the solution with the largest number of clusters (*k*). This solution (*k* clusters) is the resulting number and configuration of the hospital groups.

(k) Rename hospital groups as follows:

(i) For each hospital group, identify the HSA in which the maximum number of hospitals are located. In case of a tie, use the HSA number that is lower.

(ii) For each hospital group, sum the number of current licensed hospital beds for all hospitals.

(iii) Order the groups from 1 to *k* by first sorting by HSA number, then sorting within each HSA by the sum of beds in each hospital group. The hospital group name is then created by appending number in which it is ordered to “hg” (e.g., hg1, hg2, … hg*k*).

(iv) Hospitals that do not have patient records in the MIDB - identified in subsection (1)(a) - are designated as “ng” for non-groupable hospitals.

(2) For an application involving a proposed new licensed site for a hospital (whether new or replacement), the proposed new licensed site shall be assigned to an existing hospital group utilizing the methodology described in “A Methodology for Defining Hospital Groups” by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) Calculate the road distance from proposed new site (*s*) to all existing hospitals, resulting in a list of *n* observations (s_n).

(b) Rescale s_n by dividing each observation by the maximum road distance between any two hospitals identified in subsection (1)(c).

(c) For each hospital group, subset the cluster center location identified in subsection (1)(e)(i) to only the entries corresponding to the road distance between hospitals. For each hospital group, the result is a list of *n* observations that define each hospital group's central location in relative road distance.

(d) Calculate the distance ($d_{K,S}$) between the proposed new site and each existing hospital group

where: $d_{k,s} = \sqrt{\left(HG_{k,1} - s_1\right)^2 + \left(HG_{k,2} - s_2\right)^2 + \left(HG_{k,3} - s_3\right)^2 + \ldots + \left(HG_{k,n} - s_n\right)^2}$

(e) Assign the proposed new site to the closest hospital group (HG*k*) by selecting the minimum value of $d_{k,s}$.

(f) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (a) – (e) must be repeated until all applicants have been assigned to an existing hospital group.

(3) The Department shall amend the hospital groups to reflect: (a) approved new licensed site(s) assigned to a specific hospital group; (b) hospital closures; and (c) licensure action(s) as appropriate.

(4) As directed by the Commission, new hospital group assignments established according to subsection (1) shall supersede the previous subarea/hospital group assignments and shall be posted on the State of Michigan CON web site effective on the date determined by the Commission.

Section 4. Determination of the needed hospital bed supply

Sec. 4. (1) The determination of the needed hospital bed supply for a hospital group for a planning year shall be made using the MIDB and the methodology detailed in "New Methodology for Determining Needed Hospital Bed Supply" by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) All hospital discharges for normal newborns (DRG 391 prior to 2008, DRG 795 thereafter) and psychiatric patients (ICD-9-CM codes 290 through 319, see Appendix E for ICD-10-CM Codes, as a principal diagnosis) will be excluded.

(b) For each county, compile the monthly patient days used by county residents for the previous five years (base year plus previous four years). Compile the monthly patient days used by non-Michigan residents in Michigan hospitals for the previous five years as an "out-of-state" unit. The out-of-state patient days unit is considered an additional county thereafter. Patient days are to be assigned to the month in which the patient was discharged. For patient records with an unknown county of residence, assign patient days to the county of the hospital where the patient received service.

(c) For each county, calculate the monthly patient days for all months in the planning year. For each county, construct an ordinary least squares linear regression model using monthly patient days as the dependent variable and months (1-60) as the independent variable. If the linear regression model is significant at a 90% confidence level (F-score, two tailed *p* value $\leq$ 0.1), predict patient days for months 109-120 using the model coefficients. If the linear regression model is not significant at a 90% confidence level (F-score, two tailed *p* value > 0.1), calculate the predicted monthly patient day demand in the planning year by finding the monthly average of the three previous years (months 25-60).

(d) For each county, calculate the predicted yearly patient day demand in the planning year. For counties with a significant regression model, sum the monthly predicted patient days for the planning year. For counties with a non-significant regression model, multiply the three year monthly average by 12.

(e) For each county, calculate the base year patient day commitment index (%c) to each hospital group. Specifically, divide the base year patient days from each county to each hospital group by the total number of base year patient days from each county.

(f) For each county, allocate the planning year patient days to the hospital groups by multiplying the planning year patient days by the %c to each hospital group from subsection (e).

(g) For each hospital group, sum the planning year patient days allocated from each county.

(h) For each hospital group, calculate the average daily census (ADC) for the planning year by dividing the planning year patient days by 365. Round each ADC value up to the nearest whole number.

(i) For each hospital group, select the appropriate occupancy rate from the occupancy table in Appendix C.

(j) For each hospital group, calculate the planning year bed need by dividing the planning year ADC by the appropriate occupancy rate. Round each bed need value up to the nearest whole number.

(2) The determination of the needed hospital bed supply for a limited access area shall be made using the MIDB and the methodology detailed in "A Methodology for Determining Needed Hospital Bed Supply" by Paul L. Delamater, Ashton M. Shortridge, And Joesph P. Messina, 2011 as follows:

(a) All hospital discharges for normal newborns (DRG 391 prior to 2008, DRG 795 thereafter) and psychiatric patients (ICD-9-CM codes 290 through 319, see Appendix E for ICD-10-CM Codes, as a principal diagnosis) will be excluded.

(b) Calculate the average patient day use rate of Michigan residents. Sum total patient days of Michigan residents in the base year and divide by estimated base year population for the state (population data available from US Census Bureau).

(c) Calculate the minimum number of patient days for designation of a limited access area by multiplying the average patient day use rate by 50,000. Round up to the nearest whole number.

(d) Follow steps outlined in Section 4(1)(b) – (d) to predict planning year patient days for each underserved area. Round up to the nearest whole number. The patient days for each underserved area are defined as the sum of the zip codes corresponding to each underserved area.

(e) For each underserved area, compare the planning year patient days to the minimum number of patient days for designation of a limited access area calculated in (c). Any underserved area with a planning year patient day demand greater than or equal to the minimum is designated as a limited access area.

(f) For each limited access area, calculate the planning year bed need using the steps outlined in Section 4(1)(h) – (j). For these steps, use the planning year patient days for each limited access area.

Section 5. Bed Need

Sec. 5. (1) The bed-need numbers shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise.

(2) The Department shall re-calculate the acute care bed need methodology in Section 4 every two years, or as directed by the Commission.

(3) ~~The Commission shall designate the base year and the future planning year which shall be utilized in applying the methodology pursuant to subsection (2).~~

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

(~~5~~4) New bed-need numbers established by subsections (2) and (3) shall supersede PREVIOUS bed-need numbers and shall be posted on the State Of Michigan CON web site as part of the hospital bed inventory.

(~~6~~5) 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 6. Requirements for approval -- new beds in a hospital

Sec. 6. (1) An applicant proposing new beds in a hospital, except an applicant meeting the requirements of subsection 2, 3, 4, or 5 shall demonstrate that it meets all of the following:

(a) The new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 25 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(b) The total number of existing hospital beds in the hospital group to which the new beds will be assigned does not currently exceed the needed hospital bed supply. The Department shall determine the hospital group to which the beds will be assigned in accord with Section 3 of these standards.

(c) Approval of the proposed new beds in a hospital shall not result in the total number of existing hospital beds, in the hospital group to which the new beds will be assigned, exceeding the needed hospital bed supply. The Department shall determine the hospital group to which the beds will be assigned in accord with Section 3 of these standards.

(2) An applicant proposing to begin operation as a new LTAC hospital, IRF HOSPITAL or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection:

(a) If the LTAC OR IRF hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as an LTAC OR IRF hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as an LTAC OR IRF hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically.

(b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement and renewal of a lease between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following:

(i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital or any subsequent application to add additional beds.

(ii) That the proposed new beds shall be for use in space currently licensed as part of the host hospital.

(iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project delivery requirements or any other applicable requirements of these standards, the beds licensed as part of the new hospital must be disposed of by one of the following means:

(A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the LTAC OR IRF hospital. In the event that the host hospital applies for a CON to acquire the LTAC OR IRF hospital [including the beds leased by the host hospital to the LTAC OR IRF hospital] within six months following the termination of the lease with the LTAC OR IRF hospital, it shall not be required to be in compliance with the hospital bed supply if the host hospital proposes to add the beds of the LTAC OR IRF hospital to the host hospital's medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital);

(B) Delicensure of the hospital beds; or

(C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and that entity must meet and shall stipulate to the requirements specified in Section 6(2).

(c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently, for CON approval to initiate any other CON covered clinical services; provided, however, that this section is not intended, and shall not be construed in a manner which would prevent the licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with its host hospital or any other CON approved provider of covered clinical services.

(d) The new licensed hospital shall remain within the host hospital.

(e) The new hospital shall be assigned to the same hospital group as the host hospital.

(f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

(g) The lease will not result in an increase in the number of licensed hospital beds in the hospital group.

(h) Applications proposing a new hospital under this subsection shall not be subject to comparative review.

(3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The approval of the proposed new hospital beds shall not result in an increase in the number of licensed hospital beds as follows:

(i) In the hospital group pursuant to Section 8(2)(a), or

(ii) in the HSA pursuant to Section 8(2)(b).

(b) Where the source hospital was subject to Section 8(3)(b), the receiving hospital shall have an average adjusted occupancy rate of 40 percent or above.

(c) Where the source hospital was subject to Section 8(3)(b), the addition of the proposed new hospital beds at the receiving hospital shall not exceed the number determined by the following calculation:

(i) As of the date of the application, calculate the adjusted patient days for the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .40.

(ii) Divide the result of subsection (i) by 1095 (or 1096, if the 36-month period includes a leap year) and round up to next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the receiving hospital.

(iii) Subtract the receiving hospital's total number of licensed beds and approved beds from the result of subsection (ii). This is the maximum number of beds that can be added to the receiving hospital.

(d) Where the source hospital was subject to Section 8(3)(b), the receiving hospital's average adjusted occupancy rate must not be less than 40 percent after the addition of the proposed new hospital beds.

(e) Subsection (3)(b), (c), and (d) shall not apply to excluded hospitals.

(f) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

(g) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(4) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed hospital site shall not be required to be in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The beds are being added at the existing licensed hospital site.

(b) The hospital at the existing licensed hospital site has operated at an adjusted occupancy rate of 80 percent or above for the previous, consecutive 24 months based on its licensed and approved hospital bed capacity. The adjusted occupancy rate shall be calculated as follows:

(i) Calculate the number of adjusted patient days during the most recent, consecutive 24-month period for which verifiable data are available to the Department.

(ii) Divide the number calculated in (i) above by the total possible patient days [licensed and approved hospital beds multiplied by 730 (or 731 if including a leap year)]. This is the adjusted occupancy rate.

(c) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the adjusted occupancy rate for the hospital to 75 percent. The number of beds shall be calculated as follows:

(i) Divide the number of adjusted patient days calculated in subsection (b)(i) by .75 to determine licensed bed days at 75 percent occupancy.

(ii) Divide the result of step (i) by 730 (or 731 if including a leap year) and round the result up to the next whole number.

(iii) Subtract the number of licensed and approved hospital beds as documented on the "Department Inventory of Beds" from the result of step (ii) and round the result up to the next whole number to determine the maximum number of beds that may be approved pursuant to this subsection.

(d) A licensed acute care hospital that has relocated its beds, after the effective date of these standards, shall not be approved for hospital beds under this subsection for five years from the effective date of the relocation of beds.

(e) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(f) Applicants proposing to add new hospital beds under this subsection shall demonstrate to the Department that they have pursued a good faith effort to relocate acute care beds from other licensed acute care hospitals within the HSA. At the time an application is submitted to the Department, the applicant shall demonstrate that contact was made by one certified mail return receipt for each organization contacted.

(5) An applicant proposing a new hospital in a limited access area shall not be required to be in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards, agrees and assures to comply with all applicable project delivery requirements, and all of the following subsections are met.

(a) The proposed new hospital, unless a critical access hospital, shall have 24 hour/7 days a week emergency services, obstetrical services, surgical services, and licensed acute care beds.

(b) The Department shall assign the proposed new hospital to an existing hospital group based on the current market use patterns of existing hospital groups.

(c) Approval of the proposed new beds in a hospital in a limited access area shall not exceed the bed need for the limited access area as determined by the bed need methodology in Section 4 and as set forth in Appendix D.

(d) The new beds in a hospital in a limited access area shall result in a hospital of at least 100 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. If the bed need for a limited access area, as shown in Appendix D, is less, then that will be the minimum number of beds for a new hospital under this provision. If an applicant for new beds in a hospital under this provision simultaneously applies for status as a critical access hospital, the minimum hospital size shall be that number allowed under state/federal critical access hospital designation.

(e) Applicants proposing to create a new hospital under this subsection shall not be approved, for a period of five years after beginning operation of the facility, of the following covered clinical services: (i) open heart surgery, (ii) therapeutic cardiac catheterization, (iii) fixed positron emission tomography (PET) services, (iv) all transplant services, (v) neonatal intensive care services/beds, and (vi) fixed urinary extracorporeal shock wave lithotripsy (UESWL) services.

(f) Applicants proposing to add new hospital beds under this subsection shall be prohibited from relocating the new hospital beds for a period of 10 years after beginning operation of the facility.

(g) An applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital as follows:

(i) In a metropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 30 minutes drive time from the proposed new hospital.

(ii) In a rural or micropolitan statistical area county, an applicant proposing to add a new hospital pursuant to this subsection shall locate the new hospital within the limited access area and serve a population of 50,000 or more inside the limited access area and within 60 minutes drive time from the proposed new hospital.

Section 7. Requirements for approval to replace beds

Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing to replace beds in a hospital within the replacement zone shall demonstrate that the new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 25 beds in

a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(2) The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, ~~or~~ to replace a portion of the licensed beds at the existing licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26

(3) The applicant shall demonstrate that the new licensed site is in the replacement zone.

(4) The applicant shall comply with the following requirements, as applicable:
(a) The applicant's hospital shall have an average adjusted occupancy rate of 40 percent or above.
(b) If the applicant hospital does not have an average adjusted occupancy rate of 40 percent or above, then the applicant hospital shall reduce the appropriate number of licensed beds to achieve an average adjusted occupancy rate of 60 percent or above. The applicant hospital shall not exceed the number of beds calculated as follows:
(i) As of the date of the application, calculate the number of adjusted patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.
(ii) Divide the result of subsection (i) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the licensed hospital site after the replacement.
(c) Subsection (4)(a) and (b) shall not apply to excluded hospitals.

(5) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

Section 8. Requirements for approval of an applicant proposing to relocate existing licensed hospital beds

Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(3) of these standards.

(2) Any existing licensed acute care hospital (source hospital) may relocate all or a portion of its beds to another existing licensed acute care hospital as follows:
(a) The licensed acute care hospitals are located within the same hospital group, or
(b) the licensed acute care hospitals are located within the same HSA if the receiving hospital meets the requirements of Section 6(4)(b) of these standards.

(3) The applicant shall comply with the following requirements, as applicable:
(a) The source hospital shall have an average adjusted occupancy rate of 40 percent or above.
(b) If the source hospital does not have an average adjusted occupancy rate of 40 percent or above, then the source hospital shall reduce the appropriate number of licensed beds to achieve an average adjusted occupancy rate of 60 percent or above upon completion of the relocation(s). The source hospital shall not exceed the number of beds calculated as follows:
(i) As of the date of the application, calculate the number of adjusted patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the source hospital site after the relocation.

(c) Subsections (3)(a) and (b) shall not apply to excluded hospitals.

(4) A source hospital shall apply for multiple relocations on the same application date, and the applications can be combined to meet the criteria of (3)(b) above. A separate application shall be submitted for each proposed relocation.

(5) The hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

(6) The relocated beds shall be licensed to the receiving hospital and will be counted in the inventory for the applicable hospital group.

(7) The relocation of beds under this section shall not be subject to a mileage limitation.

Section 9. Project delivery requirements terms of approval for all applicants

Sec. 9. An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(a) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(3) Compliance with the following access to care requirements:

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

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

(i) Not deny services to any individual based on ability to pay or source of payment.

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

(iii) Provide services to any individual based on clinical indications of need for the services.

(4) Compliance with the following monitoring and reporting requirements:

(a) An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75 percent over the last 12-month period in the three years after the new beds are put into operation, and for each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a minimum of 75 percent average annual occupancy for the revised licensed bed complement.

(b) The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-month period after the new beds are put into operation and for each subsequent calendar year, within 30 days after the end of the year.

(c) The applicant shall participate in a data collection system 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, and demographic, 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.

(d) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(e) The applicant shall provide the Department with timely notice of the proposed project implementation consistent with applicable statute and promulgated rules.

(5) 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 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties**~~

~~Sec. 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties, for purposes of these standards, are incorporated as part of these standards as Appendix B. The Department may amend Appendix B as appropriate to reflect changes by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget.~~

Section ~~11~~10. Department inventory of beds

Sec. ~~11~~10. The Department shall maintain and provide on request a listing of the Department inventory of beds for each hospital group.

Section ~~12~~11. Effect on prior planning policies; comparative reviews

Sec. ~~12~~11. (1) These CON review standards supersede and replace the CON standards for hospital beds approved by the CON Commission on ~~June 14, 2012~~MARCH 18, 2014 and effective ~~September 28, 2012~~JUNE 2, 2014.

(2) Projects reviewed under these standards shall be subject to comparative review except those projects meeting the requirements of Section 7 involving the replacement of beds in a hospital within the replacement zone and projects involving acquisition (including purchase, lease, donation or comparable arrangements) of a hospital.

Section ~~13~~12. Additional requirements for applications included in comparative reviews

Sec. ~~13~~12. (1) Except for those applications for limited access areas, any application for hospital beds, that is subject to comparative review under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) Each application in a comparative review group shall be individually reviewed to determine whether the application is a qualifying project. If the Department determines that two or more competing applications are qualifying projects, it shall conduct a comparative review. 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 that, 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 will be awarded points based on the percentile ranking of the applicant's uncompensated care volume and as measured by percentage of gross hospital revenues as set forth in the following table. The applicant's uncompensated care volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the Department for purposes of calculating disproportionate share hospital payments.

Percentile Ranking	Points Awarded
90.0 – 100	25 pts
80.0 – 89.9	20 pts
70.0 – 79.9	15 pts
60.0 – 69.9	10 pts
50.0 – 59.9	5 pts

Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation.

(b) A qualifying project will be awarded points based on the health service area percentile rank of the applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the

following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the department for purposes of calculating disproportionate share hospital payments.

percentile rank	points awarded
87.5 – 100	20 pts
75.0 – 87.4	15 pts
62.5 – 74.9	10 pts
50.0 – 61.9	5 pts
less than 50.0	0 pts

Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation.

(c) A qualifying project shall be awarded points as set forth in the following table in accordance with its impact on inpatient capacity. If an applicant proposes to close a hospital(s), points shall only be awarded if (i) closure of that hospital(s) does not create a bed need in any hospital group as a result of its closing; (ii) the applicant stipulates that the hospital beds to be closed shall not be transferred to another location or facility; and (iii) the utilization (as defined by the average daily census over the previous 24-month period prior to the date that the application is submitted) of the hospital to be closed is at least equal to 50 percent of the size of the proposed hospital (as defined by the number of proposed new licensed beds).

Impact on Capacity	Points Awarded
Closure of hospital(s)	25 pts
Closure of hospital(s) which creates a bed need	-15 pts

(d) A qualifying project will be awarded points based on the percentage of the applicant's historical market share of inpatient discharges of the population in an area which will be defined as that area circumscribed by the proposed hospital locations defined by all of the applicants in the comparative review process under consideration. This area will include any zip code completely within the area as well as any zip code which touches, or is touched by, the lines that define the area included within the figure that is defined by the geometric area resulting from connecting the proposed locations. In the case of two locations or one location or if the exercise in geometric definition does not include at least ten zip codes, the market area will be defined by the zip codes within the county (or counties) that includes the proposed site (or sites). Market share used for the calculation shall be the cumulative market share of the population residing in the set of above-defined zip codes of all currently licensed Michigan hospitals under common ownership or control with the applicant**,** which are in the same health service area.

Percent	Points Awarded
% of market share	% of market share served x 30 (total pts. awarded)

The source for calculations under this criterion is the MIDB.

Section ~~14~~13. Review standards for comparative review of a limited access area

Sec. ~~14~~13. (1) Any application subject to comparative review, under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(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, being Section 333.22225(1) of the Michigan Compiled Laws, 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, when taken together, that do not exceed the need, as defined in Section 22225(1) in the order in which the applications were received by the Department based on the date and time stamp placed on the application by the Department when the application is filed.

(3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's uncompensated care volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's uncompensated care will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source document for the calculation shall be the most recent Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

Percentile Ranking	Points Awarded
90.0 – 100	25 pts
80.0 – 89.9	20 pts
70.0 – 79.9	15 pts
60.0 – 69.9	10 pts
50.0 – 59.9	5 pts

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

(b) A qualifying project will be awarded points based on the statewide percentile rank of the applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source documents for the calculation shall be the Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

Percentile Rank	Points Awarded
87.5 – 100	20 pts
75.0 – 87.4	15 pts
62.5 – 74.9	10 pts
50.0 – 61.9	5 pts
Less than 50.0	0 pts

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

(c) A qualifying project shall be awarded points as set forth in the following table in accordance with its impact on inpatient capacity in the health service area of the proposed hospital site.

Impact on Capacity	Points Awarded
Closure of hospital(s)	15 pts
Move beds	0 pts
Adds beds (net)	-15 pts
or	
Closure of hospital(s) or delicensure of beds which creates a bed need	
or	
Closure of a hospital which creates a new Limited Access Area	

(d) A qualifying project will be awarded points based on the percentage of the applicant's market share of inpatient discharges of the population in the limited access area as set forth in the following table. Market share used for the calculation shall be the cumulative market share of Michigan hospitals under common ownership or control with the applicant.

Percent	Points Awarded
% of market share	% of market share served x 15 (total pts awarded)

The source for calculations under this criterion is the MIDB.

(e) A qualifying project will be awarded points based on the percentage of the limited access area's population within a 30 minute travel time of the proposed hospital site if in a metropolitan statistical area county, or within 60 minutes travel time if in a rural or micropolitan statistical area county as set forth in the following table.

Percent	Points Awarded
% of population within 30 (or 60) minute travel time of proposed site	% of population covered x 15 (total pts awarded)

(f) All applicants will be ranked in order according to their total project costs as stated in the CON application divided by its proposed number of beds in accordance with the following table.

Cost Per Bed	Points Awarded
Lowest cost	10 pts
2nd Lowest cost	5 pts
All other applicants	0 pts

Section ~~15~~14. Requirements for approval -- acquisition of a hospital

Sec. ~~15~~14. (1) An applicant proposing to acquire a hospital shall not be required to be in compliance with the needed hospital bed supply for the hospital group in which the hospital subject to the proposed acquisition is assigned if the applicant demonstrates that all of the following are met:

(a) the acquisition will not result in a change in bed capacity,

(b) the licensed site does not change as a result of the acquisition,

(c) the project is limited solely to the acquisition of a hospital with a valid license, and

(d) if the application is to acquire a hospital, which was proposed in a prior application to be established as an LTAC OR IRF hospital and which received CON approval, the applicant also must meet

the requirements of Section 6(2). Those hospitals that received such prior approval are so identified on the Department inventory of beds.

(2) The applicant shall comply with the following requirements, as applicable:

(a) The existing licensed hospital shall have an average adjusted occupancy rate of 40 percent or above.

(b) If the existing licensed hospital does not have an average adjusted occupancy rate of 40 percent or above, the applicant shall agree to all of the following:

(i) The hospital to be acquired will achieve an annual adjusted occupancy of at least 40% during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition. Annual adjusted occupancy shall be calculated as follows:

(a) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period for which verifiable data is available to the Department.

(b) Divide the number of adjusted patient days calculated in (a) above by 365 (or 366 if a leap year).

(c) If the hospital to be acquired does not achieve an annual adjusted occupancy of at least 40 percent, as calculated in (b) above, during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition, the applicant shall relinquish sufficient beds at the existing hospital to raise its adjusted occupancy to 60 percent. The revised number of licensed beds at the hospital shall be calculated as follows:

(i) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) above by 365 (or 366 if the 12-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed hospital site after acquisition.

(d) Subsection (2) shall not apply to excluded hospitals.

Section ~~16~~15. Requirements for approval – all applicants

Sec. ~~16~~15. (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 state code deficiency has been issued, the applicant shall certify that a plan of correction for cited state deficiencies at the health facility has been submitted and approved by the Bureau of Health Systems within the Department of Licensing and Regulatory Affairs. If a federal code deficiency has been issued, the applicant shall certify that a plan of correction for cited federal deficiencies at the health facility has been submitted and approved by the Centers for Medicare and Medicaid Services. If code deficiencies include any unresolved deficiencies still outstanding with the Department of Licensing and Regulatory Affairs 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 patients, or meets a federal conditional deficiency level, the proposed project cannot be approved without approval from the Bureau of Health Systems or, if applicable, the Centers for Medicare and Medicaid Services.

APPENDIX A

Counties assigned to each health service area are as follows:

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

Rural Michigan counties are as follows:

Alcona	~~Hillsdale~~	Oceana
Alger	Huron	Ogemaw
Antrim	Iosco	Ontonagon
Arenac	Iron	Osceola
Baraga	Lake	Oscoda
Charlevoix	Luce	Otsego
Cheboygan	Mackinac	Presque Isle
Clare	Manistee	Roscommon
Crawford	~~Mason~~	Sanilac
Emmet	~~Montcalm~~	Schoolcraft
Gladwin	Montmorency	Tuscola
Gogebic	NEWAYGO	

Micropolitan statistical area Michigan counties are as follows:

Allegan	HILLSDALE	MASON
Alpena	Houghton	Mecosta
Benzie	IONIA	Menominee
Branch	Isabella	~~Midland~~
Chippewa	Kalkaska	Missaukee
Delta	Keweenaw	St. Joseph
Dickinson	Leelanau	Shiawassee
Grand Traverse	Lenawee	Wexford
Gratiot	Marquette	

Metropolitan statistical area Michigan counties are as follows:

Barry	~~Ionia~~	MONTCALM~~Newaygo~~
Bay	Jackson	Muskegon
Berrien	Kalamazoo	Oakland
Calhoun	Kent	Ottawa
Cass	Lapeer	Saginaw
Clinton	Livingston	St. Clair
Eaton	Macomb	Van Buren
Genesee	MIDLAND	Washtenaw
Ingham	Monroe	Wayne

Source:

~~65~~ 75 F.R., p. ~~82238~~ 37245 (~~December 27~~JUNE 28, ~~2000~~2010)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

OCCUPANCY RATE TABLE

HOSPITAL GROUP PROJECTED BED ADC			ADJUSTED BED RANGE	
ADC _LOW	ADC_HIGH	OCCUPANCY RATE	BEDS_LOW	BED S_HIGH
30	31	60%	50	52
32	35	61%	53	58
36	39	62%	59	53
40	45	63%	64	72
46	50	64%	72	79
51	58	65%	79	90
59	67	66%	90	102
68	77	67%	102	115
78	88	68%	115	130
89	101	69%	129	147
102	117	70%	146	168
118	134	71%	167	189
135	154	72%	188	214
155	176	73%	213	242
177	204	74%	240	276
205	258	75%	274	344
259	327	76%	341	431
328	424	77%	426	551
425	561	78%	545	720
562	760	79%	712	963
761	895	80%	952	1119

LIMITED ACCESS AREAS

Limited access areas and the hospital bed need, effective ~~September 28, 2012~~(insert new effective date), for each of those areas are identified below. The hospital bed need for limited access areas shall be changed by the Department in accordance with section 2(1)(w) of these standards, and this appendix shall be updated accordingly.

LIMITED ACCESS AREA	BED NEED	PREDICTED PATIENT DAYS
1 Upper Peninsula	~~255~~196	~~68,551~~51,102
2 West Northern Lower Peninsula~~East/Central Northern Lower Peninsula~~	~~35,754~~84,639	~~143~~310
3~~ West Northern Lower Peninsula~~ East/Central Northern Lower Peninsula	~~106,135~~31,383	~~383~~127
~~4 East Southern Lower Peninsula~~	~~131~~	~~32,720~~

Sources:

1) Michigan State University
Department of Geography
~~2012 REPORT: Hospital Groups, Determination of Needed Hospital Bed Supply,~~ACUTE CARE HOSPITAL BED NEED and Limited Access Areas – 2014 UPDATE
August ~~22~~6, ~~2012~~2014

2) Section 4 of these standards

ICD-9-CM TO ICD-10-CM Code Translation

ICD-9 CODE	Description	ICD-10 Code	Description
290 through 319	Psychiatric Patients	F01.50-F99	Mental, Behavioral, and Neurodevelopmental Disorders

"ICD-9-CM Code" means the disease codes and nomenclature found in the International Classification of Diseases - 9th Revision - Clinical Modification, prepared by the Commission on Professional and Hospital Activities for the U.S. National Center for Health Statistics.

"ICD-10-CM Code" means the disease codes and nomenclature found in the International Classification of Diseases - 10th Revision - Clinical Modification, National Center for Health Statistics.

Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date: December 11, 2014

TO: The Certificate of Need (CON) Commission

FROM: Beth Nagel, Manager, Planning and Access to Care Section, Michigan Department of Community Health (MDCH)

RE: Summary of Public Hearing Comments on Hospital Bed (HB) and Nursing Home- Hospital Long Term Care Unit (NH-HLTCU) Beds Standards

---

Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the HB and NH-HLTCU Beds Standards at its September 25, 2014 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed HB and NH-HLTCU Beds Standards on October 23, 2014. Written testimony was accepted for an additional seven days after the hearing via an electronic link on the Commission's website. Testimony was received from three (3) organizations.

Hospital Bed Testimony:

1.) Robert G. Riney, Henry Ford Health Systems

- Supports viewing hospitals more as campuses and less as single solitary buildings which will save money by removing the requirement that all buildings be physically connected, if operations do not necessitate it.
- Recommends specific language changes to the Standards as highlighted and states that these changes in no way allow for the building to be any further away from the hospital:
  - Section (2)(1)(kk): "Replace beds" means a change in the location of the licensed hospital, or the replacement of a portion of the licensed beds at the same licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26….
  - Section 7(2): The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, or to replace a portion of the

licensed beds at the existing licensed site, OR THE ONE-TIME REPLACEMENT OF LESS THAN 50% OF THE LICENSED BEDS TO A NEW SITE WITHIN 250 YARDS OF THE BUILDING ON THE LICENSED SITE CONTAINING MORE THAN 50% OF THE LICENSED BEDS, WHICH MAY INCLUDE A NEW SITE ACROSS A HIGHWAY(S) OR STREET(S) AS DEFINED IN MCL 257.20 AND EXCLUDES A NEW SITE ACROSS A LIMITED ACCESS HIGHWAY AS DEFINED IN MCL 257.26.

Department Recommendations re: Hospital Beds

The Department supports the language as presented at the September 25, 2014 CON Commission meeting with the technical edits to include "(s)" at the end of "Highway" and "Street" in the inserted language in Section (2)(1)(kk) and Section 7(2) as noted in the public comment that was received.

Nursing Home-Hospital Long-term Care Unit Testimony:

1.) Pat Anderson, Health Care Association of Michigan (HCAM)

- Supports all changes to the standards with the exception to the definition of "proposed licensed site."
- Proposes that the "250 yards" be changed to 3 miles similar to the allowance provided in the definition of replacement zone.
- Suggests that if the replacement zone three mile radius is used it should be adequate to address problems with the site and still ensure that services are provided to the original population it was intended to serve.

2.) David Stobb, Ciena Healthcare

- Supports all changes to the standards with the exception to the definition of "proposed licensed site."
- Recommends the adoption of a 3 mile radius instead of the 250 yard radius.
- States that the adoption of the 250 yards from the federal EMTALA statute is not appropriate and is not relevant in any way to nursing homes.

Department Recommendations re: Nursing Home-Hospital Long-Term Care Unit

The Department supports the language that was presented at the September 25, 2014 CON Commission meeting without any further modifications.

CON Commission
Health Care Association of Michigan
Testimony
December 11, 2014

I am Patricia Anderson representing the Health Care Association of Michigan. HCAM represents 310 skilled nursing facility providers across the state including for- profit, not for profit, county medical care facilities and hospital based long term care units. HCAM would again like to testify in support of the proposed changes to these standards with exception to the definition of "proposed licensed site". HCAM supports the concept this definition adds to the standards but believes the 250 yards is too restrictive and does not provide an adequate allowance to address site issues that had been previously been identified.

HCAM does understand that the source of the 250 yards is from the EMTALA – Emergency Medical Treatment and Labor Act. EMTALA is a federal law that requires all Medicare-participating hospitals with dedicated EDs (Emergency Department) to provide care to anyone who comes to the ED. CFR Section 489.24 (a)(1)(i) defines the term hospital property as a "hospital campus as defined in 413.65(a), including the parking lot,... including any building owned by the hospital that are within 250 yards of the hospital." It appears this language was extended to the proposed definition of "proposed licensed site" keeping in line with the campus type arrangements for hospital settings. HCAM does not think this law applies to the nursing homes or HLTCU's settings covered by these standards.

HCAM would support tabling only the licensed site addition to the standards pending further review of the 250 yards as long as it does not hold up the approval of the remaining changes to the standards. The workgroup in the spring of 2014 did an excellent review of the charges before them and their recommendations that were included in the proposed standards should and need to move forward at this time.

Thank you.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT (HLTCU) BEDS

(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 approval ~~and delivery of nursing homes and HLTCU services~~ under Part 222 of the Code THAT INVOLVE A) BEGINNING OPERATION OF A NEW NURSING HOME/HLTCU, (B) REPLACING BEDS IN A NURSING HOME/HLTCU OR PHYSICALLY RELOCATING NURSING HOME/HLTCU BEDS FROM ONE LICENSED SITE TO ANOTHER GEOGRAPHIC LOCATION, (C) INCREASING LICENSED BEDS IN A NURSING HOME/HLTCU ~~. A nursing home~~ licensed under Part 217 and a HLTCU defined in Section 20106(6), OR (D) ACQUIRING A NURSING HOME/HLTCU. PURSUANT TO THE CODE, A NURSING HOME/HLTCU ~~are~~ IS A covered health ~~facilities~~ facilitY ~~for purposes of Part 222 of the Code~~. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

(2) AN INCREASE IN LICENSED NURSING HOME/HLTCU BEDS IS A CHANGE IN BED CAPACITY FOR PURPOSES OF PART 222 OF THE CODE.

(3) THE PHYSICAL RELOCATION OF NURSING HOME/HLTCU BEDS FROM A LICENSED SITE TO ANOTHER GEOGRAPHIC LOCATION IS A CHANGE IN BED CAPACITY FOR PURPOSES OF PART 222 OF THE CODE.

Section 2. Definitions

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

(a) "Acquisition of an existing nursing home/HLTCU" means the issuance of a new nursing home/HLTCU license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangement) of an existing licensed and operating nursing home/HLTCU and which does not involve a change in bed capacity of that health facility.

(b) "ADC adjustment factor" means the factor by which the average daily census (ADC), derived during the bed need methodology calculation set forth in Section 3(2)(d) for each planning area, is divided. For planning areas with an ADC of less than 100, the ADC adjustment factor is 0.90 and for planning areas with an ADC of 100 or more, the ADC adjustment factor is 0.95.

(c) "Applicant's cash" means the total unrestricted cash, designated funds, and restricted funds reported by the applicant as the source of funds in the application. IF THE PROJECT INCLUDES SPACE LEASE COSTS, THE APPLICANT'S CASH INCLUDES THE CONTRIBUTION DESIGNATED FOR THE PROJECT FROM THE LANDLORD.

(d) "Base year" means 1987 or the most recent year for which verifiable data collected as part of the Michigan Department of Community Health Annual Survey of Long-Term-Care Facilities or other comparable MDCH survey instrument are available.

(e) "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.

(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) "Common ownership or control" means a nursing home, regardless of the state in which it is located, that is owned by, is under common control of, or has a common parent as the applicant nursing home pursuant to the definition of common ownership or control utilized by the Department~~'s~~ OF LICENSING AND REGULATORY AFFAIRS~~'s~~(LARA), Bureau of Health ~~Systems~~CARE SERVICES.

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

(i) "Converted space" means existing space in a health facility that is not currently licensed as part of the nursing home/HLTCU and is proposed to be licensed as nursing home or HLTCU space. An example is proposing to license home for the aged space as nursing home space.

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

(k) "Department inventory of beds" means the current list, for each planning area maintained on a continuing basis by the Department: (i) licensed nursing home beds and (ii) nursing home beds approved by a valid CON issued under Part 222 of the Code which are not yet licensed. It does not include (a) nursing home beds approved from the statewide pool and (b) short-term nursing care program beds approved pursuant to Section 22210 of the Code, being Section 333.22210 of the Michigan Compiled Laws.

(l) "Existing nursing home beds" means, for a specific planning area, the total of all nursing home beds located within the planning area including: (i) licensed nursing home beds, (ii) nursing home beds approved by a valid CON issued under Part 222 of the Code which are not yet licensed, (iii) proposed nursing home beds under appeal from a final Department decision made under Part 222 or pending a hearing from a proposed decision issued under Part 222 of the Code, and (iv) proposed nursing home beds that are part of a completed application under Part 222 of the Code which is pending final Department decision. (a) Nursing home beds approved from the statewide pool are excluded; and (b) short-term nursing care program beds approved pursuant to Section 22210 of the Code, being Section 333.22210 of the Michigan Compiled Laws, are excluded.

(m) "Health service area" or "HSA" means the geographic area established for a health systems agency pursuant to former Section 1511 of the Public Health Service Act and set forth in Section 14.

(n) "Hospital long-term-care unit" or "HLTCU" means a nursing care facility, owned and operated by and as part of a hospital, that provides organized nursing care and medical treatment to seven (7) or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

(o) "Licensed only facility" means a licensed nursing home that is not certified for Medicare or Medicaid.

(p) "Licensed site" means the location of the health facility authorized by license and listed on that licensee's certificate of licensure.

(q) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396~~r-6~~ TO 1396G and1396~~r-8~~l to ~~1396v~~1396U.

~~(r) "Metropolitan statistical area county" means a county located in a metropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix C.~~

~~(s) "Micropolitan statistical area county" means a county located in a micropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix C.~~

(~~t~~r) "New design model" means a nursing home/HLTCU built in accordance with specified design requirements as identified in the applicable sections.

(~~u~~s) "Nursing home" means a nursing care facility, including a county medical care facility, but excluding a hospital or a facility created by Act No. 152 of the Public Acts of 1885, as amended, being sections 36.1 to 36.12 of the Michigan Compiled Laws, that provides organized nursing care and medical

treatment to seven (7) or more unrelated individuals suffering or recovering from illness, injury, or infirmity. This term applies to the licensee only and not the real property owner if different than the licensee.

(~~v~~t) "Nursing home bed" means a bed in a health facility licensed under Part 217 of the Code or a licensed bed in a hospital long-term-care unit. The term does not include short-term nursing care program beds approved pursuant to Section 22210 of the Code being Section 333.22210 of the Michigan Compiled Laws or beds in health facilities listed in Section 22205(2) of the Code, being Section 333.22205(2) of the Michigan Compiled Laws.

(~~w~~u) "Occupancy rate" means the percentage which expresses the ratio of the actual number of patient days of care provided divided by the total number of patient days. Total patient days is calculated by summing the number of licensed and/or CON approved but not yet licensed beds and multiplying these beds by the number of days that they were licensed and/or CON approved but not yet licensed. This shall include nursing home beds approved from the statewide pool. Occupancy rates shall be calculated using verifiable data from ~~either (i)~~ the actual number of patient days of care for 12 continuous months of data from the ~~MDCH~~ CON Annual Survey ~~of Long-Term-Care Facilities~~ or other comparable MDCH survey instrument ~~or (ii) the actual number of patient days of care for 4 continuous quarters of data as reported to the Department for purposes of compiling the "Staffing/Bed Utilization Ratios Report," whichever is the most recent available data~~.

(~~x~~v) "Planning area" means the geographic boundaries of each county in Michigan with the exception of: (i) Houghton and Keweenaw counties, which are combined to form one planning area and (ii) Wayne County which is divided into three planning areas. Section 12 identifies the three planning areas in Wayne County and the specific geographic area included in each.

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

(x) "PROPOSED LICENSED SITE" MEANS THE PHYSICAL LOCATION AND ADDRESS (OR LEGAL DESCRIPTION OF PROPERTY) OF THE PROPOSED PROJECT OR WITHIN 250 YARDS OF THE PHYSICAL LOCATION AND ADDRESS (OR LEGAL DESCRIPTION OF PROPERTY) AND WITHIN THE SAME PLANNING AREA OF THE PROPOSED PROJECT THAT WILL BE AUTHORIZED BY LICENSE AND WILL BE LISTED ON THAT LICENSEE'S CERTIFICATE OF LICENSURE.

~~(z~~x~~)"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.~~

(~~aa~~y) "Relocation of existing nursing home/HLTCU beds" means a change in the location of existing nursing home/HLTCU beds from the licensed site to a different EXISTING licensed site within the planning area.

(~~bb~~z) "Renewal of lease" means execution of a lease between the licensee and a real property owner in which the total lease costs exceed the capital expenditure threshold.

(~~cc~~aa) "Replacement bed" means a change in the location of the licensed nursing home/HLTCU, the replacement of a portion of the licensed beds at the same licensed site, or the replacement of a portion of the licensed beds pursuant to the new model design. The nursing home/HLTCU beds will be in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.) within the replacement zone.

(~~dd~~bb) "Replacement zone" means a proposed licensed site that is,

(i) for a rural or micropolitan statistical area county, within the same planning area as the existing licensed site.

(ii) for a county that is not a rural or micropolitan statistical area county,

(A) within the same planning area as the existing licensed site and

(B) within a three-mile radius of the existing licensed site.

~~(ee) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix C.~~

~~(ff~~cc) ~~"Staffing/Bed Utilization Ratios Report" means the report issued by the Department on a quarterly basis.~~

(~~gg~~cc) "Use rate" means the number of nursing home and hospital long-term-care unit days of care per 1,000 population during a one-year period.

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

Section 3. Determination of needed nursing home bed supply

Sec. 3 (1)(a) The age specific use rates for the planning year shall be the actual statewide age specific nursing home use rates using data from the base year.

(b) The age cohorts for each planning area shall be: (i) age 0 - 64 years, (ii) age 65 - 74 years, (iii) age 75 - 84 years, and (iv) age 85 and older.

(c) Until the base year is changed by the Commission in accord with Section 4(3) and Section 5, the use rates for the base year for each corresponding age cohort, established in accord with subsection (1)(b), are set forth in Appendix ~~A~~B.

(2) The number of nursing home 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 in the age cohorts established in subsection (1)(b).

(b) Multiply each population age cohort by the corresponding use rate established in Appendix ~~A~~B.

(c) Sum the patient days resulting from the calculations performed in subsection (b). The resultant figure is the total patient days.

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

(e) The following shall be known as the ADC adjustment factor. (i) If the ADC determined in subsection (d) is less than 100, divide the ADC by 0.90. (ii) If the ADC determined in subsection (d) is 100 or greater, divide the ADC by 0.95.

(f) The number determined in subsection (e) represents the number of nursing home beds needed in a planning area for the planning year.

Section 4. Bed need

Sec. 4. (1) The bed need numbers ~~shown in Appendix B and incorporated as part of these standards~~ shall apply to project applications subject to review under these standards, except where a specific CON standard states otherwise.

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

(3) The base year and the planning year that shall be utilized in applying the methodology pursuant to subsection (2) shall be set according to the most recent data available to the Department.

(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 supersede ~~the~~ PREVIOUS bed need numbers ~~shown in Appendix B~~ and shall be ~~included as an amended appendix to these standards~~POSTED ON THE STATE OF MICHIGAN CON WEB SITE AS PART OF THE NURSING HOME/HLTCU BED INVENTORY.

(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 age specific use rates by changing the base year

Sec. 5. (1) The base year shall be modified based on data obtained from the Department and presented to the Commission. The Department shall calculate use rates for each of the age cohorts set forth in Section 3(1)(b) and biennially present the revised use rates based on 2006 information, or the most recent base year information available biennially after 2006, 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 increase beds in a planning area

Sec. 6. An applicant proposing to increase the number of nursing home beds in a planning area must meet the following as applicable:

(1) An applicant proposing to increase the number of nursing home beds in a planning area by beginning operation of a new nursing home/HLTCU or increasing the number of beds to an existing licensed nursing home/HLTCU shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the State of Michigan ~~for~~ INCLUDING, BUT NOT LIMITED TO, Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) ~~-~~or Civil Monetary Penalties (CMP).

(b) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within LARA.~~the Department~~. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

(d) The proposed increase, if approved, will not result in the total number of existing nursing home beds in that planning area exceeding the needed nursing home bed supply ~~set forth in Appendix B~~, unless one of the following is met:

(i) An applicant may request and be approved for up to a maximum of 20 beds if, when the total number of "existing nursing home beds" is subtracted from the bed need for the planning area ~~set forth in Appendix B~~, the difference is equal to or more than 1 and equal to or less than 20. This subsection is not applicable to projects seeking approval for beds from the statewide pool of beds.

(ii) An exception to the number of beds may be approved, if the applicant facility has experienced an average occupancy rate of 97% for ~~12 quarters~~THREE YEARS based on the ~~Department's "Staffing/Bed Utilization Ratios Report."~~CON ANNUAL SURVEY. The number of beds that may be approved in excess of the bed need for each planning area ~~identified in Appendix B~~ is set forth in subsection (A).

(A) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the occupancy rate for the planning area in which the additional beds are proposed to the ADC adjustment factor for that planning area as shown in Appendix ~~B~~C. The number of beds shall be calculated by (1) dividing the actual number of patient days of care provided during the most recent 12-month period for which verifiable data are available to the Department provided by all nursing home (including HLTCU) beds in the planning area, including patient days of care provided in beds approved from the statewide pool of beds and dividing that result by 365 (or 366 for leap years); (2) dividing the result of step (1) by the ADC adjustment factor for the planning area in which the beds are proposed to be added; (3) rounding the result of step (2) up to the next whole number; and (4) subtracting the total number of beds in the planning area including beds approved from the statewide pool of beds from the result of step (3). If the number of beds necessary to reduce the planning area occupancy rate to the ADC adjustment factor for that planning area is equal to or more than 20, the number of beds that may be approved pursuant to this subsection shall be up to that number of beds. If the number of beds necessary to reduce the planning area occupancy rate to the ADC adjustment factor for that planning area

is less than 20, the number of additional beds that may be approved shall be that number of beds or up to a maximum of 20 beds.

(iii) An applicant may request and be approved for up to a maximum of 20 beds if the following requirements are met:

(A) The planning area in which the beds will be located shall have a population density of less than 28 individuals per square mile based on the ~~2000~~ 2010 U.S. Census figures as set forth in Appendix ~~D~~E.

(B) The applicant facility has experienced an average occupancy rate of 92% for the most recent ~~24 months~~TWO YEARS based on the ~~Department's "Staffing/Bed Utilization Ratios Report."~~CON ANNUAL SURVEY.

(2) An applicant proposing to increase the number of nursing home beds in a planning area by beginning operation of a new nursing home/HLTCU or increasing the number of beds to an existing licensed nursing home/HLTCU pursuant to the new design model shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the State of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) or Civil Monetary Penalties (CMP).

(b) The proposed project results in no more than 100 beds per new design model and meets the following design standards:

(i) For inpatient facilities that are not limited to group resident housing of 10 beds or less, the construction standards shall be those applicable to nursing homes in the document entitled Minimum Design Standards for Health Care Facilities in Michigan and incorporated by reference in Section 20145(6) of the Public Health Code, being Section 333.20145(6) of the Michigan Compiled Laws or any future versions.

(ii) For small resident housing units of 10 beds or less that are supported by a central support inpatient facility, the construction standards shall be those applicable to hospice residences providing an inpatient level of care, except that:

(A) at least 100% of all resident sleeping rooms shall meet barrier free requirements;

(B) electronic nurse call systems shall be required in all facilities;

(C) handrails shall be required on both sides of patient corridors; and

(D) ceiling heights shall be a minimum of 7 feet 10 inches.

(iii) The proposed project shall comply with applicable life safety code requirements and shall be fully sprinkled and air conditioned.

(iv) The Department may waive construction requirements for new design model projects if authorized by law.

(c) The proposed project shall include at least 80% single occupancy resident rooms with an adjoining ~~bathroom~~TOILET ROOM CONTAINING A SINK, WATER CLOSET, AND BATHING FACILITY AND serving no more than two residents in both the central support inpatient facility and any supported small resident housing units.

(d) The proposed increase, if approved, will not result in the total number of existing nursing home beds in that planning area exceeding the needed nursing home bed supply ~~set forth in Appendix B~~, unless the following is met:

(i) An approved project involves replacement of a portion of the beds of an existing facility at a geographic location within the replacement zone that is not physically connected to the current licensed site. If a portion of the beds are replaced at a location that is not the current licensed site, a separate license shall be issued to the facility at the new location.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

~~**Section 7. Requirements for approval to relocate existing nursing home/HLTCU beds**~~

~~Sec. 7. (1) An applicant proposing to relocate existing nursing home/HLTCU beds shall not be required to be in compliance with the needed nursing home bed supply set forth in Appendix B, if the applicant demonstrates all of the following:~~

~~(a) An existing nursing home may relocate no more than 50% of its beds to another existing nursing home, and an existing HLTCU may relocate all or a portion of its beds to another existing nursing home/HLTCU.~~

~~(b) The nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds shall not require any ownership relationship.~~

~~(c) The nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds must be located in the same planning area.~~

~~(d) The nursing home/HLTCU from which the beds are being relocated has not relocated any beds within the last seven (7) years.~~

~~(e) The relocated beds shall be licensed to the receiving nursing home/HLTCU and will be counted in the inventory for the applicable planning area.~~

~~(f) At the time of transfer to the receiving facility, patients in beds to be relocated must be given the choice of remaining in another bed in the nursing home/HLTCU from which the beds are being transferred or to the receiving nursing home/HLTCU. Patients shall not be involuntary discharged to create a vacant bed.~~

~~(2) An applicant proposing to add new nursing home/HLTCU beds, as the receiving existing nursing home/HLTCU under subsection (1), shall not be required to be in compliance with the needed nursing home bed supply set forth in Appendix B, if the applicant demonstrates all of the following:~~

~~(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:~~

~~Type of Applicant~~	~~Reporting Requirement~~
~~Applicant with only Michigan nursing homes/HLTCUs~~	~~All Michigan nursing homes/HLTCUs under common ownership or control~~
~~Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs~~	~~All Michigan nursing homes/HLTCUs under common ownership or control~~
~~Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs~~	~~All Michigan and out of state nursing homes/HLTCUs under common ownership or control~~

~~(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.~~

~~(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.~~

~~(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.~~

~~(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.~~

~~(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.~~

~~(vi) Outstanding debt obligation to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP).~~

~~(b) The approval of the proposed new nursing home/HLTCU beds shall not result in an increase in the number of nursing home beds in the planning area.~~

~~(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Systems within the Department. Code deficiencies include any unresolved deficiencies still outstanding with the Department.~~

Section ~~8~~7. Requirements for approval to replace beds

Sec. ~~8~~7. An applicant proposing to replace beds must meet the following as applicable.

(1) An applicant proposing to replace beds within the replacement zone shall not be required to be in compliance with the needed nursing home bed supply ~~set forth in Appendix B~~ AND~~if the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUS and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the State of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) or Civil Monetary Penalties (CMP).

(b) The proposed project is either to replace the licensed nursing home/HLTCU to a new PROPOSED LICENSED site or replace a portion of the licensed beds at the existing licensed site.

(c) The proposed LICENSED site is within the replacement zone.

(d) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

(2) An applicant proposing to replace a licensed nursing home/HLTCU outside the replacement zone shall demonstrate all of the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the State of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) or Civil Monetary Penalties (CMP).

(b) The total number of existing nursing home beds in that planning area is equal to or less than the needed nursing home bed supply ~~set forth in Appendix B~~.

(c) The number of beds to be replaced is equal to or less than the number of currently licensed beds at the nursing home/HLTCU at which the beds proposed for replacement are currently located.

(d) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

(3) An applicant proposing to replace beds with a new design model shall not be required to be in compliance with the needed nursing home bed supply ~~set forth in Appendix B~~ AND~~if the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

(a) The proposed project results in no more than 100 beds per new design model and meets the following design standards:

(i) For inpatient facilities that are not limited to group resident housing of 10 beds or less, the construction standards shall be those applicable to nursing homes in the document entitled Minimum Design Standards for Health Care Facilities in Michigan and incorporated by reference in Section 20145(6) of the Public Health Code, being Section 333.20145(6) of the Michigan Compiled Laws or any future versions.

(ii) For small resident housing units of 10 beds or less that are supported by a central support inpatient facility, the construction standards shall be those applicable to hospice residences providing an inpatient level of care, except that:

(a) at least 100% of all resident sleeping rooms shall meet barrier free requirements;

(b) electronic nurse call systems shall be required in all facilities;

(c) handrails shall be required on both sides of patient corridors; and

(d) ceiling heights shall be a minimum of 7 feet 10 inches.

(iii) The proposed project shall comply with applicable life safety code requirements and shall be fully sprinkled and air conditioned.

(iv) The Department may waive construction requirements for new design model projects if authorized by law.

(b) The proposed project shall include at least 80% single occupancy resident rooms with an adjoining ~~bathroom~~TOILET ROOM CONTAINING A SINK, WATER CLOSET, AND BATHING FACILITY AND serving no more than two residents in both the central support inpatient facility and any supported small resident housing units. If the proposed project is for replacement/renovation of an existing facility and utilizes only a portion of its currently licensed beds, the remaining rooms at the existing facility shall not exceed double occupancy.

(c) The proposed project shall be within the replacement zone unless the applicant demonstrates all of the following:

(i) The proposed LICENSED site for the replacement beds is in the same planning area~~, and not within a three mile radius of a licensed nursing home that has been newly constructed, or replaced (including approved projects) within five calendar years prior to the date of the application~~,

(~~i~~ii) The applicant shall provide a signed affidavit or resolution from its governing body or authorized agent stating that the proposed licensed site will continue to provide service to the same market, and

(~~ii~~iii) The current patients of the facility/beds being replaced shall be admitted to the replacement beds when the replacement beds are licensed, to the extent that those patients desire to transfer to the replacement facility/beds.

(d) An approved project may involve replacement of a portion of the beds of an existing facility at a geographic location within the replacement zone that is not physically connected to the current licensed site. If a portion of the beds are replaced at a location that is not the current licensed site, a separate license shall be issued to the facility at the new location.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

Section 8. Requirements for approval to relocate existing nursing home/HLTCU beds

Sec. 8. (1) An applicant proposing to relocate existing nursing home/HLTCU beds shall not be required to be in compliance with the needed nursing home bed supply ~~if~~AND ~~the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

~~(a) An existing nursing home may relocate no more than 50% of its beds to another existing nursing home, and an existing HLTCU may relocate all or a portion of its beds to another existing nursing home/HLTCU.~~

(~~b~~a) THERE SHALL NOT BE ANY OWNERSHIP RELATIONSHIP REQUIREMENTS BETWEEN ~~T~~the nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds ~~shall not require any ownership relationship~~.

(~~c~~b) THE RELOCATED BEDS SHALL BE PLACED ~~The nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds must be located~~ in the same planning area.

~~(d) The nursing home/HLTCU from which the beds are being relocated has not relocated any beds within the last seven (7) years.~~

(~~e~~c) The relocated beds shall be licensed to the receiving nursing home/HLTCU and will be counted in the inventory for the applicable planning area.

(~~f~~d) At the time of transfer to the receiving facility, patients in beds to be relocated must be given the choice of remaining in another bed in the nursing home/HLTCU from which the beds are being transferred or to the receiving nursing home/HLTCU. Patients shall not be involuntary discharged to create a vacant bed.

(e) RELOCATION OF BEDS SHALL NOT INCREASE THE ROOMS WITH THREE (3) OR MORE BED WARDS IN THE RECEIVING FACILITY.

(2) An applicant proposing to add new nursing home/HLTCU beds, as the receiving existing nursing home/HLTCU under subsection (1), shall not be required to be in compliance with the needed nursing home bed supply~~,~~ ~~if~~AND ~~the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~DELINQUENT debt obligation to the State of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) or Civil Monetary Penalties (CMP).

(b) The approval of the proposed new nursing home/HLTCU beds shall not result in an increase in the number of nursing home beds in the planning area.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

Section 9. Requirements for approval to acquire an existing nursing home/HLTCU or renew the lease of an existing nursing home/HLTCU

Sec. 9. An applicant proposing to acquire an existing nursing home/HLTCU or renew the lease of an existing nursing home/HLTCU must meet the following as applicable:

(1) An applicant proposing to acquire an existing nursing home/HLTCU shall not be required to be in compliance with the needed nursing home bed supply ~~set forth in Appendix B~~ for the planning area in which the nursing home or HLTCU is located ~~if~~ AND ~~the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common

ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the state of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ quality assurance assessment program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) OR civil monetary penalties (CMP).

(b) The acquisition will not result in a change in bed capacity.

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

(d) The project is limited solely to the acquisition of a nursing home/HLTCU with a valid license.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with the Department, and

(f) The applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health ~~Systems~~CARE SERVICES WITHIN LARA, and shall post the annual report in the facility if the facility being acquired has met any of conditions in subsections (a)(i), (ii), (iii), (iv), (v), or (vi).

(2) An applicant proposing to acquire an existing nursing home/HLTCU approved pursuant to the new design model shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) ~~Outstanding~~ DELINQUENT debt obligation to the State of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ Quality Assurance Assessment Program (QAAP), PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) or Civil Monetary Penalties (CMP).

(b) An applicant will continue to operate the existing nursing home/HLTCU pursuant to the new design model requirements.

(c) The applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health ~~Systems~~OF HEALTH CARE SERVICES WITHIN LARA, and shall post the annual report in the facility if the facility being acquired has met any of conditions in subsections (a)(i), (ii), (iii), (iv), (v), or (vi).

(d) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

(3) An applicant proposing to renew the lease for an existing nursing home/HLTCU shall not be required to be in compliance with the needed nursing home bed supply ~~set forth in Appendix B~~ for the planning area in which the nursing home/HLTCU is located, ~~if~~ AND ~~the applicant demonstrates~~ all of the following REQUIREMENTS ARE MET:

(a) The lease renewal will not result in a change in bed capacity.

(b) The licensed site does not change as a result of the lease renewal.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health ~~Systems~~ CARE SERVICES within ~~the Department~~LARA. Code deficiencies include any unresolved deficiencies still outstanding with ~~the Department~~LARA.

Section 10. Review standards for 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 under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) The degree to which each application in a comparative group meets the criterion set forth in Section 22230 of the Code, being Section 333.22230 of the Michigan Compiled Laws, shall be determined based on the sum of points awarded under subsections (a) and (b).

(a) A qualifying project will be awarded points as follows:

(i) For an existing nursing home/HLTCU, the current percentage of patient days of care reimbursed by Medicaid for the most recent 12 months of operation.

(ii) For a new nursing home/HLTCU, the proposed percentage of patient days of care to be reimbursed by Medicaid in the second 12 months of operation following project completion.

Percentage of Medicaid Patient Days (calculated using total patient days for all existing and proposed beds at the facility)	Points Awarded	
	~~Current~~ EXISTING	Proposed
~~20~~ 50 – ~~59~~69%	~~6~~4	3
~~60~~ 70 – 100%	~~10~~8	~~5~~7

(b) A qualifying project will be awarded 10 points ~~as follows:~~

~~(i) For an existing nursing home/HLTCU, nine (9) points if 100%, six (6) points if 75%, and four (4) points if 50% of the licensed nursing home beds are Medicaid certified for the most recent 12 months of operations.~~

~~(ii) For a new nursing home/HLTCU, seven (7) points if 100%, four (4) points if 75%, and two (2) points if 50% of the proposed beds will be Medicaid certified by the second 12 months of operation following project completion~~IF ALL BEDS IN THE PROPOSED PROJECT WILL BE DUALLY CERTIFIED FOR BOTH MEDICARE AND MEDICAID SERVICES BY THE SECOND 12 MONTHS OF OPERATION.

(3) ~~A qualifying project will be awarded points based on the most recent 12 months of participation level in the Medicare program for an existing nursing home/HLTCU and the proposed participation level for a new nursing home/HLTCU.~~

~~Participation Level~~	~~Points Awarded~~
~~Medicare certification of at least one (1) bed but less than 100%~~	~~1~~
~~Medicare certification of 100% of all existing and proposed beds~~	~~3~~

~~(4)~~ A qualifying project will have 15 points deducted if the applicant has any of the following at the time the application is submitted:

(a) ~~is currently a special focus nursing home/HLTCU as identified by the Centers for Medicare and Medicaid Services (CMS):~~

~~(b)~~ has been a special focus nursing home/HLTCU within the last three (3) years;

(~~c~~b) has had more than eight (8) substandard quality of care citations; immediate harm citations, and/or immediate jeopardy citations in the three (3) most recent standard survey cycles (includes intervening abbreviated surveys, standard surveys, and revisits);

(~~d~~c) has had an involuntary termination or voluntary termination at the threat of a medical assistance provider enrollment and trading partner agreement within the last three (3) years;

(~~e~~d) has had a state enforcement action resulting in a reduction in license capacity or a ban on admissions within the last three (3) years; or

(~~f~~e) has any ~~outstanding~~ DELINQUENT debt obligation to the state of Michigan INCLUDING, BUT NOT LIMITED TO, ~~for~~ quality assurance assessment program (QAAP), civil monetary penalties (CMP), Medicaid level of care determination (LOCD), or preadmission screening and annual resident review (PASARR).

(~~5~~4) A qualifying project will be awarded ~~10~~ THREE (3) points if the applicant provides documentation that it participates or ~~five (5) points~~ if it proposes to participate in a culture change model, which contains person centered care, ongoing staff training, and measurements of outcomes. An additional five (5) points will be awarded if the culture change model, either currently used or proposed, is a model approved by the Department.

(~~6~~5) A qualifying project will be awarded points based on the proposed percentage of the "Applicant's cash" to be applied toward funding the total proposed project cost as follows:

Percentage “Applicant’s Cash”	Points Awarded
Over 20%	5
10 – 20%	3

5 – 9%	2

(~~7~~6) ~~A qualifying project will be awarded five (5) points if the existing or proposed nursing home/HLTCU is fully equipped with sprinklers.~~

~~(8)~~ A qualifying project will be awarded ~~five~~ FOUR (~~5~~4) points if the ENTIRE existing ~~or~~ AND proposed nursing home/HLTCU is fully equipped with air conditioning. FULLY EQUIPPED WITH AIR CONDITIONING MEANS MEETING THE DESIGN TEMPERATURES IN TABLE 6B OF THE MINIMUM DESIGN STANDARDS FOR HEALTH CARE FACILITIES IN MICHIGAN AND CAPABLE OF MAINTAINING A TEMPERATURE OF 71 – 81 DEGREES FOR THE RESIDENT UNIT CORRIDORS.

(~~9~~7) A qualifying project will be awarded SIX (6) OR FOUR (4) points based on ~~the proposed project as follows~~ONLY ONE OF THE FOLLOWING:

(a) SIX (6) POINTS IF THE PROPOSED PROJECT HAS 100% ~~private~~ rooms with DEDICATED TOILET ROOM CONTAINING A sink, WATER CLOSET, and ~~shower~~ BATHING FACILITY OR

(b) FOUR (4) POINTS IF THE PROPOSED PROJECT HAS 80% private rooms with dedicated TOILET ROOM CONTAINING A SINK, WATER CLOSET and ~~shower~~BATHING FACILITY.

~~Facility Design~~	~~Points Awarded~~
~~100% private rooms with adjoining sink, toilet, and shower~~	~~10~~
~~100% private rooms with dedicated and shared adjoining toilet, sink and shower~~	~~5~~
~~80% private rooms with dedicated sink, shared adjoining toilet and sink, and central showers with adjoining space for drying and dressing in visual privacy~~	~~3~~

(~~10~~8) A qualifying project will be awarded 10 points if it results in a nursing home/HLTCU with 150 or fewer beds IN TOTAL.

~~(11) A qualifying project will be awarded five (5) points if the applicant provides its audited financial statements.~~

(~~12~~9) A qualifying project will be awarded five (5) points if the proposed beds will be housed in new construction.

(~~13~~10) A qualifying project will be awarded 10 points if the ENTIRE existing ~~AND PROPOSED~~ nursing home/HLTCU AND ITS PROPOSED PROJECT ~~eliminates all of its 3- and 4-bed wards~~WILL HAVE NO MORE THAN DOUBLE OCCUPANCY ROOMS AT COMPLETION OF THE PROJECT.

(~~14~~11) A qualifying project will be awarded ~~5~~ TWO (2) points if the existing or proposed nursing home/HLTCU is on or readily accessible to an existing or proposed public transportation route.

(~~15~~12) A qualifying project will be awarded ~~no more than four (4)~~ points for technological innovation as follows:

~~Technology Feature~~INNOVATIONS	Points Awarded
THE PROPOSED PROJECT WILL HAVE wireless nurse call/paging system including wireless devices carried by	1

direct care staff~~Electronic health record and computer point-of-service entry capability (including wireless tablets)~~	
WIRELESS INTERNET WITH RESIDENT ACCESS TO RELATED EQUIPMENT/DEVICE IN ENTIRE FACILITY~~Wireless nurse call/paging system including wireless devices carried by direct care staff~~	1
AN INTEGRATED ELECTRONIC MEDICAL RECORDS SYSTEM WITH POINT-OF-SERVICE ACCESS CAPABILITY (INCLUDING WIRELESS DEVICES) FOR ALL DISCIPLINES INCLUDING PHARMACY, PHYSICIAN, NURSING, AND THERAPY SERVICES AT THE ENTIRE EXISTING AND PROPOSED NURSING HOME/HLTCU~~Wireless internet in total existing and proposed facility~~	~~1~~4
~~Computer stations or internet cafes for resident use~~	~~1~~
THE PROPOSED PROJECT WILL HAVE A BACKUP GENERATOR SUPPORTING ALL FUNCTIONS WITH AN ON-SITE OR PIPED-IN FUEL SUPPLY AND BE CAPABLE OF PROVIDING AT LEAST 48 HOURS OF SERVICE AT FULL LOAD	4

(~~16~~13) A QUALIFYING PROJECT WILL BE AWARDED THREE (3) POINTS IF THE PROPOSED PROJECT INCLUDES BARIATRIC ROOMS AS FOLLOWS: PROJECT USING 0 – 49 BEDS WILL RESULT IN AT LEAST ONE (1) BARIATRIC ROOM OR PROJECT USING 50 OR MORE BEDS WILL RESULT IN AT LEAST TWO (2) BARIATRIC ROOMS. BARIATRIC ROOM MEANS THE CREATION OF PATIENT ROOM(S) INCLUDED AS PART OF THE CON PROJECT, AND IDENTIFIED ON THE ARCHITECTURAL SCHEMATICS, THAT ARE DESIGNED TO ACCOMMODATE THE NEEDS OF BARIATRIC PATIENTS WEIGHING OVER 400 POUNDS. THE BARIATRIC PATIENT ROOMS SHALL HAVE A LARGER ROOM AND BATHROOM ENTRANCE WIDTH TO ACCOMMODATE OVER-SIZED EQUIPMENT, AND SHALL INCLUDE A MINIMUM OF A BARIATRIC BED, BARIATRIC TOILET, BARIATRIC WHEELCHAIR, AND A DEVICE TO ASSIST RESIDENT MOVEMENT (SUCH AS A PORTABLE OR BUILD IN LIFT). IF AN IN-ROOM SHOWER IS NOT INCLUDED IN THE BARIATRIC PATIENT ROOM, THE MAIN/CENTRAL SHOWER ROOM THAT IS LOCATED ON THE SAME FLOOR AS THE BARIATRIC PATIENT ROOM(S) SHALL INCLUDE AT LEAST ONE (1) SHOWER STALL THAT HAS AN OPENING WIDTH AND DEPTH THAT IS LARGER THAN MINIMUM MI CODE REQUIREMENTS.

(14) Submission of conflicting information in this section may result in a lower point award. If an application contains conflicting information which could result in a different point value being awarded in this section, the Department will award points based on the lower point value that could be awarded from the conflicting information. For example, if submitted information would result in 6 points being awarded, but other conflicting information would result in 12 points being awarded, then 6 points will be awarded. If the conflicting information does not affect the point value, the Department will award points accordingly. For example, if submitted information would result in 12 points being awarded and other conflicting information would also result in 12 points being awarded, then 12 points will be awarded.

(~~17~~15) 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, being Section 333.22225(1) of the Michigan Compiled Laws, and which have the highest number of points when the results of subsections (2) through (~~15~~12) 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, as defined in Section 22225(1), in the order in which the applications were received by the Department, based on the date and time stamp on the application when the application is filed.

Section 11. Project delivery requirements ~~--~~ AND terms of approval ~~for all applicants~~

Sec. 11. ~~(1)~~ An applicant shall agree that, if approved, the ~~project~~ NURSING HOME/HLTCU SERVICES shall be delivered in compliance with the following terms of ~~CON~~ approval:

(~~a~~1) Compliance with these standards, including the requirements of Section 10. IF AN APPLICANT IS AWARDED BEDS PURSUANT TO SECTION 10 AND REPRESENTATIONS MADE IN THAT SECTION, THE DEPARTMENT SHALL MONITOR COMPLIANCE WITH THOSE STATEMENTS AND REPRESENTATIONS AND SHALL DETERMINE ACTIONS FOR NON-COMPLIANCE.

(~~b~~2) COMPLIANCE WITH THE FOLLOWING APPLICABLE QUALITY ASSURANCE STANDARDS:

(a) Compliance with Section 22230 of the Code shall be based on the nursing home's/HLTCU's actual Medicaid participation within the time periods specified in these standards. Compliance with Section 10(2)(a) of these standards shall be determined by comparing the nursing home's/HLTCU's actual patient days reimbursed by Medicaid, as a percentage of the total patient days, with the applicable schedule set forth in Section 10(2)(a) for which the applicant had been awarded points in the comparative review process. If any of the following occurs, an applicant shall be required to be in compliance with the range in the schedule immediately below the range for which points had been awarded in Section 10(2)(a), instead of the range of points for which points had been awarded in the comparative review in order to be found in compliance with Section 22230 of the Code: (i) the average percentage of Medicaid recipients in all nursing homes/HLTCUs in the planning area decreased by at least 10 percent between the second 12 months of operation after project completion and the most recent 12-month period for which data are available, (ii) the actual rate of increase in the Medicaid program per diem reimbursement to the applicant nursing home/HLTCU is less than the annual inflation index for nursing homes/HLTCUs as defined in any current approved Michigan State Plan submitted under Title XIX of the Social Security Act which contains an annual inflation index, or (iii) the actual percentage of the nursing home's/HLTCU's patient days reimbursed by Medicaid (calculated using total patient days for all existing and proposed nursing home beds at the facility) exceeds the statewide average plus 10 percent of the patient days reimbursed by Medicaid for the most recent year for which data are available from the Michigan Department of Community Health [subsection (iii) is applicable only to Section 10(2)(a)]. In evaluating subsection (ii), the Department shall rely on both the annual inflation index and the actual rate increases in per diem reimbursement to the applicant nursing home/HLTCU and/or all nursing homes/HLTCUs in the HSA.

(~~c~~b) For projects involving the acquisition of a nursing home/HLTCU, the applicant shall agree to maintain the nursing home's/HLTCU's level of Medicaid participation (patient days and new admissions) for the time periods specified in these standards, within the ranges set forth in Section 10(2)(a) for which the seller or other previous owner/lessee had been awarded points in a comparative review.

~~(d) Compliance with applicable operating standards.~~

~~(e) Compliance with the following quality assurance standards:~~

(~~i~~c) For projects involving replacement of an existing nursing home/HLTCU, the current patients of the facility/beds being replaced shall be admitted to the replacement beds when the replacement beds are licensed, to the extent that those patients desire to transfer to the replacement facility/beds.

(~~ii~~d) The applicant will assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(3) COMPLIANCE WITH THE FOLLOWING ACCESS TO CARE REQUIREMENTS:

(a) THE APPLICANT, TO ASSURE APPROPRIATE UTILIZATION BY ALL SEGMENTS OF THE MICHIGAN POPULATION, SHALL:

(i) NOT DENY SERVICES TO ANY INDIVIDUAL BASED ON PAYOR SOURCE.

(ii) MAINTAIN INFORMATION BY SOURCE OF PAYMENT TO INDICATE THE VOLUME OF CARE FROM EACH PAYOR AND NON-PAYOR SOURCE PROVIDED ANNUALLY.

(iii) PROVIDE SERVICES TO ANY INDIVIDUAL BASED ON CLINICAL INDICATIONS OF NEED FOR THE SERVICES.

(4) COMPLIANCE WITH THE FOLLOWING MONITORING AND REPORTING REQUIREMENTS:

(~~iii~~a) 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 an individual 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.

(iv) The applicant shall provide the Department with ~~a~~ TIMELY notice ~~stating the date the beds are placed in operation and such notice shall be submitted to the Department~~ OF THE PROPOSED PROJECT IMPLEMENTATION consistent with applicable statute and promulgated rules.

(~~2~~5) An applicant shall agree that, if approved, and material discrepancies are later determined within the reporting of the ownership and citation history of the applicant facility and all nursing homes under common ownership and control that would have resulted in a denial of the application, shall surrender the CON. This does not preclude an applicant from reapplying with corrected information at a later date.

(~~3~~6) 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 12. Department inventory of beds

Sec. 12. The Department shall maintain a listing of the Department Inventory of Beds for each planning area.

Section 13. Wayne County planning areas

Sec. 13. (1) For purposes of these standards the cities and/or townships in Wayne County are assigned to the planning areas as follows:

Planning Area 84/Northwest Wayne

Canton Township, Dearborn, Dearborn Heights, Garden City, Inkster, Livonia, Northville (part), Northville Township, Plymouth, Plymouth Township, Redford Township, Wayne, Westland

Planning area 85/Southwest Wayne

Allen Park, Belleville, Brownstown Township, Ecorse, Flat Rock, Gibraltar, Grosse Ile Township, Huron Township, Lincoln Park, Melvindale, River Rouge, Riverview, Rockwood, Romulus, Southgate, Sumpter Township, Taylor, Trenton, Van Buren Township, Woodhaven, Wyandotte

Planning area 86/Detroit

Detroit, Grosse Pointe, Grosse Pointe Township, Grosse Pointe Farms, Grosse Pointe Park, Grosse Pointe Woods, Hamtramck, Harper Woods, Highland Park

~~**Section 14. Health Service Areas**~~

~~Sec. 14. Counties assigned to each of the HSAs are as follows:~~

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

~~Delta~~ ~~Keweenaw~~ ~~Ontonagon~~
~~Dickinson~~ ~~Luce~~ ~~Schoolcraft~~

Section 15. Effect on prior CON review standards, comparative reviews

Sec. 15. (1) These CON review standards supersede and replace the CON Standards for Nursing Home and Hospital Long-Term-Care Unit (HLTCU) Beds approved by the CON Commission on ~~April 30, 2008~~DECEMBER 15, 2010 and effective on ~~June 20, 2008~~MARCH 11, 2011.

(2) Projects reviewed under these standards involving a change in bed capacity shall be subject to comparative review except as follows:

(a) replacement of an existing nursing home/HLTCU being replaced in a rural county;

(b) replacement of an existing nursing home/HLTCU in a micropolitan or metropolitan statistical area county that is within two miles of the existing nursing home/HLTCU;

(c) relocation of existing nursing home/HLTCU beds; or

(d) an increase in beds pursuant to Section 6(1)(d)(ii) or (iii).

(3) Projects reviewed under these standards that relate solely to the acquisition of an existing nursing home/HLTCU or the renewal of a lease shall not be subject to comparative review.

APPENDIX A

Counties assigned to each of the HSAs are as follows:

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

APPENDIX ~~A~~B

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT BEDS

The use rate per 1000 population for each age cohort, for purposes of these standards, effective ~~March~~ AUGUST 1~~1~~, ~~2011~~2013, and until otherwise changed by the Commission, is as follows.

(i) Age 0 - 64: ~~208~~ 200 days of care

(ii) Age 65 - 74: ~~2,791~~ 2,638 days of care

(iii) Age 75 - 84: ~~10,047~~9379 days of care

(iv) Age 85 +: ~~36,758~~34,009 days of care

APPENDIX ~~BC~~

CON REVIEW STANDARDS FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT BEDS

The ~~bed need numbers~~ADC ADJUST FACTOR, for purposes of these standards, effective ~~TBD~~AUGUST 1, 2013, and until otherwise changed by the Commission, are as follows:

Planning Area	~~Bed Need~~	ADC Adjustment Factor
Alcona	~~115~~	0.~~95~~90
Alger	~~65~~	0.90
Allegan	~~500~~	0.95
Alpena	~~187~~	0.95
Antrim	~~168~~	0.95
Arenac	~~100~~	0.~~95~~90
Baraga	~~58~~	0.90
Barry	~~275~~	0.95
Bay	~~603~~	0.95
Benzie	~~124~~	0.95
Berrien	~~884~~	0.95
Branch	~~224~~	0.95
Calhoun	~~675~~	0.95
Cass	~~273~~	0.95
Charlevoix	~~159~~	0.95
Cheboygan	~~188~~	0.95
Chippewa	~~202~~	0.95
Clare	~~185~~	0.95
Clinton	~~319~~	0.95
Crawford	~~95~~	0.90
Delta	~~245~~	0.95
Dickinson	~~190~~	0.95
Eaton	~~491~~	0.95
Emmet	~~201~~	0.95
Genesee	~~1,880~~	0.95
Gladwin	~~184~~	0.95
Gogebic	~~137~~	0.95
Gd. Traverse	~~455~~	0.95
Gratiot	~~209~~	0.95
Hillsdale	~~233~~	0.95
Houghton/Keweenaw	~~222~~	0.95
Huron	~~237~~	0.95

1128

APPENDIX ~~B~~ C - continued

Planning Area	~~Bed~~ ~~Need~~	ADC Adjustment Factor
Ingham	~~1,048~~	0.95
Ionia	~~260~~	0.95
Iosco	~~204~~	0.95
Iron	~~120~~	0.~~95~~90
Isabella	~~245~~	0.95
Jackson	~~777~~	0.95
Kalamazoo	~~1,077~~	0.95
Kalkaska	~~95~~	0.90
Kent	~~2,451~~	0.95
Lake	~~88~~	0.90
Lapeer	~~375~~	0.95
Leelanau	~~159~~	0.95
Lenawee	~~524~~	0.95
Livingston	~~710~~	0.95
Luce	~~36~~	0.90
Mackinac	~~78~~	0.90
Macomb	~~4,255~~	0.95
Manistee	~~169~~	0.95
Marquette	~~338~~	0.95
Mason	~~186~~	0.95
Mecosta	~~220~~	0.95
Menominee	~~167~~	0.95
Midland	~~411~~	0.95
Missaukee	~~92~~	0.90
Monroe	~~686~~	0.95
Montcalm	~~291~~	0.95
Montmorency	~~101~~	0.~~95~~90
Muskegon	~~843~~	0.95
Newaygo	~~241~~	0.95
Oakland	~~5,630~~	0.95
Oceana	~~152~~	0.95
Ogemaw	~~134~~	0.95
Ontonagon	~~59~~	0.90
Osceola	~~127~~	0.95
Oscoda	~~72~~	0.90
Otsego	~~132~~	0.95
Ottawa	~~1,145~~	0.95

APPENDIX B - continued

Planning Area	~~Bed Need~~	ADC Adjustment Factor
Presque Isle	~~124~~	0.95
Roscommon	~~227~~	0.95
Saginaw	~~1,038~~	0.95
St. Clair	~~811~~	0.95
St. Joseph	~~290~~	0.95
Sanilac	~~250~~	0.95
Schoolcraft	~~61~~	0.90
Shiawassee	~~336~~	0.95
Tuscola	~~287~~	0.95
Van Buren	~~365~~	0.95
Washtenaw	~~1,268~~	0.95
Wexford	~~170~~	0.95
NW Wayne	~~2,305~~	0.95
SW Wayne	~~1,542~~	0.95
Detroit	~~4,140~~	0.95
~~**Statewide Total**~~	~~**46,995**~~	

APPENDIX ~~CD~~

~~CON REVIEW STANDARDS~~
~~FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT BEDS~~

Rural Michigan counties are as follows:

Alcona	~~Hillsdale~~	Oceana
Alger	Huron	Ogemaw
Antrim	Iosco	Ontonagon
Arenac	Iron	Osceola
Baraga	Lake	Oscoda
Charlevoix	Luce	Otsego
Cheboygan	Mackinac	Presque Isle
Clare	Manistee	Roscommon
Crawford	~~Mason~~	Sanilac
Emmet	~~Montcalm~~	Schoolcraft
Gladwin	Montmorency	Tuscola
Gogebic	NEWAYGO	

Micropolitan statistical area Michigan counties are as follows:

Allegan	HILLSDALE	MASON
Alpena	Houghton	Mecosta
Benzie	IONIA	Menominee
Branch	Isabella	~~Midland~~
Chippewa	Kalkaska	Missaukee
Delta	Keweenaw	St. Joseph
Dickinson	Leelanau	Shiawassee
Grand Traverse	Lenawee	Wexford
Gratiot	Marquette	

Metropolitan statistical area Michigan counties are as follows:

Barry	~~Ionia~~	MONTCALM~~Newaygo~~
Bay	Jackson	Muskegon
Berrien	Kalamazoo	Oakland
Calhoun	Kent	Ottawa
Cass	Lapeer	Saginaw
Clinton	Livingston	St. Clair
Eaton	Macomb	Van Buren
Genesee	MIDLAND	Washtenaw
Ingham	Monroe	Wayne

Source:

~~65~~ 75 F.R., p. ~~82238~~ 37245 (~~December 27~~JUNE 28, ~~2000~~2010)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

APPENDIX ~~D~~E

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS

Michigan nursing home planning areas with a population density of less than 28 individuals per square mile based on ~~2000~~ 2010 U.S. Census figures.

Planning Area	Population Density Per Square Mile
Ontonagon	~~6.0~~5.11
Schoolcraft	~~7.6~~6.95
Luce	~~7.8~~7.16
Baraga	~~9.7~~9.67
~~Alger~~IRON	~~10.7~~9.76
~~Iron~~ALGER	~~11.3~~10.25
Mackinac	~~11.7~~10.45
~~Oscoda~~GOGEBIC	~~16.7~~14.35
~~Alcona~~OSCODA	~~17.4~~15.12
~~Gogebic~~ALCONA	~~15.8~~15.76
Montmorency	~~18.8~~17.36
~~Lake~~PRESQUE ISLE	~~20.0~~19.53
~~Presque isle~~LAKE	~~21.8~~20.11
~~Menominee~~CHIPPEWA	~~24.3~~21.29
~~Chippewa~~MENOMINEE	~~24.7~~22.86
Houghton/Keweenaw	~~24.7~~24.17
~~Missaukee~~CRAWFORD	~~25.5~~25.00
~~Crawford~~MISSAUKEE	~~25.6~~25.90

Source: Michigan Department of Management and Budget and the U.S. Bureau of the Census

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS
--ADDENDUM FOR SPECIAL POPULATION GROUPS

(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; definitions

Sec. 1. (1) This addendum supplements the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds and shall be used for determining the need for projects established to better meet the needs of special population groups within the long-term care and nursing home populations.

(2) Except as provided in sections 2, 3, 4, 5, 6, 7, and 8 of this addendum, these standards supplement, and do not supersede, the requirements and terms of approval required by the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(3) The definitions which apply to the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds shall apply to these standards.

(4) For purposes of this addendum, the following terms are defined:

(a) "Behavioral patient" means an individual that exhibits a history of chronic behavior management problems such as aggressive behavior that puts self or others at risk for harm, or an altered state of consciousness, including paranoia , delusions, and acute confusion.

(b) "Hospice" means a health care program licensed under Part 214 of the Code, being Section 333.21401 et seq.

(c) "Infection control program," means a program that will reduce the risk of the introduction of communicable diseases into a ventilator-dependent unit, provide an active and ongoing surveillance program to detect the presence of communicable diseases in a ventilator-dependent unit, and respond to the presence of communicable diseases within a ventilator-dependent unit so as to minimize the spread of a communicable disease.

(d) "Licensed hospital" means either a hospital licensed under Part 215 of the Code; or a psychiatric hospital or unit licensed pursuant to Act 258 of the Public Acts of 1974, as amended, being sections 330.1001 to 330.2106 of the Michigan Compiled Laws.

(e) "Private residence", means a setting other than a licensed hospital; or a nursing home including a nursing home or part of a nursing home approved pursuant to Section 6.

(f) "Traumatic brain injury (TBI)/spinal cord injury (SCI) patient" means an individual with TBI or SCI that is acquired or due to a traumatic insult to the brain and its related parts that is not of a degenerative or congenital nature. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial adjustment.

(g) "Ventilator-dependent patient," means an individual who requires mechanical ventilatory assistance.

Section 2. Requirements for approval -- applicants proposing to increase nursing home beds -- special use exceptions

Sec. 2. A project to increase nursing home beds in a planning area which, if approved, would otherwise cause the total number of nursing home beds in that planning area to exceed the needed nursing home bed supply or cause an increase in an existing excess as determined under the applicable

CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds, may nevertheless be approved pursuant to this addendum.

Section 3. Statewide pool for the needs of special population groups within the long-term care and nursing home populations

Sec. 3. (1) A statewide pool of additional nursing home beds of 1,958 beds needed in the state is established to better meet the needs of special population groups within the long-term care and nursing home populations. Beds in the pool shall be allocated as follows:

(a) These categories shall be allocated 1,109 beds and distributed as follows and shall be reduced/redistributed in accordance with subsection (c):

(i) TBI/SCI beds will be allocated 400 beds.

(ii) Behavioral beds will be allocated 400 beds.

(iii) Hospice beds will be allocated 130 beds.

(iv) Ventilator-dependent beds will be allocated 179 beds.

(b) The following historical categories have been allocated 849 beds. Additional beds shall not be allocated to these categories. If the beds within any of these categories are delicensed, the beds shall be eliminated and not be returned to the statewide pool for special population groups.

(i) Alzheimer's disease has 384 beds.

(ii) Health care needs for skilled nursing care has 173 beds.

(iii) Religious has 292 beds.

(c) The number of beds set aside from the total statewide pool established for categories in subsection (1)(a) for a special population group shall be reduced if there has been no CON activity for that special population group during at least 6 consecutive application periods.

(i) The number of beds in a special population group shall be reduced to the total number of beds for which a valid CON has been issued for that special population group.

(ii) The number of beds reduced from a special population group pursuant to this subsection shall revert to the total statewide pool established for categories in subsection (1)(a).

(iii) The Department shall notify the Commission of the date when action to reduce the number of beds set aside for a special population group has become effective and shall identify the number of beds that reverted to the total statewide pool established for categories in subsection (1)(a).

(iv) For purposes of this subsection, "application period" means the period of time from one designated application date to the next subsequent designated application date.

(v) For purposes of this subsection, "CON activity" means one or more of the following:

(A) CON applications for beds for a special population group have been submitted to the Department for which either a proposed or final decision has not yet been issued by the Department.

(B) Administrative hearings or appeals to court of decisions issued on CON applications for beds for a special population group are pending resolution.

(C) An approved CON for beds for each special population group has expired for lack of appropriate action by an applicant to implement an approved CON.

(d) By setting aside these beds from the total statewide pool, the Commission's action applies only to applicants seeking approval of nursing home beds pursuant to sections 4, 5, 6, and 7. It does not preclude the care of these patients in units of hospitals, hospital long-term care units, nursing homes, or other health care settings in compliance with applicable statutory or certification requirements.

(2) Increases in nursing home beds approved under this addendum for special population groups shall not cause planning areas currently showing an unmet bed need to have that need reduced or planning areas showing a current surplus of beds to have that surplus increased.

Section 4. Requirements for approval for beds from the statewide pool for special population groups allocated to TBI/SCI patients

Sec. 4. The CON Commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of TBI/SCI patients as compared to serving these needs in general nursing home unit(s).

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate with credible documentation to the satisfaction of the Department each of the following:

(a) The beds will be operated as part of a specialized program exclusively for TBI/SCI patients. At the time an application is submitted, the applicant shall demonstrate that it operates:

(i) A continuum of outpatient treatment, rehabilitative care, and support services for TBI/SCI patients; and

(ii) A transitional living program or contracts with an organization that operates a transitional living program and rehabilitative care for TBI/SCI patients.

(b) The applicant shall submit evidence of accreditation of its existing outpatient and/or residential programs by the Commission on Accreditation of Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for rehabilitative care and services.

(c) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another nationally-recognized accreditation organization for the nursing home beds proposed under this subsection.

(d) A floor plan for the proposed physical plant space to house the nursing home beds allocated under this subsection that provides for:

(i) Individual units consisting of 20 beds or less per unit, not to be more than 40 beds per facility.

(ii) Day/dining area within, or immediately adjacent to, the unit(s), which is solely for the use of TBI/SCI patients.

(iii) Direct access to a secure outdoor or indoor area at the facility appropriate for supervised activity.

(e) The applicant proposes programs to promote a culture within the facility that is appropriate for TBI/SCI patients of various ages.

(2) Beds approved under this subsection shall not be converted to general nursing home use without a CON for nursing home and hospital long-term care unit beds under the CON review standards for nursing home and hospital long-term care unit beds and shall not be offered to individuals other than TBI/SCI patients.

Section 5. Requirements for approval for beds from the statewide pool for special population groups allocated to behavioral patients

Sec. 5. The CON Commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of behavioral patients as compared to serving these needs in general nursing home unit(s).

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate with credible documentation to the satisfaction of the Department each of the following:

(a) Individual units shall consist of 20 beds or less per unit.

(b) The facility shall not be awarded more than 40 beds.

(c) The proposed unit shall have direct access to a secure outdoor or indoor area for supervised activity.

(d) The unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the behavioral patients.

(e) The physical environment of the unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(f) Staff will be specially trained in treatment of behavioral patients.

(2) Beds approved under this subsection shall not be converted to general nursing home use without a CON for nursing home and hospital long-term care unit beds under the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(3) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 6. Requirements for approval for beds from the statewide pool for special population groups allocated to hospice patients

Sec. 6. The CON Commission determines there is a need for beds for patients requiring both hospice and long-term nursing care services within the long-term care and nursing home populations.

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate, with credible documentation to the satisfaction of the Department, each of the following:

(a) An applicant shall be a hospice certified by Medicare pursuant to the Code of Federal Regulations, Title 42, Chapter IV, Subpart B (Medicare programs), Part 418 and shall have been a Medicare certified hospice for at least 24 continuous months prior to the date an application is submitted to the Department.

(b) An applicant shall demonstrate that, during the most recent 12-month period prior to the date an application is submitted to the Department for which verifiable data are available to the Department, at least 64% of the total number of hospice days of care provided to all of the clients of the applicant hospice were provided in a private residence.

(c) An application shall propose 30 beds or less.

(d) An applicant for beds from the special statewide pool of beds shall not be approved if any application for beds in that same planning area has been approved from the special statewide pool of beds allocated for hospice.

(2) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 7. Requirements for approval for beds from the statewide pool for special population groups allocated to ventilator-dependent patients

Sec. 7. The CON Commission determines there is a need for beds for ventilator-dependent patients within the long-term care and nursing home populations

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate, with credible documentation to the satisfaction of the Department, each of the following:

(a) An applicant proposes a program for caring for ventilator-dependent patients in licensed nursing home beds.

(b) An application proposes no more than 40 beds that will be licensed as nursing home beds.

(c) The proposed unit will serve only ventilator-dependent patients.

(2) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 8. Acquisition of nursing home/HLTCU beds approved pursuant to this addendum

Sec. 8. (1) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to religious shall meet the following:

(a) The applicant is a part of, closely affiliated with, controlled, sanctioned or supported by a recognized religious organization, denomination or federation as evidenced by documentation of its federal tax exempt status as a religious corporation, fund, or foundation under section 501(c)(3) of the United States Internal Revenue Code.

(b) The applicant's patient population includes a majority of members of the religious organization or denomination represented by the sponsoring organization.

(c) The applicant's existing services and/or operations are tailored to meet certain special needs of a specific religion, denomination or order, including unique dietary requirements, or other unique religious needs regarding ceremony, ritual, and organization which cannot be satisfactorily met in a secular setting.

(d) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(2) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to TBI/SCI shall meet the following:

(a) The beds will be operated as part of a specialized program exclusively for TBI/SCI patients. At the time an application is submitted, the applicant shall demonstrate that it operates:

(i) a continuum of outpatient treatment, rehabilitative care, and support services for TBI/SCI patients; and

(ii) a transitional living program or contracts with an organization that operates a transitional living program and rehabilitative care for TBI/SCI patients.

(b) The applicant shall submit evidence of accreditation of its existing outpatient and/or residential programs by the Commission on Accreditation of Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for rehabilitative care and services.

(c) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another nationally-recognized accreditation organization for the nursing home beds proposed under this subsection.

(d) A floor plan for the proposed physical plant space to house the nursing home beds allocated under this subsection that provides for:

(i) Individual units consisting of 20 beds or less per unit, not to be more than 40 beds per facility.

(ii) Day/dining area within, or immediately adjacent to, the unit(s), which is solely for the use of TBI/SCI patients.

(iii) Direct access to a secure outdoor or indoor area at the facility appropriate for supervised activity.

(e) The applicant proposes programs to promote a culture within the facility that is appropriate for TBI/SCI patients of various ages.

(3) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to Alzheimer’s disease shall meet the following:

(a) The beds are part of a specialized program for Alzheimer's disease which will admit and treat only patients which require long-term nursing care and have been appropriately classified as a patient on the Global Deterioration Scale (GDS) for age-associated cognitive decline and Alzheimer's disease as a level 4 (when accompanied by continuous nursing needs), 5, or 6.

(b) The specialized program will participate in the state registry for Alzheimer's disease.

(c) The specialized program shall be attached or geographically adjacent to a licensed nursing home and be no larger than 20 beds in size.

(d) The proposed Alzheimer's unit shall have direct access to a secure outdoor or indoor area at the health facility, appropriate for unsupervised activity.

(e) The Alzheimer's unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the Alzheimer's unit patients.

(f) The physical environment of the Alzheimer's unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(g) Staff will be specially trained in Alzheimer's disease treatment.

(h) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(4) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to behavioral patients shall meet the following:

(a) Individual units shall consist of 20 beds or less per unit.

(b) The facility shall not be awarded more than 40 beds.

(c) The proposed unit shall have direct access to a secure outdoor or indoor area for supervised activity.

(d) The unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the behavioral patients.

(e) The physical environment of the unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(f) Staff will be specially trained in treatment of behavioral patients.

(g) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(5) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to hospice shall meet the following:

(a) An applicant shall be a hospice certified by Medicare pursuant to the code of Federal Regulations, Title 42, Chapter IV, Subpart B (Medicare Programs), Part 418 and shall have been a Medicare certified hospice for at least 24 continuous months prior to the date an application is submitted to the Department.

(b) An applicant shall demonstrate that, during the most recent 12-month period prior to the date an application is submitted to the Department for which verifiable data are available to the Department, at least 64% of the total number of hospice days of care provided to all of the clients of the applicant hospice were provided in a private residence.

(c) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(6) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to ventilator-dependent patients shall meet the following:

(a) An applicant proposes a program for caring for ventilator-dependent patients in licensed nursing home beds.

(b) An application proposes no more than 40 beds that will be licensed as nursing home beds.

(c) The proposed unit will serve only ventilator-dependent patients.

(d) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 9. Project delivery requirements -- terms of approval for all applicants seeking approval under Section 3(1) of this addendum

Sec. 9. (1) An applicant shall agree that if approved, the services shall be delivered in compliance with the terms of approval required by the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(2) An applicant for beds from the statewide pool for special population groups allocated to religious shall agree that, if approved, the services provided by the specialized long-term care beds shall be delivered in compliance with the following term of CON approval:

(a) The applicant shall document, at the end of the third year following initiation of beds approved an annual average occupancy rate of 95 percent or more. If this occupancy rate has not been met, the applicant shall delicense a number of beds necessary to result in a 95 percent occupancy based upon its average daily census for the third full year of operation.

(3) An applicant for beds from the statewide pool for special population groups allocated to Alzheimer's disease shall agree that if approved:

(a) The beds are part of a specialized program for Alzheimer's disease which will admit and treat only patients which require long-term nursing care and have been appropriately classified as a patient on the Global Deterioration Scale (GDS) for age-associated cognitive decline and Alzheimer's disease as a level 4 (when accompanied by continuous nursing needs), 5, or 6.

(b) The specialized program will participate in the state registry for Alzheimer's disease.

(c) The specialized program shall be attached or geographically adjacent to a licensed nursing home and be no larger than 20 beds in size.

(d) The proposed Alzheimer's unit shall have direct access to a secure outdoor or indoor area at the health facility, appropriate for unsupervised activity.

(e) The Alzheimer's unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the Alzheimer's unit patients.

(f) The physical environment of the Alzheimer's unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(g) Staff will be specially trained in Alzheimer's disease treatment.

(4) An applicant for beds from the statewide pool for special population groups allocated to hospice shall agree that, if approved, all beds approved pursuant to that subsection shall be operated in accordance with the following CON terms of approval.

(a) An applicant shall maintain Medicare certification of the hospice program and shall establish and maintain the ability to provide, either directly or through contractual arrangements, hospice services as outlined in the Code of Federal Regulations, Title 42, Chapter IV, Subpart B, Part 418, hospice care.

(b) The proposed project shall be designed to promote a home-like atmosphere that includes accommodations for family members to have overnight stays and participate in family meals at the applicant facility.

(c) An applicant shall not refuse to admit a patient solely on the basis that he/she is HIV positive, has AIDS or has AIDS related complex.

(d) An applicant shall make accommodations to serve patients that are HIV positive, have AIDS or have AIDS related complex in nursing home beds.

(e) An applicant shall make accommodations to serve children and adolescents as well as adults in nursing home beds.

(f) Nursing home beds shall only be used to provide services to individuals suffering from a disease or condition with a terminal prognosis in accordance with Section 21417 of the Code, being Section 333.21417 of the Michigan Compiled Laws.

(g) An applicant shall agree that the nursing home beds shall not be used to serve individuals not meeting the provisions of Section 21417 of the Code, being Section 333.21417 of the Michigan Compiled Laws, unless a separate CON is requested and approved pursuant to applicable CON review standards.

(h) An applicant shall be licensed as a hospice program under Part 214 of the Code, being Section 333.21401 et seq. of the Michigan Compiled Laws.

(i) An applicant shall agree that at least 64% of the total number of hospice days of care provided by the applicant hospice to all of its clients will be provided in a private residence.

(5) An applicant for beds from the statewide pool for special population groups allocated to ventilator-dependent patients shall agree that, if approved, all beds approved pursuant to that subsection shall be operated in accordance with the following CON terms of approval.

(a) An applicant shall staff the proposed ventilator-dependent unit with employees that have been trained in the care and treatment of ventilator-dependent patients and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of ventilator-dependent patients.

(ii) A program director that is a registered nurse.

(b) An applicant shall make provisions, either directly or through contractual arrangements, for at least the following services:

(i) respiratory therapy.

(ii) occupational and physical therapy.

(iii) psychological services.

(iv) family and patient teaching activities.

(c) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the ventilator-dependent unit. At a minimum, the criteria shall address the amount of mechanical ventilatory dependency, the required medical stability, and the need for ancillary services.

(ii) The transfer of patients requiring care at other health care facilities.

(iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.

(iv) Patient rights and responsibilities in accordance with Sections 20201 and 20202 of the Code, being Sections 333.20201 and 333.20202 of the Michigan Compiled Laws.

(v) The type of ventilatory equipment to be used on the unit and provisions for back-up equipment.

(d) An applicant shall establish and maintain an organized infection control program that has written policies for each of the following:

(i) use of intravenous infusion apparatus, including skin preparation, monitoring skin site, and frequency of tube changes.

(ii) placement and care of urinary catheters.

(iii) care and use of thermometers.

(iv) care and use of tracheostomy devices.

(v) employee personal hygiene.

(vi) aseptic technique.

(vii) care and use of respiratory therapy and related equipment.

(viii) isolation techniques and procedures.

(e) An applicant shall establish a multi-disciplinary infection control committee that meets on at least a monthly basis and includes the director of nursing, the ventilator-dependent unit program director, and representatives from administration, dietary, housekeeping, maintenance, and respiratory therapy. This subsection does not require a separate committee, if an applicant organization has a standing infection control committee and that committee's charge is amended to include a specific focus on the ventilator-dependent unit.

(f) The proposed ventilator-dependent unit shall have barrier-free access to an outdoor area in the immediate vicinity of the unit.

(g) An applicant shall agree that the beds will not be used to service individuals that are not ventilator-dependent unless a separate CON is requested and approved by the Department pursuant to applicable CON review standards.

(h) An applicant shall provide data to the Department that evaluates the cost efficiencies that result from providing services to ventilator-dependent patients in a hospital.

(6) An applicant for beds from the statewide pool for special population groups allocated to TBI/SCI patients shall agree that if approved:

(a) An applicant shall staff the proposed unit for TBI/SCI patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of TBI/SCI patients.

(ii) A program director that is a registered nurse.

(iii) Other professional disciplines required for a multi-disciplinary team approach to care.

(b) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the unit for TBI/SCI patients. At a minimum, the criteria shall address the required medical stability and the need for ancillary services, including dialysis services.

(ii) The transfer of patients requiring care at other health care facilities, including a transfer agreement with one or more acute-care hospitals in the region to provide emergency medical treatment to any patient who requires such care.

(iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge, including support services to be provided by transitional living programs or other outpatient programs or services offered as part of a continuum of care to TBI patients by the applicant.

(iv) Utilization review, which shall consider the rehabilitation necessity for the service, quality of patient care, rates of utilization and other considerations generally accepted as appropriate for review.

(v) Quality assurance and assessment program to assure that services furnished to TBI/SCI patients meet professional recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the TBI patient receiving such services.

(7) An applicant for beds from the statewide pool for special population groups allocated to behavioral patients shall agree that if approved:

(a) An applicant shall staff the proposed unit for behavioral patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of behavioral patients.

(ii) A program director that is a registered nurse.

(iii) Other professional disciplines required for a multi-disciplinary team approach to care.

(b) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the unit for behavioral patients.

(ii) The transfer of patients requiring care at other health care facilities, including a transfer agreement with one or more acute-care hospitals in the region to provide emergency medical treatment to any patient who requires such care.

(iii) Utilization review, which shall consider the rehabilitation necessity for the service, quality of patient care, rates of utilization and other considerations generally accepted as appropriate for review.

(iv) quality assurance and assessment program to assure that services furnished to behavioral patients meet professional recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the behavioral patient receiving such services.

(v) Orientation and annual education/competencies for all staff, which shall include care guidelines, specialized communication, and patient safety.

Section 10. Comparative reviews, effect on prior CON review standards

Sec. 10. (1) Projects proposed under Section 4 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(2) Projects proposed under Section 5 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(3) Projects proposed under Section 6 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(4) Projects proposed under Section 7 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(5) These CON review standards supercede and replace the CON Review Standards for Nursing Home and Long-term Care Unit Beds--Addendum for Special Population Groups approved by the Commission on April 30, 2008 and effective on June 20, 2008.

Cardiac Catheterization Standard Advisory Committee
Report to the Certificate of Need Commission
December 11, 2014

Mr. Chairman,

The Cardiac Catheterization Standard Advisory Committee (CC SAC) was approved by the Commission on January 28, 2014. Since the last report from the committee, the CC SAC met on October 8 and November 6. As indicated in the previous report, Dr. Greg Dehmer, Chair and senior author of the SCAI/ACC/AHA Expert Consensus Document: "2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup" presented to the committee at the October meeting. The substance of his presentation was to demonstrate how the consensus document was developed. In addition, the quality and access subcommittees gave reports to the CC SAC and specific issues were agreed upon, including minimum volumes for facilities (200) and operators (50). Despite the committee's efforts, recommendations in response to the total charge were not reached during the October meeting.

Extensive discussions took place during the November meeting regarding "decoupling" therapeutic cardiac catheterizations relative to on-site open heart surgery services. Additional discussions centered on the quality metrics for new and existing programs. A decision in principle was made to allow the performance of therapeutic cardiac catheterizations without on-site surgical backup. The committee also agreed to recommend quality standards for "new" programs as well as standards for existing programs. It is anticipated that the language for these recommendations will be finalized at the December 17 meeting and presented to the commission at the March, 2015 meeting.

Respectfully submitted,

Renee Turner-Bailey, M.H.S.A.
International Union, UAW

12-1-14 Megavoltage Radiation Therapy (MRT) Services/Units Standards

Four meetings have been held, July 30, 2014 and August 28, 2014, October 2, 2014, November 19 2014. No future meetings are scheduled. Please recall that the charge approved by the CON commission chairperson Jan 28 2014 included 6 areas to review and make recommendations.

1. Update and clarify the definition of a "special purpose MRT unit" to reflect new technologies.
    a. The consensus of the group was that: A special purpose MRT unit is one that is dedicated to providing radiosurgery (1-5 fractions), total body irradiation, total skin irradiation, or IORT. The MRT SAC concerned itself only with the units providing radiosurgery and no changes to the total body irradiation, total skin irradiation, or IORT sections were recommended.
    b. If a unit is dedicated to providing radiosurgery, the consensus was that "dedicated" means that 90 percent of cases performed on the unit would be for radiosurgery (1-5 fractions)/total body irradiation/or IMRT and only 10 percent for conventional treatments. Otherwise, this would be considered as a non-special unit.
    c. The MRT SAC had consensus that "stand-alone" special purpose MRT services in which the only device(s) are special purpose units should be disallowed.
    d. The MRT SAC recommends that an existing non-special MRT unit may be replaced by a special MRT unit but not vice versa. This would only be permissible if a center has more than one MRT unit.
    e. There is currently a contractual obligation with a neurosurgeon required in order to have a cyberknife or gamma knife. The MRT SAC recommended eliminating this requirement.
    f. The MRT SAC considered the use of gating and makes the following recommendation. "Gating" also called "Motion management" is considered to be more time consuming and was therefore assigned an ETV of 1. This ETV would be in addition to the usual ETV multiplier assigned based on the use of simple, complex, IMRT methods, etc.
    g. Updated definitions for the terms "megavoltage radiation therapy," and "dedicated stereotactic radiosurgery," "gating," as well as "simulator" were constructed.
    h. The MRT SAC requests that the Department no longer track cases treated with IGRT. This is because in the near future the IGRT billing codes will be bundled with IMRT codes.
    i. Specific language reflecting the changes outlined in 1a through 1h were proposed and accepted by the SAC.
2. Review and revise the current definition and use of a "Cyber Knife."
    a. Until recently, Cyber Knife was used exclusively for radiosurgery applications, the addition of multileaf collimator to this device may facilitate treatment with conventional fractionation as well.
    b. There was consensus that the use of a trade name such as "Cyber Knife" or "Gamma Knife" in the standards should be avoided. Such units would be defined as either dedicated radiosurgery devices (i.e. more than 90 percent of cases treated in 1-5

fractions), or alternatively (in the case of a cyberknife) could be designated as non-special unit. In that instance, the somewhat more stringent requirements of non-special unit would apply.

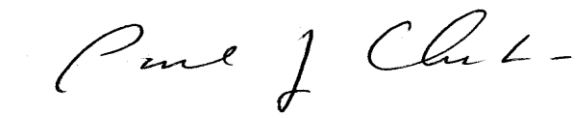
c. Specific language reflecting these changes was proposed and accepted by the SAC.

3. Determine and add language that addresses the expansion of more than one special purpose MRT unit.
    a. It was proposed that expansion of an MRT service could include more than one "special purpose MRT unit." A service would include at least one non-special unit but more than one special purpose unit could be allowed.
    b. Specific language reflecting this change was proposed and accepted by the SAC.
4. Consider methodologies of need that utilize patient residence data.
    a. The purpose of this charge appears to be to make it easier for new MRT services to emerge in rural or underserved areas.
    b. The Department provided an analysis to examine whether early stage breast cancer patients may choose mastectomy instead of combined lumpectomy and radiation based on geographic location. (This would imply a problem with access to MRT facilities). It was determined that a very small fraction of patients would be affected by geographic access issues. The Department has provided data showing that less than 2 percent of the population travels significant distance for radiation treatment.
    c. The argument was made that previous workgroups made it easier for rural areas to start-up radiation services. However, it appears that economic factors rather than CON standard requirements have inhibited rural start-ups.
    d. A subcommittee was formed to examine charge "4." There was no change in the standard recommended by the subcommittee. The full MRT-SAC also recommended no change in the standard.
5. Develop specific measurable quality metrics in the project delivery requirements.
    a. Quality metrics currently defined in the project delivery requirements include:
        i. Evidence of a cancer treatment program approved by the American College of Surgeons Commission on Cancer and participation in the ACOS Commission on Cancer.
        ii. Evidence of accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or the Healthcare Facilities Accreditation Program (HCAP) within the first three years of operation and continue to participate annually thereafter.
        iii. Evidence of accreditation by the American College of Radiology (ACR), the American Society for Radiation Oncology (ASTRO), or the American College of Radiation Oncology (ACRO) within the first three years of operation and continue to participate annually thereafter.
    b. These requirements were reviewed with examples provided.
    c. There was also public comment regarding the possibility of additional requirements to address quality especially with respect to the use of intensity modulated radiation therapy.

d. Discussion of possible additional quality metrics was centered around:
    i. Requirement for participation in MROCQ program. One of the leaders of the MROCQ program, Dr. Jim Hayman, was part of the SAC and did not support that. An important obstacle to this may also be funding by the BCBSM.
    ii. Requirement to make the results of the ACOS survey public (see below).
    iii. Asking the Department to track specific cancer cases. It was not clear what one would do with the results of the tracking.
e. A motion to make the results of the ACOS survey public was put forward by Dr. Bruce Carl but did not pass. (Some cancer programs have voluntarily published the ACOS survey results). Briefly, the consensus was that the ACOS surveys go beyond the scope of the MRT SAC and requiring publication could lead to unintended consequences. For example, the ACOS survey also includes surgical and medical oncology.

6. Consider any technical or other changes from the Department, e.g., updates or modifications consistent with other CON review standards and the Public Health Code.
    a. The department presented the proposed updates and modifications without objection.
    b. Specific language reflecting these changes was proposed and accepted by the SAC.

Respectfully Submitted,



Paul Chuba MD PhD FACR

Department of Radiation Oncology

St. John Macomb Oakland Hospital

11800 E 12 Mile Rd, Warren, MI 48093

CERTIFICATE OF NEED (CON) COMMISSION BYLAWS

ARTICLE I	-	PREAMBLE
ARTICLE II	-	DEFINITIONS
ARTICLE III	-	GENERAL PURPOSE
ARTICLE IV	-	MEMBERSHIP OF THE COMMISSION
ARTICLE V	-	MEETINGS OF THE COMMISSION
ARTICLE VI	-	OFFICERS AND PROCEDURES FOR ELECTING OFFICERS
ARTICLE VII	-	COMMITTEES
ARTICLE VIII	-	PROCEDURE AND LEGAL COUNSEL
ARTICLE IX	-	STANDARDS OF CONDUCT BY COMMISSION MEMBERS AND CONFLICT OF INTEREST PROVISIONS
ARTICLE X	-	AMENDMENTS OF BYLAWS

ARTICLE I - PREAMBLE

The Michigan CON Commission (Commission) is created in the Michigan Department of Community Health (the Department) and is established under the Michigan Public Health Code, 1978 PA 368, MCL 333.1101, et seq., as amended (the Code). The Bylaws developed by the Commission remain in effect until amended as provided for in Article X.

ARTICLE II - DEFINITIONS

Unless defined in these Bylaws, the terms used in these Bylaws have the meaning ascribed to them in Parts 201 and 222 of the Code.

ARTICLE III - GENERAL PURPOSE

The duties of the Commission are set forth in Section 22215 of the Code. The Commission exercises its duties to promote all of the following:

A. The availability and accessibility of quality health services at reasonable cost and with reasonable geographic proximity for all people in the state;

B. Appropriate differential consideration of the health care needs of residents in rural counties in ways that do not compromise the quality and affordability of health care services for those residents; and

C. Consideration of the impact of a proposed restriction on the acquisition of or availability of covered clinical services on the quality, accessibility, and cost of health services in this state.

ARTICLE IV - MEMBERSHIP OF THE COMMISSION

A. Size and Composition

The Commission consists of 11 members as designated under Section 22211 of the Code.

B. Term of Office

Commission members will serve a term as set forth in Section 22211(3) of the Code.

ARTICLE V - MEETINGS OF THE COMMISSION

A. Quorum, Voting Procedures, and Proxy Votes

1. Section 22213 of the Code defines a quorum for the Commission. With an 11 member Commission, a quorum is 6 of the 11 members appointed and serving.

2. Final action by the Commission shall be only by affirmative vote of a majority of the Commission members appointed and serving. Any action taken in the absence of a quorum is invalid. If the Commission properly notices a meeting under the Open Meetings Act, but lacks a quorum when it actually convenes, the Commission members in attendance may receive reports and comments from the public or from the Department, ask questions, and comment on matters of interest.

3. Commission members cannot assign a proxy.

B. Compliance with Open Meetings Act

The Commission must adhere to the provisions of the Michigan Open Meetings Act, 1976 PA 267, as amended, MCL 15.261, et seq.

C. Governance under Robert's Rules of Order Revised

The Commission's procedural activities are governed by Robert's Rules of Order Newly Revised if they are consistent with state law and these Bylaws.

D. Regular and Special Meetings

1. In September, the Commission must announce the regular meeting dates for the following year. Special meetings may be called as provided for in Section 22213 of the Code.

2. A regular or special meeting of the Commission may be recessed and reconvened consistent with the provisions of the Michigan Open Meetings Act, 1976 PA 267, as amended, MCL 15.261, et seq.

E. Meeting Attendance

1. Commission members are expected to attend all regular and special meetings except on those occasions where good cause exists.

2. When a Commission member will be unable to attend a regular or special meeting, every effort should be made to give advance notice to the

Department, which must notify the Commission chairperson or vice-chairperson.

3. The Commission chairperson determines whether good cause exists for the absence of a member from a regular or special meeting of the Commission. When the attendance of the chairperson is under question, the responsibility for determining good cause falls to the Commission vice-chairperson.

4. Pursuant to the Code, the Governor may remove a Commission member from office for failure to attend 3 consecutive meetings in a 1-year period. The Commission chairperson must promptly inform the Governor's office (a) if a member fails to attend the statutory minimum number of consecutive meetings in a 1-year period, and (b) indicate whether good cause existed for such absences.

F. Teleconferencing

Commission members may participate in meetings by teleconferencing consistent with the Open Meetings Act (1976 PA 267, as amended, MCL 15.261. et seq). Upon approval of the Chairperson, Commission members may appear at a meeting via electronic device, including speaker phone or interactive television, provided that a quorum is present at the meeting site and all individuals attending the meeting can hear, and can be heard by, the Commissioner(s) attending via electronic device. Commission members participating in meetings by teleconference cannot use teleconferencing to vote but may speak on matters being considered.

G. Agenda and Background Materials

1. In consultation with the Department and other Commission members, the chairperson must set a tentative agenda for each meeting.

2. No later than 7 days before each meeting, the Department must place the tentative agenda on the appropriate section of the Department's Web site.

3. No later than 5 days before each meeting, the Department must deliver the text for any CON review standards for proposed or final actions and relevant background to each Commissioner (using overnight delivery or Email, as necessary) and post it on the appropriate section of the Department's Web site. At the start of a meeting, the Commission, by unanimous approval, may add CON review standards, that meet statutory requirements for proposed or final action, to the agenda.

ARTICLE VI - OFFICERS AND PROCEDURES FOR ELECTING OFFICERS

A. Election of Chairperson and Vice-Chairperson

On an annual basis, the Commission must elect a chairperson and vice-chairperson for a 1-year term not to exceed 3 consecutive terms. The chairperson and vice-chairperson cannot be members of the same major political party.

B. Procedures for Selecting Officers

1. Any Commission member may nominate officers if the member is appointed and serving and attending the meeting where the selection of officers is to occur.

2. Officers are elected by a majority vote by the Commission members appointed and serving.

C. Responsibilities of Officers

1. The chairperson presides over Commission meetings. In the chairperson's absence, the vice-chairperson presides over the Commission meetings. If neither the chairperson nor vice-chairperson is able to preside over any portion of a meeting, the remaining members of the Commission must select a temporary presiding officer.

2. In the chairperson's absence, the vice-chairperson or the temporary presiding officer will perform the duties designated to the chairperson in the Code and these Bylaws.

D. Filling Vacancies in Officers

1. If the office of chairperson becomes vacant for any reason, the vice-chairperson must vacate the vice-chairperson position and serve as the chairperson for the remaining months of the chairperson's 1-year term.

2. If the office of vice-chairperson becomes vacant for any reason, the Commission must elect a new vice-chairperson by an affirmative vote of a majority of those members appointed and serving, and that person will serve the remaining months of the vice-chairperson's term.

3. If the offices of chairperson and vice- chairperson become vacant simultaneously, the Commission must conduct a special election to fill those positions. New officers must be elected by an affirmative vote of a majority of those members appointed and serving and they must serve the remaining months of the chairperson's and vice-chairperson's term.

ARTICLE VII – COMMITTEES

A. Standing New Medical Technology Advisory Committee (NEWTAC)

Composition and duties of the NEWTAC are set forth in Section 22241 of the Code.

B. Standard Advisory Committee (SAC)

If the Commission determines it necessary, it may appoint a SAC to assist in the development of proposed CON review standards in accordance with Section 333.22215(1)(I).

1. The Commission must adopt the duties for a SAC. The duties of the SAC must be defined in a written charge. The written charge to the SAC may be adopted by vote of the Commission, or the Commission may instruct the chairperson to write the charge, consistent with the language adopted by the Commission.

2. The term of any SAC expires 6 months from the first meeting of the SAC or at an earlier date as specified by the Commission.

3. The chairperson appoints the members of a SAC consistent with statutory requirements and the criteria outlined in this subpart.

    a. The Department determines whether a candidate for a SAC meets the following criteria:

        i. The candidate has not served on more than 2 SACs within any 2-year period.

        ii. The candidate is not a lobbyist registered under 1978 PA 472, MCL 4.411 TO 4.431.

        iii. The candidate is not affiliated with a program with a Letter of Intent (LOI) or a pending application in the CON process related to the standard(s) being reviewed.

    b. A SAC consists of a 2/3 majority of experts with professional competence in the subject matter of the proposed standard. The Department determines whether a candidate seeking to be appointed as an expert to a SAC meets the following criteria:

        i. The candidate is a clinician, e.g., doctor, nurse, or other health care professional, who has specific education, training, and experience in the service being considered; or the candidate is a representative of

an organization concerned with licensed health facilities, e.g., administrator or a specialist in the subject matter of the standard being reviewed, who have specific education, training, and experience in the service being considered.

ii. Professional competence demonstrated by relevant professional activity over a majority of the last five years.

c. A SAC includes representatives of health care provider organizations concerned with licensed health facilities or licensed health professions, as well as representatives of organizations concerned with health care consumers, and the purchasers and payers of health care services.

~~d. Only one employee, director, or officer of any one health system, either directly or through the subsidiaries of a system can be appointed as a member of the same SAC. For purposes of these Bylaws, "health system" means facilities where health care is provided and includes without limitation hospitals, nursing homes, county medical care facilities, home health agencies, hospices, out-patient surgical facilities, laboratories, rural health clinics, freestanding surgical units, ambulatory surgical units, and end stage renal disease and dialysis facilities.~~

4. The Commission chairperson appoints the chairperson of a SAC.

C. Members of the NEWTAC and a SAC are subject to the following provisions:

1. Conflicts of interest consistent with Article IX of these Bylaws.

2. Teleconferencing consistent with Article V(F) of these Bylaws.

3. Michigan Open Meetings Act, 1976 PA 267, as amended, MCL 15.261, et seq.

ARTICLE VIII - PROCEDURE AND LEGAL COUNSEL

A. The presiding officer will use the laws of the State, these Bylaws, and Robert's Rules of Order Newly Revised to resolve any question arising concerning procedure at a meeting of the Commission.

B. The Attorney General of the State of Michigan, or the duly designated Assistant Attorney General, serves as legal counsel to the Commission.

ARTICLE IX - STANDARDS OF CONDUCT BY COMMISSION MEMBERS AND CONFLICT OF INTEREST PROVISIONS

A. Commission members are subject to the provisions of:

1. 1968 PA 317, MCL 15.321 to 15.330 (contracts of public servants with public entities);

2. 1973 PA 196, MCL 15.341 to 15.348 (code of ethics for public officers and employees); and

3. 1978 PA 472, MCL 4.411 to 4.431, (lobbyists and lobbying regulation).

B. Definition - Conflict of Interest

1. Under the State Ethics Act, 1973 PA 196, MCL 15.341, et seq, and in accordance with the Advisory Opinion of the State Board of Ethics of November 5, 2004, a conflict of interest for Commission members exists when the individual member has a financial or personal interest in a matter under consideration by the Commission. The personal interest of a Commission member includes the interest of the member's employer, even though the member may not receive monetary or pecuniary remuneration as a result of an adopted CON review standard.

2. A Commission member does not violate the State Ethics Act if the member abstains from deliberating and voting upon the matter in which the member's personal interest is involved.

3. A Commission member may deliberate and vote on matters of general applicability that do not exclusively benefit certain health care facilities or providers who employ the Commission member, even if the matter involves the member's employer or those for whom the member's employer does work.

4. Deliberating includes all discussions of the pertinent subject matter, even before a motion being made.

C. Procedures - Conflict of Interest

1. A Commission member must disclose any potential conflict of interest after the start of a meeting, when the Commission begins to consider a substantive matter, or, where consideration has already commenced, when a conflict or potential conflict of interest becomes apparent to the member.

2. After a meeting is called to order and the agenda reviewed, the chairperson must inquire whether any Commission member has a conflict or potential conflict of interest with regard to any matters on the agenda.

3. A Commission member who is disqualified from deliberating and voting on a matter under consideration due to a conflict of interest may not be counted to establish a quorum regarding that particular matter.

4. Where a Commission member has not discerned any conflict of interest, any other Commission member may raise a concern whether another member has a conflict of interest on a matter. If a second member joins in the concern, the Commission must discuss and vote on whether the member has a conflict of interest before continuing discussion or taking any action on the matter under consideration. The question of conflict of interest is settled by an affirmative vote of a majority of those Commission members appointed and serving, excluding the member or members in question.

5. The minutes of the meeting must reflect when a conflict of interest had been determined and that an abstention from deliberation and voting had occurred.

ARTICLE X - AMENDMENT OF BYLAWS

A. At a regular or special meeting, a majority of Commission members appointed and serving may propose an amendment to these Bylaws. Any proposal by the Commission to amend these Bylaws must be made at least 30 days in advance of the meeting where final action regarding the amendment is taken.

B. Any Commission member may propose an amendment to these Bylaws. Any proposal by a Commission member to amend these Bylaws must be presented to the Commission and the Department, in writing, at least 30 days in advance of the meeting where final action regarding the amendment is taken.

C. The Department may propose an amendment to these Bylaws. Any proposal by the Department to amend these Bylaws must be presented to the Commission, in writing, at least 30 days in advance of the meeting where final action regarding the amendment is taken.

D. Any amendments to these Bylaws become effective on the date the Commission takes final action to approve the amendment or on a later date if specified in the amendment.

E. Upon adoption of any amendment to these Bylaws, the Department must provide the Commission members with a copy of the updated Bylaws.

F. These Bylaws supercede and replace the Bylaws approved and amended by the Commission on ~~March 25~~June 10, 2010.

STATE OF MICHIGAN

RICK SNYDER, Governor

Michigan Certificate of Need Commission

CAPITOL VIEW BUILDING
201 TOWNSEND STREET
LANSING, MI 48913
Phone: (517) 335-6708
Fax: (517) 241-1200

Commissioners:
Denise Brooks-Williams
Gail J. Clarkson, RN
Kathleen Cowling, DO
James B. Falahee, Jr, JD
Charles M. Gayney
Robert L. Hughes
Marc D. Keshishian, MD, Chairperson
Jessica A. Kochin
Gay L. Landstrom
Suresh Mukherji, MD, Vice-Chairperson
Luis A. Tomatis, MD

MEMORANDUM

Date: December 11, 2014

To: Joint Legislative Committee (JLC)

From: Certificate of Need (CON) Commission

RE: Recommendations Pertaining to the CON Program

MCL 333.22215(1)(f) requires the Commission, by January 1, 2005, and every 2 years after January 1, 2005, to "make recommendations to the joint committee regarding statutory changes to improve or eliminate the certificate of need program."

At the outset, we would like to remind the JLC that the CON Commission is composed of 11 volunteers and oversees 15 covered services. The CON Commissioners receive no compensation for their services, other than reimbursement for travel expenses. The Commission meets five times per year and all meetings are held in Lansing. Every CON Commission meeting is open to the public and subject to the Open Meetings Act. Each CON Commission meeting starts with a declaration of conflicts of interests.

The Commission respectfully submits the following:

Based on our continuous review of the program, the Commission believes and unanimously recommends that the program should be fully supported as it is serving a valuable need. In our bipartisan judgment, we strongly believe the current CON process meets the three statutory objectives for the program, i.e., affordability, accessibility, and quality of health care in Michigan. Members of the Commission as well as staff met with members of the Legislature throughout the past two years and in particular during the summer of 2013 during the House of Representatives CON Workgroup. Commissioners, including the Chairperson and Vice-Chairperson, were available to the House of Representatives CON Workgroup to assist in explaining CON history and processes as well as providing input to the deliberations. As a result, the House of Representatives CON Workgroup decided that due to its complexity, the CON process needed further evaluation if any changes are to be recommended. The Commission supports this finding, and we look forward to working with the Legislature to assist in the evaluation.

In addition to the responsibility of submitting the 2-year report to the JLC, MCL 333.22215(1)(e) of the CON law requires the Commission to "Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission." Copies of FY2013 and FY2014 CON Program Annual Activity Reports are being provided with this Memo. Along with these annual reports, the Department provides quarterly program section performance reports to the Commission. These reports demonstrate the effectiveness of the CON program in processing letters of intent, applications, emergency applications, and amendments, as well as issuing decisions within the specified time frames set forth in the Administrative Rules.

Pursuant to MCL 333.22215 (1)(m), the CON Commission is to "… review and, if necessary, revise each set of certificate of need review standards at least every 3 years." A Public Comment Period is held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. The following review standards are up for review in 2015: Bone Marrow Transplantation (BMT) Services, Heart/Lung and Liver Transplantation Services, Magnetic Resonance Imaging (MRI) Services, Psychiatric Beds and Services. Currently, there are Standard Advisory Committees (SACs) reviewing CON Review Standards for Cardiac Catheterization Services and CON Review Standards for Megavoltage Radiation Therapy (MRT) Services/Units. There is a workgroup reviewing CON Review Standards for Positron Emission Tomography (PET) Scanner Services. The Commission actively seeks input from the public and always includes opportunities for public comment/hearings prior to any Commission action.

We would like to provide the JLC a brief summary of our activities and accomplishments since the January, 2013 report. In the last two years, the Commission has updated 13 of the 15 Review Standards for covered services. In some instances, technical changes were made to modernize standards. For example, all applicable standards were updated to include International Disease Codes version 10 conversion charts to reflect the healthcare industry transition to this new diagnosis coding system. In other instances, major changes were made to benefit the cost, quality and access of healthcare for Michigan citizens. Some examples include specific quality measures added to Open Heart Surgery Standards, the inclusion of national safety standards for Special Newborn Nursing Services in the Neonatal Intensive Care Unit (NICU) Standards, and revision to the Computed Tomography (CT) methodology to reflect current coding practices that will ensure better accuracy in determining need. All of these changes, both technical and policy, have been made with the multiple opportunities for public input and with the recommendations of subject matter experts.

Further, in continuing to fulfill our legislative charge in MCL 333.22215 (1)(a) to “revise, add to, or delete one or more of the covered clinical services”, the Commission engaged in discussion to end the CON regulation of Air Ambulance Services due to federal law that limits the ability for states to limit the number of Air Ambulance services with need-based standards. The Commission worked closely with the Emergency Medical Services administration to determine a path to continue regulating the quality of Air Ambulance services through already established programs within the Department while defining a strategy for discontinuing CON oversight at the appropriate time. A summary of all of the approved changes to various CON Review Standards is attached.

The CON Commission appreciates the continuing support of the Governor and the Legislature for the CON program.

Respectfully yours,

Marc D. Keshishian, MD, Chairperson

Suresh K. Mukherji, MD, FACR, Vice-Chairperson

Denise Brooks-Williams

Gail J. Clarkson, RN

Kathleen Cowling, DO

James B. Falahee, Jr., JD

Charles M. Gayney

Robert L. Hughes

Jessica A. Kochin

Gay L. Landstrom, RN

Luis A. Tomatis, MD

c: Nick Lyon, Director, MDCH
Tim Becker, Chief Deputy Director, MDCH
Elizabeth Hertel, Director of Health Policy and Innovation, MDCH
Joseph Potchen, First Assistant Attorney General, Attorney General's Office
Scott Blakeney, Director, Health Policy and Organizational Support, MDCH
Tulika Bhattacharya, Manager, CON Evaluation Section, MDCH
Beth Nagel, Manager, Planning and Access to Care Section, MDCH
Brenda Rogers, Special Assistant to the CON Commission, Planning and Access to Care Section, MDCH

SUMMARY OF CON REVIEW STANDARDS REVISIONS
(FY2013 – FY2014)

During FY2013, the Certificate of Need Commission revised the review standards for Bone Marrow Transplantation (BMT) Services, Magnetic Resonance Imaging (MRI) Services, Megavoltage Radiation Therapy (MRT) Services/Units, and Psychiatric Beds and Services.

The revisions to the CON Review Standards for BMT Services include the following and have been implemented.

- Section 1 - Modified for consistency with other CON review standards.
- Section 2 - Definitions used only in certain section(s) were moved to the applicable section to make it easier for the reader to identify the defined terms, and other definitions were updated.
    - "Acquisition of a BMT service" was moved to Section 4.
    - "Initiate a BMT service" was moved to Section 3.
- Section 6 - Updated Medicaid participation section consistent with other CON review standards.
- Section 7 - Divided project delivery requirements into distinct groups (quality assurance, access to care, and monitoring and reporting).
- Appendix A - Health Service Areas moved to an Appendix consistent with other CON review standards.
- Other technical changes.

The revisions to the CON Review Standards for MRI Services include the following and have been implemented:

- Section 2 - Definitions were modified and/or moved to applicable section.
- Section 4 - Clarified replace and upgrade definitions. Added a new definition for "repair an existing MRI unit." This is to allow components of an MRI unit to be repaired if under a service/maintenance agreement.
    - Under subsection (3), added a one-time replacement of an existing MRI unit that is below 1 tesla with an MRI unit that is a 1 tesla or higher outside of volume requirements.
    - Under subsection (4), added requirements to allow replacement of an existing mobile MRI host site to a new location similar to other CON standards.
- Section 7 - Modified for consistency with other CON review standards in that the applicant agrees that the dedicated research MRI unit will be used primarily (70% or more of the procedures) for research purposes only.
- Section 11 - Added requirements similar to intraoperative MRI (IMRI) to initiate, replace, or acquire an MRI simulator that will not be used solely for MRT treatment planning purposes.
- Section 14 - Divided requirements into distinct groups consistent with other standards (quality assurance, access to care, and monitoring and reporting).
    - Under subsection (2)(d)(i)(D), revised to align with the "American College of Radiology (ACR) Practice Guideline for Performing and Interpreting Magnetic Resonance Imaging (MRI)" language on MRI accreditation to ensure consistency with national standards.

    - Under subsection (4)(b), added reporting requirement for MRI simulators approved under Section 11.
- Section 15 - Increased the base value for functional MRI (fMRI) procedures, MRI-guided interventions, and cardiac MRI procedures, and added definitions for these procedures too.
- Other technical edits.

The revisions to the CON Review Standards for MRT Services/Units include the following and have been implemented:

- Section 2 - Definitions were eliminated as they are no longer necessary, and a new definition was added.
    - "Excess Equivalent Treatment Visits (ETVs)" means the number of ETVs performed by an existing MRT service in excess of 10,000 per MRT unit. The number of MRT units used to compute excess ETVs shall include both existing and approved but not yet operational MRT units. In the case of an MRT service that operates or has a valid CON to operate that has more than one MRT unit at the same site, the term means number of ETVs in excess of 10,000 multiplied by the number of MRT units at the same site. For example, if an MRT service operates, or has a valid CON to operate, two MRT units at the same site, the excess ETVs is the number that is in excess of 20,000 (10,000 x 2) ETVs.
- Old Section 3 - Eliminated as it's no longer needed due to other changes within the standard.
- New Section 3 - Added language to allow for greater geographic access in Planning Area 8. An applicant will be exempt from projecting ETVs for initiation if it meets other specific criteria.
- Section 9 - New methodology for projecting ETVs – projections will be based on the historical MRT volume of treating physicians. "Treating physician" is defined as the staff physician of the MRT service directing and providing the MRT treatment, not the referring physician. This models the language in the CON Review Standards for Computed Tomography (CT) Scanner Services.
- Old sections 12 and 13 - Eliminated as they are no longer needed due to other changes within the standard.
- New Section 11 - Added requirements to be accredited by the American College of Surgeons Commission on Cancer, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or the Healthcare Facilities Accreditation Program (HFAP) and to be accredited by the American College of Radiology/American Society for Radiation Oncology (ACR/ASTRO) or the American College of Radiation Oncology (ACRO).
    - Under subsection (4)(b), MRT units approved pursuant to Section 3(3) in Planning Area 8 shall be operating at a minimum average volume of 5,500 ETVs annually.
- Old Appendices A and B - Eliminated as they are no longer needed.
- Other technical changes.

The revisions to the CON Review Standards for Psychiatric Beds and Services include the following and have been implemented:

- Section 1 - Modified for consistency with other CON review standards.

- Section 2 - Definitions were modified and new definitions were added.
    - "Flex bed" is defined as an existing adult psychiatric bed converted to a child/adolescent psychiatric bed in an existing child/adolescent psychiatric service to accommodate during peak periods and meet patient demand.
    - "Relocate existing licensed inpatient psychiatric beds" means a change in the location of existing inpatient psychiatric beds from the existing licensed psychiatric hospital site to a different existing licensed psychiatric hospital site within the same planning area. This definition does not apply to projects involving replacement beds in a psychiatric hospital or unit governed by Section 7 of these standards.
- Section 3 - The bed need methodology was run using the base year of 2010 and a planning year of 2015 (The bed need numbers were given immediate effect).
- Section 4 - Updated consistent with other standards and current practice. The bed need numbers will continue to be posted on the web site as part of the Psychiatric bed inventory, and the appendix in the standards will be eliminated.
- Section 7 - Modified for consistency with other CON review standards.
- Section 8 - Added requirements to allow for relocation of existing licensed inpatient psychiatric beds consistent with other standards.
- Section 9 – Requirements for approval to increase beds were updated.
    - Under subsection (2), defined calculation for average occupancy rate and modified the time period from 24 months to 12 months.
    - Under subsection (3), modified the time period from 24 months to 12 months and added a calculation for high occupancy for facilities with flex beds.
    - Added requirements under subsection (10) for a facility receiving licensed inpatient psychiatric beds under relocation (Section 8) consistent with other standards.
- Section 10 - Added new section for flex beds. This will allow for a facility with an existing adult psychiatric service and an existing child/adolescent psychiatric service to convert adult psychiatric beds to child/adolescent psychiatric beds to accommodate during peak periods and meet patient demand.
    - The existing adult psychiatric service/unit shall not become non-compliant with the minimum size requirements within section 6(4).
    - The applicant shall meet all applicable sections of the standards.
    - The facility shall be in compliance and meet all design standards of the most recent Minimum Design Standards for Health Care Facilities in Michigan.
    - The applicant shall convert the beds back to adult inpatient psychiatric beds if the bed has not been used as a flex bed serving a child/adolescent patient for a continuous 12-month period or if the CON application is withdrawn.
- Section 14 - Divided requirements into distinct groups consistent with other standards (quality assurance, access to care, and monitoring and reporting).
    - Under subsection (4), added the calculation for average occupancy.
- Updated/eliminated Appendices as applicable.
- Other technical changes.

During FY2014, the CON Commission revised the review standards for Air Ambulance Services, Bone Marrow Transplantation (BMT) Services, Cardiac Catheterization Services, Computed Tomography (CT) Services, Hospital Beds, Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services, Open Heart Surgery (OHS) Services, Positron Emission

Tomography (PET) Scanner Services, and Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services/Units.

The revisions to the CON Review Standards for Air Ambulance Services include the following and have been implemented:

- Section 1: Modified for consistency with other CON review standards. Relocation is a part of replacement.
- Section 2: Definitions have been moved to applicable sections if only used in that section. "Medicaid" definition has been removed as it is defined in Part 222 of the Public Health Code.
- Section 3: Removed "need" requirements for initiation.
- Section 4: Moved from Section 5 and removed "need" requirements for replacement. Added subsection (5) as a technical edit consistent with initiation and acquisition.
- Section 5: Moved from Section 4 and removed "need" requirements for expansion. Added subsection (4) as a technical edit consistent with initiation and acquisition.
- Section 6: Removed "need" requirements for acquisition.
- Section 8: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (2), removed "need" based requirement for 275 patient transports annually.
- Section 9: "Need" based methodology removed.
- Other technical edits.
- Note: Due to federal law preventing states from regulating air ambulance based on need, all need requirements were removed.

The revisions to the CON Review Standards for BMT Services include the following and have been implemented:

- Section 2(1)(e): "Cancer Hospital" is being redefined and "means a hospital that has been approved as a comprehensive cancer center by the National Cancer Institute or operates a comprehensive cancer center as an affiliate of a Michigan university that is designated as a comprehensive cancer center by the National Cancer Institute."
- Section 4(1): Updated to reflect the removal of the PPS exemption requirement for acquisition by a cancer hospital.
- Section 4(2): Language added to allow for reacquisition of a BMT service by the current CON holder.
- Section 10(1): Technical edits.

The revisions to the CON Review Standards for Cardiac Catheterization Services include the following and have been implemented:

- Section 2: Definition moved to applicable Appendix.
- Subsection (1)(k): Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix B: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for CT Services include the following and have been implemented:

- Section 1: Modified for consistency with other CON review standards. Relocation is a part of replacement.
- Section 2: Definitions have been modified, definitions moved to applicable sections if only used in that section, and new definitions have been added.
    - "Billable procedure" has been modified.
    - "Bundled body scan" is a new definition and is defined as "two or more body scans billed as one CT procedure.
    - "CT-angio hybrid unit" is a new definition and is defined as "an integrated system comprised of both CT and angiography equipment sited in the same room that is designed specifically for interventional radiology or cardiac procedures. The CT unit is a guidance mechanism and is intended to be used as an adjunct to the procedure. The CT unit shall not be used for diagnostic studies unless the patient is currently undergoing a CT-angio hybrid procedure and is in need of a secondary diagnostic study."
    - "Initiate a CT scanner service" has been modified as relocation is a part of replacement.
    - "Metropolitan statistical area county" is included in Appendix B.
    - "Micropolitan statistical area county" is included in Appendix B.
    - Relocation terms combined with replacement terms and/or section.
    - "Replace an existing CT scanner" modified to include relocation.
    - "Rural county" is included in Appendix B.
- Section 3: Under new subsection (4), added requirements to initiate CT scanner services as an existing host site on a different mobile CT scanner service consistent with other CON review standards.
- Section 4: Modified to include initiation of mobile dental CT scanner services.
    - Under new subsection (6), added requirements to initiate mobile dental CT scanner services as an existing host site on a different mobile dental CT scanner service consistent with other CON review standards.
- Section 6: Modified to include expansion of an existing mobile dental CT scanner service.
- Section 7:
    - Removed volume requirements for replacement of an existing fixed, mobile, or dedicated pediatric CT scanner.
    - New subsection (2) moved from old Section 9(1) and modified accordingly consistent with other CON review standards.
    - New subsection (3) moved from old Section 9(2) and modified accordingly consistent with other CON review standards.
- Section 8:
    - Removed volume requirements for replacement of an existing dental CT scanner or service.
    - New subsection (2) moved from old Section 10(1) and modified accordingly consistent with other CON review standards.
    - New subsection (3) moved from old Section 10(2) and modified accordingly consistent with other CON review standards.
- Section 9: Modified acquisition volume requirement of 7,500 CT equivalents for mobile to 3,500 CT equivalents consistent with required maintenance volumes.
- Section 10: Modified to include acquisition of an existing mobile dental CT scanner service or an existing mobile dental CT scanner.

- Section 11: Added requirements for a dedicated research fixed CT scanner consistent with other CON review standards.
- Section 12: Moved from Section 16.
- Section 13: Removed pilot language and made the requirements for approval of a hospital-based portable CT scanner for initiation, expansion, replacement, and acquisition a permanent part of the standards.
- Section 15: Added requirements for approval of a CT-angio hybrid unit for initiation, replacement, and acquisition.
- Section 17: Added additional requirements for approval of a mobile dental CT scanner service.
- Section 20: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (4)(a), clarified language for maintenance volume requirements.
    - Under subsection (7), removed the reference to "pilot" program and updated language.
    - Under subsection (8), added project delivery requirements for CT-angio hybrid units.
- Section 22: Modified table for clarity and added "bundled body scan" with a conversion factor of 3.50 for adults and a conversion factor of 4.00 for pediatric/special needs patients.
- Section 23: Modified for clarity.
- Appendix A: Modified for consistency with other CON review standards.
- Other technical edits.

The revisions to the CON Review Standards for Hospital Beds include the following and have been implemented:

- Section 4: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix E: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for NICU and Special Newborn Nursing Services include the following and have been implemented:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been modified, definitions moved to applicable sections if only used in that section, and a new definition has been added for "special care nursery services" or "SCN services."
- Section 5: Moved from previous Section 7.
- Section 6: Moved from previous Section 6.
- Section 7: Moved from previous Section 5.
- Section 9: Added requirements to initiate, acquire, or replace SCN services.
- Section 12: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (3), added quality assurance requirements for SCN services.
    - Under subsection (5)(a)(i), added data reporting requirements for SCN services.
- Section 14: Added language to exempt SCN services from comparative review.
- Appendix B: Moved from previous Section 12.

- Other technical edits.

The revisions to the CON Review Standards for OHS Services include the following and have been implemented:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been modified and a new definition has been added as follows:
    - "Hospital" means a health facility licensed under part 215 of the code.
- Section 7: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (2)(b), reduced the minimum number of cases to be performed by the attending physician from 75 to 50 consistent with the national guidelines.
    - Under subsection (2)(c), added a requirement to participate with the Society of Thoracic Surgeons (STS) National Database and the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative and Database or a designee of the Department that monitors quality and risk adjusted outcomes.
    - Under subsection (4)(a), for consistency, the data that is submitted to the CON Annual Survey will be the same data that is submitted to the STS Database for consistency. The maintenance volume is being reduced from 300 to 150 adult open heart surgical cases a year.
    - Under subsection (4)(d) and (e), added requirements to utilize and report the STS Composite Star Rating System for all procedures.
- Section 8: Modified for clarification.
- Section 9: Modified for clarification.
- Appendix A: Updated utilizing the 2010 Michigan Inpatient Data Base (MIDB).
- Appendix B: Updated utilizing the 2010 Michigan Inpatient Data Base (MIDB).
- Other technical edits.

A second set of revisions to the CON Review Standards for OHS Services include the following and have been implemented:

- Section 2: Definition moved to applicable Appendix.
- Subsection (1)(m): Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Section 8(3): Modified for the CD-9-CM to ICD-10-CM Code translation.
- Section 9(1)(a) and (e), (2)(a) and (c), and (3): Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix A: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix B: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix C: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix E: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for PET Scanner Services include the following and have been implemented:

- Section 12(4): Modified for the ICD-9-CM to ICD-10-CM Code translation.

- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for UESWL Services/Units include the following and have been implemented:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been moved to applicable sections if only used in that section.
- Section 3: Modified definition as relocation is a part of replacement.
- Section 4: Modified as relocation is a part of replacement.
- Section 5: Moved from Section 8.
- Section 7: Moved from Section 5.
- Section 9: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
- Section 10: Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix A: Modified for the ICD-9-CM to ICD-10-CM Code translation.
    - Under subsection (1), updated the factor from .94 to 1.09.
    - Modified for clarity.
- Appendix B: Moved from Section 1.
- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

CERTIFICATE OF NEED

4th Quarter Compliance Report to the CON Commission

October 1, 2013 through September 30, 2014 (FY 2014)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients 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 tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

Activity	4th Quarter	Year-to-Date
Approved projects requiring 1-year follow up	94	350
Approved projects contacted on or before anniversary date	61	224
Approved projects completed on or before 1-year follow up	65%	
CON approvals expired	29	103
Total follow up correspondence sent	293	1,065
Total approved projects still ongoing	319	

Compliance: In accordance with Section 22247 and Rule 9419, the Department performs compliance checks on approved and operational Certificates of Need to determine if projects have been implemented, or if other applicable requirements have been met, in accordance with Part 222 of the Code.

The Department has taken the following actions:

- After a statewide review of the Open Heart Surgery data based on the 2010 Annual Survey, the Department opened 6 compliance investigations of Open Heart Surgery programs not meeting the approved volume requirement. The Department has completed collection of information and investigation of the same. The Department has conducted meetings with all 6 hospitals and is in the process of determining proposed compliance actions.

- After a statewide review of the Psychiatric Beds and Services data based on the 2010 Annual Survey, the Department opened 14 compliance investigations of adult and child/adolescent psychiatric programs not meeting the approved occupancy rates. The Department has completed collection of information and investigation of the same. The Department has closed 4 investigations based on more recent data and updated information. The Department has conducted meetings with the remaining 10 psychiatric hospitals (10 adult programs and 1 child/adolescent program) and has determined proposed compliance actions. The Department is working to finalize settlement agreements with the 10 programs to resolve these investigations.

- Michigan Institute for Neurological Disorders – This facility entered into a renewal lease for the fixed MRI unit without CON approval. The facility was required to correct the issue within an active CON and paid a civil fine of $2,750.

Source: Certificate of Need Evaluation Section, Michigan Department of Community Health.

CERTIFICATE OF NEED

4th Quarter Program Activity Report to the CON Commission

October 1, 2013 through September 30, 2014 (FY 2014)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Letters of Intent Received	100	N/A	333	N/A
Letters of Intent Processed within 15 days	100	100%	332	99%
Letters of Intent Processed Online	100	100%	333	100%

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Applications Received	60	N/A	235	N/A
Applications Processed within 15 Days	60	100%	235	100%
Applications Incomplete/More Information Needed	27	45%	157	67%
Applications Filed Online*	56	93%	217	99%
Application Fees Received Online*	13	23%	54	25%

* Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

Activity	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Nonsubstantive Applications	26	100%	119	100%
Substantive Applications	39	100%	130	100%
Comparative Applications	2	100%	6	100%

Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.

Measures – continued

Administrative Rule R325.9227 requires the Department to determine if an emergency application will be reviewed pursuant to Section 22235 of the Public Health Code within 10 working days upon receipt of the emergency application request.

Activity	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Emergency Applications Received	2	N/A	2	N/A
Decisions Issued within 10 workings Days	2	100%	2	100%

Administrative Rule R325.9413 requires the Department to process amendment requests within the same review period as the original application.

Activity	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Amendments	16	98%	59	98%

Section 22231(10) of the Public Health Code requires the Department to issue a refund of the application fee, upon written request, if the Director exceeds the time set forth in this section for a final decision for other than good cause as determined by the Commission.

Activity	4th Quarter	Year-to-Date
Refunds Issued Pursuant to Section 22231	0	0

Other Measures

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
FOIA Requests Received	88	N/A	197	N/A
FOIA Requests Processed on Time	86	98%	191	97%
Number of Applications Viewed Onsite	2	N/A	7	N/A

FOIA – Freedom of Information Act.

Source: Certificate of Need Evaluation Section, Michigan Department of Community Health.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) PROGRAM

ANNUAL ACTIVITY REPORT

October 2013 through September 2014
(FY2014)

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
Nick Lyon, Director

http://www.michigan.gov/con

MDCH is an Equal Opportunity Employer, Services and Program Provider

TABLE OF CONTENTS

Executive Summary 3

Historical Overview of Michigan's Certificate of Need Program 5

Administration of the Certificate of Need Program 6

Certificate of Need Process 7

Letters of Intent 8

Types of Certificate of Need Reviews 8

Emergency Certificates of Need 10

Proposed Decisions 10

Final Decisions 11

Certificate of Need Activity Comparison 14

Amendments 14

CON Capacity 15

Compliance Actions 16

Analysis of Certificate of Need Program Fees and Costs 16

Certificate of Need Commission Activity 18

APPENDIX I - CERTIFICATE OF NEED COMMISSION 23

EXECUTIVE SUMMARY

One of the Michigan Department of Community Health's (MDCH or Department) duties under Part 222 of the Public Health Code, MCL 333.22221(b), is to report to the Certificate of Need (CON) Commission annually on the Department's performance under this Part. This is the Department's 26th report to the Commission and covers the period beginning October 1, 2013, through September 30, 2014 (FY 2014). Data contained in this report may differ from prior reports due to updates subsequent to each report's publishing date.

Administration

The Department through its Policy and Planning Administration provides support for the CON Commission (Commission) and it's Standards Advisory Committees (SAC). The Commission is responsible for setting review standards and designating the list of covered services. The Commission may utilize a SAC to assist in the development of proposed CON review standards, which consists of a 2/3 majority of experts in the subject area. Further, the Commission, if determined necessary, may submit a request to the Department to engage the services of consultants or request the Department to contract with an organization for professional and technical assistance and advice or other services to assist the Commission in carrying out its duties and functions.

The Department, through its CON Evaluation Section, manages and reviews all incoming Letters of Intent, applications and amendments. These functions include determining if a CON is required for a proposed project as well as providing the necessary application materials, when applicable. In addition, the Section is responsible for monitoring implementation of approved projects, as well as the compliance with the terms and conditions of approvals.

During FY 2014, the Department has continued to make process improvements in both the Policy and Evaluation Sections. The Evaluation Section developed processes to implement the new CON fees approved under House Bill No. 4787; the new CON fees include additional categories other than the base application fees, i.e., LOI waiver fee, amendment fee, complex review fee, expedited processing fee, and annual survey fee. The revised CON administrative rules were promulgated and became effective in February 2014. The Section completed enhancements to the CON Annual Survey tool for collecting data as it relates to the project delivery requirements in various review standards; specifically, quality of care and access. The Section worked with the MDCH Medical Policy Unit to translate all of the ICD-9 codes to ICD-10 codes that appear in the CON review standards, application forms and annual survey tool. The Section also facilitated several webinars and seminars to reach out to the providers regarding implementation plans for the newly adopted Special Care Nursery CON standards.

The Policy Section assisted the Commission to make the necessary modifications to the CON Review standards to include International Disease Codes version 10 conversion charts to reflect the healthcare industry transition to this new diagnosis coding system; specific quality measures were added to standards; national safety standards for Special Newborn Nursing Services in the Neonatal Intensive Care Unit (NICU) Standards were added; revision to the Computed Tomography (CT) methodology to reflect current coding practices that will ensure better accuracy in determining need; and engaged in discussion to end the CON regulation of Air Ambulance Services due to federal law that limits the ability for states to limit the number of Air Ambulance services with need-based standards.

These initiatives have greatly increased the availability of CON-related information and data to improve and streamline the review process, better inform policy makers, and enhance community knowledge about Michigan's healthcare system.

CON Required

In accordance with MCL 333.22209, a person or entity is required to obtain a Certificate of Need, unless elsewhere specified in Part 222, for any of the following activities:

- Acquire an existing health facility or begin operation of a health facility
- Make a change in the bed capacity of a health facility
- Initiate, replace, or expand a covered clinical service
- Make a covered capital expenditure.

CON Application Process

To apply for a CON, the following steps must be completed:

- Letter of Intent filed and processed prior to submission of an application
- CON application filed on appropriate date as defined in the CON Administrative Rules
- Application reviewed by the Evaluation Section
- Issuance of Proposed Decision by the Policy and Planning Administration
    - Appeal if applicant disagrees with the Proposed Decision issued
- Issuance of the Final Decision by the MDCH Director.

There are three types of CON review: nonsubstantive, substantive individual, and comparative. The Administrative Rules for the CON program establish time lines by which the Department must issue a proposed decision on each CON application. The proposed decision for a nonsubstantive review must be issued within 45 days of the date the review cycle begins, 120 days for substantive individual, and 150 days for comparative reviews.

FY 2014 in Review

In FY 2014, there were 333 Letters of Intent received resulting in 235 applications filed for CON review and approval, including two (2) emergency applications. In addition, the Department received 63 amendments to previously approved applications. In total, the Department approved 251 proposed projects resulting in approximately $1,101,326,083 of new capital expenditures into Michigan's healthcare system. The Department also surveyed 1,191 facilities and collected statistical data.

As required by Administrative Rules, the Department was timely in processing Letters of Intent, pending CON applications and issuing its decisions on pending applications. These measures, along with the other information contained in this report, aid the Commission in its duties as set forth in Part 222 of the Public Health Code.

The CON Commission also reviewed and revised nine (9) different CON review standards including: Air Ambulance Services, Bone Marrow Transplantation (BMT) Services, Cardiac Catheterization Services, Computed Tomography (CT) Services, Hospital Beds, Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services, Open Heart Surgery (OHS) Services, Positron Emission Tomography (PET) Scanner Services, and Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services/Units

This report is filed by the Department in accordance with MCL 333.2221(f). The report presents information about the nature of these CON applications and decisions, as well as the Commission's actions during the reporting period. Several tables include benchmarks for timely processing of applications and issuing decisions as set forth in the CON Administrative Rules. Note that the data in the report represents some applications that were carried over from last fiscal year while others may be carried over into next fiscal year.

HISTORICAL OVERVIEW OF MICHIGAN'S CERTIFICATE OF NEED PROGRAM

1972 Legislation was introduced in the Michigan legislature to enact the Certificate of Need (CON) program. The Michigan CON program became effective on April 1, 1973.

1974 Congress passed the National Health Planning and Resources Development Act (PL 93-641) including funding incentives that encouraged states to establish a CON program. The purpose of the act was to facilitate recommendations for a national health planning policy. It encouraged state planning for health services, manpower, and facilities. And, it authorized financial assistance for the development of resources to implement that policy. Congress repealed PL 93-641 and certificate of need in 1986. At that time, federal funding of the program ceased and states became totally responsible for the cost of maintaining CON.

1988 Michigan's CON Reform Act of 1988 was passed to develop a clear, systematic standards development process and reduce the number of services requiring a CON.

Prior to the 1988 CON Reform Act, the Department found that the program was not serving the needs of the state optimally. It became clear that many found the process to be excessively unclear and unpredictable. To strengthen CON, the 1988 Act established a specific process for developing and approving standards used in making CON decisions. The review standards establish how the need for a proposed project must be demonstrated. Applicants know before filing an application what specific requirements must be met.

The Act also created the CON Commission. The CON Commission, whose membership is appointed by the Governor, is responsible for approving CON review standards. The Commission also has the authority to revise the list of covered clinical services subject to CON review. However, the CON sections inside the Department are responsible for day-to-day operations of the program, including supporting the Commission and making decisions on CON applications consistent with the review standards.

1993 Amendments to the 1988 Act required ad hoc committees to be appointed by the Commission to provide expert assistance in the formation of the review standards.

2002 Amendments to the 1988 Act expanded the CON Commission to 11 members, eliminated the previous ad hoc committees, and established the use of Standard Advisory Committees or other private consultants/organizations for professional and technical assistance.

Present The CON program is now more predictable so that applicants can reasonably assess, before filing an application, whether a project will be approved. As a result, there are far fewer appeals of Department decisions. Moreover, the 1988 amendments appear to have reduced the number of unnecessary applications, i.e., those involving projects for which a need cannot be demonstrated.

The standards development process now provides a public forum and involves organizations representing purchasers, payers, providers, consumers, and experts in the subject matter. The process has resulted in CON review standards that are legally enforceable, while assuring that standards can be revised promptly in response to the changing healthcare environment.

ADMINISTRATION OF THE CERTIFICATE OF NEED PROGRAM

Commission The Commission is an 11-member body. The Commission, appointed by the Governor and confirmed by the Senate, is responsible for approving CON review standards used by the Department to make decisions on individual CON applications. The Commission also has the authority to revise the list of covered clinical services subject to CON review. Appendix I is a list of the CON Commissioners for FY2014.

NEWTAC The New Technology Advisory Committee is a standing committee responsible for advising the Commission on the new technologies, including medical equipment and services that have not yet been approved by the federal Food and Drug Administration for commercial use.

SAC A Standards Advisory Committee (SAC) may be appointed by and report to the CON Commission. The SACs advise the Commission regarding creation of, or revisions to the standards. The Committees are composed of a 2/3 majority of experts in the subject matter and include representatives of organizations of healthcare providers, professionals, purchasers, consumers, and payers.

MDCH The Michigan Department of Community Health is responsible for administering the CON program and providing staffing support for the Commission. This includes promulgating applicable rules, processing and rendering decisions on applications, and monitoring and enforcing the terms and conditions of approval. These functions are within the Policy and Planning Administration.

Policy Section The Policy Section within the Administration provides professional and support staff assistance to the Commission and its committees in the development of new and revised standards. Staff support includes researching issues related to specific standards, preparing draft standards, and performing functions related to both Commission and Committee meetings.

Evaluation Section The Evaluation Section also within the Administration has operational responsibility for the program, including providing assistance to applicants prior to and throughout the CON process. The Section is responsible for reviewing all Letters of Intent and applications as prescribed by the Administrative Rules. Staff determines if a proposed project requires a CON. If a CON is required, staff identifies the appropriate application forms for completion by the applicant and submission to the Department. The application review process includes the assessment of each application for compliance with all applicable statutory requirements and CON review standards, and preparation of a Program Report and Finance Report documenting the analysis and findings. These findings are used by the Director to make a final decision to approve or deny a project.

In addition to the application reviews, the Section reviews requests for amendments to approved CONs as allowed by the Rules. Amendment requests involve a variety of circumstances, including changes in how an approved project is financed and authorization for cost overruns. The Section is also responsible for monitoring the implementation of approved projects, as well as the long-term compliance with the terms and conditions of approvals.

The Section also provides the Michigan Finance Authority (MFA) with information when healthcare entities request financing through MFA bond issues and Hospital Equipment Loan Program (HELP) loans. This involves advising on whether a CON is required for the item(s) that will be bond financed.

CERTIFICATE OF NEED PROCESS

The following discussion briefly describes the steps an applicant follows in order to apply for a Certificate of Need.

Letter of Intent — An applicant must file an LOI with the Department and, if applicable, the regional CON review agency. The CON Evaluation Section identifies for an applicant all the necessary application forms required based on the information contained in the LOI.

Application — On or before the designated application date, an applicant files an application with the Department and the regional review agency, if applicable. The Evaluation Section reviews an application to determine if it is complete. If not complete, additional information is requested. The review cycle starts after an application is deemed complete or received in accordance with the Administrative Rules.

Review Types and Time Frames — There are three review types: nonsubstantive, substantive individual and comparative. Nonsubstantive reviews involve projects such as replacement of covered equipment or changes in ownership that do not require a full review. Substantive individual reviews involve projects that require a full review but are not subject to comparative review as specified in the applicable CON review standards. Comparative reviews involve situations where two or more applicants are competing for a resource limited by a CON review standard, such as hospital and nursing home beds. The maximum review time frames for each review type, from the date an application is deemed complete or received until a proposed decision is issued, are: 45 days for nonsubstantive, 120 for substantive individual and 150 days for comparative reviews. The comparative review time frame includes an additional 30-day period for determining if a comparative review is necessary. Whenever this determination is made, the review cycle begins for comparative reviews.

Review Process — The Evaluation Section reviews the application. Each application is reviewed separately unless part of a comparative review. Each application review includes a program and finance report documenting the Department's analysis and findings of compliance with the statutory review criteria, as set forth in Section 22225 of the Public Health Code and the applicable CON review standards.

Proposed Decision — The Policy and Planning Administration in which the Evaluation Section resides issues a proposed decision to the applicant within the required time frame. This decision is binding unless reversed by the Department Director or appealed by the applicant. The applicant must file an appeal within 15 days of receipt of the proposed decision if the applicant disagrees with the proposed decision or its terms and conditions. In the case of a comparative review, a single decision is issued for all applications in the same comparative group.

Final Decision — If the proposed decision is not appealed, a final decision is made by the Director of the Department of Community Health in accordance with MCL 333.22231. If a hearing on the proposed decision is requested, the final decision by the Director is not issued until completion of the hearing and any filing of exceptions to the proposed decision by the Michigan Administrative Hearing System. A final decision by the Director may be appealed to the applicable circuit court.

LETTERS OF INTENT

The CON Administrative Rules, specifically Rule 9201, provides that Letters of Intent (LOI) must be processed within 15 days of receipt. Processing an LOI includes entering data in the management information system, verifying historical facility information, and obtaining proof of authorization to do business in Michigan. This information determines the type of review for the proposed project, and the Department then notifies the applicant of applicable application forms to be completed.

Table 1 provides an overview of the number of LOIs received and processed in accordance with the above-referenced Rule.

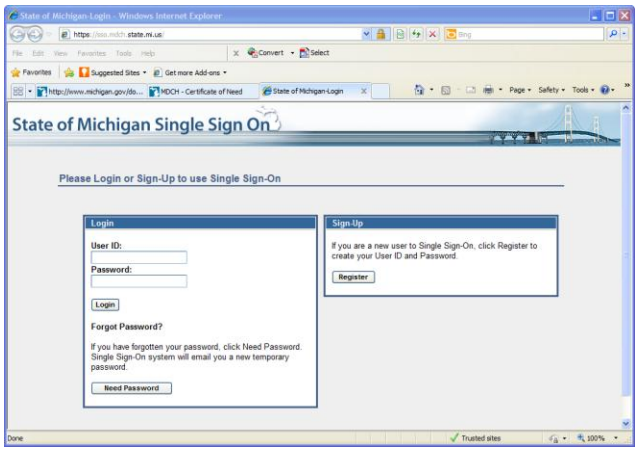
TABLE 1
LETTERS OF INTENT RECEIVED AND PROCESSED WITHIN 15 DAYS
FY2010 - FY2014

	LOIs Received	Processed within 15 Days	Percent Processed within 15 Days	Waivers Processed*
FY2010	435	433	100%	61
FY2011	441	438	99%	51
FY2012	422	422	100%	43
FY2013	440	438	99%	61
FY2014	333	332	99%	39

* Waivers are proposed projects that do not require CON review, but an LOI was submitted for Department's guidance/confirmation.

In FY 2014, LOIs were processed in a timely manner as required by Administrative Rule and available for public viewing on the online application system. The online system allows for faster processing of LOIs and subsequent applications by the Evaluation Section, as well as modifying these applications by applicants when needed.

In 2006, Michigan became the first state to have an online application and information system. Today 100% of all LOIs and applicable applications are submitted online.



http://www.mi.gov/con

TYPES OF CERTIFICATE OF NEED APPLICATION REVIEWS

The Administrative Rules also establish three types of project reviews: nonsubstantive, substantive individual, and comparative. The Rules specify the time frames by which the Bureau (Evaluation Section) must issue its proposed decision related to a CON application. The time allowed varies based on the type of review.

Nonsubstantive

Nonsubstantive reviews involve projects that are subject to CON review but do not warrant a full review. The following describes types of projects that are potentially eligible for nonsubstantive review:

- Acquire an existing health facility
- Replace a health facility within the replacement zone and below the covered capital expenditure

- Add a host site to an existing mobile network/route that does not require data commitments
- Replace or upgrade a covered clinical equipment
- Acquire or relocate an existing freestanding covered clinical service.

The Rules allow the Bureau (Evaluation Section) up to 45 days from the date an application is deemed complete to issue a proposed decision. Reviewing these types of proposed projects on a nonsubstantive basis allows an applicant to receive a decision in a timely fashion while still being required to meet current CON requirements, including quality assurance standards.

Substantive Individual

Substantive individual review projects require a full review but are not subject to comparative review and not eligible for nonsubstantive review. An example of a project reviewed on a substantive individual basis is the initiation of a covered clinical service such as Computed Tomography (CT) scanner services. The Bureau (Evaluation Section) must issue its proposed decision within 120 days of the date a substantive individual application is deemed complete or received.

Comparative

Comparative reviews involve situations where two or more applications are competing for a limited resource such as hospital or nursing home beds. A proposed decision for a comparative review project must be issued by the Bureau (Evaluation Section) no later than 120 days after the review cycle begins. The cycle begins when the determination is made that the project requires comparative review. According to the Rules, the Department has the additional 30 days to determine if, in aggregate, all of the applications submitted on a window date exceed the current need. A comparative window date is one of the three dates during the year on which projects subject to comparative review must be filed. Those dates are the first working day of February, June, and October.

Section 22229 established the covered services and beds that were subject to comparative review. Pursuant to Part 222, the CON Commission may change the list subject to comparative review.

Figure 1 delineates services/beds subject to comparative review.

FIGURE 1 *Services/Beds Subject to Comparative Review in FY2014*	
Neonatal Intensive Care Unit	Nursing Home/HLTCU Beds
Hospital Beds	Nursing Home Beds for Special Population Groups
Psychiatric Beds	
Transplantations	

Note: See individual CON review standards for more information.

Table 2 shows the number of applications received by the Department by review type.

TABLE 2 *APPLICATIONS RECEIVED BY REVIEW TYPE* *FY2010 - FY2014*					
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2014**
Nonsubstantive*	144	166	160	161	117
Substantive Individual	131	122	135	152	114
Comparative	22	28	10	8	2
TOTALS	297	316	305	321	233

Note: Does not include two (2) emergency CON applications.

* Includes swing bed applications.

Table 3 provides a summary of applications received and processed in accordance with Rule 9201. The Rule requires the Evaluation Section to determine if additional information is needed within 15 days of receipt of an application. Processing of applications includes: updating the management information system, verifying submission of required forms, and determining if other information is needed in response to applicable Statutes and Standards.

TABLE 3
APPLICATIONS RECEIVED AND PROCESSED WITHIN 15 DAYS
FY2010 - FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Applications Received	303	318	305	326	235
Processed within 15 Days	303	315	290	326	235
Percent Processed within 15 Days	100%	99%	95%	100%	100%

Note: Includes emergency CON and swing bed applications.

Table 4 provides an overview of the average number of days taken by the Evaluation Section to complete reviews by type.

TABLE 4
AVERAGE NUMBER OF DAYS IN REVIEW CYCLE BY REVIEW TYPE
FY2010- FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Nonsubstantive	37	31	41	38	40
Substantive Individual	113	110	114	117	117
Comparative	153	117	117	119	116

Note: Average review cycle accounts for extensions requested by applicants.

EMERGENCY CERTIFICATES OF NEED

Table 5 shows the number of emergency CONs issued. The Department is authorized by Section 22235 of the Public Health Code to issue emergency CONs when applicable. Rule 9227 permits up to 10 working days to determine if an emergency application is eligible for review under Section 22235. Although it is not required by Statute, the Bureau (Evaluation Section) attempts to issue emergency CON decisions to the Director for final review and approval within 10 days from receipt of request.

TABLE 5
EMERGENCY CON DECISIONS ISSUED
FY2010 - FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Emergency CONs Issued	4	2	2	5	2
Percent Issued within 10 Working Days	100%	100%	100%	100%	100%

PROPOSED DECISIONS

Part 222 establishes a 2-step decision making process for CON applications that includes both a proposed decision and final decision. After an application is deemed complete and reviewed by the Evaluation Section, a proposed decision is issued by the Bureau (Evaluation Section) to the applicant and the Department Director according to the timeframes established in the Rules.

Table 6 shows the number of proposed decisions by type, issued within the applicable timeframes set forth in the Administrative Rules 325.9206 and 325.9207: 45 days for nonsubstantive, 120 days for substantive individual, and 150 days for comparative reviews, or any requested extension(s) to the review cycle.

TABLE 6
PROPOSED DECISIONS ISSUED
FY2010- FY2014

	Nonsubstantive		Substantive Individual		Comparative	
	Issued	Issued on Time	Issued	Issued on Time	Issued	Issued on Time
FY2010	123	99%	103	100%	17	100%
FY2011	180	100%	129	100%	34	100%
FY2012	155	100%	115	100%	3	100%
FY2013	147	100%	145	100%	9	100%
FY2014	119	100%	130	100%	6	100%

Note: Table 6 does not include two (2) emergency applications.

Table 7 compares the number of proposed decisions by decision type made.

TABLE 7
COMPARISON OF PROPOSED DECISIONS BY DECISION TYPE
FY2010- FY2014

	Approved	Approved w/ Conditions	Disapproved	Percent Disapproved	TOTAL
FY2010	212	27	7	3%	246
FY2011	298	30	15	6%	343
FY2012	244	19	10	4%	243
FY2013	261	35	10	3%	306
FY2014	222	28	7	3%	257

Note: Not all proposed decisions issued in a given year will have a final decision in the same year.

If a proposed decision is disapproved, an applicant may request an administrative hearing that suspends the time frame for issuing a final decision. After a proposed disapproval is issued, an applicant may also request that the Department consider new information. The Administrative Rules allow an applicant to submit new information in response to the areas of noncompliance identified by the Department's analysis of an application and the applicable Statutory requirements to satisfy the requirements for approval.

FINAL DECISIONS

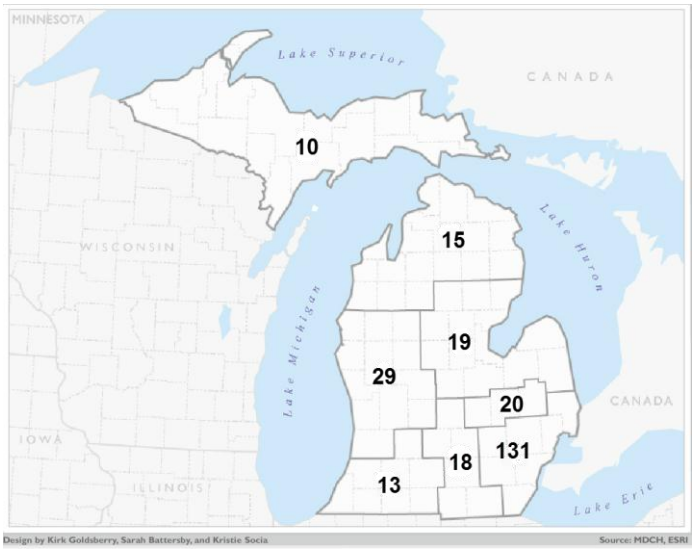
The Director issues a final decision on a CON application following either a proposed decision or the completion of a hearing, if requested, on a proposed decision. Pursuant to Section 22231(1) of the Public Health Code, the Director may issue a decision to approve an application, disapprove an application, or approve an application with conditions or stipulations. If an application is approved with conditions, the conditions must be explicit and relate to the proposed project. In addition, the conditions must specify a time period within which the conditions shall be met, and that time period cannot exceed one year after the date the decision is rendered. If approved with stipulations, the requirements must be germane to the proposed project and agreed to by the applicant.

This section of the report provides a series of tables summarizing final decisions for each of the review thresholds for which a CON is required. It should be noted that some tables will not equal other tables, as many applications fall into more than one category.

Table 8 and **Figure 2** display the number of final decisions issued.

TABLE 8 *FINAL DECISIONS ISSUED FY2010- FY2014*	
FY2010	269
FY2011	323
FY2012	283
FY2013	309
FY2014	256

FIGURE 2
FY 2014 FINAL DECISIONS ISSUED BY HEALTH SERVICE AREAS



Note: Figure 2 does not include 1 out-state decision.

Table 9 summarizes final decisions by review categories defined in MCL 333.22209(1) and as summarized below:

Acquire, Begin Operation of, or Replace a Health Facility
Under Part 222, a health facility is defined as a general hospital, hospital long-term care unit, psychiatric hospital or unit, nursing home, freestanding surgical outpatient facility (FSOF), and health maintenance organization under limited circumstances. This category includes projects to construct or replace a health facility, as well as projects involving the acquisition of an existing health facility through purchase or lease.

Change in Bed Capacity
This category includes projects to increase in the number of licensed hospital, nursing home, or psychiatric beds; change the licensed use; and relocate existing licensed beds from one geographic location to another without an increase in the total number of beds.

Covered Clinical Services
This category includes projects to initiate, replace, or expand a covered clinical service: neonatal intensive care services, open heart surgery, extrarenal organ transplantation, extracorporeal shock wave lithotripsy, megavoltage radiation therapy, positron emission tomography, surgical services, cardiac catheterization, magnetic resonance imaging services, computed tomography scanner services, and air ambulance services.

Covered Capital Expenditures
This category includes capital expenditure project in a clinical area of a licensed health facility that is equal to or above the threshold set forth in Part 222. Typical examples of covered capital expenditure projects include construction, renovation, or the addition of space to accommodate increases in patient treatment or care areas not already covered. In 2013 the covered capital expenditure threshold was $3,097,500 and as of January 1, 2014, the covered capital expenditure threshold was increased to $3,160,000. The threshold is updated in January of every year.

TABLE 9 *FINAL DECISIONS ACTIVITY CATEGORY* *FY2010 - FY2014*					
Approved	**FY2010**	**FY2011**	**FY2012**	**FY2013**	**FY2014**
Acquire, Begin, or Replace a Health Facility	44	43	25	38	47
Change in Bed Capacity	43	54	57	52	46
Covered Clinical Services	192	212	188	241	191
Covered Capital Expenditures	39	78	55	44	47
Disapproved					
Acquire, Begin, or Replace a Health Facility	5	0	9	2	4
Change in Bed Capacity	13	0	12	5	5
Covered Clinical Services	2	1	2	0	0
Covered Capital Expenditures	9	0	10	3	5

Note: Totals above may not match Final Decision totals because one application may include multiple categories.

Table 10 provides a comparison of the total number of final decisions and total project costs by decision type.

TABLE 10 *COMPARISON OF FINAL DECISIONS BY DECISION TYPE* *FY2010 - FY2014*				
	Approved	**Approved With Conditions**	**Disapproved**	**Totals**
Number of Final Decisions				
FY2010	225	29	15	269
FY2011	229	25	1	325
FY2012	245	24	14	283
FY2013	268	36	5	309
FY2014	223	28	5	256
Total Project Costs				
FY2010	$ 712,964,774	$ 82,921,512	$ 36,912,278	$ 832,798,564
FY2011	$ 4,237,317,904	$ 78,451,908	$ 96,000	$ 4,315,865,812
FY2012	$ 1,018,583,923	$ 61,902,640	$ 119,186,198	$ 1,199,672,761
FY2013	$ 724,546,360	$ 239,908,373	$ 321,167,591	$ 1,285,622,324
FY2014	$ 904,329,614	$ 196,996,469	$ 39,529,999	$ 1,140,856,082

Note: Final decisions include emergency CON applications.

In FY2014, five (5) CON applications received final decision of disapproval from the Department. These projects included new nursing home beds.

CERTIFICATE OF NEED ACTIVITY SUMMARY COMPARISON

Table 11 provides a comparison for various stages of the CON process.

TABLE 11 CON ACTIVITY COMPARISON FY2010 - FY2014				
	Number of Applications	**Difference from Previous Year**	**Total Project Costs**	**Difference from Previous Year**
Letters of Intent Processed				
FY2010	435	30%	$1,675,525,170	97%
FY2011	441	1%	$4,104,907,789	144%
FY2012	422	(4%)	$1,969,641,919	(52%)
FY2013	440	4%	$1,661,621,556	(16%)
FY2014	333	(24%)	$1,282,834,192	(23%)
Applications Submitted				
FY2010	303	38%	$1,503,768,132	149%
FY2011	318	5%	$3,896,990,034	159%
FY2012	307	(3%)	$1,351,924,859	(65%)
FY2013	326	6%	$1,539,877,626	14%
FY2014	235	(28%)	$ 904,601,983	(41%)
Final Decisions Issued				
FY2010	269	(1%)	$ 832,798,564	(25%)
FY2011	325	21%	$4,315,865,812	418%
FY2012	283	(13%)	$1,199,672,761	(72%)
FY2013	309	9%	$1,285,622,324	7%
FY2014	256	(17%)	$1,140,856,082	(11%)

Note: Applications submitted and final decisions Issued include Emergency CONs and swing bed applications.

AMENDMENTS

The Rules allow an applicant to request to amend an approved CON for projects that are not complete. The Department has the authority to decide when an amendment is appropriate or when the proposed change is significant enough to require a separate application. Typical reasons for requesting amendments include:

- **Cost overruns -** The Rules allow the actual cost of a project to exceed the approved amount by 15 percent of the first $1 million and 10 percent of all costs over $1 million. Fluctuations in construction costs can cause projects to exceed approved amounts

- **Changes in the scope of a project -** An example is the addition of construction or renovation required by regulatory agencies to correct existing code violations that an applicant did not anticipate in planning the project

- **Changes in financing -** Applicants may decide to pursue a financing alternative better than the financing that was approved in the CON.

- **Change in construction start date** – The Rules allow an Applicant to request an extension to start construction/renovation for an approved project.

Table 12 provides a summary of amendment requests received by the Department and the time required to process and issue a decision. Rule 9413 permits that the review period for a request to amend a CON-approved project be no longer than the original review period.

TABLE 12
AMENDMENTS RECEIVED AND DECISIONS ISSUED
FY2010 - FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Amendments Received	85	83	68	73	63
Amendment Decisions Issued	87	76	66	84	60
Percent Issued within Required Time Frame	98%	99%	100%	100%	99%

NEW CERTIFICATE OF NEED CAPACITY

Table 13 provides a comparison of existing covered services, equipment and facilities already operational to new capacity approved in FY 2014. One hundred and four (104) of the 251 CON approvals in FY 2014 were for new or additional capacity. The remaining approvals were for replacement equipment, renovations and other capital expenditures.

TABLE 13
COVERED CLINICAL SERVICES AND BEDS
FY2014

Covered Clinical Services/Beds	Existing Sites	Existing Units/Beds	New Sites	New Units/Beds
Air Ambulances	13	16	1	1
Cardiac Catheterization Services/ Primary PCI	68	214	0	5
Open Heart Surgical Services	34	N/A	0	N/A
Surgical Services	259	1,418	5	12
CT Scanners Services	393	483	42	43
MRI Services	310	240	14	2
PET Services	86	26	2	1
Lithotripsy Services	93	11	3	0
MRT Services	67	133	0	0
Transplant Services	8	N/A	0	N/A
Hospitals	177	26,440	6	0
NICU Services	22	632	0	0
Extended Care Services Program (Swing Beds)	33	309	1	5
Nursing Homes/HLTCU	500	51,906	5	460
Psychiatric Hospitals/Units	62	2,433	1	92

Note: Table 13 does not account for facilities closed, services or equipment no longer operational, or beds delicensed and returned to the various bed pools. New sites include mobile host sites for CT, Lithotripsy, MRI and PET services.

COMPLIANCE ACTIONS

Table 14 shows there were 350 projects requiring follow-up for FY 2014 based on the Department's Monthly Follow-up/Monitoring Report as shown below.

TABLE 14
FOLLOW UP AND COMPLIANCE ACTIONS
FY2010 - FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Projects Requiring 1-yr Follow-up	326	341	386	340	350
Approved CONs Expired	217	80	69	127	97
Compliance Orders Issued	0	0	2	1	6

Note: CONs are expired due to non-compliance with terms and conditions of approval or when the recipient has notified the Department that either the approved-project was not implemented or the site is no longer providing the covered service/beds. Compliance Orders include orders issued by the Department under MCL 333.22247 or remedies for non-compliance.

ANALYSIS OF CERTIFICATE OF NEED PROGRAM FEES AND COSTS

Section 20161(3) sets forth the fees to be collected for CON applications. **Figure 3A** shows the application fees that are based on total project costs from October 1, 2013 thru October 14, 2013.

FIGURE 3A
CON APPLICATION FEES 10/01/2013-10/14/2013

Total Project Costs	CON Application Fee
$0 to $500,000	$1,500
$500,001 to $4,000,000	$5,500
$4,000,001 and above	$8,500

Figure 3B shows the application fees based on total projects costs and additional fees per the new fee structure, effective October 15, 2013, approved under House Bill No. 4787.

FIGURE 3B
CON APPLICATION FEES 10/15/2013-09/30/2014

Total Project Costs	CON Application Fee
$0 to $500,000	$3,000
$500,001 to $3,999,999	$8,000
$4,000,000 to $9,999,999	$11,000
$10,000,000 and above	$15,000
Additional Fee Category	**Additional Fee**
Complex Projects (i.e. Comparative Review, Acquisition or replacement of a licensed health facility with two or more covered clinical services.)	$3,000
Expedited Review - Applicant Request	$1,000
Letter of Intent (LOI) Resulting in a Waiver	$500
Amendment Request to Approved CON	$500
CON Annual Survey	$100 per Covered Clinical Service

Table 15A, 15B analyzes the number of applications by fee assessed.

TABLE 15A
NUMBER OF CON APPLICATIONS BY FEE 10/01/2013-10/14/2013
FY2010 - FY2014

CON Fee	FY2010	FY2011	FY2012	FY2013	FY2014
$ 0*	6	2	2	6	0
$1,500	113	104	147	139	5
$5,500	107	101	96	97	8
$8,500	77	110	62	84	7
TOTAL	303	317	307	326	20

TABLE 15B
NUMBER OF CON APPLICATIONS BY FEE 10/15/2013-09/30/2014
FY2014

CON Fee	FY2014
$ 0*	3
$3,000	103
$8,000	70
$11,000	23
$15,000	16
TOTAL	215

Note: Table 15A and 15B may not match fee totals in Table 16, as Table 16 accounts for refunds, overpayments, MFA funding, etc.

** No fees are required for emergency CON and swing beds applications.*

Table 15C analyzes the fees collected for the additional fee categories. More than one fee category may be assessed for one application.

TABLE 15C
NUMBER OF ADDITIONAL CON APPLICATIONS FEES 10/15/2013-09/30/2014
FY2014

CON Fee Category	FY2014	Total Amount
Complex Project	8	$ 24,000
Expedited Review	27	$ 27,000
LOI Waiver	37	$ 18,500
Amendment*	32	$ 16,000
Annual Survey	1,191 (Facilities)	$ 183,400
TOTAL		$ 268,900

*Note: Some amendments do not require an amendment fee based on the type of change requested.

Table 16 provides information on CON program costs and source of funds.

TABLE 16
CON PROGRAM
COST AND REVENUE SOURCES FOR FY2010– FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Program Cost	$1,972,254	$1,902,658	$1,802,307	$1,785,688	$1,967,395
Fees/Funding	$1,423,451	$1,715,588	$1,298,504	$1,508,118	$1,823,772
Fees % of Costs	72%	90%	72%	84%	93%

Source: MDCH Budget and Finance Administration.

CERTIFICATE OF NEED COMMISSION ACTIVITY

During FY2014, the CON Commission revised the review standards for Air Ambulance Services, Bone Marrow Transplantation (BMT) Services, Cardiac Catheterization Services, Computed Tomography (CT) Services, Hospital Beds, Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services, Open Heart Surgery (OHS) Services, Positron Emission Tomography (PET) Scanner Services, and Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services/Units.

The revisions to the CON Review Standards for Air Ambulance Services received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 1: Modified for consistency with other CON review standards. Relocation is a part of replacement.
- Section 2: Definitions have been moved to applicable sections if only used in that section. "Medicaid" definition has been removed as it is defined in Part 222 of the Public Health Code.
- Section 3: Removed "need" requirements for initiation.
- Section 4: Moved from Section 5 and removed "need" requirements for replacement. Added subsection (5) as a technical edit consistent with initiation and acquisition.
- Section 5: Moved from Section 4 and removed "need" requirements for expansion. Added subsection (4) as a technical edit consistent with initiation and acquisition.
- Section 6: Removed "need" requirements for acquisition.
- Section 8: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (2), removed "need" based requirement for 275 patient transports annually.
- Section 9: "Need" based methodology removed.
- Other technical edits.

The revisions to the CON Review Standards for BMT Services received final approval by the CON Commission on June 12, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective September 29, 2014. The final language changes include the following:

- Section 2(1)(e): "Cancer Hospital" is being redefined and "means a hospital that has been approved as a Comprehensive Cancer Center by the National Cancer Institute or operates a Comprehensive Cancer Center as an affiliate of a Michigan university that is designated as a Comprehensive Cancer Center by the National Cancer Institute."
- Section 4(1): Updated to reflect the removal of the PPS exemption requirement for acquisition by a cancer hospital.
- Section 4(2): Language added to allow for reacquisition of a BMT service by the current CON holder.
- Section 10(1): Technical edits.

The revisions to the CON Review Standards for Cardiac Catheterization Services received final approval by the CON Commission on March 18, 2014 and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 2: Definition moved to applicable Appendix.
  - Subsection (1)(k): Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix B: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for CT Services received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 1: Modified for consistency with other CON review standards. Relocation is a part of replacement.
- Section 2: Definitions have been modified, definitions moved to applicable sections if only used in that section, and new definitions have been added.
  - "Billable procedure" has been modified.
  - "Bundled body scan" is a new definition and is defined as "two or more body scans billed as one CT procedure.
  - "CT-angio hybrid unit" is a new definition and is defined as "an integrated system comprised of both CT and angiography equipment sited in the same room that is designed specifically for interventional radiology or cardiac procedures. The CT unit is a guidance mechanism and is intended to be used as an adjunct to the procedure. The CT unit shall not be used for diagnostic studies unless the patient is currently undergoing a CT-angio hybrid procedure and is in need of a secondary diagnostic study."
  - "Initiate a CT scanner service" has been modified as relocation is a part of replacement.
  - "Metropolitan statistical area county" is included in Appendix B.
  - "Micropolitan statistical area county" is included in Appendix B.
  - Relocation terms combined with replacement terms and/or section.
  - "Replace an existing CT scanner" modified to include relocation.
  - "Rural county" is included in Appendix B.
- Section 3: Under new subsection (4), added requirements to initiate CT scanner services as an existing host site on a different mobile CT scanner service consistent with other CON review standards.
- Section 4: Modified to include initiation of mobile dental CT scanner services.
  - Under new subsection (6), added requirements to initiate mobile dental CT scanner services as an existing host site on a different mobile dental CT scanner service consistent with other CON review standards.
- Section 6: Modified to include expansion of an existing mobile dental CT scanner service.
- Section 7:
  - Removed volume requirements for replacement of an existing fixed, mobile, or dedicated pediatric CT scanner.
  - New subsection (2) moved from old Section 9(1) and modified accordingly consistent with other CON review standards.

  - New subsection (3) moved from old Section 9(2) and modified accordingly consistent with other CON review standards.
- Section 8:
  - Removed volume requirements for replacement of an existing dental CT scanner or service.
  - New subsection (2) moved from old Section 10(1) and modified accordingly consistent with other CON review standards.
  - New subsection (3) moved from old Section 10(2) and modified accordingly consistent with other CON review standards.
- Section 9: Modified acquisition volume requirement of 7,500 CT equivalents for mobile to 3,500 CT equivalents consistent with required maintenance volumes.
- Section 10: Modified to include acquisition of an existing mobile dental CT scanner service or an existing mobile dental CT scanner.
- Section 11: Added requirements for a dedicated research fixed CT scanner consistent with other CON review standards.
- Section 12: Moved from Section 16.
- Section 13: Removed pilot language and made the requirements for approval of a hospital-based portable CT scanner for initiation, expansion, replacement, and acquisition a permanent part of the standards.
- Section 15: Added requirements for approval of a CT-angio hybrid unit for initiation, replacement, and acquisition.
- Section 17: Added additional requirements for approval of a mobile dental CT scanner service.
- Section 20: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
  - Under subsection (4)(a), clarified language for maintenance volume requirements.
  - Under subsection (7), removed the reference to “pilot” program and updated language.
  - Under subsection (8), added project delivery requirements for CT-angio hybrid units.
- Section 22: Modified table for clarity and added “bundled body scan” with a conversion factor of 3.50 for adults and a conversion factor of 4.00 for pediatric/special needs patients.
- Section 23: Modified for clarity.
- Appendix A: Modified for consistency with other CON review standards.
- Other technical edits.

The revisions to the CON Review Standards for Hospital Beds received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 4: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix E: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for NICU and Special Newborn Nursing Services received final approval by the CON Commission on December 12, 2013, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action

within 45 days; therefore, the revisions became effective March 3, 2014. The final language changes include the following:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been modified, definitions moved to applicable sections if only used in that section, and a new definition has been added for "special care nursery services" or "SCN services."
- Section 5: Moved from previous Section 7.
- Section 6: Moved from previous Section 6.
- Section 7: Moved from previous Section 5.
- Section 9: Added requirements to initiate, acquire, or replace SCN services.
- Section 12: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (3), added quality assurance requirements for SCN services.
    - Under subsection (5)(a)(i), added data reporting requirements for SCN services.
- Section 14: Added language to exempt SCN services from comparative review.
- Appendix B: Moved from previous Section 12.
- Other technical edits.

The revisions to the CON Review Standards for OHS Services received final approval by the CON Commission on September 17, 2013, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective November 15, 2013. The final language changes include the following:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been modified and a new definition has been added as follows:
    - "Hospital" means a health facility licensed under part 215 of the code.
- Section 7: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
    - Under subsection (2)(b), reduced the minimum number of cases to be performed by the attending physician from 75 to 50 consistent with the national guidelines.
    - Under subsection (2)(c), added a requirement to participate with the Society of Thoracic Surgeons (STS) National Database and the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative and Database or a designee of the Department that monitors quality and risk adjusted outcomes.
    - Under subsection (4)(a), for consistency, the data that is submitted to the CON Annual Survey will be the same data that is submitted to the STS Database for consistency. The maintenance volume is being reduced from 300 to 150 adult open heart surgical cases a year.
    - Under subsection (4)(d) and (e), added requirements to utilize and report the STS Composite Star Rating System for all procedures.
- Section 8: Modified for clarification.
- Section 9: Modified for clarification.
- Appendix A: Updated utilizing the 2010 Michigan Inpatient Data Base (MIDB).
- Appendix B: Updated utilizing the 2010 Michigan Inpatient Data Base (MIDB).
- Other technical edits.

A second set of revisions to the CON Review Standards for OHS Services received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 2: Definition moved to applicable Appendix.
  - Subsection (1)(m): Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Section 8(3): Modified for the CD-9-CM to ICD-10-CM Code translation.
- Section 9(1)(a) and (e), (2)(a) and (c), and (3): Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix A: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix B: Modified for the CD-9-CM to ICD-10-CM Code translation.
- Appendix C: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix E: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for PET Scanner Services received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 12(4): Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

The revisions to the CON Review Standards for UESWL Services/Units received final approval by the CON Commission on March 18, 2014, and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective June 2, 2014. The final language changes include the following:

- Section 1: Modified for consistency with other CON review standards.
- Section 2: Definitions have been moved to applicable sections if only used in that section.
- Section 3: Modified definition as relocation is a part of replacement.
- Section 4: Modified as relocation is a part of replacement.
- Section 5: Moved from Section 8.
- Section 7: Moved from Section 5.
- Section 9: Divided requirements into distinct groups consistent with other standards: quality assurance, access to care, and monitoring and reporting.
- Section 10: Modified for the ICD-9-CM to ICD-10-CM Code translation.
- Appendix A: Modified for the ICD-9-CM to ICD-10-CM Code translation.
  - Under subsection (1), updated the factor from .94 to 1.09.
  - Modified for clarity.
- Appendix B: Moved from Section 1.
- Appendix D: Added new Appendix for the ICD-9-CM to ICD-10-CM Code translation.
- Other technical edits.

APPENDIX I - CERTIFICATE OF NEED COMMISSION

James B. Falahee, Jr., JD, CON Commission Chairperson (10/1/13 – 3/18/14)
Marc D. Keshishian, MD, CON Commission Vice-Chairperson (10/1/13 – 3/18/14); Chairperson (Eff. 3/19/14)
Denise Brooks-Williams
Gail A. Clarkson
Kathleen Cowling, DO
Charles M. Gayney
Edward B. Goldman, JD (Appointment expired 4/9/13 and replaced by Denise Brooks-Williams)
Robert L. Hughes
Brian A. Klott (Resigned 11/14/13)
Jessica A. Kochin (Replaced Brian A. Klott)
Gay L. Landstrom
Suresh Mukherji, MD, Vice-Chairperson (Eff. 3/19/14)
Luis A. Tomatis, MD

For a list and contact information of the current CON Commissioners, please visit our web site at **www.michigan.gov/con**.

CERTIFICATE OF NEED LEGAL ACTION

(12.03.14)

Case Name	Date Opened	Case Description	Status
Pontiac Osteopathic Hospital dba McLaren Oakland Oakland County Circuit Court Includes: CON App # 12-0024 and 12-0025	6/20/13	Appeal of the MDCH Director's final decision.	On 12/20/13, the Oakland County Cir. Ct. affirmed the Department's denial of McLaren's CON applications. On 1/13/14, McLaren filed an Application for Leave to Appeal in the Court of Appeals that was denied for lack of merit. On 7/22/14, McLaren filed an Application for Leave to Appeal in the Michigan Supreme Court. Both parties filed briefs and we are awaiting a decision.
Case Name	Date Opened	Case Description	Status
Medilodge of Monroe Michigan Administrative Hearing System Includes: CON App # 14-0015	9/5/14	Administrative appeal of proposed decision denying application for new nursing home beds based on results of comparative review by the Department.	At the 11/20/14 pre-hearing conference, Medilodge of Monroe indicated that it would be withdrawing its appeal. We will close our file when the Order of Dismissal is entered.

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 N

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2014												2015											
	J*	F	M*	A	M	J*	J	A	S*	O	N	D*	J*	F	M*	A	M	J*	J	A	S*	O	N	D*
Bone Marrow Transplantation (BMT) Services	• D	•	• R —	• P	•	• ▲F				PC			• R A											
Cardiac Catheterization Services**	• R P A	• S	• ▲F S	• S	• S	▮	▮	▮	▮	▮	▮	▮	•	•	• R—	• P	•	• ▲F						
Computed Tomography (CT) Scanner Services	• P	•	• ▲F			• R—	• P	•	• ▲F															
Heart/Lung and Liver Transplantation Services										PC			• R A											
Hospital Beds	• R P A	•	• ▲F R	•	•	• R	•	•	• R—	• P	•	• ▲F												
Magnetic Resonance Imaging (MRI) Services						• R—	• P	•	• ▲F	PC			• R A											
Megavoltage Radiation Therapy (MRT) Services/Units**	• R A	• S	• S	• S	• S	• S	▮	▮	▮	▮	▮	•	•	•	• R—	• P	•	• ▲F						
Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services						• R—	• P	•	• ▲F															
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	•	•	•	•	•	R—	P	•	• R—	• P	•	• F▲												
Positron Emission Tomography (PET) Scanner Services	• R P A	•	• ▲F	•	•	•	•	•	•	•	•	•	•	•	R—									
Psychiatric Beds and Services										PC			• R A											
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	• P	•	• ▲F			• R—	• P	•	• ▲F															
New Medical Technology Standing Committee	•M	•M	•M	•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			M			M			M			M		

Attachment N

KEY

▬	-	Receipt of proposed standards/documents, proposed Commission action	A	-	Commission Action
*	-	Commission meeting	C	-	Consider proposed action to delete service from list of covered clinical services requiring CON approva
▉	-	Staff work/Standard advisory committee meetings	D	-	Discussion
▲	-	Consider Public/Legislative comment	F	-	Final Commission action, Transmittal to Governor/Legislature for 45-day review period
**	-	Current in-process standard advisory committee or Informal Workgroup	M	-	Monitor service or new technology for changes
•		Staff work/Informal Workgroup/Commission Liaison Work/Standing Committee Work	P	-	Commission public hearing/Legislative comment period
			PC	-	Public Comment Period for initial comments on review standards for review in the upcoming year
[1]		ICD-10 Translation	R	-	Receipt of report
			S	-	Solicit nominations for standard advisory committee or standing committee membership

For Approval December 11, 2014

Updated December 4, 2014

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, Office of Health Policy and Innovation, Planning and Access to Care 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 2, 2014	2016
Bone Marrow Transplantation Services	March 22, 2013	2015
Cardiac Catheterization Services	June 2, 2014	2017
Computed Tomography (CT) Scanner Services	June 2, 2014	2016
Heart/Lung and Liver Transplantation Services	September 28, 2012	2015
Hospital Beds	June 2, 2014	2017
Magnetic Resonance Imaging (MRI) Services	September 18, 2013	2015
Megavoltage Radiation Therapy (MRT) Services/Units	May 24, 2013	2017
Neonatal Intensive Care Services/Beds (NICU)	March 3, 2014	2016
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	March 11, 2011	2016
Open Heart Surgery Services	June 2, 2014	2017
Positron Emission Tomography (PET) Scanner Services	June 2, 2014	2017
Psychiatric Beds and Services	March 22, 2013	2015
Surgical Services	February 27, 2012	2017
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	June 2, 2014	2016

*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 Comment Period 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.