MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
CERTIFICATE OF NEED (CON) COMMISSION MEETING

Thursday, December 10, 2015

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

APPROVED 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 arrived at 9:35 a.m.
Kathleen Cowling, DO
James B. Falahee, Jr., JD
Marc Keshishian, MD, Chairperson
Jessica Kochin
Gay L. Landstrom, RN arrived at 9:40 a.m.
Thomas Mittelbrun
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 Health and Human Services Staff Present:

Tulika Bhattacharya
Natalie Kellogg
Amber Myers
Beth Nagel
Tania Rodriguez
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Mittelbrun, seconded by Commissioner Tomatis, to amend the agenda to include Public Comment and Commission Discussion under the Psychiatric Beds and Services Workgroup Report. Motion Carried.

III. Declaration of Conflicts of Interests

None.

IV. Review of Minutes of September 24, 2015

Motion by Commissioner Cowling, seconded by Commissioner Mittelbrun, to amend the minutes of September 24, 2015 to reflect Commissioner Mittelbrun was present and Commissioner Falahee was absent. Motion Carried.

V. Magnetic Resonance Imaging (MRI) Services Workgroup Final Report

Vice-Chairperson Mukherji gave a power point presentation of the workgroup's recommendations (see Attachment A) and an overview of the draft standards (see Attachment B).

A. Public Comment

None.

B. Commission Discussion

Discussion followed.

C. Commission Proposed Action

Motion by Commissioner Falahee, seconded by Commissioner Brooks-Williams to accept the language as presented and move forward for Public Hearing and the Joint Legislative Committee (JLC). Motion carried in a vote of 10- Yes, 0- No, and 0- Abstained.

VI. Psychiatric Beds & Services Workgroup Report

Commissioner Cowling gave a power point presentation of the workgroup's recommendations (see Attachment C).

A. Public Comment

Bob Nycamp, Pine Rest

B. Commission Discussion

Discussion followed.

VII. Nursing Home and Hospital Long-Term Care Unit (NH-HLTCU) Bed Need Effective Date- Action Delayed from September 24, 2015 CON Commission Meeting

Ms. Rogers gave an overview.

A. Public Comment

Pat Anderson, Health Care Association of Michigan (HCAM) (see Attachment D)
David Walker, Spectrum Health

B. Commission Discussion

Discussion followed.

C. Commission Action

Action on setting the effective date of the bed need delayed to the March 16, 2016 meeting.

VIII. Bone Marrow Transplantation (BMT) Services Standards Advisory Committee (SAC)- Interim Report (Written Only)

See Attachment E.

IX. Legislative Report

Ms. Nagel reported that there is no legislative update.

X. Administrative Update

A. Planning and Access to Care Update

Ms. Nagel announced that the meeting locations will be changing in the upcoming year.

B. CON Evaluation Section Update

Ms. Bhattacharya gave an update.

1. Compliance Report (see Attachment F)
2. Quarterly Performance Measures (see Attachment G)

XI. Legal Activity Report

Mr. Potchen reported that there is no legal activity update.

XII. 2016 Meeting Dates- January 28, 2016- CON Special Commission Meeting, March 16, 2016, June 15, 2016, September 21, 2016, & December 7, 2016

XIII. Public Comment

None.

XIV. Review of Commission Work Plan

Ms. Rogers gave an overview of the Commissions future work plan to include the decisions made at today's meeting (see Attachment H).

A. Commission Discussion

None.

B. Commission Action

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

XV. Adjournment

Motion by Commissioner Landstrom, seconded by Commissioner Mittelbrun, to adjourn the meeting at 11:09 a.m. Motion Carried in a vote of 10 - Yes, 0 - No, and 0 - Abstained.

MR CON Workgroup Report

Suresh K. Mukherji, M.D., M.B.A., F.A.C.R.
Certificate of Need Commissioner

December 10, 2015

Attendees

- Natalie Kellogg
- Brenda Rogers
- Umbrin Ateequi
- Steven Szelag
- Brent Wheeler
- Tulika Bhattacharya
- Sallie Flanders
- Micahel Ketscareh
- Nancy List
- Meg Tipton
- Melissa Cupp
- Geralyn Will
- Sean Gehle
- Gregg Hedegore
- David Williams
- Amber Myers
- David Williams
- Louisa Wolcott
- Dale Downes
- Ashton Shortridge
- Beth Nagel
- Suresh Mukherji
- Alice Pichan
- Cheryl Martin
- Dennis McCafferty
- Cheryl Martin
- Dee Jordan
- Eric Fischer
- Allsion Stark
- Carrie Linderoth
- Andrea Moore
- Arlene Elliott
- Michael Lala, MD
- Mike Vanderpol
- Deidre Wilson
- Michelle Rizor
- Tom Ostrander

Review and update, if necessary, the MRI Adjusted Procedure volume threshold for expansion at a freestanding site or consider adding an additional scan weight for fixed MRI scanners located at a freestanding site.

- Did not increase the threshold
- Did add language that updates the definition of "Special Needs Patient"
  - Implantable cardiac devices
  - Unable to comply with the motionless requirements and whose resulting movements result in non-diagnostic quality images therefore requiring the technologist to repeat the same sequence in an attempt to obtain a diagnostic quality image.

Improved Quality

Review and update, if necessary, the standards to allow facilities to update equipment when it has surpassed its useful life and/or removes volume requirements for replacement consistent with other CON review standards.

- Removed volume threshold for replacement

Reduced regulation by understanding that replacement is a business decision

Consider any necessary technical or other changes from the Department, Commission, or SAC, e.g., updates or modifications consistent with other CON review standards and the Public Health Code.

- Changes made as appropriate
- "American College of Radiology (ACR) Practice parameter for Performing and Interpreting Magnetic Resonance Imaging (MRI)."

Improved Quality

Relocation Requirements Draft Language.

(i) The owner of the building where the site is located has incurred a filing for bankruptcy under chapter seven (7) within the last three years.

(ii) The ownership of the building where the site is located has changed within 24 months of the date of the service being operational.

(iii) The MRI service being replaced is part of the replacement of an entire hospital to a new geographic site and has only one (1) MRI unit.

Reduced regulation

Review and update, if necessary, the designation of rural counties in Michigan by considering the utilization of population instead of the current federal designations.

- Informational item
- This would affect all standards. The CON Commission may wish to hear such a presentation if appropriate

Review and update, if necessary, the allowance for freestanding Emergency Departments to meet the same volume requirements as hospitals as defined in Section 3(2)(b)(iii)(B) of the standards.

- No changes were felt to be necessary

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS
FOR MAGNETIC RESONANCE IMAGING (MRI) SERVICES

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

Section 1. Applicability

Sec. 1. These standards are requirements for the approval of the initiation, expansion, replacement, or acquisition of MRI services and the delivery of services under Part 222 of the Code. Pursuant to Part 222 of the Code, MRI is a covered clinical service. 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.

Section 2. Definitions

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

(a) "Acquisition of an existing MRI service or existing MRI unit(s)" means obtaining control or possession of an existing fixed or mobile MRI service or existing MRI unit(s) by contract, ownership, lease, or other comparable arrangement.

(b) "Actual MRI adjusted procedures" or "MRI adjusted procedures," means the number of MRI procedures, adjusted in accordance with the applicable provisions of Section 15, performed on an existing MRI unit, or if an MRI service has two or more MRI units at the same site, the average number of MRI adjusted procedures performed on each unit, for the 12-month period reported on the most recently published "MRI Service Utilization List," as of the date an application is deemed submitted by the Department.

(c) "Available MRI adjusted procedures" means the number of MRI adjusted procedures performed by an existing MRI service in excess of 8,000 per fixed MRI unit and 7,000 per mobile MRI unit. For either a fixed or mobile MRI service, the number of MRI units used to compute available MRI adjusted procedures shall include both existing and approved but not yet operational MRI units. In determining the number of available MRI adjusted procedures, the Department shall use data for the 12-month period reported on the most recently published list of available MRI adjusted procedures as of the date an application is deemed submitted by the Department.

In the case of a mobile MRI unit, the term means the sum of all MRI adjusted procedures performed by the same mobile MRI unit at all of the host sites combined that is in excess of 7,000. For example, if a mobile MRI unit serves five host sites, the term means the sum of MRI adjusted procedures for all five host sites combined that is in excess of 7,000 MRI adjusted procedures.

(d) "Central service coordinator" means the organizational unit that has operational responsibility for a mobile MRI unit(s).

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

(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) "Contrast MRI procedure" means an MRI procedure involving either of the following: (i) a procedure following use of a contrast agent or (ii) procedures performed both before and after the use of a contrast agent.

(h) "Dedicated pediatric MRI" means an MRI unit on which at least 80% of the MRI procedures are performed on patients under 18 years of age

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

(j) "Doctor" means an individual licensed under Article 15 of the Code to engage in the practice of medicine, osteopathic medicine and surgery, chiropractic, dentistry, or podiatry.

(k) "Existing MRI service" means either the utilization of a CON-approved and operational MRI unit(s) at one site in the case of a fixed MRI service, and in the case of a mobile MRI service, the utilization of a CON-approved and operational mobile MRI unit(s) at each host site, on the date an application is submitted to the Department.

(l) "Existing MRI unit" means a CON-approved and operational MRI unit used to provide MRI services.

(m) "Expand an existing fixed MRI service" means an increase in the number of fixed MRI units to be operated by the applicant.

(n) "Expand an existing mobile MRI service" means the addition of a mobile MRI unit that will be operated by a central service coordinator that is approved to operate one or more mobile MRI units as of the date an application is submitted to the Department.

(o) "Group practice" means a group practice as defined pursuant to the provisions of 42 U.S.C. 1395nn (h)(4), commonly known as Stark II, and the Code of Federal Regulations, 42 CFR, Part 411, published in the Federal Register on August 14, 1995, or its replacement.

(p) "Health service area" or "HSA" means the geographic areas set forth in Section 21.

(q) "Host site" means the site at which a mobile MRI unit is authorized by CON to provide MRI services.

(r) "Initiate a fixed MRI service" means begin operation of a fixed MRI service at a site that does not provide or is not CON approved to provide fixed MRI services as of the date an application is submitted to the Department. The term does not include the acquisition or replacement of an existing fixed MRI service to a new site or the renewal of a lease.

(s) "Initiate a mobile MRI host site" means the provision of MRI services at a host site that has not received any MRI services within 12 months from the date an application is submitted to the Department. The term does not include the renewal of a lease.

(t) "Initiate a mobile MRI service" means begin operation of a mobile MRI unit that serves two or more host sites.

The term does not include the acquisition of an existing mobile MRI service or the renewal of a lease.

(u) "Inpatient" means an MRI visit involving an individual who has been admitted to the licensed hospital at the site of the MRI service/unit or in the case of an MRI unit that is not located at that licensed hospital site, an admitted patient transported from a licensed hospital site by ambulance to the MRI service.

(v) "Institutional review board" or "IRB" means an institutional review board as defined by Public Law 93-348 that is regulated by Title 45 CFR 46.

(w) "Intra-operative magnetic resonance imaging" or "IMRI" means the integrated use of MRI technology during surgical and interventional procedures within a licensed operative environment.

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

(y) "Magnetic resonance imaging" or "MRI" means the analysis of the interaction that occurs between radio frequency energy, atomic nuclei, and strong magnetic fields to produce cross sectional images similar to those displayed by computed tomography (CT) but without the use of ionizing radiation.

(z) "MRI adjusted procedure" means an MRI visit, at an existing MRI service, that has been adjusted in accordance with the applicable provisions of Section 15.

(aa) "MRI database" means the database, maintained by the Department pursuant to Section 14 of these standards, that collects information about each MRI visit at MRI services located in Michigan.

(bb) "MRI-guided electrophysiology intervention" or "MRI-guided EPI" means equipment specifically designed for the integrated use of MRI technology for the purposes of electrophysiology interventional procedures within a cardiac catheterization lab.

(cc) "MRI procedure" means a procedure conducted by an MRI unit approved pursuant to sections 3, 4, 5, 6, 7, or 9 of these standards which is either a single, billable diagnostic magnetic resonance procedure or a procedure conducted by an MRI unit at a site participating with an approved diagnostic

radiology residency program, under a research protocol approved by an IRB. The capital and operating costs related to the research use are charged to a specific research account and not charged to or collected from third-party payors or patients. The term does not include a procedure conducted by an MRI unit approved pursuant to Section 7.

(dd) "MRI services" means either the utilization of an authorized MRI unit(s) at one site in the case of a fixed MRI service or in the case of a mobile MRI service, the utilization of an authorized mobile MRI unit at each host site.

(ee) "MRI unit" means the magnetic resonance system consisting of an integrated set of machines and related equipment necessary to produce the images and/or spectroscopic quantitative data from scans including FDA-approved positron emission tomography (PET)/MRI scanner hybrids if used for MRI only procedures. The term does not include MRI simulators used solely for treatment planning purposes in conjunction with a Megavoltage Radiation Therapy (MRT) unit.

(ff) "MRI visit" means a single patient visit to an MRI service/unit that may involve one or more MRI procedures.

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

(hh) "Mobile MRI unit" means an MRI unit operating at two or more host sites and that has a central service coordinator. The mobile MRI unit shall operate under a contractual agreement for the provision of MRI services at each host site on a regularly scheduled basis.

(ii) "Ownership interest, direct or indirect" means a direct ownership relationship between a doctor and an applicant entity or an ownership relationship between a doctor and an entity that has an ownership relationship with an applicant entity.

(jj) "Pediatric patient" means a patient who is 12 years of age or less, except for Section 8.

(kk) "Planning area" means

(i) in the case of a proposed fixed MRI service or unit, the geographic area within a 20-mile radius from the proposed site if the proposed site is not in a rural or micropolitan statistical area county and a 75-mile radius from the proposed site if the proposed site is in a rural or micropolitan statistical area county.

(ii) in the case of a proposed mobile MRI service or unit, except as provided in subsection (iii), the geographic area within a 20-mile radius from each proposed host site if the proposed site is not in a rural or micropolitan statistical area county and within a 75-mile radius from each proposed host site if the proposed site is in a rural or micropolitan statistical area county.

(iii) in the case of a proposed mobile MRI service or unit meeting the requirement of Section 15(2)(d), the health service area in which all the proposed mobile host sites will be located.

(ll) "Referring doctor" means the doctor of record who ordered the MRI procedure(s) and either to whom the primary report of the results of an MRI procedure(s) is sent or in the case of a teaching facility, the attending doctor who is responsible for the house officer or resident that requested the MRI procedure.

(mm) "Renewal of a lease" means extending the effective period of a lease for an existing MRI unit that does not involve either replacement of the MRI unit, as defined in Section 4, or (ii) a change in the parties to the lease.

(nn) "Research scan" means an MRI scan administered under a research protocol approved by the applicant's IRB.

(oo) "Re-sedated patient" means a patient, either pediatric or adult, who fails the initial sedation during the scan time and must be extracted from the unit to rescue the patient with additional sedation.

(pp) "Sedated patient" means a patient that meets all of the following:

(i) whose level of consciousness is either conscious-sedation or a higher level of sedation, as defined by the American Association of Anesthesiologists, the American Academy of Pediatrics, the Joint Commission on the Accreditation of Health Care Organizations, or an equivalent definition.

(ii) who is monitored by mechanical devices while in the magnet.

(iii) who requires observation while in the magnet by personnel, other than employees routinely assigned to the MRI unit, who are trained in cardiopulmonary resuscitation (CPR).

(qq) "Site" means

(i) in the case of a licensed hospital site, a location that is part of the licensed hospital site or a location that is contiguous to the licensed hospital site or

(ii) in the case of a location that is not a licensed hospital site, a location at the same address or a location that is contiguous to that address.

(rr) "Special needs patient" means a non-sedated patient, either pediatric or adult, with any of the following conditions: down syndrome, autism, attention deficit hyperactivity disorder (ADHD), developmental delay, malformation syndromes, hunter's syndrome, multi-system disorders, psychiatric disorders, IMPLANTABLE CARDIAC DEVICES (ICDS), and other conditions that make the patient unable to comply with the positional requirements of the exam OR IS UNABLE TO COMPLY WITH THE MOTIONLESS REQUIREMENTS AND WHOSE RESULTING MOVEMENTS RESULT IN NON-DIAGNOSTIC QUALITY IMAGES THEREFORE REQUIRING THE TECHNOLOGIST TO REPEAT THE SAME SEQUENCE IN AN ATTEMPT TO OBTAIN A DIAGNOSTIC QUALITY IMAGE.

(ss) "Teaching facility" means a licensed hospital site, or other location, that provides either fixed or mobile MRI services and at which residents or fellows of a training program in diagnostic radiology, that is approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association, are assigned.

(tt) "Unadjusted MRI scan" means an MRI procedure performed on a single anatomical site as defined by the MRI database and that is not adjusted pursuant to the applicable provisions of Section 15.

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

Section 3. Requirements to initiate an MRI service

Sec. 3. An applicant proposing to initiate an MRI service or a host site shall demonstrate the following requirements, as applicable:

(1) An applicant proposing to initiate a fixed MRI service shall demonstrate 6,000 available MRI adjusted procedures per proposed fixed MRI unit from within the same planning area as the proposed service/unit.

(2) An applicant proposing to initiate a fixed MRI service that meets the following requirements shall not be required to be in compliance with subsection (1):

(a) The applicant is currently an existing host site.

(b) The applicant has received in aggregate, one of the following:

(i) At least 6,000 MRI adjusted procedures.

(ii) At least 4,000 MRI adjusted procedures and the applicant meets all of the following:

(A) Is located in a county that has no fixed MRI machines that are pending, approved by the Department, or operational at the time the application is deemed submitted.

(B) The nearest fixed MRI machine is located more than 15 radius miles from the application site.

(iii) At least 3,000 MRI adjusted procedures and the applicant meets all of the following:

(A) The proposed site is a hospital licensed under Part 215 of the Code.

(B) The applicant hospital operates an emergency room that provides 24-hour emergency care services and at least 20,000 visits within the most recent 12-month period for which data, verifiable by the Department, is available.

(c) All of the MRI adjusted procedures from the mobile MRI service referenced in Section 3(2)(b) shall be utilized even if the aggregated data exceeds the minimum requirements.

(d) The applicant shall install the fixed MRI unit at the same site as the existing host site or within the relocation zone. If applying pursuant to Section 3(2)(b)(iii), the applicant shall install the fixed MRI unit at the same site as the existing host site.

(e) The applicant shall cease operation as a host site and not become a host site for at least 12 months from the date the fixed service and its unit becomes operational.

(3) An applicant proposing to initiate a mobile MRI service shall demonstrate 5,500 available MRI adjusted procedures from within the same planning area as the proposed service/unit, and the applicant shall meet the following:

(a) Identify the proposed route schedule and procedures for handling emergency situations.
(b) Submit copies of all proposed contracts for the proposed host site related to the mobile MRI service.
(c) Identify a minimum of two (2) host sites for the proposed service.

(4) An applicant, whether the central service coordinator or the host site, proposing to initiate a host site on a new or existing mobile MRI service shall demonstrate the following, as applicable:
(a) 600 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, for a proposed host site that is not located in a rural or micropolitan statistical area county, or
(b) 400 available MRI adjusted procedures from within the same planning area for a proposed host site that is located in a rural or micropolitan statistical area county, and
(c) The proposed host site has not received any mobile MRI service within the most recent 12-month period as of the date an application is submitted to the Department.

(5) An applicant proposing to add or change service on an existing mobile MRI service that meets the following requirements shall not be required to be in compliance with subsection (4):
(a) The host site has received mobile MRI services from an existing mobile MRI unit within the most recent 12-month period as of the date an application is submitted to the Department.
(b) Submit copies of all proposed contracts for the proposed host site related to the mobile MRI service.

(6) The applicant shall demonstrate that the available MRI adjusted procedures from the "Available MRI Adjusted Procedures List" or the adjusted procedures from the "MRI Service Utilization List," as applicable, are from the most recently published MRI lists as of the date an application is deemed submitted by the Department.

Section 4. Requirements to replace an existing MRI unit

Sec. 4. Replace an existing MRI unit means (i) any equipment change involving a change in, or replacement of, the entire MRI unit resulting in an applicant operating the same number and type (fixed or mobile) of MRI units before and after project completion or (ii) an equipment change that involves a capital expenditure of $750,000 or more in any consecutive 24-month period or (iii) the renewal of a lease. Replacement also means the relocation of an MRI service or unit to a new site. The term does not include the replacement of components of the MRI system, including the magnet, under an existing service contract or required maintenance to maintain the system to operate within manufacturer specifications. The term does not include an upgrade to an existing MRI unit or repair of an existing MRI service or unit, and it does not include a host site that proposes to receive mobile MRI services from a different central service coordinator if the requirements of Section 3(5) have been met.

(1) "Upgrade an existing MRI unit" means any equipment change that
(i) does not involve a change in, or replacement of, the entire MRI unit, does not result in an increase in the number of MRI units; or does not result in a change in the type of MRI unit (e.g., changing a mobile MRI unit to a fixed MRI unit); and
(ii) involves a capital expenditure related to the MRI equipment of less than $750,000 in any consecutive 24-month period.

(2) “Repair an existing MRI unit” means restoring the ability of the system to operate within the manufacturer’s specifications by replacing or repairing the existing components or parts of the system, including the magnet, pursuant to the terms of an existing maintenance agreement WITH THE MANUFACTURER OF THE MRI UNIT that does not result in a change in the strength of the MRI unit.

(3) An applicant proposing to replace an existing MRI unit shall demonstrate the following requirements~~, as applicable~~:

~~(a) An applicant shall demonstrate that the applicable MRI adjusted procedures are from the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department. An applicant proposing to replace an existing MRI unit that is below 1 tesla with an MRI unit that is a 1 tesla or higher, shall be exempt once, as of September 18, 2013, from the minimum volume requirements for replacement:~~

~~(i) Each existing mobile MRI unit on the network has performed at least an average of 5,500 MRI adjusted procedures per MRI unit.~~

~~(ii) Each existing fixed MRI unit at the current site has performed at least an average of 6,000 MRI adjusted procedures per MRI unit unless the applicant demonstrates compliance with one of the following:~~

~~(A) The existing fixed MRI unit initiated pursuant to Section 3(2)(b)(ii) has performed at least 4,000 MRI adjusted procedures and is the only fixed MRI unit at the current site.~~

~~(B) The existing fixed MRI unit initiated pursuant to Section 3(2)(b)(iii) has performed at least 3,000 MRI adjusted procedures and is the only fixed MRI unit at the current site.~~

~~(iii) Each existing dedicated pediatric MRI unit at the current site has performed at least an average of 3,500 MRI adjusted procedures per MRI unit.~~

~~(b)~~ Equipment that is replaced shall be removed from service and disposed of or rendered considerably inoperable on or before the date that the replacement equipment becomes operational.

(~~c~~b) The replacement unit shall be located at the same site.

(~~d~~c) An applicant proposing to replace an existing MRI unit that does not involve a renewal of a lease shall demonstrate that the MRI unit to be replaced is fully depreciated according to generally accepted accounting principles; the existing equipment clearly poses a threat to the safety of the public; or the proposed replacement equipment offers a significant technological improvement which enhances quality of care, increases efficiency, and reduces operating costs.

(4) An applicant proposing to replace an existing mobile MRI host site to a new location shall demonstrate the following:

(a) The applicant currently operates the MRI mobile host site to be relocated.

(b) The MRI mobile host site to be relocated has been in operation ~~for at least 36 months~~ as of the date an application is submitted to the Department.

(c) The proposed new site is within a 5-mile radius of the existing site for a metropolitan statistical area county or within a 10-mile radius for a rural or micropolitan statistical area county.

~~(d) The mobile MRI host site to be relocated performed at least the applicable minimum number of MRI adjusted procedures set forth in Section 14 based on the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department.~~

(~~e~~d) The relocation will not involve a change in the current central service coordinator unless the requirements of Section 3(5) are met.

(5) An applicant proposing to replace an existing fixed MRI service and its unit(s) to a new site shall demonstrate the following:

(a) The existing MRI service and its unit(s) to be replaced has been in operation for at least 36 months as of the date an application is submitted to the Department UNLESS THE APPLICANT MEETS THE REQUIREMENT IN SUBSECTION (c)(i) OR (ii).

(b) The proposed new site is within a 10-mile radius of the existing site.

(c) Each existing MRI unit to be relocated performed at least the applicable minimum number of MRI adjusted procedures set forth in Section 14 based on the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department,UNLESS ONE OF THE FOLLOWING REQUIRMENTS ARE MET~~.~~:

(i) THE OWNER OF THE BUILDING WHERE THE SITE IS LOCATED HAS INCURRED A FILING FOR BANKRUPTCY UNDER CHAPTER SEVEN (7) WITHIN THE LAST THREE YEARS;

(ii) THE OWNERSHIP OF THE BUILDING WHERE THE SITE IS LOCATED HAS CHANGED WITHIN 24 MONTHS OF THE DATE OF THE SERVICE BEING OPERATIONAL; OR

(iii) THE MRI SERVICE BEING REPLACED IS PART OF THE REPLACEMENT OF AN ENTIRE HOSPITAL TO A NEW GEOGRAPHIC SITE AND HAS ONLY ONE (1) MRI UNIT.

(6) An applicant proposing to replace a fixed MRI unit of an existing MRI service to a new site shall demonstrate the following:

(a) The applicant currently operates the MRI service from which the unit will be relocated.

(b) The existing MRI service from which the MRI unit(s) to be relocated has been in operation for at least 36 months as of the date an application is submitted to the Department.

(c) The proposed new site is within a 10-mile radius of the existing site.

(d) Each existing MRI unit at the service from which a unit is to be relocated performed at least the applicable minimum number of MRI adjusted procedures set forth in Section 14 based on the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department.

(e) For volume purposes, the new site shall remain associated to the original site for a minimum of three years.

Section 5. Requirements to expand an existing MRI service

Sec. 5. An applicant proposing to expand an existing MRI service shall demonstrate the following:

(1) An applicant shall demonstrate that the applicable MRI adjustable procedures are from the most recently published MRI Service Utilization List as of the date of an application is deemed submitted by the Department:

(a) Each existing MRI unit on the network has performed at least an average of 9,000 MRI adjusted procedures per MRI unit.

(b) Each existing fixed MRI unit at the current site has performed at least an average of 11,000 MRI adjusted procedures per MRI unit.

(c) Each existing dedicated pediatric MRI unit at the current site has performed at least an average of 3,500 MRI adjusted procedures per MRI unit.

(2) The additional fixed unit shall be located at the same site unless the requirements of the replacement section have been met.

Section 6. Requirements to acquire an existing MRI service or an existing MRI unit(s)

Sec. 6. ~~(1)~~ An applicant proposing to acquire an existing fixed or mobile MRI service and its unit(s) shall demonstrate the following:

(~~a~~1) For the first application proposing to acquire an existing fixed or mobile MRI service on or after July 1, 1997, the existing MRI service and its unit(s) to be acquired shall not be required to be in compliance with the volume requirements applicable to a seller/lessor on the date the acquisition occurs. The MRI service shall be operating at the applicable volume requirements set forth in Section 14 of these standards in the second 12 months after the effective date of the acquisition, and annually thereafter.

(~~b~~2)For any application proposing to acquire an existing fixed or mobile MRI service and its unit(s), except the first application approved pursuant to subsection (a), an applicant shall be required to document that the MRI service and its unit(s) to be acquired is operating in compliance with the volume requirements set forth in Section 14 of these standards applicable to an existing MRI service on the date the application is submitted to the Department.

(~~2~~3) An applicant proposing to acquire an existing fixed or mobile MRI unit of an existing MRI service shall demonstrate that the proposed project meets all of the following, AS APPLICABLE:

(a) AN APPLICANT SHALL DEMONSTRATE THAT THE APPLICABLE MRI ADJUSTABLE PROCEDURES ARE FROM THE MOST RECENTLY PUBLISHED MRI SERVICE UTILIZATION LIST AS OF THE DATE OF AN APPLICATION IS DEEMED SUBMITTED BY THE DEPARTMENT:

(i)- THE FIXED MRI UNIT(S) TO BE ACQUIRED PERFORMED AT LEAST 6,000 MRI ADJUSTED PROCEDURES PER FIXED MRI UNIT.

(ii) THE MOBILE MRI UNIT(S) TO BE ACQUIRED PERFORMED AT LEAST 5,500 MRI ADJUSTED PROCEDURES PER MOBILE MRI UNIT.

(b) The project will not change the number of MRI units at the site ~~of the MRI service~~FROM WHICH THE NUMBER OF UNITS ARE being acquired, subject to the applicable requirements under Section 4(6), unless the applicant demonstrates that the project is in compliance with the requirements of the initiation or expansion Section, as applicable.

(~~b~~c) The project will not result in the replacement of an MRI unit at the MRI service to be acquired unless the applicant demonstrates that the requirements of the replacement section have been met.

Section 7. Requirements to establish a dedicated research MRI unit

Sec. 7. An applicant proposing an MRI unit to be used exclusively for research shall demonstrate the following:

(1) The applicant agrees that the dedicated research MRI unit will be used primarily (70% or more of the procedures) for research purposes only.

(2) Submit copies of documentation demonstrating that the applicant operates a diagnostic radiology residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or an equivalent organization.

(3) Submit copies of documentation demonstrating that the MRI unit shall operate under a protocol approved by the applicant's IRB.

(4) An applicant meeting the requirements of this section shall be exempt from meeting the requirements of sections to initiate and replace.

(5) THE DEDICATED RESEARCH MRI UNIT APPROVED UNDER THIS SECTION MAY NOT UTILIZE MRI ADJUSTED PROCEDURES PERFORMED ON THE DEDICATED MRI UNIT TO DEMONSTRATE NEED OR TO SATISFY MRI CON REVIEW STANDARDS REQUIREMENTS.

Section 8. Requirements to establish a dedicated pediatric MRI unit

Sec. 8. An applicant proposing to establish dedicated pediatric MRI shall demonstrate all of the following:

(1) The applicant shall have experienced at least 7,000 pediatric (< 18 years old) discharges (excluding normal newborns) in the most recent year of operation.

(2) The applicant shall have performed at least 5,000 pediatric (< 18 years old) surgeries in the most recent year of operation.

(3) The applicant shall have an active medical staff that includes, but is not limited to, physicians who are fellowship-trained in the following pediatric specialties:

(a) pediatric radiology (at least two)
(b) pediatric anesthesiology
(c) pediatric cardiology
(d) pediatric critical care
(e) pediatric gastroenterology
(f) pediatric hematology/oncology
(g) pediatric neurology

(h) pediatric neurosurgery
(i) pediatric orthopedic surgery
(j) pediatric pathology
(k) pediatric pulmonology
(l) pediatric surgery
(m) neonatology

(4) The applicant shall have in operation the following pediatric specialty programs:
(a) pediatric bone marrow transplant program
(b) established pediatric sedation program
(c) pediatric open heart program

(5) An applicant meeting the requirements of this section shall be exempt from meeting the requirements of Section 5 of these standards.

Section 9. Requirements for all applicants proposing to initiate, replace, or acquire a hospital based IMRI

Sec. 9. An applicant proposing to initiate, replace, or acquire a hospital based IMRI service shall demonstrate each of the following, as applicable to the proposed project.

(1) The proposed site is a licensed hospital under Part 215 of the Code.

(2) The proposed site has an existing fixed MRI service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(3) The proposed site has an existing and operational surgical service and is meeting its minimum volume requirements pursuant to the CON Review Standards for Surgical Services.

(4) The applicant has achieved one of the following:
(a) at least 1,500 oncology discharges in the most recent year of operation; or
(b) at least 1,000 neurological surgeries in the most recent year of operation; or
(c) at least 7,000 pediatric (<18 years old) discharges (excluding normal newborns) and at least 5,000 pediatric (<18 years old) surgeries in the most recent year of operation.

(5) The proposed IMRI unit must be located in an operating room or a room adjoining an operating room allowing for transfer of the patient between the operating room and this adjoining room.

(6) Non-surgical diagnostic studies shall not be performed on an IMRI unit approved under this section unless the patient meets one of the following criteria:
(a) the patient has been admitted to an inpatient unit; or
(b) the patient is having the study performed on an outpatient basis, but is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists.

(7) The approved IMRI unit will not be subject to MRI volume requirements.

(8) The applicant shall not utilize the procedures performed on the IMRI unit to demonstrate need or to satisfy MRI CON review standards requirements.

Section 10. Requirements for all applicants proposing to initiate, replace, or acquire a hospital based MRI-guided EPI service

Sec. 10. An applicant proposing to initiate, replace, or acquire a hospital based MRI-guided EPI service shall demonstrate each of the following, as applicable to the proposed project.

(1) The proposed site is a licensed hospital under part 215 of the Code.

(2) The proposed site has an existing fixed MRI service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(3) The proposed site has an existing and operational therapeutic cardiac catheterization service and is meeting its minimum volume requirements pursuant to the CON review standards for cardiac catheterization services and open heart surgery services.

(4) The proposed MRI-guided EPI unit must be located in a cardiac catheterization lab containing a flouroscopy unit with an adjoining room containing an MRI scanner. The rooms shall contain a patient transfer system allowing for transfer of the patient between the cardiac catheterization lab and the MRI unit, utilizing one of the following:
(a) moving the patient to the MRI scanner, or
(b) installing the MRI scanner on a sliding gantry to allow the patient to remain stationary.

(5) Non-cardiac MRI diagnostic studies shall not be performed in an MRI-guided EPI unit approved under this section unless the patient meets one of the following criteria:
(a) The patient has been admitted to an inpatient unit; or
(b) The patient is having the study performed on an outpatient basis as follows:
(i) is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists, or
(ii) has an implantable cardiac device.

(6) The approved MRI-guided EPI unit shall not be subject to MRI volume requirements.

(7) The applicant shall not utilize the procedures performed on the MRI-guided EPI unit to demonstrate need or to satisfy MRI CON review standards requirements.

Section 11. Requirements for all applicants proposing to initiate, replace, or acquire an MRI simulator that will not be used solely for MRT treatment planning purposes

Sec. 11. MRI simulation is the use of MRI to help simulate (or plan) a patient's MRT treatment and to incorporate superior delineation of soft tissues for MRT treatment plans. An applicant proposing to initiate, replace, or acquire an MRI simulator shall demonstrate each of the following, as applicable to the proposed project.

(1) The proposed site has an existing fixed MRI service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(2) The proposed site has an existing and operational MRT service and is meeting its minimum volume requirements pursuant to the CON review standards for MRT services/units.

(3) MRI diagnostic studies shall not be performed using an MRI simulator approved under this section unless the patient meets one of the following criteria:
(a) The patient has been admitted to an inpatient unit; or
(B) The patient is having the study performed on an outpatient basis, but is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists.

(4) The approved MRI simulator will not be subject to MRI volume requirements.

(5) The applicant shall not utilize the procedures performed on the MRI simulator to demonstrate need or to satisfy MRI CON review standards requirements.

Section 12. Requirements for approval of an FDA-approved PET/MRI scanner hybrid for initiation, expansion, replacement, and acquisition

Sec. 12. An applicant proposing to initiate, expand, replace, or acquire an FDA-approved PET/MRI scanner hybrid shall demonstrate that it meets all of the following:

(1) There is an approved PET CON for the FDA-approved PET/MRI hybrid, and the FDA-approved PET/MRI scanner hybrid is in compliance with all applicable project delivery requirements as set forth in the CON review standards for PET.

(2) The applicant agrees to operate the FDA-approved PET/MRI scanner hybrid in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

(3) The approved FDA-approved PET/MRI scanner hybrid shall not be subject to MRI volume requirements.

(4) An FDA-approved PET/MRI scanner hybrid approved under the CON review standards for PET scanner services and the review standards for MRI scanner services may not utilize MRI procedures performed on an FDA-approved PET/MRI scanner hybrid to demonstrate need or to satisfy MRI CON review standards requirements.

Section 13. Requirements for all applicants

Sec. 13. 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.

Section 14. Project delivery requirements – terms of approval

Sec. 14. An applicant shall agree that, if approved, MRI services, whether fixed or mobile, shall be delivered and maintained in compliance with the following:

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(a) An applicant shall develop and maintain policies and procedures that establish protocols for assuring the effectiveness of operation and the safety of the general public, patients, and staff in the MRI service.

(b) An applicant shall establish a schedule for preventive maintenance for the MRI unit.

(c) An applicant shall provide documentation identifying the specific individuals that form the MRI team. At a minimum, the MRI team shall consist of the following professionals:

(i) Physicians who shall be responsible for screening of patients to assure appropriate utilization of the MRI service and taking and interpretation of scans. At least one of these physicians shall be a board-certified radiologist.

(ii) An appropriately trained MRI technician who shall be responsible for taking an MRI scan.

(iii) An MRI physicist/engineer available as a team member on a full-time, part-time, or contractual basis.

(d) An applicant shall document that the MRI team members have the following qualifications:

(i) Each physician credentialed to interpret MRI scans meets the requirements of each of the following:

(A) The physician is licensed to practice medicine in the State of Michigan.

(B) The physician has had at least 60 hours of training in MRI physics, MRI safety, and MRI instrumentation in a program that is part of an imaging program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and the physician meets the requirements of subdivision (1), (2), or (3):

(1) Board certification by the American Board of Radiology, the American Osteopathic Board of Radiology, or the Royal College of Physicians and Surgeons of Canada. If the diagnostic radiology program completed by a physician in order to become board certified did not include at least two months of MRI training, that physician shall document that he or she has had the equivalent of two months of postgraduate training in clinical MRI imaging at an institution which has a radiology program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

(2) Formal training by an imaging program(s), accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association that included two years of training in cross-sectional imaging and six months training in organ-specific imaging areas.

(3) A practice in which at least one-third of total professional time, based on a full-time clinical practice during the most recent 5-year period, has been the primary interpretation of MR imaging.

(C) The physician has completed and will complete a minimum of 40 hours every two years of Category in Continuing Medical Education credits in topics directly involving MR imaging.

(D) The physician complies with the "American College of Radiology (ACR) Practice ~~Guideline~~ PARAMETER for Performing and Interpreting Magnetic Resonance Imaging (MRI)."

(ii) An MRI technologist who is registered by the American Registry of Radiologic Technicians or by the American Registry of Magnetic Resonance Imaging Technologists (ARMRIT) and has, or will have within 36 months of the effective date of these standards or the date a technologist is employed by an MRI service, whichever is later, special certification in MRI. If a technologist does not have special certification in MRI within either of the 3-year periods of time, all continuing education requirements shall be in the area of MRI services.

(iii) An applicant shall document that an MRI physicist/engineer is appropriately qualified. For purposes of evaluating this subdivision, the Department shall consider it prima facie evidence as to the qualifications of the physicist/engineer if the physicist/engineer is certified as a medical physicist by the American Board of Radiology, the American Board of Medical Physics, or the American Board of Science in Nuclear Medicine. However, the applicant may submit and the Department may accept other evidence that an MRI physicist/engineer is qualified appropriately.

(e) The applicant shall have, within the MRI unit/service, equipment and supplies to handle clinical emergencies that might occur in the unit. MRI service staff will be trained in CPR and other appropriate emergency interventions. A physician shall be on-site, in, or immediately available to the MRI unit at all times when patients are undergoing scans.

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

The applicant, to assure that the MRI unit will be utilized by all segments of the Michigan population, shall

(a) provide MRI services to all individuals based on the clinical indications of need for the service and not on ability to pay or source of payment.

(b) maintain information by source of payment to indicate the volume of care from each source provided annually.

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

(d) The operation of and referral of patients to the MRI unit shall be in conformance with 1978 PA 368, Sec. 16221, as amended by 1986 PA 319; MCL 333.16221; MSA 14.15 (16221).

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

(a) MRI units shall be operating at a minimum average annual utilization during the second 12 months of operation, and annually thereafter, as applicable:

(i) 6,000 MRI adjusted procedures per unit for fixed MRI services unless compliant with (~~1~~A) or (~~2~~B),

(A) 4,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(ii) and is the only fixed MRI unit at the current site,

(B) 3,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(iii) and is the only fixed MRI unit at the hospital site licensed under part 215 of the code,

(ii) 5,500 MRI adjusted procedures per unit for mobile MRI services.

(iii) 3,500 MRI adjusted procedures per unit for dedicated pediatric MRI units.

(iv) Each mobile host site in a rural or micropolitan statistical area county shall have provided at least a total of 400 adjusted procedures during its second 12 months of operation, and annually thereafter, from all mobile units providing services to the site. Each mobile host site not in a rural or micropolitan statistical area county shall have provided at least a total of 600 adjusted procedures during its second 12 months of operation and annually thereafter, from all mobile units providing services to the site.

(v) In meeting these requirements, an applicant shall not include any MRI adjusted procedures performed on an MRI unit used exclusively for research and approved pursuant to Section 7 or for an IMRI unit approved pursuant to Section 9.

(b) 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, operating schedules, demographic and diagnostic information, and the volume of care provided to patients from all payor sources, as well as other data requested by the Department or its designee and approved by the Commission. The applicant shall provide the required data in a format established by the Department and in a mutually agreed upon media no later than 30 days following the last day of the quarter for which data are being reported to the Department. An applicant shall be considered in violation of this term of approval if the required data are not submitted to the Department within 30 days following the last day of the quarter for which data are being reported. The Department may elect to verify the data through on-site review of appropriate records. Data for an MRI unit approved pursuant to Section 7, Section 8, Section 9, Section 10, or Section 11 shall be reported separately.
For purposes of Section 9, the data reported shall include, at a minimum, how often the IMRI unit is used and for what type of services, i.e., intra-operative or diagnostic. For purposes of Section 10, the data reported shall include, at a minimum, how often the MRI-guided EPI unit is used and for what type of services, i.e., electrophysiology or diagnostic. For purposes of Section 11, the data reported shall include, at a minimum, how often the MRI simulator is used and for what type of services, i.e., treatment plans or diagnostic services.

(c) The applicant shall provide the Department with a notice stating the first date on which the MRI unit became operational, and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(d) An applicant who is a central service coordinator shall notify the Department of any additions, deletions, or changes in the host sites of each approved mobile MRI unit ~~within 10 days~~ after the change(s) in host sites is made.

(5) An applicant for an MRI unit approved under Section 7 shall agree that the services provided by the MRI unit are delivered in compliance with the following terms.

(a) The capital and operating costs relating to the research use of the MRI unit shall be charged only to a specific research account(s) and not to any patient or third-party payor.

(b) The MRI unit shall not be used for any purposes other than as approved by the IRB unless the applicant has obtained CON approval for the MRI unit pursuant to Part 222 and these standards, other than Section 7.

(c) The dedicated research MRI unit will be used primarily (70% or more of the procedures) for research purposes only.

(6) The dedicated pediatric MRI unit approved under Section 8 shall include at least 80% of the MRI procedures that are performed on patients under 18 years of age.

(7) 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 15. MRI procedure adjustments

Sec. 15. (1) The Department shall apply the following formula, as applicable, to determine the number of MRI adjusted procedures that are performed by an existing MRI service or unit:

(a) The base value for each MRI procedure is 1.0. For functional MRI (fMRI) procedures, MRI-guided interventions, and cardiac MRI procedures, the base value is 2.0.

(i) fMRI means brain activation studies.

(ii) MRI-guided interventions means any invasive procedure performed requiring MRI guidance performed in the MRI scanner.

(iii) Cardiac MRI Procedure means dedicated MRI performed of the heart done for the sole purpose of evaluation of cardiac function, physiology, or viability.

(b) For each MRI visit involving a pediatric patient, 0.25 shall be added to the base value.

(c) For each MRI visit involving an inpatient, 0.50 shall be added to the base value.

(d) For each MRI procedure performed on a sedated patient, 0.75 shall be added to the base value.

(e) For each MRI procedure performed on a re-sedated patient, 0.25 shall be added to the base value.

(f) For each MRI procedure performed on a special needs patient, 0.25 shall be added to the base value.

(g) For each MRI visit that involves both a clinical and research scan on a single patient in a single visit, 0.25 shall be added to the base value.

(h) For each contrast MRI procedure performed after use of a contrast agent, and not involving a procedure before use of a contrast agent, 0.35 shall be added to the base value.

(i) For each contrast MRI procedure involving a procedure before and after use of a contrast agent, 1.0 shall be added to the base value.

(j) For each MRI procedure performed at a teaching facility, 0.15 shall be added to the base value.

(k) The results of subsections (a) through (j) shall be summed, and that sum shall represent an MRI adjusted procedure.

(2) The Department shall apply not more than one of the adjustment factors set forth in this subsection, as applicable, to the number of MRI procedures adjusted in accordance with the applicable provisions of subsection (1) that are performed by an existing MRI service or unit.

(a) For a site located in a rural or micropolitan statistical area county, the number of MRI adjusted procedures shall be multiplied by a factor of 1.4.

(b) For a mobile MRI unit that serves hospitals and other host sites located in rural, micropolitan statistical area, and metropolitan statistical area counties, the number of MRI adjusted procedures for a site located in a rural or micropolitan statistical area county, shall be multiplied by a factor of 1.4 and for a site located in a metropolitan statistical area county, the number of MRI adjusted procedures shall be multiplied by a factor of 1.0.

(c) For a mobile MRI unit that serves only sites located in rural or micropolitan statistical area counties, the number of MRI adjusted procedures shall be multiplied by a factor of 2.0.

(d) For a mobile MRI unit that serves only sites located in a health service area with one or fewer fixed MRI units and one or fewer mobile MRI units, the number of MRI adjusted procedures shall be multiplied by a factor of 3.5.

(e) Subsection (2) shall not apply to an application proposing a subsequent fixed MRI unit (second, third, etc.) at the same site.

(3) The number of MRI adjusted procedures performed by an existing MRI service is the sum of the results of subsections (1) and (2).

Section 16. Documentation of actual utilization

Sec. 16. Documentation of the number of MRI procedures performed by an MRI unit shall be substantiated by the Department utilizing data submitted by the applicant in a format and media specified by the Department and as verified for the 12-month period reported on the most recently published "MRI Service Utilization List" as of the date an application is deemed submitted by the Department. The number of MRI procedures actually performed shall be documented by procedure records and not by application of the methodology required in Section 17. The Department may elect to verify the data through on-site review of appropriate records.

Section 17. Methodology for computing the number of available MRI adjusted procedures

Sec. 17. (1) The number of available MRI adjusted procedures required pursuant to Section 3 shall be computed in accordance with the methodology set forth in this section. In applying the methodology, the following steps shall be taken in sequence, and data for the 12-month period reported on the most recently published “Available MRI Adjusted Procedures List,” as of the date an application is deemed submitted by the Department, shall be used:

(a) Identify the number of actual MRI adjusted procedures performed by each existing MRI service as determined pursuant to Section 15.

(i) For purposes of computing actual MRI adjusted procedures, MRI adjusted procedures performed on MRI units used exclusively for research and approved pursuant to Section 7 and dedicated pediatric MRI approved pursuant to Section 8 shall be excluded.

(ii) For purposes of computing actual MRI adjusted procedures, the MRI adjusted procedures, from the host site routes utilized to meet the requirements of Section 3(2)(c), shall be excluded beginning at the time the application is submitted and for three years from the date the fixed MRI unit becomes operational.

(iii) For purposes of computing actual MRI adjusted procedures, the MRI adjusted procedures utilized to meet the requirements of Section 5(1) shall be reduced by 8,000 and shall be excluded beginning at the time the application is submitted and for three years from the date the fixed MRI unit becomes operational.

(b) Identify the number of available MRI adjusted procedures, if any, for each existing MRI service as determined pursuant to Section 2(1)(c).

(c) Determine the number of available MRI adjusted procedures that each referring doctor may commit from each service to an application in accordance with the following:

(i) Divide the number of available MRI adjusted procedures identified in subsection (b) for each service by the number of actual MRI adjusted procedures identified in subsection (a) for that existing MRI service.

(ii) For each doctor referring to that existing service, multiply the number of actual MRI adjusted procedures that the referring doctor made to the existing MRI service by the applicable proportion obtained by the calculation in subdivision (c)(i).

(A) For each doctor, subtract any available adjusted procedures previously committed. The total for each doctor cannot be less than zero.

(B) The total number of available adjusted procedures for that service shall be the sum of the results of (A) above.

(iii) For each MRI service, the available MRI adjusted procedures resulting from the calculation in (c)(ii) above shall be sorted in descending order by the available MRI adjusted procedures for each doctor. Then any duplicate values shall be sorted in descending order by the doctors’ license numbers (last 6 digits only).

(iv) Using the data produced in (c)(iii) above, sum the number of available adjusted procedures in descending order until the summation equals at least 75 percent of the total available adjusted procedures. This summation shall include the minimum number of doctors necessary to reach the 75 percent level.

(v) For the doctors representing 75 percent of the total available adjusted procedures in (c)(iv) above, sum the available adjusted procedures.

(vi) For the doctors used in subsection (c)(v) above, divide the total number of available adjusted procedures identified in (c)(ii)(B) above by the sum of those available adjusted procedures produced in (c)(v) above.

(vii) For only those doctors identified in (c)(v) above, multiply the result of (c)(vi) above by the available adjusted procedures calculated in (c)(ii)(A) above.

(viii) The result shall be the “Available MRI Adjusted Procedures List.”

(2) After publication of the "Available MRI Adjusted Procedures List" resulting from (1) above, the data shall be updated to account for a) doctor commitments of available MRI adjusted procedures in subsequent MRI CON applications and b) MRI adjusted procedures used in subsequent MRI CON applications received in which applicants apply for fixed MRI services pursuant to Section 3(2).

Section 18. Procedures and requirements for commitments of available MRI adjusted procedures

Sec. 18. (1) If one or more host sites on a mobile MRI service are located within the planning area of the proposed site, the applicant may access available MRI adjusted procedures from the entire mobile MRI service.

(2)(a) At the time the application is submitted to the Department, the applicant shall submit a signed data commitment on a form provided by the Department in response to the applicant’s letter of intent for each doctor committing available MRI adjusted procedures to that application for a new MRI unit that requires doctor commitments.

(b) An applicant also shall submit, at the time the application is submitted to the Department, a computer file that lists, for each MRI service from which data are being committed to the same application, the name and license number of each doctor for whom a signed and dated data commitment form is submitted.

(i) The computer file shall be provided to the Department on mutually agreed upon media and in a format prescribed by the Department.

(ii) If the doctor commitments submitted on the Departmental forms do not agree with the data on the computer file, the applicant shall be allowed to correct only the computer file data which includes adding physician commitments that were submitted at the time of application.

(c) If the required documentation for the doctor commitments submitted under this subsection is not submitted with the application on the designated application date, the application will be deemed submitted on the first applicable designated application date after all required documentation is received by the Department.

(3) The Department shall consider a signed and dated data commitment on a form provided by the Department in response to the applicant’s letter of intent that meets the requirements of each of the following, as applicable:

(a) A committing doctor certifies that 100% of his or her available MRI adjusted procedures for each specified MRI service, calculated pursuant to Section 17, is being committed and specifies the CON application number for the MRI unit to which the data commitment is made. A doctor shall not be required to commit available MRI adjusted procedures from all MRI services to which his or her patients are referred for MRI services but only from those MRI services specified by the doctor in the data commitment form provided by the Department and submitted by the applicant in support of its application.

(b) A committing doctor certifies ownership interest, either direct or indirect, in the applicant entity. Indirect ownership includes ownership in an entity that has ownership interest in the applicant entity. This requirement shall not apply if the applicant entity is a group practice of which the committing doctor is a member. Group practice means a group practice as defined pursuant to the provisions of 42 U.S.C. 1395nn (h)(4), commonly known as Stark II, and the Code of Federal Regulations, 42 CFR, Part 411, published in the Federal Register on August 14, 1995, or its replacement.

(c) A committing doctor certifies that he or she has not been provided, or received a promise of being provided, a financial incentive to commit any of his or her available MRI adjusted procedures to the application.

(4)(a) The Department shall not consider a data commitment from a doctor for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support approval of an application for a new ~~or additional~~ MRI unit, pursuant to Section 3, for which a final decision to approve has been issued by the Director of the Department until either of the following occurs:

(i) The approved CON is withdrawn or expires.

(ii) The MRI service or unit to which the data were committed has been in operation for at least 36 continuous months.

(b) The Department shall not consider a data commitment from a doctor for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support an application for a new fixed or mobile MRI unit ~~or additional mobile MRI unit~~ pursuant to Section 3, for which a final decision to disapprove was issued by the Director of the Department until either of the following occurs:

(i) A final decision to disapprove an application is issued by the Director and the applicant does not appeal that disapproval or

(ii) If an appeal was made~~, either~~THE ~~that~~ appeal is withdrawn by the applicant ~~or the committing doctor withdraws his or her data commitment pursuant to the requirements of subsection (8)~~.

(5) The Department shall not consider a data commitment from a committing doctor for available MRI adjusted procedures from the same MRI service if that doctor has submitted a signed data commitment, on a form provided by Department, for more than one (1) application for which a final decision has not been issued by the Department. If the Department determines that a doctor has submitted a signed data commitment for the same available MRI adjusted procedures from the same MRI service to more than one CON application pending a final decision for a new fixed or mobile MRI unit or additional mobile MRI unit pursuant to Section 3, the Department shall,

(a) if the applications were submitted on the same designated application date, notify all applicants, simultaneously and in writing, that one or more doctors have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the doctors' data from the same MRI service shall not be considered in the review of any of the pending applications submitted on the same designated application date until the doctor notifies the Department, in writing, of the one (1) application for which the data commitment shall be considered.

(b) if the applications were submitted on different designated application dates, consider the data commitment in the application submitted on the earliest designated application date and shall notify, simultaneously in writing, all applicants of applications submitted on designated application dates subsequent to the earliest date that one or more committing doctors have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the doctors' data shall not be considered in the review of the application(s) submitted on the subsequent designated application date(s).

(6) The Department shall not consider any data commitment submitted by an applicant after the date an application is deemed submitted unless an applicant is notified by the Department, pursuant to subsection (5), that one or more committing doctors submitted data commitments for available MRI adjusted procedures from the same MRI service. If an applicant is notified that one or more doctors' data commitments will not be considered by the Department, the Department shall consider data commitments submitted after the date an application is deemed submitted only to the extent necessary to replace the data commitments not being considered pursuant to subsection (5).

(a) The applicant shall have 30 days to submit replacement of doctor commitments as identified by the Department in this Section.

(7) ~~In accordance with either of the following, t~~The Department shall not consider a withdrawal of a signed data commitment~~:~~

~~(a)~~ on or after the date an application is deemed submitted by the Department.

~~(b) after a proposed decision to approve an application has been issued by the Department.~~

(8) The Department shall consider a withdrawal of a signed data commitment if a committing doctor submits a written notice to the Department BEFORE THE APPLICATION IS DEEMED SUBMITTED, that specifies the CON application number and the specific MRI services for which a data commitment is being withdrawn~~, and if an applicant demonstrates that the requirements of subsection (7) also have been met~~.

Section 19. Lists published by the Department

Sec. 19. (1) On or before May 1 and November 1 of each year, the Department shall publish the following lists:

(a) A list, known as the "MRI Service Utilization List," of all MRI services in Michigan that includes at least the following for each MRI service:

(i) The number of actual MRI adjusted procedures;

(ii) The number of available MRI adjusted procedures, if any; and

(iii) The number of MRI units, including whether each unit is a clinical, research, or dedicated pediatric.

(b) A list, known as the "Available MRI Adjusted Procedures List," that identifies each MRI service that has available MRI adjusted procedures and includes at least the following:

(i) The number of available MRI adjusted procedures;

(ii) The name, address, and license number of each referring doctor, identified in Section 17(1)(c)(v), whose patients received MRI services at that MRI service; and

(iii) The number of available MRI adjusted procedures performed on patients referred by each referring doctor, identified in Section 17(1)(c)(v), and if any are committed to an MRI service. This number shall be calculated in accordance with the requirements of Section 17(1). A referring doctor may have fractional portions of available MRI adjusted procedures.

(c) For the lists published pursuant to subsections (a) or (b), the May 1 list will report 12 months of data from the previous January 1 through December 31 reporting period, and the November 1 list will report 12 months of data from the previous July 1 through June 30 reporting period. Copies of both lists shall be available upon request.

(d) The Department shall not be required to publish a list that sorts MRI database information by referring doctor, only by MRI service.

(2) When an MRI service begins to operate at a site at which MRI services previously were not provided, the Department shall include in the MRI database, data beginning with the second full quarter of operation of the new MRI service. Data from the start-up date to the start of the first full quarter will not be collected to allow a new MRI service sufficient time to develop its data reporting capability. Data from the first full quarter of operation will be submitted as test data but will not be reported in the lists published pursuant to this section.

(3) In publishing the lists pursuant to subsections (a) and (b), if an MRI service has not reported data in compliance with the requirements of Section 14, the Department shall indicate on both lists that the MRI service is in violation of the requirements set forth in Section 14, and no data will be shown for that service on either list.

Section 20. Effect on prior CON Review Standards; Comparative reviews

Sec. 20. (1) These CON review standards supersede and replace the CON Review Standards for MRI Services approved by the CON Commission on ~~June 13, 2013~~September 25, 2014 and effective ~~September 18, 2013~~December 22, 2014.

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

Section 21. Health Service Areas

Sec. 21. Counties assigned to each of the health service areas 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

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

Allegan	Hillsdale	Mason
Alpena	Houghton	Mecosta
Benzie	Ionia	Menominee
Branch	Isabella	Missaukee
Chippewa	Kalkaska	St. Joseph
Delta	Keweenaw	Shiawassee
Dickinson	Leelanau	Wexford
Grand Traverse	Lenawee	
Gratiot	Marquette	

Metropolitan statistical area Michigan counties are as follows:

Barry	Jackson	Muskegon
Bay	Kalamazoo	Oakland
Berrien	Kent	Ottawa
Calhoun	Lapeer	Saginaw
Cass	Livingston	St. Clair
Clinton	Macomb	Van Buren
Eaton	Midland	Washtenaw
Genesee	Monroe	Wayne
Ingham	Montcalm	

Source:

75 F.R., p. 37245 (June 28, 2010)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

Psych Bed Task Force
CON Commission

Kathleen Cowling, MS, DO, FACEP
Professor, Emergency Medicine
December 10th, 2015

Conflict of Interest

- Nothing to disclose

Psych Bed and Services Workgroup Charge

- Review and Update, if necessary, the occupancy rate requirements.
- Review and update, if necessary, the standards to promote the accommodation of special populations like geriatric, developmentally disabled, and high acuity patients.
- Review whether or not the number of inpatient beds within hospital based units should be assessed separately from the

Psych Bed and Services Workgroup Charge

- Consider any necessary technical or other changes from the Department, Commission, or SAC, e.g., updates or modifications consistent with other CON review standards and the Public Health Code.
- Review what other states are doing with respect to providing an online consortium of psychiatric facilities regarding available (open) beds and the requirement for psychiatric facilities to provide psychiatric services under EMTALA when beds are open, if they participate with CMS.

Work Group Members

- Beth Nagel, MDHHS
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- S Vinton, Kelley-cawthorne
- Heather Treib, Pinerest
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- Scott Miles, UHSINC
- Mickey Dexter, MidMichigan
- Iola Raddke, MidMichigan

OCT 28, 2015 @ 10:58 AM 2,055 VIEWS

Most ER Doctors Don't Believe The Mental Health System Is Working For Patients

Robert Glatter, MD,
CONTRIBUTOR
I cover breaking news in medicine, med tech and public health
FOLLOW ON FORBES (185)
Opinions expressed by Forbes Contributors are their own.

FULL BIO

Over 80% of emergency physicians believe that the mental health systems currently in place in their communities and surrounding regions are not providing optimal care for patients, based on a national survey of nearly 1,500 emergency physicians by the American College of Emergency Physicians (ACEP).

The survey, conducted in July 2015, was recently released at ACEP's annual Scientific Assembly, held this year in Boston, October 25-29. ACEP is currently the largest advocacy group for emergency physicians in the U.S.

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1401 "Person requiring treatment" defined; exception.

Sec. 401.

(1) As used in this chapter, "person requiring treatment" means (a), (b), (c), or (d):

(a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

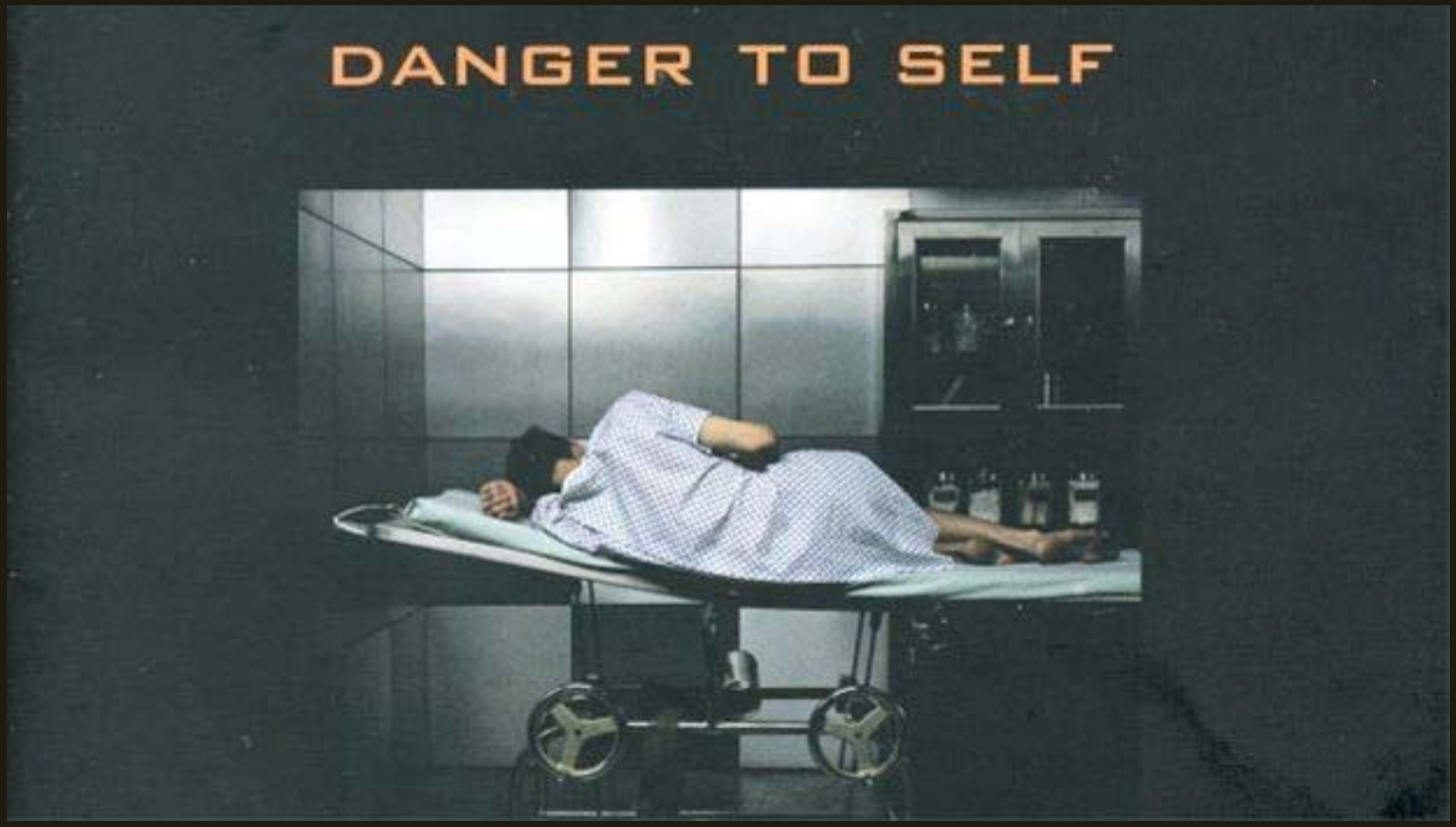
(c) An individual who has mental illness, whose judgment is so impaired that he or she is unable to understand his or her need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to himself, herself, or others. This individual shall receive involuntary mental health treatment initially only under the provisions of sections 434 through 438.

(d) An individual who has mental illness, whose understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in treatment voluntarily, who is currently noncompliant with treatment that has been recommended by a mental health, professional and that has been determined to be necessary to prevent a relapse or harmful deterioration of his or her condition and whose noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months or whose noncompliance with treatment has been a factor in the individual's committing 1 or more acts, attempts, or threats of serious violent behavior within the last 48 months. An individual under this subdivision is only eligible to receive assisted outpatient treatment under section 433 or 469a.

(2) An individual whose mental processes have been weakened or impaired by a dementia, an individual with a primary diagnosis of epilepsy, or an individual with alcoholism or other drug dependence is not a person requiring treatment under this chapter unless the individual also meets the criteria specified in subsection (1). An individual described in this subsection may be hospitalized under the informal or formal voluntary hospitalization provisions of this chapter if he or she is considered clinically suitable for hospitalization by the hospital director.

History: 1974, Act 258, Eff. Nov. 6, 1974 ;-- Am. 1975, Act 179, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2004, Act 496, Eff. Mar. 30, 2005

Psych related ED visits are 5% of 136 million visits each year



Emergency Medicine Practice Research Network

- 2015 poll of 682 EM physicians
- 70% reported having boarded psych patients on their last shift
- >50% reported that average boarding time is 2 days

Impact psych holds have on the ED

- Lost revenue because the bed is ‘occupied’
- lower patient satisfaction
- Burden to nursing staff
- Patient safety issue
- Delays in care, increased length of stay
- community burden
  - EMS, diversion

“Ripple effect” of an over- crowded ED

HealthAffairs

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VOL. 34 | NO. 8
August 2015

Variety Issue

Ambulance Diversion Associated With Reduced Access To Cardiac Technology And Increased One-Year Mortality

Expand

Yu-Chu Shen[1,*] and Renee Y. Hsia[2]

[+] Author Affiliations

*Corresponding author

Abstract

Ambulance diversion, which occurs when a hospital emergency department (ED) is temporarily closed to incoming ambulance traffic, is an important system-level interruption that causes delays in treatment and potentially lower quality of care. There is little empirical evidence investigating the mechanisms through which ambulance diversion might affect patient outcomes. We investigated whether ambulance diversion affects access to technology, likelihood of treatment, and ultimately health outcomes for Medicare patients with acute myocardial infarction

SCOPE of the problem

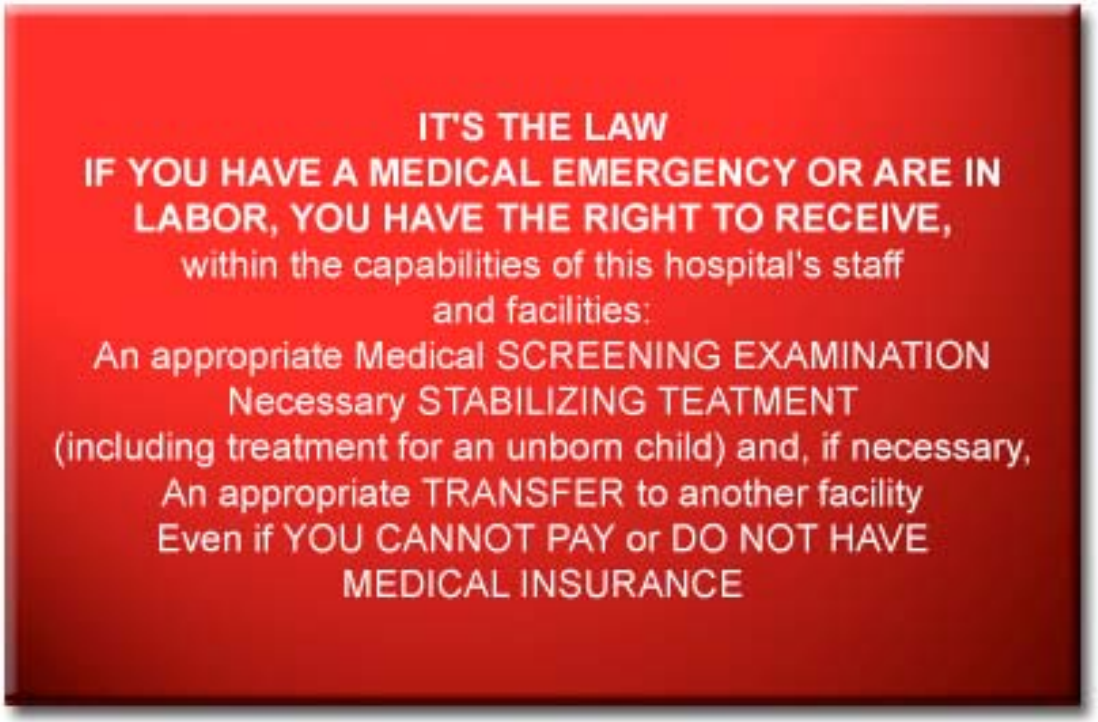
- Patients with mental health issues are presenting to ED's in increasing numbers

- Federal law requires that these patients be evaluated and stabilized, however this presents significant challenges to ED's that have limited resources

The ED is America's "Safety Net"

EMTALA=

Emergency Medical Treatment Active Labor Act



What is EMTALA?

- Federal statute which governs when and how a patient may be refused treatment or transferred from one facility to another when he/she has an unstable medical or psychiatric condition.
- Passed in 1986 as part of the COBRA law
- Applies to all hospitals that participate with Medicare

Old Data

Acad Emerg Med. 2004 Feb;11(2):193-5.

Epidemiology of adult psychiatric visits to US emergency departments.

Hazlett SB[1], McCarthy ML, Londner MS, Onyike CU.

⊕ **Author information**

Abstract

OBJECTIVES: To characterize psychiatric-related emergency department visits (PREDVs) among adults in the United States for the year 2000 and to analyze PREDV trends from 1992 to 2000.

METHODS: Emergency department (ED) visit data from the National Hospital Ambulatory Medical Care Survey were used to estimate the number of PREDVs for adults aged 18 years and older. A PREDV was defined as any visit with a psychiatric discharge diagnosis (ICD N290- N312) or a suicide attempt (ICD E950-E959).

RESULTS: Approximately 4.3 million PREDVs occurred in the United States in the year 2000, yielding an annual rate of 21 visits per 1000 adults. The PREDV rates increased 15% between 1992 and 2000. The PREDVs accounted for 5.4% of all ED visits. Substance abuse (27%), neuroses (26%), and psychoses (21%) were the most common conditions. African Americans had significantly higher visit rates (29/1000; 95% CI = 27/1000 to 31/1000) compared with whites (23/1000; 95% CI = 22/1000 to 25/1000). Persons with Medicaid (66/1000; 95% CI = 64/1000 to 68/1000) had double the rate of PREDVs than the uninsured (33/1000; 95% CI = 31/1000 to 35/1000) and almost eight times the rate of those privately insured (8/1000; 95% CI = 7/1000 to 10/1000). Patients with psychiatric diagnoses had a higher admission rate (22%) than those with nonpsychiatric diagnoses (15%). The uninsured were the least likely to be admitted for all major psychiatric conditions except suicide ($p < 0.0001$).

CONCLUSIONS: Psychiatric-related ED visits represent a substantial and growing number of ED visits each year. Patient characteristics influence the likelihood of a PREDV. Further research is needed to better understand the role that hospital EDs play in the delivery of health care services to those with mental illness.

Bed shortages, are they real?

- 2006 survey of state mental health authorities
  - 80% had shortage of MH beds
  - 34 states had shortage of acute care beds
  - 16 states had shortage of long term care beds

APA: The psychiatric delivery system is "fragile and beset by problems"

Getting true “updated” data

- We need a national system for collecting, interpreting, and acting on this data.

- Which metrics to use?
  - Wait time to be seen
  - Length of stay in the ED
  - Disposition
    - Home, inpatient, community program?

HEALTH POLICY/BRIEF RESEARCH REPORT

Effect of Decreasing County Mental Health Services on the Emergency Department

Arica C. Nesper, MD, MAS*; Beth A. Morris, MPH; Lorin M. Scher, MD; James F. Holmes, MD, MPH

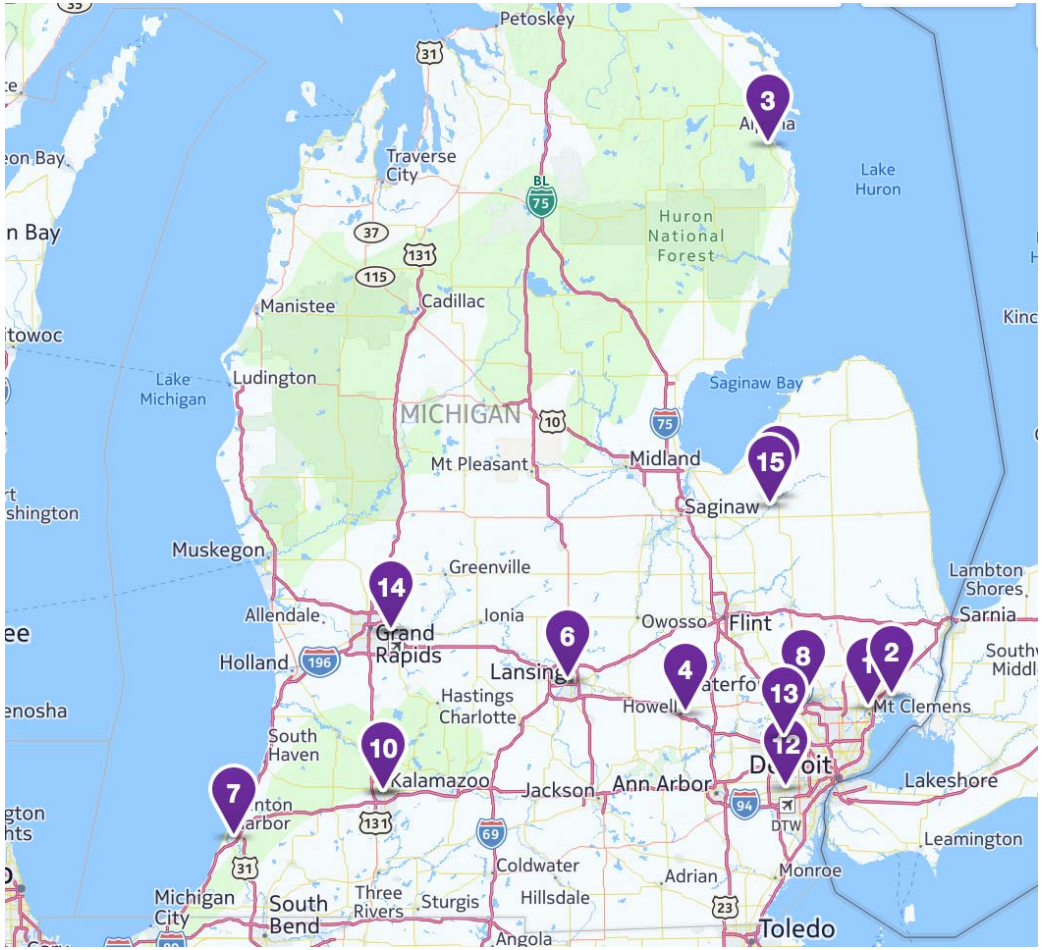
*Corresponding Author. E-mail: nesperarica@gmail.com.

Study objective: We evaluate the effect of decreasing county mental health services on the emergency department (ED).

Methods: This is a retrospective before-and-after study at a Level I academic university hospital adjacent to the county mental health treatment center. On October 1, 2009, the county decreased its inpatient psychiatric unit from 100 to 50 beds and closed its outpatient unit. Electronic health record data were collected for ED visits for the 8 months before the decrease in county services (October 2008 to May 2009) and the 8 months after the decrease (October 2009 to May 2010). Data for all adult patients (≥18 years) evaluated for a psychiatric consultation by a licensed clinical social worker were included. Outcome measures included the number of patients evaluated and the ED length of stay for those patients.

Results: One thousand three hundred ninety-two patient visits included a psychiatry consultation for the study period. The median age was 38 years (interquartile range [IQR] 27, 49), with no difference in age between periods. The mean number of daily psychiatry consultations increased from 1.3 (95% confidence interval [CI] 1.2 to 1.5) before closure to 4.4 (95% CI 4.1 to 4.7) afterward, with a difference in means of 3.0 visits (95% CI 2.7 to 3.3 visits). Average ED length of stay for psychiatry consultation patients was 14.1 hours (95% CI 13.1 to 15.0 hours) before closure and 21.9 hours (95% CI 20.7 to 23.2 hours) afterward, with a difference in means of 7.9 hours (95% CI 5.5 to 10.2 hours).

Service providers in Michigan
Do we have enough beds?



State-Operated Psychiatric Hospitals

Caro Center
Director: Rose Laskowski, R.N.,B.S.N.
2000 Chambers Road
Caro, MI 48723
Phone: (989) 673-3191
Fax: (989) 673-6749

Center for Forensic Psychiatry
Director: Carol E. Holden, PhD
P O Box 2060
Ann Arbor, MI 48158
Phone: (734) 429-2531
Fax: (734) 944-0802
TTY: (734) 994-7012

Hawthorn Center
Director: George Mellos, MD
18471 Haggerty Road
Northville, MI 48167
Phone: (248) 349-3000
Fax: (248) 349-9552

Kalamazoo Psychiatric Hospital
Director: Jill Krause
Box A, 1312 Oakland Drive
Kalamazoo, MI 49008
Phone: (269) 337-3000
Fax: (269) 337-3350

Walter Reuther Psychiatric Hospital
Director: Richard T. Young, FACHE
30901 Palmer Road
Westland, MI 48186
Phone: (734) 367-8400
Fax: (734) 722-5562
Dir Fax: (734) 722-8478

Related Content

- Kalamazoo Psychiatric Hospital
- Walter P. Reuther Psychiatric Hospital
- Hawthorn Center
- Local Programs
- Center for Forensic Psychiatry

November 2015 Statewide Bed Need

Adult Psychiatric Bed Need		
Health Service Area	Counties	Bed Need (Excess)
HSA 1	Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw Wayne	-118
HSA 2	Clinton, Eaton, Ingham, Jackson, Hillsdale, Lenawee	18
HSA 3	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	5
HSA 4	Allegan, Ionia, Kent, Lake, Mason, Montcalm, Muskegon, Newaygo, Oceana, Ottawa	-35
HSA 5	Genesee, Lapeer, Shiawassee	9
HSA 6	Arenac, Bay, Clare, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Mecosta, Ogemaw, Osceloa, Oscoda, Saginaw, Sanilac, Tuscola	-7
HSA 7	Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ostego, Presque Isle, Roscommon, Wexford	1
HSA 8	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	5

November 2015 Statewide Bed Need

Child/Adolescent Psychiatric Bed Need		
Health Service Area	Counties	Bed Need (Excess)
HSA 1	Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw Wayne	-24
HSA 2	Clinton, Eaton, Ingham, Jackson, Hillsdale, Lenawee	16
HSA 3	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	13
HSA 4	Allegan, Ionia, Kent, Lake, Mason, Montcalm, Muskegon, Newaygo, Oceana, Ottawa	-32
HSA 5	Genesee, Lapeer, Shiawassee	13
HSA 6	Arenac, Bay, Clare, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Mecosta, Ogemaw, Osceloa, Oscoda, Saginaw, Sanilac, Tuscola	-17
HSA 7	Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ostego, Presque Isle, Roscommon, Wexford	9
HSA 8	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	1

Does Michigan Have Enough Beds?

- Most Areas have Adult and Child beds available
- The standards allow for even over-bedded areas to add beds through “high occupancy” provisions:
  - If a facility with 19 beds or less is at 75% occupancy or a facility with 20 or more beds is at 80% occupancy for 1 year, then beds can be added despite excessive beds in a planning area.
  - Section 9(3) of the current standards

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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

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

Section 1. Applicability

Sec. 1. These standards are requirements for the approval under Part 222 of the Code that involve (a) beginning operation of a new psychiatric service, (b) replacing licensed psychiatric beds or physically relocating licensed psychiatric beds from one licensed site to another geographic location, or (c) increasing licensed psychiatric beds within a psychiatric hospital or unit licensed under the Mental Health Code, 1974 PA 258, or (d) acquiring a psychiatric service pursuant to Part 222 of the Code. A psychiatric hospital or unit 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.

Certificate of Need Commission

- Sets the standards for bed need based on population
- Sets the levels of minimum occupancy to maintain # licensed beds
- Increasing the number of beds
- Relocating beds geographically
- Categorization of beds
  - Adult vs Pediatric

Reasons for not reaching minimum occupancy requirements

- In adequate staffing
  - Nursing, and ancillary staff
  - Psychiatrists

- Wrong ‘milieu’
  - medical needs (needs supplemental oxygen)
  - Geriatric age >65
  - developmental/functioning issues
  - aggressive/hostile

- ????Payer

Mental Health Parity and Addiction Equity Act of 2008

- Medicaid – is the largest payer for mental health patients
- Problems with Medicaid not covering inpatient stays at freestanding psych hospitals
- Medicaid Emergency Psychiatric Demonstration, initiated in 2012

Health Affairs

A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients

Expand

Vidhya Alakeson[1,*], Nalini Pande[2] and Michael Ludwig[3]

+ Author Affiliations

*Corresponding author

Abstract

Overcrowded U.S. emergency rooms have become a place of last resort for psychiatric patients. Psychiatric boarding, defined as psychiatric patients' waiting in hallways or other emergency room areas for inpatient beds, is a serious problem nationwide. Boarding consumes scarce emergency room resources and prolongs the amount of time that all patients must spend waiting for services. It is often the result of an inability to gain timely access to community-based care. As policy makers implement the new health reform law, improving access and continuity of community mental health care through health homes must be a priority. We present a seven-point plan to address psychiatric boarding.

The Seattle Times
Winner of Nine Pulitzer Prizes

Local News

THE TODAY FILE

Your guide to the latest news from around the Northwest

August 7, 2014 at 9:25 AM

State Supreme Court rules psychiatric boarding unlawful

Posted by Lynn Thompson

The Washington State Supreme Court ruled Thursday that boarding psychiatric patients temporarily in hospital emergency rooms and acute care centers because there isn't space at certified psychiatric treatment facilities is unlawful.

The New York Times

E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way

By JULIE CRESWELL DEC. 25, 2013

RALEIGH, N.C. — As darkness fell on a Friday evening over downtown Raleigh, N.C., Michael Lyons, a paramedic supervisor for Wake County Emergency Medical Services, slowly approached the tall, lanky man who was swaying back and forth in a gentle rhythm.

In answer to Mr. Lyons's questions, the man, wearing a red shirt that dwarfed his thin frame, said he was bipolar, schizophrenic and homeless. He was looking for help because he did not think his prescribed medication was working.

In the past, paramedics would have taken the man to the closest hospital emergency room — most likely the nearby WakeMed Health and Hospitals, one of the largest centers in the region. But instead, under a pilot program, paramedics ushered him through the doors of Holly Hill Hospital, a commercial psychiatric facility.

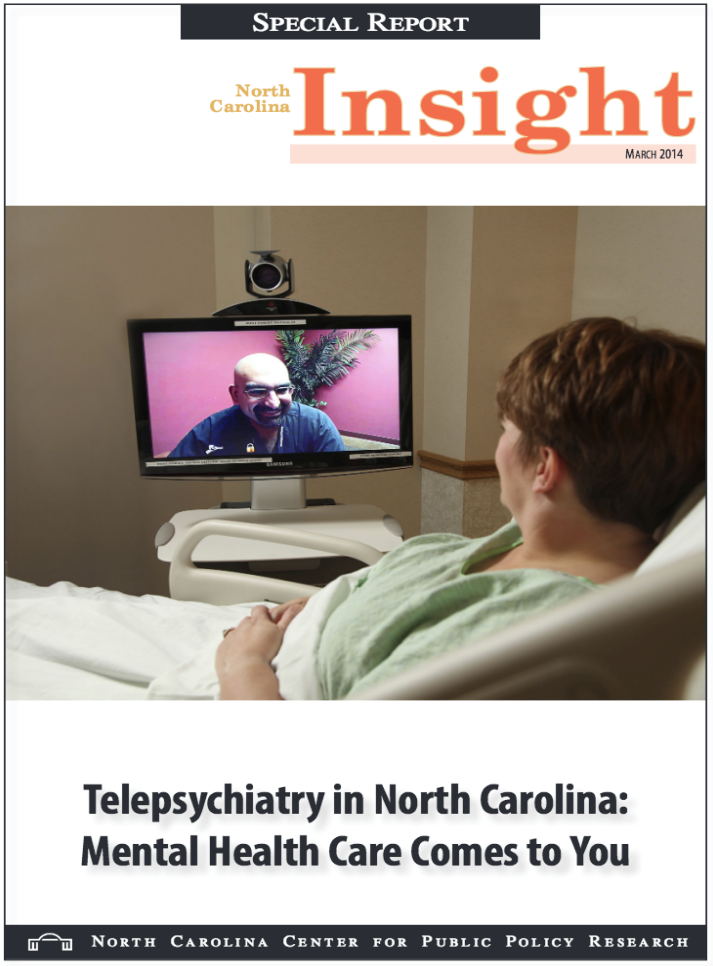
Proposed solutions

- Telepsychiatry
- Psych observation units
- EMS involvement
- Mobile crisis units
- State Health Registry- available bed dashboard
- Protocols for safe discharge
- Emergency Department Evaluation
- Enhanced Education-lessons learned case studies
- Change the state laws
- Universal transfer forms-medical clearance

Telepsychiatry

North Carolina's experience

- Length of stay (LOS) in the emergency rooms for patients waiting to be discharged to inpatient treatment has declined from 48 hours to 22.5 hours



Psychiatric Medical Clearance Checklist

1. Does the patient have new psychiatric condition? ☐ Yes ☐ No
2. Any history of active medical illness needing evaluation? ☐ Yes ☐ No
3. Any abnormal vital signs prior to transfer ☐ Yes ☐ No
   Temperature >101F
   Pulse outside of 50 to 120 beats/minute
   Blood pressure systolic < 90 or > 200; diastolic > 120
   Respiratory rate > 24 breaths/minute
   (For a pediatric patient, vital signs indices outside the normal range for his/her age and sex)
4. Any abnormal physical exam (unclothed) ☐ Yes ☐ No
   a. Absence of significant part of body, eg, limb
   b. acute and chronic trauma (including signs of victimization/abuse)
   c. Breath sounds
   d. Cardiac dysrhythmia, murmurs
   e. Skin and vascular signs: diaphoresis, pallor, cyanosis, edema
   f. Abdominal distention, bowel sounds
   g. Neurological with particular focus on:
      i. ataxia ii. pupil symmetry, size iii. nystagmus iv. paralysis v. meningeal signs vi. reflexes
5. Any abnormal mental status indicating medical illness such as lethargic, stuporous, comatose, spontaneously fluctuating mental status? ☐ Yes ☐ No

ALL PATIENTS ARE TO HAVE BLOOD COUNT, ELECTROLYTES, PREGNANCY TEST AND DRUG SCREEN PERFORMED.

If no to all of the above questions, no further evaluation is necessary. Go to question #9. If yes to any of the above questions go to question #6, additional testing may be indicated.

6. Were any additional labs done? ☐ Yes ☐ No
7. What lab tests were performed? _____
   What were the results? _____
   Possibility of pregnancy? ☐ Yes ☐ No What were the results? _____
8. Were X-rays performed? ☐ Yes ☐ No What kind of x-rays performed? _____
   What were the results? _____
9. Was there any medical treatment needed by the patient prior to medical clearance? ☐ Yes ☐ No
   What treatment? _____
10. Has the patient been medically cleared in the ED? ☐ Yes ☐ No
11. Any acute medical condition that was adequately treated in the emergency department that allows transfer to a state operated psychiatric facility (SOF)? ☐ Yes ☐ No
    What treatment? _____
12. Current medications and last administered? _____
13. Diagnoses: Psychiatric _____
    Medical _____
    Substance abuse _____
14. Medical follow-up or treatment required on psych floor or at SOF: _____
15. I have had adequate time to evaluate the patient and the patient's medical condition is sufficiently stable that transfer to
    ☐ SOF or ☐ psych floor does not pose a significant risk of deterioration.

Physician Signature: _____ MD/DO

On-line Bed Registry

- Virginia Acute Psychiatric and CSB Bed Registry

Senator Stabenow: Michigan Selected as Finalist for First-of-its-kind Mental Health Initiative

Monday, Oct 19, 2015

U.S. Senator Debbie Stabenow today announced that Michigan will be awarded $982,373 to compete in a nation-wide program to improve and expand access to mental health care. This first-of-its-kind initiative is based on Senator Stabenow's *Excellence in Mental Health Act,* which is one of the most significant steps forward in community mental health funding in decades. Selected by the Substance Abuse and Mental Health Services Administration, Michigan is one step closer to being chosen to be part of a new eight-state demonstration program to expand quality mental health care. This new program will offer patients increased services like 24-hour crisis psychiatric care, counseling, and integrated treatments for mental illness. Senator Stabenow's bipartisan *Excellence in Mental Health Act* was cosponsored by Senator Roy Blunt (R-MO) and signed into law by President Obama last year.

Effect of Decreasing County Mental Health Services on the Emergency Department, Arica C. Nesper, MD, MAS, Annals Emerg Med, print in press

Report and Recommendations Regarding Psychiatric Emergency and Crisis Services A Review and Model Program Descriptions, APA Task Force on Psychiatric Emergency Services, Michael H. Allen, M.D., August 2002

A Plan to Reduce Emergency Room 'Boarding' of Psychiatric Patients, Health Affairs, Sept, 2010 p.1637-1641

In Psychiatric Emergencies, Emergency Rooms Not Always Safe., Huffington Post, February 4, 2013.

Psychiatric Patients in the Emergency Department: The Dilemma of Extended Lengths of Stay. Anne Manton, RN, PhD

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Hospitals try to stem flow of mentally ill in ERs, FierceHealthFinance, Shinkman, R., December 2013

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CON Solution Proposed by the Psychiatric Beds Workgroup:

- Add beds in a “special pool” for specific needs like geriatric, developmentally disabled, and those requiring medical attention in addition to psychiatric services
- Change the “on site” requirement for pediatric specialties to “available”

CON Solution Proposed by the Department:

- Review the required occupancy rates with the CON Commission
- Develop monitoring of facility denials to ensure that project delivery requirements are met, specifically:
  - Section 14(2)(d): "*The inpatient psychiatric hospital or unit shall provide clinical, administrative, and support services that will be at a level sufficient to accommodate patient needs and volume, and will be provided seven days a week to assure continuity of services and the capacity to deal with emergency admissions*."
  - Section 14(3)(b)(i) and (ii): "*The applicant, to assure appropriate utilization by all segments of the Michigan population, shall: (i) not deny acute inpatient mental health services to any individual based on ability to pay, source of payment, age, race, handicap, national origin, religion, gender, sexual orientation or commitment status; (ii) provide acute inpatient mental health services to any individual based on clinical indications of need for the services*."

DIST at MTG
12-10-15
Attachment D

CON Commission
Nursing Home/Hospital LTC Standards
Testimony by Health Care Association of Michigan
December 10, 2015

Good morning, I am Pat Anderson Executive Vice President for the Health Care Association of Michigan. Thank you for the opportunity to testify regarding the nursing home and hospital LTC units bed need calculation. At the September CON Commission meeting, HCAM expressed great concern on the bed need calculation based on our very limited review of the data. Since that time HCAM working with CON staff have analyzed the data used in the calculation and have come to two conclusions.

First, the 2013 CON Annual survey data is flawed and not reliable for performing the bed need calculation; and secondly. the bed need methodology in the Standards needs to be reviewed to determine the appropriateness of the calculation to predict the projected demographic and health care needs for these types of services.

HCAM is requesting that the CON Commission not implement the recomputed bed need with the 2013 data and that a Strategic Action Committee or workgroup be formed in 2016 to review this part of the Standards.

Data Review: HCAM compared the total inpatient days as reported on the CON Annual Survey to the Medicaid cost report to determine if all days were reported. Our review disclosed that at least 25% of the facilities total inpatient day data differed between these two sources. Also, there is about a 9% difference in the total inpatient days.

HCAM could not verify if the requested CON Annual survey age distribution as reported was accurate. We did discuss the issue with a few of our members as to their source for this information. This type of data by age category is not reported to any other entity and not readily available. Some nursing facilities can obtain the data from their electronic medical record systems but they were unsure of its reliability.

CON staff set up a conference call with their contractor Paul Delamater, George Mason University, and HCAM to discuss concerns with the data and provide detail on the calculation. He confirmed his concerns with the data and the statements made in his report that was shared with the Commission at the September meeting.

His report stated:

> An ongoing concern in the Nursing Home and HLTCU updates is missing facility data. In the previous update (performed in 2013), three facilities provided care, but did not report utilization data. In the current update, this number increased to 12 facilities (2.7% of the 448 facilities in MI). Because of these missing data, the new values in Appendix B are *guaranteed* to be lower than the true utilization in the state. Effectively, the missing data artificially drives the use rates downward, which results in an under prediction in the number of beds needed throughout the state. In the current update, this may be as much as a 2.6% under prediction, given the missing facilities' recent utilization data.

Based on the joint concerns regarding the data we did discuss attempting to correct the information for 2013. It was determined that too much time had passed since the filing and numerous changes would have occurred at the facility level to correct the data. Between staff changes and sales of nursing homes it was resolved that we would put our efforts into getting the 2015 data filed accurately.

Bed Need Methodology: More importantly, during our conversations regarding the data the discussion turned to the bed need methodology and its appropriateness to adequately project the bed need. One of the shortfalls in the current bed need is the utilization of historical usage to project future need. Today's nursing home has become a premier setting for post-acute care primarily rehabilitation services. Our rehabilitation services are provided to a "younger" than normal population for a nursing home which will impact usage. Other key changes that are coming is the decrease in the number of caregivers, aging of the population and utilization of nursing homes by health plans in meeting their managed care contracts. All of these impact usage but are not part of the methodology. HCAM is supportive of a comprehensive review of this methodology now to avoid an inadequate bed supply in the future, that could cause disruption and hinder access to services leading to a threat to health care delivery systems.

Thank you for your time and I will be glad to answer any questions.

Pat Anderson, HCAM

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Jamieson Nursing Home	7,716	6,767	(949)	1
Lincoln Haven Nursing and Rehabilitation Community	13,059	13,065	6	
Tendercare Health Center - Munising	32,221	32,309	88	
Grace of Douglas	17,082	16,932	(150)	
Life Care Center of Plainwell	39,079	39,081	2	
The Laurels of Sandy Creek	28,264	34,674	6,410	1
Ely Manor	27,844	23,993	(3,851)	1
Resthaven Care Center	51,127	51,308	181	
Allegan County Medical Care Facility	23,999	6,282	(17,717)	1
Tendercare Green View	16,657	16,738	81	
Tendercare Alpena	41,936	42,237	301	
Meadow Brook Medical Care Facility	38,132	38,132	-	
Standish Community Hospital/SNF	11,283	10,159	(1,124)	1
MediLodge of Sterling	24,514	24,513	(1)	
Bayside Village	21,008	21,193	185	
Magnumcare of Hastings, LLC	29,868	29,866	(2)	
Thornapple Manor Medical Care Facility	51,356	51,356	-	
Caretel Inns of Tri-Cities	16,690	16,688	(2)	
Carriage House of Bay City	46,362	24,760	(21,602)	1
Heartland Health Care Center - Hampton	15,672	15,275	(397)	
Huron Woods Nursing Center	19,543	19,401	(142)	
Bay Shores Nursing Center	42,543	41,756	(787)	
Bay County Medical Care Facility	71,828	71,828	-	
Paul Oliver Memorial Hospital LTCU	12,129	12,766	637	1
The Maples	19,945	20,084	139	
Caretel Inns of Lakeland	10,790		(10,790)	1
Lakeland Specialty Hospital at Berrien Center	37,748	1,368	(36,380)	1
Riveridge Manor Inc	21,756	5,311	(16,445)	1
Lakeland Continuing Care Center St Joseph	31,029	27,885	(3,144)	1
West Woods of Niles	41,295	41,289	(6)	
Orchard Grove Nursing & Rehab Center	28,017	28,014	(3)	
Silverbrook Manor	27,300	27,261	(39)	
Jordans Nursing Home Inc	31,411	31,139	(272)	
Royalton Manor	38,911	38,917	6	
The Laurels of Coldwater	48,835	48,798	(37)	
Maple Lawn Medical Care Facility	39,893	39,947	54	
The Oaks at Northpointe Woods	24,804	24,816	12	
Heartland Health Care Center - Battle Creek	16,442	16,207	(235)	
Tendercare Marshall	27,146	27,316	170	
Marshall Nursing and Rehabilitation Community	20,317	20,361	44	
Magnum Care of Albion	17,436	17,432	(4)	
Manor of Battle Creek Skilled Nrsg & Rehab Center	23,690	23,663	(27)	
The Laurels of Bedford	35,372	35,334	(38)	
Evergreen Manor Senior Care Center	28,558	28,557	(1)	
Calhoun County Medical Care Facility	42,795	43,514	719	
The Timbers of Cass County	32,630	11,851	(20,779)	1
Cass County Medical Care Facility	27,538	27,153	(385)	
Boulder Park Terrace	20,504	19,650	(854)	
Grandvue Medical Care Facility	40,681	37,611	(3,070)	1
Tendercare Health Center of Cheboygan	26,959	27,071	112	
Chippewa County War Memorial Hospital LTCU	17,530	6,675	(10,855)	1

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Tendercare Sault Ste Marie	24,161	24,345	184	
North Woods Nursing Center	23,613	23,608	(5)	
Tendercare Clare	27,280	27,442	162	
Ovid Healthcare Center	29,498	29,498	-	
Hazel I Findlay Country Manor	53,319	53,322	3	
Mercy Hospital Grayling LTCU	13,411	13,432	21	
Grayling Nursing and Rehabilitation Community	22,698	22,706	8	
Bishop Noa Home	28,373	28,303	(70)	
Christian Park Village	20,476	20,476	-	
Christian Park Health Care Center	32,922	32,926	4	
Freeman Nursing and Rehabilitation Community	15,229	15,229	-	
Manor Care Nursing and Rehabilitation	36,403	36,850	447	
Hyland Nursing Home	15,854		(15,854)	1
Tendercare West	32,012	32,150	138	
Dimondale Nursing Care Center	46,426	38,583	(7,843)	1
Eaton County Health & Rehabilitation Services	49,535	49,568	33	
Hiland Cottage	1,916	1,890	(26)	
Bortz Health Care of Petoskey	34,003	7,544	(26,459)	1
Bay Bluffs-Emmet County Medical Care Facility	42,197	42,226	29	
Caretel Inns of Linden	19,465	19,456	(9)	
Maple Woods Manor	51,456	50,074	(1,382)	1
Fenton Health Care	36,805	36,804	(1)	
Heartland Health Care Center - Fostrian	39,707	38,797	(910)	1
MediLodge of Montrose Inc	40,965	40,957	(8)	
Argentine Care Center Inc	19,288	19,145	(143)	
Genesys Convalescent Center	45,830	44,015	(1,815)	1
Heartland Health Care Center - Briarwood	36,010	36,228	218	
Crestmont Nursing Care Center	38,480	38,933	453	
Kith Haven	51,585	51,585	-	
Grand Blanc Rehabilitation & Nursing Center	26,395	8,759	32,023	1
Grand Blanc Rehabilitation & Nursing Center (Vent)	14,387			
Heritage Manor Healthcare Center	46,371	43,759	(2,612)	1
Willowbrook Manor	33,289	33,392	103	
Regency at Grand Blanc	8,759		(8,759)	1
The Oaks at Woodfield	14,912	14,924	12	
Gladwin Nursing and Rehabilitation Community	19,514	19,508	(6)	
MidMichigan Gladwin Pines	31,273	29,633	(1,640)	1
Westgate Nursing and Rehabilitation Community	21,327	3,867	(17,460)	1
Gogebic County Medical Care Facility	37,973	37,973	-	
Bortz Health Care of Traverse City	28,952	11,341	(17,611)	1
Tendercare Health Center - Birchwood	37,422	37,854	432	
Tendercare Traverse City	27,010	27,159	149	
Grand Traverse Medical Care Facility	85,486	85,498	12	
The Laurels of Fulton	16,488	16,477	(11)	
Pine River Healthcare Center	21,996	21,549	(447)	
Ashley Care Center	20,676	19,941	(735)	1
Masonic Pathways	72,261	72,261	-	
Schnepp Health Care Center	31,716	31,715	(1)	
Warwick Living Center	15,973	15,973	-	
Hillsdale Community Health Center LTCU	7,109	6,369	(740)	1
Hillsdale County Medical Care Facility	59,780	18,690	(41,090)	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
PortagePointe	21,606	21,872	266	
Our Lady of Mercy Health & Rehab	18,505	18,517	12	
Cypress Manor Health and Rehabilitation Center	20,009	11,499	(8,510)	1
Houghton County Medical Care Facility	66,244	66,226	(18)	
Scheurer Hospital	6,744	6,765	21	
Lakeview Extended Care & Rehabilitation Facility	11,669	11,672	3	
Courtney Manor	36,416	36,417	1	
Huron County Medical Care Facility	34,141	34,141	-	
Hospice House of Mid Michigan	3,373	2,426	(947)	
Holt Senior Care and Rehab Center LLC	33,102	33,071	(31)	
Northwind Rehabilitation and Health Care Center	32,815	-	(32,815)	1
Whitehills Health Care Center	30,821	30,822	1	
The Pines Rehabilitation & Health Care Center	38,035	38,035	-	
Burcham Hills Retirement Center II	39,630	40,372	742	
Okemos Health and Rehabilitation Center	30,961	31,258	297	
Capital Area Health & Rehab Center	36,950	37,689	739	
Ingham County Medical Care Facility	82,235	82,275	40	
Metron of Belding	40,021	40,005	(16)	
Heartland Health Care Center - Ionia	32,873	30,774	(2,099)	1
Tendercare - Tawas City	28,019	28,203	184	
Lakeview Manor Healthcare Center	17,037	17,037	-	
Iosco County Medical Care Facility	25,498	25,498	-	
Iron River Care Center	21,045	21,045	-	
Iron County Medical Care Facility	56,500	56,500	-	
Woodland Hospice	1,602	1,683	81	
The Laurels of Mt Pleasant	33,138	33,108	(30)	
Tendercare - Mt Pleasant	30,716	30,883	167	
Isabella County Medical Care Facility	35,664	35,458	(206)	
Vista Grand Villa	22,265	15,461	(6,804)	1
Allegiance Hospice	5,932	5,807	(125)	
Faith Haven Senior Care and Rehab Centre	27,629	27,629	-	
Heartland Health Care Center - Jackson	27,479	29,370	1,891	1
Arbor Manor Care Center	36,772	36,772	-	
Countryside Care Center Inc	35,398	34,364	(1,034)	1
RidgeCrest Health Campus	17,264	17,347	83	
Jackson County Medical Care Facility	66,373	66,415	42	
Friendship Village	20,805	9,529	(11,276)	1
Plainwell Pines Nursing and Rehabilitation Comm	12,937	12,925	(12)	
Alamo Nursing Home Inc	33,754	33,809	55	
The Springs at the Fountains	15,250	15,349	99	
Heartland Health Care Center - Kalamazoo	31,348	30,610	(738)	
Harold and Grace Upjohn Care and Rehabilitation Cente	38,556	38,501	(55)	
Borgess Gardens	35,957	35,789	(168)	
Tendercare - Kalamazoo	30,181	30,310	129	
The Laurels of Galesburg	31,155	31,192	37	
Tendercare of Westwood	29,167	29,351	184	
Tendercare - Portage	37,880	38,089	209	
Kalkaska Memorial Health Center	30,651	30,363	(288)	
Covenant Village of The Great Lakes	13,505	10,033	(3,472)	1
Beacon Hill at Eastgate	10,259		(10,259)	1
Valley Health Center	7,208	7,233	25	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Faith Hospice Trillium Woods	3,431	3,811	380	
Christian Rest Home	51,339	50,007	(1,332)	1
The Lodge at Maplecreek	43,907	16,668	(27,239)	1
Brookcrest	42,287	36,381	(5,906)	1
Holland Home Breton Rehabilitation Living Centre	19,572	19,474	(98)	
Clark Retirement Community Inc	37,010	36,768	(242)	
Heartland Health Care Center - Crestview	29,212	29,156	(56)	
Spectrum Health Rehab and Nursing Center	54,596	54,623	27	
Heartland Health Care Center - Greenview	23,291	22,912	(379)	
Holland Home Fulton Manor	27,926	27,891	(35)	
Pilgrim Manor Inc	17,078	17,078	-	
St Anns Home	18,983	6,516	(12,467)	1
Heartland Health Care Center - Grand Rapids	58,306	59,929	1,623	1
Porter Hills Health Center	26,758	27,308	550	
Metron of Forest Hills	27,842	27,838	(4)	
The Laurels of Kent	47,558	47,556	(2)	
Sanctuary at Saint Marys	63,492	62,902	(590)	
Metron of Cedar Springs	25,988	25,995	7	
Heather Hills Rehabilitation and Care Center	17,367	17,523	156	
Holland Home Raybrook Manor	35,728	35,625	(103)	
Spectrum Health Kent Community Campus	92,907	83,390	(9,517)	1
Grand Oaks Nursing Center	24,690	24,690	-	
Ferguson Convalescent Home Inc	27,533	25,190	(2,343)	1
Stonegate Health Campus	13,527	13,562	35	
Lapeer County Medical Care Facility	73,040	72,887	(153)	
Orchard Creek Skilled Nursing	6,930	6,930	-	
Maple Valley Nursing Home of Maple Valley	7,543	7,543	-	
Tendercare Health Center of Leelanau	25,378	25,479	101	
Herrick Memorial Hospital Manor	8,231	4,908	(3,323)	1
Hospice of Lenawee	1,958	1,958	-	
Lynwood Manor Healthcare Center	25,810	26,656	846	
Provincial House of Adrian	39,324	39,312	(12)	
Magnum Care of Adrian	36,168	36,141	(27)	
Lenawee County Medical Care Facility	49,023	49,051	28	
White Pine Rehabilitation & Healthcare of Howell	26,074	34,868	85	
White Pine Rehabilitation & Healthcare of Howell (Vent)	8,709			
Caretel Inns of Brighton	16,878	17,021	143	
Wellbridge of Brighton	4,402	4,525	123	
Medilodge of Howell	73,102	71,301	(1,801)	1
Helen Newberry Joy Hospital	14,533	14,297	(236)	
Mackinac Straits Long Term Care Unit	17,117	17,054	(63)	
Shelby Nursing Center	54,178	54,139	(39)	
Heartland Health Care - Sterling Heights	11,256	11,261	5	
Regency Manor Nursing & Rehabilitation Center LLC	13,041	3,124	(9,917)	1
Romeo Continuing Care	8,539	9,098	559	
Romeo Nursing Center	10,594	10,409	(185)	
Sanctuary at the Abbey	55,096	52,476	(2,620)	1
Shore Pointe Nursing Center	61,105	60,884	(221)	
The Village of East Harbor	30,776	29,934	(842)	
Sanctuary at Fraser Villa	49,599	49,707	108	
Evangelical Home - Sterling Heights	45,768	44,960	(808)	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Cherrywood Nursing and Living Center	58,330	54,251	(4,079)	1
Lakepointe Senior Care and Rehab Center	45,997	45,994	(3)	
The Village Rehabilitation and Care Center	22,810	5,918	(16,892)	1
Warren Woods Health and Rehabilitation	60,322	59,312	(1,010)	1
St Mary's Nursing & Rehab Center	33,139	33,141	2	
Medilodge of Richmond	40,889	40,880	(9)	
Henry Ford Continuing Care Corporation - Roseville	50,284	50,284	-	
Bortz Health Care of Warren	46,323	8,961	(37,362)	1
Clinton-Aire Healthcare Center	44,876	44,955	79	
Church of Christ Care Center	40,246	40,218	(28)	
St. Anthony Healthcare Center	32,684	32,689	5	
Shelby Crossing Health Campus	13,045	13,084	39	
Medilodge of Sterling Heights	100,217	99,961	(256)	
Father Murray Nursing and Rehabilitation Centre	76,812	76,809	(3)	
Autumn Woods Residential Health	108,587	108,588	1	
Martha T Berry Memorial Medical Care Facility	76,615	76,700	85	
Manistee County Medical Care Facility	34,552	34,950	398	
Norlite Nursing Centers Of Marquette Inc	31,407	31,403	(4)	
Eastwood Nursing Center	35,442	35,405	(37)	
Mather Nursing Center	32,884	36,568	3,684	1
Marquette County Medical Care Facility	50,119	50,121	2	
Tendercare of Ludington	25,939	26,109	170	
Oakview Medical Care Facility	32,934	33,045	111	
Metron of Big Rapids	24,693	24,697	4	
Altercare of Big Rapids	31,182		(31,182)	1
Roubal Care and Rehab Center	14,134	14,134	-	
Menominee Care Center	19,002	19,356	354	
Pinecrest Medical Care Facility	48,441	48,441	-	
Midland King's Daughter's Home	10,255	10,292	37	
MidMichigan Stratford Village	26,992	27,591	599	
Brittany Manor	40,172	40,172	-	
Tendercare - Midland	34,438	34,720	282	
Autumnwood of McBain	29,226	29,227	1	
Magnum Care of Monroe	40,568	40,538	(30)	
Lutheran Home - Monroe	42,282	41,844	(438)	
Mercy Memorial Nursing Center	22,986	23,349	363	
Medilodge of Monroe	31,435	31,434	(1)	
Fountain View of Monroe	40,474	40,478	4	
Hickory Ridge of Temperance	24,276	24,288	12	
Sisters, Servants Immaculate Heart of Mary	19,024	19,688	664	
Spectrum Health Kelsey	10,068	10,308	240	
Spectrum Health United Memorial	12,967	12,894	(73)	
Metron of Greenville	31,059	31,040	(19)	
The Laurels of Carson City	28,024	28,040	16	
Medilodge of Hillman	24,533	24,525	(8)	
Roosevelt Park Nursing and Rehabilitation Communit	12,531	12,531	-	
Harbor Hospice aka Leila and Cyrus Poppen Hospice	2,410	2,860	450	
Christian Care Nursing Center	16,134	16,134	-	
Lake Woods Nursing & Rehabilitation	25,360	4,682	(20,678)	1
Hillcrest Nursing and Rehabilitation Community	14,726	13,655	(1,071)	1
Heartland Health Care Center - Knollview	36,140	36,212	72	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Sanctuary at the Park	33,701	34,238	537	
Heartland Health Care Center - Whitehall	39,107	38,381	(726)	
Sanctuary at McAuley	33,106	33,574	468	
Brookhaven Medical Care Facility	50,468	48,936	(1,532)	1
Transitional Health Services of Fremont	43,334	43,331	(3)	
Newaygo County Medical Care Facility	41,991	41,956	(35)	
Renaissance Gardens at Fox Run	25,406		(25,406)	1
Oakland Nursing Center	7,741	7,760	19	
Sanctuary at White Lake	26,222	30,722	4,500	1
Heartland - West Bloomfield	34,556	40,320	5,764	1
Heartland Health Care - Bloomfield Hills	17,927	17,932	5	
Heartland Health Care Center - Oakland	54,300	54,308	8	
St. Anne's Mead Nursing Facility	8,341	5,410	(2,931)	1
Marvin & Betty Danto Family Health Care Center	41,836	35,974	(5,862)	1
Boulevard Health Center	57,459	57,464	5	
Canterbury on the Lake	43,688	43,872	184	
Sanctuary at Bellbrook	23,030	22,944	(86)	
West Bloomfield Nursing & Convalescent Center	40,908	40,908	-	
Evergreen Health and Living Center	46,052	45,862	(190)	
Clarkston Specialty Healthcare Center	34,415		(34,415)	1
Lake Orion Nursing and Rehabilitation Centre	41,066	41,293	227	
MediLodge of Rochester Hills Inc	41,626	39,673	(1,953)	1
Bortz Health Care on Green Lake	29,643	3,386	(26,257)	1
Woodward Hills Nursing Center	57,442	57,205	(237)	
Bortz Health Care of Oakland	32,560	4,939	(27,621)	1
Cambridge South Healthcare Center	3,383	7,909	4,526	1
Oakridge Manor Nursing & Rehab Center LLC	19,721	21,170	1,449	1
Lourdes Nursing Home	35,153	25,153	(10,000)	1
South Lyon Senior Care and Rehab Center LLC	24,436	24,435	(1)	
Bloomfield Orchard Villa	16,848	16,848	-	
Greenfield Rehab and Nursing Center	37,718	37,680	(38)	
Holly Convalescent Center Inc	21,602	21,270	(332)	
West Hickory Haven	36,287	36,274	(13)	
Westlake Health Campus	19,373	18,996	(377)	
Whitehall Healthcare Center of Novi	27,851	27,644	(207)	
White Pine Rehabilitation & Healthcare of Farmington	21,631	33,771	86	
White Pine Rehabilitation $ Healthcare of Farmington (V	12,054			
The Manor of Novi	47,819	47,804	(15)	
Botsford Continuing Health Center	60,261	60,547	286	
Medilodge of Southfield Inc	64,280	61,411	(2,869)	1
Cambridge East Healthcare Center	51,171	50,168	(1,003)	1
The Lakeland Center	29,756	29,756	-	
The Manor of Farmington Hills	32,973	32,979	6	
Cambridge North Healthcare Center	41,352	41,187	(165)	
Lahser Hills Care Centre	49,301	13,036	(36,265)	1
Medilodge of Milford	30,354	30,655	301	
Notting Hill of West Bloomfield	11,278	11,293	15	
Regency at Waterford	41,286	41,322	36	
Oceana County Medical Care Facility	36,703	36,703	-	
Bortz Health Care of West Branch	23,170	5,101	(18,069)	1
Bortz Health Care of Rose City	31,859	7,326	(24,533)	1

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Aspirus Ontonagon Hospital	16,567	16,435	(132)	
Spectrum Health Reed City Campus	18,039	18,085	46	
Wellspring Lutheran Springs	19,293	19,300	7	
Otsego County Memorial Hospital	10,868	10,869	1	
Tendercare - Gaylord	29,759	35,487	305	
Tendercare - Gaylord (Vent)	5,423			
Inn at Freedom Village	11,503	11,546	43	
Metron of Lamont	12,203	12,203	-	
Riverside Nursing and Rehabilitation Community	11,628	11,628	-	
Hospice of North Ottawa Community	2,008	700	(1,308)	1
Heartland Health Care Center - Holland	22,505	21,112	(1,393)	1
The Laurels of Hudsonville	36,298	36,298	-	
North Ottawa Care Center	27,968	28,468	500	
Heritage Nursing and Rehabilitation Community	16,674	16,663	(11)	
Allendale Nursing and Rehabilitation Community	20,428	20,500	72	
Sanctuary at the Shore	39,643	40,536	893	
Providence Christian Healthcare & Rehab Ctr	45,447	45,448	1	
Tendercare Health and Rehab Center of Holland	23,686	23,810	124	
Tendercare Health Center - Rogers City	36,032	36,068	36	
King Nursing and Rehabilitation Community	21,029	21,056	27	
Hilltop Manor Health Care Center	27,152	8,234	(18,918)	1
Covenant Medical Center	7,300	6,328	(972)	
Chesaning Nursing Care Center	13,326	13,252	(74)	
Health Source Saginaw - Skilled	67,274	67,558	284	
Tendercare Health Center of Frankenmuth	33,262	33,410	148	
Saginaw Senior Care and Rehab Center LLC	23,669	23,668	(1)	
Hoyt Nursing & Rehab Centre	41,541	41,458	(83)	
Heartland Health Care Center - Saginaw	29,368	25,137	(4,231)	1
Luther Manor Nursing Home	32,290	32,299	9	
MagnumCare of Saginaw LLC	28,208	28,192	(16)	
Wellspring Lutheran Services	35,690	35,695	5	
St. Francis Home	28,102	28,102	-	
Saginaw Geriatrics Home	15,319	16,111	792	
Medilodge of St. Clair	56,708	48,679	(8,029)	1
Medilodge of Yale	37,103	36,561	(542)	
Medilodge of Port Huron	31,816	31,785	(31)	
Regency on the Lake - Fort Gratiot	33,168	33,171	3	
Marwood Manor Nursing Home	80,132	79,546	(586)	
Fairview Nursing and Rehabilitation Community	20,804	20,981	177	
Riverview Manor	28,661	30,493	1,832	1
Froh Community	37,863	36,866	(997)	1
Heartland Health Care Center - Three Rivers	30,189	29,841	(348)	
Marlette Community Memorial	13,906	13,966	60	
Autumnwood of Deckerville	25,423	25,426	3	
Sanilac County Medical Care Facility	36,212	36,218	6	
Schoolcraft County Medical Care Facility	27,266	26,808	(458)	
Memorial Healthcare Center	7,740	-	(7,740)	1
Durand Senior Care and Rehab Center	45,732	45,733	1	
Shiawassee County Medical Care Facility	40,321	40,278	(43)	
Fisher Senior Care and Rehab	17,029	17,028	(1)	
Tendercare - Cass City	24,389	24,567	178	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
Tuscola County Medical Care Facility	57,308	57,073	(235)	
Meadow Woods Nursing & Rehabilitation Center	20,559	20,559	-	
South Haven Nursing and Rehabilitation Community	21,247	21,235	(12)	
Bronson Commons	34,671	34,667	(4)	
Countryside Nursing and Rehabilitation Community	29,990	31,576	1,586	1
Heartland Health Care - Ann Arbor	47,300	47,904	604	
Glacier Hills Inc	53,830	49,883	(3,947)	1
The Gilbert Residence	11,420	9,062	(2,358)	1
Arbor Hospice	10,950		(10,950)	1
Chelsea Retirement Community	27,517	27,512	(5)	
Regency at Bluffs Park	15,601	15,611	10	
Superior Woods Healthcare Center	29,898	30,440	542	
Whitehall Healthcare Center of Ann Arbor	31,317	28,829	(2,488)	1
Regency at Whitmore Lake	43,292	43,293	1	
Bortz Health Care of Ypsilanti Inc	49,166	8,153	(41,013)	1
Evangelical Home Saline	67,737	72,382	4,645	1
Heartland - Grosse Pointe Woods	24,937	24,941	4	
Heartland Healthcare Center - Canton	46,526		(46,526)	1
Henry Ford Village Inc	27,033	32,429	5,396	1
Angela Hospice Care Center	4,380	4,192	(188)	
Star Manor of Northville	13,057	13,087	30	
Special Tree Neurocare Center	12,555	13,208	653	
Woodhaven Retirement Community	10,706	10,430	(276)	
Heartland Health Care Center - Allen Park	45,906	45,168	(738)	
Oakwood Rehab & Skilled Nursing Center - Dearborn	61,394	61,381	(13)	
Livonia Woods Nursing and Rehabilitation	22,490	22,489	(1)	
Aberdeen Rehabilitation and Skilled Nursing Center	35,298	35,297	(1)	
Henry Ford Continuing Care Corporation - Belmont	45,747	45,747	-	
Transitional Health Services of Wayne	16,892	8,115	(8,777)	1
Heartland Health Care Center - Dearborn Heights	41,384	38,091	(3,293)	1
Marywood Nursing Care Center	35,020	34,733	(287)	
Heartland Health Care Center - Livonia NE	36,008	36,232	224	
Park Geriatric Village Inc	36,490	6,216	(30,274)	1
Heartland Health Care Center - Plymouth	24,582	27,510	2,928	1
Hope Healthcare Center	40,549	41,303	754	
Wellspring Lutheran Services	29,379	27,699	(1,680)	1
Belle Fountain Nursing & Rehab Center	13,602	9,850	(3,752)	1
Marycrest Manor	18,174	17,792	(382)	
The Village of Redford	29,556	578	(28,978)	1
St. Jude Nursing Center	17,780	17,780	-	
Regency Heights - Detroit	40,976	41,064	88	
The Manor of Southgate Skilled Nrsg & Rehab Center	32,522	29,779	(2,743)	1
Heartland Health Care Center - Livonia	36,047	34,738	(1,309)	1
MediLodge of Plymouth Inc	14,589	14,000	(589)	
St. Josephs Healthcare Center	55,254	55,236	(18)	
Four Seasons Nursing Center of Westland	57,014	57,014	-	
Medilodge of Taylor	41,036	41,032	(4)	
Autumnwood of Livonia	44,676	44,693	17	
Camelot Hall Convalescent Center	37,124	37,125	1	
Four Chaplains Nursing Care Centre	32,634	32,633	(1)	
Rivergate Health Care Center	68,841	68,841	-	

DBA	Total Inpatient Days	CON 2013 Days	Difference w/CON less CR	
The Manor of Wayne Continuing Care Center	54,072	46,700	(7,372)	1
Tendercare Health & Rehabilitation Center of Taylor	50,198	51,008	810	
Applewood Nursing Center	48,743	49,492	749	
Maple Manor Rehab Center	20,023	20,023	-	
Samaritan Manor	38,854	41,920	3,066	1
Regency at Canton	28,477	28,486	9	
Imperial Healthcare Centre	88,498	88,475	(23)	
Westland Nursing & Rehabiliation Centre	76,699	76,699	-	
Rivergate Terrace	94,422	94,422	-	
Regency Healthcare Centre	80,334	80,314	(20)	
Omni Continuing Care	36,402	45,595	-	
Omni Continuing Care (Vent)	9,193			
Riverview Health and Rehab Center North	54,236	52,479	(1,757)	1
Alpha Manor Nursing Home	22,428	22,430	2	
Westwood Nursing Center	34,317	34,086	(231)	
Boulevard Temple Care Center, LLC	38,903	38,920	17	
St. Francis Nursing Center	26,344	26,344	-	
Lakeshore Healthcare Cranbrook Campus, Inc.	16,186	16,344	158	
Redford Geriatric Village Inc	29,049	3,137	(25,912)	1
Hartford Nursing and Rehabilitation Center	48,359	48,369	10	
Eastwood Convalescent Center	20,506	18,178	(2,328)	1
Hamilton Nursing Home	22,576	22,141	(435)	
Law-Den Nursing Home	33,325		(33,325)	1
Boulevard Manor, LLC	29,367	10,786	(18,581)	1
Ambassador Nursing & Rehabilitation Center	55,814		(55,814)	1
Beaconshire Nursing Centre	32,725	8,636	(24,089)	1
St Anne's Convalescent Center	22,168	22,168	-	
The Manor of Northwest Detroit	46,835	46,860	25	
St. James Nursing Center	38,049	38,049	-	
Qualicare Nursing Home	31,776	31,776	-	
Sheffield Manor Nursing & Rehab Center	33,956	33,958	2	
Lakeshore Healthcare - Woodward Campus	35,277	21,296	(13,981)	1
OakPointe Senior Care and Rehab Center	44,094	42,914	(1,180)	1
West Oaks Senior Care and Rehab Center	32,184	32,178	(6)	
Lakeshore Healthcare Elmwood Campus, Inc.	25,683		(25,683)	1
Heritage Manor Nursing & Rehab Center	32,664	5,915	(26,749)	1
Riverview Health & Rehab Center	37,011	26,574	(16,195)	1
Riverview Health & Rehab Center (Vent)	5,758			
Fairlane Senior Care and Rehab Center	67,675	14,866	(52,809)	1
The Lakeview of Cadillac	35,719	35,728	9	
Tendercare Health Center of Wyoming	27,258	27,446	188	
	14,428,436	**13,139,471**	**(1,224,919)**	**115**
		1,288,965	91.07%	25.61%

Attachment D

County Code	License Number	Bortz Health Care Facilities	CON Licensed Beds	CON Bed Days	CON Survey Patient Days of Care	Discharges	Average Daily Census	CON Occupancy	Length of Stay		Cost Report Total Days	Difference CON to CR Days
24	401	Bortz Health Care of Petoskey	110	40,150	7,544	131	20.7	18.8%	57.6		34,003	(26,459)
28	401	Bortz Health Care of Traverse City	96	35,040	11,341	277	31.1	32.4%	40.9		28,952	(17,611)
50	419	Bortz Health Care of Warren	152	55,480	8,961	138	24.6	16.2%	64.9		46,323	(37,362)
63	406	Bortz Health Care of West Bloomfield (Green Lake)	85	31,025	3,386	37	9.3	10.9%	91.5		29,643	(26,257)
63	416	Bortz Health Care of Oakland	106	38,690	4,939	57	13.5	12.8%	86.6		32,560	(27,621)
65	401	Bortz Health Care of West Branch	70	26,510	5,101	130	14.0	19.2%	39.2		23,170	(18,069)
65	402	Bortz Health Care of Rose City	102	37,230	7,326	116	20.1	19.7%	63.2		31,859	(24,533)
81	410	Bortz Health Care of Ypsilanti	144	52,560	8,153	92	22.3	15.5%	88.6		49,166	(41,013)
82	413	Bortz Health Care - Park Geriatric	114	41,914	6,216	85	17.0	14.8%	73.1		36,490	(30,274)
83	429	Bortz Health Care - Cranbrook Geriatric (sold 2013)	66	24,090	16,344	31	44.8	67.8%	527.2		16,186	158
83	434	Bortz Health Care - Redford Geriatric	98	35,770	3,137	65	8.6	8.8%	48.3		29,049	(25,912)
83	498	Bortz Health Care - Elmwood Geriatric (sold 2013)	120	43,800	19,069	74	52.2	43.5%	257.7		25,683	(6,614)
		Bortz Totals	1,263	462,259	101,517	1,233	278.1	22.0%	82.3		383,084	(281,567)
		Bortz without Sold	1,077	394,369	66,104	1,128	181.1	16.8%	58.6		341,215	(275,111)

Nursing Home and HLTCU Beds:
Appendix and Bed Need Updates, 2015

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Executive Summary

The Nursing Home and HLTCU Bed Need was updated using 2013 CON Survey data, 2013 US Census data, and 2018 population projection data from the Michigan Department of Technology, Management & Budget. The base year for the current update is 2013 and the planning year is 2018. The output includes three standalone Excel tables, 1: Patient day use rates by age cohort (Appendix B, formerly Appendix A), 2: Planning areas with a population density less than 28 people per mile^2 (Appendix E, formerly Appendix D), and 3: the Bed Need output. The code required to calculate the appendices and the bed need, written in R, is also provided in separate files. This report provides a brief explanation of the methodology, the updates, and the update process.

Appendix B: Patient day use rates by age cohort

The methodology used to update the Use Rates in Appendix B is found in Section 3.(1). The rates are based on current state-wide patient day utilization and population counts in four age cohorts: 0-64, 65-74, 75-84, and 85+.

The updates for Appendix B are relatively straight-forward; the statewide patient days for each age cohort are summed as is the statewide population for each cohort. The respective sums are then divided, then multiplied by 1,000 to produce a rate of patient days per 1,000 people. The 2013 patient days, state population, and use rates by age cohort are found in Table 1.

Table 1. Age specific use rates for 2013. The results are for the entire Michigan population and all facilities that reported data in 2013. PD Rate is patient days per 1,000 people and is the updated information for Appendix B of the Review Standards.

Age Cohort	Patient Days	Population	PD Rate
0-64	1,604,742	8,408,029	191
65-74	1,951,163	835,439	2,336
75-84	3,533,789	443,520	7,968
85p	6,052,397	208,634	29,010

An ongoing concern in the Nursing Home and HLTCU updates is missing facility data. In the previous update (performed in 2013), three facilities provided care, but did not report utilization data. In the current update, this number increased to 12 facilities (2.7% of the 448 facilities in MI). Because of these missing data, the new values in Appendix B are *guaranteed* to be lower than the true utilization in

the state. Effectively, the missing data artificially drives the use rates downward, which results in an underprediction in the number of beds needed throughout the state. In the current update, this may be as much as a 2.6% underprediction, given the missing facilities' recent utilization data. The missing facilities along with their patient day utilization data from 2012 are provided in Table 2.

Table 2. Facilities that did not report utilization data in 2013. Patient days are reported data from 2012, except for Arbor Hospice which is from 2011 because the facility did not report in 2013 or 2012.

Facility ID	Name	Patient Days (2012)
224040	Hyland Nursing Home	18,383
254240	Grand Blanc Rehabilitation & Nursing Center	45,167
294040	Michigan Masonic Home	71,006
544022	Altercare Of Big Rapids	33,344
634023	Clarkston Specialty Healthcare Center	37,779
634360	Greenfield Rehab And Nursing Center	38,373
754030	Riverview Manor	26,417
814140	Arbor Hospice	7,077
824290	Southgate Manor Skilled Nursing & Rehab	31,375
834070	Westwood Nursing Center	35,855
834540	Law-Den Nursing Home	7,126
783010	Memorial Healthcare Center LTCU	6,843
State Total		*358,745*

Appendix E: Population Density

A special high occupancy provision for adding beds is found in Section 6.(1)(d)(iii). Beds may be added if the planning area meets volume requirements and has less than 28 people per mile^2. Planning areas having a population density less than this requirement are identified in Appendix E of the Review Standards.

Using updated county and municipal boundaries (downloaded from the Michigan Center for Geographic Information) and 2013 US Census data, the population density for each planning area was calculated. Those having a population density less than 28 people per mile^2 are listed in Table 3.

Bed Need

The methodology used to calculate the number of nursing home and HLTCU beds can be found in Section 3.(2) of the Standards. For each planning area, the predicted population for the planning year (2018) in each age cohort is multiplied by its respective use rate from Appendix B. This produces the planning year patient days per age cohort, which are then summed for each planning area. The resulting total patient days are divided by 365 to produce the planning areas' average daily census (ADC) for the planning year.

In Section 3.(2)(e), the bed need in the planning year is calculated by dividing the planning year ADC by an ADC adjustment factor. For planning areas having an ADC less than 100, the factor is 0.9

Table 3. Population Density of NH planning areas. Based on 2013 population data for planning areas with a population density of less than 28 people per mile^2.

Planning Area	Area	Population	Population Density
Ontonagon	1,327.8	6,322	4.76
Schoolcraft	1,220.9	8,247	6.75
Luce	926.2	6,502	7.02
Baraga	916.7	8,695	9.49
Iron	1,210.9	11,516	9.51
Alger	936.2	9,522	10.17
Mackinac	1,063.4	11,061	10.40
Gogebic	1,144.7	15,916	13.90
Oscoda	571.2	8,379	14.67
Alcona	694.4	10,578	15.23
Montmorency	562.4	9,350	16.63
Presque Isle	684.8	13,062	19.07
Lake	573.9	11,386	19.84
Chippewa	1,809.0	38,696	21.39
Menominee	1,051.0	23,791	22.64
Houghton-Keweenaw	1,604.4	38,416	23.94
Crawford	563.0	13,904	24.70
Missaukee	573.4	15,051	26.25

and for those with an ADC of 100 or greater, the factor is 0.95. This result is rounded up to the next whole number under the assumption that a partial bed is a bed. The updated bed need calculations can be found in Table 4.

Table 4. **Nursing Home and HLTCU bed need.** Base year: 2013, Planning year: 2018.

Planning Area	AF	Bed Need	Planning Area	AF	Bed Need
Alcona	0.9	80	Lapeer	0.95	336
Alger	0.9	52	Leelanau	0.95	157
Allegan	0.95	411	Lenawee	0.95	405
Alpena	0.95	146	Livingston	0.95	660
Antrim	0.95	118	Luce	0.9	34
Arenac	0.9	85	Mackinac	0.9	60
Baraga	0.9	39	Macomb	0.95	3,606
Barry	0.95	245	Manistee	0.95	129
Bay	0.95	478	Marquette	0.95	295
Benzie	0.9	108	Mason	0.95	141
Berrien	0.95	688	Mecosta	0.95	174
Branch	0.95	174	Menominee	0.95	118
Calhoun	0.95	545	Midland	0.95	370
Cass	0.95	230	Missaukee	0.9	71
Charlevoix	0.95	127	Monroe	0.95	601
Cheboygan	0.95	148	Montcalm	0.95	248
Chippewa	0.95	149	Montmorency	0.9	67
Clare	0.95	155	Muskegon	0.95	634
Clinton	0.95	302	Newaygo	0.95	206
Crawford	0.9	78	Oakland	0.95	4,673
Delta	0.95	201	Oceana	0.95	107
Dickinson	0.95	121	Ogemaw	0.95	119
Eaton	0.95	464	Ontonagon	0.9	41
Emmet	0.95	159	Osceola	0.9	109
Genesee	0.95	1,666	Oscoda	0.9	44
Gladwin	0.95	138	Otsego	0.95	118
Gogebic	0.9	94	Ottawa	0.95	952
Grand Traverse	0.95	395	Presque Isle	0.9	99
Gratiot	0.95	176	Roscommon	0.95	154
Hillsdale	0.95	212	Saginaw	0.95	858
Houghton and Keweenaw	0.95	156	Saint Clair	0.95	654
Huron	0.95	183	Saint Joseph	0.95	246
Ingham	0.95	855	Sanilac	0.95	191
Ionia	0.95	209	Schoolcraft	0.9	51
Iosco	0.95	161	Shiawassee	0.95	276
Iron	0.9	92	Tuscola	0.95	221
Isabella	0.95	212	Van Buren	0.95	272
Jackson	0.95	627	Washtenaw	0.95	1,141
Kalamazoo	0.95	947	Wexford	0.95	144
Kalkaska	0.9	81	South Wayne County	0.95	1,465
Kent	0.95	2,058	Northwest Wayne County	0.95	2,485
Lake	0.9	70	Detroit and Eastern Wayne County	0.95	2,414

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Below is a list of the data (and source) used in Nursing Home and LTCU (NH/LTCU) bed need calculations performed in September, 2015. The base year for the calculations is 2013 and the planning year is 2018. In the recent calculations, Appendix B, Appendix E, and the NH/LTCU bed need were updated.

2013 Survey Table Section N for Bed Need Methodology. 09 04 2015.xlsx (and 2013.nh.survey.data.upd.csv)

- Received from Andrea Moore (Compliance Analyst) on 9/4/2015
- NH/LTCU utilization data for the base year
- Used to update Appendix B in the Review Standards
- Contains the NH/LTCU discharges, patient days, facility type, and beds in Michigan for 2013. The data are broken down by age categories and facility.
    - Note that the facilities highlighted in yellow in the Excel file failed to provide utilization data in 2013 (and previous years' utilization data are reported)
    - Note that the facilities highlighted in orange in the Excel file are facilities that reported their utilization data after 5/20/2015
    - Note that the facilities highlighted in purple have various notes that were used to track facility operation and data reporting
- The .csv file is a simplification of the Excel file. The facilities that did not report utilization data in 2013 were removed. The file only contains patient day utilization information. The age categories for patient day utilization from the Excel file are consolidated to match the age categories required for Appendix B (0-64, 65-74, 75-84, 85+). This file was used in the R code to calculate the use rates in Appendix B.

2013-State.xlsx (and 2013-State.csv)

- Received from Eric Guthrie (Michigan's State Demographer) on 4/30/2015
- Population data for the base year
- Used to update Appendix B in the Review Standards
- Used to update Appendix E in the Review Standards
- Contains the male, female, and total population in Michigan for 2013. The data are broken down by the age categories and by county (however, only state-level information is required, thus the county data were summed for the entire state).
- The .csv file is simply an exported version of the Excel file, which was then used in the R code to calculate the use rates in Appendix B and population density in Appendix E.

2018 Populations.xlsx (and nursing.home.pop.data.2018.csv)

- Received from Eric Guthrie (Michigan's State Demographer) on 4/30/2015
- Population data for the planning year
- Used in the bed need calculation
- Contains the predicted male, female, and total population for 2018. The data are broken down by age categories required for the NH/LTCU bed need (0-64, 65-74, 75-84, 85+) and by county (sheet: Export_State) and by NH/LTCU Planning Area for Wayne County (sheet: Export_Wayne)
- The .csv file is a less detailed, consolidated version of the Excel file. The male and female breakdowns were removed (unnecessary) and the two tabs were consolidated/modified to match the NH/LTCU Planning Areas. This file was used in the R code to calculate the bed need.

App-B-2013.xls

- Output from the Appendix B calculation
- Used in the bed need calculation

App-E-2013.xls

- Output from the Appendix E calculation

MI_NH_planningareas.dbf

- Contains the area for each of the NH/LTCU Planning Areas
- Used to update Appendix E in the Review Standards

Nursinghome-Bedneed-13-18.xls

- Contains the "step by step" output from the NH/LTCU bed need calculation

verifiable data from the actual number of patient days of care for 12 continuous months of data from the CON Annual Survey or other comparable MDCH survey instrument.

(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.

(w) "Planning year" means 1990 or the year in the future, at least three (3) years but no more than seven (7) years, 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.

(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.

(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.

(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.

(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.

(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 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 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 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 previous bed need numbers and shall be 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:

APPENDIX 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 August 1, 2013, and until otherwise changed by the Commission, is as follows.

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

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

(iii) Age 75 - 84: 9,379 days of care

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

2014 Michigan Certificate of Need Annual Survey

000000	TEMPLATE	ANY CITY	HOSPITAL

SECTION N: Nursing Home Services / Hospital Long-Term Care Units

Contact information for the person responsible for completing this section: ☐ Check here if same as Section A

Contact Name		HN_CNAME
Contact E-mail		HN_CEMAIL
Contact Phone		HN_CPHONE
Contact Fax		HN_CFAX

Instructions:

1. Report the number of patients that were discharged from the Nursing Home/Hospital Long-Term-Care Unit during the survey year by age group.
2. Report the number of patient days of care provided by the Nursing Home/Hospital Long-Term-Care Unit during the survey year by age group. All patient days of care must be counted, not just patient days of care for the discharged patients. The Department will be using this data to calculate the facility occupancy rate.
3. Total discharges and patient days will automatically sum from the data supplied in the age groups. Verify that the total is accurate for the facility.
4. Report if the facility has met the terms of approval and the project delivery requirements
   a. For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
   b. If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this section.

Definitions:

Discharges mean the number of patients who expire or are released from the Nursing Home/Hospital Long-Term-Care Unit. Do not count a patient as a discharge, if the patient's bed is held for them while hospitalized and they return to that bed.

Patient Days means the number of days that the licensed beds were occupied by a patient.

Age Group	Discharges**		Patient Days	
1. Under 60 Years		HN_1D1		HN_2D1
2. 60 to 64 Years		HN_1D2		HN_2D2
3. 65 to 74 Years		HN_1D3		HN_2D3
4. 75 to 84 Years		HN_1D4		HN_2D4
5. 85 to 94 Years		HN_1D5		HN_2D5
6. 95 Years and Older		HN_1D6		HN_2D6
Total		HN_1D7		HN_2D7
**Discharge counts were unavailable so Admissions were substituted (Y/N).				H25_L1

Medicaid and Medicare Utilization

7. Of the total patient days reported in the Age Group box above, how many patient days of care did Medicaid pay for?		HN_MD1
8. Of the total patient days reported in the Age Group box above, how many patient days of care did Medicare pay for?		HN_MA1

Terms of Approval and Project Delivery Requirements

BONE MARROW TRANSPLANTATION (BMT) SERVICES

STANDARD ADVISORY COMMITTEE (SAC)

INTERIM REPORT TO THE CERTIFICATE OF NEED (CON) COMMISSION ON DECEMBER 10, 2015

The Bone Marrow Standard Advisory Committee met on December 18, 2015. All appointed members were in attendance except one who had been excused. The committee reviewed and approved the agenda. Members then introduced themselves sharing information about their specialty status or interest in the CON process. The MDCH presented an overview of the CON process and answered questions concerning member's role in this process. It was noted in the Department's presentation that there are five institutions that are currently providing bone marrow transplant services in the state: Spectrum Health Butterworth Hospital, University of Michigan Hospitals, Children's Hospital of Michigan, Henry Ford Hospital, and Karmanos Cancer Center. All five institutions are members of and reviewed by the Foundation for the Accreditation of Cellular Therapy. It was also shown that the number of bone marrow transplants, including both autologous and allogeneic, has remained stable at around 600 cases per year over the last 5 years. The chairman then discussed the six charges that the SAC will review and vote upon in future meetings. The committee members then had a lengthy discussion on patient access, physician availability, waiting times to see a transplant specialist, institutional operations and occupancy, and finally staff training and the need for there to be physician and nursing availability 24/7- 365 days of the year for their transplant patients. Several expert physicians said that they did not expect the transplant case load to increase as newer drugs were delaying or decreasing the need for transplants. Also, innovative immunological therapies are already being developed that may bypass the need for many transplants in the 10-15 year horizon. On the other hand there were some newer indications for transplants such as sickle cell and metabolic diseases but the extent that this will create new volumes was unknown. The committee will address adequacy and access of current transplant facilities by doing a zip code analysis of bone marrow transplants in previous years. Individual members agreed to submit materials of interest to the MDCH to circulate to all members of the committee. The next meeting is scheduled for December 16, 2015 in which several charges will be reviewed and possibly voted upon.

Submitted by Bruce Carl, MD, BMTSAC Chairperson

CERTIFICATE OF NEED

4th Quarter Compliance Report to the CON Commission

October 1, 2014 through September 30, 2015 (FY 2015)

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	67	251
Approved projects contacted on or before anniversary date	35	123
Approved projects completed on or before 1-year follow up	52%	
CON approvals expired	14	95
Total follow up correspondence sent	237	1,000
Total approved projects still ongoing	358	

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 adopted a schedule for compliance monitoring following which the Department will be completing statewide compliance reviews of at least two services annually. For calendar year 2015, Air Ambulance and Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services were selected for statewide compliance review. The finding of the statewide compliance reviews will be reported at the next CON Commission meeting.

The Department has taken the following actions:

- After a statewide review of the Open Heart Surgery data based on the 2013 Annual Survey, the Department opened 5 additional compliance investigations of Open Heart Surgery programs not meeting the approved volume requirement. The Department has investigated and conducted meetings with all 5 hospitals and is in the process of determining proposed compliance actions. A settlement proposal has been offered to all 5 hospitals with open compliance investigations. The Department has finalized settlement agreements with 3 hospitals and is still working with the 2 remaining hospitals.

CERTIFICATE OF NEED

4th Quarter Program Activity Report to the CON Commission

October 1, 2014 through September 30, 2015 (FY 2015)

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	111	N/A	435	N/A
Letters of Intent Processed within 15 days	111	100%	435	100%
Letters of Intent Processed Online	111	100%	435	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	326	N/A
Applications Processed within 15 Days	60	100%	324	99%
Applications Incomplete/More Information Needed	46	77%	246	75%
Applications Filed Online*	60	100%	316	97%
Application Fees Received Online*	8	13%	62	19%

* 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	22	100%	194	100%
Substantive Applications	45	100%	117	100%
Comparative Applications	0	N/A	0	N/A

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	3	N/A
Decisions Issued within 10 workings Days*	1	100%	2	100%

*Does not include requests that have been withdrawn.

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	23	100%	88	100%

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	40	N/A	177	N/A
FOIA Requests Processed on Time	40	100%	169	94%
Number of Applications Viewed Onsite	0	N/A	7	N/A

FOIA – Freedom of Information Act.

Source: Certificate of Need Evaluation Section, Michigan Department of Health & Human Services.

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 H

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2015												2016											
	J*	F	M*	A	M	J*	J	A	S*	O	N	D*	J*	F	M*	A	M	J*	J	A	S*	O	N	D*
Air Ambulance (AA)										PC	•	•	• R A											
Bone Marrow Transplantation (BMT) Services**	• R A		D A	•	•	• S	•S	•S	•S	•S	▮	▮	▮	▮	▮	▮	▮	• R—	•P	•	•▲ F			
Computed Tomography (CT) Scanner										PC	•	•	• R A											
Magnetic Resonance Imaging (MRI) Services**	• R A	•	•	•	•	•	•	•	•	•	•	• R—	•P	•	•▲ F									
Neonatal Intensive Care Services/Beds and Special Newborn Nursing Services										PC	•	•	• R A											
Nursing Home and Hospital Long-Term-Care Unit (NH-HLTCU) Beds										PC	•	•A	• R A	•	• A									
Psychiatric Beds and Services**	• R A	•	•	•	•	•	•	•	•	•	•	• R	•	•	• R—	• P	•	•▲ F						
Urinary Extracorporeal Shock Wave Lithotripsy Services										PC	•	•	• R A											
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			•M			•M
FY2015 CON Annual Activity Report															R									

KEY

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

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

For Approval December 10, 2015

Updated December 3, 2015

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 Health and Human Services (MDHHS), Office of Health Policy and Innovation, Planning and Access to Care Section, 15th Floor Grand Tower Bldg., 235 S. Grand Ave., Lansing, MI 48933, 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	September 29, 2014	2018
Cardiac Catheterization Services	September 14, 2015	2017
Computed Tomography (CT) Scanner Services	December 22, 2014	2016
Heart/Lung and Liver Transplantation Services	September 28, 2012	2018
Hospital Beds	March 20, 2015	2017
Magnetic Resonance Imaging (MRI) Services	December 22, 2014	2018
Megavoltage Radiation Therapy (MRT) Services/Units	September 14, 2015	2017
Neonatal Intensive Care Services/Beds (NICU)	December 22, 2014	2016
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	March 20, 2015	2016
Open Heart Surgery Services	June 2, 2014	2017
Positron Emission Tomography (PET) Scanner Services	September 14, 2015	2017
Psychiatric Beds and Services	March 22, 2013	2018
Surgical Services	December 22, 2014	2017
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	December 22, 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.