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

Tuesday, September 19, 2006

Capitol View Building
201 Townsend Street
MDCH Conference Room B/C
Lansing, MI 48913

FINAL MINUTES

I. Call to Order

Vice-Chairperson Goldman called the meeting to order at 9:13 a.m.

a. Members Present:

Edward Goldman, Vice-Chairperson
Peter Ajluni, DO
Roger Andrzejewski
Bradley Cory
Dorothy Deremo
Marc Keshishian, MD
Adam Miller
Michael Sandler, MD
Kathie VanderPloeg-Hoekstra
Michael Young, DO (left @ 2:48 p.m.)

b. Members Absent:

Norma Hagenow, Chairperson

c. Department of Attorney General Staff:

Ronald Styka (Arrived @ 9:48 a.m.)

d. Staff Present:

Umbrin Ateequi
Tulika Bhattacharya
Jan Christensen
Sallie Flanders
Tom Freebury
Carol Halsey
Bill Hart
Larry Horvath
John Hubinger
Matt Jordan
Joette Laseur
Irma Lopez
Bruce Matkovich
Jeff McManus
Andrea Moore

Stan Nash
Taleitha Pytlowanyj
Brenda Rogers

II. Review of Agenda and Revised Commission Procedures

Vice-Chairperson Goldman gave an overview of the revised procedures for Public Comment as identified on the Agenda.

Motion by Commissioner Sandler, seconded by Commissioner Deremo, to approve the agenda as presented. Motion Carried.

III. Declaration of Conflicts of Interests

Commissioner Sandler may have a potential conflict with the wording of the Bone Marrow Transplantation (BMT) language. Commissioner Goldman may have a potential conflict with CT Scanner Services – Dental Scanners.

IV. Review of Minutes – June 21, 2006

Commissioner Sandler suggested modifications to the titles of Cynthia Rider, Sharon Brooks, and Glenn Melenyk. They should be identified as follows on page 3: "Sharon Brooks, DDS, University of Michigan," "Glenn Melenyk, DDS, blue Cross Blue Shield of Michigan," and "Cynthia Rider, DDS, Self."

Motion by Commissioner Cory, seconded by Commissioner Sandler, to accept the minutes as modified. Motion Carried.

V. Public Comment for Action Items (i.e., VI, VII, VIII, IX, X, XI, & XII)

Computed Tomography (CT) Scanner Services – Dental Scanners

Melissa Cupp, Wiener Associates
Sharon Brooks, DDS, University of Michigan

BMT Services

Glenn Melenyk, DDS, Blue Cross Blue Shield of Michigan
Joseph Uberti, MD, Karmanos Cancer Center
Elizabeth Palazzolo, Henry Ford Health System
Patrick O'Donovan, William Beaumont Hospitals (written, Attachment A, & oral testimony)
Lyle Sensenbrenner, Independent
Sean Gehle, St. John Health (written, Attachment B, & oral testimony)

Hospital Beds – Long-Term (Acute) Care Hospitals (LTACHs)

Dr. Akhtar, William Beaumont Hospitals
James Foresman, Miller Canfield
Robert Desotelle, Select Specialty Hospital – Karmanos (written, Attachment C, & oral testimony)
Patrick Dyson, Borgess Health
Kira Carter, Sparrow Specialty Hospital (written, Attachment D, & oral testimony)
Lyndean Brick, Murer Group (written, Attachment E, & oral testimony)

Hospital Beds

Cheryl Miller, Trinity Health (written, Attachment F, & oral testimony)

Penny Crissman, Crittenton Hospital
Patrick O'Donovan, William Beaumont Hospitals (written, Attachment G, & oral testimony)
Robert Hoban, St. John Health

Positron Emission Tomography (PET) Scanner Services

Chad Grant, Detroit Medical Center

Multiple CON Review Standards Comments

Robert Meeker, Spectrum Health (written, Attachment H, & oral testimony)
Barbara Winston Jackson, Economic Alliance for Michigan (written, Attachment I, & oral testimony)

Break from 11:08 a.m. to 11:20 a.m.

VI. Computed Tomography (CT) Scanner Services – Dental Scanners – Public Hearing Comments

A. Commission Discussion

Department staff member Matt Jordan gave a brief report regarding the Computed Tomography (CT) Scanner Services – Dental Scanners Public Hearing. He provided a general consensus of the opinions given by the public. Discussion followed.

B. Commission Final Action

Motion by Commissioner Sandler, seconded by Commissioner Young, to approve the standards as presented and forward them to the Joint Legislative Committee and Governor for the forty-five day review period. Motion Carried.

VII. Hospital Beds

A. Report from Standard Advisory Committee (SAC)

Hospital Bed (HB) SAC Chairperson Ball gave a report over the Committee's progress. Department staff member Brenda Rogers provided the HB Committee's recommended changes. Discussion followed.

B. Report of Hospital Bed Need Numbers Pursuant to Section 5(2) & (3) of the CON Review Standards for Hospital Beds – Commission to Set Effective Date

Motion by Commissioner Deremo, seconded by Commissioner Keshishian, to establish September 20, 2006 as the effective date for the recalculated Bed Need numbers, with the calculation accepted as proposed. Motion Carried.

C. Commission Proposed Action

Motion by Commissioner Deremo, seconded by Commissioner Miller, to move the Hospital Bed standards forward for Public Hearing and to have the Department review the outstanding issues of replacement zone and comparative review.

Friendly amendment by Commissioner Sandler to take out review of replacement zone in the Deremo/Miller Motion.

Deremo/Miller Motion as amended. Motion Carried.

Lunch Break from 12:14 p.m. to 1:05 p.m.

VIII. Positron Emission Tomography (PET) Scanner Services

A. Report from SAC

PET SAC Chairperson Nagle gave an oral report of the Committee's decisions. Chairperson Nagle provided an overview of the Charges given to the Committee by the Commission and also the ones that were added by the Committee itself to review. Discussion followed.

B. Commission Proposed Action

Motion by Commissioner Keshishian, seconded by Commissioner Miller, to strike Section 11 of the PET Standards and to accept the standards as modified to be moved forward for Public Hearing. Motion Carried. Commissioner Sandler abstained from voting.

Commissioner Sandler abstained.

IX. Bone Marrow Transplantation (BMT) Services

A. Report from Workgroup

Commissioner Young gave an update on the Workgroup's progress. Commissioner Sandler posed the question as to whether or not there is a need for more BMTs and is there only a need for an additional program in Western Michigan? Discussion followed.

B. Commission Action

Motion by Commissioner Deremo, seconded by Commissioner Keshishian, to adopt the language to be moved forward for Public Hearing and to have the Department look into the access questions regarding western and northern Michigan. Motion Carried. Commissioner Sandler abstained from voting.

X. Hospital Beds – Long-Term (Acute) Care Hospitals (LTACHs)

A. Workgroup Report

Commissioner Goldman provided an oral and written report (Attachment J) of the Workgroup's progress. Discussion followed.

B. Commission Action

Motion by Commissioner Keshishian, seconded by Commissioner Ajluni, to make no changes to the standards and accept Sub-section c of the Workgroup's recommendations which is to charge the Department with doing research for options for LTACH services, on a broader basis, in Michigan. Motion Carried.

XI. Nursing Home and Hospital Long-Term Care Unit Beds

A. Workgroup Report

Commissioner Cory provided a brief update on the Workgroup. He reported that the Workgroup had met three times. Department staff member Mr. Jan Christensen provided an oral update as well. There was no consensus from the Workgroup to recommend language at this time. Discussion followed.

XII. Magnetic Resonance Imaging (MRI) Services

A. Workgroup Report

Commissioner Sandler provided a brief update on the Workgroup and stated that another Workgroup meeting would be scheduled to discuss the remaining issues. Discussion followed.

B. Commission Action

Motion by Commissioner Sandler, seconded by Commissioner Ajluni, to accept the language as presented to be moved forward for Public Hearing. Motion Carried.

XIII. Psychiatric Beds and Services Workgroup – Update

A. Workgroup Report

Commissioner Deremo provided an oral and written (Attachment K) report of the Workgroup's progress. The Workgroup plans to meet one more time in October. The Workgroup plans to provide a final report to the Commission at the next meeting. Discussion followed.

XIV. Revised Resolution Regarding Expert Representation on SACs

A. Commission Action

Motion by Commissioner Cory, seconded by Commissioner Ajluni, to accept the Revised Resolution (Attachment L). Motion Carried.

XV. New Medical Technology

Commissioner Keshishian will be the liaison for the New Medical Technology Committee.

XVI. Legislative Report

None.

XVII. Compliance Report

Mr. Jan Christensen provided a brief update.

XVIII. CON Program Update

A. On-line Application System

Department staff member Ms. Brenda Rogers provided a brief report on behalf of CON Program.

B. Quarterly Performance Measures

Once again, Ms. Brenda Rogers provided a brief report on behalf of CON Program. CON Program provided a written report (Attachment M) for the Commission.

XIX. Administrative Update

A. Report from Attorney General's Office (Workgroups and Replacement Zone/Comparative Review)

Mr. Ron Styka provided a brief overview of the memo provided to the Commissioners regarding the replacement zone and comparative review issue.

B. Workgroup Structure

Mr. Ron Styka reported that it is legal to appoint Workgroups. Workgroup meetings should be posted at least seventy-two hours in advance to allow people enough notice to attend if they so choose and there needs to be time for public comment. Department staff member Mr. Bill Hart also provided an oral and written (Attachment N) report regarding Workgroup structure. Discussion followed.

XX. Future Meeting Dates

December 12, 2006
March 13, 2007
June 13, 2007
September 18, 2007
December 11, 2007

XXI. Review of Commission Work Plan (Attachment O)

A. Commission Discussion

Ms. Brenda Rogers provided a brief report.

B. Public Comment

Larry Horwitz, Economic Alliance for Michigan

C. Commission Action

Motion by Commissioner Ajluni, seconded by Commissioner Deremo, to approve the Work Plan as presented. Motion Carried.

XXII. Adjournment

Motion by Commissioner Vander-Ploeg Hoekstra, seconded by Commissioner Deremo, to adjourn the meeting at 3:26 p.m. Motion Carried.

DIII -

Beaumont Hospitals®

September 15, 2006

Dear CON Commissioner:

On behalf of the Beaumont Hospitals, we are writing to ask your support to establish a Standards Advisory Committee to develop institution-specific needs based criteria for Bone Marrow Transplant (BMT) programs in Michigan for the following reasons:

- From a review of CON programs in the 34 states, we can find only 8 states that still cover BMT under their CON programs, and NONE have arbitrarily limited the number of programs. Michigan's limit of 3 BMT programs was established 20 years ago, when BMT was a new cancer treatment.

- A review of the literature (see attached report "Select Trends in Bone Marrow Transplants") shows that due to technological advancements of BMT and its indications, BMT can now be used to treat a larger base of patients for both cancerous and non-cancerous conditions. And, recent medical literature further concludes that BMT is broadly underused or attempted too late in the diagnosis process (New England Journal of Medicine, April 27, 2006, p. 1823).

  > "Autologous transplantation is substantially better than chemotherapy for treating the first relapse of large-cell non-Hodgkin's lymphoma that is sensitive to chemotherapy. Nevertheless, data from the Center for International Blood and Marrow Transplant Research show that many patients undergo transplantation belatedly, when a cure is less likely (Horowitz M: personal communication). Other data from the center and data from the National Cancer Institute (available at http://seer.cancer.gov) suggest that only a minority of patients with a relapse responsive to chemotherapy ever undergo autologous transplantation. This finding agrees with that of a report from 2001 and with the expert opinion that transplantation is broadly underused. The General Accounting Office estimates that in the United States, only one-third of patients who need transplants from unrelated donors have preliminary searches requested from the National Marrow Donor Registry."

Michigan has the 3rd highest cancer incidence rate for men and 8th highest cancer incidence rate for women of any state. It also has higher cancer incidence rates and higher death rates for Non-Hodgkin Lymphoma—appropriate for BMT treatment—than national averages.

Corporate Administration
3711 W. Thirteen Mile Rd.
Royal Oak, MI 48073-6769

	Michigan		U.S.	
	Male	Female	Male	Female
Non-Hodgkin Lymphoma* Incidence Rate 1997-2001	23.2	17.0	22.7	16.1
Death Rate*	11.3	7.5	10.5	6.9

* per 100,000 (source: American Cancer Society)

- Just this week, the Michigan House of Representatives passed legislation (House Bills 6291-6295) supported by the Department of Community Health, to establish a statewide network of umbilical cord blood stem cell banks. Testimony in support of the legislation showed a list of 75 life-threatening diseases – not just cancer – that are now treated with stem cells, including sickle cell anemia. The director of the cord blood bank at the Karmanos Cancer Institute testified that this legislation can spark further stem cell research and make it more likely that Michigan can attract federal funding. This legislation would encourage research involving cord blood stem cells by making it eligible for funding under the 21st Century Jobs Fund. Certainly, this legislation would result in greater availability of cord blood for use in bone marrow transplantation

Beaumont has been represented at the BMT workgroup meetings chaired by Dr. Young, and has heard many arguments against expanding the number of BMT programs in the state. These arguments have come from the existing three BMT programs, which argue that:

1. *The number of BMTs in decreasing, so there is no need for more BMT programs.*
2. *Existing BMT programs have unused capacity and could perform more transplants at their facilities, so there is no need for more programs.*
3. *Only 450 of 1.2 million hospital admissions in 2005 were for BMT patients.*
4. *BMT is an expensive program to implement, and costs will increase if new programs are allowed to develop.*

Beaumont disagrees with these points for the following reasons:

1. Based on data gathered from MDCH, the total number of BMTs in Michigan has declined from 498 in 2001 to 438 in 2005. We believe this signifies an access problem in Michigan. Two other states that provided data to MDCH on their BMT activities don't show a decline in BMTs. North Carolina, which has CON regulations for BMT, reported 424 BMTs in 2001 and 426 in 2005. Not only does North Carolina have a lower incidence rate of Non-Hodgkin Lymphoma than does Michigan (18.7 for males and 13.1 for females), their population is approximately 1.5 million less than Michigan. Ohio, which doesn't have CON, reported 482 BMTs in 2001 and 503 in 2005.
2. All non-bed related CON standards that have been updated have adopted institution-specific criteria and no longer consider unused capacity at one facility as a reason for denying a program at another facility.

3. The 450 figure should be higher, and will be higher, with more access to BMT programs.

4. We believe there are significant cost savings to patients when eliminating the duplicative testing now being done when patients in large cancer centers without BMT must be referred out to a transplant program. And, costs of BMT transplants are no more expensive than current cancer drug treatments that are not regulated by CON. Extra costs of adding BMT to comprehensive cancer programs that currently see a high number of patients with cancer will be minimal.

In conclusion, the often-repeated goals of the CON program are to meet the objectives of cost, quality and access. We believe the current literature – in conjunction with Michigan's declining rate of BMTs – demonstrate there is an access problem to BMT in Michigan. The CON program is often criticized by legislators as not being more responsive to changes in the standard of care for medical treatments. The 20-year-old standards limiting Michigan to a fixed number of BMT programs lend credence to this allegation. We urge you to appoint a SAC with a charge to develop an institute specific need based methodology to assure appropriate access to quality BMT services at reasonable cost.

We do think the citizens of Michigan will be better served by having improved access to comprehensive, quality cancer treatments.

Thank you for your consideration.

Sincerely,

Kenneth J. Matzick
President and Chief Executive Officer

Frank Vicini, M.D.
Corporate Chief Oncology Services

/cj

Enclosure

General and Vascular Surgery, P.C.

James B. Babel, M.D., F.A.C.S.
Daniel E. Stewart, M.D., F.A.C.S.
Nancy J. Kalinowski, M.D., F.A.C.S.
Thomas J. Rohs, M.D., F.A.C.S.
Stuart R. Verseman, M.D., F.A.C.S.

1717 Shaffer, Suite 108 • Kalamazoo, MI 49048
Phone: (269) 343-9113 • Fax: (269) 343-0510

September 18, 2006

To Whom It May Concern:

General and Vascular Surgery, P.C. physicians provide surgical services at Borgess-Pipp Hospital on a regular basis. These include outpatient consultation services, outpatient surgery, and inpatient consultations. I understand there is a question about specialty support in this location because of the 15-mile distance from Kalamazoo.

We are a small physician group providing surgical services at Borgess Medical Center, Bronson Methodist Hospital and in the surrounding outlying areas. Despite our many areas of commitment, the distance to Borgess-Pipp has not been a barrier for us to provide services to our patients there. In addition, we are committed to caring for patients whose own attending physicians may choose not to practice at Borgess-Pipp Hospital and for other patients who may have a new need for surgical services.

There are unused beds at Borgess-Pipp Hospital. As members of the Kalamazoo medical community, we encourage you to carefully review the request for additional beds outside of the established Certificate of Need process. Thank you for your consideration.

Sincerely,

James B. Babel, M.D.
JBB/ckw

BORGESS PULMONARY AND CRITICAL CARE ASSOCIATES, P.C.
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SPECIALISTS IN: PULMONARY DISEASES AND CRITICAL CARE MEDICINE

Stephen E. Jefferson, M.D., F.C.C.P.
Michael A. Warlick, M.D., F.C.C.P.
Paul A. Lange, M.D., F.C.C.P.
Lori A. Hughes, PA-C

September 15, 2006

To Whom It May Concern:

Pulmonary & Critical Care Services, P.C. provides inpatient pulmonary services at Borgess-Pipp Hospital on a regular basis. There are 3-6 patients requiring ventilator support at Borgess-Pipp at any one time and an occasional need for new consultations. I understand there is a question about specialty support in this location because of the 15 mile distance from Kalamazoo.

We are a small physician group providing pulmonary and critical care services at Borgess Medical Center and the surrounding outlying areas. Despite a severe shortage in our physician staffing at Borgess Medical Center the distance to Borgess-Pipp has not been a barrier for us to provide services to our patients there. In addition, we are committed to caring for patients whose own attending physicians may choose not to practice at Borgess-Pipp Hospital and for other patients who may have a new need for pulmonary expertise.

There are unused beds at Borgess-Pipp Hospital. As members of the Kalamazoo medical community, we encourage you to carefully review the request for additional beds outside of the established Certificate of Need process. Thank you.

Sincerely,

Stephen E. Jefferson, MD

HEART CENTER
for excellence

William B. Campbell, MD
FACC, FACP, FSCAI

E erdi, MD
FACC, FACP

Robert J. LaPenna, MD
FACC, FACP

Janos R. Gellert, MD

Sharma Saith, MD
FACC, FACP

Anthony King, MD
FACC, FACP, FASE

Alicia Williams, DO
FACC, FACOI

Philip L. Dawson, MD
FACC

Ronald J. Zegerius, MD

David W. Burke, MD
FACC

Benjamin A. Perry, MD
FACC, FAHA

Ramon C. Raneses, Jr., MD
MPH, FACC

Tim A. Fischell, MD
FACC, FACP, FAHA, FSCAI

Victor I. Owusu, MD
FACC

Gregorio Tan, MD
FA FACP

W . Salman, MD

Stanley E. Caines, MD

G. Glenn Kabell, MD, PhD
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Arne Sippens Groenewegen, MD
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September 15, 2006

To Whom It May Concern:

The Heart Center for Excellence physicians provide cardiology services at Borgess-Pipp Hospital on a regular basis. These include outpatient consultation services, a full range of stress testing, and inpatient consultations. I understand there is a question about specialty support in this location because of the 15 mile distance from Kalamazoo.

We are a physician group providing cardiac services at Borgess Medical Center, Bronson Methodist Hospital and the surrounding outlying areas. Despite our many areas of commitment, the distance to Borgess-Pipp has not been a barrier for us to provide services to our patients there. In addition, we are committed to caring for patients whose own attending physicians may choose not to practice at Borgess-Pipp Hospital and for other patients who may have a new need for cardiology services.

There are unused beds at Borgess-Pipp Hospital. As members of the Kalamazoo medical community, we encourage you to carefully review the request for additional beds outside of the established Certificate of Need process. Thank you.

Sincerely,

William B. Campbell, M.D., F.A.C.C., F.A.C.P.,F.S.C.A.I.
President & CEO, Premier Medical Care, Inc.

SEP-15-2006 FROM-NEPHROLOGY CENTER +2693497450 T-706 P.002/002 F-961

Board Certified Nephrologists

Sanjay P. Dalal, M.D.
Ahmed Aqeel, M.D.
Gregorio V. Hernandez, M.D.

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Board Certified Nephrologists

Prince J. Sidhu, M.D.
Than N. Oo, M.D.
Ahsan A. Qureshi, M.D.

September 15, 2006

To Whom It May Concern:

The Nephrology Center physicians provide inpatient renal and dialysis services at Borgess-Pipp Hospital on a regular basis. There are 2-4 patients requiring dialysis support at Borgess-Pipp at any one time and an occasional need for new consultations. I understand there is a question about specialty support in this location because of the 15 mile distance from Kalamazoo.

We are a small physician group providing nephrology services at Borgess Medical Center, Bronson Methodist Hospital and the surrounding outlying areas. Despite our many areas of commitment, the distance to Borgess-Pipp has not been a barrier for us to provide services to our patients there. In addition, we are committed to caring for patients whose own attending physicians may choose not to practice at Borgess-Pipp Hospital and for other patients who may have a new need for nephrology services.

There are unused beds at Borgess-Pipp Hospital. As members of the Kalamazoo medical community, we encourage you to carefully review the request for additional beds outside of the established Certificate of Need process. Thank you.

Sincerely,

Sanjay Dalal, MD

a division of PARAGON HEALTH, PC

Public Comments
Select Specialty Hospital-Kalamazoo
Robert Desotelle, CEO
September 19, 2006

Thank you for allowing me to address the Commission. I would like to thank Commissioner Goldman, Jan Christensen, Brenda Rogers and their staff for support during the workgroup meetings over the last 12-plus months.

I am not here today because I want to be. I am here requesting relief as a result of changes Medicare made that affects where I am allowed to continue our hospital operations.

Other LTCHs are relocating in the State, but Select in Kalamazoo is not allowed to. The two primary reasons we can not get beds are: Borgess owns a similar facility 15 miles away in Plainwell and as a competitor would like to see us leave and secondly, Bronson has seen a tremendous growth in census and needs more beds.

After all comments are made from our competitors and other interested parties opposing our continued operation in Kalamazoo the question for you really gets down to this:

> Is the Commission willing to adapt to a federal change in rules that will allow us to continue providing the most accessible option for the residents of Kalamazoo in a cost effective manner or not?

Cost

Many commercial insurers pay a percent of charges. We offer a lower cost option in caring for patients than typical area hospitals with base rates over $3,000/day for intensive care. We can save employers and auto insurers money because of our lower cost structure.

If we are forced to close in 2007, patients will stay longer in hospitals resulting in increased census, ER diversion rates, and length of stay. The only other viable options would be Borgess-Pipp in Allegan County and local nursing homes which do not provide the same level of care and would likely increase State Medicaid spending.

As for the cost of a new facility, Select is willing to bear that burden and still offer a lower cost option than typical hospitals for our level of care.

Access

There can be no argument that an LTCH in Kalamazoo is the most accessible option for patients, families, physicians and services. Since the average age of our patients is 70 years, having your grandparents driving to Plainwell, Battle Creek or Berrien is not a desirable option. Using the CON limited access criteria Select is on average a 14 minute drive of 6.6 miles for Kalamazoo County residents versus 30 minutes and 19 miles to Plainwell in Allegan County.

Regardless of what may be said, there are limited physician services in Plainwell when compared to Kalamazoo. A recent survey I conducted showed that 80% of our physicians will not go to Plainwell and resoundingly supported a location near a hospital in Kalamazoo as the most preferred option. I also have three physician letters attesting to this. A Kalamazoo location will have easier access to services like radiation therapy, hyperbaric services, and cardiac cath labs that are not readily available in Plainwell.

It is naïve to think that location is not an issue when the Borgess location in Plainwell has had little growth in census as compared to Select in Kalamazoo given that Borgess Medical Center is the largest Medicare provider in Kalamazoo and has the largest number of patients greater than 15 days. In 2005 Bronson & Borgess combined, lost over $9 million on theses cases, and we all know how these losses are made up.

Borgess states that it can go to 39-beds in Plainwell with a combination of private, semi-private and possibly 3-bed wards. With infection control and gender issues they would be lucky to average 85% occupancy or 33 patients. With the combined census of Select and Borgess-Pipp running 36-38 patients and peaks over 47 patients, there will not be enough beds to keep up with current demand let alone the increasing number of Medicare discharges which are up over 33% from 2000.

After a year of meetings, the workgroup came to no specific conclusions other than the Department revue its existing policy for LTCHs. Some states like Georgia have specific LTCH CON regulations that Michigan may want to review. A straw poll approach by competitors and lobbyist is not how policy should be determined.

Finally, I was recently shown a letter from the "Friends of Certificate of Need" urging support of the CON process, which I do. I would like to quote from this letter:

> "We send this letter because assuring an effective and responsive CON program has become even more important to the continued viability of Michigan's health care system and economy. There are growing problems assuring access to quality health services. Health Costs are escalating at more than double the rate of inflation. The number of medically uninsured is increasing. All these trends threaten financial viability of businesses as well as hospitals and other healthcare providers. They also endanger health benefits and jobs for Michiganians. CON helps respond to all of those critical problems."

In the spirit of this I am asking the CON commission to respond favorably to our request to continue providing quality, accessible and cost effective care to the residents of Kalamazoo for our specialized services, which will also retain 75-80 jobs with a payroll in excess of $4.5 million at no cost to the State.

Thank you for your consideration.

1 copy dist @ mtg
9-19-06
(Select)

Physician Relocation Survey Results

In response to the question of would physicians go to the Borgess-Pipp location we conducted a survey of physicians on 9/14/06. The questions and responses are summarized below. Of the 36 responses, 5 physicians were comfortable stating their names due to employed physician status.

Of the physicians not currently on staff at Borgess-Pipp, none stated they would follow patients at that location. The overwhelming response was for a location near one of the hospitals in Kalamazoo, followed by another Kalamazoo location, then Portage and lastly, Borgess-Pipp in Plainwell.

One could infer from this that physicians prefer to follow their patients which contributes to the low occupancy rate of 37% at the Borgess-Pipp location versus 84% occupancy at Select in Kalamazoo. Given that Borgess-Pipp has a much larger pool of patients to draw from since Borgess Medical Center in Kalamazoo has 2,000 more Medicare discharges than Bronson and over 370 patient stays greater than 15 days; it does not seem plausible that location is not an issue when the Plainwell location can only run an ADC of 15-17 patient and Select in Kalamazoo is running over 21. In addition, 14% of Select's patients come from Borgess Medical Center.

Select Specialty Hospital- Kalamazoo
Physician Relocation Questionnaire

In order for Select to stay in Kalamazoo we will have to relocate outside of Bronson due to new Medicare rules.

Do you currently follow patients at Select Hospital in Kalamazoo? Yes -31 No-5

Do you follow patients at Borgess-Pipp? Yes-7 No – 29

Would you follow patients at the following locations?

Plainwell at Borgess-Pipp Yes – 6 No – 29 Maybe -1

In Kalamazoo near one of the hospitals? Yes – 30 No – 5 Maybe – 1

In another location in Kalamazoo? Yes – 20 No- 11 Maybe – 4 No answer -1

In Portage? Yes – 8 No – 22 Not Sure – 6

Comments:
Depends on many factors.

Closer to hospitals would be better or Woodbridge area (in Portage).

Between both hospitals (Borgess Medical Center- Kalamazoo & Bronson). Special Urology equipment if continue to consult.

Downtown (Kalamazoo) area, track between two hospitals. Woodbridge (Portage), Oakland Drive.

If (near) Borgess would probably come.

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Internal Medicine - Kalamazoo
David H. Doan, MD
John R. Lawlor, MD
Mark D. Schauer, MD
Eric S. Shay, MD
Robert E. LeFevre, MD
Jonathan Crooks, MD
Susan Carlson, MD
Richard Kammenzind, MD, MPH
Constance B. Purser, MD

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September 14, 2006

Dear Sirs:

I am currently a member of the medical staff of Select specialty Hospital, Kalamazoo, and realize that they are in the process of attempting to move to a different location within the immediate Kalamazoo area. Realizing that having a patient's primary care physician involved in their medical care is very important, I would find it concerning that if my patient needed care provided in such a facility they would have to leave the immediate Kalamazoo area.

Due to work scheduling issues, and travel issues my partners and I would not be able to provide care to our patients at the Borgess Pipp facility. As a primary care internal medicine group we find that continuity of care is very important. It has been my experience locally, that Kalamazoo based physicians, in general aren't able or willing to travel to that facility, on a regular basis, to care for patients. I do feel that that would potentially limit the patient's access to be cared for by their usual primary care physician, and their normal sub-specialist.

I do realize that it may be possible to get the appropriate subspecialties and internal medicine evaluations outside of the immediate Kalamazoo area, but this would be involving physicians that would typically not be following the patient long term.

I hope that the option of a LTAC hospital will continue to be a reality here in Kalamazoo.

Thank you,

M. Jonathan Crooks, M.D.

Geoffrey R. Grambau, MD, FCCP
Thomas A. Abraham, MD, FCCP
John W. Dircks, MD, FCCP

Pulmonary & Sleep Medicine Associates, P.C.

September 14, 2006

TO WHOM IT MAY CONCERN:

Dear Sirs:

Pulmonary & Sleep Medicine, P.C. is currently providing pulmonary services on a daily basis (weekends included) to Select Specialty Hospital of Kalamazoo.

If Select in Kalamazoo was to close, we would find it extremely difficult to provide the same level of care to hospitalized pulmonary medicine patients in Plainwell at Borgess-Pipp. It would be highly unlikely that other physicians in our same specialty or other specialties based in Kalamazoo would be able to travel to Plainwell on a seven day a week basis.

We strongly support the option of allowing Select Specialty Hospital of Kalamazoo to stay in Kalamazoo and will continue to provide services there. The location here in Kalamazoo will provide the best services for residents of this community who need long term acute care.

Sincerely,

Geoffrey R. Grambau, M.D., FCCP
Pulmonary & Sleep Medicine Associates, P.C.

G2:ri

cc: Robert Desotelle, CEO
Select Specialty Hospital

601 John Street, Suite M424 • Kalamazoo, MI 49007-5342 • 269-388-5864 • Fax 269-388-5211

Advanced
Cardiac Healthcare, P.L.C.
601 John Street, Suite 100, Kalamazoo, MI 49007 • (269) 373-1222 • 1-800-483-8333 • Fax (269) 373-6270 • Satellite Offices: Allegan • Vicksburg • Pa

Douglas J. Wunderly, MD • Gilbert T. Olivares, MD • Joel H. Reinoehl, MD • Christopher Rogers, DO
John F. Schonder, MD • Michael S. Pawlik, DO • Robert A. Williams, DO • Thomas A. Keller, MD
Sarah L. Moshier, ANP-C • Kimberly Staley, MS, PA-C • Elizabeth Sayers, MS, PA-C
Sean J. O'Neill, PA-C • Barbara L. Radawski, PA-C • Tracie L. White, ANP-C

September 14, 2006

To Whom It May Concern:

Advanced Cardiac Healthcare, P.L.C. provides inpatient cardiology services to the patients of Select Specialty Hospital in Kalamazoo. We understand that Select Specialty Hospital is being challenged by state regulatory agencies as to the need for these services being available in Kalamazoo.

As a large cardiology group providing coverage at several hospitals throughout Southwest Michigan, the challenge of providing inpatient coverage at Select Hospital is expedited by the facility being located in close proximity to Kalamazoo's existing hospitals. In the event that this long term acute care service was unavailable in Kalamazoo, the potential arises for quality of patient care to suffer, either as a result of specialty groups not being able to provide service within an acceptable period of time. Likewise, the continuity of care would be adversely impacted by the specialty groups not being able to follow their patients in the LTAC setting.

It is a known fact that, due to shortages existing in outlying medical communities, many subspecialty practices are challenged covering the hospitals in which they currently practice. Additionally, families, who play a vital role in the long term patient's recovery, would experience an additional hardship as they attempt to visit during their family member's extended stay.

As members of the Kalamazoo medical community, we encourage you to consider and support Select Specialty Hospital's request to relocate their facility within the Kalamazoo area.

Sincerely,

Douglas J. Wunderly, MD, F.A.C.C.
President, Advanced Cardiac Healthcare, P.L.C.

LTACH - Kira Carter

September 18, 2006

Dear Certificate of Need Commissioners:

On behalf of Bay Special Care and Sparrow Specialty Hospital, I would like to thank you for the opportunity to provide public comment regarding the development and implementation of a pilot program to allow current Hospital within Hospitals (HWHs) LTACHs to move into freestanding facilities in response to the 25% rule at 42 C.F.R. §412.534, which institutes a quota on the number of admissions an LTACH can take from their host hospital. While we don't agree with CMS's approach to curtailing the growth of the LTACH industry, we do not support the creation of a pilot program to allow for HWHs to move into freestanding facilities. According to the Federal Register/Vol 71, No. 18 (January 27, 2006) and Vol. 71, No. 92 (May 12, 2006) the transition of HWHs into freestanding facilities is viewed as side stepping a Federal Ruling.

As of October 2005, there were 376 LTACHs recorded in CMS's database, 175 of which are reported as HWHs and 201 as Freestanding. However, since October 2004, of the 25 new LTACHs established 22 are freestanding. According to CMS this transition of HWHs into freestanding facilities is clearly in response to the creation of the 25% rule and is the basis of CMS's current plan to role the 25% rule into freestanding and satellite facilities within the upcoming year.

It is our belief that instead of creating a work around at the State level to allow for hospitals to side step a federal ruling, better time would be spent lobbying and educating CMS on the potential affects that the current and proposed rulings will have on the LTACH industry within Michigan.

We support the LTACH workgroup recommendation for a broader analysis of the LTACH industry within Michigan, including the determination of LTACH bed need and lobbying efforts. While we do agree the current and proposed 25 % rulings are bad public policy, we do not feel that the Certificate of Need Process was designed to side step federal rulings, and can therefore not support a pilot program at this time.

Thank you for your time,

Cherri A. Burzynski, President, Bay Special Care Hospital 9/18/06

Kira M. Carter

Cherri Burzynski, MSN, RN, CNA, BC
President
Bay Special Care Hospital

Kira M. Carter, MHA, CHE
Interim President and CEO
Sparrow Specialty Hospital

Read and submitted by: Kira Carter, Interim President of Sparrow Specialty Hospital

LTACH - Michigan Board

Coalition for LTACH Access

The Coalition for Long-Term Acute Care Hospital Access in Northern Michigan

Testimony

Good Morning, I'm [redacted] and I'm the Senior Vice President and a Principal of the Murer Group. The Murer Group is a healthcare consulting firm which works primarily with the development and regulation of post acute care providers including long term care hospitals. I have worked in the development of long term care hospitals for the past 20 years and have served as interim CEO of Dubuis Health System – the largest chain of nonprofit long term care hospitals. I am also Chairperson of the Illinois Hospital Licensing Board. I have attached curriculum vitae for your reference.

I have been working with the Coalition regarding the development of a long term care hospital – more generally referred to as an "LTCH". As you know, LTCHs are acute hospitals that specialize in the treatment of patients whose average length of stay averages in excess of 25 days. Michigan currently has approximately 20 LTCHs.

Working with the Coalition, I analyzed several factors which indicated the need for a LTCH in Northern Michigan. First, an analysis of acute care hospital discharges in the area illustrated that a significant number of patients could likely benefit from treatment in an LTCH. In addition, reviews of current LTCH utilization and the increasing size of the elderly population in Northern Michigan supports the development of an LTCH.

Currently, patients in Northern Michigan do not have access to LTCH services. The closest LTCH providers appear to be located in Bay City, Saginaw and Muskegon. However, Bay City is nearly 160 miles from Petoskey and is a 2 ½ hour drive. Traverse City is nearly 150 miles from both Muskegon and Bay City and in excess of 2 ½ hours travel time from both. St. Ignace is 187 miles from Bay City. These distances are prohibitive to Northern Michigan patients who would benefit from LTCH care.

Proximity of a facility to the population which it serves is particularly important for LTCHs. Due to the long lengths of stay involved; patients must be nearby family and other support structures. Similarly, physicians must be nearby to a degree in which they may maintain contact with their patients. The current concentration of LTCHs in the Southern areas of the State does not address the needs of patients further north. The Upper Peninsula is particularly isolated from existing LTCH facilities and is sufficiently remote that patients residing there do not have access to this service. Even those who travel to the Lower Peninsula for hospital services are unlikely to significantly augment their travels for treatment at the northernmost LTCHs. While there is very limited access afforded to the northern populations, these patients are currently in need of LTCH services and this need will increase over time.

As indicated above, LTCHs primarily treat elderly patient populations. Elderly populations are generally more pronounced in rural areas and areas which attract retirees. Northern Michigan's is both rural and is continuing to grow as a popular retirement destination. These factors joined by the increasing percentage of elderly in the population generally strongly support the availability of a LTCH in Northern Michigan.

The rural areas of Northern Michigan also do not allow for development of a "hospital-within-hospital." LTCHs are commonly structured as HWHs in Michigan and other states. As you know, Michigan's CON standards have provided for development of HWHs but development of a freestanding LTCH would be much more difficult under the standards. Unfortunately, development of HWHs does not make sense in Northern Michigan.

Restricting LTCH development in Northern Michigan to HWHs rather than allowing a freestanding LTCH results in several difficult issues. First, the sizes of the acute hospitals in Northern Michigan are more modest than in the more populous southern portions of the State. These hospitals do not have the requisite space for HWH development. Second, restricting LTCH placement to within one of the larger

referring hospitals ignores the needs and locations of other referral sources. Centrally locating a freestanding LTCH to serve as many referral sources as possible would be ideal. Third, if a central location is not feasible, patients and their families will be faced with a choice of forgoing this specialized care or undergoing difficulty associated with treatment that is far from home. Thus, a centralized location will provide greater access to a higher percentage of residents than would a HWH.

I very much appreciate the opportunity to discuss these matters with you. If you have any questions or believe certain topics bear additional discussion, I would be pleased to address your questions.

Lyndean Lenhoff Brick, J.D.
Senior Vice President

Biographical Sketch

Lyndean Lenhoff Brick, J.D., is the Senior Vice President with the Murer Group. She received her Juris Doctor degree from Ohio State University College of Law. Since that time, she has been actively engaged in Health Care Law, and Management Consulting.

Ms. Brick's practice is concentrated on health care law including: Medicare/Medicaid regulation and reimbursement; health care compliance; HIPAA compliance; Certificate of Need development and review; corporate restructuring, joint ventures, acquisitions and capital formation; reimbursement review and TEFRA structuring; managed health care and regulation; and risk management for health care facilities. Ms. Brick has lectured on a variety of health related topics including: Case Management, Provider-Based Regulations; HIPAA; Compliance and CORF development. The Healthcare Financial Management Association (HFMA) has honored Ms. Brick with their Annual National Institute's (ANI) Distinguished Speaker Award in 2002 and 2003. She is nationally recognized for her work and client representation in the field of Medicare and Medicaid rules and regulations. She is the regulatory lead counsel to a national base of clients and has served as the acting CEO of a seven-chain hospital system in Texas and Louisiana.

Ms. Brick also consults in the areas of strategic and long range planning for health care providers and regularly advises clients in the assessment and development of joint venture opportunities in the health care industry. Additionally, she works with the feasibility of development for alternative sites of care such as Ambulatory Surgery Centers (ASCs) and Independent Diagnostic Testing Facilities (IDTFs).

Ms. Brick additionally has significant experience in assisting providers with emergency disaster preparation and recovery. Ms. Brick works with providers individually to ensure that requisite policies and procedures are implemented and in place in anticipation of emergency disasters to ensure optimal reimbursement potential from Federal and State sources of funding. Based on her experiences with past disasters, most recently Hurricane Katrina and Hurricane Rita, Ms. Brick has gained beneficial insight as to Federal disaster reimbursement processes and what measures need to be taken before, during, and after a disaster occurs to promote a provider's eligibility for reimbursement.

Ms. Brick also has considerable operational experience in the health care industry, having been the contract Administrative Director of a 42-bed inpatient rehabilitation unit in Johnson City, Tennessee, and Contract Manager of program development for a 175,000 square foot outpatient health care facility in Canada. In June 2005, Ms. Brick was appointed by Governor Rod Blagojevich to serve as a member of the Illinois Hospital Licensing Board and has since been elected the Board's Chairperson. Ms. Brick was appointed as one of two members of the board representing governing bodies of hospitals. She serves on the Regional Board of Provena Saint Joseph Medical Center Board of Directors in Joliet.

She has contributed to such health care newsletters as *Eli Research* and *CCH Healthcare Compliance Letter*. One of her most recent articles for the *CCH Healthcare Compliance Letter*, was titled "Independent Diagnostic Testing Facilities (IDTFs) – A Good Way to Cooperate." Ms. Brick and Cherilyn G. Murer, J.D., CRA have co-authored *The Case Management Sourcebook* published by McGraw-Hill. The 300-page text serves as a guide to designing and implementing a centralized case management system. A second book published entitled, *Post Acute Care Reimbursement Manual – A Financial and Legal Guide* has quarterly updates for timely response to an ever changing market. Ms. Brick, Cherilyn G. Murer and Michael A. Murer, J.D. of The Murer Group, co-authored a third book on *Compliance Audits and Plans for Healthcare*, as well as a fourth book entitled *The Complete Legal Guide to Medical Records Management*. A fifth book, entitled *Understanding Provider-Based Status*, was published in April of 2003 by Commerce Clearing House, Inc. (CCH).

Prior to joining Murer Consultants, Inc. Ms. Brick worked as an international attorney with a particular expertise in German. As a business consultant in Chicago, Illinois, her responsibilities included the negotiation and formation of international health care joint ventures, medical product development, international marketing and market research, commercial and regulatory law, and capital formation.

Ms. Brick has considerable experience in the formation and operation of foreign-based health care clinics as well as having guided international clients through the marketing and the American regulatory process.

September 2006

AB -

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September 19, 2006

Norma Hagenow, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building
201 Townsend Street
Lansing, Michigan 48913

RE: Public Comment Concerning Proposed Changes to CON Standards for Hospital Beds

Dear Ms. Hagenow,

On behalf of Trinity Health's 12 Michigan hospitals, we commend the Commission for its work around standards for hospital beds.

Overall, Trinity Health is supportive of the proposed changes as recommended by the Hospital Bed Standard Advisory Committee (HBSAC). However, we do have concerns about the proposed comparative review criteria. While we recognize it is unlikely that these criteria will actually be applied anytime soon due to excess bed capacity in the state, we believe it is in the best interest of the health care consumers of this state to change the comparative review criteria to include both a quality metric and consideration of community benefit. The general purpose of the Certificate of Need Commission, as identified in section 3 of the bylaws, is to evaluate the impact of a proposed action on the quality, accessibility, and cost of health services in this state. Trinity Health believes two of these three prongs can and should be better addressed.

Quality is not currently considered under the proposed comparative review criteria before you today. Similarly, there are more comprehensive ways to evaluate accessibility than included in the comparative review criteria before you today. In the spirit of promoting quality and access, as well as cost constraints, we recommend the following two changes:

- Incorporate quality metrics into the comparative review criteria. One potential measurement of quality is the "CMS Hospital Compare" metrics. All hospitals must currently submit quality measures for heart attack, heart failure, pneumonia and surgical infection for incorporation into this publicly available database.

- Incorporate community benefit into the comparative review criteria. This addition would allow applicants to include their direct expenditures made in support of specific community health initiatives targeted at the uninsured. A possible source for this information is the Michigan Health and Hospital Association community benefit data. Currently, almost 90% of Michigan hospitals voluntarily submit their data in an objective format. Adding this additional component provides a more accurate description of a hospital's commitment to addressing access barriers.

We hope you will share our belief that the comparative review criteria needs further amending and we look forward to working with you to find a solution that comprehensively meets the charge of this commission and that is in the best interest of health care consumers across this state.

Thank you for the opportunity to provide this input.

Sincerely,

Garry C. Faja
President and Chief Executive Officer
Saint Joseph Mercy Health System, Ann Arbor
Regional Market Executive – East Michigan

Philip H. McCorkle, Jr.
President and Chief Executive Officer
Saint Mary's Health Care, Grand Rapids
Regional Market Executive – West Michigan

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September 15, 2006

Via E-Mail

Norma Hagenow, Chairperson
Certificate of Need Commission
c/o Genesys Health System
One Genesys Parkway
Grand Blanc, MI 48439

Dear Commissioner Hagenow:

I am writing on behalf of William Beaumont Hospital concerning the proposed revisions in the certificate of need review standards for hospital beds and particularly the revisions set forth in section 13(3).

The revisions in section 13(3) would result in the awarding of points in a comparative review based on the payor mix throughout the applicant hospital's entire system. Points would be awarded on the basis of the applicant's system-wide medicaid and uncompensated patient volume.

The proposed revisions are apparently intended to implement MCL 333.22230 which provides that:

> In evaluating applications for a health facility as defined under section 22205(1)(c) in a comparative review, the department shall include participation in title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v, as a distinct criterion, weighted as very important, and determine the degree to which an application meets this criterion based on the extent of participation in the medicaid program.

MCL 333.22230.

Notwithstanding the apparent intent to comply with this provision, we believe that the proposed revisions are wholly inconsistent with it and are not authorized by any other provision. There are three reasons for this conclusion.

First, MCL 333.22230 refers to determining "the degree to which an application meets this criterion" (emphasis supplied). An application involves a proposed new facility or proposed new beds. It does not involve the percentage of medicaid or uncompensated care provided at other facilities owned by the applicant.

Second, MCL 333.22230 requires consideration of "the extent of participation in the medicaid program" (emphasis supplied). The "extent of participation" does not refer to the number or percentage of medicaid patients treated by a health facility but, rather the extent to which the health facility itself is willing to participate in the medicaid program. This would include things such as the percentage of beds in a proposed nursing home that will be available to medicaid patients or the number and types of services a hospital offers to patients funded by medicaid. This interpretation is confirmed by the legislative history of the 1989 revisions to the certificate of need law. An analysis prepared by the House Legislative Analysis Section on January 25, 1989 states, for example, that "[i]n a comparative review, willingness to participate in the federal medicaid program would be weighted as very important."

Third, MCL 333.22230 does not authorize any distinctions based on uncompensated care.

For these reasons, we believe the proposal before the Certificate of Need Commission is legally infirm and should not be adopted.

Very truly yours,

Peter H. Ellsworth

PHE/jrb
cc: Certificate of Need Commission Members
Ronald J. Styka

LANSING 32068-11 380948v1

Comparative Review Case Study Example - Revised

Case: Two hospital organizations want to build hospitals in area of bed need

Comparative review applicants are:
Hospital Organization A
Hospital Organization B

Comparative Review Scoring:	Hospital A measure	Hospital A points	Hospital B measure	Hospital B points	Total Points Available
Uncompensated care percentile ranking	79	15	90	25	25
Medicaid volume percentile ranking	74	10	88	20	20
Reduce capacity	move	0	move	0	25
Market share	67%	20.1	2%	0.6	30
Severity adjusted mortality rate (compared to statewide average)	Far Below	0	Far Above	0	0
Intent to provide uncompensated care at proposed site?	Yes	0	No	0	0
County Commission Resolution in Support?	Yes	0	No	0	0
Cost/Bed	$500,000	0	$1,000,000	0	0
Total points		45.1		45.6	

Hospital B gets the new hospital even though:
1) Hospital A has a strong market presence in the area and Hospital B has virtually no market presence
2) Hospital A has higher quality as measured by severity adjusted mortality rates
3) Hospital A intends to serve uncompensated care patients while Hospital B does not
4) County Commission supports Hospital A's proposed hospital over Hospital B's proposed hospital
5) Hospital A cost per bed is one half the cost per bed of Hospital B

concomparativereviewcasestudyrevised8-22-06.xls

Spectrum Health

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September 19, 2006

Norma Hagenow, Chair
Certificate of Need Commission
c/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Hagenow,

This letter presents the comments of Spectrum Health on the substantive issues included on the CON Commission agenda for September 19, 2006. Spectrum Health commends the members of the various Standards Advisory Committees (SAC) and work groups for the time and effort that they devoted to considering necessary changes to the existing CON Review Standards. We appreciate their service.

Specifically, the comments contained in this letter address recommended changes to the following CON Review Standards: Hospital Beds, PET, Bone Marrow Transplant, Long-Term Acute Care, and MRI.

Hospital Beds

High Occupancy

Spectrum Health supports the proposed changes to the Hospital Beds Standards related to high-occupancy. Specifically, these provisions are improved by eliminating the distinction between larger and smaller hospitals, and by adjusting for high obstetric and pediatric volumes. These revisions are the result of extensive study by a work group and are based on statistical analysis of existing hospital utilization.

Comparative Review Criteria

Spectrum Health supports the proposed comparative review criteria recommended by the SAC.

Hospital Relocation

Spectrum Health is concerned about the lack of resolution of the perceived inadequacies in the existing CON Review Standards which inhibit the relocation of existing hospitals into areas which some believe to be underserved by hospitals. We are prepared to support a new SAC to address the issue of establishing hospitals in perceived underserved areas, as long as the participants commit to a good-faith effort, and agree not to resort to possible remedies outside the CON system.

PET

Volume Requirements for Expansion

Spectrum Health fully supports the proposed language that would lower the volume requirement for adding additional units to a PET service from 6,000 PET equivalents to 5,500 PET equivalents. PET is a unique modality that only allows a fixed number of patients per day, because of the need to pre-order the appropriate radioactive materials. Therefore, it is very difficult to schedule additional patients, when others need to cancel appointments on short notice.

Relocation of a Fixed PET Unit

We also support the addition of language which allows relocation of an existing fixed PET unit. Provisions for relocation are included in other CON standards, and we fully support this addition to the PET standards. The proposed distances of 10 miles in metropolitan areas and 25 miles in other areas is appropriate, as PET services draw from a large population of people.

Dedicated pediatric PET Unit

Spectrum Health fully supports the addition of language for a dedicated pediatric PET service. Pediatric imaging services are very different from adult services. Pediatrics requires special facilities, nursing and other equipment. Because children require more time on the machine, hospitals are not likely to dedicate an entire unit to a pediatric service, even if such an arrangement would represent better care for pediatric patients.

The SAC has crafted the language for a dedicated pediatric PET that mirrors the language that is currently in the MRI standards for a dedicated pediatric MRI. The only addition is a requirement to have at least 50 new pediatric cancer patients on the most recent Cancer Registry for the hospital. Because these requirements are so restrictive, this provision will result in no more than three (3) additional PET units in Michigan.

Spectrum Health strongly encourages the Commission to approve this addition to the PET CON standards to foster quality, imaging services for children.

Clinical/Research PET Unit

Spectrum Health does not support the proposal which would allow a shared clinical and research PET unit. The current PET standards include provisions for a fully dedicated PET unit and allow facilities to conduct research on clinical PET units.. We believe that this provision is not necessary in the PET Standards.

Duration of Cancer Case Commitments

The proposed PET Standards change the length of time cancer cases are committed to a PET service from a lifetime commitment to three (3) years. Spectrum Health encourages the Commission to lengthen this time requirement to at least a five years, which is the generally accepted depreciation period for a new PET unit.

Bone Marrow Transplant

Access to Adult Services

In previous testimony, Spectrum Health has expressed concerns about access to adult bone marrow transplant (BMT) services in West Michigan. Currently, all three (3) full-service BMT programs are located in southeastern Michigan, at least 120 miles from Grand Rapids. While acknowledging the legitimacy of our concern, the Work Group could not agree on whether BMT access is solely an out state issue, or whether there are legitimate access issues in Southeastern Michigan, as well. Spectrum Health concurs with the non-unanimous consensus of the Work Group to recommend that the Commission establish a SAC to address this issue. We agree that further meetings of the Work Group are unlikely to resolve this issue.

Depending on whether the Commission decides to continue to regulate BMT services on the basis of large planning areas, or to adopt institution-specific CON criteria, as some have suggested, the comparative review criteria may need to be revised. If comparative review continues to apply to BMT, the existing criteria are inadequate to permit differentiation among otherwise complying CON applications. At a minimum, the comparative review criteria for BMT should include the following factors: distance to existing BMT programs, availability of necessary infrastructure, number of related cancer cases, and provision of both autologous and allogeneic BMT.

Technical Changes

Spectrum Health endorses the technical changes recommended by the Work Group and urges their approval. However, these changes are not of sufficient importance to warrant their adoption before the SAC has considered substantive recommendations related to the access questions. We suggest that proposed standards not be submitted for public hearing before the SAC has met.

Long-Tern Acute Care (LTAC)

Spectrum Health understands that changes in federal reimbursement policies have disadvantaged some established LTACs in Michigan. A Work Group met, without consensus, to attempt to address this issue. Given the explicit admonition by CMS against states attempting to circumvent the federal regulations, Spectrum Health supports making no changes to the provisions for LTACs in the CON Review Standards.

MRI

Conversion from Mobile to Fixed MRI in Rural Areas

Contrary to general understanding, there is no rural provision in the current MRI standards for conversion of MRI services from mobile to fixed. The current MRI standards require 6,000 adjusted MRI procedures performed at a mobile host site to convert the site into a fixed unit. However, they also contain an exception that lowers the volume requirement to 4,000 for a non-profit hospital which 1) is the first fixed MRI site in the county, and 2) is located at least 15 miles away from the nearest fixed MRI service. Spectrum Health believes that this language requires a minor modification to become a true rural provision.

Our proposal is to lower the volume requirement to 4,000 for all hospitals located in rural or micropolitan counties while maintaining the 15-mile radius to prevent the duplication of services in the same market. This modification would eliminate the requirement to be the only fixed MRI service in the county and allow this provision to apply to all hospitals located in rural or micropolitan counties, provided that they are located more than 15 miles from the nearest fixed MRI.

The impact of this proposal would be minimal. There are only four (4) counties that potentially would benefit from the change, resulting in no more than four (4) additional fixed MRI units in the state. The four counties that would be affected by this change are Lenawee, Marquette, Montcalm, and St. Joseph Counties.

It is important to note that this change would not immediately add four (4) MRI units to the system. Hospitals with existing MRI host sites would still have to reach the 4,000 adjusted procedure volume to qualify. Currently only one of the four (4) possible sites meets this requirement, and another is about half way there. In the other two counties, the hospital sites with the lower MRI volume currently have volumes considerably less than 4,000 adjusted procedures.

Spectrum Health strongly urges the Commission to adopt this minor change in the MRI Standards that would benefit all hospitals in rural or micropolitan counties, not just the first one to have a fixed MRI. We respectfully request that this change (proposed language is attached to this letter) be included in the draft of the MRI standards submitted for public comment before the next CON Commission meeting.

Dedicated Pediatric MRI expansion

Spectrum Health fully supports the additional language for the expansion of a dedicated pediatric MRI service. Under the current language, the requirements for adding subsequent dedicated pediatric MRI units are unclear. The proposed requirements erase this ambiguity, while acknowledging that the provision of pediatric imaging is different from an adult service, necessitating lower volume requirements.

Relocation Zone t

We also support the proposed change of the relocation zone for MRI from a variable distance for rural and urban areas to ten (10) miles for all areas. This requirement reflects a resonable distance patients are willing to travel for imaging services.

Research/Clinical Unit

Spectrum Health supports the current MRI standards in regard to research use of MRI units. Spectrum Health does not support the proposal allowing a shared clinical and research MRI unit. The current standards permit additional MR capacity for research purposes, either through expansion of a clinical service, or by adding a dedicated research unit.

Technical Changes

There are proposed technical changes in the standards that Spectrum Health fully supports. Among those are adding new weights for patients who have both a clinical scan and research scan in a single session, for special needs patients, and for re-sedated patients. As the implementation time for these new weights may be as much as two (2) years, we endorse submitting these recommendations for public comment immediately, even before resolving some of the more controversial issues for MRI.

Additionally, we support the workgroup's recommendation to modify the definition of "upgrading an MRI unit" from an expenditure of $500,000 over a 2-year period to $750,000 over the same period.

Spectrum Health appreciates the opportunity to present our positions on these important issues. We wish the CON Commission well in attempting to resolve these issues in a very full agenda.

Please feel free to contact me if you have any questions about these comments.

Sincerely,

Robert A. Meeker
Strategic Program Manager

Spectrum Health Recommendations for Draft Language for the CON Review Standards for MRI Services

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

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

(4) An applicant that meets all of the following requirements shall not be required to be in compliance with subsection (1):

(a) The applicant is proposing to initiate a fixed MRI service.

(b) The applicant is currently a host site being served by one or more mobile MRI units.

(c) If the applicant is located in an metropolitan county, the applicant has received, in aggregate, the following:

(i) at least 6,000 MRI adjusted procedures within the most recent 12-month period for which data, verifiable by the Department, are available, or

(ii) at least 4,000 MRI adjusted procedures within the most recent 12-month period for which data, verifiable by the Department are available, and the application meetings 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; **or the applicant is located in a rural or micropolitan county;**

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

(C) the applicant is a non-profit licensed hospital site; and

(D) the applicant certifies in its CON application, by providing a governing body resolution, that the board of trustees of the facility has performed a due diligence investigation and has determined that the fixed MRI service will be economically viable to ensure provision of safe and appropriate patient access within the community hospital setting.

Certificate of Need Commission Meeting Testimony
September 19, 2006
The Economic Alliance for Michigan,
the statewide business-labor coalition

Hospital BED SAC

EAM commends the Hospital Bed SAC member for their hard work and deliberations, via a multitude of meetings and work groups!

- **We support the good compromise of the high occupancy change of 80% for 24 months incorporating a bump for provided service for pediatric and obstetrics.**
- **We agree there is no further need to address Limited Access Area hospitals (LAA)**
- **We support retaining 2 mile replacement zone in large counties, based on the rationale that it is easier to find appropriate land available in urban areas than rural**
- **We support establishment of comparative review criteria—although we would point out that given patient utilization rates and high occupancy factor there is no expected or future indication of bed need. Although it is not likely that these criteria will be used in the future—we urge adoption of these criteria. However, we understand that others have concerns and we feel that they have time to bring data to the forefront. In this process, we think it would be help full to add factors for quality, including the ability to operationalize it.**

The new bed need number to be submitted to Comm. with the 3 year update will probably show a few beds needed statewide, based on 2000 census projected to 2009. However, there continues to be no actual bed need in any subarea.

There are significant differences between need for new beds and need for new hospitals. On Aug. 29th, our board reiterated that we are always open to demonstration of community need, meriting CON change. We've gone thru a 6 month SAC with very little evidence presented publicly or via private conversation. Although we've had not received data that supports community need so far, we are open to it and the challenge is to those who want it to pull together evidence on these lines

Imaging Standards

MRI/PET: EAM's Health Policy Group voted to support the various technical changes that Dr. Sandler is scheduled to present today. These changes include updating some of the patient weighting factors, modifying the replacement zone and modifying the dollar threshold levels.

Many of the other MRI items relate to more substantive issues relating to requested changes for various rural situations. EAM will be glad to participate in the subsequent consideration of those issues.

However, we continue to oppose combined clinical and research units whether for MRI, PET or any other equipment. EAM's Health Group maintains its long-standing support for an exemption from the minimum volume requirements for 100% research/training units, of whatever type. Although we don't want CON to become a barrier to medical personnel training or for applied research, **our policy group**

maintained its opposition to a situation where selected providers are able to initiate a service at lower indicated community need -- and lower ultimate clinical utilization:

- **This allows an unfair advantage in the market place** for those saying they will be doing research or training vs. others providing this service, or wanting to start a new program.
- **Soon many providers will be claiming that they will be using the equipment for research/training.** We know suggestions have been made to assure that this provision will not be subject to abuse. However, no matter what rules are established, many providers -- hospital or physician -- could arrange for the local hospital's Institutional Review Board to authorize research
- MDCH enforcement would be quite difficult for whatever would be the split between clinical vs. research/training

In addition EAM continues to support the concept of dedicated data for the duration of that program for which that data that was committed

Dental CT

This proposed CON Standard for Dental CT Is Appropriate For Patients' Needs: CON provides the one mechanism that allows promotion of the State's responsibility pertaining to affordability, quality, and accessibility of health services.

Cost-Effectiveness via Minimum Volume: EAM is a group of businesses and unions concerned about health care costs. **We continue to be focused on the TOTAL cost of health care, whether borne by the employer, government, or the individual** (which will for be the case for dental CTs, at least in the short-term).
We applaud the Commission for establishing a standard that allows the immediate diffusion of this technology yet implements minimum requirements that prevents this new technology from immediately becoming a standard piece of equipment in dentists' offices.

EAM Health Policy Group Discussed This Draft Standard Again Last Week:

- We are satisfied that dental CT units represent a valuable advance in technology but agree that the availability of this technology should be predicated on an appropriate diffusion for Michigan residents.
- **The proposed standard of 200 annual scans, breaks down to only 4 studies per week. At the June Commission meeting we stated that the volume thresholds should be increased to assure enhanced cost-effectiveness and continue to support a threshold of 400 annual scans.**
- **Information from various sources regarding the value of dental CT for specialized surgery related to specific orthodontics is being analyzed. However, the current proposed language already covers oral surgery which is for orthodontic use.**

LTACH

EAM's Health Policy Group has concluded that the case has <u>not</u> been made for an exception to the CON hospital bed standards to allow additional free-standing long-term acute care hospitals (LTACHs).

Our group took this unanimous position per our Board policy that would have allowed EAM to support an exception IF a "clear and compelling case" was shown that patient safety, access, quality and/or costs would be significantly negatively harmed without such an exception. Our Group did <u>not</u> find that this case had been made by Select-Kalamazoo, despite its provision of various physician support materials.

We received assurances that the other Kalamazoo-area LTACH, Borgess-Pipp in Plainwell, can accommodate all LTACH patient needs now provided by Select-Kalamazoo, as well as responding to the concerns raised by Select re physicians' willingness to serve Borgess-Pipp and access by family and friends to Borgess-Pipp, despite it being 15 miles from downtown Kalamazoo.

This position was developed as requested by Select Medical-Kalamazoo (and other LTACH sponsors) to become a free-standing LTAC hospital (despite the absence of CON bed need in a planning area). Select-Kalamazoo wants to convert from the status of a hospital-in-a-hospital, with beds leased from its host, Bronson Hospital, to avoid the imminent restrictions in Federal Medicare payments for LTACHs. Those restrictions would reduce the payments for LTACH patients beyond a higher-than-allowed proportion of the LTACH patients coming from the host hospital. Those new Federal restrictions don't apply to free-standing hospitals.

We received copies of Select-Kalamazoo materials and heard oral report on Burgess's response. The Group voted that EAM should maintain its position of NOT supporting an exception to the CON Hospital Bed Need Standards (thus to not exempt an applicant for a new hospital from the CON hospital bed need constraint), which would permit hospital-in-hospital LTACHs to replace themselves as free-standing hospitals.

Burgess's response to the Select-Kalamazoo material emphasized that the current physician practice groups now serving Borgess-Pipp is adequate to care for all Kalamazoo LTACH patients, even if Select-Kalamazoo closes down. (It has indicated that this will happen if it can't secure "regulatory relief.)

The EAM Health Group's conclusion was based on Burgess's assurance that it is has adequate specialty physician support for the option of an expanded Borgess-Pipp LTACH service and readiness to serve patients in Plainwell, despite being 15 miles from downtown Kalamazoo. These letters will be distributed at the Tuesday September 19th Commission meeting.

In addition to adequacy of physician services, our EAM Health Group took into account that Borgess made the following case indicating its ability to serve the entire LTACH population in the Kalamazoo area. Borgess included responses to the various concerns raised by Select-Kalamazoo regarding the Borgess-Pipp facility in Plainwell:

1. Increased Staffed Beds to Accommodate Select-Kalamazoo's Current Capacity: Borgess has committed to expand their staffed bed complement from the current 25 to 45, and all double occupancy (thus replacing the few three-patient rooms that it now has). They also have committed to transferring additional beds from the main Borgess hospital in Kalamazoo if that would be required to accommodate all LTACH patients in the Kalamazoo area should Select-Kalamazoo close its LTACH at Bronson Hospital.

2. Subsidized Transportation Access for Family and Friends of LTACH patients to Borgess-Pipp. This transportation access will be secured through a local van program, serving the city of Kalamazoo and also suburban areas.

3. Other Relevant Medical Services already are Available at Borgess-Pipp: Due to being a long-standing community hospital, Borgess Pipp already has other services relevant to LTACH patients: two operating rooms, 24-7 emergency room, which is recognized as a "911" emergency service, fixed CT, mobile MRI host site, and other services.

4. Borgess-Pipp Renovation Cost will be Something Like 10% of Select's Capital Costs: Borgess-Pipp estimates that its costs for remodeling its current facility and expanding to 45 staffed beds would be under $500,000. That is far less than Select's estimate of $5 to $8 million for acquisition and renovation of a building in downtown Kalamazoo. [EAM acknowledges that Select indicates that it will bear the risk for all capital costs. However, EAM has long been concerned that there is a tendency for health care spending to end up being spread across other payers. Also, Federal Medicare expenditures are borne by employers and employees.]

In conclusion:

- **There is clearly profitable cash-flow at issue here, between a Michigan non-profit general hospital vs. a for-profit specialized non-Michigan company.**
- Borgess, like many other Michigan hospitals, are under financial stress, due to its provision of general inpatient and outpatient health care to Medicaid and the indigent, and emergency and other non-profitable but important community services. The additional Federal Medicare LTACH payments would help the financial situation of either Borgess or the LTACH company.
- **Why should the CON Commission create an exception to allow that revenue to be secured by non-Michigan for-profit companies by creating an exception to the CON Hospital Standards and establishing a whole new hospital or later other new hospitals?**

BMT

Based on provider presentation and attendance at the BMT Work Group meetings, our organization has extensively reviewed this issue earlier this year and made the following recommendations:

- No demonstrated need for additional BMT programs in Planning Area 1 (eastside of Michigan),
- No demonstrated problem regarding cost, accountability, access or quality of existing programs.
- Over the past five years, BMT volumes have flattened and decreased.
- So far, there has been no evidence presented regarding future growth in BMT utilization
- Other medical or pharmaceutical applications for diseases previously treated by BMT.
- Data show that the majority of BMT procedures (83% total for most recent year) are performed by just two of the current providers for this service.
- NO need for A SAC for additional program in planning area 1

However, based on the geographic access issue, an additional adult BMT program may be needed on the west side of the state. Previously, EAM supported dividing the state into east and west planning areas for pediatric BMT purposes and supported a standard change that allowed a pediatric BMT in West Michigan (now located at Spectrum Health). Accordingly, based on these geographic concerns, EAM could support an adult BMT program in West Michigan if there is a demonstration of a projected significant volume.

Thanks for the opportunity to speak to these issues. Again, we commend the Commission for its deliberative processes CON continues to need to stay focused on key issues!

Long-term (Acute) Care Hospital (LTACH) Workgroup Report
September 15, 2006
Submitted by: Ed Goldman

1. Introduction

This workgroup was approved by the Commission on December 13, 2005 in response to a concern raised by Select Hospitals about a change in federal reimbursement policy. In short, the original policy was to reimburse LTACH's a specific amount regardless of where they were located. Michigan helped create a hospital within a hospital program so that an LTACH could locate within an existing hospital thereby avoiding duplication of services.

Center for Medicare and Medicaid Services (CMS) recently changed their reimbursement policy to say that an LTACH receiving more than a specific percentage of referrals from their host hospital would receive dramatically lower reimbursement. In order to avoid this decrease in revenue, the LTACH would have to be physically removed from the host facility.

The workgroup was set up to assess this policy change and its impact on existing LTACH's and to determine options should any LTACH demonstrate possible problems for an existing patient population.

2. Meetings

The workgroup, after posting notices, met on the following dates: February 24, 2006, March 27, 2006, August 17, 2006, and September 8, 2006. The meetings were attended by representatives of LTACH's in the State and other interested parties (*Attachment A).*

3. Identification of issues

There was substantial discussion of the new reimbursement rule and its impact. Select indicated that the reimbursement change affected several of their facilities but that they had a remedy for all facilities except for the facility in Kalamazoo. That facility is located in Bronson Hospital and has 25 beds. It runs around 80-85% occupancy and receives more than 25% (currently in excess of 60%) of its referrals from its host hospital. Accordingly Select asked for an approach that would allow it to leave its host and establish a freestanding hospital facility. It estimated a cost in excess of $8M to establish a new facility plus it indicated it would need an allocation of beds. The Kalamazoo area is over-bedded so no beds are available from any allocation pool and the host hospital, while acknowledging the usefulness of the LTACH, indicated it had a need for the beds and would not be able to transfer any beds.

There was substantial discussion over the issues of cost, quality and access. Cost to construct a new facility as well as costs to rehab existing facilities, such as Borgess-Pipp, were reviewed. Problems with quality of care were not seen as an issue. Access was a major discussion point. Select said that if it was forced to close its facility there would not be sufficient access in the area for existing and projected LTACH patients. Others said that access could be made adequate through rehabilitation of existing facilities. All acknowledged that patients, family and physicians may have to travel longer distances (15

miles) to other facilities. The Departmental analysis showed availability of access options (*Attachment B).*

4. Identification of Possible Recommendations for the CON Commission

Following full and open discussion, the following options were identified for discussion and recommendation to the Commission:

a. Amend the existing standards to allow for a pilot program that would create a free standing LTACH and allocate beds to the facility. Attached is a detailed approach submitted by Select (*Attachment C).* Implications: This would allow for creation of an LTACH in any planning area that met the criteria. The Commission would receive feed back about the program. The problems include amending the existing standard and creating added beds in an overbedded area. In discussing this option, as indicated above, the question of alternatives for the current patient population was discussed (access questions) and facilities were identified in the area that had capacity.

b. Do not change the existing standards.

c. Suggest that the Commission charge the Department to: 1) Look at options for LTACH services in the State given the change in reimbursement policy and possible future changes in policy, and 2) Engage in discussions with CMS about their reimbursement policy. During the workgroup meetings it was suggested that CMS may feel LTACH's are being over used and may be considering further changes in reimbursement policy and that we ought to be planning for possible future changes in a way that does not look like we are trying to ignore Federal policy.

After considerable discussion, the workgroup took a straw poll (allowing one vote to each interested group, i.e. if there were several people attending from one facility, they got one vote) and determined there was not a majority for options a and b but there was a majority for option c.

5. Conclusions

The workgroup is to be commended for its diligent and collegial work on a difficult issue. Ultimately, the majority concluded that this was too large an issue for an informal workgroup to solve and therefore only recommended an approach whereby the Department could take a comprehensive look at existing policy for LTACH's.

Note: This may be an instructive lesson for the future use of work groups. It may be best to convene a workgroup only after detailed Departmental fact gathering and analysis of an issue with a conclusion that the issue is manageable by an informal process.

9-24-2006

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Brenda Rogers
Matt Deniston
Lynne Koepsell
Andrea Moore

Conference Call Participants

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Jim Pomeroy, Joliet Medical Corp
Jim Faulmann, Miller Canfield
Gary Hagan, Joliet Specialty
Ed Feldmann, CON Commission
Larry Hunter, Economic Alliance

03-27-2006 LTACH

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LTACH August 17, 2006
1 PM CVB

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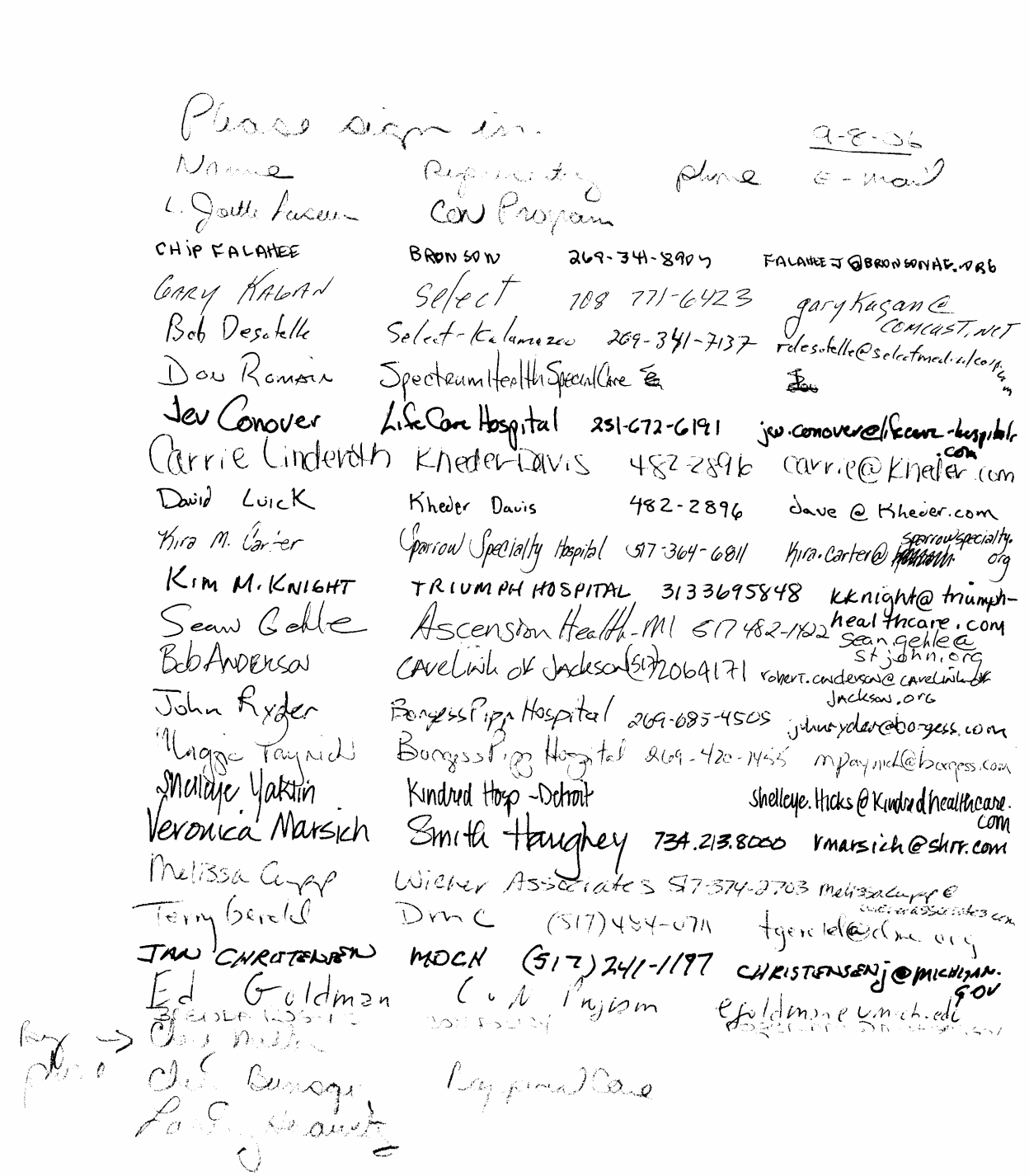

Please sign in. 9-8-06

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Selected Statistics from the
MDCH Annual Hospital Statistical Survey
Draft 2005 Data

Facility Number	HSA	Carenet Name	Facility Number	Host Hospital	Set-up Beds	LTAC Beds	Avail. Days	Patient Days	Lic. Bed days	Set-up Occup.	Lic. Occup.
500111	1	Select Specialty Hospital - Macomb	500080	St. Joe's Speciality	36	36	365	11,136	13,140	84.7%	84.7%
630172	1	Select Specialty Hospital - Pontiac	630140	St. Joe Mercy/Oak	30	30	365	9,694	10,950	88.5%	88.5%
810081	1	Select Specialty Hospital - Ann Arbor	810030	St. Joe AA	36	36	365	10,475	13,140	79.7%	79.7%
820130	1	Kindred Hospital - Detroit		N/A	130	220	365	9,323	80,300	19.6%	11.6%
820272	1	Select Specialty Hospital - Wyandotte	820230	H.F. Wyandotte	35	35	365	12,055	12,775	94.4%	94.4%
830521	1	Triumph Hospital - Detroit	830230	St. John NE	53	53	365	12,310	19,345	63.6%	63.6%
820276	1	Select Specialty Hospital - Grosse Pointe Far	820040	Cottage Hospital		30	1st Patient - April 4, 2006				
820279	1	Select Specialty Hospital - Downriver	820250	Oakwood Heritage		40	Approved 2/28/2006				
830523	1	Select Specialty Hospital - NW Detroit	830450	Sinai-Grace	36	36	365	10,976	13,140	83.5%	83.5%
830526	1	LTAC Hospital Detroit	820278	Detroit Hope Hosp		20	Approved 2/8/2006				
830527	1	Select Specialty Hospital - CN (Detroit)	830240	DMC Central Hospital		60	Approved 6/2006		May be Withdrawn		
		Totals for Health Service Area			356	596	365	75,969	162,790	58.5%	46.7%
330061	2	Sparrow Specialty Hospital	330060	Sparrow HS	36	36	365	6,650	13,140	50.6%	50.6%
380030	2	Carelink of Jackson	380010	Foote HS	30	64	365	7,313	23,360	66.8%	31.3%
		Totals for Health Service Area			66	100	365	13,963	36,500	58.0%	38.3%
030031	3	Borgess-Pipp Health Center		N/A	30	43	365	5,335	15,695	48.7%	34.0%
110080	3	Lakeland Specialty Hospital		N/A	44	55	365	8,392	20,075	52.3%	41.8%
130111	3	Select Specialty Hospital - Battle Creek	130031	Battle Creek HS	32	32	365	9,352	11,680	80.1%	80.1%
390032	3	Select Specialty Hospital - Kalamazoo	390010	Bronson	25	25	365	7,379	9,125	80.9%	80.9%
		Totals for Health Service Area				155		30,458	56,575		53.8%
410090	4	Spectrum Health - Kent Community Campus		N/A	30	76	365	7,001	27,740	63.9%	25.2%
610051	4	Select Specialty Hospital - Western MI	610010	Hackley	31	31	365	6,417	11,315	56.7%	56.7%
610052	4	Lifecare Hospitals of Western MI	610030	Mercy General	20	20	365	5,156	7,300	70.6%	70.6%
		Totals for Health Service Area			81	127	365	18,574	46,355	62.8%	40.1%
250071	5	Select Specialty Hospital - Flint	25.004	Hurley	32	32	365	7,627	11,680	65.3%	65.3%
		Totals for Health Service Area						7,627	11,680	65.3%	65.3%
090010	6	Bay Special Care[1]	090010	Bay Regional MC	26	31	365	8,398	11,315	88.5%	74.2%
730062	6	Select Specialty Hospital - Saginaw	730061	Covenant-Harrison	32	32	365	9,610	11,680	82.3%	82.3%
		Totals for Health Service Area			58	63	365	18,008	22,995	85.1%	78.3%

1 - Approved for 11 additional beds on 6/2006 - new total is 42 beds.

Revised 9/15/2006
LTACH table 3.06.xls

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS ADDENDUM FOR THE RELOCATION OF CERTAIN QUALIFYING LONG TERM (ACUTE) CARE HOSPITALS

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

Section 1. Applicability; definitions

Sec. 1. (1) This addendum supplements the CON Review Standards for Hospital Beds and may be used for determining the need for the relocation of certain long term (acute) care hospitals originally issued a certificate of need to initiate a new long term (acute) care hospital utilizing the hospital within - a - hospital model under the provisions of Section 6(2) of the Certificate of Need Review Standards for Hospital Beds, and which meet the criteria set forth in Sec. 2 of this addendum.

(2) Except as provided by sections 2 and 3 below, these standards supplement and do not supercede the requirements and terms of approval required by the CON Review Standards for Hospital Beds.

(3) Except as stated below, the definitions that apply to the CON Review Standards for Hospital Beds apply to these standards.

(a) For purpose of this addendum, "Qualifying Facility" means an existing long-term (acute) care hospital approved as a hospital within a hospital in accordance with section 6(2) of the Certificate of Need Review Standards for Hospital Beds effective as of May 27, 2005 or previous versions of those Standards; which is then and has been licensed as a hospital by the Department and certified by CMS as being exempt from PPS under Title XVIII of the Social Security Act for a period of not less than three (3) years immediately preceding the filing of its application under this Addendum; and which documents compliance with the criteria contained in section 2 of this addendum.

(b) For purposes of this addendum, "Replacement Zone" means a proposed licensed site that is (i) in the same subarea as the existing licensed site of a Qualifying Facility as determined by the Department in accord with section 3 of these Standards and (ii) on the same site, on a contiguous site, or on a site located within ___ (__) miles of the existing site of the Qualifying Facility, provided that the applicant is found to be in compliance with the criteria set forth in section 2 of this addendum.

Received Time Sep.15. 10:19AM

Section 2. Requirements for approval; relocation

Sec. (2)(1) An applicant proposing to construct a replacement facility shall demonstrate that it meets all of the requirements of this section and shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C. Beds approved under this addendum shall be added to the bed supply of the subarea in which the replacement facility is established:

(a) the applicant is a Qualifying Facility which is now, and from the date of its formation to the time that its application is submitted to the Department has only accepting patients who meet the admission requirements for a hospital exempt from PPS under Title XVIII of the Social Security Act;

(b) the applicant is proposing to construct a replacement hospital for a Qualifying Facility within the Replacement Zone;

(c) in the twelve (12) months immediately preceding the filing of its application under this addendum the applicant: (i) experienced an average annual occupancy rate of not less than 75%, and (ii) received no less than 50% of its admissions from its host hospital; and

(d) the applicant is proposing to establish a freestanding facility having a bed complement equal to or less than the licensed bed capacity of the Qualifying Facility to be replaced.

(2) the applicant must agree to voluntarily de-license a replacement hospital and all beds licensed and approved under this addendum should it fail to maintain certification by Medicare as a long term acute care hospital exempt from PPS under Title XVIII of the Social Security Act.

(3) The provisions of Section 6(1)(a) of these Standards establishing minimum licensed capacity for urban and rural hospitals are waived with respect to new facilities approved under this addendum.

(4) The applicant shall have filed its application for a certificate of need with the Department under this addendum within forty five (45) days from the effective date of this Addendum.

Section 3. Project delivery requirements

Sec. 3 (1) An applicant shall agree that if approved under this addendum, it shall deliver all services in compliance with the Project Delivery Requirements established in the Certificate of Need Review Standards for Hospital Beds.

Received Time Sep.15. 10:19AM

(2) The applicant must agree to terminate its lease with its host hospital, and to cease all operations at that site effective as of the date of the Medicare Certification of the new facility approved under this addendum. Upon the termination of such lease, the host hospital shall have all rights afforded it under Section 6(2)(b)(iii)(A) of these Standards with respect to the beds previously leased to such long term (acute) care hospital.

(3) With the exception of mobile MRI and/or mobile CT Scanning Services, the applicant shall not apply, initially or subsequently, for certificate of need approval to initiate any covered clinical services; provided, however, that this section is not intended and shall not be construed in a manner which would prevent the applicant-licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with any other certificate of need approved provider of covered clinical services.

Section 4. Additional limitations; transferability

Sec. 4 Neither the beds approved under this Addendum nor any other beds thereafter acquired by the applicant at the site of the facility approved under this Addendum shall be used for any purpose other than the delivery of medical services to patients meeting the admission requirements of a long term (acute) care hospital exempt from PPS under Title XVIII of the Social Security Act. Such beds may not be transferred, leased, sold, donated, conveyed or otherwise made available for use by any party other than the applicant except in the case of a sale of the facility to another entity which shall continue the operation of the facility as a long term (acute) care hospital exempt from PPS under Title XVIII of the Social Security Act.

Section 5. Comparative reviews

Sec. 5 Projects proposed under this addendum shall not be subject to comparative review.

Section 6. Sunset Date

Sec. 6(1) This addendum shall expire and shall be of no further force and effect thirty (30) days following the issuance of the last final decision of the Director on any application filed in accordance with the time lines required under Section 2(3), above. If no application is filed within the time lines required under Section 2(3), this addendum shall expire forty six (46) days following their effective date.

(2) The expiration of this addendum shall not impair the validity of a certificate of need issued in accordance with its terms, nor shall the same impair any rights of appeal which an applicant may have should its application have been denied by the Director nor the rights of a prior host hospital under Section 6(2)(b)(iii)(A) of these Standards.

SGLIB:2876.2\123816-00003

Psychiatric Beds and Services Workgroup 2006

Report to the Certificate of Need Commission

September 19, 2006

The Psychiatric Beds and Services Workgroup was established at the March 21, 2006 Certificate of Need (CON) Commission Meeting. The Commission assigned the Workgroup to follow up on the comments received regarding these Standards at the Public Hearing, held on January 31, 2006. The Workgroup has met on three (3) occasions and the next meeting is scheduled for October.

The Workgroup has reached a proposed consensus package consisting of modifying the following: the adult planning areas, the replacement zone and the minimum number of beds per unit. In addition, the number of licensed beds per facility will fluctuate with the facility's occupancy rate for the previous 24 months under a renewing license concept. This would eliminate both underutilized beds at some facilities and high occupancy at other facilities.

This innovative approach uses concepts of quality improvement so that normal fluctuations in bed need within a reasonable range (common cause variation) will be handled via this automatic process. The advantage of this approach is the freeing up of the Department of Community and the CON Commission to focus their valuable time and attention on unusual (special cause variation) requests that require significant study and deliberation.

The proposed package and draft language will be reviewed by the Workgroup at the October meeting. The final proposal and draft language is expected to be presented at the December 12, 2006 Commission meeting.

The Workgroup continues to evaluate the informal Workgroup meeting model. An informational email was sent to all Psychiatric facilities that completed the 2005 Survey giving an overview of the Workgroup's responsibilities, current status and provided the upcoming meeting date and meeting materials. This resulted in greater facilities representation at the August meeting.

Respectfully submitted,

Dorothy E. Deremo, CON Commission Liaison
Psychiatric Beds and Services Workgroup

CERTIFICATE OF NEED (CON) COMMISSION RESOLUTION REGARDING EXPERT REPRESENTATION ON STANDARD ADVISORY COMMITTEES (SAC)

MCL 333.22215(1)(L) REQUIRES THE CON COMMISSION TO CONVENE A SAC TO ASSIST IN THE DEVELOPMENT OF NEW OR REVISED CON REVIEW STANDARDS. THE LEGISLATIVE ALSO PRESCRIBES THE COMPOSITION OF A SAC. MORE SPECIFICALLY, A SAC MUST HAVE 1) A 2/3 MAJORITY OF "EXPERTS WITH PROFESSIONAL COMPETENCE IN THE SUBJECT MATTER OF THE PROPOSED STANDARD" AND 2) MUST INCLUDE "REPRESENTATIVES OF HEALTH CARE PROVIDER ORGANIZATIONS CONCERNED WITH LICENSED HEALTH FACILITIES OR LICENSED HEALTH PROFESSIONS," AS WELL AS "CONSUMERS," "PURCHASERS," AND "PAYERS" OF HEALTH CARE SERVICES.

THEREFORE, THE CON COMMISSION RESOLVES THAT WHEN IT APPOINTS MEMBERS TO A SAC, CONVENED BY THE COMMISSION PURSUANT TO SECTION 22215(1)(L) OF THE CON LAW, THAT THE COMMISSION SHALL CONSIDER INDIVIDUALS AS EXPERT MEMBERS OF A COMMITTEE IN ACCORDANCE WITH THE FOLLOWING:

Experts typically are clinicians - doctors, nurses, and other health care professionals - with specific education, training, and experience in the service being considered. The CON Commission also recognizes that other individuals, who are not clinicians, may have professional competence in the service being considered. Specifically, the CON Commission will consider, as experts, individuals with demonstrated "professional competence in the subject matter of the proposed standard" through significant experience as a professional with organizations concerned with licensed health facilities. Examples of significant professional competence include, but are not limited to, service as an administrator or a specialist in the subject matter of a proposed standard.

Experience must be demonstrated through relevant professional activity over a majority of the last five years.

Prepared 7/10/06 for Adoption by CON Commission on 9/19/06
Revised and Approved by the CON Commission on 3/12/02
Prepared 9/13/01 for Adoption by CON Commission on 9/21/01
Original Draft - 3/11/97

CERTIFICATE OF NEED

Quarterly Program Section Activity Report to the CON Commission

April 1, 2006 through June 30, 2006 (FY 2006)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the Program Section in accordance with Section 22215(1)(e) of the Public Health Code.

Measures

Administrative Rule 325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

Activity	Most Recent Quarter	Year-to-Date
Letters of Intent Received	106	422
Letters of Intent Processed within 15 days	104	409

Administrative Rule 325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application.

Activity	Most Recent Quarter	Year-to-Date
Applications Received	98	291
Applications Processed within 15 Days	98	291
Applications Incomplete/More Information Needed	95	282

Administrative rules 325.9206 and 325.9207 requires 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	Most Recent Quarter		Year-to-Date	
	Issued on Time	Not Issued on Time	Issued on Time	Not Issued on Time
Nonsubstantive Applications	41	0	120	0
Substantive Applications	58	1	143	2
Comparative Review Applications	0	0	4	0

Administrative Rule 325.9227 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	Most Recent Quarter	Year-to-Date
Emergency Applications Received	0	3
Decisions Issued within 10 workings Days	0	3

Quarterly Program Section Activity Report
April 1, 2006 through June 30, 2006 (FY 2006) Page 2 of2

Measures – continued

Administrative Rule 325.9413 requires the Department to process amendment requests within the same review period as the original application.

Activity	Most Recent Quarter		Year-to-Date	
	Issued on Time	Not Issued on Time	Issued on Time	Not Issued on Time
Amendments	20	1	66	11

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 other than good cause as determined by the Commission.

Activity	Most Recent Quarter	Year-to-Date
Refunds Issued Pursuant to Section 22231	0	0

Other

Activity	Most Recent Quarter	Year-to-Date
FOIA Requests Received	71	274
FOIA Requests Processed on Time	71	274
Number of Applications Viewed Onsite	68	202

FOIA – Freedom of Information Act. Processing on time includes extension requests.

Proposed Annual Standard Advisory Committee (SAC) and Workgroup Cycle

January	Public Hearing for scheduled standards' reviews.
Week 1	
Week 2	Hold public hearing.
Week 3	
Week 4	Full hearing transcripts available to the Commission and on website.
February	
Week 1	Staff analysis of hearing transcript and recommendations completed for DCH management level review/approval. Recommendations should identify whether there is a need to modify standards, develop new language, and a DCH recommended course of action. This may include SAC appointment, direct Commission discussion and action, or DCH given a task to lead a workgroup, gather expert information, or enter into a contract for expert consultation.
Week 2	
Week 3	Commission provided with copy of staff analysis and recommendations.
Week 4	
March	Commission Meeting & Actions (Meetings typically held 2nd week of month).
Week 1	
Week 2	At this first meeting, the Commission decides whether an issue should be addressed at this time, by the Commission. The Commission then determines the appropriate course of action to be taken on any of the identified issues. Their decision may be to form a SAC, to ask that the Department lead a workgroup to bring information back to the Commission, to ask the Department to contract with an expert entity to bring information back to the Commission, or other. If a SAC has been recommended by the Department, staff will also provide a draft of a defined charge.
Week 3	
Week 4	
April	
Week 1	
Week 2	Commission chair makes 1st round SAC appointments.
Week 3	2nd round of SACs (from the previous year cycle) meets for the last time.
Week 4	
May	
Week 1	1st round of SAC(s) meet for the first time.
Week 2	2nd round of SAC(s) provide written report and draft language to Commission
Week 3	All DCH workgroup activity and expert consultation asked for during the March Commission meeting must be completed by this time. In the event that workgroup activity leads to an identified need for additional discussion/deliberations, DCH will provide relevant information to the Commission including a suggestion for a SAC, recommended SAC charge, workgroup suggestions and recommended standards language, or make the recommendation that no further action/discussion be taken on any particular issue.
Week 4	
June	Commission Meeting & Action.
Week 1	

Week 2	Written report from 2nd round SAC is presented to the Commission. At this second meeting, the Commission takes appropriate action after having reviewed the workgroup report(s) from the Department and listening to public comments. If a SAC has been recommended as a result of workgroup deliberations, and the Commission has determined this as the appropriate action, the Commission chair will begin the process to appoint the SAC members and will give the SAC a clearly defined charge.
Week 3	
Week 4	
July	
Week 1	
Week 2	2nd round SAC (of current year cycle) appointed.
Week 3	
Week 4	2nd round SAC(s) meet for the first time.
August	
Week 1	
Week 2	
Week 3	
Week 4	
September	Commission Meeting & Action.
Week 1	
Week 2	Commission action regarding workgroup/task activities.
Week 3	
Week 4	
October	
Week 1	
Week 2	
Week 3	
Week 4	
November	
Week 1	1st round of SAC(s) meet for the last time (This schedule assumes that a SAC is given 6 months to produce its report. Note that six months is the maximum allowable time, and that the Commission may request a report from the SAC in less than 6 months.)
Week 2	
Week 3	1st round SAC(s) prepare their written report and language to Commission.
Week 4	
December	Commission Meeting & Action.
Week 1	
Week 2	1st round SAC recommendations/language presented to Commission.
Week 3	
Week 4	

Proposed MDCH Workgroup Guidelines

The use of informal, Commissioner-led workgroups to assist the Commission in discharging the CON review standards responsibilities as outlined in Section 22215 has not been particularly successful. While there has been some success, overall the process has proven to be unwieldy, unfocused to a large extent, and often seen as simply a step (or delaying tactic) toward ultimate creation of a SAC.

The statute provides the Commission with several decision-making assistance mechanisms to assist them and which fall into two broad categories: 1. utilize the thoroughly defined SAC tool; 2. approach the Department for assistance (Section 333.22215(1)(n) states, in part, "submit a request to the department to engage the services of private consultants or request the department to contract with any private organization for professional and technical assistance and advice or other services to assist the commission in carrying out its duties and functions under this part.") The latter option gave rise to the use of Commissioner-led workgroups.

The statute provides the Department with personnel resources to assist the Commission. The Department can be expected to respond to Commission questions and inquiries with analysis and recommendations in a timely and thorough fashion. To this end, the following structure is proposed.

The Department will respond to Commission requests sought during one meeting no later than at the next meeting of the Commission. The Department will gather information from experts, consult with external individuals or agencies on a case-by-case basis in order to respond to Commission requests. When a workgroup would be helpful or is particularly requested, the Department will convene the group in the following fashion:

The workgroup will be convened and led by MDCH. Commission members may participate in any of the workgroup meetings.

MDCH staff is responsible for generating ongoing analyses, and providing a final report to the Commission.

The workgroup will operate under the narrow/specific charge or assignment from the Commission.

A workgroup will have a lifespan of no more than 3 months. It meets only between the Commission meeting at which it is formed until the next Commission meeting at which time a final report and analysis will be offered. If so directed, the Department will include recommendations and draft language. If, at the end of the 3-month period, the issue that is under discussion is determined to be more complex than originally thought, the Department will provide an analysis of the issue, description of workgroup activities, and a recommended course of action to be considered by the Commission.

Workgroup participation will be inclusive, and the Department will provide notices of the meeting dates at MDCH/CON website.

Workgroups are a resource tool for the Commission and are intended to provide factual information/advice/recommendations that will be summarized by the Department and presented to the Commission members. If specific recommendations can be developed during the workgroup discussions, these should reflect the group's consensus whenever possible. However, when it is clear that no consensus can be reached on a key issue, and further action is necessary, the report to the Commission will thoroughly present all views and stated opinions. The report by the Department will include a Departmental recommendation for next step(s).

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.

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2006												2007											
	J	F	M*	A	M	J*	J	A	S*	O*	N	D*	J	F	M*	A	M	J*	J	A	S*	O*	N	D*
Air Ambulance Services													*PH*		D									
Bone Marrow Transplantation Services**	PH		D	•	•	•D	•	•	R D															
Cardiac Catheterization Services						D	S		▮	▮	▮	▮	▮	▮	▮	▮	▮	—		P	▲ F			
Computed Tomography (CT) Scanner Services													PH		D									
Computed Tomography (CT) Scanner Services – I-Cat**	•	•	D	•	•	•D —	P		▲F															
Hospital Beds**		▮	▮	▮	▮	▮	▮	▮	—		P	▲ F												
Hospital Beds – LTACs**		•	D•	•	•	D			R D															
Magnetic Resonance Imaging (MRI) Services**	PH		D	•	•	•D	•	•	—	P•	•	▲F —	P	•	▲F									
Neonatal Intensive Care Services/Beds (NICU)													PH		D									
Nursing Home and Hospital Long-term Care Unit Beds**			•D	•	•	•D			R D				PH		D									
Open Heart Surgery Services						D	S		▮	▮	▮	▮	▮	▮	▮	▮	▮	—		P	▲ F			
Positron Emission Tomography (PET) Scanner Services**		▮	▮	▮	▮	▮	▮	▮	—		P	▲ F												
Psychiatric Beds and Services**	PH		D	•	•	•D	•	•	•D	•	•	—		P	▲ F									
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units													PH		D									
New Medical Technology Standing Committee			MR			M	S		• M		•	M R	• M	• M	M R	M	M	M R	M	M	M R	M	M	M R
Commission & Department Responsibilities			DR			M			M			M R			M			M			M			M

KEY

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

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

FOR APPROVAL SEPTEMBER 19, 2006

UPDATED SEPTEMBER 14, 2006

ON 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 UNITY HEALTH, HEALTH POLICY, REGULATION & PROFESSIONS ADMINISTRATION, CON POLICY SECTION, 7TH FLOOR CAPITOL VIEW BLDG., 201 TOWNSEND ST., LANSING, MI 48913, 517-335-6708, WWW.MICHIGAN.GOV/CON.

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

Standards	Effective Date	Next Scheduled Update**
Air Ambulance Services	June 4, 2004	2007
Bone Marrow Transplantation Services	September 21, 2005	2006
Cardiac Catheterization Services	June 4, 2004	2005
Computed Tomography (CT) Scanner Services	June 4, 2004	2007
Heart/Lung and Liver Transplantation Services	June 4, 2004	2009
Hospital Beds and Addendum for HIV Infected Individuals	May 27, 2005	2005
Magnetic Resonance Imaging (MRI) Services	October 17, 2005	2006
Megavoltage Radiation Therapy Services/Units	January 30, 2006	2008
Neonatal Intensive Care Services/Beds (NICU)	June 4, 2004	2007
Nursing Home and Hospital Long-Term Care Unit Beds, Addendum for Special Population Groups, and Addendum for New Design Model Pilot Program	December 3, 2004	2007
Open Heart Surgery Services	June 4, 2004	2005
Pancreas Transplantation Services	June 4, 2004	2009
Positron Emission Tomography (PET) Scanner Services	June 4, 2004	2005
Psychiatric Beds and Services	October 17, 2005	2006
Surgical Services	June 5, 2006	2008
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	June 4, 2004	2007

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

**A Public Hearing will be held in January of each 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.