THE MICHIGAN CERTIFICATE OF NEED PROGRAM

February 2005

Report 338

This Report was made possible by grants from the W.K. Kellogg Foundation

A publication of the Citizens Research Council of Michigan

Chairman
W. Frank Fountain

Vice Chairman
Kent J. Vana

President
Earl M. Ryan

Treasurer
Jeffrey D. Bergeron

Board of Directors

Jeffrey D. Bergeron
Ernst & Young LLP
Jeffrey D. Bergeron
Ernst & Young LLP
J. Edward Berry
General Motors Corporation
William M. Brodhead
Attorney At Law
John T. Bozzella
Ford Motor Company
Beth Chappell
Detroit Economic Club
Gary L. Collins
Collins Selections
James G. Davidson
Pfizer Inc.
Terence M. Donnelly
Dickinson Wright PLLC
Randall W. Eberts
W. E. Upjohn Institute
David O. Egner
Hudson-Webber Foundation
Joshua D. Eichenhorn
Standard Federal Bank
W. Frank Fountain
DaimlerChrysler Corporation
Eugene A. Gargaro, Jr.
Masco Corporation
Ingrid A. Gregg
Earhart Foundation
Frank M. Hennessey
Hennessey Capital LLC
Marybeth S. Howe
National City Bank of Michigan/Illinois
Nick A. Khouri
DTE Energy
Daniel T. Lis
Kelly Services, Inc.
Michael Michalak
Comerica Incorporated
Irving Rose
Edward Rose & Sons
Amanda Van Dusen
Miller, Canfield, Paddock and Stone PLC
Kent J. Vana
Varnum, Riddering, Schmidt & Howlett LLP
Gail L. Warden
Henry Ford Health System
Jeffrey K. Willemain
Deloitte.

Advisory Directors

Louis Betanzos
Will Scott

Board of Trustees

Chairman
Daniel J. Kelly

Vice Chairman
Patrick J. Ledwidge

Terence E. Adderley
Kelly Services, Inc.
Judith Bailey
Western Michigan University
Jeffrey D. Bergeron
Ernst & Young LLP
Rebecca M. Blank
University of Michigan
Lee Bollinger
Columbia University
Richard Breon
Spectrum Health – East Campus
Beth Chappell
Detroit Economic Club
Mary Sue Coleman
University of Michigan
Keith E. Crain
Crain Communications Inc.
George H. Cress
United Bank & Trust - Washtenaw
Terry Daoud
Al Long Ford
Stephen R. D'Arcy
PricewaterhouseCoopers LLP
James N. De Boer, Jr.
Varnum, Riddering, Schmidt & Howlett LLP
Walter E. Douglas, Sr.
Avis Ford, Inc.
David O. Egner
Hudson-Webber Foundation
David L. Eisler
Ferris State University
Gerald D. Fitzerald
Oakwood Healthcare Inc.
W. Frank Fountain
DaimlerChrysler Corporation
Mark Gaffney
Michigan State AFL-CIO
Ralph J. Gerson
Guardian Industries Corporation
Eric R. Gilbertson
Saginaw Valley State University
Roderick D. Gillum
General Motors Corporation
Alfred R. Glancy III
Unico Investment Company
David Handleman
Handleman Company
William R. Hartman
Citizens Banking Corporation
Frank M. Hennessey
Hennessey Capital LLC
Todd W. Herrick
Tecumseh Products Company
Joseph L. Hudson, Jr.
Hudson-Webber Foundation
Dorothy A. Johnson
Ahlburg Company
F. Martin Johnson
JSJ Corporation
Elliot Joseph
St. John Health System
Daniel J. Kelly
Deloitte.
David B. Kennedy
Earhart Foundation
Samuel Kirkpatrick
Patrick J. Ledwidge
Dickinson Wright PLLC
Edward C. Levy, Jr.
Edw. C. Levy Co.
Harry A. Lomason II
Magna International
Alphonse S. Lucarelli
William L. Matthews
Plante & Moran PLLC
Kenneth Matzick
William Beaumont Hospital
Paul W. McCracken
University of Michigan
M. Peter McPherson
Michigan State University
Glenn D. Mroz
Michigan Technological University
Mark A. Murray
Grand Valley State University
Donald R. Parfet
Apjohn Group LLC
Michael Rao
Central Michigan University
Dean E. Richardson
Irving Rose
Edward Rose & Sons
Gary D. Russi
Oakland University
Roger Samuel
The Flint Journal
Nancy M. Schlichting
Henry Ford Health System
Lloyd A. Semple
Dykema Gossett PLLC
Mark Silverman
The Detroit News
Lou Anna K. Simon
Michigan State University
S. Martin Taylor
DTE Energy
Curtis J. Tompkins
Amanda Van Dusen
Miller, Canfield, Paddock and Stone PLC
Kent J. Vana
Varnum, Riddering, Schmidt & Howlett LLP
Brian C. Walker
Herman Miller, Inc.
Gail L. Warden
Henry Ford Health System
Richard E. Whitmer
Blue Cross & Blue Shield of Michigan
Jeffrey K. Willemain
Deloitte.
Larry D. Yost
Betty J. Youngblood
Lake Superior State University

Citizens Research Council of Michigan is a tax deductible 501(c)(3) organization

The Michigan Certificate of Need Program

February 2005

Report 338

This Report was made possible by grants from the W.K. Kellogg Foundation

Citizens Research Council of Michigan

www.crcmich.org
38777 West Six Mile Road • Livonia, Michigan • 48152-2660 • (734) 542-8001 • Fax (734) 542-8004 • crcmich@crcmich.org
124 West Allegan • Suite 1502 • Lansing, Michigan • 48933-1738 • (517) 485-9444 • Fax (517) 485-0423 • tclay@crcmich.org

The Michigan Certificate of Need Program

Contents

I. Introduction 1
II. Certificate of Need Beginnings 1
III. CON National Overview 2
IV. Michigan Certificate of Need Background 5
- A. Legal History 5
  - 1. Public Act 256 of 1972 5
  - 2. Public Act 368 of 1978 (The Public Health Code) 7
    - a. Long-term Care 7
    - b. Clinical Services 7
  - 3. Public Acts 331 and 332 of 1988 7
  - 4. Public Act 88 of 1993 8
  - 5. Public Act 619 of 2002 9
    - a. Composition and Responsibilities of the CON Commission 9
    - b. Changes to CON Standards 9
    - c. Role of the Governor and Legislature in the CON Process 10
    - d. Establish a Process for the Relocation of Beds to Allow a Limited Number of New Hospitals without a Certificate of Need 10
    - e. Administration 11
  - 6. Current Law and Administrative Rules 11
- B. Recent Reports 12
  - 1. Auditor General Report of April 2002 12
  - 2. CON Evaluation Report 2003 12
  - 3. Federal Trade Commission/Department of Justice Report 2004 12

V. CON Coverage 13
- A. Current Coverage 13
  - 1. Capital Expenditures for Health Facilities 13
  - 2. Bed Need 13
  - 3. Clinical Services 13
- B. Changes in CON Coverage 13
  - 1. Beds and Capital Construction 13
  - 2. Clinical Services 13

VI. CON Application Process 15
VII. CON Review Standards 17
- A. Legal Requirements 17
- B. Review Standards 18
  - 1. Capital Expenditures 18
  - 2. Bed Need 18
    - a. Acute Care Hospital Beds 18
    - b. Psychiatric Hospital Beds 21
    - c. Long-Term Care Beds 21

a. Air Ambulance 26
b. Cardiac Catheterization 27
c. Computed Tomography (CT) Scanning 27
d. Magnetic Resonance Imaging (MRI) Services 28
e. Megavoltage Radiation Therapy (MRT) 28
f. Open Heart Surgery Services 29
g. Positron Emission Tomography (PET) Scanner Services 29
h. Surgical Services 30
i. Bone Marrow Transplant 30
j. Heart/Lung and Liver Transplantation Services 31
k. Pancreas Transplantation Services 31
l. Urinary Extracorporeal Shock Wave Lithotripsy Services (UESWL) 31

VIII. Health Care Bed and Services Data 1996 – 2000 32
A. Health Care Equipment Counts 32

IX. CON Issues 34
A. Cost, Quality and Access 34
1. Cost 34
2. Quality 34
3. Access 35
B. CON and Acute Care Hospitals 36
1. Relocation of Detroit Hospital Beds 36
a. Proposed Hospital Relocation Standard 36
2. High Occupancy Hospitals 37
C. CON and Other Medical Services 38
D. Reimbursement Policy and CON 38
E. Compliance 38
F. Adding or Deleting Services from the Michigan CON Program 39
G. Legislative Action in Setting CON Requirements or Standards 39
H. Court Intervention in CON 39

X. Public Policy Questions 40
A. What is the role of the State of Michigan in health care? 40
B. Is it time to reconsider the methodology for acute care bed need? 41
C. Does CON contribute to the financial viability of hospitals by limiting competition? 42
D. Should Michigan consider a more direct means to address access and financial issues raised by the disproportionate amount of uninsured and uncompensated care provided among hospitals? 42

XI. Summary 42

Appendix A 43
Appendix B 46
Appendix C 48
Appendix D 50
Appendix E 52
Appendix F 58
Appendix G 59
Appendix H 61

The Michigan Certificate of Need Program

Tables

1. National Health Expenditures: Aggregate Amounts Selected Calendar Years 6
2. Michigan Hospital Licensed and Setup Bed Inventory vs. Need for Certificate of Need Program by Health Service Area 19
3. Michigan Adult Psychiatric Hospital Bed Inventory vs. Need at December 31, 2003 for Certificate of Need Program 22
4. Michigan Child/Adolescent Psychiatric Hospital Bed Inventory vs. Need at August 12, 2003 for Certificate of Need Program 23
5. Michigan Long-Term Bed Inventory vs. Need at December 31, 2003 for Certificate of Need Program 24
6. Statewide Rates for Selected Medical Services Covered by CON 33
7. CON Approvals and Disapprovals, 1998-2003 35
8. Health Spending vs. School Aid, State of Michigan, Fiscal Years 2001 and 2005 40

Charts

1. The CON Matrix of 2004 Relative Scope and Review Thresholds: CON Regulated Services by State 3
2. Duration of CON Regulation by State 4
3. Certificate of Need (CON) Application Review Process: Overview 15
4. Process for Developing Certificate of Need (CON) Review Standards Pursuant to Section 22215 17

Maps

1. Michigan Health Service Areas (HSAs) 20

This page intentionally left blank

The Michigan Certificate of Need Program

In Brief

- Michigan is one of 36 states with a Certificate of Need (CON) program.
- A CON is required when a provider begins, upgrades, expands, relocates or acquires a covered health service or entity
- No analysis is available that clearly identifies the overall effect of the CON program in Michigan
- Michigan CON has features that distinguishes it from many other states
- Michigan CON is the subject of ongoing debate and adjustments
- The Michigan CON program administered by the Department of Community Health has not been sufficiently staffed to carry out its responsibilities
- Recent fee increases will permit staff growth from 10 to 14
- CON is not designed to address all of the health concerns of Michigan residents

Introduction

The Michigan Certificate of Need program has been the subject of heightened debate and review in recent years. Three subjects have been prominent: the overall value of the program; the setting of standards used to evaluate applications and for monitoring ongoing operations of certificate recipients; and, the inability of certain hospitals within the City of Detroit to open new hospitals in suburban locations.

Certificate of Need Beginnings

In 1964, local businesses and Blue Cross in Rochester, New York established a community health planning council composed of payers, consumers and providers to evaluate the need for hospital beds. The council concluded that there was a surplus. This work led to the passing of the nation's first Certificate of Need (CON) legislation by the State of New York in 1966.

While attention is given to the construction and related costs of capital expansion and improvements, the focus in New York, Michigan and many other states is on the increase in health care costs that can arise from the availability of unneeded service capacity and total operating expenses that are more costly than necessary. CON is directed at constraining excess capacity by requiring health care service providers to demonstrate the need for the initiation, upgrading, expansion, relocation and acquisition of services and beds subject to CON review. It also addresses the potential impact of excess capacity or inefficient design on the higher total operating costs that are the concern for those who make payments for care – particularly employers, health insurers and the state and federal governments.

In 1974, the federal government passed the Federal Health Planning and Resources Development Act. It was enacted in response to both a general concern with increasing inflation and the view that Medicare and Medicaid had resulted in duplicative, unneeded and costly health system capacity expansion. It provided federal funds for state health planning and development agencies as well as local health planning agencies.

By 1975, 31 states had enacted CON statutes. In 1976 the federal government passed an amendment to the Social Security Act (SSA) that had the effect of mandating states to pass CON acts by denying federal Medicaid and Medicare funds for the costs of health facility capital construction if they were not formally approved by a state or the federal government. By 1983, all but Louisiana had a CON law (Louisiana passed CON legislation in 1991). Federal action in 1983 eliminated this requirement and currently 14 states have repealed their CON programs. In 1986, Congress repealed the Federal Health Planning Act and federal funds for state and local health planning agencies were terminated effective January 1, 1987.

What is Certificate of Need?

A Certificate of Need (CON) program is established by state law. It prohibits identified health facilities/services/equipment from being initiated, upgraded or modernized, expanded, relocated or acquired without a certificate from that state determining the facility/service/equipment is needed. Criteria for the approval or denial of a CON application are established by law or regulation as review standards and include cost, quality and access considerations. Covered facilities/services/equipment varies from state to state as do review standards. The latest data available, February 2004, indicates that 36 states and the District of Columbia have CON and 14 states do not.

Ten CON states (Alaska, Louisiana, Massachusetts, Missouri, Montana, Nebraska, Ohio, Oklahoma, Oregon and Wisconsin) do not include acute care hospitals in their program, but all 36 do include long-term care. The number of services covered by any one state program varies from 1 to 26 and there are wide variances in how the programs are administered.

A CON program is not designed to address the entire range of factors that impact the cost, quality and access of health care. For example, the availability of health professionals impacts cost, quality and access but is not addressed by CON. State regulation of Blue Cross Blue Shield of Michigan and other health insurance organizations, the state administered Medicaid and Community Mental Health programs and the licensing and regulation of health services providers are other examples of state activities that affect cost, quality and access outside the scope of CON.

CON National Overview

The history of CON legislation across the nation is shown in **Chart 1**. **Chart 2** is an overview of the scope of current state programs. As stated in the chart footnote, rank order relates to volume of items and not the intensity of analysis or nature of conclusions that are based on individual state criteria and standards. **Appendix A** shows the relative scope and review thresholds of states and contains CON fee information. All come from the American Health Planning Association's National Directory for 2004.[1]

Michigan is classified by the American Health Planning Association in the mid-range of states for scope of CON coverage and monetary review thresholds. There is a difference between the number of covered services in Michigan shown in **Chart 2** (18) and the number reflected in this report (16). This is because the AHPA separates gamma knives from MRT and distinguishes swing beds apart from acute care hospital beds.

Some states evaluate projects according to rather general criteria, as was the case in Michigan before the 1988 CON statute revisions. Others make distinctions as to what entity provides the service – usually including hospitals but excluding other providers. This makes cross state comparisons difficult. For example, while 20 states include MRI in their scope of CON regulated-services, some limit MRI coverage to those at inpatient hospitals, while exempting non-hospital based MRI equipment. One of the features of the 1988 Michigan CON reform statute requires that services be reviewed regardless of the type of provider applicant.

[1] www.ahpanet.org/

Chart 1

Duration of CON Regulation by State

States	CON Range
New York	1966–present
Dist. of Columbia	1968–present
Rhode Island	1968–present
Maryland	1968–present
California	1969–1987
New Jersey	1971–present
South Carolina	1971–present
Washington	1971–present
Oklahoma	1971–present
Nevada	1971–present
Minnesota	1971–1985
North Dakota	1971–1995
Oregon	1971–present
Arizona	1971–1985
Massachusetts	1972–present
Kentucky	1972–present
Michigan	1972–present
South Dakota	1972–1988
Kansas	1972–1985
Connecticut	1973–present
Florida	1973–present
Tennessee	1973–present
Virginia	1973–present
Colorado	1973–1987
Illinois	1974–present
Hawaii	1974–present
Ohio	1975–present
Arkansas	1975–present
Montana	1975–present
Texas	1975–1985
Alaska	1976–present
West Virginia	1977–present
Iowa	1977–present
Alabama	1977–present
Wisconsin	'77–'87, '93–pres
Wyoming	1977–1989
Maine	1978–present
North Carolina	1978–present
Delaware	1978–present
New Mexico	1978–1983
Missouri	1979–present
Vermont	1979–present
Georgia	1979–present
Mississippi	1979–present
New Hampshire	1979–present
Nebraska	1979–present
Utah	1979–1984
Pennsylvania	1979–1996
Idaho	1980–1983
Indiana	'80–'96, '97–'99
Louisiana	1991–present

Voluntary-continued | Voluntary-terminated | Mandatory-continued | Mandatory-terminated

Updated: February 14, 2004

(from 1966 to 1975, 30 states voluntarily started CON before it was a nationally mandated by P.L. 93-641; of those, 8 terminated CON after the end of these mandates; six of the remaining 20 mandatory CON programs also terminated after mandates ended)

Source: American Health Planning Association's National Directory for 2004

Chart 2

The CON Matrix of
2004 Relative Scope and Review Thresholds: CON Regulated Services by State

(this information is summarized from the 2004 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association, also see map)

Categories: Acute Care, Air Ambulance, Amb Surg Ctrs, Burn Care, Business Cmplts, Cardiac Cath., CT Scanners, Gamma Knives, Home Hlth, ICF/MR, Lithotripsy, Long Term Care, Med Off Bldg, Mobile Hi Tech, MRI Scans, Neo-nt Int Care, Obstetric Svcs, Open Heart Svcs, Orgn Transplnt, PET Scans, Psychiatric Svcs, Rad Therapy, Rehab, Renal Dialysis, Res Care Fac, Subacute, Substance Abuse, Swing Beds, Ultra-sound

compiled by Thomas R. Piper
Missouri CON program
Jefferson City, MO
573-751-6403

8 nrsg hm/hosp

Rank (no. of svcs. x weight)	Categories	Other (items not otherwise covered)	Count (no. of svcs.)	Reviewability Thresholds: Capital	Med Eqpt	New Svc	Weight
28.8	Connecticut		24	1,000,000	400,000	0	1.2
26.0	Alaska	Assisted living	26	1,000,000	1,000,000	1,000,000	1.0
22.5	Vermont		25	3.0/1.5M	1,000,000	500,000	0.9
21.6	Maine		24	2,400,000	1,200,000	110,000	0.9
20.9	Georgia		19	1,250,199	694,556	any	1.1
20.7	West Virginia	Behavioral hlth	23	2,000,000	2,000,000	23 svcs	0.9
20.0	South Carolina		20	2,000,000	600,000	1,000,000	1.0
18.4	North Carolina	IC & others	23	2,000,000	750,000	n/a	0.8
17.0	Mississippi		17	2,000,000	1,500,000	any	1.0
16.8	Tennessee	hospice, meth	21	2,000,000	1,500,000	any beds	0.8
16.1	Dist. of Columbia		23	2,500,000	1,500,000	600,000	0.7
15.2	Rhode Island		19	2,000,000	1,000,000	750,000	0.8
15.0	New York		25	3,000,000	3,000,000	any	0.6
15.0	Hawaii		25	4,000,000	1,000,000	any	0.6
14.4	Maryland	fed. swing bed	16	1,500,000	n/a	any	0.9
14.4	Michigan	Hosp & Surg	18	2,500,000	any	any clin.	0.8
14.4	Kentucky	Mobile svcs	18	1,870,973	1,870,973	n/a	0.8
12.8	Washington	Hospice	16	var. by svc.	n/a	any	0.8
12.6	New Hampshire		14	1,924,579	400,000	any	0.9
12.1	New Jersey		11	1,000,000	1,000,000	any	1.1
11.9	Illinois	Other	17	6,543,050	6,293,090	any	0.7
10.8	Alabama	ESRD & ALC	18	4,108,000	2,054,000	any	0.6
10.4	Missouri	New hosp.	13	0.6M/1.0M	0.4M/1.0M	1,000,000	0.8
8.1	Iowa		9	1,500,000	1,500,000	500,000	0.9
8.0	Virginia	MRI, SPECT	20	5,000,000	n/a	n/a	0.4
7.7	Florida	Hospice	11	none	none	any	0.7
7.0	Oklahoma	psych., chem.	5	500,000	n/a	any beds	1.4
6.3	Montana		7	1,500,000	n/a	150,000	0.9
6.0	Arkansas		5	500,000	n/a	n/a	1.2
4.8	Massachusetts	ECMO	16	10,392,634	651,209	all	0.3
4.8	Delaware	Birthing ctrs.	8	5,000,000	5,000,000	n/a	0.6
4.4	Wisconsin	Others	4	1,000,000	600,000	any LTC	1.1
3.5	Nevada		7	2,000,000	n/a	n/a	0.5
2.4	Oregon		2	anyLTC/hs	n/a	LTC/hsp	1.2
0.5	Ohio		1	2M renov	n/a	n/a	0.5
0.4	Nebraska		2	n/a	n/a	LTC >10%	0.2
0.4	Louisiana		2	n/a	n/a	LTC/MR	0.2

Disclaimer: Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

Source: Updated February 14, 2004, using most recent information available

Source: American Health Planning Association's National Directory for 2004

Michigan Certificate of Need Background

The overall approach in Michigan has not been to regulate the practice of medicine but to regulate the utilization of facilities and equipment and the location of services using a consistent measuring tool for each. Applicants are required to demonstrate that the service is needed, that it is not duplicative and that explorations have been made of the ways that the need can be met at the least cost. Generally a dollar threshold is set for facility upgrades and renovations so that smaller projects do not require a CON.

While capital costs are an important consideration, the potential impact of excess capacity on higher total operating costs is the concern for those who make payments for care – particularly employers, health insurers and the state and federal governments.

A commission governs the standards for Michigan's CON and the Department of Community Health reviews each application according to these standards. This separates policymaking from decisions on specific projects and is designed to reduce subjective judgments. Other states often assign both the policymaking for standards and the review of applications to a department of state government.

CON was among several initiatives in the 1960s and 1970s designed to impact health care in Michigan. Along with constraining the increase in the number of hospital beds and the encouragement of health maintenance organizations, CON was viewed as an important public policy tool for what came to be called the "containment" of health care costs. Primary attention was given to hospital costs because they represented the largest portion of health care costs then as they do today. **Table 1** (on page 6) shows national health expenditure data for selected years. In 2003, hospital expenditures were $515.9 billion with physician and clinical care second at $369.7 billion.

In the beginning, Michigan CON covered only hospitals. At that time there were four primary sources for hospital payments: Blue Cross, Medicare, Medicaid and for-profit insurance companies. Blue Cross paid a negotiated rate to each hospital that was related to costs, Medicare and Medicaid paid costs adjusted for certain factors such as whether or not the hospital had a teaching program, and for-profit insurance companies generally paid listed prices set in excess of cost. Since Blue Cross and the governmental programs covered the greatest portion of hospital care, most hospital care payments in Michigan were related to costs. It was recognized that a CON program based solely on costs, however, could have a distorting effect on health care that could adversely affect both quality and access. For example, the least costly location in which to start a new service might not be one that improves access or might not have an adequate supply of the health professionals needed to staff it. All three areas were addressed in Act 256 of 1972, the first Michigan CON law and continue to be a part of the program today.

Objective and Premise of the Michigan CON Program

The Department of Community Health states that the objective of CON, as reflected in law, "is to promote and assure the availability and access of quality health services at a reasonable cost and within a reasonable geographic proximity for all the people of the state. And, to "promote and assure appropriate differential consideration for the health care needs of residents in rural counties in ways that do not compromise the quality and affordability of health care services for those residents." See page 2 at: www.michigan.gov/documents/2003_CON_Brochure_83318_7.pdf

An expression of the premise of the Michigan CON program is that traditional supply and demand theory does not work in health care because providers, typically doctors and other health care professionals through their diagnosis and treatment decisions have the predominant role in determining the demand for medical services. These providers are also paid for supplying these services. Further, consumers often do not have sufficient information to make decisions based on cost and quality.

Table 1
National Health Expenditures
Aggregate Amounts Selected Calendar Years
(Billions of Dollars, Totals may not add due to rounding)

Expenditure Type	1970	1980	1993	1997	1999	2001	2002	2003	Percent Change 1993-2003	Percent Change 2002-2003
HEALTH SERVICES & SUPPLIES	**$ 67.3**	**$ 233.5**	**$ 856.3**	**$1,055.8**	**$1,180.2**	**$1,373.8**	**$1,499.8**	**$1,614.2**	**88.5**	**7.6**
Personal Health Care	**63.2**	**214.6**	**775.8**	**959.2**	**1,065.6**	**1,235.5**	**1,342.9**	**1,440.8**	**85.7**	**7.3**
Hospital care	**27.6**	**101.5**	**320.0**	**367.6**	**393.4**	**446.4**	**484.2**	**515.9**	**61.2**	**6.5**
Professional services	**20.7**	**67.3**	**280.7**	**352.2**	**397.7**	**464.4**	**503.0**	**542.0**	**93.1**	**7.8**
Physician & clinical	14.0	47.1	201.2	241.0	270.9	315.1	340.8	369.7	83.7	8.5
Other professional services	0.7	3.6	24.5	33.4	36.7	42.6	46.1	48.5	98.0	5.2
Dental	4.7	13.3	38.9	50.2	56.4	65.6	70.9	74.3	91.0	4.8
Other personal health care	1.3	3.3	16.1	27.7	33.7	41.1	45.3	49.5	207.5	9.3
Nursing home & home health	**4.4**	**20.1**	**87.6**	**119.6**	**122.9**	**134.9**	**143.1**	**150.8**	**72.1**	**5.4**
Home health	0.2	2.4	21.9	34.5	32.3	33.7	36.5	40.0	82.6	9.6
Nursing home	4.2	17.7	65.7	85.1	90.7	101.2	106.6	110.8	68.6	3.9
Retail sales of medical products	**10.5**	**25.7**	**87.5**	**119.8**	**151.6**	**189.7**	**212.6**	**232.1**	165.3	9.2
Prescription drugs	5.5	12.0	51.3	75.7	104.4	140.8	161.8	179.2	249.3	10.8
Durable medical equipment	1.6	3.9	12.8	16.2	17.2	18.4	19.6	20.4	59.4	4.1
Other nondurable products	3.3	9.8	23.4	27.9	30.0	30.5	31.1	32.5	38.9	4.5
Program administration & net cost of private insurance	**2.8**	**12.1**	**53.3**	**61.3**	**73.3**	**90.9**	**105.7**	**119.7**	124.6	13.2
Government public health activities	**1.4**	**6.7**	**27.2**	**35.5**	**41.2**	**47.4**	**51.2**	**53.8**	97.8	5.1
INVESTMENT	**5.7**	**12.3**	**31.8**	**37.2**	**42.0**	**52.6**	**59.2**	**64.6**	103.1	9.1
Research (Pharmaceuticals and other manufacturers/suppliers included above in service/supply categories)	2.0	5.5	15.6	18.7	23.7	32.8	36.5	40.2	157.7	10.1
Construction	3.8	6.8	16.2	18.5	18.3	19.7	22.7	24.5	51.2	7.9
TOTAL	**$ 73.1**	**$ 245.8**	**$ 888.1**	**$1,093.1**	**$1,222.2**	**$1,426.4**	**$1,559.0**	**$1,678.9**	89.0	7.7
Population (millions)	210.2	230.4	264.8	277.6	284.1	290.3	293.2	296.1	11.8	1.0
NHE per capita	$348	$1,067	$3,354	$3,938	$4,302	$4,914	$5,317	$5,670	69.1	6.6
Gross Domestic Product (billions)	$1,039	$2,790	$6,657	$8,304	$9,268	$10,128	$10,487	$11,004	65.3	4.9
Real NHE as percent of Real GDP	7.0%	8.8%	13.3%	13.2%	13.2%	14.1%	14.9%	15.3%	15.0	2.7
Implicit Price Deflator for GDP	27.5	54.0	88.4	95.4	97.9	102.4	104.1	106.0	19.9	1.8
Real GDP (billions)	$3,772	$5,162	$7,533	$8,704	$9,470	$9,891	$10,075	$10,381	37.8	3.0
Real NHE (billions)	$265.3	$454.7	$1,004.8	$1,145.6	$1,248.8	$1,393.0	$1,497.7	$1,583.9	57.6	5.8
Personal health deflator	16.0	34.4	81.6	92.2	96.7	103.9	107.9	111.8	37.0	3.6

Source: Health Affairs (January/February, 2005), Volume 24, Number 1, page 186. Component totals may not add due to rounding.

Legal History

Public Act 256 of 1972

Act 256 was directed at limiting hospital capital costs and the ongoing operating expenses for the addition or modernization of patient rooms and/or ancillary service areas or accommodations. Specifically the law provided that a hospital facility shall not be constructed, converted, added to or modernized without first obtaining a CON that documents a demonstrated need for the proposed project. Responsibility for CON was placed in the Department of Public Health and a commission was established to oversee but not govern or administer the program.

In addition to cost considerations, Act 256 addressed access to, and the quality of, hospital services. A series of tests were statutorily required. CON review was to include:

1. The patterns and level of utilization, availability and adequacy of existing facilities, institutions, programs and services in the immediate community and region.
2. The degree to which residents and physicians in a community are provided access to the hospital applying for the CON.
3. The availability and adequacy of services such as preadmission, ambulatory or home care services that may serve as alternatives to hospital care.
4. The economies and service improvements that could be achieved from consolidation of highly specialized services or from shared central services such as laboratory, radiology and the like.
5. The economies and service improvements that could be achieved from affiliation or contractual arrangements between hospitals and others.
6. The availability of personnel to fulfill the services to be offered.
7. That the hospital does not discriminate in activities including employment, room assignment, and training.
8. That the governing body of a nonprofit hospital has a majority of consumers.
9. That the hospital has the financial capacity to both fund the construction and operate the facility following completion.
10. That the project complies with local and regional rules, regulations and standards.
11. Other factors which contribute to the orderly development of quality health care.

CON applicants were required to pay a fee of 0.5 percent of the project cost or $500, whichever was less. The initial appropriation for the administration of CON was $60,000 in Fiscal Year 1972-73. The fiscal year 2004-05 direct appropriation for the CON program is $1,007,600 of which some $900,200 is met by fee income.

Public Act 368 of 1978 (The Public Health Code)

The Public Health Code of 1978, Act 368, amended the 1972 CON statute significantly. It extended its coverage to non-hospital facilities, including nursing homes and to certain clinical services and the facilities used to provide them.

Long-term Care

At the time, it was widely reported that 25 to 50 percent of the people in nursing homes did not need the services nursing homes were licensed to provide. These residents were in nursing homes because they could not function independently rather than because they needed the range of medical services provided by a nursing home. Many areas of the state did not have alternative settings and there were not sufficient support services available to allow these persons to remain at home. In many communities today, alternative services are available.

Medicaid had become the predominant funding source for nursing home residents and there was pressure to contain state costs by limiting the number of long-term care beds. It was the view of many that additional beds would be filled with more Medicaid eligible persons who did not require nursing home services. It was thought that bringing long-term care under CON would mitigate this.

Clinical Services

The 1978 law amended CON to include additional clinical services, some of which were previously covered by CON under regulation. These included outpatient facilities providing: physical therapy, kidney disease treatment, licensed home health care, ambulatory care and tertiary care. As was true with long-term care, these services were putting stress on the Medicaid budget.

Public Acts 331 and 332 of 1988

Acts 331 and 332, made significant revisions to the Michigan CON program.

Act 331 included in statute seven covered clinical services and defined seven covered medical equipment categories

in state law. These had come under CON previously but had not been reflected in CON legislation itself. Consistent with previous practice, Act 331 permitted the CON Commission to designate others in the future.

Covered clinical services were:

- Cardiac services – open heart and cardiac catheterization
- Extrarenal organ transplantation
- Specialized psychiatric programs (subsequently deleted by Commission action)
- Special radiological procedure rooms
- Specialized radiation therapy services
- Partial-day hospital psychiatric programs
- Neonatal intensive care.

Covered equipment was identified as:

- Extracorporeal shock wave lithotripter
- Magnetic resonance imaging (MRI) units
- Fixed computerized tomography (CT) scanners
- Mobile CT scanners
- Surgical facilities
- Air ambulance
- Positron emission tomography (PET) scanners.

Distinction between services and equipment has since been consolidated into services.

Act 331 also defined the role and responsibilities of the regional health planning agencies that had previously been eligible for federal funding under the comprehensive health-planning act until it was repealed on January 1, 1987. The local regional health planning agencies reviewed CON proposals and made recommendations to the state as to whether they should be approved. If the Department of Public Health director issued a CON that had not been recommended by a regional agency, the director was obligated to provide the regional body with a detailed rationale. Act 331 continued authorizations for regional health planning agencies under state law, although it did not provide for their funding.

At present, there is one active regional agency, the Alliance for Health, which serves 12 counties in western Michigan and is headquartered in Grand Rapids.[2]

Act 332 was a major revision to the basic statute and responded to concerns with both review standards and processes that had resulted in a numerous court interventions. It established more specific statutory criteria and directed the CON Commission to implement some of those criteria according to verifiable, and sometimes quantifiable, standards. The objective of the reform was to have clear and consistent standards by which applicant proposals would be evaluated and thus lessen the possibility of differential consideration. Since changes were implemented in 1989, most potential project sponsors have been aware of whether their proposals were approvable prior to submitting their application. The increased clarity has reduced the time and cost of the application process and as well as the previously frequent administrative and legal appeals of CON denials.

It defined a new five-member CON Commission appointed by the governor with authority to approve review standards. The 1988 legislature considered, but chose not to designate, categories of required representation for Commission membership. But it did stipulate that three Commission members were to be members of a major political party and two members were to be members of another major political party. This body was significantly smaller than its predecessor, the Statewide Health Coordinating Council that had been established during the years of the Federal Comprehensive Health Planning Act. It consisted of some 50 individuals representing a range of provider and purchaser constituencies but with a consumer majority.

Act 332 stipulated that a CON would continue to be required to:

1. Acquire or begin operation of a health facility;
2. Make a change in the bed capacity of a health facility;
3. Initiate certain new services – covered clinical services identified in Act 331;
4. Acquire covered medical equipment identified in Act 331; and,
5. Make capital expenditures on health facilities in excess of a dollar threshold but increased the amount from $150,000 to $750,000 or $1,500,000 depending on the nature of the project. It increased these amounts in 1991 and thereafter.

It permitted the Department of Public Health to recommend new services and equipment for coverage if approved by the Commission and it allowed for the deletion of a covered service. Both the additions and deletions were subject to veto by the governor or legislature. In the 1990s, the Commission deleted partial day psychiatric programs.

[2] www.afh.org/

Act 332 allowed the Department to require the submission of data and statistics as a part of a CON application and it established in law the obligation to monitor CON projects after approval to determine conformance with the approved project. A series of actions ranging from admonitions to sanctions were identified that included authority to revoke or suspend a CON. They permitted a fine of not more than the amount of billings for the services provided in violation. In addition to the fine, the violator could be required to refund the monies received for the services to the person from whom payment was received.

Public Act 88 of 1993

Act 88 transferred the authority to appoint the required Ad Hoc Advisory Committees to assist in the development of proposed CON standards from the Department to the Commission. These committees were to include: experts with professional competence in the subject matter; representatives of health care provider organizations concerned with licensed facilities or professions; and, representatives of organizations concerned with health care consumers, purchasers and payers.

Public Act 619 of 2002

The most recent CON revisions took effect on March 19, 2003.

Act 619 of 2002 addressed the nature, role and responsibilities of the commission by altering its composition and changed processes to assure more frequent updating of standards. It exempted existing operating rooms in hospitals with less than 70 licensed beds from minimum volume requirements and authorized an additional MRI unit in St. Clair County by letter of intent rather than by obtaining a CON. It provided a focused location for legislative involvement with CON by creating a joint legislative committee and established administrative requirements for the Department of Community Health (DCH) including that DCH assign at least two full-time professional employees to staff the Commission. Finally, it addressed the issue raised by some Detroit hospitals desiring to gain improved financial results through expansion into communities where residents have more favorable health insurance coverage.

Composition and Responsibilities of the CON Commission

The Commission was expanded from 5 to 11 members. Act 619 reverted Commission memberships to designated categories of representation, as had been the case with the State Health Coordinating Council before the 1988 CON law revisions. Although the 1988 law did not stipulate representation, governors appointed CON Commissioners who were primarily consumer/payer/purchaser representatives with usually one provider representative among the five. This reflected the view that the Commission provided balance to the standards proposed through expert, provider dominated ad hoc advisory committees responsible for proposing changes to standards or to the list of covered services.

Act 619 continued the requirement that Commissioners must be members of a political party with six Commissioners from of one major political party and five from another major political party. When fully implemented in 2006: two are to be representatives of hospitals; one is to be a physician M.D.; one a physician D.O.; one from an M.D. or D.O. medical school; one representing nursing homes; one representing nurses; one representing a self-insured company; one representing a company not self-insured; one representing Blue Cross/Blue Shield of Michigan; and, one representing organized labor. Thus, about two-thirds of the Commission are providers (7) and about one-third (4) are consumers/payers/purchasers.[3]

The Commission is required to report on recommended statutory changes every two years. The previous requirement had been every five years. The 2005 recommendations have not been issued as of the publication of this report.

The Commission continues to have authority to add, revise or delete covered clinical services subject to veto by the governor or the legislature.

Act 619 changed the name of Ad Hoc Advisory Committees to Standard Advisory Committees and eliminated the provision that a committee be appointed for each and every change to a CON review standard. Determination of the need for a Standard Advisory Committee is left to the Commission. If a committee is appointed, two-thirds must be composed of professional experts, almost always providers. Previously a majority of committee members were to be professional experts. The Commission may request the DCH to hire a private consultant or organization for technical assistance and advice in lieu of an advisory committee.

[3] Current membership can be found at: www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-35111—,00.html.

Changes to CON Standards

Act 619 continued the then current dollar threshold for covered capital expenditures at $2.5 million, but provided that it is to be annually adjusted. The adjustment is determined by the state treasurer to reflect the annual change in the consumer price index (CPI) with the CPI defined as the most comprehensive index of consumer prices available for Michigan (the Detroit Metropolitan area). The amount effective January 1, 2005, is set at $2,655,000 up $32,500 from the 2004 amount.

Act 619:

- Permits a hospital to provide covered clinical services in a federal veteran's health care facility. Specifically, this permits the University of Michigan's University Hospital to provide services in the adjoining Veteran's Hospital without a CON. This provision could also apply to the Detroit Medical Center and the Dingell Veteran's Hospital in Detroit.
- Eliminates minimum volume requirements for existing operating rooms in a hospital with fewer than 70 licensed beds until such time as the hospital applies for a new CON. There are 49 of these in Michigan.
- Permits the initiation, expansion or replacement of a fixed or mobile MRI unit by letter of intent rather by obtaining a CON within a county having a population of 160,000 having less than two MRI units (St. Clair County) if the service meets the prerequisites in law.
- Provides that, except for nursing home and hospital long-term care units standards, the Commission shall revise all standards to include a requirement that each applicant participate in Medicaid.

Role of the Governor and Legislature in the CON Process

Act 619 creates a six-member Joint Legislative Committee on Certificate of Need and requires the Commission to communicate certain information to the joint committee. The joint committee has authority to administer oaths, subpoena witnesses and examine the application, documentation or other reports and papers of an applicant for a certificate of need. It may develop a plan of revision for the CON program and recommend changes to the legislature. It must review revisions of CON application fees proposed by the CON Commission and submit a written report to the legislature. Legislative intent is that these represent some three-quarters of total CON costs.

The act continued the 1988 legislative and gubernatorial review requirement. Thirty days or more before final Commission action members of the Joint Committee are to be given a concise summary of the expected impact of the action for review and comment. The committee is to promptly review the proposed action and submit its recommendations to the Commission. Certain actions taken by the Commission must be submitted to the governor and the legislature for review. These include: revision, addition or deletion of a clinical service; review standards; criteria for determining health facility viability; review standards for new technology; and, standard revisions governing the increase of licensed hospital beds, the physical relocation of licensed hospital beds from one location to another and the replacement of hospital beds.

Either the governor or the full legislature may disapprove of these proposed final actions within a 45-day period. The 45-day period begins the next legislative day if the legislature is not in session when the submittal is made. Legislative disapproval is expressed by the adoption of a concurrent resolution by both houses.

Establish a Process for the Relocation of Beds to Allow a Limited Number of New Hospitals without a Certificate of Need

One of the more controversial measures of Act 619 exempts the relocation of certain hospital beds from CON.

Acute hospitals standards have limited the movement of beds under CON. Standards stipulate that *replacement* beds must be located within a replacement zone defined as within a two-mile radius of the current location (a five-mile radius applies to hospitals in counties with a population of less than 200,000). Replacement of beds is the term used for the movement of all the beds in an entire hospital from one site to a new site. Hospitals may *relocate* some of their beds, but only to any other existing hospital within the same subarea. There is an important distinction between health service areas (See **Map 1**, page 18) and hospital subareas. The 64 subareas are defined by CON bed need methodology and are smaller than the eight health service areas. Subareas are not geographically based. Rather they are a list of

[4] See web site: www.michiganlegislature.org/mileg.asp?page=getObject&objName=mcl-333-22209&highlight=

those acute care hospitals that serve patients from an identified area. This list is found in **Appendix E**.

Act 619, section 22209, subsections (3, 7, 8 and 9) permit relocation of hospital beds without requiring a CON.[4]

The transfers and their conditions provide as follows:

- Subsection (3)(a) permits a hospital to transfer beds from one hospital to another if they are under the same license and they are within two miles of each other.

- Subsection (3)(b) permits Providence/St. John Hospital to make a one-time transfer of licensed hospital beds to its freestanding outpatient facility (FSOF) in Novi and Henry Ford Hospital to make a one time transfer of licensed hospital beds to its freestanding outpatient facility in West Bloomfield. Each FSOF would become a new hospital. The language would also appear to permit St. Mary's Hospital in Saginaw to take similar action with its FSOF in southern Saginaw County.

- Subsections 7 – 8 apply to subsection 3(b) and identify certain requirements of hospitals applying for relocation such as: not transferring more than 35 percent of its licensed beds; not reactivating licensed beds in the transferring hospital that were not staffed and available for patient care as of December 2, 2002, until five years after the relocation; and, one of every two beds transferred, up to a maximum of 100 beds, must be beds that were staffed and available for care on December 2, 2002.

- Subsection 9 also applied to subsection (3)(b) and stipulated that no licensed bed could be physically relocated under the CON exemption if, before June 15, 2003, seven or more of the eleven CON Commission members "determine that relocation of licensed beds… may cause great harm and detriment to the access and delivery of health care to the public and the relocation of beds should not occur without a certificate of need." This did not occur.

- Subsection (3)(c) permits the relocation of licensed beds within the same health services area if the hospital receiving the beds is owned by, is under common control of, or has a common parent corporation.

This topic is reviewed in more detail later in the report under CON and Acute Care Hospitals on page 36.

Administration

DCH is required to furnish at least two full-time administrative employees as well as secretarial and other staff necessary to allow the proper exercise and duties of the Commission. Additionally, DCH is to assign at least two full-time professional employees to staff and assist the Commission.

Act 619 states legislative intent that fees charged by the CON program be sufficient to cover 75 percent of the cost of the program with a 10 percent allowance. This represents a change from the former 50 percent. Costs include both the direct appropriation for the CON program as well as associated DCH administrative and Attorney General legal amounts.

DCH is to prepare and publish a monthly report, previously required annually, of application reviews conducted including a statement of each review completed and its findings and decisions.

DCH is required to provide copies of any application, or part thereof, to any requestor and may charge a reasonable fee for the service.

Current Law and Administrative Rules

Current law is Part 222 of the Public Health Code, Act 368 of 1978, as amended (www.michiganlegislature.org/mileg.asp?page=getObject&objName=mcl-368-1978-17-222).

Further guidance for the program is found in administrative rules sections 325.9101-325.9525. (www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=32509101&Dpt=&RngHigh=32577115)

Recent Reports

Auditor General Report of April 2002

The Michigan Auditor General issued a report on the CON program in April of 2002 that contained five findings. One of these was "material," meaning that a condition existed which could impair the ability of management to operate the program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. The finding was that: "the CON commission had not evaluated the CON program in order to determine whether the CON program was achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan." CON law required the Commission to issue this report based on a report from DCH that had not been submitted for some years.[5] The four other findings related to: costs and revenues of the program including fee structure; monitoring approved CON projects; application fee refunds; and, monitoring compliance with CON review standards.

CON Evaluation Report 2003

The Department of Community Health agreed with the material finding regarding the evaluation of the program and the Department hired an independent contractor to conduct a comprehensive evaluation. The resulting "Evaluation of Certificate of Need in Michigan" by Professors Conover and Sloan of the Center for Health Policy, Law and Management of the Terry Sanford Institute of Public Policy at Duke University was published in July 2003.[6]

This report concluded that "With its roots in the rapidly disappearing cost-based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and/or access to care." (p. 127) A summary of Professors Conover and Sloan's report is found at **Appendix B**.

Federal Trade Commission/Department of Justice Report 2004[7]

Among its recommendations, the organizations find that states "should reconsider whether CON programs best serve their citizens health care needs. On balance, the Federal Trade Commission (FTC) & the Department of Justice (DOJ) believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits."

Supporters of the Michigan CON program state that Michigan's approach distinguishes it from most of the other programs in the nation because standards are established by an independent commission that are tied to quantifiable requirements insofar as possible and cover all types of providers wishing to offer the service.

The FTC and DOJ also recommend that states consider: broadening the membership of licensing boards; implementing uniform licensing standards to reduce barriers to telemedicine and competition from out-of-state providers; and, providing direct subsidies to compensate for providers who use higher profits in certain areas to cross-subsidize uncompensated care.

The report notes "vigorous competition, both price and non-price, can have important benefits in health care." It also recognizes that it is not a panacea for all problems with American health care. "Competition cannot provide its full benefits without good information and properly aligned incentives" nor will it "shift resources to those who do not have them."

---

[5] audgen.michigan.gov/comprpt/docs/r3964401L.pdf This report contains the latest available maps of the location of CON covered services on pages 54-69.

[6] http://www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771---,00.html

[7] The Federal Trade Commission and the Department of Justice released a report in July of 2004 entitled "Improving Health Care: A Dose of Competition". (www.usdoj.gov/atr/public/health_care/204694.htm)

CON Coverage

Current Coverage

In Michigan, the CON program can be divided into three general types: capital construction; bed need; and, clinical services.

Capital Expenditures for Health Facilities

Since enactment of PA 256 in 1972, hospitals have been prohibited from incurring capital costs that exceed a dollar threshold without a CON. Over the years, long-term care facilities (primarily nursing homes and long-term care units in hospitals) and freestanding surgical outpatient facilities (FSOF) were also included. This threshold applies to capital expenditures for those facilities where diagnosis, treatment and/or rehabilitation will occur. Capital expenditures for purposes such as parking, lobbies and information technology do not require a CON.

The threshold amount is now updated annually based on the change in the all-inclusive consumer price index for Michigan issued by the United States Department of Labor. For the year 2005, the amount is $2,655,000.

Michigan is among the least regulatory of CON capital expense programs. It restricts review to the larger facility renovation and building projects and to specialized clinical services that require a CON regardless of the monetary value involved.

Bed Need

Three facility types must receive a certificate of need on the basis of bed need: acute care hospitals, psychiatric hospitals, including specialized programs for child/adolescents; and, long-term care facilities. Any entity that seeks to increase the number of licensed beds, physically relocate beds from one licensed site to another (except that hospitals may relocate beds within the same subarea), replace beds, or acquire a hospital, psychiatric hospital or long-term care facility must receive a CON to do so.

Clinical Services

CON applies to 13 clinical services, and associated beds if any. At present these are:

- Air Ambulance
- Cardiac Catheterization
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Megavoltage Radiation Therapy (MRT)
- Neonatal Intensive Care
- Open Heart Surgery
- Positron Emission Tomography (PET)
- Surgical Services
- Bone Marrow Transplantation
- Heart/Lung and Liver Transplantation
- Pancreas Transplantation
- Urinary Extracorporeal Shock Wave Lithotripsy

Changes in CON Coverage

Beds and Capital Construction

CON coverage of certain capital construction projects and hospital and long-term care beds is defined by statute and can only be altered by law.

Clinical Services

CON coverage for clinical services is defined by law and regulation. Before March 31, 2003, the department responsible for the administration of CON could recommend additions and deletions for covered CON services/equipment to the CON Commission for approval. In the 1990s, the Commission dropped partial day psychiatric services from coverage. Act 619 of 2002 gives sole discretion for this function to the CON Commission although the Department of Community Health may still make recommendations. Section 22215 (1) (a) stipulates that if the Commission determines it necessary, the Commission may revise, add to, or delete, one or more of the covered clinical services subject to disapproval by the governor or legislature.

CON Application Process

The first step in seeking a CON is the filing of a *letter of intent* with the Department of Community Health.[8] Applicants in Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, and Ottawa counties are also required to submit a letter of intent to the regional review agency, the Alliance for Health located in Grand Rapids.[9]

Chart 3 details the process and timelines for the processing of an application.[10]

As seen near the middle of the chart, applications are sorted into one of three possible review processes: nonsubstantive; substantive; or, comparative. Non-substantive reviews require DCH to reach a proposed decision within 45 days compared to 120 days for a substantive review. Because there is a 30-day period during which additional information may be prepared to fully complete the application, the effective times are 75 days and 150 days respectively.

Nonsubstantive reviews may be requested for a project if:

- There will be no increase in the number of beds at the site where the project is proposed
- The project is not an initiation or expansion of a covered clinical service
- The project is not starting the new operation of a health facility at a site that is not currently licensed for that type of facility
- The project meets a need already demonstrated and established by the CON program
- The project is not subject to comparative review.

Substantive reviews are applied to all other CON requests.

Comparative review. If two or more applicants are competing for certain project types; acute and psychiatric hospital beds; long-term care beds; and transplantation services (excluding pancreas), a comparative review is undertaken. Factors that are considered in a comparative review are defined in the review standards. Although there is currently no bed need for acute care hospitals, it is noted that there are no comparative review criteria in the standards.

When the application review process is complete, DCH staff recommends final action to the director of the department. If the recommendation is for approval and the director agrees a CON is granted. If the recommendation is for denial and the director concurs or if the director decides to deny an application recommended by staff for approval, the CON is denied. Applicants denied a CON have 15 days in which to request a hearing. The hearing must be held within 90 days of the request unless the applicant waives this time period. If after a decision following the hearing the applicant's request is still denied, the applicant may seek favorable action through the courts.

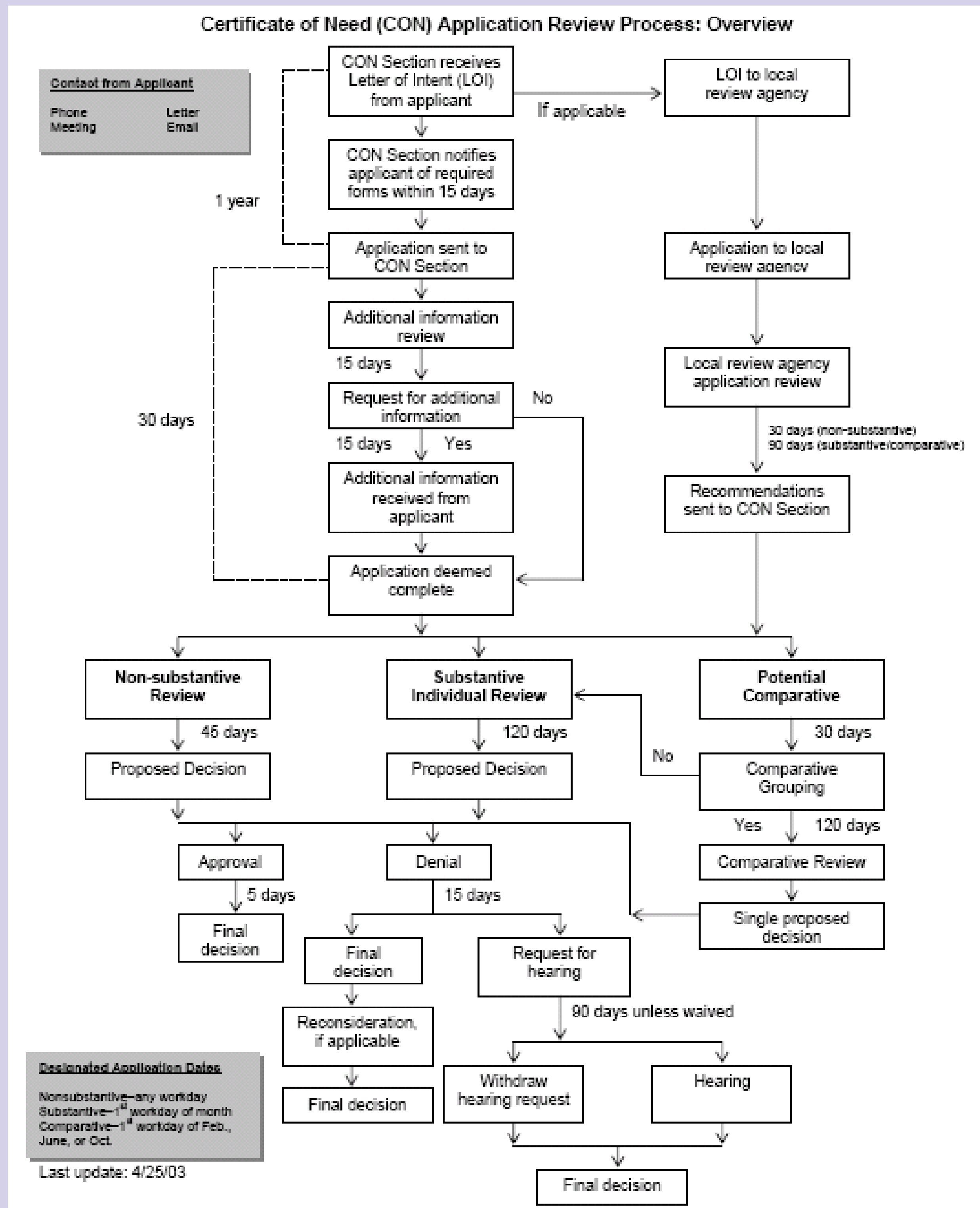
---

[8] www.michigan.gov/documents/CON-149(E)_Letter_of_Intent_62061_7.doc and www.michigan.gov/documents/CON-149-EXP(E)_LOI_Non-Sub_or_Expedited_62057_7.doc

[9] http://www.afh.org/

[10] www.michigan.gov/documents/Appl_Process_Overview_Revised_63228_7.doc

Chart 3



Source: Department of Community Health

CON Review Standards

Legal Requirements

Review standards are the basis upon which any application for a CON is judged. These can be initiated either by law or by the CON Commission. A chart showing selected components of the standards for each covered bed or service can be found at **Appendix C**.

Section 22225 of the CON law requires that applicants demonstrate to the satisfaction of the Department of Community Health that a proposal will meet six tests. Some of the criteria are implemented by standards established by the Commission; the statute establishes others.

First, the proposal must meet an unmet need. CON standards established by the Commission spell out how this is to be documented.

Second, the proposal must include what alternatives have been considered and the reasons why this particular approach is best. If there are no alternatives, the application must state why.

Third, applications are to document that the service for which a CON is requested is the least costly. Factors considered are: that capital design and cost will result in the least total annual operating costs; that funds are available to meet the capital *and* operating needs of the project; and that the least costly method of financing is to be used.

Fourth, the proposed project must be delivered in compliance with operating standards and quality assurance standards. It is to include a description of how it will assure appropriate utilization, indicate how the effectiveness of the project will be measured and that the applicant has both current and historical compliance with federal and state licensing and certification requirements.

Fifth, if the project relates to a facility, the applicant must demonstrate that the facility in which the proposed service will be delivered is viable by meeting one of six requirements. These include minimum percentage occupancy of licensed beds, a minimum percentage of the number of discharges in the facility's planning area and the like as well as other criteria approved by the Commission. This criterion is to be implemented by standards proposed by DCH for Commission action. To date a recommendation has not been submitted and the facility viability standard is not in effect.

Sixth, the board of a non-profit applicant must be composed of a majority of consumers.

When the CON Commission acts to establish a review standard, it must include any applicable statutory language in the standard. Examples of statutory requirements include general requirements for all applicants such as providing data and statistics to DCH and language applicable to specific application types such as short-term nursing care units in hospitals, magnetic resonance imaging units and freestanding surgical outpatient services.

Fundamental to all review standards is documentation that any proposed project addresses an unmet need in the area proposed to be served. In most cases this is done through credible documentation of applicable review standards. For example, an applicant wanting to add a fixed CT scanner at a given location must demonstrate that: the new scanner will operate at a level of at least 7,500 CT equivalents for the added scanner in the second 12 month period after approval; and, that the present scanner(s) have performed at an average of at least 10,000 CT equivalents for the immediately preceding 12 months. The use of equivalents accounts for the various types of CT scans in comparison to a head scan without contrast and range from 1.0 for that procedure to 2.75 for a full body scan with and without contrast.

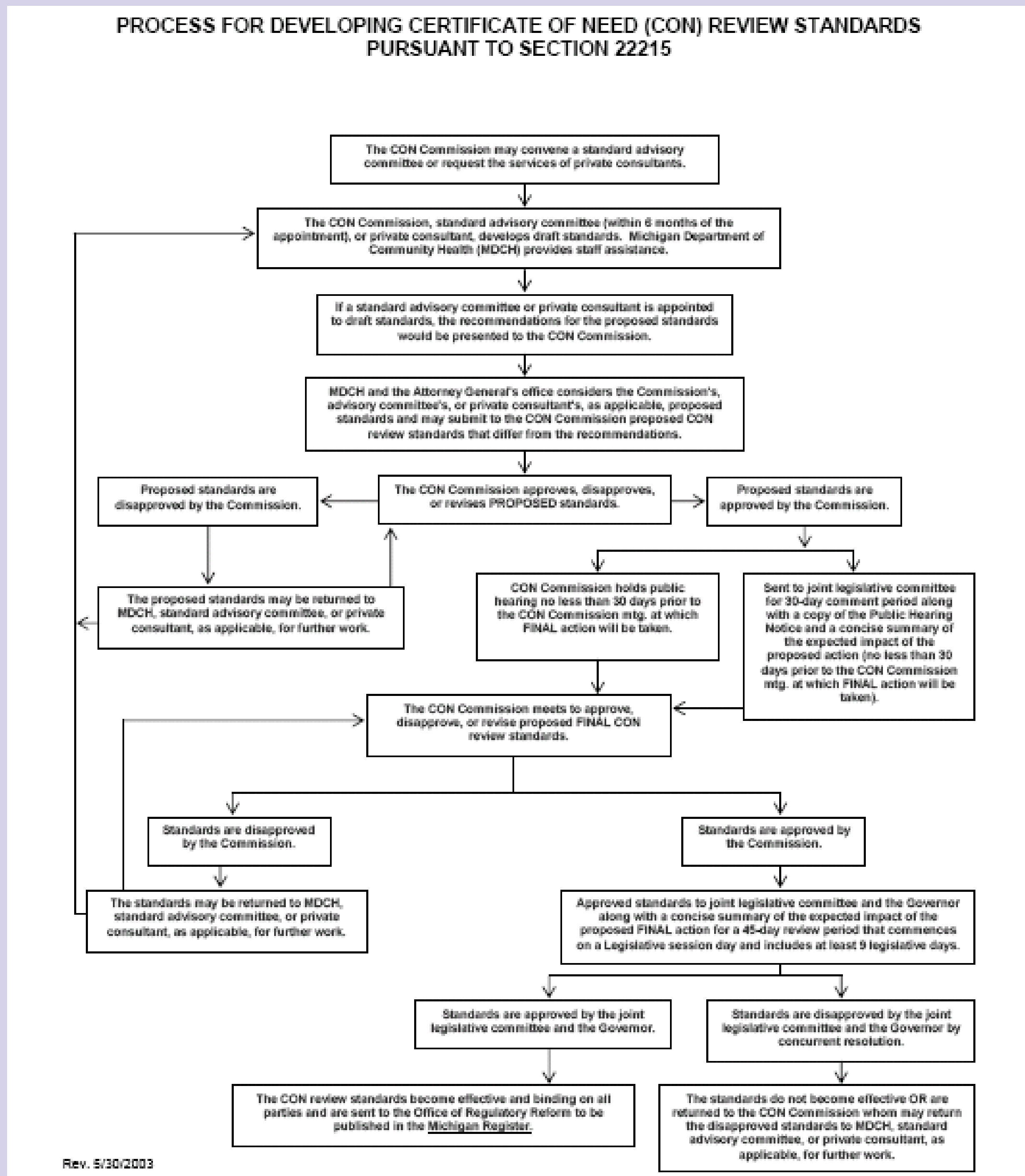
The process by which the CON commission establishes bed and clinical CON standards is shown in **Chart 4**.

As noted earlier, new or revised standards are submitted to the governor and legislature for review. Either may disapprove them.

Both bed need and services review standards are in similar formats. The first section(s) contains definitions. Subsequent sections address: methodology; quality; access and related issues. For a full understanding of each review standard, reference is made to the web location where they may be found.[11] What follows is a summary version with attention to selected factors.

[11] www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-25558—,00.html

Chart 4



Source: Department of Community Health

Review Standards

Review standards can be separated into three types: 1.) capital expenditure; 2.) beds; and 3.) clinical services.

1.) Capital Expenditures in excess of $2,655,000 require a CON if they are for clinical purposes in an acute care or psychiatric hospital, a freestanding surgical outpatient facility, or a nursing home. Non-clinical capital projects in these facilities (parking lots, phone systems, administrative offices, etc.) are no longer regulated by CON.

Applicants for a capital expenditure CON must address the requirements set forth in Section 22225 of the CON law. These include demonstration:

- That it will be geographically accessible and efficiently and appropriately utilized
- That alternatives have been considered and this approach is the most efficient and effective in meeting an unmet need
- That capital costs will result in the least costly annual operating costs
- That funds are available for the project using the least costly method of financing, that the project will be competitively bid, or if the applicant proposes otherwise, demonstrate that the cost will achieve substantially the same results
- That there is evidence of current and historical compliance with state and federal licensing and certification requirements
- That the project be judged financially viable by demonstrating at least one of the following: a minimum percentage occupancy of beds; a minimum percentage of combined uncompensated discharges and discharges under Medicaid in the planning area; evidence that the facility is the only provider in the planning area of a service that is considered essential by the CON commission; or other criteria established by the CON commission. As noted earlier, the standards for this requirement have not been proposed or adopted.

2.) Bed Need[12] review standards apply to acute and psychiatric hospitals and nursing homes. There is a separate clinical standard for neonatal intensive care beds addressed in the clinical services section of this report.

Acute Care Hospital Beds

Need & Methodology. The first requirement in establishing the need for acute care (non-psychiatric) hospital beds is to determine the actual number of days of hospitalization compared to the number days that can be accommodated by the number of hospital licensed beds. If patients use 36,500 days of care, 100 beds would be needed (365 x 100 = 36,500). Of course, it's not quite that simple because hospitals do not have an equal number of patients each day, and it's not possible to achieve 100 percent occupancy due to the need to place patients in designated areas of the hospital such as the Intensive Care Unit, and other variables. The bed need determination methodology accounts for this by adjusting the average daily census (ADC) derived from the bed need methodology by an occupancy factor. The occupancy factor varies from a low of 60 percent for ADC in a hospital with 50 beds of less to a high of 85 percent in a hospital of 200 or more beds.[13]

If one hospital served all the population of only one governmental unit such as a county or city, the bed need methodology could be relatively easy. But in most areas of the state multiple hospitals serve persons from a variety of communities.

Michigan uses a market-based method to determine bed need.

When the bed need methodology was established, a first step was to define the locations from which patients were served by specific hospitals. Data was obtained by use of the Patient Origin Hospital Utilization Study (POHUS). The Department of Public Health requested the assistance of three experts in defining the methodology. J. William Thomas, John R. Griffith and Paul Durance developed a methodology described in "The Specification of Hospital Service Communities in a Large Metropolitan Area," April, 1979.

A statistical model permitted the establishment of what could be called spheres of influence for each hospital. These

[12] For the detailed methodology used in hospital bed need determination see sections 3-5 "Certificate of Need (CON) Review standards for Hospital Beds" (www.michigan.gov/documents/CON-214CONRevStdsforHospitalBeds_70990_7.doc).

[13] See pages 22-23 of 25 at: www.michigan.gov/documents/CON-214_CON_Rev_Stds_for_Hospital_Beds_6-4-04_93535_7.pdf

were then analyzed to permit the grouping of individual hospitals into subareas. Each hospital was assigned to one subarea. It is important to understand that these subareas are not geographical jurisdictions of the state. They are not cities, townships or counties, or combinations thereof. They are a list of hospitals and the list is determined through the use of patient origin data. The subareas are, however, assigned to Health Service Areas (HSA). These are county based and are shown in **Map 1**.

The essence of the acute care hospital bed need determination is a comparison of beds available (licensed) versus the actual utilization of beds. CON does not attempt to determine the "proper" use of hospital beds for a given population rather it examines the actual use of hospital beds resulting from the practice of medicine in the area and compares that use to the number of licensed hospital beds. The use of hospital beds is derived from the Hospital Inpatient Data Base (HIDB) maintained and operated by the Michigan Health and Hospitals Association.[14]

Hospital use is stratified by age and gender in order to achieve a more uniform application of the methodology across the state.

[14] www.mhaservicecorp.com/

The CON Commission approved the most recent determination of bed need on March 9, 2004. It became effective on June 4, 2004 after the governor and legislature did not disapprove it. There are 7,770 excess beds in Michigan. **Table 2** shows these by HSA. Detail by subarea is found in **Appendix D** and **Appendix E** shows those hospitals assigned to each subarea.

CON is based upon licensed beds since hospitals are able to use all licensed beds even if lower occupancy results in fewer beds being set up for current use. As noted earlier on page 11, Act 619 of 2002 placed conditions on those beds that could be relocated from the City of Detroit. One of every two beds to be relocated must be beds that were staffed and available for care on December 2, 2002. The "usable" beds are often referred to as "staffed" or "setup" beds. The latest available figure for licensed beds is as of December 31, 2003, while the latest numbers for setup beds come from the 2002 hospital survey report. The number of licensed beds for 2002 is not currently available so a direct comparison is not possible. Because the number of licensed beds varies little from year to year, data using different time periods is thought to be reasonable.

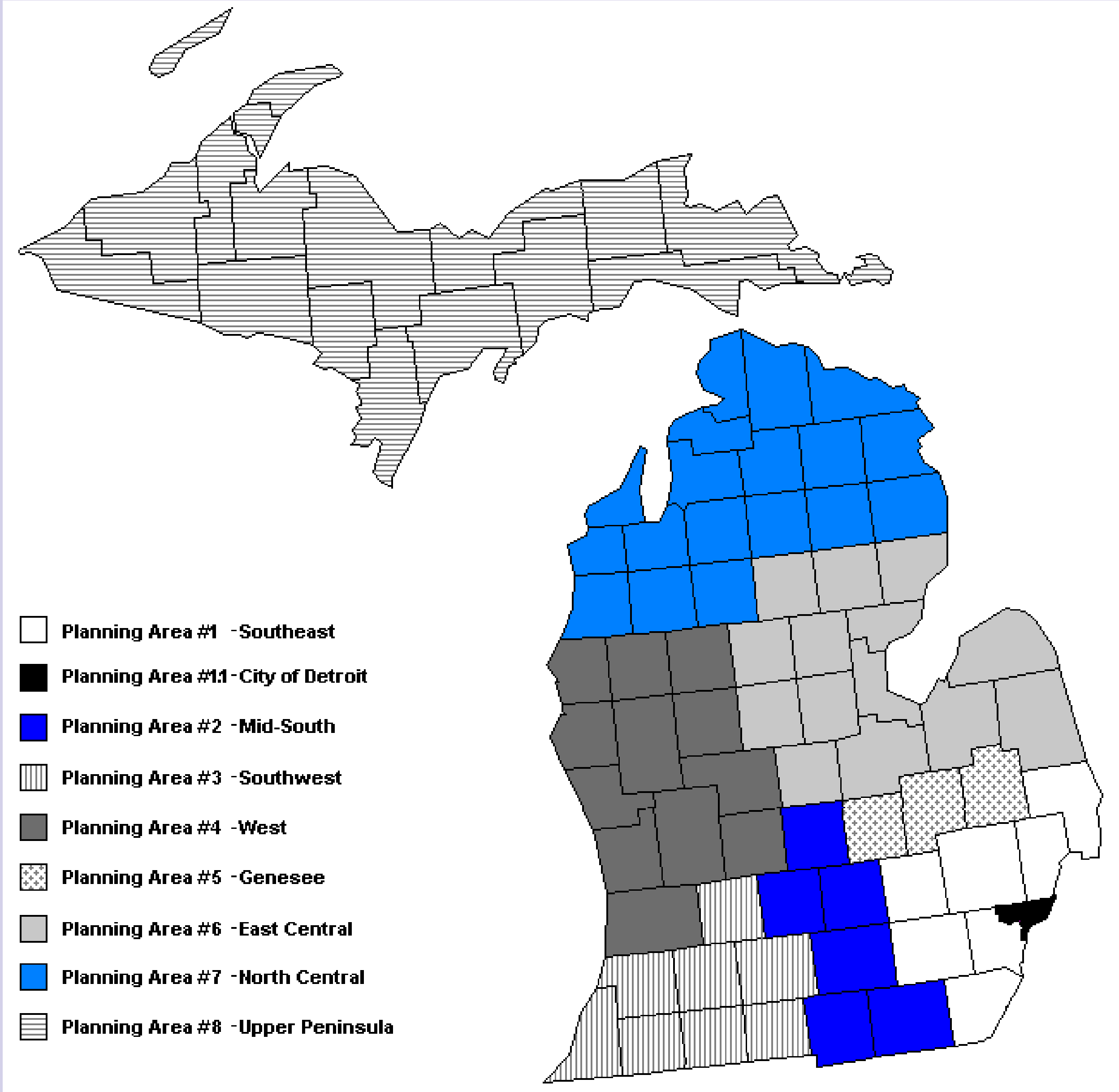
At December 31, 2003, there were 27,554 licensed beds and in 2002 hospitals reported 23,532 "setup" beds – a 15 percent difference. A review of the setup bed data suggests there is some inaccuracy resulting in an over reporting but there has been no audit to verify this.

Table 2
Michigan Hospital Licensed and Setup Bed Inventory vs. Need for Certificate of Need Program by Health Service Area

Health Service Area	Bed Need	Bed Inventory 12-31-03	Difference Need to Inventory	Setup Beds 2002	Difference Need to Setup Beds
AREA 1 (Southeast)	10,570	14,618	4,048	12,217	1,647
AREA 2 (Mid-Southern)	1,305	1,778	473	1,478	173
AREA 3 (Southwest)	1,450	2,043	593	1,867	417
AREA 4 (West)	2,198	3,277	1,079	2,656	458
AREA 5 (Genesee, Lapeer, Shiawassee)	1,318	1,539	221	1,403	85
AREA 6 (East)	1,561	2,288	727	2,155	594
AREA 7 (Northern Lower Peninsula)	876	1,148	272	985	109
AREA 8 (Upper Peninsula)	506	863	357	771	265
STATE TOTAL	19,784	27,554	7,770	23,532	3,748

Source: Michigan Department of Community Health

Map 1
Michigan Health System Areas (HSAs)



Urban/Rural Consideration. Entire hospitals wishing to relocate beds to a new site must do so within a replacement zone. In counties with a population of 200,000 or more, the replacement zone is a two-mile radius from the present facility. In counties with a population under 200,000 the replacement zone is a five-mile radius.

Quality criteria are not included in general hospital standards because of the licensing and certification requirements of the federal and state government and because hospitals are subject to accreditation by the Joint Commission on Accreditation of Healthcare Organizations.[15]

Access requirements include that hospital services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. General hospital applications are subject to comparative review but no distinct criteria has been developed since there is currently no need for beds. The CON Commission is considering exceptions to the current standards for limited access areas. If they are adopted they will contain comparative review criteria for this purpose, but not for the overall standard.

Psychiatric Hospital Beds[16]

Psychiatric hospitals, except those owned by the State of Michigan, are subject to CON.

Need & Methodology. The need for psychiatric hospital beds is set by the CON Commission and differs between adults and child/adolescents. Planning areas for each are different (See Appendices A and B of the review standards). The population of the planning area is multiplied by a factor set by the CON Commission and needed beds are derived from that factor (See sections 3 and 4 and Appendices C & D of the review standards.) The occupancy standard is 90 percent for adult beds and 75 percent for child/adolescent beds.

Tables 3 and **4** show a statewide need for an additional 290 adult and 83 child/adolescent psychiatric hospital beds.

Urban/Rural Consideration. Entire psychiatric hospitals wishing to relocate beds to a new site must do so within a replacement zone. In counties with a population of 200,000 or more, the replacement zone is a two-mile radius from the present facility. In counties with a population under 200,000 the replacement zone is a five-mile radius

Quality requirements include that: operations are appropriate for the persons served including ethnic, socioeconomic and demographic characteristics; procedures are established for disruptive, combative or suicidal behaviors; and, staffing is sufficient to assure continuity of service and the ability to respond to emergencies. Additional requirements pertain to child/adolescent beds.

Access requirements include that hospital services will not be denied on the ability to pay or source of payment and services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. Psychiatric hospital beds are subject to comparative review.

Long-Term Care Beds[17]

Long-term care beds include those in nursing homes, county medical care facilities, and long-term care units of hospitals.

Need & Methodology. Like hospital bed need, long-term care bed need is based upon the actual use of nursing home and hospital long-term care beds in a given area. Counties are used as the geographical area except that Wayne County is divided into three parts and the counties of Houghton and Keweenaw are combined.

The population of each county is divided into four age groups: 0-64; 65-74; 75-84; and, 85 and older. A statewide average for each age group serves as the standard for the

[15] www.jcaho.org/

[16] Review standards are found at: www.michigan.gov/documents/CON-205_CON_Rev_Stds_Psychiatric_Beds_Svcs_6-4-04_93527_7.pdf.

[17] Review standards can be found at: www.michigan.gov/documents/CON-217_CON_Rev_Stds_for_NH-HLTCU_6-4-04_93537_7.pdf. Pages 20-28 cover special population groups.

Table 3
Michigan Adult Psychiatric Hospital Bed Inventory vs. Need at December 31, 2003 for Certificate of Need Program

Health Service Area	Bed Need	Bed Inventory 12-31-03	Excess/ (Deficit)
Detroit/Wayne	717	766	49
Livingston	39	0	(39)
Macomb	230	229	(1)
Monroe	22	21	(1)
Oakland	380	405	25
St. Clair	43	23	(20)
Washtenaw	103	87	(16)
Clinton-Eaton-Ingham	114	144	30
Jackson-Hillsdale	40	40	0
Lenawee	31	35	4
Barry	17	0	(17)
Berrien	30	30	0
Branch	14	16	2
Calhoun	47	56	9
Cass	17	0	(17)
Kalamazoo	44	40	(4)
St. Joseph	13	0	(13)
Van Buren	15	15	0
Allegan	9	9	0
Ionia	19	0	(19)
Kent	166	154	(12)
Lake	3	0	(3)
Mason	9	14	5
Montcalm	16	16	0
Muskegon	43	27	(16)
Newaygo	13	16	3
Oceana	8	0	(8)
Ottawa	20	12	(8)
Genesee	141	108	(33)
Lapeer	20	20	0
Shiawassee	24	16	(8)
Ausable Valley	20	0	(20)
Bay-Arenac	28	28	0
Central Michigan	14	19	5
Gratiot	12	12	0
Huron	12	0	(12)
Midland-Gladwin	20	20	0
Saginaw	71	55	(16)
Sanilac	14	0	(14)
Tuscola	19	0	(19)
Antrim-Kalkaska	11	0	(11)
Grand Traverse- Leelanau	14	14	0
Manistee-Benzie	12	0	(12)
North Central	20	20	0
Northeast Michigan	23	15	(8)
Northern Michigan	14	14	0
Alger-Marquette	28	37	9
Copper Country	20	0	(20)
Delta	13	0	(13)
Dickinson-Iron	14	0	(14)
Eastern Upper Peninsula	16	0	(16)
Gogebic	7	0	(7)
Luce	2	0	(2)
Menominee	9	0	(9)
Schoolcraft	3	0	(3)
STATEWIDE	2,823	2,533	(290)

Source: Michigan Department of Community Health

Table 4
Michigan Child Adolescent Psychiatric Hospital Bed Inventory vs. Need at August 12, 2003 for Certificate of Need Program

Planning Area	Bed Need	Bed Inventory 8/12/2003	Excess/ (Deficit)
AREA 1 (Southeast)	217	166	(51)
AREA 2 (Mid-Southern)	35	16	(19)
AREA 3 (Southwest)	39	55	16
AREA 4 (West)	60	70	10
AREA 5 (Genesee, Lapeer, Shiawassee)	30	40	10
AREA 6 (East)	40	14	(26)
AREA 7 (Northern Lower Peninsula)	18	0	(18)
AREA 8 (Upper Peninsula)	15	10	(5)
STATEWIDE	454	371	(83)

Source: Michigan Department of Community Health

county-by-county analysis so that the bed need for a county with a disproportionate number of 85 and older, for example, reflects that fact. Bed need methodology is based on actual usage adjusted for age, and the population of the county.

Until 1997, the state used a comprehensive survey to determine long-term care bed utilization. When the federal government implemented a "minimum data set" requirement, it was felt that this data would prove sufficient to replace the survey. This proved to be a faulty assumption. The survey has not been reinstituted; rather, information from quarterly staffing reports sent by nursing homes to the state to demonstrate sufficient staff to care for residents is used.

The population base used for long-term care bed need calculations is the 1990 census. The population of Michigan increased from 9,295,287 in 1990 to 9,938,444 in 2000 (7 percent) and the portion of the population 65 and older increased from 1,108,461 to 1,219,018 – a 10 percent growth – according to the U.S. Bureau of the Census.[18]

Table 5 details long-term care occupancy data for December 31, 2003. The statewide nursing home bed inventory is 50,599 compared to a need of 48,915 – a surplus of 1,684 beds. There are 22 counties, however, which show need for more beds ranging from 1 to 314. Counties with facilities with an average daily census of 100 or less have bed need adjusted to reflect a 90 percent occupancy rate while those with more than 100 are adjusted to 95 percent.

CON long-term care standards include special recognition for certain groups in an addendum. These include recognition of religious groups and specialized services by permitting an additional 2 percent of the beds needed in the state for such purposes. The CON Commission sets aside 300 beds from the statewide pool for the care of persons with Alzheimer's disease. Another 257 beds from the statewide pool are set aside for use in low density population areas – those with less than 28 individuals per square mile – and 100 beds are set aside for persons requiring both long-term care and hospice services. Beds allocated under the special needs category do not affect the bed surplus or deficit calculated by the bed need methodology.

The Commission approved revisions, effective December 12, 2004, to the long-term care standards. A new section was added permitting pilot projects for existing nursing

[18] www.michigan.gov/documents/c2kbr01-10_31902_7.pdf

[19] See pages 29-32 of: www.michigan.gov/documents/NH-HLTCU_New_Construction_Pilot_Program_Language_for_9-14-04_Commission_Final_Action_101999_7.pdf.

Table 5
Michigan Long-Term Bed Inventory vs. Need at December 31, 2003
for Certificate of Need Program

County	Bed Need	Bed Inventory	Excess/ (Deficit)	Average Daily Census Adjustment
Alcona	102	106	4	0.90
Alger	70	106	36	0.90
Allegan	474	565	91	0.95
Alpena	203	208	5	0.95
Antrim	134	113	(21)	0.95
Arenac	106	148	42	0.90
Baraga	72	87	15	0.90
Barry	262	252	(10)	0.95
Bay	638	668	30	0.95
Benzie	93	102	9	0.90
Berrien	965	899	(66)	0.95
Branch	241	283	42	0.95
Calhoun	805	850	45	0.95
Cass	272	222	(50)	0.95
Charlevoix	134	134	0	0.95
Cheboygan	154	162	8	0.95
Chippewa	193	173	(20)	0.95
Clare	173	200	27	0.95
Clinton	251	251	0	0.95
Crawford	85	160	75	0.90
Delta	260	292	32	0.95
Dickinson	230	256	26	0.95
Eaton	431	444	13	0.95
Emmet	167	230	63	0.95
Genesee	1,951	1,951	0	0.95
Gladwin	150	180	30	0.95
Gogebic	195	221	26	0.95
Grand Traverse	368	552	184	0.95
Gratiot	272	556	284	0.95
Hillsdale	262	262	0	0.95
Houghton/Keweenaw	314	335	21	0.95
Huron	278	313	35	0.95
Ingham	1,180	1,028	(152)	0.95
Ionia	275	248	(27)	0.95
Iosco	193	243	50	0.95
Iron	150	149	(1)	0.95
Isabella	214	309	95	0.95
Jackson	828	847	19	0.95
Kalamazoo	1,120	1,154	34	0.95
Kalkaska	76	88	12	0.90
Kent	2,566	2,495	(71)	0.95
Lake	78	89	11	0.90
Lapeer	291	292	1	0.95
Leelanau	111	110	(1)	0.90
Lenawee	497	497	0	0.95

Table 5 (continued)
Michigan Long-Term Bed Inventory vs. Need

County	Bed Need	Bed Inventory	Excess/ (Deficit)	Average Daily Census Adjustment
Livingston	421	475	54	0.95
Luce	46	61	15	0.90
Mackinac	81	79	(2)	0.90
Macomb	3,636	3,933	297	0.95
Manistee	170	221	51	0.95
Marquette	361	441	80	0.95
Mason	197	202	5	0.95
Mecosta	184	232	48	0.95
Menominee	197	179	(18)	0.95
Midland	338	414	76	0.95
Missaukee	81	95	14	0.90
Monroe	619	595	(24)	0.95
Montcalm	285	202	(83)	0.95
Montmorency	89	104	15	0.90
Muskegon	904	917	13	0.95
Newaygo	222	245	23	0.95
Oakland	5,241	5,189	(52)	0.95
Oceana	130	113	(17)	0.95
Ogemaw	131	233	102	0.95
Ontonagon	76	110	34	0.90
Osceola	118	54	(64)	0.95
Oscoda	69	90	21	0.90
Otsego	111	154	43	0.90
Ottawa	874	796	(78)	0.95
Presque Isle	111	126	15	0.95
Roscommon	171	179	8	0.95
Saginaw	1,156	1,175	19	0.95
St. Clair	789	722	(67)	0.95
St. Joseph	355	369	14	0.95
Sanilac	269	287	18	0.95
Schoolcraft	72	75	3	0.90
Shiawassee	350	327	(23)	0.95
Tuscola	292	293	1	0.95
Van Buren	411	424	13	0.95
Washtenaw	1,032	1,285	253	0.95
Wexford	161	209	48	0.95
NW Wayne	3,166	3,153	(13)	0.95
SW Wayne	1,818	2,028	210	0.95
Detroit	6,297	5,983	(314)	0.95
STATE TOTAL	48,915	50,599	1,684	

Source: Michigan Department of Community Health

homes for the next four years.[19] Using existing beds, nursing facilities are permitted to establish "new design model" units either as a part of an existing facility or at a nearby location. The purpose of the change is to allow existing facilities to construct beds differently from the traditional two person rooms and reflect new designs such as the Eden Alternative. The Eden Alternative guidelines seek to improve the nursing home environment by giving it a homier atmosphere.

Urban/Rural Consideration. The occupancy requirement for bed need determination is 95 percent in urban counties and 90 percent in rural counties. (See Appendix B of Certificate of Need (CON) Review Standards for Nursing Home and Hospital Long Term Care Beds.) The relocation zone for rural counties is the planning area in which the county rests. In urban counties the relocation zone is a three-mile radius from the existing site. There is a special set aside of 257 beds for counties with a population density of less than 28 persons per square mile. See section 3(5)(a) of the Addendum for Special Population Groups.

Quality. There are not a great number of quality requirements in long-term care standards because these facilities are subject to federal and state licensure and certification.

Access. Nursing homes and long-term care units of hospitals are not required to participate in the Medicaid program. While current standards do not permit them to deny service based on ability to pay or the source of payment, legal interpretations suggest that this requirement will be deleted in the future.

Comparative Review. Long-term care beds are subject to comparative review.

3.) Clinical Services

As noted earlier, Michigan has CON review standards for 13 clinical services:

Air Ambulance[20]

Air ambulances are helicopters capable of providing treatment or transportation of a patient at or from the scene of an emergency. They are also used for transport of patients between two facilities.

Need & Methodology. In order to obtain a CON in Michigan an applicant must use a defined methodology to show that the service will transport at least 275 patients in months 7 through 18 after beginning operation and that at least 80 percent of these will result in admission to a hospital or the patient will die prior to admission. The basic information used in the methodology is the number of ground transportation emergency cases for which air transportation would have been more appropriate. Services wishing to add an additional helicopter must have had an average of at least 600 patient transports during the preceding 12-month period and must project at least 800 transports for the two aircraft during months 7 through 18 after approval. A CON is required for replacement, expansion and acquisition.

Urban/Rural. There are no differing requirements between rural and urban areas.

Quality. Service quality requirements are deemed met if the Commission on the Accreditation of Air Medical Services accredits the applicant as an air medical service. If the applicant is not accredited, the service may meet a series of requirements including employment of a physician with appropriate training and appropriately trained and licensed medical support, communications, flight operations and maintenance personnel.

Access. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter. An air ambulance service cannot deny service based on ability to pay or the source of payment.

Comparative Review. Air Ambulance applications are not subject to comparative review.

Cardiac Catheterization[21]

Cardiac catheterization is a diagnostic or therapeutic procedure during which a catheter is inserted into a vein or artery of the patient and manipulated by a physician into the chamber or vessels of the heart.

[20] Review standards can be found at: www.michigan.gov/documents/CON-228_CON_Rev_Stds_Air_Ambulance_Services_6-4-04_93577_7.pdf. Specific information on air ambulance services in Michigan can be found at Appendix A of the review standards.

[21] Review standards can be found at: www.michigan.gov/documents/CON-210_CON_Rev_Stds_Cardiac_Cath_Svcs_6-4-04_93530_7.pdf.

Need & Methodology. In order to obtain a CON for this service for adults, the applicant must project a minimum of 300 procedure equivalents in the second 12 months after initiation of the service. Applicants are required to specify how the volume projections were developed including a detailed description of data sources used, assessments of the accuracy of the data used and the statistical method used to make the projections. Procedure equivalents represent a way to account for the additional time and/or difficulty associated with certain types of catheterization. For example, a therapeutic cardiac catheterization in an adult is 1.5 the equivalent of an adult diagnostic catheterization and a therapeutic catheterization in a child is 3.0 equivalents of a diagnostic catheterization in an adult.

There are different equivalent requirements for a new surgical laboratory room if the service is in concert with open heart surgery and if the service is to be for pediatric (children's) care only. There are also additional requirements for a mobile cardiac catheterization network.

A CON is also required for replacement/upgrading and expansion.

Urban/Rural. There are differing requirements for the minimum number of services required for approval (See sections 4, 6 and 9 of the standards).

Quality factors include that: staffing levels are sufficient to permit regular hours of operation and continuous 24 hour on-call availability; that the governing body of the hospital receive reports at least annually describing complication rates, morbidity and mortality data, success rates and the number of procedures performed; and, each physician credentialed by the hospital to perform various cardiac catheterizations performs as the primary operator at least 100 adult diagnostic procedures per year in the second 12 months after having been credentialed, at least 75 therapeutic adult catheterization for the same period, and/or a minimum of 50 pediatric catheterizations for that period. A minimum of two credentialed physicians must be on the hospital staff.

Access. An applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter. Cardiac catheterization services cannot deny service based on ability to pay or the source of payment.

Comparative Review. Cardiac Catheterization applications are not subject to comparative review.

Computed Tomography (CT) Scanning[22]

CT scanning is an x-ray scanning system capable of performing either head or full-body patient procedures. CT scans can see inside the brain and other parts of the body that cannot be seen by regular x-ray examination.

Need & Methodology. Hospital applicants initiating a service must document the methodology used to demonstrate that the proposed unit will perform at least 7,500 CT equivalents in the second year after obtaining a CON and the hospital must provide 24-hour emergency care service. Applicants for a mobile CT scanner must document projections for at least 3,500 equivalents for the same period. Applicants are required to specify how the volume projections were developed including a detailed description of data sources used, assessments of the accuracy of the data used and the statistical method used to make the projections.

A CON must also be obtained to expand, replace or upgrade, relocate or acquire CT services.

Urban/Rural. Relocation requirements are different for of a fixed CT scanner. In an urban area relocation must be within a 10-mile radius of the current site while the rural standard is 20 miles.

Quality requirements include: appropriate training and experience of physicians and others operating the equipment; in the case of an urgent or emergency CT scan that an initial reading of the scan by a proper physician is accomplished in one hour; that there is a formal program of utilization review and quality assurance; and, that the applicant participates in data collection as established or administered by the Department of Community Health.

Access requirements include that: fixed CT scanners are available 24 hours a day if the service is located in a hospital; the acceptance of referrals for CT scans from all appropriately licensed practitioners; that services will not be denied on

[22] CT review standards can be found at: www.michigan.gov/documents/CON-212_CON_Rev_Stds_CT_Scanners_6-4-04_93532_7.pdf.

the ability to pay or source of payment; and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. CT Scanning applications are not subject to comparative review.

Magnetic Resonance Imaging (MRI) Services[23]

Magnetic resonance is the analysis of the interaction that occurs between radio frequency energy, atomic nuclei and strong magnetic fields to produce cross sectional images similar to those displayed by CT scanning but without the use of ionizing radiation. MRI is very helpful in examining soft tissue, such as organs, muscle, cartilage, ligaments, and tendons in many parts of the body. While x-rays are best for showing bones, MRIs can identify and show the difference between healthy and unhealthy tissue.

Need & Methodology. Applicants for a new MRI must demonstrate that the new MRI will perform at least 6,000 adjusted procedures for a fixed unit and 5,500 for a mobile unit from within its health planning area using methodology prescribed by the commission.

A CON is required for MRI expansion, replacement, relocation and acquisition.

Urban/Rural. The number of MRI adjusted procedures for mobile unit host sites are different for urban and rural areas. In urban areas, the minimum service requirements are 600 MRI adjusted procedures while the standard in rural areas is 400. An urban fixed site relocation must be within a five-mile radius while the rural standard is 10 miles. Effective July 12, 2004 a special provision allows a fixed MRI unit based on 4,000 or more adjusted procedures for a nonprofit hospital that: is located in a county with no fixed site; is more than 15 miles from another fixed MRI site; and, is currently a host site for a mobile unit. There are some 10 hospitals that could apply under these terms.

Quality requirements include: policies and protocols for MRI systems performance; policies and protocols for assuring the functionality of MRI accessories; assurance of safety for the general public, patients and staff; regular in-service training; scheduled preventive maintenance; and, appropriated training and credentialing of physician and support personnel. Participation in a data collection network established and administered by the Department of Community Health or its designee is required.

Access requirements include that MRI scanner services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. MRI applications are not subject to comparative review.

Megavoltage Radiation Therapy (MRT)[24]

MRT is a clinical procedure in which patients with cancer, other neoplasms, or cerebrovascular system abnormalities are treated with radiation that is delivered by a megavoltage radiation therapy unit.

Need & Methodology. Applicants for a new MRT unit must show that the MRT will perform at least 8,000 equivalent treatment visits (ETV – See Section 12) using the methodology prescribed by the Commission. If the applicant is a hospital with 90 or more licensed beds, is located in a rural county and is at least 60 miles from the nearest MRT unit, the minimum ETV requirement is 5,500. The number of new cancer cases documented by the Michigan Office of the State Registrar is the primary information used to determine MRT need.

A CON is required for MRT expansion, replacement or upgrade, relocation and acquisition.

Urban/Rural. As noted above, the minimum number of services to be provided differ by urban and rural areas.

Quality requirements include: the MRT must be operated by qualified physicians and/or radiation therapy technologists; a minimum of one physician staffing for each 250 patients; the immediate availability of a radiation physicist during hours of operation; and, the operation of a cancer

[23] MRI review standards can be found at: www.michigan.gov/documents/CON-213_CON_Rev_Stds_for_MRI_Svcs_6-4-04_93534_7.pdf.

[24] Review standards can be found at: www.michigan.gov/documents/MRT_16110_7.pdf.

treatment program which meets the standards of the American College of Surgeons Commission on Cancer.

Access requirements include that MRT services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need.

Comparative Review. MRT applications are not subject to comparative review.

Open Heart Surgery Services[25]

Open-heart surgery means any cardiac surgical procedure involving the heart and/or thoracic great vessels (excluding transplantation) intended to correct congenital and acquired cardiac and coronary artery disease and/or great vessels.

Need & Methodology. Applicants for a new open-heart surgery service must have a written consulting agreement with an existing service performing a minimum of 350 open heart surgical procedures per year and must demonstrate that the new service will perform at least 300 adult, or 100 pediatric surgeries per year by the third year. The projections must be made in accordance with CON Commission defined methodology. The methodology uses the hospital's latest data from the Michigan Hospital Data Base system maintained by the Michigan Health and Hospitals Association and selects appropriate diagnoses to determine the need for open-heart surgery services. (See sections 8, adult, and 9, pediatric.)

Urban/Rural. There are no differing requirements between rural and urban areas.

Quality requirements include that each physician credentialed by the hospital for adults must perform a minimum of 50 surgeries each year and the design and implementation of a process that measures, evaluates and reports the clinical outcomes of the service including mortality rates, complication rates, success rates and infection rates at least annually. Participation in a data collection network established and administered by the Department of Community Health or its designee is required.

Access requirements include that open heart services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The standard for Medicaid participation for surgical services is pending adoption.

Comparative Review. Open-heart surgery applications are not subject to comparative review.

Positron Emission Tomography (PET) Scanner Services[26]

PET scanner means an FDA approved full or partial ring scanner or coincidence system that has a crystal at least 5/8-inch thick, techniques to minimize or correct for scatter and/or randoms and digital detectors and iterative reconstruction. It provides unique information, not available through MRI or CT scans, on the viability and normality of sick tissues or organs.

Need & Methodology. Applicants for new PET scanners must project a use rate of 2,600 PET data units per year for a fixed unit and 2,100 per year for a mobile unit. The basis on which projections are made is defined by the commission and relate to the number of cancer cases, diagnostic cardiac catheterizations and intractable epilepsy cases experienced in the service area.

Urban/Rural Mobile PET units proposed for urban areas must meet a minimum PET data unit standard of 360 while those proposed to rural areas have a standard of 240.

Quality requirements include: a standing medical staff and governing body that provides administrative control of the ordering and utilization of PET scans; staffing that assures a physician with appropriate training and familiarity with the PET procedures and interpretation screens requests for its use; staffing for the use and maintenance of the scanner is composed of qualified personnel; and that the service has necessary supplies, personnel and equipment to handle an emergency. Participation in a data collection network established and administered by the Department of Community Health or its designee is required.

---

[25] Open-heart surgery review standards can be found at: www.michigan.gov/documents/CON-208_CON_Rev_Stds_Open_Heart_Surgery_Svcs_6-4-04_93528_7.pdf.

[26] PET review standards can be found at: www.michigan.gov/documents/CON-227_CON_Rev_Stds_PET_Scanner_Services_6-4-04_93541_7.pdf. A CON is required for PET expansion, replacement or upgrade, and acquisition.

Access requirements include that PET scanning services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. PET applications are not subject to comparative review.

Surgical Services[27]

Surgical services provided in a hospital, freestanding surgical outpatient facility (FSOF), or ambulatory surgical center hospital are subject to CON.

Need & Methodology. Applicants for a new surgical service must demonstrate that each operating room will average at least 1,200 cases per year in the second 12 months of operation and annually thereafter. Applicants must document the projections and specify how the projections were developed.

A CON is required for surgical services expansion, replacement or upgrade, relocation and acquisition.

Urban/Rural. There are different minimum service levels for applicants seeking to replace surgical services in urban areas from those for rural areas. Relocation must be within a 10-mile radius in urban counties and 20 miles in rural counties.

Quality requirements include: facilities must have established procedures for the selection of patients and delineate procedures which may be performed at the particular facility; provision for the handling of emergencies including cardiopulmonary resuscitation must be established; outpatient facilities must have policies which permit the hospitalization when necessary; written position descriptions of all personnel including education and other requirements must be in place; and written policies and procedures for informing patients of their rights must be established.

Access requirements include that surgical services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. Medicaid participation requirements for surgical services are pending adoption.

Comparative Review. Surgical services applications are not subject to comparative review.

Bone Marrow Transplant[28]

Need & Methodology. Applicants for a bone marrow transplant service CON must specify whether the transplant service will be for either or both adult or pediatric patients and name the hospital in which the service will be located. Projections for the number of services to be provided must be at least 10 in the third year after initiation of the service. Applicants must demonstrate that the addition of the service will not result in more than three adult bone marrow transplant services in the state or more than two pediatric units in health planning areas 1, 2, 5, 6 and a portion of 7 (Alcona, Alpena, Cheboygan, Crawford, Montmorency, Oscoda, Otsego and Presque Isle), or one pediatric unit in areas 3, 4, 8 and the remainder of area 7 (See **Map 1**).

Urban/Rural. The bone marrow transplant planning areas reflect urban/rural considerations.

Quality requirements include: that the hospital provide each of an extensive list of medical services; that implementation plans for the initiation of the services is submitted; that a new service has a consulting agreement of at least three years with an existing bone marrow transplantation service; and that policies and procedures are in place to assure the service is performed by appropriate personnel and in accord with defined procedures.

Access requirements include that services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. Bone marrow transplant services applications are subject to comparative review.

[27] Surgical services standards can be found at: www.michigan.gov/documents/Surgical_16119_7.pdf.

[28] Review standards for bone marrow transplant services can be found at: www.michigan.gov/documents/CON-229_CON_Rev_Stds_Bone_Marrow_Transplantation_Svcs_6-4-04_93547_7.pdf.

Heart/Lung and Liver Transplantation Services[29]

Need & Methodology. Applicants for a new heart or heart/lung transplantation service CON must propose service in a planning area with no more than two current such services and must project a minimum of 12 heart or heart/lung or lung transplants during the second year of operation. These same requirements pertain to a new liver transplant service provider. Additionally, a heart or heart/lung applicant must demonstrate that the hospital performs at least 300 and/or 100 pediatric open-heart procedures annually and a cardiac catheterization service that provides at least 500 adult and/or 250 pediatric cardiac catheterization and coronary arteriograms annually.

Urban/Rural. There are no differing requirements between rural and urban areas.

Quality requirements include: the provision of certain services or programs deemed necessary for support or provision of the type(s) of transplants; a written agreement with Michigan's federally designated organ procurement organization to promote organ donation at the hospital; participation in the education of the general public and medical community about transplantation including the provision of organ donation literature in public areas of the hospital; an active formal multi-disciplinary transplantation research program; maintenance of a transplant registry; and participation in a data collection network established the Department of Community Health or its designee.

Access requirements include that services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. Heart/lung and liver transplantation services applications are subject to comparative review.

Pancreas Transplantation Services[30]

CON requirements for pancreas transplantation services are similar to those for heart/lung and liver transplants noted above but are contained in a separate standard.

Comparative Review. Pancreas transplantation services applications are not subject to comparative review.

Urinary Extracorporeal Shock Wave Lithotripsy Services (UESWL)[31]

Urinary Extracorporeal Shock Wave Lithotripsy is the removal of kidney stones by use of shock waves that pulverize stones so that they can pass through the urinary tract.

Need & Methodology. Applicants for a new fixed or mobile service must project 1,000 procedures per unit per year on the basis of defined methodology. Projections are based upon actual discharge data involving kidney stones for the hospitals to be served by the applicant. Those wishing to expand services must demonstrate that at least 1,800 procedures per unit occurred during the most recent year for which verifiable data is available.

A CON is required for UESWL expansion, replacement or upgrade, relocation and acquisition.

Urban/Rural. An adjustment factor is used in the need methodology that differentiates between urban and rural applicants. There is also a special provision for a mobile UESWL based in a rural county that operates predominantly outside the State of Michigan.

Quality requirements include: on-call availability of an anesthesiologist and a surgeon; on-site advanced cardiac life support; appropriate training and credentialing of personnel; and, review by the medical staff and governing body of reports describing the activities of the UESWL service including complication rates, morbidity data, and retreatment rates.

---

[29] Review standards for heart/lung and liver transplant services can be found at www.michigan.gov/documents/CON-209_CON_Rev_Stds_Heart_Lung_&_Liver_Transplantation_Svcs_6-4-04_93529_7.pdf.

[30] Review standard for pancreas transplantation services can be found at: www.michigan.gov/documents/CON-226_CON_Rev_Stds_Pancreas_Transplantation_Svcs_6-4-04_93539_7.pdf.

[31] UESWL standards can be found at: www.michigan.gov/documents/CON-202_CON_Rev_Stds_for_UESWL_Svcs_6-4-04_93524_7.pdf.

Access requirements include that services will not be denied on the ability to pay or source of payment and that services are provided to any individual based on clinical indications of need. The applicant must participate in Medicaid at least 12 consecutive months within the first two years of operation and annually thereafter.

Comparative Review. UESWL services applications are not subject to comparative review.

Health Care Bed and Services Data 1996 - 2000

Table 6 shows the number of services by service type by Michigan providers under CON for the years 1996 – 2000 expressed as a per capita rate. Data for the absolute numbers and rates statewide and for each of the Health Service Areas can be found in **Appendix F**.

Of the services for which there is data, five declined in use per 1,000 or 100,000 population during the period while rates for nine increased. MRI visits are not shown because data is not comparable. The Department of Community Health indicates that the most rapidly growing services since 2000 are those of magnetic resonance imaging (MRI) and positron emission tomography (PET) scanning.

Health Care Equipment Counts

Currently there are the following numbers of equipment in Michigan:

Computed tomography (CT)	316
Magnetic resonance imaging (MRI)	102
Positron emission tomography (PET)	16
Megavoltage radiation therapy (MRT)	153
Lithotripters	10

Table 6
Statewide Rates for Selected Medical Services Covered by CON

Item	Rate per 100,000 or 1,000 (P) Michigan Population					Percent Change 1996 to 2000 (1997 to 2000 for Surgical)
	1996	1997	1998	1999	2000	
BEDS:						
General Hospital Beds*	3.13	3.14	3.06	2.91	2.81	(10.33)
Psychiatric Hospital Beds:						
Inpatient						
Specialized children/adolescent care						
Neonatal Intensive Care Beds	6.19	6.34	6.45	6.37	6.34	2.42
Long-term Care Beds						
Long-term Care Special Population Beds						
SERVICES:						
Cardiac Catheterization* (Includes Diagnostic and Therapeutic Sessions)	12.29	10.80	10.47	10.43	10.81	(12.05)
Computed Tomography (CT) Scanners (Fixed ONLY)	1.81	2.12	2.18	2.25	2.27	25.37
Computed Tomography CTE (Includes Mobile)* (Weighted by CON Weights)	136.45	146.32	153.00	171.18	189.84	39.13
Magnetic Resonance Imaging (MRI) Visits* (Data for 1996, 1997, and 1998 Excludes Freestanding)	16.10	17.93	20.39	n/a	39.08	
Megavoltage Radiation Therapy ETV* (Weighted by CON Weights)	63.85	67.78	71.34	71.26	70.46	10.36
Open Heart Surgery	166.13	166.51	166.25	160.47	156.82	(5.61)
Positron Emission Tomography (PET) Visits	18.33	19.60	22.99	26.41	29.35	60.10
Surgical Services - All ORs: (Excludes dedicated Endoscopy/Cystoscopy data in 1996)	11.00	11.83	11.83	11.69	11.71	(0.96)
Cases* (Excludes dedicated Endoscopy/Cystoscopy data in 1996)	88.27	94.04	98.06	100.25	99.37	5.66
Kidney Transplant	4.42	5.57	4.66	4.95	5.07	14.82
Heart/Lung and Liver Transplant	1.98	1.69	1.94	1.93	2.19	10.91
Pancreas Transplant	0.37	0.32	0.11	0.11	0.16	(56.36)
Urinary Extracorporeal Shock Wave Lithotripsy (UESWL)	53.63	58.81	54.56	57.80	65.41	21.96

* Rate Per 1,000 Michigan Population

Source: Population Division U.S. Census Bureau, Release Date: April 17, 2002

CON Issues

Cost, Quality and Access

Cost

There is difficulty in assessing the impact of CON on health costs in Michigan. The CON Commission reports on the amounts approved, approved with conditions and disapproved each year. Because the Michigan CON standards are relatively straight forward, applicants can often determine in advance whether their request will be approved or not. Many other states operate with standards that are less well defined and applications are more subject to interpretation and value judgments. For this reason, interstate comparisons of CON approvals, modifications and rejections are not meaningful.

The Michigan results for fiscal years 1998-2003 are shown in **Table 7**.

These figures do not reveal the total effect of CON on health costs in Michigan. They show the capital outlay dollar amounts of CON approvals and disapprovals by year but they do not account for how CON impacts provider decisions to initiate, change, delay or forgo providing services covered by CON. The cost savings of this chilling effect have not been quantified. Figures do not reflect the potential impact on ongoing operating and maintenance costs savings resulting from the process.

Somewhat conflicting analyses of the cost effect of the Michigan CON program have been performed.

DailmerChrysler, Ford Motor Company and General Motors report that comparing their per capita costs by state by state, all three companies found that their health care costs were lower in states with CON programs than in states without CON.[32] (See **Attachment G**.) All express support for the continuation of CON in Michigan. They note that their findings are based upon comparable health care data because company benefits do not differ from state to state and there is some standardization for gender and age. Macro-level analyses are made difficult because of differing health benefit plans within states, varying demographics, and health status of the population.

Professors Conover and Sloan found that "upon reviewing a large body of national and Michigan-specific material regarding acute care CON, including an analysis of what happened in states that dropped acute care CON…There is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[33]

Quality

As noted, CON standards contain quality requirements. These range greatly with greater or lesser dependence on certifications or accreditations by other governmental and non-governmental licensing and reviewing agencies. There are few detailed requirements for acute care hospitals where reliance is placed on accreditation by the Joint Commission on Accreditation of Health Care Organizations,[34] while quality standards for a cardiac care service are quite detailed.

The most significant impact of CON on quality outcomes, according to Professors Conover and Sloan, occurs in cardiac catheterizations (CCs) and open heart (OH) surgery. "With respect to quality, both the key informant interviews and literature suggest that there is a solid volume-quality relationship for both CCs and OH surgeries, with mortality rates for the latter being reduced by 20 percent or more in high-volume facilities."[35] The authors find that for other services included in the report the quality impact of CON is less clear.

With the recent movement of health care licensing from the former Department of Consumer and Industry Services to the Department of Community Health (DCH) both facility and health professions licensing is the responsibility of DCH. This may be an opportune time to examine whether the quality requirements now present in CON

[32] The findings are available on the Department of Community Health Web page as Addendum J to the Conover/Sloan report. www.michigan.gov/documents/CON_Volume_II_Appendices_J_-_L_81600_7.pdf.

[33] www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771—,00.html (p. 127)

[34] www.jcaho.org/

[35] www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771—,00.html (p. 131)

Table 7
CON Approvals and Disapprovals, 1998-2003

Year	Approved	Approved with Conditions	Disapproved	Total	Percent Approved or Approved With Conditions	Percent Disapproved
Number of Final Decisions						
1998	185	1	9	195	95.38%	4.62%
1999	178	6	2	186	98.92%	1.08%
2000	153	11	4	168	97.62%	2.38%
2001	182	4	12	198	93.94%	6.06%
2002	210	6	8	224	96.43%	3.57%
2003	240	25	3	268	98.88%	1.12%
Total Project Costs						
1998	$ 853,035,470	$ 50,000	$ 8,496,000	$ 861,581,470	99.01%	0.99%
1999	461,603,485	42,956,484	246,910	504,806,879	99.95%	0.05%
2000	467,085,573	16,666,330	5,818,762	489,570,665	98.81%	1.19%
2001	974,220,693	3,205,149	9,316,888	986,742,730	99.06%	0.94%
2002	1,030,698,218	11,898,680	22,141,586	1,064,738,484	97.92%	2.08%
2003	992,397,822	$7,078,656	700,000	1,070,176,478	99.93%	0.07%

Source: Michigan Department of Community Health

would be better placed in the licensing and regulatory function of DCH. In some instances it appears that the CON requirements could be unenforceable through the CON program. The cardiac care standards require that "each physician credentialed by a hospital to perform adult diagnostic cardiac catheterizations shall perform, as the primary operator, a minimum of 100 adult diagnostic cardiac catheterizations per year in the second 12 months after being credentialed to perform procedures at the applicant hospital, and annually thereafter." It is not clear that actions available to the CON program against a hospital for the failure of a physician to meet this requirement would be enforceable.

There appears to be no significant objection to the quality standards established for CON covered services. Many health care professionals and concerned organizations support them although some argue that it could be advantageous to have the process include a greater degree of disinterested input. Current practice tends to rely on provider participation. In many cases they are standards set by national organizations and represent currently defined best practices. They often represent requirements above and beyond licensing and certification law and regulation and are considered to contribute to improved service quality. A review of the role of state government in setting quality standards for medical care and the best way in which to accomplish this could lead to a more comprehensive and cohesive approach for Michigan.

Access

The only direction for the geographical location of CON covered services is that they result in reasonable access by Michigan residents. There are no specific mileages or time standards in current standards but the Commission is considering the establishment of these in the acute care hospital standards through work with the Geography Department at Michigan State University. Areas of the state where more than 50,000 people are not within 30 minutes of a hospital with an active emergency department have been identified as limited access areas, but it is not clear that a new facility could be financially viable and/or located so that there did not remain a portion of the 50,000 still more than 30 minutes from the new hospital.

[36] www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771—,00.html (See pages 128 & 130 of Conover, Sloan Report)

Professors Conover and Sloan found that the strongest case for continuing CON for acute care hospitals related to access. They also note that CON for MRI services appears to have improved access in rural areas while access is suburban areas is almost certainly less than it would be without CON.[36]

Act 619 of 2002 requires, that with the exception of nursing home and hospital long-term care units, all CON standards must contain a requirement each applicant participate in the Medicaid program.

Again with the exception of nursing home and hospital long-term care units, all standards require that "to assure appropriate utilization by all segments of the Michigan population" applicants shall: not deny services based on ability to pay or source of payment; provide services to all individuals based on the clinical indications of need for the service; and, maintain information by payor and non-paying sources to indicate the volume from each source provided annually. Staffing levels for the CON program preclude the regular review of this requirement for all CON recipients. The revised annual hospital survey will request this information of hospitals.

CON and Acute Care Hospitals

The issue that has caused the most concern recently is that the standards for acute care hospital CON precludes hospitals from establishing new beds outside the subarea where a current hospital is located. This is because there is no need for additional acute care beds and CON standards state that no hospital can relocate beds outside the subarea in which a current hospital is located. Act 619 of 2002 contained exemptions permitting certain hospitals to relocate beds outside their subarea. (See page 11.)

Relocation of Detroit Hospital Beds

In debating the CON amendments passed as Act 619 of 2002, the legislature addressed concerns of two Detroit hospital systems that their inability to relocate beds to suburban areas had a significant impact on their ability to remain financially viable. There are a relatively high number of individuals in Detroit who have no insurance, very limited insurance or who are Medicaid eligible. Across the state, costs incurred by hospitals exceeded Medicaid payments by some $200 million during the State of Michigan Fiscal Year 2000.[37] Losses due to uninsured patients are most significant in Southeast Michigan. Health Services Area 1, including the City of Detroit, experienced uninsured and uncompensated care losses totaling $313.2 million in FY2000. Some $186 million of this occurred in the City of Detroit. The amount for the rest of the state was $143.0 million.[38]

The Henry Ford and St. John systems stated that they are disadvantaged because they could not move beds from Detroit to facilities they owned in Oakland County where the greater number of insured patients would result in surpluses that could help to offset their losses in Detroit. At the time Act 619 was passed, they were joined by the Detroit Medical Center although the Center does not now support the relocation of beds from the city.

Suburban hospitals argued against the relocation language in Act 619 saying that hospitals should go through the regular CON process to request beds rather than seeking an exception through legislative intervention.

Henry Ford and St. John submitted documents to the DCH under the terms of Act 619 requesting the relocation of 300 and 200 beds respectively. The DCH Director issued a letter of authorization on March 3, 2004, to proceed effective upon the issuance of a final court order favoring Henry Ford and St. John or one year from the date of the approval letter – March 3, 2005.

The contingency in the approval letter resulted from a lawsuit filed by William Beaumont Hospital, Trinity Health System, Botsford General Hospital, Covenant Medical System and Mount Clemens General Hospital, and three metropolitan Detroit residents filed in Ingham County Circuit Court to stop the provision from taking effect. In July

[37] See CRC Memorandum 1069: www.crcmich.org/PUBLICAT/2000s/2002/memo1069.html

[38] See CRC Memorandum 1061: www.crcmich.org/PUBLICAT/2000s/2002/memo1061.html

2004, the court issued a ruling stating that the plaintiffs did not have legal standing to challenge the projects. The plaintiffs have filed appeals.

Proposed Hospital Relocation Standard. The DCH submitted a proposed amendment to the CON hospital standards for consideration by the CON Commission. The Special Bed Allocation is offered: "To address critical problems of a 35 percent increase in Medicaid within the last four years, the closure of significant numbers of community hospitals within urban areas, and to promote the continued viability of large urban hospitals that are experiencing unsustainable increases in uncompensated care and adverse payer mix..."

A pool of 689 beds would be established above and beyond those determined as needed by current the standard, but hospitals would be required to delicense an equal number of beds within its hospital system or at an individual hospital. Applications would be accepted from hospitals or health care systems owning a hospital in a combined metropolitan statistical area to create or expand a licensed hospital subject to certain conditions that include: the application cannot be for more than 300 beds; beds created must be in the same health service area (see **Map 1**, page 20) as the applicant; only one application can be submitted by a hospital system; and the system would not increase its total number of licensed beds or move more than 35 percent of its licensed beds from any individual hospital. Equally weighted criteria to be used in evaluating applications would include: the number of Medicaid eligible persons in the county where the largest hospital in a system is located; the number of Medicaid eligibles served from the health services area of the largest hospital; the percentage of Medicaid eligible persons compared with Medicare and other insured persons of the individual hospital or hospital system; the amount of direct government subsidy allocated to the applicant over the last three years; the amount of Disproportionate Share Payments received by the individual hospital or system; the capital cost of beds being moved; the extent of financial benefit to the financial viability of the individual hospital or system; the individual hospital or system's documented direct involvement and support with Federally Qualified Health Centers over the last three years; and the extent of hospital closures over the last five years within the metropolitan county served by the applicant's largest hospital."

A second pool of 200 beds would also be created in the City of Detroit to permit the movement of active licensed beds from any hospital within the city to re-establish a community hospital at a previously licensed hospital site provided the move does not result in an increase in the number of active licensed beds in the City.

The CON Commission referred the proposal to its Hospital Standard Advisory Committee on June 15, 2004. That body has recommended that the Commission not adopt the proposal.

High Occupancy Hospitals

On March 11, 2003, the CON Commission amended the CON Standards for Hospital Beds by adding a new item 4 to Section 6 which took effect on May 12, 2003. It established a time limited pilot program – applications were accepted until November 30, 2003 – permitting hospitals to apply for additional beds if all of the following conditions were met: the beds being added are at the existing hospital site and the applying hospital has operated for the previous 12 consecutive months at a occupancy of 80 percent or above for a hospital with fewer than 300 licensed hospital beds or at 85 percent or above if licensed for more than 300 licensed beds.

The number of beds that could be approved was limited to that number that reduces the occupancy rate to 75 percent for hospitals with fewer than 300 licensed beds and to 80 percent for those with more than 300 licensed beds.

Applicants were not subject to comparative review.

The rationale for the pilot provision was that certain highly used hospitals should be permitted to expand even though located in an area that is over bedded. There was no provision that the applicants provide evidence that other hospitals in the area would reduce beds by the same number. Two hospitals applied for and received additional beds under the pilot: Beaumont Royal Oak received a CON for 94 beds and Beaumont Troy for 28.

A revision making the high occupancy provision permanent is pending action by the CON Commission.

CON and Other Medical Services

Other services areas that have received attention recently are surgery centers, MRI and other imaging services, and cardiac catheterization. There is interest by some providers to expand services. While issues of quality and access are a part of the discussions, the focus of attention is often financial. There is little likelihood that these services would be expanded if they did not bring favorable financial results. Those concerned with containing costs resist the expansions.

The federal Medicare Modernization Act addressed the rapid growth of specialty hospitals, sometimes called "boutique" hospitals. Congress placed an 18-month moratorium, ending in June 2005, on Medicare payments to any physician who has a financial relationship with a specialty hospital for services provided by that physician in that specialty hospital. Specialty hospitals were defined as those "primarily or exclusively engaged in the treatment of: patients with a cardiac condition; patients with an orthopedic condition; patients receiving a surgical procedure; and, any other specialized category of services that the Secretary of Health and Human Services designates as inconsistent with the purpose of permitting physician ownership and investment interests under this section." The section generally prohibits physicians and their immediate family from billing Medicare for services provided in a facility with which they have a financial relationship.

Reimbursement Policy and CON

There are a myriad of reasons why certain medical services are reimbursed more favorably than others. Part of the explanation is historic, part is the result of Medicare changes that have not been continuously updated, and part is the result of new technologies. "Boutique" hospitals would likely not be increasingly proposed if payment for services provided in them were not favorable. Health services that are not economically desirable put lesser pressure on CON than those that are.

Compliance

All standards require recipients of a CON to meet ongoing standards over time. In those cases where a certificate of need is granted based upon submission of data by the applicant rather than on data collected by a third party, there is no regularly scheduled post certification review to determine if the standards are being met. The same is true of ongoing requirements for CON recipients.

Applicants for a new CON are tested for compliance as a part of the review process.

The Auditor General report of April 2002 details compliance review findings in item five determining that:

CON Review Standard	Number of Facilities Reviewed	Number of Facilities Not Meeting Project Delivery Requirements	Percent
Surgical	217	58	27%
Cardiac catheterization	66	5	8%
Pancreas transplants	2	1	50%
Megavoltage tomography	188	27	14%

The Auditor General also found that the Division for Vital Records and Health Statistics of DCH collected compliance information for MRI certification but that the CON program did not routinely use this information to monitor compliance.

The CON Commission concurred with the findings and responded that staff shortages affected the ability to address the issue. At the time of the Auditor General report there were 10 full time equivalent positions in the CON program. As of January 2005 there were 10. Funds for an additional four staff would come from increased fees contained in Public Act 469 of 2004 which became effective on December 28, 2004.

Adding or Deleting Services from the Michigan CON Program

The Commission will address the question of adding or deleting services from CON as part of its comprehensive recommendations required by Act 619 due to be submitted in January 2005. The report has not been issued as of the publication of this report.

Legislative Action in Setting CON Requirements or Standards

The legislature has amended CON law from time to time. Until Act 619 of 2002, changes largely focused on the services to be covered, the composition and authority of the Commission and the way in which standards are set. Act 619 exempted the relocation of certain hospital beds from CON, grandfathered certain hospital operating rooms into CON compliance and permitted the addition of an MRI unit in St. Clair County. Some feel that the nature of the CON program itself was largely responsible for keeping disputes from legislative action. Others think that the financial downturn after the 1990s brought a new level of financial distress to providers who sought to expand services with favorable financial outcomes by direct legislative intervention.

There were four bills (SB 0807 and its companion HB 5213, HB 5975 and HB 6045) introduced in the last legislative session that would have exempted certain services from CON coverage. None passed.[39]

Court Intervention in CON

Early in the program's history, there were a number of lawsuits contesting CON decisions. Many of these were filed by hospitals that did not receive a CON in a comparative review. Act 332 of 1988 was passed in large measure to address difficulties identified as a result of courts' decisions and the revisions did result in a significant lessening of court involvement. The relocation provisions of Act 619, challenged unsuccessfully in Ingham County Circuit Court, are now the subjects of appeal to higher courts.

[39] www.michiganlegislature.org/

Public Policy Questions

What is the role of the State of Michigan in health care?

Constitution. Article IV, Section 51 of the Michigan Constitution states that "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health." Article VII, Section 23 provides that "Any city or village may acquire, own, establish and maintain within or without its corporate limits, parks, boulevards, cemeteries, hospitals and all works which involve the public health or safety." Article IX, Section 36 requires that six percent of the proceeds from the tax on tobacco products be dedicated to improving the quality of health of the residents of this state. There are no other references to health in the Constitution.

The details of Michigan's public policy on health care is thus a product of legislative action or voter initiative or referendum and not a matter of constitutional obligation.

Michigan Public Health Care Policy can be generalized as:

- Administering and financially supporting public and mental health programs at the state and local levels
- Supporting health and health profession education
- Promoting health education and individual responsibility
- Regulating health insurance
- Administering the federal Medicaid, food stamp, women's, infants and children (WIC) nutrition programs and school lunch programs
- Regulating environmental health hazards
- Regulating dairy and food operations
- Licensing and certifying health care providers
- Limiting, defining and affecting access to Michigan health services through the CON program.

In appropriations for FY 2005, health spending is second highest only to education (See **Table 8**). Of $39.2 billion appropriated, education and health programs each total some $12.5 billion – each nearly one-third of total spending.

It is estimated that the health insurance costs for active school employees paid from the School Aid Fund is $1.2 billion. If that amount is included on the health portion of 2005 spending the respective amounts would be: health $13.7 billion and education $11.3 billion.

Major Michigan programs aimed at health care access are: the CON program; support for medical education; and projects designed to improve the number of health care workers in Michigan; and, Medicaid. The Medicaid pro-

Table 8
Health Spending vs. School Aid
State of Michigan
Fiscal Years 2001 and 2005

	FY 2001 Actual*	FY 2005 Appropriated
Gross Spending	$37,277.0	$39,236.5
School Aid**	$10,958.8	$12,527.4
DCH	$ 9,024.8	10,103.2
Health/Vision/Dental Insurance***	1,245.1	1,700.0
All Other***	710.9	710.9
Health Total	$10,980.8	$12,514.1
Health as a Percent of School Aid	100.2%	99.9%

* Appropriated for Health/Vision/Dental Insurance and All Other
** 2001 actual does not include federal funds reflected in 2005
*** Estimated for 2005

Source: State appropriation acts, CRC estimates.

gram provides financial access to health services for the 1.4 million persons now enrolled in that program – some 14 percent of state residents.

In the past year, the State, the City of Detroit, and Wayne County have provided leadership to establish a new Detroit Wayne County Health Authority designed to help ensure that uninsured and underinsured residents in Detroit and Wayne County have access to quality health care.

Recent Governmental Initiatives. One state – Maine – has initiated a state plan to provide health care to all citizens either through traditional insurance companies or in another fashion. The Dirigo Health Plan is a set of reform initiatives with a goal of providing all Maine people with access to health care by 2009.[40]

In response to a request from the Secretary of the Department of Health and Human Services, the Institute of Medicine convened a committee to identify possible demonstration projects that might be implemented in 2003, with the hope of yielding models for broader health system reform within a few years. Among the recommendations was that the federal government sponsor three to five states in making health insurance coverage available to all citizens.[41]

The most vital health care services are emergency and acute hospital care. As noted, Michigan does not explicitly take responsibility for the reasonable availability and accessibility of these services. Many hospitals have closed in recent years and many local governments, including the City of Detroit and Wayne County have ceased to operate hospitals. In Fiscal Year 2003-04, the State took unusual action by authorizing up to $50 million to assist the Detroit Medical Center provided that $7 million in local funds were received from the City of Detroit and Wayne County. The local funds were made available.

Two states are formally involved in providing assistance to financially distressed hospitals without the use of state funds. Both New York and Massachusetts operate a funding pool supported by health care providers that is used to make payments to hospitals with high amounts of uninsured care.[42] New York generated $2.3 billion in FY 2004 from health services fees to support its Public Goods Pool of which $875 million was used for Indigent Care. The Massachusetts Uncompensated Care Pool amount for FY 2003 was $345 million, all of which was distributed for uncompensated care.

The State of Connecticut prepares and publishes an analysis of the financial status of its hospitals every year as information for interested parties.[43]

The State of North Carolina has reporting requirements for local governments that extend to hospitals. Financial statements filed with the State are used to review financial conditions and check compliance with applicable laws.[44]

Is it time to reconsider the methodology for acute care bed need?

The methodology for establishing acute care hospital need is based on beds and has remained essentially unchanged since the program's inception over 30 years ago. With the exception that virtually all hospitals in Michigan remain non-profit institutions, almost everything else about acute hospital care has changed. Hospital stays have shortened and more people avoid hospitalization altogether; the intensity and specialization of care has increased; some beds are now specialized and are not interchangeable; technology has improved diagnosis and treatment; concerns about quality and safety are better quantified and reported; reimbursement methodology has changed dramatically; there has been a consolidation of many hospitals into systems; the cost of care for the uninsured has risen sharply; and, more comprehensive data is collected and analyzed by increasingly sophisticated systems.

One view suggests that it is time to approach acute care hospital CON on the basis of the need for defined hospital services (See **Appendix H**). Professor Griffith was one of the authors of the original methodology used to determine acute hospital bed need when the Michigan CON

[40] www.dirigohealth.maine.gov/dhlp01.html

[41] See committee recommendations at www.crcmich.org/PUBLICAT/2000s/2005/FosteringRapidAdvances.pdf

[42] See New York: www.health.state.ny.us/nysdoh/hcra/reports/statewide/swins.htm and Massachusetts: www.mass.gov/dhcfp/pages/dhcfp_22.htm.

[43] www.ohca.state.ct.us/Publications/FSReport2002revised3.pdf

[44] http://www.treasurer.state.nc.us/NR/rdonlyres/7368C3A1-4040-4F33-AA70-F2E7B57DC049/0/Memo1008.pdf)

program began and has followed the program over the intervening years. An applicant would request a CON for a specific health service based on: an objective analysis of the future demand for the service; the market share the hospital anticipates and the impact this would have on other hospitals; the revenues generated and the expenses incurred by the service; and, the commitment to meeting national standards of care for the service. Also included would be measures of overall institutional performance on quality, cost, patient satisfaction and financial viability as well as a requirement that data on the hospital's contribution to the community be a part of the application and be released annually.

Does CON contribute to the financial viability of hospitals by limiting competition?

CON limits competition between hospitals and those who in the absence of CON might choose to begin, expand or relocate services. Without CON, many financially favorable services now carried out in a particular hospital could be offered in other settings owned and operated by other organizations or individuals.

In recent years Ohio, Indiana and Missouri have removed many services from CON including hospitals, MRI and other imaging. A study of the effects these changes have had in those states could be instructive for Michigan which shares some of their characteristics.

Should Michigan consider a more direct means to address access and financial issues raised by the disproportionate amount of uninsured and uncompensated care provided among hospitals?

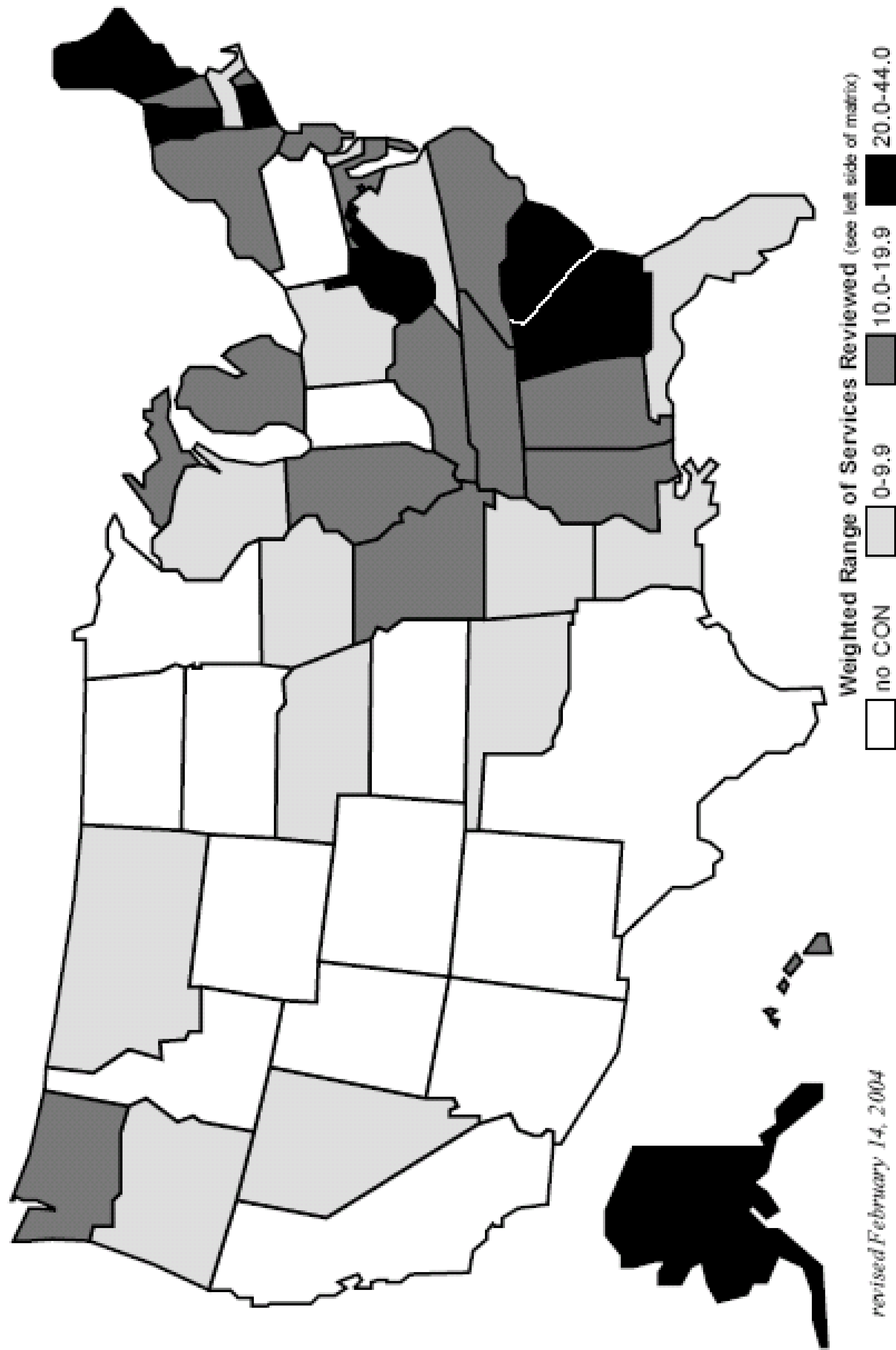
The reports of Professors Conover and Sloan and of the Federal Trade Commission/Department of Justice note that CON does play a limited role in providing access to the uninsured. Both also suggest that the issue would be better addressed directly rather than as an aspect of CON.

Summary

There is no clear analysis concluding that CON should be continued or repealed in its entirety. As professors Conover and Sloan state: evidence provided by their report "does not provide unambiguous evidence that acute care CON in Michigan has failed and should be ended; nor does it provide uncontestable proof that CON has succeeded in its objectives and should be unequivocally retained. What all sides might be able to agree upon is that the program can and should be improved so that it attains its objectives in the most effective and equitable fashion." (Page 132)

Many in the business community, labor unions and hospitals support CON. Those who believe that traditional market supply and demand forces do not work in health care as in other aspects of the economy because consumers often pay but a fraction of the cost and don't have sufficient information to make decisions based on cost and quality support CON. Those who do believe that the health services market is like most others, generally oppose it.

Appendix A



Source: American Health Planning Association's National Directory for 2004

Appendix A (continued)
State Certificate of Need Review Thresholds (in dollars)

State	Capital	Equipment	New Service
Alabama	4,108,000	2,054,000	any
Alaska	1,000,000	1,000,000	1,000,000
Arkansas	500,000 NH	n/a	0
Connecticut	1,000,000	400,000	0
Delaware	5,000,000	5,000,000	n/a
Dist. of Columbia	2,500,000	1,500,000	600,000
Florida	None	None	any
Georgia	1,280,204	711,225	any
Hawaii	4,000,000	1,000,000	any
Illinois	6,543,050	6,293,090	any
Iowa	1,500,000	1,500,000	500,000
Kentucky	1870973	1870973	n/a
Louisiana	not applicable	n/a	any LTC/MR
Maine	2,400,000	1,200,000	110,000 capital
Maryland	1.55 million	n/a	any
Massachusetts	10,651,247	568,066	all
Michigan	2,500,000	any	any clinical
Mississippi	2,000,000	1,500,000	any
Missouri	0.6/1.0 M	0.4/1.0 M	1,000,000
Montana	1,500,000	n/a	150,000
Nebraska	LTC	n/a	n/a
Nevada	2,000,000	n/a	n/a
New Hampshire	1,924,579	400,000	any
New Jersey	1,000,000	1,000,000	any
New York	3,000,000	3,000,000	any
North Carolina	2,000,000	750,000	None-cer. svcs
Ohio	2M renovations	n/a	n/a
Oklahoma	500,000	n/a	any w/beds
Oregon	any LTC/hosp	n/a	any LTC/hosp
Rhode Island	2,000,000	1,000,000	750,000
South Carolina	2,000,000	600,000	1.000,000
Tennessee	2,000,000	1,500,000	any w/ beds
Vermont	3.0M hsp/1.5Mothr	1,000,000	500,000
Virginia	5,000,000	n/a	n/a
Washington	var. by svc.	n/a	any
West Virginia	2,000,000	2,000,000	list of 23 svcs.
Wisconsin	1,000,000	600,000	Any LTC

n/a: not applicable

Source: American Health Planning Association's National Directory for 2004

Appendix A (continued)

State	Description of Fees
Alabama	One percent of project cost (maximum $15,641).
Alaska	No CON fee; all conversions of space to nursing home beds are reviewed.
Arkansas	$1,000 for all reviews
Connecticut	Base fee of $1,000 for any application for capital expenditure in excess of $1,000,000 & new equipment acquisition exceeding $400,000 plus an adjustment of 0.0005 times total expenditure.
Delaware	<$0.5 M=$100; $0.5-1 M=$750; $1-5 M=$3,000; $5-10 M=$7,500; >$10 M=$10,000
Dist. of Columbia	The greater of 3% of capital expenditures or $5,000, with a maximum of $300,000 (a voluntary "tax" of hospitals established in March 2003 provides operating funds in lieu of application fees).
Florida	$5000 + 0.015 of project cost; max. $22,000
Georgia	< $0.5 million = $500; > $0.5 million = 0.1%; max. $20,000
Hawaii	Base fee of $200, plus 0.1% of the total capital cost up to $1 million, plus 0.05% of the costs of the project above $1 million.
Illinois	0.2% of capitalized cost; min. $700; max. $100,000
Iowa	0.3% of capital expenditure, with a minimum fee of $600 and a maximum of $21,000
Kentucky	no cap. exp. or <$50,000=$250; $50,000-$100,000=$500; $100,000-$1,000,000= $2,000; $1,000,000-$5,000,000=$6,000; $5,000,000-$10,000,000=$11,000; =$10,000,001=$11,000+0.05% of exp.
Louisiana	$10 per bed Participating in Medicaid.
Maine	$1,000 per any portion of $1,000,000 increments *or 3rd year operating $400,000
Maryland	No CON fee; annual facility user fee based on revenue and admissions for hospitals and nursing homes
Massachusetts	0.1% of project cost
Michigan	< $0.15M = $750; $0.15–1.5M = $2,750; >$1.5M=$4,250
Mississippi	0.5% of project cost; min. $500; max. $25,000
Missouri	0.1% of project cost (minimum $1,000/no maximum)
Montana	0.3% of project cost; min. $500
Nebraska	$1,000 per application
Nevada	$9,500 for any project; CON Law covers only "new construction projects" in counties with less than 100,000 population (Clark County & Washoe County exempt).
New Hampshire	0.25% of project cost; min. $500; max. $12,000; $1,000 for standard dvlpmt; 0.1% of annual rev.
New Jersey	$57,500 + 0.25% of total project cost (for projects of $1,000,000 or more).
New York	$1,000 plus 0.45% of project cost (if reviewed by the Council)
North Carolina	$2,000 minimum fee; if cap. exp. then $3,500 + .003% of proj. cost over $1 Million; max. $17,500
Ohio	$3,000 or 0.9% of proj. cost, whichever is greater; max. $20,000 ($3,000 for non-cap.)
Oklahoma	For psych. and chemical dependency: 0.75% of proj.; min. $1,500; max. $10,000. For long term care: 1.0% of proj; min. $1,000; $1000 on facility replacement projects.
Oregon	Full Review (2%, min. $10,000; max. $25,000), Abbreviated or expedited (1%, min $5,000; max $15,000)
Rhode Island	$500 plus one third of one percent (0.33%) of total capital expenditure
South Carolina	Initial Filing Fee: $500 for every appl; Application Fee: 0.005 of total project cost up to $1.4 M maximum; Issuance Fee: $7,500 for projects greater than $1.4 M
Tennessee	0.225% of proj. cost; min. $3,000; max. $45,000 * Hospital Threshold $5M; all other projects threshold $2M
Vermont	0.125% of proj. cost; min. $250; max. $20,000
Virginia	1.0% of project cost; $20,000 maximum; $1,000 minimum
Washington	Variable based on service: ASC $13,379, amendments $8,432, Emergency $5,427, Exemptions $883–$5,427, HmHlth $16,155, NH $30,293, Hospital $26,506, Hospice Care Centers $8,432, Kidney Disease Treatment Centers $16,409
West Virginia	$25 to 0.1% of cost of project depending on type of facility, type of application and rate assessment
Wisconsin	0.37% of proj. cost; min. $1,850; max. $37,000; only a few nursing home projects are reviewed.

Information is extracted from individual CON state pages, and may be more complex than space allows to display.

Source: American Health Planning Association's National Directory for 2004

Appendix B

Summary of Conclusions from Michigan Certificate of Need Program Report, July 2003[45]

Overall finding: "With its roots in the rapidly disappearing cost-based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and/or access to care." [46]

CON in General[47]

1. There is little evidence that CON results in acute care cost reduction and some evidence that it increases costs.

2. Removal of CON does not consistently result in a surge in either acquisition of new facilities or medical expenditures.

3. Michigan's CON does constrain the supply of MRI units, open-heart programs and cardiac catheterization faculties that may result in improved outcomes from higher volume use.

4. Means other than CON such as outcomes reporting or licensure standards might be as effective in improving health services quality.

5. CON may have a beneficial impact on access to care for the uninsured but the evidence is thin and even if true the impact is modest in the context of the state's one million uninsured.

6. CON appears to improve inner city access at the expense of access in the suburbs so that elimination of CON could create financial difficulties for them absent some way of more equitably distributing the burden of uncompensated care.

7. Understanding the State's fiscal situation, a useful thought experiment might be to consider whether anyone would propose adopting CON now if the system were not already in place. "In light of the evidence presented, reasonable people are likely to disagree on the answer to this question." [48]

Acute Care Hospital Bed CON[49]

1. Available evidence provides weak support for the view that CON restrains the building of hospital beds

2. There is little evidence that hospital bed CON affects quality.

3. The strongest case for hospital bed CON relates to access. It is an open question whether the removal of hospital bed CON would lead to a two-tiered system with hospitals fleeing inner cities to relocate in the suburbs jeopardizing access to care for selected populations and/or the financial health of inner city hospital that remain.

Magnetic Resonance Imaging (MRI) CON[50]

1. Repealing CON for MRI is associated with a reduction in units in the short run but not in the long run.

2. There is fairly good evidence that Michigan's CON has inhibited growth in the supply of MRIs, but there are mixed reviews on whether this is good or bad for consumers.

3. While there is no evidence that CON adversely affects quality, there is also no solid volume-quality evidence or standards to warrant CON review.

---

[45] The Full Report is Available at: www.michigan.gov/mdch/0,1607,7-132-2945_5106-83771—,00.html.

[46] p. 127

[47] pages 127-8

[48] page 128

[49] pages 128-9

[50] pages 129-30

4. There is no evidence to refute the view that CON for MRIs has had a beneficial impact on access in Michigan. On balance, CON seems to have improved access in rural areas while constraining them in the suburbs.

Cardiac Services CON[51]

1. Evidence of the CON impact on costs and availability of cardiac services is mixed but there is mixed review as to whether this is good or bad for consumers. Key informants report that Michigan's CON has inhibited the growth in the supply of open heart/cardiac catheterization (OHCC) services.

2. Michigan's open heart surgery supply is 13 percent below the national average but its cardiac care supply is 3 percent above. Data suggests that CON may not have much impact overall on quantity of services even if it might constrain supply of facilities.

3. Both key informant interviews and the literature suggest that there is a solid volume-quality relationship for both cardiac catheterization and open heart surgery with mortality rates some 20 percent lower in high volume facilities. Literatures on CON as it relates to coronary artery bypass graft (GABG) is mixed.

4. Key informants viewed CON as having no impact on access to cardiac services for the uninsured and underinsured and that CON seems to have improved access in rural areas. The impact of CON is lessening access in the suburbs did not appear a severe as is the case with MRI.

5. On balance, the case for continuing CON for cardiac care seems to be less of a trade-off than that for MRI because the supply seems to be well enough distributed and the quality-volume effect improves outcomes significantly.

Overall Conclusions[52]

1. There are significant problems with the current program that suggest the scrapping or modification of certain portions.

2. CON has limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured.

3. It may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost effective means such as regulation and licensing and/or outcome reporting to the public.

4. In short, "evidence does not provide unambiguous evidence that acute care CON in Michigan has failed and should be ended; nor does it provide uncontestable proof that CON has succeeded in its objectives and should be unequivocally retained. What all sides might be able to agree upon is that the program can and should be improved so that it attains its objectives in the most effective and equitable fashion."

[51] pages 130-1

[52] page 132

Appendix C
CON Standards Reference Table
Michigan Certificate of Need Program
Numbers & Appendices References for Selected Criteria
(A Blank Means No Requirement)

	Section(s) of Review Standards Covering								
	Need Methodology	Need Standard(s)	Initiate Service	Replace/ Upgrade	Add/ Expand	Relocate	Acquire	Terms of Approval for All Applicants	Quality Requirements
BEDS:									
General Hospital Beds	3,4,5	5, Appx C	6	7	6	8	15	9,16	9
Psychiatric Hospital Beds:									
Inpatient	3,4	3,4, Appx C&D	6	8	6	8	9	6,11	11
Specialized children/adolescent care	3,4,5		7	7	7	8	9	6,11,12	
Neonatal Intensive Care Beds	3		5	8	6	7	9	4,11	
Long-term Care Beds	3,4,5	Appx A	7	6,7,8	6	8	9	11	7
Long-term Care Special Population Beds	3	3	3		3		6	4	4
SEVICES:									
Air Ambulance	9	3,7	3,7	5	4		6	8	8
Cardiac Catheterization	2,13	4,5,6,8,10	4,5,6,8,10	9	7			3,10(mobile),11	5,11
Computed Tomography (CT) Scanner	13,14	3	3,8,9(mobile)10	5,8	4,8	6,8	7,8	11,9&12 (mobile)	11,12
Magnetic Resonance Imaging (MRI)	13,15.16	3,4,5	3,6(mobile),9,10	5	4	7	8	12,6 (mobile)	10,12
Megavoltage Radiation Therapy (MRT)	11,12,13,14	5,6,7	5,8	7	6	10	9	15	15
Open Heart Surgery	4,5,6,8,9	4	4,5					7	7
Positron Emission Tomography (PET) Scanner	13,14,15,16,17,18	4	4,8	6	5		7	3, 9&12 (mobile),10,11	3,11
Surgical Services:									
Hospital	10	4,5,6,7	4	6	5	7	8	9	9
Freestanding Surgical Outpatient Facility (FSOF)	10	4	4	6	5	7	8	9	9
Bone Marrow Transplant	3,7	3	3					6	3
Heart/Lung and Liver Transplant	4,5,11	4	3,4,5					3,7,8,9,10	3,4,5,7,8,9,10
Pancreas Transplant	3,5	3	3					3,4	3
Urinary Extracorporeal Shock Wave Lithotripsy (UESWL)	3,13,14,Appx A	3	3,5(mobile)	4	8	7	6	5&11(mobile),10	10

Source: Michigan Department of Community Health CON Review Standards

Appendix C: CON Standards Reference Table (continued)

	Section(s) of Review Standards Covering								
	Annual Requirement to Meet Minimums	**Practitioner Related Requirements**	**Comparative Review**	**Access Requirements**	**Medicaid Participation**	**Urban/Rural**	**Data Requirements**	**Consulting Agreements**	**Organ Donation**
BEDS:									
General Hospital Beds			12	7,9	9,16	7,10	9		
Psychiatric Hospital Beds:									
Inpatient		11	10,15	11	6	2	Annual Survey		
Specialized children/adolescent care		12			6	2	Annual Survey		
Neonatal Intensive Care Beds		11			4	5,7	11		
Long-term Care Beds			10,15	11		2,3	11		
Long-term Care Special Population Beds			5			5			
SEVICES:									
Air Ambulance	3,4,8	7	No	8	7,8		8		
Cardiac Catheterization	4-10	11	No	11	3,11	4,6,7	11		
Computed Tomography (CT) Scanner	3,4,7,11	11	No	11	10	2,6	11		
Magnetic Resonance Imaging (MRI)	8,12,14	12	No	12	11,12	2,3,7	12,14		
Megavoltage Radiation Therapy (MRT)	15	15	No	15	Pending	5	15		
Open Heart Surgery	7	7	No	7	3,7		7	3	
Positron Emission Tomography (PET) Scanner	11,12	11	No		10	4	11		
Surgical Services:									
Hospital	4,5,8,9		No	9	Pending	2,7	9		
Freestanding Surgical Outpatient Facility (FSOF)	4,5,8,9		No	9	Pending	2,6,7	9		
Bone Marrow Transplant	4,6	3	4	6	5	2	6	3	
Heart/Lung and Liver Transplant	4,7	8,9,10	6	7	5,6		6		3
Pancreas Transplant	3,4	4	No	4	4		4		3
Urinary Extracorporeal Shock Wave Lithotripsy (UESWL)	6,10	3,10	No	10	9,10	5	10		

Appendix D
Michigan Hospital Bed Inventory vs. Need at December 31, 2003
for Certificate of Need Program

Health Service Area	Bed Need	Bed Inventory 12-31-03	Excess/ (Deficit)
Southeast (1)			
1A	2,693	3,408	715
1B	415	551	136
1C	1,372	2,143	771
1D	3,098	4,828	1,730
1E	451	578	127
1F	636	770	134
1G	275	282	7
1H	1,431	1,773	342
1I	50	68	18
1J	149	217	68
Area 1 Subtotal	10,570	14,618	4,048
Mid-Southern (2)			
2A	866	1,143	277
2B	293	390	97
2C	48	65	17
2D	98	180	82
Area 2 Subtotal	1,305	1,778	473
Southwest (3)			
3A	763	1,080	317
3B	282	341	59
3C	261	431	170
3D	85	89	4
3E	59	102	43
Area 3 Subtotal	1,450	2,043	593
West (4)			
4A	57	81	24
4B	63	126	63
4C	17	42	25
4D	11	24	13
4E	38	61	23
4F	136	191	55
4G	391	568	177
4H	1,240	1,738	498
4I	47	65	18
4J	153	250	97
4K	21	77	56
4L	24	54	30
Area 4 Subtotal	2,198	3,277	1,079

Appendix D (continued)
Michigan Hospital Bed Inventory vs. Need

Health Service Area	Bed Need	Bed Inventory 12-31-03	Excess/ (Deficit)
Genesee, Lapeer, Shiawassee (5)			
5A	79	115	36
5B	1,120	1,241	121
5C	119	183	64
Area 5 Subtotal	1,318	1,539	221
East (6)			
6A	99	148	49
6B	55	118	63
6C	47	64	17
6D	216	272	56
6E	299	443	144
6F	765	1,091	326
6G	43	64	21
6H	13	40	27
6I	24	48	24
Area 6 Subtotal	1,561	2,288	727
Northern Lower Peninsula (7)			
7A	43	46	3
7B	203	273	70
7C	-	36	36
7D	27	53	26
7E	99	124	25
7F	349	354	5
7G	62	97	35
7H	53	90	37
7I	40	75	35
Area 7 Subtotal	876	1,148	272
Upper Peninsula (8)			
8A	24	54	30
8B	7	25	18
8C	21	36	15
8D	11	24	13
8E	50	85	35
8F	88	96	8
8G	228	358	130
8H	57	110	53
8I	4	25	21
8J	7	25	18
8K	9	25	16
Area 8 Subtotal	506	863	357
State Total	19,784	27,554	7,770

Source: Michigan Department of Community Health

Appendix E

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
1 - Southeast			
	1A	North Oakland Med Centers (Fac #63-0110)	Pontiac
	1A	Pontiac Osteopathic Hospital (Fac #63-0120)	Pontiac
	1A	St. Joseph Mercy – Oakland (Fac #63-0140)	Pontiac
	1A	Select Specialty Hospital - Pontiac (LTAC – FAC #63-0172)*	Pontiac
	1A	Crittenton Hospital (Fac #63-0070)	Rochester
	1A	Huron Valley – Sinai Hospital (Fac #63-0014)	Commerce Township
	1A	Wm Beaumont Hospital (Fac #63-0030)	Royal Oak
	1A	Wm Beaumont Hospital – Troy (Fac #63-0160)	Troy
	1A	Providence Hospital (Fac #63-0130)	Southfield
	1A	Great Lakes Rehabilitation Hospital (Fac #63-0013)	Southfield
	1A	Straith Hospital for Special Surg (Fac #63-0150)	Southfield
	1A	The Orthopaedic Specialty Hospital (Fac #63-0060)	Madison Heights
	1A	St. John Oakland Hospital (Fac #63-0080)	Madison Heights
	1A	Southeast Michigan Surgical Hospital (Fac #50-0100)	Warren
	1B	Bi-County Community Hospital (Fac #50-0020)	Warren
	1B	St. John Macomb Hospital (Fac #50-0070)	Warren
	1C	Oakwood Hosp and Medical Center (Fac #82-0120)	Dearborn
	1C	Garden City Hospital (Fac #82-0070)	Garden City
	1C	Henry Ford –Wyandotte Hospital (Fac #82-0230)	Wyandotte
	1C	Select Specialty Hosp Wyandotte (LTAC - Fac #82-0272)*	Wyandotte
	1C	Oakwood Annapolis Hospital (Fac #82-0010)	Wayne
	1C	Oakwood Heritage Hospital (Fac #82-0250)	Taylor
	1C	Riverside Osteopathic Hospital (Fac #82-0160)	Trenton
	1C	Oakwood Southshore Medical Center (Fac #82-0170)	Trenton
	1C	Kindred Hospital – Detroit (Fac #82-0130)	Lincoln Park
	1D	Sinai-Grace Hospital (Fac #83-0450)	Detroit
	1D	Rehabilitation Institute of Michigan (Fac #83-0410)	Detroit
	1D	Harper University Hospital (Fac #/83-0220)	Detroit
	1D	St. John Detroit Riverview Hospital (Fac #83-0034)	Detroit
	1D	Henry Ford Hospital (Fac #83-0190)	Detroit
	1D	St. John Hospital & Medical Center (Fac #83-0420)	Detroit
	1D	Children's Hospital of Michigan (Fac #83-0080)	Detroit
	1D	Detroit Receiving Hospital & Univ Health (Fac #83-0500)	Detroit
	1D	St. John Northeast Community Hosp (Fac #83-0230)	Detroit
	1D	Kindred Hospital–Metro Detroit (Fac #83-0520)	Detroit
	1D	SCCI Hospital-Detroit (LTAC - Fac #83-0521)*	Detroit
	1D	Greater Detroit Hosp–Medical Center (Fac #83-0350)	Detroit
	1D	Renaissance Hosp & Medical Centers (Fac #83-0390)	Detroit
	1D	United Community Hospital (Fac #83-0490)	Detroit

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

Appendix E (continued)

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
1 – Southeast (continued)			
	1D	Harper-Hutzel Hospital (Fac #83-0240)	Detroit
	1D	Select Specialty Hosp–NW Detroit (LTAC - Fac #83-0523)*	Detroit
	1D	Bon Secours Hospital (Fac #82-0030)	Grosse Pointe
	1D	Cottage Hospital (Fac #82-0040)	Grosse Pointe Farm
	1E	Botsford General Hospital (Fac #63-0050)	Farmington Hills
	1E	St. Mary Mercy Hospital (Fac #82-0190)	Livonia
	1F	Mount Clemens General Hospital (Fac #50-0060)	Mt. Clemens
	1F	Select Specialty Hosp – Macomb Co. (FAC #50-0111)*	Mt. Clemens
	1F	St. John North Shores Hospital (Fac #50-0030)	Harrison Township
	1F	St. Joseph's Mercy Hosp & Health Serv (Fac #50-0110)	Clinton Township
	1F	St. Joseph's Mercy Hospital & Health (Fac #50-0080)	Mt. Clemens
	1G	Mercy Hospital (Fac #74-0010)	Port Huron
	1G	Port Huron Hospital (Fac #74-0020)	Port Huron
	1H	St. Joseph Mercy Hospital (Fac #81-0030)	Ann Arbor
	1H	University of Michigan Health System (Fac #81-0060)	Ann Arbor
	1H	Select Specialty Hosp–Ann Arbor (Ltac - Fac #81-0081)*	Ann Arbor
	1H	Chelsea Community Hospital (Fac #81-0080)	Chelsea
	1H	Saint Joseph Mercy Livingston Hosp (Fac #47-0020)	Howell
	1H	Saint Joseph Mercy Saline Hospital (Fac #81-0040)	Saline
	1H	Forest Health Medical Center (Fac #81-0010)	Ypsilanti
	1H	Brighton Hospital (Fac #47-0010)	Brighton
	1I	St. John River District Hospital (Fac #74-0030)	East China
	1J	Mercy Memorial Hospital (Fac #58-0030)	Monroe
2 - Mid-Southern			
	2A	Clinton Memorial Hospital (Fac #19-0010)	St. Johns
	2A	Eaton Rapids Medical Center (Fac #23-0010)	Eaton Rapids
	2A	Hayes Green Beach Memorial Hosp (Fac #23-0020)	Charlotte
	2A	Ingham Reg Med Center (Greenlawn) (Fac #33-0020)	Lansing
	2A	Ingham Reg Med Center (Pennsylvania) (Fac #33-0010)	Lansing
	2A	Edward W. Sparrow Hospital (Fac #33-0060)	Lansing
	2A	Sparrow – St. Lawrence Campus (Fac #33-0050)	Lansing
	2B	Carelink of Jackson (Ltac Fac #38-0030)*	Jackson
	2B	W. A. Foote Memorial Hospital (Fac #38-0010)	Jackson
	2C	Hillsdale Community Health Center (Fac #30-0010)	Hillsdale
	2D	Emma L. Bixby Medical Center (Fac #46-0020)	Adrian
	2D	Herrick Memorial Hospital (Fac #46-0030)	Tecumseh

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

Appendix E (continued)

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
3 – Southwest			
	3A	Borgess Medical Center (Fac #39-0010)	Kalamazoo
	3A	Bronson Methodist Hospital (Fac #39-0020)	Kalamazoo
	3A	Borgess-Pipp Health Center (Fac #03-0031)	Plainwell
	3A	Lakeview Community Hospital (Fac #80-0030)	Paw Paw
	3A	Bronson – Vicksburg Hospital (Fac #39-0030)	Vicksburg
	3A	Pennock Hospital (Fac #08-0010)	Hastings
	3A	Three Rivers Area Hospital (Fac #75-0020)	Three Rivers
	3A	Sturgis Hospital (Fac #75-0010)	Sturgis
	3A	Sempercare Hospital at Bronson (LTAC - Fac #39-0032)*	Kalamazoo
	3B	Fieldstone Center of Battle Crk. Health (Fac #13-0030)	Battle Creek
	3B	Battle Creek Health System (Fac #13-0031)	Battle Creek
	3B	Select Spec Hosp–Battle Creek (Ltac - Fac #13-0111)*	Battle Creek
	3B	SW Michigan Rehab. Hospital (Fac #13-0100)	Battle Creek
	3B	Oaklawn Hospital (Fac #13-0080)	Marshall
	3C	Community Hospital (Fac #11-0040)	Watervliet
	3C	Lakeland Hospital, St. Joseph (Fac #11-0050)	St. Joseph
	3C	Lakeland Specialty Hospital (LTAC - Fac #11-0080)*	Berrien Center
	3C	South Haven Community Hospital (Fac #80-0020)	South Haven
	3D	Lakeland Hospital, Niles (Fac #11-0070)	Niles
	3D	Lee Memorial Hospital (A) (Fac #14-0010)	Dowagiac
	3E	Community Health Center of Branch County (Fac #12-0010)	Coldwater
4 – West			
	4A	Memorial Medical Center of West Michigan (Fac #53-0010)	Ludington
	4B	Kelsey Memorial Hospital (Fac #59-0050)	Lakeview
	4B	Mecosta County General Hospital (Fac #54-0030)	Big Rapids
	4C	Spectrum Health-Reed City Campus (Fac #67-0020)	Reed City
	4D	Lakeshore Community Hospital (Fac #64-0020)	Shelby
	4E	Gerber Memorial Hospital (Fac #62-0010)	Fremont
	4F	Carson City Hospital (Fac #59-0010)	Carson City
	4F	Gratiot Community Hospital (Fac #29-0010)	Alma
	4G	Hackley Hospital (Fac #61-0010)	Muskegon
	4G	Mercy Gen Health Partners–(Sherman) (Fac #61-0020)	Muskegon
	4G	Mercy Gen Health Partners–(Oak) (Fac #61-0030)	Muskegon
	4G	Lifecare Hospitals of Western MI (LTAC - Fac #61-0052)*	Muskegon
	4G	Select Spec Hosp–Western MI (LTAC - Fac #61-0051)*	Muskegon

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

Appendix E (continued)

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
4 – West (continued)			
	4G	North Ottawa Community Hospital (Fac #70-0010)	Grand Haven
	4H	Spectrum Health–Blodgett Campus (Fac #41-0010)	East Grand Rapids
	4H	Spectrum Health–Butterworth Campus (Fac #41-0040)	Grand Rapids
	4H	Spectrum Health–Kent Community Campus (Fac #41-0090)	Grand Rapids
	4H	Mary Free Bed Hospital & Rehab Center (Fac #41-0070)	Grand Rapids
	4H	Metropolitan Hospital (Fac #41-0060)	Grand Rapids
	4H	Saint Mary's Mercy Medical Center (Fac #41-0080)	Grand Rapids
	4I	Sheridan Community Hospital (A) (Fac #59-0030)	Sheridan
	4I	United Memorial Hospital & LTCU (Fac #59-0060)	Greenville
	4J	Holland Community Hospital (Fac #70-0020)	Holland
	4J	Zeeland Community Hospital (Fac #70-0030)	Zeeland
	4K	Ionia County Memorial Hospital (Fac #34-0020)	Ionia
	4L	Allegan General Hospital (Fac #03-0010)	Allegan
5 – GLS			
	5A	Memorial Healthcare (Fac #78-0010)	Owosso
	5B	Genesys Regional Medical Center–Health Park (Fac #25-0072)	Grand Blanc
	5B	Hurley Medical Center (Fac #25-0040)	Flint
	5B	Mclaren Regional Medical Center (Fac #25-0050)	Flint
	5B	Select Specialty Hospital-Flint (LTAC - Fac #25-0071)*	Flint
	5C	Lapeer Regional Hospital (Fac #44-0010)	Lapeer
6 – East			
	6A	West Branch Regional Medical Center (Fac #65-0010)	West Branch
	6A	Tawas St Joseph Hospital (Fac #35-0010)	Tawas City
	6B	Central Michigan Community Hosp (Fac #37-0010)	Mt. Pleasant
	6C	Mid-Michigan Medical Center-Clare (Fac #18-0010)	Clare
	6D	Mid-Michigan Medical Center - Gladwin (Fac #26-0010)	Gladwin
	6D	Mid-Michigan Medical Center - Midland (Fac #56-0020)	Midland

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) Licensed sites with less than 15 acute care med/surg beds and up to 10 med/surg beds designated for short-term nursing care program ("swing beds"). These hospitals have state/federal critical access hospital designation.

Appendix E (continued)

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
6 – East (continued)			
	6E	Bay Regional Medical Center (Fac #09-0050)	Bay City
	6E	Bay Regional Medical Center-West (Fac #09-0020)	Bay City
	6E	Samaritan Health Center (Fac #09-0051)	Bay City
	6E	Bay Special Care (LTAC - Fac #09-0010)*	Bay City
	6E	Standish Community Hospital (A) (Fac #06-0020)	Standish
	6F	Select Specialty Hosp–Saginaw (LTAC - Fac #73-0062)*	Saginaw
	6F	Covenant Medical Centers, Inc (Fac #73-0061)	Saginaw
	6F	Covenant Medical Center–N Michigan (Fac #73-0030)	Saginaw
	6F	Covenant Medical Center–N Harrison (Fac #73-0020)	Saginaw
	6F	Healthsource Saginaw (Fac #73-0060)	Saginaw
	6F	St. Mary's Medical Center (Fac #73-0050)	Saginaw
	6F	Caro Community Hospital (Fac #79-0010)	Caro
	6F	Hills And Dales General Hospital (Fac #79-0030)	Cass City
	6G	Harbor Beach Community Hosp (A) (Fac #32-0040)	Harbor Beach
	6G	Huron Medical Center (Fac #32-0020)	Bad Axe
	6G	Scheurer Hospital (A) (Fac #32-0030)	Pigeon
	6H	Deckerville Community Hospital (A) (Fac #76-0010)	Deckerville
	6H	Mckenzie Memorial Hospital (A) (Fac #76-0030)	Sandusky
	6I	Marlette Community Hospital (Fac #76-0040)	Marlette
7 - Northern Lower			
	7A	Cheboygan Memorial Hospital (Fac #16-0020)	Cheboygan
	7B	Charlevoix Area Hospital (Fac #15-0020)	Charlevoix
	7B	Mackinac Straits Hospital (A) (Fac #49-0030)	St. Ignace
	7B	Northern Michigan Hospital (Fac #24-0030)	Petoskey
	7C	Rogers City Rehabilitation Hospital (Fac #71-0030)	Rogers City
	7D	Otsego Memorial Hospital (Fac #69-0020)	Gaylord
	7E	Alpena General Hospital (Fac #04-0010)	Alpena
	7F	Kalkaska Memorial Health Center (A) (Fac #40-0020)	Kalkaska
	7F	Leelanau Memorial Health Center (A) (Fac #45-0020)	Northport
	7F	Munson Medical Center (Fac #28-0010)	Traverse City
	7F	Paul Oliver Memorial Hospital (A) (Fac #10-0020)	Frankfort

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) Licensed sites with less than 15 acute care med/surg beds and up to 10 med/surg beds designated for short-term nursing care program ("swing beds"). These hospitals have state/federal critical access hospital designation.

Appendix E (continued)

CON Review Standards for Hospital Beds

Hospital Subarea Assignments

Health Service Area	Sub Area	Hospital Name	City
7 - Northern Lower (continued)			
	7G	Mercy Hospital - Cadillac (Fac #84-0010)	Cadillac
	7H	Mercy Hospital - Grayling (Fac #20-0020)	Grayling
	7I	West Shore Medical Center (Fac #51-0020)	Manistee
8 - Upper Peninsula			
	8A	Grand View Hospital (Fac #27-0020)	Ironwood
	8B	Ontonagon Memorial Hospital (A) (Fac #66-0020)	Ontonagon
	8C	Iron County General Hospital (Fac #36-0020)	Iron River
	8D	Baraga County Memorial Hospital (A) (Fac #07-0020)	L'anse
	8E	Keweenaw Memorial Medical Center (Fac #31-0010)	Laurium
	8E	Portage Health System (Fac #31-0020)	Hancock
	8F	Dickinson County Memorial Hospital (Fac #22-0020)	Iron Mountain
	8G	Bell Memorial Hospital (Fac #52-0010)	Ishpeming
	8G	Marquette General Hospital (Fac #52-0050)	Marquette
	8H	St. Francis Hospital (Fac #21-0010)	Escanaba
	8I	Munising Memorial Hospital (A) (Fac #02-0010)	Munising
	8J	Schoolcraft Memorial Hospital (A) (Fac #77-0010)	Manistique
	8K	Helen Newberry Joy Hospital (A) (Fac #48-0020)	Newberry
	8L	Chippewa County War Memorial Hospital (Fac #17-0020)	Sault Ste Marie

(A) Licensed sites with less than 15 acute care med/surg beds and up to 10 med/surg beds designated for short-term nursing care program ("swing beds"). These hospitals have state/federal critical access hospital designation.

Source: Michigan Department of Community Health

Appendix F
Service Data for Selected Medical Services Covered by CON
Upper Peninsula

Item	Number of Beds/Services/Procedures 1996	1997	1998	1999	2000		Rate per 100,000 or 1,000 Michigan Population 1996	1997	1998	1999	2000
Population**	315,867	316,424	317,278	317,354	317,616						
BEDS:											
General Hospital Beds	1,170	1,159	1,096	1,057	971	**P**	3.70	3.66	3.45	3.33	3.06
Psychiatric Hospital Beds:											
Inpatient											
Specialized children/adolescent care											
Neonatal Intensive Care Beds	10	10	10	10	10	**R**	3.17	3.16	3.15	3.15	3.15
Long-term Care Beds											
Long-term Care Special Population Beds											
SEVICES:											
Air Ambulance	N/A	N/A	N/A	N/A	N/A						
Cardiac Catheterization++	N/A	N/A	N/A	N/A	N/A						
Computed Tomography (CT) Scanners (Fixed ONLY)	14	15	15	15	14	**R**	4.43	4.74	4.73	4.73	4.41
Computed Tomography CTE (Includes Mobile)+	33,450	36,303	39,795	47,436	49,225	**P**	105.90	114.73	125.43	149.47	154.98
Magnetic Resonance Imaging (MRI) Visits*	N/A	N/A	N/A	N/A	7,908	**P**					24.90
Megavoltage Radiation Therapy ETV+	10,136	11,285	12,954	13,210	12,796	**P**	32.09	35.66	40.83	41.63	40.29
Open Heart Surgery	422	402	367	424	368	**R**	133.60	127.04	115.67	133.60	115.86
Positron Emission Tomography (PET) Visits	0	0	0	0	0	**R**	0.00	0.00	0.00	0.00	0.00
Surgical Services - All ORs:	45^	49	49	48	47	**R**	14.25	15.49	15.44	15.13	14.80
Cases	24,730^	27,823	29,085	29,945	31,702	**P**	78.29	87.93	91.67	94.36	99.81
Kidney Transplant	0	0	0	0	0	**R**	0.00	0.00	0.00	0.00	0.00
Heart/Lung and Liver Transplant	0	0	0	0	0	**R**	0.00	0.00	0.00	0.00	0.00
Pancreas Transplant	0	0	0	0	0	**R**	0.00	0.00	0.00	0.00	0.00
Urinary Extracorporeal Shock Wave Lithotripsy (UESWL)	86	85	56	63	76	**R**	27.23	26.86	17.65	19.85	23.93

*Data for 1996, 1997, and 1998 Excludes Freestanding
+Weighted by CON Weights
++ Includes Diagnostic and Therapeutic Sessions
R = Rate Per 1,000 Michigan Population / **P** = Rate Per 1,000 Michigan Population
^ Excludes dedicated Endoscopy/Cystoscopy data
Source: Michigan Department of Community Health and Population Division U.S. Census Bureau, Release Date: April 17, 2002

Appendix G
Excerpts of Analyses of Automobile Manufacturer Employee Health Costs*

DaimlerChrysler Corporation

DCC's three lowest cost areas are in states with Certificate of Need laws in place, while the two highest cost areas are in states without CON laws. The adjusted per person costs in the Kenosha/Southeast **Wisconsin** area, for example, are about triple what they are in Syracuse, **New York**.

Location	Adjusted 2000 Cost*
Kenosha, WI	$3,519
Indiana	2,741
Newark, DE	2,100
Michigan	1,839
Syracuse	1,331

*Age, gender, and geographically adjusted. Adjusted numbers use Syracuse as a base.

DCC believes it is important to recognize that CON not only contributes to lower health care costs but that it also helps to ensure quality. The Leapfrog Group for Patient Safety maintains that the push to open new centers may have a negative impact on quality. There is evidence that new centers may not do enough surgeries to meet the "practice makes perfect" maxim. Leapfrog recommends that, for a coronary artery bypass, for example, a minimum of 500 procedures a year should be the benchmark. Scientific literature documents significantly superior patient outcomes in hospitals with higher volumes.

Ford Motor Company

- **Indiana** and **Ohio**, which eliminated CON coverage for most services, consistently had the highest relative costs.
- **Michigan**, with a CON program since 1972 covering a wide range of services, consistently had among the lowest relative costs.
- **Kentucky** and **Missouri**, which also have had CON programs covering a wide range of services, also had low relative costs.
- This consistent correlation between CON and lower costs was quite notable because the pattern was the same across a range of different services. This was true for the broad but differing categories of hospital in-patient and out-patient services, *and* the narrower focus on CABG (an inpatient surgical procedure) or on MRI (a diagnostic service, mostly done on an out-patient basis).

To assure statistical significance, Ford Motor Company data were from states where Ford has a significant presence (at least 10,000 members—actives, dependents, and retirees—enrolled in PPO and traditional health-benefit plans combined) in the year 2000 and there were a significant number of services in year 2000 for Ford's members.

MRI Service

Ohio started a three-year program in 1995 to phase out CON, including MRI services. Of the three states, it had the highest relative costs, 20 percent above **Michigan.**

Indiana: No CON covering MRI services since the 1980s. It had the second highest relative costs, 11 percent above **Michigan.**

Michigan has had a full coverage CON program since 1972. Its relative MRI costs were the lowest among all states in which Ford Motor has a significant presence and there were a statistically significant number of MRI services performed for Ford Motor's members.

Coronary Artery Bypass Graft (CABG)

Indiana: No CON program covering CABG services since the 1980s. It had the highest relative costs, 39 percent above **Michigan.**

Ohio started a three-year program in 1995 to phase out CON, including deregulating CABG services. Of the three states, it had the second highest relative costs, 20 percent above **Michigan.**

* The findings are available on the Department of Community Health Web page as Addendum J to the Conover/Sloan report at: www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771---,00.html.

Michigan has had a full coverage CON program since 1972. Its relative CABG costs were the lowest among all states in which Ford Motor has a significant presence and there were a statistically significant number of CABGs performed for Ford Motors' members.

Hospital Inpatient Relative Cost

Indiana: No CON program covering inpatient acute care hospitals since the 1980s. It had the highest costs, 18 percent above **Michigan.**

Ohio started a three-year program in 1995 to phase out CON, thus deregulating most in-patient services. It had the second highest costs, 12 percent above **Michigan's.**

Kentucky has had a relatively extensive CON program for many years. Its relative in-patient costs were low, just 5 percent above **Michigan's.**

Missouri has had a full coverage CON program since 1979. It repealed the program, effective December 2001, but that was after the period covered by this data. Missouri's relative costs were low, just two percent above **Michigan's.**

Michigan has had a full coverage CON program since 1972. Its relative inpatient hospital costs were the lowest among all states in which Ford has a significant presence.

Hospital Outpatient Relative Cost

Indiana: No CON program covering outpatient hospital service since the 1980s. Like **Ohio**, **Indiana** had the highest costs, 21 percent above **Michigan.**

Ohio started a three-year program in 1995 to phase out CON, thus deregulating outpatient hospital services. Like **Indiana**, it had the highest outpatient hospital service costs, 21 percent above **Michigan.**

Kentucky has had a relatively extensive CON program for many years. Its relative outpatient hospital costs were about the same as **Michigan's.**

Michigan has had a full coverage CON program since 1972. Its relative outpatient hospital costs were among the lowest among all states in which Ford has a significant presence.

Missouri has had a full coverage CON program since 1979. It repealed the program, effective December 2001, but that was after the period covered by this data. Missouri's relative costs for outpatient hospital services were the lowest, at 4 percent below **Michigan.**

General Motors Corporation

Our data for 1996 through 2001 in **Michigan**, **Ohio**, **Indiana** and **New York** – four states with very significant GM populations – includes all of our self-insured hospital, surgical and medical expenses in a age-adjusted, dollars-per-life basis. We have been authorized to include Delphi Corporation data since it was a GM subsidiary during that period.

	1996	1997	1998	1999	2000	2001	CON Status
Indiana	$1,611	$1,629	$1,613	$1,706	$1,846	$2,008	No CON for many years
Ohio	$1,556	$1,559	$1,465	$1,606	$1,746	$1,834	Recently repealed CON
Michigan	$1,487	$1,487	$1,483	$1,560	$1,606	$1,732	Has CON
New York	$1,306	$1,228	$1,204	$1,271	$1,347	$1,501	Has stringent CON

While the GM populations served and the benefits and cost-sharing provisions are quite similar in all four states, our health care costs are highest in **Indiana** a state with no CON regulation – and lowest in **New York** – a state with stringent CON regulation. (See Table.) There can be multiple reasons for this trend and we are not suggesting that the differences are only a function of CON regulation, but regulation cannot be totally ruled out as a contributing factor.

Appendix H
Changing "Certificate of Need" to "Certificate of Service"

John R. Griffith
University of Michigan School of Public Health

Professor Griffith was one of the authors of the original methodology used to determine acute hospital bed need when the Michigan CON program began and has followed the program over the intervening years.

Michigan has supervised major health care investments such as surgical centers, hospitals, new acute care beds, and advanced diagnostic machinery for 32 years under a program called "Certificate of Need" (CON). Although the program has helped discourage unnecessary and undesirable investments, it has become outmoded by changes in technology and health care finance. It should be replaced with an approach that awards certificates to those organizations that can demonstrate high quality, good patient service, and reasonable cost as well as need.

It would not be difficult to change the existing system of review; all that is required is to update the criteria for approving CON requests. At the present time, certificates are issued when the CON Commission approves proposals for beds and facilities that document reasonable need in a local area. Without a certificate, the providers cannot contract with Medicare or Michigan Blue Cross Blue Shield. If the Commission expanded the criteria to reflect more modern issues of quality and cost effective performance, Michigan citizens would benefit by better use of scarce capital, and greater assurance of effective overall health care.

In addition to need, applications for investment under the CON program should include:

1. Measures of overall institutional performance on quality, cost, patient satisfaction, and financial stability that can be compared to other Michigan hospitals and national benchmarks. Approval should be contingent upon meeting standards set by the Commission and commitment to continue to release these measures to the public annually.

2. Evidence of contribution to the community, and a commitment to release such evidence annually. Contribution is measured by expenditures for charitable or uncompensated care, education of caregiving professionals, and support of wellness and health promotion programs. Minimum standards of community contribution as a percent of net revenues would be appropriate for not-for-profit corporations, which receive a substantial subsidy in the form of sales, property, and income tax relief, and access to tax exempt bonds.

3. A expanded statement of the need for the specific health services (not "beds" or facilities) to be added or expanded, backed by a reputable analysis of the future demand for the service, the market share the hospital anticipates and the impact upon its competitors, the expected cost and revenues of the service, and a commitment to meeting minimum national standards of quality of care for the service. (A growing number of standard national measures of quality are in widespread use, and most Michigan hospitals already have many of these in place.)

4. Documentation of an acceptable plan for future ability to maintain adequate financial support.

In reviewing applications, the Commission should explicitly evaluate the overall record of the applicant as well as the commitment to achievement in the specific expansion requested. State and national comparative data for these measures can easily be compiled. The Michigan Health and Hospitals Corporation, BCBSM, Medicare, and several national organizations collect it.

An outside review group, The Center for Health Policy, Law, and Management, at Duke University, conducted an extensive review of the CON program in 2002. Although many questions they addressed about the cost effectiveness of CON were difficult to evaluate, they reported:

> …it does seem reasonable to conclude from these findings that retaining the current CON program unchanged is probably undesirable. There are sufficient problems or limitations…that portions either should be scrapped or at least modified….(S)trengthening certain aspects—e.g., monitoring and enforcement of project delivery standards-may merit consideration.[53]

[53] Conover CJ, Sloan FA, Center for Health Policy, Law, and Management, at Duke University, *Evaluation of the Certificate of Need in Michigan.* 2002, p. *xi* Available on the Commission web site.

Conditions have changed enormously since the bed need methodology was first installed. Medical care itself, health insurance, information availability, and population needs have changed to an extent that makes the approach of approving hospital investment based on counts of total beds inappropriate. To wit:

- Many more patients totally avoid hospitalization than was true in 1978.
- When patients are admitted, the inpatient stay, though critical, is a substantially smaller part of treatment than was true in 1978.
- Beds for adult non-obstetrical patients are no longer uniform and interchangeable. As noted in the discussion, there are critical access beds, intensive care beds, step-down beds, general medicine beds, beds specialized by clinical service (cardiology, orthopedics, neurology, etc.), long-term acute beds, rehabilitation beds, and other specialized adaptations. These changes, have led to documented improvements in the quality, comfort, and cost of care.[54] They render decisions based on totals unacceptable.
- Beds for pediatric patients are used so differently now than in 1978 that a specific study of child health needs would be appropriate. Adult rules for bed need and service area should no longer apply.
- An approach based on population need for services is substantially superior to one based on beds. Data are now available to estimate population need according to disease group and treatment pattern, allowing a hospital to forecast with reasonable accuracy the numbers of admissions, outpatient cases, and procedures of a given type, based upon analysis of its market. The hospital can calculate expected revenue and cost per case, and can compare those forecasts against national benchmarks. Commercial services automate and standardize these calculations.[55] Similar opportunities exist to identify acceptable levels of quality and service.
- Safety, quality, and effective use of hospitals have become a major concern in healthcare. National work has shown clearly that what hospitals do now is not acceptable,[56] and that substantial improvement is possible.[57] The Leapfrog Group, a national organization sponsored by General Motors and other Michigan corporations, has developed programs to encourage improvement.[58] Michigan has pioneered with the Blue Cross and Blue Shield quality incentive program, and 100 percent of hospitals participate.[59]
- Changes in the payment mechanisms have enforced a cost discipline upon hospitals that did not exist in 1978, and the hospitals, have responded with continuous improvement programs. Hospitals that have been unable to make this transition have faced substantial financial difficulty. It would be contrary to the best interests of the people of Michigan to allow hospital construction that would not be cost-effective and financially sound.
- Hospitals have reorganized in response to the clinical and financial changes, creating systems and relationships that did not exist 25 years ago. In the Detroit MSA, 80 percent of admissions are to systems that operate more than one hospital. It is imperative that these systems be held to standards of quality, service, and efficiency.[53]

For these reasons, the current need methodology be abandoned. In its stead, the CON Commission requirements should emphasize quality of care, efficiency, and service.

---

[54] Griffith JR, White KR, *The Well-Managed Healthcare Organization,* 5th ed. Chicago, Health Administration Press, 2002; Griffith, JR, White KR, *Thinking Forward: Six Strategies for Highly Successful Organizations* Chicago, Health Administration Press, 2003.

[55] The Medstat Group, Ann Arbor MI, www.inforumonline.com.

[56] Committee on Quality of Health Care in America, Institute of Medicine, L T Kohn, J M Corrigan M S Donaldson, eds., *To Err is Human: Building a Safer Health System.* Washington DC, National Academies Press, 2000.

[57] Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington D C, National Academies Press, 2001. Also see Committee on Rapid Advance Demonstration Projects: Health Care Finance and Delivery Systems, J. M. Corrigan, A. Greiner, S. M. Erickson, Eds. *Fostering Rapid Advances in Health Care: Learning from System Demonstrations,* Washington D C, National Academies Press, 2002.

[58] The Leapfrog Group, www.leapfroggroup.org/

[59] Blue Cross and Blue Shield of Michigan, www.bcbsm.com/pr030204.shtml

[60] Cuellar, AE, Gertler PJ. Trends in hospital consolidation: The formation of local systems, *Health Affairs.* Chevy Chase: Nov/Dec 2003.22(6):82