Act No. 88
Public Acts of 1993
Approved by the Governor
July 07, 1993
Filed with the Secretary of State
July 09, 1993

STATE OF MICHIGAN
87TH LEGISLATURE
REGULAR SESSION OF 1993

Introduced by Senators Pridnia, Emmons, Arthurhultz, Cisky, Gast, Carl, McManus, Dunaskiss, Koivisto and Kelly

ENROLLED SENATE BILL No. 396

AN ACT to amend sections 20145, 22203, 22205, 22207, 22208, 22209, 22210, 22213, 22215, 22221, 22225, 22227, 22229, 22231, 22232, 22239, 22241, 22247, and 22260 of Act No. 368 of the Public Acts of 1978, entitled as amended "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for penalties and remedies; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," section 20145 as amended by Act No. 13 of the Public Acts of 1991, section 22203 as added by Act No. 331 of the Public Acts of 1988, sections 22205, 22207, 22213, 22215, 22221, 22225, 22227, 22229, 22231, 22232, 22239, 22241, 22247, and 22260 as added by Act No. 332 of the Public Acts of 1988, and sections 22208, 22209, and 22210 as amended by Act No. 260 of the Public Acts of 1990, being sections 333.20145, 333.22203, 333.22205, 333.22207, 333.22208, 333.22209, 333.22210, 333.22213, 333.22215, 333.22221, 333.22225, 333.22227, 333.22229, 333.22231, 333.22232, 333.22239, 333.22241, 333.22247, and 333.22260 of the Michigan Compiled Laws; and to repeal certain parts of the act.

The People of the State of Michigan enact:

Section 1. Sections 20145, 22203, 22205, 22207, 22208, 22209, 22210, 22213, 22215, 22221, 22225, 22227, 22229, 22231, 22232, 22239, 22241, 22247, and 22260 of Act No. 368 of the Public Acts of 1978, section 20145 as amended by Act No. 13 of the Public Acts of 1991, section 22203 as added by Act No. 331 of the Public Acts of 1988, sections 22205, 22207, 22213, 22215, 22221, 22225, 22227, 22229, 22231, 22232, 22239, 22241, 22247, and 22260 as added by Act No. 332 of the Public

Acts of 1988, and sections 22208, 22209, and 22210 as amended by Act No. 260 of the Public Acts of 1990, being sections 333.20145, 333.22203, 333.22205, 333.22207, 333.22208, 333.22209, 333.22210, 333.22213, 333.22215, 333.22221, 333.22225, 333.22227, 333.22229, 333.22231, 333.22232, 333.22239, 333.22241, 333.22247, and 333.22260 of the Michigan Compiled Laws, are amended to read as follows:

Sec. 20145. (1) Before contracting for and initiating a construction project involving new construction, additions, modernizations, or conversions of a health facility or agency with a capital expenditure of $1,000,000.00 or more, a person shall obtain a construction permit from the department. The permit shall not be issued under this subsection unless the applicant holds a valid certificate of need if a certificate of need is required for the project pursuant to part 222.

(2) To protect the public health, safety, and welfare, the department may promulgate rules to require construction permits for projects other than those described in subsection (1) and the submission of plans for other construction projects to expand or change service areas and services provided.

(3) If a construction project requires a construction permit under subsection (1) or (2), but does not require a certificate of need under part 222, the department shall require the applicant to submit information considered necessary by the department to assure that the capital expenditure for the project is not a covered capital expenditure as defined in section 22203(9).

(4) If a construction project requires a construction permit under subsection (1), but does not require a certificate of need under part 222, the department shall require the applicant to submit information on a 1-page sheet, along with the application for a construction permit, consisting of all of the following:

(a) A short description of the reason for the project and the funding source.

(b) A contact person for further information, including address and phone number.

(c) The estimated resulting increase or decrease in annual operating costs.

(d) The current governing board membership of the applicant.

(e) The entity, if any, that owns the applicant.

(5) The information filed under subsection (4) shall be made publicly available by the department by the same methods used to make information about certificate of need applications publicly available.

(6) The review and approval of architectural plans and narrative shall require that the proposed construction project is designed and constructed in accord with applicable statutory and other regulatory requirements.

(7) The department shall promulgate rules to further prescribe the scope of construction projects and other alterations subject to review under this section.

(8) The department may waive the applicability of this section to a construction project or alteration if the waiver will not affect the public health, safety, and welfare.

(9) Upon request by the person initiating a construction project, the department may review and issue a construction permit to a construction project that is not subject to subsection (1) or (2) if the department determines that the review will promote the public health, safety, and welfare.

(10) The department shall assess a fee for each review conducted under this section. The fee shall be .5% of the first $1,000,000.00 of capital expenditure and .85% of any amount over $1,000,000.00 of capital expenditure, up to a maximum of $30,000.00.

(11) As used in this section, "capital expenditure" means that term as defined in section 22203(2), except that it does not include the cost of equipment that is not fixed equipment.

Sec. 22203. (1) "Addition" means adding patient rooms, beds, and ancillary service areas, including, but not limited to, procedure rooms or fixed equipment, surgical operating rooms, therapy rooms or fixed equipment, or other accommodations to a health facility.

(2) "Capital expenditure" means an expenditure for a single project, including cost of construction, engineering, and equipment that under generally accepted accounting principles is not properly chargeable as an expense of operation. Capital expenditure includes a lease or comparable arrangement by or on behalf of a health facility by which a person obtains a health facility or licensed part of a health facility or equipment for a health facility, the expenditure for which would have been considered a capital expenditure under this part if the person had acquired it by purchase. Capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of physical plant and equipment.

(3) "Certificate of need" means a certificate issued pursuant to this part authorizing a new health facility, a change in bed capacity, the initiation, replacement, or expansion of a covered clinical service, or a covered capital expenditure that is issued in accordance with this part.

(4) "Certificate of need review standard" or "review standard" means a standard approved by the commission or the statewide health coordinating council under section 22215.

(5) "Change in bed capacity" means 1 or more of the following:

(a) An increase in licensed hospital beds.

(b) An increase in licensed nursing home beds or hospital beds certified for long-term care.

(c) An increase in licensed psychiatric beds.

(d) A change from 1 licensed use to a different licensed use.

(e) The physical relocation of beds from a licensed site to another geographic location.

(6) "Clinical" means directly pertaining to the diagnosis, treatment, or rehabilitation of an individual.

(7) "Clinical service area" means an area of a health facility, including related corridors, equipment rooms, ancillary service and support areas that house medical equipment, patient rooms, patient beds, diagnostic, operating, therapy, or treatment rooms or other accommodations related to the diagnosis, treatment, or rehabilitation of individuals receiving services from the health facility.

(8) "Commission" means the certificate of need commission created under section 22211.

(9) "Covered capital expenditure" means a capital expenditure of $2,000,000.00 or more, as adjusted by the department under section 22221(g), by a person for a health facility for a single project, excluding the cost of nonfixed medical equipment, that includes or involves the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of a clinical service area or a capital expenditure of $3,000,000.00 or more, as adjusted by the department under section 22221(g), by a person for a health facility for a single project that involves the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of nonclinical service areas only.

(10) "Covered clinical service", except as modified by the commission pursuant to section 22215 after the effective date of the 1993 amendatory act that amended this subsection, means 1 or more of the following:

(a) Initiation or expansion of 1 or more of the following services:

(*i*) Neonatal intensive care services or special newborn nursing services.

(*ii*) Open heart surgery.

(*iii*) Extrarenal organ transplantation.

(b) Initiation, replacement, or expansion of 1 or more of the following services:

(*i*) Extracorporeal shock wave lithotripsy.

(*ii*) Megavoltage radiation therapy.

(*iii*) Positron emission tomography.

(*iv*) Surgical services provided in a freestanding surgical outpatient facility, an ambulatory surgery center certified under title XVIII, or a surgical department of a hospital licensed under part 215 and offering inpatient or outpatient surgical services.

(*v*) Cardiac catheterization.

(*vi*) Fixed and mobile magnetic resonance imager services.

(*vii*) Fixed and mobile computerized tomography scanner services.

(*viii*) Air ambulance services.

(c) Initiation, replacement, or expansion of a partial hospitalization psychiatric program service.

(d) Initiation or expansion of a specialized psychiatric program for children and adolescent patients utilizing licensed psychiatric beds.

(e) Initiation, replacement, or expansion of a service not listed in this subsection, but designated as a covered clinical service by the commission under section 22215(1)(a).

(11) "Fixed equipment" means equipment that is affixed to and constitutes a structural component of a health facility, including, but not limited to, mechanical or electrical systems, elevators, generators, pumps, boilers, and refrigeration equipment.

Sec. 22205. (1) "Health facility", except as otherwise provided in subsection (2), means:

(a) A hospital licensed under part 215.

(b) A psychiatric hospital, psychiatric unit, or partial hospitalization psychiatric program licensed under the mental health code, Act No. 258 of the Public Acts of 1974, being sections 330.1001 to 330.2106 of the Michigan Compiled Laws.

(c) A nursing home licensed under part 217 or a hospital long-term care unit as defined in section 20106(6).

(d) A freestanding surgical outpatient facility licensed under part 208.

(e) A health maintenance organization licensed under part 210.

(2) "Health facility" does not include the following:

(a) An institution conducted by and for the adherents of a church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend solely upon spiritual means through prayer for healing.

(b) A health facility or agency located in a correctional institution.

(c) A veterans facility operated by the state or federal government.

(d) A facility owned and operated by the department of mental health.

(3) "Initiate" means the initiation of a covered clinical service by a person if the covered clinical service has not been offered in compliance with this part or former part 221 on a regular basis by that person at the location where the covered clinical service is to be offered within the 12-month period immediately preceding the date the covered clinical service will be offered.

(4) "Medical equipment" means a single equipment component or a related system of components that is used for clinical purposes.

Sec. 22207. (1) "Medicaid" means the program for medical assistance administered by the department of social services under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.119b of the Michigan Compiled Laws.

(2) "Modernization" means an upgrading, alteration, or change in function of a part or all of the physical plant of a health facility. Modernization includes, but is not limited to, the alteration, repair, remodeling, and renovation of an existing building and initial fixed equipment and the replacement of obsolete fixed equipment in an existing building. Modernization of the physical plant does not include normal maintenance and operational expenses.

(3) "New construction" means construction of a health facility where a health facility does not exist or construction replacing or expanding an existing health facility or a part of an existing health facility.

(4) "Person" means a person as defined in section 1106 or a governmental entity.

(5) "Planning area" means the area defined in a certificate of need review standard for determining the need for, and the resource allocation of, a specific health facility, service, or equipment. Planning area includes, but is not limited to, the state, a health facility service area, or a health service area or subarea within the state.

(6) "Proposed project" means a proposal to acquire an existing health facility or begin operation of a new health facility, make a change in bed capacity, initiate, replace, or expand a covered clinical service, or make a covered capital expenditure.

(7) "Rural county" means a county not located in a metropolitan area as that term is defined pursuant to the "revised standards for defining metropolitan areas in the 1990's" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 55 F.R. p. 12154 (March 30, 1990).

(8) "Statewide health coordinating council" means the state agency created by section 7 of Act No. 323 of the Public Acts of 1978, being section 325.2007 of the Michigan Compiled Laws, before section 7 was amended by the 1988 amendatory act that created the state health planning council.

(9) "Stipulation" means a requirement that is germane to the proposed project and has been agreed to by an applicant as a condition of certificate of need approval.

Sec. 22208. (1) "Short-term nursing care" means nursing care provided in a hospital to a patient who has been discharged or is ready for transfer from a licensed hospital bed other than a hospital long-term care unit bed and cannot be placed in a nursing home bed, county medical care facility bed, or hospital long-term care unit bed located within a 50-mile radius of the patient's residence.

(2) "Title XVIII" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(3) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396u.

Sec. 22209. (1) Except as otherwise provided in this part, a person shall not do any of the following without first obtaining a certificate of need:

(a) Acquire an existing health facility or begin operation of a health facility at a site that is not currently licensed for that type of health facility.

(b) Make a change in the bed capacity of a health facility.

(c) Initiate, replace, or expand a covered clinical service.

(d) Make a covered capital expenditure.

(2) A certificate of need is not required for a reduction in licensed bed capacity or services at a licensed site.

(3) An applicant seeking a certificate of need for the acquisition of an existing health facility may file a single, consolidated application for the certificate of need if the project results in the acquisition of an existing health facility but does not result in an increase or relocation of licensed beds or the initiation, expansion, or replacement of a covered clinical service. Except as otherwise provided in this subsection, a person acquiring an existing health facility is subject to the applicable certificate of need review standards in effect on the date of the transfer for the covered clinical services provided by the acquired health facility. The department may except 1 or more of the covered clinical services listed in section 22203(10)(b), except the covered clinical service listed in section 22203(10)(b)(*iv*), from the minimum volume requirements in the applicable certificate of need review standards in effect on the date of the transfer, if the equipment used in the covered clinical service is unable to meet the minimum volume requirements due to the technological incapacity of the equipment. A covered clinical service excepted by the department under this subsection is subject to all the other provisions in the applicable certificate of need review standards in effect on the date of the transfer, except minimum volume requirements.

(4) The center for rural health created in section 2612 shall designate a certificate of need ombudsman to provide technical assistance and consultation to hospitals and communities located in rural counties regarding certificate of need proposals and applications under this part. The ombudsman shall also act as an advocate for health concerns of rural counties in the development of certificate of need review standards under this part.

Sec. 22210. (1) A hospital that applies to the department for a certificate of need and meets all of the following criteria shall be granted a certificate of need for a short-term nursing care program with up to 10 licensed hospital beds:

(a) Is eligible to apply for certification as a provider of swing-bed services under section 1883 of title XVIII, 42 U.S.C. 1395tt.

(b) Subject to subsection (2), has fewer than 100 licensed beds not counting beds excluded under section 1883 of title XVIII of the social security act.

(c) Does not have uncorrected licensing, certification, or safety deficiencies for which the department or the state fire marshal, or both, has not accepted a plan of correction.

(d) Provides evidence satisfactory to the department that the hospital has had difficulty in placing patients in skilled nursing home beds during the 12 months immediately preceding the date of the application.

(2) After October 1, 1990, the criteria set forth in subsection (1)(b) may be modified by the commission, using the procedure set forth in section 22215(3). The department shall not charge a fee for processing a certificate of need application to initiate a short-term nursing care program.

(3) A hospital that is granted a certificate of need for a short-term nursing care program under subsection (1) shall comply with all of the following:

(a) Not charge for or otherwise attempt to recover the cost of a length of stay for a patient in the short-term nursing care program that exceeds the length of time allowed for post-hospital extended care under title XVIII.

(b) Admit patients to the short-term nursing care program only pursuant to an admissions contract approved by the department.

(c) Not discharge or transfer a patient from a licensed hospital bed other than a hospital long-term care unit bed and admit that patient to the short-term nursing care program unless the discharge or transfer and admission is determined medically appropriate by the attending physician.

(d) Permit access to a representative of an organization approved under section 21764 to patients admitted to the short-term nursing care program, for all of the purposes described in section 21763.

(e) Subject to subsection (8), not allow the number of patient days for the short-term nursing care program to exceed the equivalent of 1,825 patient days for a single state fiscal year.

(f) Transfer a patient in the short-term nursing care program to an appropriately certified nursing home bed, county medical care facility bed, or hospital long-term care unit bed located within a 50-mile radius of the patient's residence within 5 business days after the hospital has been notified, either orally or in writing, that a bed has become available.

(g) Not charge or collect from a patient admitted to the short-term nursing care program, for services rendered as part of the short-term nursing care program, an amount in excess of the reasonable charge for the services as determined by the United States secretary of health and human services under title XVIII.

(h) Assist a patient who has been denied coverage for services received in a short-term nursing care program under title XVIII to file an appeal with the medicare recovery project operated by the office of services to the aging.

(i) Operate the short-term nursing care program in accordance with this section and the requirements of the swing bed provisions of section 1883 of title XVIII, 42 U.S.C. 1395tt.

(j) Provide data to the department considered necessary by the department to evaluate the short-term nursing care program. The data shall include, but is not limited to, all of the following:

(*i*) The total number of patients admitted to the hospital's short-term nursing care program during the period specified by the department.

(*ii*) The total number of short-term nursing care patient days for the period specified by the department.

(*iii*) Information identifying the type of care to which patients in the short-term care nursing program are released.

(k) As part of the hospital's policy describing the rights and responsibilities of patients admitted to the hospital, as required under section 20201, incorporate all of the following additional rights and responsibilities for patients in the short-term nursing care program:

(*i*) A copy of the hospital's policy shall be provided to each short-term nursing care patient upon admission, and the staff of the hospital shall be trained and involved in the implementation of the policy.

(*ii*) Each short-term nursing care patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall take into consideration the special circumstances of each visitor, shall be established for short-term nursing care patients to receive visitors. A short-term nursing care patient may be visited by the patient's attorney or by representatives of the departments named in section 20156 during other than established visiting hours. Reasonable privacy shall be afforded for visitation of a short-term nursing care patient who shares a room with another short-term nursing care patient. Each short-term nursing care patient shall have reasonable access to a telephone.

(*iii*) A short-term nursing care patient is entitled to retain and use personal clothing and possessions as space permits, unless medically contraindicated, as documented by the attending physician in the medical record.

(*iv*) A short-term nursing care patient is entitled to the opportunity to participate in the planning of his or her medical treatment. A short-term nursing care patient shall be fully informed by the attending physician of the short-term nursing care patient's medical condition, unless medically contraindicated, as documented by a physician in the medical record. Each short-term nursing care patient shall be afforded the opportunity to discharge himself or herself from the short-term nursing care program.

(*v*) A short-term nursing care patient is entitled to be fully informed either before or at the time of admission, and during his or her stay, of services available in the hospital and of the related charges for those services. The statement of services provided by the hospital shall be in writing and shall include those services required to be offered on an as needed basis.

(*vi*) A patient in a short-term nursing care program or a person authorized in writing by the patient may, upon submission to the hospital of a written request, inspect and copy the patient's personal or medical records. The hospital shall make the records available for inspection and copying within a reasonable time, not exceeding 7 days, after the receipt of the written request.

(*vii*) A short-term nursing care patient has the right to have his or her parents, if the short-term nursing care patient is a minor, or his or her spouse, next of kin, or patient's representative, if the short-term nursing care patient is an adult, stay at the facility 24 hours a day if the short-term nursing care patient is considered terminally ill by the physician responsible for the short-term nursing care patient's care.

(*viii*) Each short-term nursing care patient shall be provided with meals that meet the recommended dietary allowances for that patient's age and sex and that may be modified according to special dietary needs or ability to chew.

(*ix*) Each short-term nursing care patient has the right to receive a representative of an organization approved under section 21764, for all of the purposes described in section 21763.

(*l*) Achieve and maintain medicare certification under title XVIII.

(4) A hospital or the owner, administrator, an employee, or a representative of the hospital shall not discharge, harass, or retaliate or discriminate against a short-term nursing care patient because the short-term nursing care patient has exercised a right described in subsection (3)(k).

(5) In the case of a short-term nursing care patient, the rights described in subsection (3)(k)(*iv*) may be exercised by the patient's representative, as defined in section 21703(2).

(6) A short-term nursing care patient shall be fully informed, as evidenced by the short-term nursing care patient's written acknowledgment, before or at the time of admission and during stay, of the rights described in subsection (3)(k). The written acknowledgment shall provide that if a short-term nursing care patient is adjudicated incompetent and not restored to legal capacity, the rights and responsibilities set forth in subsection (3)(k) shall be exercised by a person designated by the short-term nursing care patient. The hospital shall provide proper forms for the short-term nursing care patient to provide for the designation of this person at the time of admission.

(7) Subsection (3)(k) does not prohibit a hospital from establishing and recognizing additional rights for short-term nursing care patients.

(8) Upon application, the department may grant a variation from the maximum number of patient days established under subsection (3)(e), to an applicant hospital that demonstrates to the satisfaction of the department that there is an immediate need for skilled nursing beds within a 100-mile radius of the hospital. A variation granted under this subsection shall be valid for not more than 1 year after the date the variation is granted. The department shall promulgate rules to implement this subsection including, at a minimum, a definition of immediate need and the procedure for applying for a variation.

(9) A hospital that violates subsection (3) is subject to the penalty provisions of section 20165.

(10) A person shall not initiate a short-term nursing care program without first obtaining a certificate of need under this section.

Sec. 22213. (1) The commission shall, within 2 months after appointment and confirmation of all members, adopt bylaws for the operation of the commission. The bylaws shall include, at a minimum, voting procedures that protect against conflict of interest and minimum requirements for attendance at meetings.

(2) The governor may remove a commission member from office for failure to attend 3 consecutive meetings in a 1-year period.

(3) The commission annually shall elect a chairperson and vice-chairperson.

(4) The commission shall hold regular quarterly meetings at places and on dates fixed by the commission. Special meetings may be called by the chairperson, by not less than 2 commission members, or by the department.

(5) A majority of the commission members appointed and serving constitutes a quorum. Final action by the commission shall be only by affirmative vote of a majority of the commission members appointed and serving. A commission member shall not vote by proxy.

(6) The legislature annually shall fix the per diem compensation of members of the commission. Expenses of members incurred in the performance of official duties shall be reimbursed as provided in section 1216.

(7) The department shall furnish administrative services to the commission, shall have charge of the commission's offices, records, and accounts, and shall provide secretarial and other staff necessary to allow the proper exercise of the powers and duties of the commission. The department shall make available the times and places of commission meetings and keep minutes of the meetings and a record of the actions of the commission.

(8) The department shall assign professional employees to staff the commission to assist the commission in the performance of its substantive responsibilities under this part.

Sec. 22215. (1) Pursuant to the requirements of this part, the commission shall do all of the following:

(a) If determined necessary by the commission, revise, add to, or delete 1 or more of the covered clinical services listed in section 22203. If the commission proposes to add to the covered clinical services listed in section 22203, the commission shall develop proposed review standards and make the review standards available to the public not less than 30 days before conducting a hearing under subsection (3).

(b) Approve, disapprove, or revise certificate of need review standards that establish for purposes of section 22225 the need, if any, for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning the operation of a health facility, making changes in bed capacity, or making covered capital expenditures, including conditions, standards, assurances, or information that must be met, demonstrated, or provided by a person who applies for a certificate of need. A certificate of need review standard may also establish ongoing quality assurance requirements including any or all of the requirements specified in section 22225(2)(c). The statewide health coordinating council may perform the duties of the commission under this subdivision, only until all members of the commission are appointed and confirmed, or until March 1, 1989, whichever is sooner.

(c) Direct the department to prepare and submit recommendations regarding commission duties and functions that are of interest to the commission including, but not limited to, specific modifications of proposed actions considered under this section.

(d) Approve, disapprove, or revise proposed criteria for determining health facility viability under section 22225.

(e) Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission.

(f) By October 1, 1992, and every 5 years after October 1, 1992, make recommendations to the standing committees in the senate and the house that have jurisdiction over matters pertaining to public health regarding statutory changes to improve or eliminate the certificate of need program.

(g) Upon submission by the department approve, disapprove, or revise standards to be used by the department in designating a regional certificate of need review agency, pursuant to section 22226.

(h) Approve, disapprove, or revise certificate of need review standards governing the acquisition of new technology.

(i) In accordance with section 22255, approve, disapprove, or revise proposed procedural rules for the certificate of need program.

(j) Consider the recommendations of the department and the department of attorney general as to the administrative feasibility and legality of proposed actions under subdivisions (a), (b), and (c).

(k) Consider the impact of a proposed restriction on the acquisition of or availability of covered clinical services on the quality, availability, and cost of health services in this state.

(l) Appoint ad hoc advisory committees to assist in the development of proposed certificate of need review standards. An ad hoc advisory committee shall complete its duties under this subdivision and submit its recommendations to the commission within the time limit specified by the commission when an ad hoc advisory committee is appointed. The composition of the ad hoc advisory committee shall include all of the following:

(i) Experts with professional competence in the subject matter of the proposed standard, who shall constitute a majority of the ad hoc advisory committee.

(ii) Representatives of health care provider organizations concerned with licensed health facilities or licensed health professions.

(iii) Representatives of organizations concerned with health care consumers and the purchasers and payers of health care services.

(2) The commission shall exercise its duties under this part to promote all of the following:

(a) The availability and accessibility of quality health services at reasonable cost and with reasonable geographic proximity for all people in the state.

(b) Appropriate differential consideration of the health care needs of residents in rural counties in ways that do not compromise the quality and affordability of health care services for those residents.

(3) Not less than 30 days before final action is taken by the commission under subsection (1)(a), (b), (d), or (h), the commission shall conduct a public hearing on its proposed action. In addition, not less than 30 days before final action is taken by the commission under subsection (1)(a), (b), (d), or (h), the commission shall submit the proposed action for comment to the standing committees in the senate and house of representatives with jurisdiction over public health matters.

(4) The commission shall submit the proposed final action to the governor and the standing committee of each house of the legislature with jurisdiction over public health matters. The governor or the legislature may disapprove the proposed final action within 45 days after the date of submission. If the proposed final action is not submitted on a legislative session day, the 45 days commence on the first legislative session day after the proposed final action is submitted. The 45 days shall include not less than 9 legislative session days. Legislative disapproval shall be expressed by concurrent resolution which shall be adopted by each house of the legislature. The concurrent resolution shall state specific objections to the proposed final action. A proposed final action by the commission under subsection (1)(a), (b), (d), or (h) is not effective if it has been disapproved under this subsection. If the proposed final action is not disapproved under this subsection, it is effective and binding on all persons affected by this part upon the expiration of the 45-day period or on a later date specified in the proposed final action. As used in this subsection, "legislative session day" means each day in which a quorum of either the house of representatives or the senate, following a call to order, officially convenes in Lansing to conduct legislative business.

(5) Within 2 years after the effective date of the amendatory act that added this sentence, the ad hoc advisory committee for psychiatric services appointed by the department under section 22221 or by the commission under section 22215 shall develop and submit certificate of need review standards under this section for the covered clinical services described in section 22203(10)(c) and (d). The ad hoc advisory committee for psychiatric services shall include in the review standards a specific methodology for the determination of need. If the ad hoc advisory committee for psychiatric services does not develop and submit review standards for the covered clinical services described in section 22203(10)(c) and (d) within the 2-year time limit set forth in this subsection, the commission shall delete the covered clinical services described in section 22203(10)(c) and (d) pursuant to subsection (1)(a).

(6) If the reports received under section 22221(f) indicate that the certificate of need application fees collected under section 20161(2) have not been within 10% of 1/2 the cost to the department of implementing this part, the commission shall make recommendations regarding the revision of those fees so that the certificate of need application fees collected equal approximately 1/2 of the cost to the department of implementing this part.

Sec. 22221. The department shall do all of the following:

(a) Promulgate rules to implement its powers and duties under this part.

(b) Report to the commission at least annually on the performance of the department's duties under this part.

(c) Develop proposed certificate of need review standards for submission to the commission.

(d) Administer and apply certificate of need review standards. In applying a review standard that establishes the minimum number of magnetic resonance imaging procedures necessary for a certificate of need for a mobile magnetic resonance imaging service servicing only hospitals located in rural counties, the department shall use an adjustment factor of 2.0. In applying a review standard that establishes the minimum number of magnetic resonance imaging procedures necessary for a certificate of need for a mobile magnetic resonance imaging service servicing hospitals located in both rural and nonrural counties, for a hospital located in a rural county the department shall use an adjustment factor of 1.4.

(e) Designate adequate staff or other resources to directly assist hospitals and nursing homes with less than 100 beds in the preparation of applications for certificates of need.

(f) Following the first state fiscal year after October 1, 1988, and annually thereafter, report to the commission regarding the costs to the department of implementing this part and the certificate of need application fees collected under section 20161(2) in the immediately preceding state fiscal year.

(g) Beginning January 1, 1995 annually adjust the $2,000,000.00 and $3,000,000.00 thresholds set forth in section 22203(9) by an amount determined by the state treasurer to reflect the annual percentage change in the consumer price index, using data from the immediately preceding period of July 1 to June 30. As used in this subdivision, "consumer price index" means the most comprehensive index of consumer prices available for this state from the bureau of labor statistics of the United States department of labor.

Sec. 22225. (1) In order to be approved under this part, an applicant for a certificate of need shall demonstrate to the satisfaction of the department that the proposed project will meet an unmet need in the area proposed to be served. An applicant shall demonstrate the need for a proposed project by credible documentation of compliance with the applicable certificate of need review standards. If no certificate of need review standards are applicable to the proposed project or to a portion of a proposed project that is otherwise governed by this part, the applicant shall demonstrate to the satisfaction of the department that an unmet need for the proposed project or portion of the proposed project exists by credible documentation that the proposed project will be geographically accessible and efficiently and appropriately utilized, in light of the type of project and the existing health care system. Whether or not there are applicable certificate of need review standards, in determining compliance with this subsection, the department shall consider approved projects that are not yet operational, proposed projects under appeal from a final decision of the department, or proposed projects that are pending final department decision.

(2) If, and only if, the requirements of subsection (1) are met, in order for an application to be approved under this part, an applicant shall also demonstrate to the reasonable satisfaction of the department all of the following:

(a) With respect to the method proposed to meet the unmet need identified under subsection (1), that the applicant has considered alternatives to the proposed project and that, in light of the alternatives available for consideration, the chosen alternative is the most efficient and effective method of meeting that unmet need.

(b) With respect to the financial aspects of the proposed project, that each of the following is met:

(*i*) The capital costs of the proposed project will result in the least costly total annual operating costs.

(*ii*) Funds are available to meet the capital and operating needs of the proposed project.

(*iii*) The proposed project utilizes the least costly method of financing, in light of available alternatives.

(*iv*) In the case of a construction project, the applicant stipulates that the applicant will competitively bid capital expenditures among qualified contractors or alternatively, the applicant is proposing an alternative to competitive bidding that will achieve substantially the same results as competitive bidding.

(c) The proposed project will be delivered in compliance with applicable operating standards and quality assurance standards approved under section 22215(1)(b), including 1 or more of the following:

(*i*) Mechanisms for assuring appropriate utilization of the project.

(*ii*) Methods for evaluating the effectiveness of the project.

(*iii*) Means of assuring delivery of the project by qualified personnel and in compliance with applicable safety and operating standards.

(*iv*) Evidence of the current and historical compliance with federal and state licensing and certification requirements in this state by the applicant or the applicant's owner, or both, to the degree determined appropriate by the commission in light of the subject of the review standard.

(*v*) Other criteria approved by the commission as appropriate to evaluate the quality of the project.

(d) The health services proposed in the project will be delivered in a health facility that meets the criteria, if any, established by the commission for determining health facility viability, pursuant to this subdivision. The criteria shall be proposed by the department and the office, and approved or disapproved by the commission. At a minimum, the criteria shall specify, to the extent applicable to the applicant, that an applicant shall be considered viable by demonstrating at least 1 of the following:

(*i*) A minimum percentage occupancy of licensed beds.

(*ii*) A minimum percentage of combined uncompensated discharges and discharges under title XIX in the health facility's planning area.

(*iii*) A minimum percentage of the total discharges in the health facility's planning area.

(*iv*) Evidence that the health facility is the only provider in the health facility's planning area of a service that is considered essential by the commission.

(*v*) An operating margin in an amount determined by the commission.

(*vi*) Other criteria approved by the commission as appropriate for statewide application to determine health facility viability.

(e) In the case of a nonprofit health facility, the health facility is in fact governed by a body composed of a majority consumer membership broadly representative of the population served. In the case of a health facility sponsored by a religious organization, or if the nature of the nonprofit health facility is such that the legal rights of its owners or sponsors might be impaired by a requirement as to the composition of its governing body, an advisory board with majority consumer membership broadly representative of the population served may be construed by the department to be equivalent to the governing board described in this subdivision, if the advisory board meets all of the following requirements:

(*i*) The role assigned to the advisory board is meaningful, as determined by the department.

(*ii*) The functions of the advisory board are clearly prescribed.

(*iii*) The advisory board is given an opportunity to influence policy formulation by the legally recognized governing body, as determined by the department.

Sec. 22227. (1) A health maintenance organization is required to obtain a certificate of need only for 1 or more of the following purposes:

(a) The acquisition of, purchase of, new construction of, modernization of, replacement of, or addition to a hospital or other health facility providing inpatient services, if a covered capital expenditure is required.

(b) The initiation, replacement, or expansion of a covered clinical service.

(2) A covered capital expenditure proposed to be undertaken by a health maintenance organization that is not intended principally to serve the needs of the enrollees of the health maintenance organization, as determined by the department, is subject to this part.

(3) In making determinations and conducting reviews for certificates of need for health maintenance organizations, the department shall consider the special needs and circumstances of health maintenance organizations, and shall apply all of the following criteria:

(a) The availability of the proposed service from a provider of health care other than the health maintenance organization on a long-term basis, at reasonable terms, and in a cost-effective manner consistent with the health maintenance organization's basic method of operation.

(b) The long-term needs of the health maintenance organization, and its current and expected future membership.

(c) The long-term impact of the proposed service on health care costs in the health maintenance organization's service area.

Sec. 22229. (1) The following proposed projects are subject to comparative review:

(a) Proposed projects specified as subject to comparative review in a certificate of need review standard.

(b) New beds in a health facility that is a hospital, hospital long-term care unit, or nursing home if there are multiple applications to meet the same need for projects that, when combined, exceed the need of the planning area as determined by the applicable certificate of need review standards.

(2) Replacement beds in a hospital that are proposed for construction on the original site, on a contiguous site, within a 5-mile radius of the original site if the hospital is located in a county with a population of less than 200,000, or within a 2-mile radius of the original site if the hospital is located in a county with a population of 200,000 or more, are not subject to comparative review.

(3) Replacement beds in a nursing home that is located in a nonrural county that are proposed for construction on the original site, on a contiguous site, or within a 2-mile radius of the original site are not subject to comparative review. Replacement beds in a nursing home that is located in a rural county that are proposed for construction on the original site, on a contiguous site, or within the same planning area are not subject to comparative review.

(4) The commission may approve certificate of need review standards that establish comparative review or an alternative procedure for determining whether 1 or more of several qualified applicants may be approved if the level of

need is not sufficient to justify approval of all qualified applicants. If an applicant involves more than 1 health facility, the applicant shall indicate on the application the proposed site or sites for the project and arrangements for the utilization and financing of the covered clinical services.

Sec. 22231. (1) The decision to grant or deny an application for a certificate of need shall be made by the director. A decision shall be proposed to the director by a bureau within the department designated by the director as responsible for the certificate of need program. A decision shall be in writing and shall indicate 1 of the following:

(a) Approval of the application.

(b) Disapproval of the application.

(c) Subject to subsection (2), approval of the application with conditions.

(d) If agreed to by the department and the applicant, approval of the application with stipulations.

(2) If an application is approved with conditions pursuant to subsection (1)(c), the conditions shall be explicit, shall be related to the proposed project or to the applicable provisions of this part, and shall specify a time, not to exceed 1 year after the date the decision is rendered, within which the conditions shall be met.

(3) If the department is conducting a comparative review, the director shall issue only 1 decision for all of the applications included in the comparative review.

(4) Before a final decision on an application is made, the bureau of the department designated by the director as responsible for the certificate of need program shall issue a proposed decision with specific findings of fact in support of the proposed decision with regard to each of the criteria listed in section 22225. The proposed decision also shall state with specificity the reasons and authority of the department for the proposed decision. If a proposed decision is issued within the application review period specified in the rules promulgated under former part 221, the department is in compliance with the review period requirement of those rules. The department shall transmit a copy of the proposed decision to the applicant.

(5) The proposed decision shall be submitted to the director on the same day the proposed decision is issued.

(6) If the proposed decision is other than an approval without conditions or stipulations, the director shall issue a final decision not later than 60 days after the date a proposed decision is submitted to the director unless the applicant has filed a request for a hearing on the proposed decision. If the proposed decision is an approval, the director shall issue a final decision not later than 5 days after the proposed decision is submitted to the director.

(7) The director shall review the proposed decision before a final decision is rendered.

(8) If a proposed decision is an approval, and if, upon review, the director reverses the proposed decision, the director immediately shall notify the applicant of the reversal. Within 15 days after receipt of the notice of reversal, the applicant may request a hearing under section 22232. After the hearing, the applicant may request the director to reconsider the reversal of the proposed decision, based on the results of the hearing.

(9) The final decision of the director may be appealed only by the applicant and only on the record directly to the circuit court for the county where the applicant has its principal place of business in this state or the circuit court for Ingham county. Judicial review is governed by sections 103 to 106 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.303 to 24.306 of the Michigan Compiled Laws.

(10) The review and appeal of a certificate of need application submitted with the required filing fee before October 1, 1988 shall be conducted under former part 221 and the rules promulgated under that part. The certificate of need board created by former section 22121(2) shall continue for the purpose of performing the functions vested in it by former part 221, until all appeals lawfully brought under former part 221 are concluded.

(11) If the department exceeds the time frames set forth in this section for other than good cause, as determined by the commission, upon the written request of an applicant, the department shall return to the applicant all of the certificate of need application fee paid by the applicant under section 20161(2).

Sec. 22232. (1) The applicant may, within 15 days after receipt by the applicant of the bureau's proposed decision to deny the application or receipt of notice of reversal by the director of a proposed decision that is an approval, submit a written request for a hearing to demonstrate that the application filed by the applicant meets the requirements for approval under this part.

(2) The department shall appoint a hearing officer for a hearing held under this section. The hearing officer shall establish a schedule for the hearing, control the presentation of proofs, and take such other action determined by the hearing officer to be necessary to ensure that the hearing is conducted in an expeditious manner and completed within a reasonable period of time. The hearing officer shall convene the hearing within 90 days after receipt of a request for a hearing under this section. Upon written request by a party, a hearing officer may issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence. The department shall establish appropriate qualifications for hearing officers appointed under this section.

(3) If a hearing is requested under this section, chapter 4 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws, governs.

Sec. 22239. A certificate of need ceases to be effective if the certificate of need approval was based on a stipulation that the project would participate in title XIX and the project has not participated in title XIX for not less than 12 consecutive months within the first 2 years of operation. A stipulation described in this section is germane to all health facility projects.

Sec. 22241. (1) For purposes of this section and sections 22243 and 22245, "new technology" means medical equipment that requires, but has not yet been granted, the approval of the federal food and drug administration for commercial use.

(2) The period ending 12 months after the date of federal food and drug administration approval of new technology for commercial use shall be considered the new technology review period. A person shall not acquire new technology before the end of a new technology review period, unless 1 of the following occurs:

(a) The department, with the concurrence of the commission, issues a public notice that the new technology will not be added to the list of covered medical equipment during the new technology review period. The notice may apply to specific new technology or classes of new technology.

(b) The person complies with the requirements of section 22243.

(c) The commission approves the addition of the new technology to the list of covered medical equipment, and the person obtains a certificate of need for that covered medical equipment.

(3) To assist in the identification of new medical technology or new medical services that may be appropriate for inclusion as a covered clinical service in the earliest possible stage of its development, the commission shall appoint a standing new medical technology advisory committee. A majority of the new medical technology advisory committee shall be representatives of health care provider organizations concerned with licensed health facilities or licensed health professions and other persons knowledgeable in medical technology. The commission also shall appoint representatives of health care consumer, purchaser, and third party payer organizations to the committee.

Sec. 22247. (1) The department may monitor compliance with certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.

(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department may do 1 or more of the following:

(a) Revoke or suspend the certificate of need.

(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.

(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.

(d) Request enforcement action under section 22253.

(e) Take any other enforcement action authorized by this code.

(f) Publicize or report the violation or enforcement action, or both, to any person.

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

Sec. 22260. (1) The department shall prepare and publish at least annually reports of reviews conducted under this part. The reports shall include a statement on the status of each pending review and a statement as to each review completed, including statements of the findings and decisions made in the course of the reviews since the last report, and the recommendations of regional certificate of need review agencies.

(2) The department and, if applicable, the appropriate regional certificate of need review agency shall make available to the public for examination during all business hours the applications received by them and pertinent written materials on file.

Section 2. Section 22251 of Act No. 368 of the Public Acts of 1978, being section 333.22251 of the Michigan Compiled Laws, is repealed.

This act is ordered to take immediate effect.

Secretary of the Senate.

Co-Clerk of the House of Representatives.

Approved _____

Governor.