This revised summary replaces the summary of Senate Bill 1436 (Substitute H-7) dated 12-12-02.

House
Legislative
Analysis
Section

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CERTIFICATE OF NEED AMENDMENTS

Senate Bill 1436 as passed by the House
Sponsor: Sen. John J. H. Schwarz, M.D.
Committee: Health Policy

Complete to 12-12-02

A REVISED SUMMARY OF SENATE BILL 1436 AS PASSED BY THE HOUSE 12-12-02

As provided under Part 222 of the Public Health Code the Certificate of Need program essentially requires a health facility or person to apply for and obtain a Certificate of Need (CON) from the state before making large capital expenditures for a new health facility or certain other capital expenditures, a change in bed capacity, or the initiation, replacement, or expansion of specific clinical services. The premise of the program is that controlling the supply of health facilities and services is an effective way of controlling health care costs as well as ensuring both quality health care and the fair allocation of resources.

Senate Bill 1436 as passed by the House would amend Part 222 of the Public Health Code to make various changes to the state's Certificate of Need (CON) program. Among other things, the bill would do all of the following:

- increase from $2 million to $2.5 million the capital expenditure threshold at which a health facility must obtain a CON before improving, constructing, or replacing a clinical service area;

- eliminate from the CON program capital expenditures for nonclinical service areas;

- remove from CON requirements the physical relocation of beds, in certain circumstances;

- allow hospitals to provide clinical covered services to and use beds in federal veterans health care facilities without a CON, in certain circumstances;

- allow hospitals in certain counties to initiate, expand, replace, relocate, or acquire fixed MRI service without obtaining a CON, in certain circumstances;

- increase the number of CON commission members from five to eleven and specify different groups that must have representation on the commission;

- revise CON commission requirements and Department of Community Health (DCH) requirements concerning the CON program;

- replace "ad hoc advisory committees" with "standard advisory committees" and give the CON commission the option of contracting with private consultants or organizations rather than consulting such a committee;

• create a “joint committee”--consisting of the chairpersons, majority vice-chairpersons, and minority vice-chairpersons of the House and Senate standing committees on health policy issues--to review certain proposed actions of the CON commission and make recommendations to the legislature;

• allow an applicant to file a single, consolidated CON application under certain conditions;

• require the DCH to review the CON application process each year and to provide additional staff to the CON commission;

• allow a regional CON review agency to appeal a final decision on a CON application; and

• require the CON commission to include in CON review standards other than nursing home and hospital long-term care unit bed review standards a requirement that each applicant participate in Title 19 of the Social Security Act (Medicaid).

A detailed summary of the bill follows.

CON thresholds. Currently, under Part 222, a "covered capital expenditure" is either: (a) a capital expenditure of $2 million or more 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 (b) a capital expenditure of $3 million or more for a nonclinical service area. The bill would raise the former threshold to $2.5 million and would eliminate the CON requirements for capital expenditures for nonclinical service areas. As under current law, the threshold for capital expenditures for clinical service areas would have to be adjusted each year for inflation. The bill would also require the Department of Community Health, in consultation with the CON Commission, to define “single project” as it applies to capital expenditures.

(Part 222 defines “clinical service area” as “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”.)

Physical relocation of licensed beds – nearby facilities. Part 222 states that, except as otherwise provided, a person shall not make a change in the bed capacity of a health facility without first obtaining a CON. One exception to this requirement is that a CON is not required for a reduction in licensed bed capacity or services at a licensed site.

The bill would specify that if the relocation did not result in an increase of licensed beds within the health service area a CON would not be required for either of the following:

• the physical relocation of licensed beds from a nursing home licensed under the code to another nursing home licensed under the code if the nursing homes were within three miles of one another; or

• the physical relocation of licensed beds from a hospital site licensed under the code to another hospital site licensed under the same license if the hospitals are located within two miles of one another.

Physical relocation of licensed beds to hospital site within same service area. If the relocation did not result in an increase of licensed beds within the health service area, a CON would not be required for the physical relocation of licensed beds from a hospital licensed under the code to another hospital site within the same health service area if the site receiving the licensed beds was owned by, under common control of, or had as a common parent the hospital seeking to relocate its licensed beds, subject to the following requirement. A hospital could transfer no more than 35 percent of its licensed beds to another hospital not more than one time after the bill's effective date. The relocated licensed beds would not be included as new beds in a hospital or as a new hospital under the CON review standards for hospital beds.

Physical relocation of beds to licensed hospital in same subarea. If the relocation did not result in an increase of licensed beds within the health service area a CON would not be required for the physical relocation of licensed beds from a hospital licensed under the code to another hospital licensed under the code and located within the same hospital subarea, subject to two requirements. First, the site receiving the licensed bed would have to be owned by, under common control of, or had as a common parent the hospital seeking to relocate the licensed beds. Second, a hospital could not make such a transfer more than one time per facility after the bill's effective date.

Physical relocation of licensed beds to freestanding surgical outpatient facility. If the relocation did not result in an increase of licensed beds within the health service area a CON would not be required for the physical relocation of licensed beds from a hospital licensed under the code to a freestanding surgical outpatient facility licensed under the code, subject to the following requirements and conditions. First, the surgical outpatient facility would have to have met all of the following criteria on December 2, 2002:

• be owned by, under common control of, or had as a common parent, the hospital seeking to relocate its licensed beds;

• be licensed prior to January 1, 2002;

• provide 24-hour emergency care services at that site; and

• provide at least four different covered clinical services at that site.

Second, before relocating beds, the hospital seeking to relocate its beds would have to request a certification from the Department of Consumer and Industry Services verifying the number of licensed beds that were staffed and available for patient care at that hospital as of December 2, 2002. Third, a hospital could transfer no more than 35 percent of its licensed beds to a freestanding surgical outpatient facility (as described above) not more than one time after the bill's effective date. Fourth, the relocated licensed beds would not be included as new beds in a hospital or as a new hospital under the CON review standards for hospital beds. Fifth, one of every two beds transferred, up to a maximum of 100 beds, would have to be beds that were staffed and available for patient care as of December 2, 2002. Sixth, a hospital relocating beds

could not reactivate licensed beds within that hospital that were staffed or available for patient care as of December 2, 2002 for a period of five years after the bill's effective date.

"Covered clinical services". Part 222 lists those services that are considered "covered clinical services" (and thus subject to CON requirements). The bill would remove the initiation, replacement, and expansion of partial hospitalization psychiatric program services from the list. (The bill would also remove partial hospitalization psychiatric programs from the definition of "health facility".)

Providing covered clinical services or using beds in federal veterans facilities. Under the bill a hospital licensed under the code would not be required to obtain a CON to provide one or more covered clinical services in a federal veterans health care facility or to use long-term care unit beds or acute care beds that were owned and located in such a facility if the hospital had each of the following:

- an active affiliation or "sharing agreement" with the federal veterans health care facility;

- physicians who either (1) had faculty appointments at the federal veterans health care facility or (2) had an affiliation with a medical school that was affiliated with such a facility and had physicians who had faculty appointments at the facility;

- an active grant or agreement with the state or federal government to provide education, patient care, research, and/or teaching relating to bioterrorism.

A hospital that provided one or more clinical services in a federal veterans health care facility or used long-term care unit beds or acute care beds located in such a facility could not utilize procedures performed at the facility to demonstrate need or to satisfy a CON review standard, unless the federal veterans health care facility had obtained a CON for the covered clinical service provided at the facility.

"Sharing agreement" would be defined as a written agreement between a federal veterans health care facility and a hospital licensed under the code for the use of the facility's beds or equipment (or both) to provide covered clinical services. (House Bill 5761 as passed by the Senate would add similar—but not identical—language to the same section of the health code.)

Hospital with fewer than 70 beds on December 1, 2002. Under the bill, if a hospital licensed under the code had fewer than 70 licensed beds on December 1, 2002, that hospital would not be required to satisfy the minimum volume requirements under the CON review standards for its existing operating rooms as long as those operating rooms continued to exist at that licensed hospital site.

Consolidated applications. The bill specifies that an applicant seeking a CON for the relocation or replacement of an existing health facility could file a single, consolidated application if the project did not result in an increase of licensed beds, or the initiation, expansion, or replacement of a covered clinical service. A person relocating or replacing an existing health facility would be subject to the applicable CON review standards in effect on the date of the relocation or replacement of the health facility.

The bill would also require the DCH to create a consolidated application for a CON for the relocation or replacement of an existing health facility within six months of the bill's effective date.

CON commission. Part 222 establishes a Certificate of Need commission within the Department of Community Health. Currently the CON commission consists of five members—three from one major political party and two from another major political party—appointed by the governor, with the advice and consent of the Senate. The members are appointed to three-year terms, which were staggered when the commission was first created so that no more than two members' terms expire in any given year.

The bill would provide for the reorganization of the commission. The commission would consist of eleven members, of whom not more than six could be from the same political party. (The other five would not have to be from a major political party.) The members constituting the commission on the day before the bill's effective date would serve for the remainder of their terms. On the expiration of the terms of each of the members serving on the commission on the day before the bill's effective date, the governor would appoint a successor, according to the following requirements. The successor to the member whose term expired first would have to be an individual who represented nurses. The successor to the member whose term expired second would have to be an individual representing a company that was self-insured for health coverage. The successor to the member whose term expired third would have to be an individual representing a company that was not self-insured for health coverage. The successor to the member whose term expired fourth would have to be an individual representing a nonprofit health care corporation operating under the Nonprofit Health Care Corporation Reform Act. The successor to the member whose term expired fifth (and last) would have to be an individual who represented organized labor unions in Michigan. The new members would be appointed for terms lasting three years or until a successor was appointed.

Within 30 days after the bill's effective date, the governor would have to appoint six additional members to the commission as follows:

- two individuals representing hospitals;
- one individual representing allopathic physicians (MDs) licensed under the health code;
- one individual representing osteopathic physicians (DOs) licensed under the health code;
- one MD or one DO licensed under the health code representing a school of allopathic or osteopathic medicine;
- one individual representing nursing homes.

The terms of these six members would be staggered, with two of the members appointed for one-year terms, two of the members appointed for two-year terms and two of the members appointed for three-year terms. After these initial terms, each member would be appointed to serve a term of three years or until a successor was appointed. Successors to initial appointees would also have to satisfy the representation requirements set forth above.

Currently, in making appointments to the commission, the governor must ensure (to the extent feasible) that its membership is broadly representative of the interests of all of the people of the state. The bill would additionally require the governor to ensure that the membership was representative of the state's various geographic regions.

Currently special meetings of the commission may be called by the chairperson, by at least two commission members, or by the DCH. Under the bill, special meetings could be called by the chairperson, by at least *three* commission members, or by the DCH.

Staffing requirements. The DCH is currently required to "provide secretarial and other staff" necessary to allow the proper exercise of the CON commission's powers and duties. The DCH must also assign professional employees to staff the commission and assist it in the performance of its substantive responsibilities. The bill would require DCH to assign at least two full-time administrative employees and two full-time professional employees to staff the commission, in addition to providing secretarial and other staff.

Departmental information requirements. Currently the DCH is required to make available the times and places of CON commission meetings and to keep minutes of the meetings and a record of the commission's actions. The bill would specify further that the DCH had to make available a brief summary of the commission's actions.

Review standards. Part 222 requires the commission to approve, disapprove, or revise CON review standards that establish for 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. The bill would permit the commission to *develop* such standards as well.

By January 1, 2004, the commission would have to revise all CON review standards, except for nursing home and hospital long-term care unit bed review standards, to include a requirement that each applicant participate in Title 19 of the Social Security Act (Medicaid). Within 6 months after the bill's effective date, the commission would have to develop, approve, or revise CON review standards governing the increase of licensed beds in a licensed hospital, the physical relocation of hospital beds from one licensed site to another geographic location, and the replacement of beds in a licensed hospital. Also, the bill would add a requirement that the commission review and, if necessary, revise each set of CON review standards at least once every three years.

The bill would make two other changes to the commission's responsibilities regarding review standards. First, the bill would also authorize the commission to develop CON review standards governing the acquisition of new technology. Currently Part 222 states that the commission shall approve, disapprove, or revise such standards. Second, within 60 days after the bill's effective date, and within 60 days after each succeeding federal decennial status is available, the commission would have to evaluate and revise the planning areas defined in the CON review standards in accordance with the latest official federal decennial census figures.

Finally, the bill would prohibit the CON commission from developing, approving, or revising a CON review standard that required the payment of money, goods, or services as a

condition, standard, or assurance that had to be provided by a person seeking a CON for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning the operation of a facility, making changes in bed capacity or making covered capital expenditures.

Standard advisory committees. Part 222 states that the CON commission shall appoint ad hoc advisory committees to assist in the development of proposed CON review standards. Part 222 sets forth certain guidelines for the composition of such committees. Specifically, each committee must be composed of members of the following three groups:

- experts with professional competence in the subject matter of the proposed standard;
- representatives of health care provider organizations concerned with licensed health facilities or licensed health professions; and
- representatives of organizations concerned with health care consumers and with the purchasers and payers of health care services.

Under current law, experts with professional competence must compose a majority of the members of each committee. An ad hoc advisory committee must complete its duties and submit its recommendations to the commission within the time limit specified by the commission when it appoints the committee.

The bill would eliminate the requirement that the commission appoint "ad hoc" advisory committees and instead give the commission the option of appointing "standard" advisory committees. Instead of requiring that a majority of each committee be composed of experts with professional competence in the subject matter of the proposed standard, the bill would require that each committee be equally balanced among the three groups listed above. A committee would have to complete its duties and submit its recommendations to the commission within six months, unless the commission specified otherwise when it appointed the committee. The bill would prohibit an individual from serving on more than two standard advisory committees in any two-year period and prohibit lobbyists registered under the state's Lobby Act (PA 472 of 1978) from serving on a standard advisory committee.

Also, the bill would state that if a standard advisory committee was not appointed by the commission and the commission determined it necessary, the commission could submit a request to the DCH to engage the services of private consultants or to contract with any private organization for professional and technical assistance and advice or other services to assist it in carrying out its duties and functions under Part 222.

"Joint committee". Part 222 requires the CON commission to make recommendations regarding statutory changes to improve or eliminate the CON program to the standing committees in the Senate and the House with jurisdiction over public health matters every five years. The bill would specify instead that the commission would have to make such recommendations to the "joint committee" by January 1, 2005 and every two years after thereafter.

The "joint committee", which the bill proposes to create, would be a joint legislative committee that focused on proposed actions of the CON commission regarding the CON program and reviewed other CON issues. The joint committee would consist of six members--the chairpersons, vice-chairpersons, and minority vice-chairpersons of the Senate and House Health Policy Committees. The joint committee would be co-chaired by the chairpersons of the Senate and House Health Policy Committees.

The joint committee could develop a plan for the revision of the CON program, and if it did so, it would have to recommend to the legislature the appropriate statutory changes to implement the plan. The joint committee could administer oaths, subpoena witnesses, and examine the application, documentation, or other reports and papers of an applicant or any other person involved in a matter properly before the committee.

Application fees. Under current law, if the CON application fees collected do not add up to within ten percent of one-half of the cost to the DCH of implementing part 222, the commission must make recommendations regarding the revision of those fees so that the fees collected equal approximately one-half of DCH's CON implementation costs. The bill would instead state that if the CON application fees collected did not come to within ten percent of four-fifths of DCH's CON implementation costs, the commission would have to make recommendations to each member of the joint committee regarding the revision of CON application fees.

The joint committee would be required to review the commission's recommendations regarding the revision of the CON application fees and to submit a written report to the legislature outlining the costs to DCH of implementing the program, the amount of fees collected, and its recommendation regarding the revision of those fees.

Commission action and approval procedures. Under current law, at least 30 days before taking final action, the CON commission must conduct a public hearing on the proposed action, if the action concerns any of the following matters:

- revising, adding to, or deleting one or more "covered clinical services";

- approving, disapproving, or revising CON review standards that establish 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;

- approving, disapproving, or revising proposed criteria for determining health facility viability; and

- approving, disapproving, or revising CON review standards governing the acquisition of new technology.

The commission must submit the proposed action for comment to the standing committees in the Senate and House with jurisdiction over public health matters. Then the commission must submit proposed final action to the governor and the committees. The governor or the legislature may disapprove the proposed final action within 45 days after the date of the submission, and if the action is disapproved, the proposed final action does not take effect. The legislature or governor's failure to disapprove of the proposed final action results in the action taking effect

and being binding on all such persons upon the expiration of the 45-day period or a later date as specified in the action.

The bill would add a requirement that the CON commission conduct a public hearing on a proposed action to develop, approve, or revise CON review standards governing the increase of licensed beds in a licensed hospital, the physical relocation of hospital beds from one licensed site to another geographical location, and the replacement of beds in a licensed hospital. As is the case with the matters listed above, the public hearing would have to take place at least 30 days before final action was taken by the commission. For final action on all of these matters, not less than 30 days before final action is taken, the commission's chairperson would have to submit the proposed action as well as a concise summary of the expected impact of the proposed final action to each member of the joint committee. The joint committee would have to promptly review the proposed action and submit its recommendations and concerns to the commission. Then the commission chairperson would have to submit the proposed final action including a concise summary of the proposed final action of the governor and each member of the joint committee. Procedures by which the governor or legislature could disapprove the proposed final action would remain the same.

DCH requirements. The bill would change several of the DCH's requirements under part 222. First, the DCH would have to annually review the CON application process, including all forms, reports, and other materials that are required to be submitted with the application. If needed to promote administrative efficiency, DCH would have to revise the forms, reports, and any other required application materials. Second, the DCH is currently required to promulgate rules implementing its powers and duties. The bill would specify that the DCH's rules would be subject to the commission's approval. Third, Part 222 requires the DCH to report to the commission regarding departmental costs of implementing part 222 and the CON application fees collected in the immediately preceding state fiscal year. Currently the DCH must report every fiscal year, whereas the bill would require that the DCH report by October 1, 2003 and every year thereafter.

Fixed MRI in certain counties. Under the bill, a "person" seeking to initiate, expand, replace, relocate, or acquire a fixed MRI service within a county that has a population of more than 160,000 but that does not have at least one fixed MRI unit or at least one pending CON application to obtain a fixed MRI unit could file a letter of intent with the DCH prior to the initiation, expansion, replacement, relocation, or acquisition of a fixed MRI unit within that county instead of obtaining a CON. However, the person would have to be a nonprofit organization that participated in Title 19 of the Social Security Act (Medicaid) and would have to demonstrate that the service would be accessible to all patients regardless of their ability to pay.

Within 30 days after receiving the letter of intent, if the DCH verified that the county had a population of more than 160,000 and that the county does not already have at least one fixed MRI unit or at least one pending CON application to obtain a fixed MRI unit, the DCH would be required to send a written acknowledgment to the person approving the initiation, expansion, replacement, relocation, or acquisition of a fixed MRI unit. Unless the person—i.e., nonprofit organization meeting the requirements above—had received such written acknowledgment of approval, the person could not initiate, expand, replace, relocate or acquire a fixed MRI unit without a CON.

Regional CON review agency. Under current law, the DCH and "the office" are required to jointly develop standards for the designation by the DCH of a regional CON review agency for each review area to develop advisory recommendations for proposed projects. The standards must be approved by the CON commission before implementation. The designation of a regional CON review agency may be terminated by the DCH at any time for noncompliance with the approved standards.

The bill would instead require the commission to develop the standards for the designation by the DCH of a regional CON review agency for each review area. ("The office" is an obsolete reference to the Office of Health and Medical Affairs in the Department of Management and Budget. Executive order 1991-10 transferred statutory authority, powers, duties, functions, and responsibilities to the Department of Public Health, which subsequently became part of the Department of Community Health.) The designation of a regional CON review agency could be terminated by the DCH for noncompliance only with the concurrence of the commission. The bill would also repeal an obsolete reference to local health systems agencies.

Regional CON review agency hearing and DCH hearing. Part 222 requires a regional CON review agency to hold a public hearing on a proposed project before developing a recommendation on a CON application. If the DCH determines that local interest merits a public hearing and a regional CON review agency has not been designated for the review area in which the proposed project will be located, the DCH may hold a public hearing on the proposed project. The bill would require the DCH to hold a public hearing on a project proposed in a review area for which no regional CON review agency had been designated if DCH determined that local interest merited such a hearing.

Part 222 sets forth procedures governing the approval or denial of a CON application. The final decision to grant or deny an application is made by the director of the Department of Community Health. However, Part 222 also states that if the director makes a final decision that is inconsistent with the recommendations of the regional CON review agency for the review area in which a proposed project would be located, the DCH must promptly provide the regional review agency with a detailed statement of the reasons for the director's decision. Currently, only the applicant may appeal the director's final decision. The bill would allow a regional CON review agency to appeal the director's final decision and would specify that an appeal would have to be made within 30 days after the decision was made.

Emergency CONs. Part 222 permits the DCH to issue an emergency CON after necessary and appropriate review. An emergency CON is subject to special limitations and restrictions, in regard to duration and right of extension or renewal and other factors, imposed by the DCH. The bill would specify that if the DCH issued an emergency CON, its decision would be final, and the applicant would not be required to submit a formal application for a second review. A CON issued for emergency purposes would still be subject to special limitations and restrictions imposed by the DCH.

Medicaid. Under the bill, the DCH would have to monitor the participation in Title 19 of the Social Security Act (Medicaid) of each CON applicant approved under Part 222. The DCH would have to require each applicant to provide verification of participation in Title 19 with its application and annually thereafter, with the following qualification: the DCH could not revoke

or deny a CON for a nursing home licensed in the state if that nursing home did not participate in Title 19 on the bill's effective date but agreed to participate in Title 19 if beds became available. The bill would further specify that this language would not prohibit a person from applying for and obtaining a CON to acquire or begin operation of a nursing home that did not participate in Title 19.

Also, the DCH would have to revoke a CON if its approval was based on a stipulation that the project would participate in Title 19 and the project had not participated for at least 12 consecutive months within the first two years of operation. (Currently, under these conditions, a CON ceases to be effective.) The bill also would require revocation if a project did not continue to participate annually after its first two years of operation, if CON approval was based on a stipulation that the project would participate.

Standing new medical technology advisory committee. Part 222 requires the CON commission to appoint a standing new medical technology advisory committee to assist in identifying new medical technology or new medical services that may be appropriate for inclusion as a covered clinical service in the earliest possible stage of their development. A majority of the committee must 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 must also appoint to the committee representatives of health care consumer, purchaser, and third party payer organizations. In addition to the current committee composition requirements, the bill would require that the commission appoint faculty members from schools of medicine, osteopathy, and nursing in Michigan.

Monitoring compliance. Part 222 allows the DCH to monitor compliance with issued CONs. The bill instead would require the DCH to monitor compliance with all CONs issued. Further, Part 222 contains a list of actions the DCH may take if it determines that a CON recipient is not in compliance with the CON terms or is in violation of the provisions of Part 222 or rules; the actions may include revoking or suspending the CON, imposing fines, and taking any enforcement action authorized by the code. The bill would require the DCH to take one or more of the specific actions listed—or any other appropriate action—if it determined that the recipient of a CON was not in compliance with the terms of the CON, or was in violation of Part 222 or the rules.

"Health planners". The bill would define "health planner" as an individual who has experience in quantitative and qualitative research and data analysis and is responsible for long-range planning and implementation of policies, rules, and regulations mandated by state and federal governmental agencies including, but not limited to, CON procedures. [Senate Bill 1436 (H-7) contains no mention of health planners other than the definition.]

"Rural counties". The bill would revise the definition of "rural county". Currently, a rural county is a county not located in a "metropolitan area" as defined under the "Revised Standards for Defining Metropolitan Areas in the 1990's", set by the Statistical Policy Office of the Office of Information and Regulatory Affairs of the United States Office of Management and Budget. The bill would instead define a rural county as a county not located in a "metropolitan statistical area" or "micropolitan statistical area", as those terms are defined in the Statistical

Policy Office's "Standards for Defining Metropolitan and Micropolitan Statistical Areas", published December 27, 2000.

In a related matter, the bill would eliminate certain guidelines for applying CON review standards for mobile MRI services provided by hospitals located in rural counties. Specifically, the code currently states that, in applying for a review standard that establishes the minimum number of magnetic MRI procedures necessary for a CON for a mobile MRI service servicing only hospitals located in rural counties, the DCH shall use an adjustment factor of 2.0. The code also states that in applying a review standard that establishes the minimum number of magnetic MRI procedures necessary for a CON for a mobile MRI service servicing hospitals located in both rural and nonrural counties, for a hospital located in a rural county the DCH shall use an adjustment factor of 1.4. The bill would eliminate both of these guidelines.

Center for Rural Health. The code currently states that the Center for Rural Health must designate a CON ombudsman to provide technical assistance and consultation to hospitals and communities located in rural counties regarding CON proposals and applications. The code also specifies that the ombudsman is to act as an advocate for the health concerns of rural counties in the development of CON review standards. The bill would eliminate this language. With executive reorganization order 1997-04, the governor transferred all the statutory duties and responsibilities of the Center for Rural Health to the director of the Department of Community Health. In effect, then, the bill would eliminate the DCH director's statutory responsibility to designate a CON ombudsman to help rural hospitals and communities with their CON proposals.

Statewide health coordinating council. The bill would eliminate the definition of "statewide health coordinating council" and all references to the council.

Other provisions. Part 222 requires the DCH to prepare and publish annual reports of reviews conducted under Part 222, and prescribes the content of the reports. The bill would require the DCH to prepare and publish the reports monthly.

Part 222 requires the department and, if applicable, the appropriate regional CON review agency to make available to the public for examination during all business hours the applications received by them and pertinent written materials on file. The bill would eliminate this requirement for regional CON review agencies.

The bill would require the DCH, upon request, to provide copies of an application or part of an application, and would allow the DCH to charge a reasonable fee for the copies.

Repeal. The bill would repeal a section of the code that sets forth various provisional procedures and lists specific documents, policies, and guidelines that were to be followed by the DCH as CON standards until other CON review standards were approved under Part 222.

MCL 333.22203 et al.

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■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.