PERFORMANCE AUDIT
OF THE

CERTIFICATE OF NEED PROGRAM

CERTIFICATE OF NEED COMMISSION
DEPARTMENT OF COMMUNITY HEALTH

April 2002

39-644-01L

EXECUTIVE DIGEST

CERTIFICATE OF NEED PROGRAM

INTRODUCTION

This report, issued in April 2002, contains the results of our performance audit* of the Certificate of Need (CON) Program, CON Commission, Department of Community Health (DCH).

AUDIT PURPOSE

This performance audit was conducted in response to a legislative request and as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are typically conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.

BACKGROUND

DCH administers the CON Program, which was originally established in Michigan by Act 256, P.A. 1972. The CON Program is intended to regulate the health care industry in Michigan by balancing cost, quality, and access issues and ensuring that only needed health care services are developed.

The CON Commission was created within the Department of Public Health (DPH) by Act 332, P.A. 1988 (the CON Reform Act of 1988). Executive Order No. 1996-1, effective April 1, 1996, created the Department of Community Health and transferred duties and responsibilities for the CON Program from DPH to DCH. The CON Commission, which consists of five members appointed by the Governor with the advice and consent of

* *See glossary at end of report for definition.*

the Senate, is responsible for developing proposed CON review standards and proposing modifications in the statutory list of covered medical services. CON Commission actions to propose changes in CON review standards and in the statutory list of covered medical services are first subject to comment by the Legislature's health committees, and then any final standards are subject to ultimate veto by either the Legislature or the Governor. DCH provides administrative support to the CON Commission and carries out the day-to-day operations of the CON Program. This includes approving, disapproving, or approving with conditions or stipulations CON applications consistent with the review standards.

During fiscal year 2000-01, DCH reported expenditures totaling approximately $1.4 million. As of September 30, 2001, the CON Program had 10 permanent, full-time employees.

AUDIT OBJECTIVES AND CONCLUSIONS

Audit Objective: To assess DCH's efforts to evaluate the performance of the CON Program in relation to the CON Program's goals* and objectives*.

Conclusion: We concluded that DCH's efforts to evaluate the performance of the CON Program in relation to the CON Program's goals and objectives were generally not effective. Our audit disclosed one material condition*:

- DCH, in conjunction with the CON Commission, had not evaluated the CON Program in order to determine whether the CON Program was achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan (Finding 1).

* *See glossary at end of report for definition.*

DCH agrees with the corresponding recommendation and, in consultation with the CON Commission, will enhance existing processes in order to determine whether the CON Program is achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan.

DCH will contract with an independent outside contractor to conduct a comprehensive evaluation of the CON Program. This study will assist DCH in determining more meaningful, quantifiable measures for assessing the CON Program. These measures will be incorporated in future iterations of the CON Program Annual Activity Report. Moreover, this comprehensive evaluation will assist the CON Commission in making recommendations to the Senate and House of Representatives committees regarding the CON Program, as required in Section 333.22215(1)(f) of the *Michigan Compiled Laws* .

The CON Commission agrees with the corresponding recommendation and believes that the lack of the statutorily required information from DCH staff on CON Program operations is a serious issue. The CON Commission is dependent on the information from DCH to fulfill its statutory responsibilities to provide both the annual review of the CON Program operations and recommendations at least every five years to the Legislature on the future of the Program, including changing the list of covered services.

Our audit also disclosed a reportable condition* related to the costs and revenues of the CON Program and the application fee structure (Finding 2).

** See glossary at end of report for definition.*

Audit Objective: To assess DCH's effectiveness and efficiency in administering CON applications.

Conclusion: We concluded that DCH was generally effective and efficient in processing and issuing decisions on CON applications but generally was not effective or efficient in monitoring approved CON projects. Our audit disclosed one material condition:

- DCH had not sufficiently monitored projects that received an approved CON to help ensure that the projects were completed within the allowed time frames. Also, DCH did not ensure that facilities submitted required documentation relating to CON applications and project contracts on a timely basis. (Finding 3)

  DCH agrees with the corresponding recommendations and will improve and clarify procedures to monitor projects that received an approved CON to help ensure that the projects are completed within the allowed time frames. DHC also will ensure that facilities submit required documentation relating to CON applications and project contracts on a timely basis.

Our audit also disclosed a reportable condition related to CON application fee refunds (Finding 4).

Audit Objective: To assess DCH's effectiveness and efficiency in monitoring health care facilities' and service providers' compliance with applicable CON provisions.

Conclusion: We concluded that DCH was generally not effective or efficient in monitoring health care facilities' and service providers' compliance with

applicable CON provisions. Our audit disclosed one material condition:

- DCH did not have effective policies and procedures in place to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in CON review standards. In addition, DCH had not taken appropriate remedial action for facilities identified as not being in compliance with quality assurance requirements. (Finding 5)

  DCH agrees with the corresponding recommendations and will develop and implement effective policies and procedures to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in the CON review standards. When necessary, DCH will take appropriate remedial action for facilities identified as not being in compliance with quality assurance requirements.

  The CON Commission agrees with the corresponding recommendations and believes that compliance information is critical to ensure that recipients of CON approvals are actually meeting the quality standards, not just in the first year but thereafter.

AUDIT SCOPE AND METHODOLOGY

Our audit scope was to examine the program and other records of the Certificate of Need Program. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

When developing our audit objectives, we considered the following nine legislative questions:

Question 1: What are the CON Program's stated mission, goals, and objectives?

Question 2: What performance measurements exist for the CON Program?

Question 3: Have Michigan's health care costs been compared to other states that have repealed or deregulated their CON programs?

Question 4: How does the level of regulation in Michigan compare with other states that have CON programs?

Question 5: How does the CON Program determine and evaluate quality of care for Michigan hospitals and other health care providers?

Question 6: Has DCH assessed the CON Program's impact on the availability of and access to medical care?

Question 7: What are the costs of operating the CON Program?

Question 8: Has DCH established a methodology for determining whether the CON Program is cost effective and efficient?

Question 9: Does DCH monitor the costs to hospitals and other health care providers associated with going through the CON application process?

Responses to these questions are included in this report as supplemental information (Exhibit 1).

Our audit procedures included examining the CON Program's records and activities primarily for the period October 1, 1998 through January 31, 2002. Our methodology included a preliminary review, which consisted of interviewing DCH and CON Commission personnel and reviewing various records and procedures to gain an understanding of CON Program operations and to form a basis for selecting operations to audit. We assessed DCH's and the CON Commission's efforts to evaluate the performance of the CON Program in relation to the stated goals and objectives, we evaluated DCH's administration of the CON application process, and we analyzed DCH's monitoring of compliance with applicable CON provisions.

In addition, we conducted a survey of health care providers who had applied for a CON during the period October 1, 1998 through June 30, 2001. A summary of the responses to our survey is included in this report as supplemental information (Exhibit 8).

AGENCY RESPONSES

Our audit report includes 5 findings and 7 corresponding recommendations. DCH's preliminary response indicated that it agreed with our recommendations and has taken or will take steps to implement them.

The CON Commission chairperson submitted a separate response on behalf of the CON Commission that included overall comments on our audit report and specific comments related to 3 of the findings. The CON Commission's preliminary response indicated that it agreed with our recommendations.

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April 30, 2002

Ms. Renee Turner-Bailey, Chairperson
Certificate of Need Commission
and
Mr. James K. Haveman, Jr., Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Ms. Turner-Bailey and Mr. Haveman:

This is our report on the performance audit of the Certificate of Need Program, Certificate of Need Commission, Department of Community Health.

This report contains our executive digest; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; various exhibits, including responses to legislative questions, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agencies' responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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GLOSSARY

Description of Agency

Michigan's Certificate of Need (CON) Program is governed by Sections 333.22201 - 333.22260 of the *Michigan Compiled Laws*. The CON Program was originally established by Act 256, P.A. 1972, and was later amended by Act 368, P.A. 1978. Act 332, P.A. 1988 (the CON Reform Act of 1988), repealed Sections 22101 - 22181 of Act 368, P.A. 1978 (being Sections 333.22101 - 333.22181 of the *Michigan Compiled Laws*), and established the current framework for establishing the number of services requiring a CON.

The National Health Planning and Resource Development Act (Health Planning Act) was enacted in 1974 to help contain health care costs and mandated that certain federal health care funds would be made available to the states on the condition that the states enacted CON laws. CON was originally intended to bring health care costs under control by preventing certain designated health care facilities from expanding unnecessarily, buying duplicative or unneeded costly equipment, or creating duplicative or unnecessary services. CON laws also were intended to ensure the quality of clinical care by limiting the number of providers performing certain complex medical procedures and, thereby, ensuring clinician proficiency. However, in 1986, the 1974 Health Planning Act was repealed and it was left to the discretion of each state as to whether to continue its CON program. Six states had either allowed their CON programs to lapse or repealed their CON programs prior to 1986, and 8 states have allowed their CON programs to lapse or repealed their CON programs since 1986.

The CON Program is intended to regulate the health care industry in Michigan by balancing cost, quality, and access issues and ensuring that only needed health care services are developed. Michigan's current CON Program regulations cover certain capital expenditures for construction; proposed increases in the number of licensed hospital beds or relocation of licensed beds from one site to another; acquisitions of other health care facilities or specialized equipment; operation of new health care facilities; and initiation, replacement, or expansion of covered clinical services. In addition, capital expenditure projects (construction, renovation, etc.) that involve a health care facility require a CON. The capital expenditure thresholds are indexed annually by the Department of Community Health (DCH), based on the Consumer Price Index.

The CON Commission was created within the Department of Public Health (DPH) by the CON Reform Act of 1988. Executive Order No. 1996-1, effective April 1, 1996,

created the Department of Community Health and transferred duties and responsibilities for the CON Program from DPH to DCH. The CON Commission, which consists of five members appointed by the Governor with the advice and consent of the Senate, is responsible for developing proposed CON review standards and proposing modifications in the statutory list of covered medical services. CON Commission actions to propose changes in CON review standards and in the statutory list of covered medical services are first subject to comment by the Legislature's health committees, and then any final standards are subject to ultimate veto by either the Legislature or the Governor. DCH provides administrative support to the CON Commission and carries out the day-to-day operations of the CON Program. This includes approving, disapproving, or approving with conditions or stipulations CON applications consistent with the review standards.

During fiscal years 1998-99, 1999-2000, and 2000-01, DCH received 676 applications for a CON. Of these, 513 (76%) were approved, 21 (3%) were approved with conditions, and 18 (3%) were not approved. DCH had not rendered a final decision on 124 (18%) of the applications. This was because some applicants had requested extensions on their applications or because a final decision was not yet due. In addition, applicants sometimes withdraw their applications before DCH makes a final decision or an applicant might appeal a proposed decision by DCH to deny the application. The costs for approved projects totaled approximately $1.9 billion, the costs for projects approved with conditions totaled approximately $62.8 million, and the costs for projects not approved totaled approximately $15.4 million.

During fiscal year 2000-01, DCH reported expenditures totaling approximately $1.4 million. As of September 30, 2001, the CON Program had 10 permanent, full-time employees.

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit of the Certificate of Need (CON) Program, CON Commission, Department of Community Health (DCH), had the following objectives:

1. To assess DCH's efforts to evaluate the performance of the CON Program in relation to the CON Program's goals and objectives.

2. To assess DCH's effectiveness and efficiency in administering CON applications.

3. To assess DCH's effectiveness and efficiency in monitoring health care facilities' and service providers' compliance with applicable CON provisions.

Audit Scope

Our audit scope was to examine the program and other records of the Certificate of Need Program. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

When developing our audit objectives, we considered the following nine legislative questions:

Question 1: What are the CON Program's stated mission, goals, and objectives?

Question 2: What performance measurements exist for the CON Program?

Question 3: Have Michigan's health care costs been compared to other states that have repealed or deregulated their CON programs?

Question 4: How does the level of regulation in Michigan compare with other states that have CON programs?

Question 5: How does the CON Program determine and evaluate quality of care for Michigan hospitals and other health care providers?

Question 6: Has DCH assessed the CON Program's impact on the availability of and access to medical care?

Question 7: What are the costs of operating the CON Program?

Question 8: Has DCH established a methodology for determining whether the CON Program is cost effective and efficient?

Question 9: Does DCH monitor the costs to hospitals and other health care providers associated with going through the CON application process?

Responses to these questions are included in this report as supplemental information (Exhibit 1).

Audit Methodology

Our audit procedures, performed from August 2001 through January 2002, included examining the CON Program's records and activities primarily for the period October 1, 1998 through January 31, 2002. Our methodology included a preliminary review, which consisted of interviewing DCH and CON Commission personnel and reviewing various records and procedures to gain an understanding of CON Program operations and to form a basis for selecting operations to audit.

To accomplish our first objective, we reviewed the stated goals and objectives of the CON Program. We assessed DCH's and the CON Commission's efforts to evaluate the performance of the CON Program in relation to these goals and objectives. We examined the CON Commission bylaws and minutes from quarterly CON Commission meetings held during our audit period. In addition, we interviewed various DCH management and CON Commission personnel and inquired about the efforts made to evaluate the CON Program. Further, we analyzed the reported costs of the CON Program in relation to the reported revenues, and we assessed DCH's efforts to report cost and revenue data to the CON Commission.

To accomplish our second objective, we obtained an understanding of the CON Program's operations related to administering CON applications. We evaluated DCH's administration of the CON application process, including the timeliness of the initial approval process. In addition, we reviewed DCH's efforts to monitor approved CON projects. Further, we assessed DCH's procedures for issuing application fee refunds during our audit period.

To accomplish our third objective, we obtained an understanding of the CON Program's operations related to monitoring compliance with applicable CON provisions. We analyzed DCH's monitoring of compliance with the provisions. We examined the quality assurance requirements for CON covered services and evaluated DCH's efforts to ensure facilities' ongoing compliance with those requirements.

In addition, we conducted a survey of health care providers who had applied for a CON during the period October 1, 1998 through June 30, 2001. A summary of the responses to our survey is included in this report as supplemental information (Exhibit 8).

Agency Responses

Our audit report includes 5 findings and 7 corresponding recommendations. DCH's preliminary response indicated that it agreed with our recommendations and has taken or will take steps to implement them.

The CON Commission chairperson submitted a separate response on behalf of the CON Commission that included overall comments on our audit report and specific comments related to 3 of the findings. The CON Commission's preliminary response indicated that it agreed with our recommendations. The following is an excerpt from the CON Commission chairperson's overall comments that were included in the response to the audit:

> The Commission has no substantive objections to the "draft analysis in total" regarding the Certificate of Need program. In fact, we find that many of the Audit's findings and recommendations support repeated requests made by the Commission for the Michigan Department of Community Health to provide additional staff to fulfill the CON program's responsibilities, including the staffing of the Commission's update of standards. We are pleased with MDCH's recent actions, in response to legislative concerns, by which it began to rectify problems related to staffing of the Commission, even though it would require additional staff. In fact, some of the additional staff that was recently made available has enabled the Commission to pursue various needed updates of standards in various areas.
>
> We recognize that the draft audit focused on the operational requirement of the program, which is the responsibility of the MDCH staff (as opposed to the updates of the standards which is the Commission responsibility). Meeting these MDCH staff responsibilities also will require additional permanent staff

positions (many of which would be restorations of prior positions). Spotlighting those problems is a significant service that has been provided by the audit.

This audit supports the concerns expressed by the Commission through testimony by [the prior Commission chairperson] and myself at recent House and Senate hearings on Certificate of Need. We are gratified by MDCH adding temporary staff to rectify those problems. We are still concerned, however, about the need for ongoing additional [staffing] to fulfill the program's responsibilities, now including the additional staff to respond to the problems identified in the audit. We hope that the Legislature can help address the need to make long-term corrections in the staffing and thus the resulting shortfalls in the CON program meeting its statutory requirements.

The agency preliminary response that follows each recommendation in our report was taken from the agencies' written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS TO EVALUATE THE PERFORMANCE OF THE CON PROGRAM

COMMENT

Audit Objective: To assess the Department of Community Health's (DCH's) efforts to evaluate the performance of the Certificate of Need (CON) Program in relation to the CON Program's goals and objectives.

Conclusion: We concluded that DCH's efforts to evaluate the performance of the CON Program in relation to the CON Program's goals and objectives were generally not effective. Our audit disclosed one material condition. DCH, in conjunction with the CON Commission, had not evaluated the CON Program in order to determine whether the CON Program was achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan.

Our audit also disclosed a reportable condition related to the costs and revenues of the CON Program and the application fee structure.

FINDING

1. Evaluation of the CON Program

DCH, in conjunction with the CON Commission, had not evaluated the CON Program in order to determine whether the CON Program was achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan.

DCH and the CON Commission should establish an evaluation process for the CON Program. Such a process would help facilitate the CON Commission's statutorily required assessments of the CON Program, as the CON Commission relies on data provided to it by DCH to fulfill its responsibilities.

An evaluation process should include: performance indicators* for measuring outputs* and outcomes*; quantifiable performance standards* or goals and objectives that describe the level of outputs and outcomes based on management expectations, peer group performance, and/or historical data; a management information system to gather actual output and outcome data; a comparison of the actual data with desired outputs and outcomes; a reporting of the comparison results to management; and proposals of program changes to improve effectiveness.

The stated goal for the CON Program is to balance cost, quality, and access issues and ensure that only needed services are developed in Michigan. The objectives of the CON Program are to: provide a cost-control mechanism to address overbedding and the oversupply of health care services and facilities; promote access to certain health care services and facilities for all residents, particularly in rural areas and for the medically indigent; promote quality services by requiring compliance with standards developed by health experts; and provide a forum for public input and community involvement prior to the development of facilities and services.

Our review disclosed:

a. DCH, in conjunction with the CON Commission, had not established quantifiable goals or objectives that could help assess the performance of the CON Program.

   The stated goal and objectives for the CON Program use generalized terms, such as "balance," "provide," and "promote." For example, the goal of the CON Program is "to balance cost, quality, and access issues" and program objectives included "promoting access to certain health care services" and "promoting quality services by requiring compliance with standards." However, these nonquantified goals and objectives do not provide a measurable basis for determining specific program performance.

   DCH and the CON Commission should develop methodologies to determine the cost-effectiveness of operating the CON Program; to assess the impact it has on health care cost savings and the availability, access, and quality of

* *See glossary at end of report for definition.*

medical care; to assess changes in health care costs; and to assess changes in services that are a result of CON regulation. To facilitate such an evaluation, program goals and objectives should accurately reflect the mission of the program and be measurable.

b. DCH did not have an effective management information system to gather relevant data to use to measure program performance and to compare against desired outputs and outcomes. At the time of our audit, DCH limited its efforts to collecting data relevant to CON applications and monitoring health facilities for compliance with CON review standards. This is further addressed in Finding 5.

c. DCH, in conjunction with the CON Commission, did not evaluate the operations and effectiveness of the CON Program annually, as required by State law.

Section 333.22215(1)(e) of the *Michigan Compiled Laws* requires the CON Commission to annually assess the operations and effectiveness of the CON Program based on periodic reports from DCH. DCH should provide the CON Commission with a periodic assessment of the program and other reports, including the CON Program Annual Activity Report, in order for the CON Commission to fulfill its duties as required by State law.

DCH's annual activity reports present application activities outputs and a brief summary of CON Commission activities. These reports do not include an evaluation of the performance of the program. The CON Commission adopts the annual activity reports as its annual assessment.

d. DCH could not provide support for the conclusions in the most recent five-year report on the CON Program that it prepared for the CON Commission.

Section 333.22215(1)(f) of the *Michigan Compiled Laws* requires that by October 1, 1992, and every five years after October 1, 1992, the CON Commission make recommendations to the standing committees in the Senate and the House of Representatives that have jurisdiction over matters pertaining to public health regarding statutory changes to improve or eliminate the CON Program. The most recent report, dated September 15, 1999,

recommended that no statutory changes be made to the CON Program and made no recommendations for improvements to the CON Program.

e. An evaluation of the CON Program should include an assessment of the relevance of the current CON review standards.

For example, in November 2001, the CON Commission approved revisions to the CON review standards for acute medical care hospital beds that allowed DCH to use 1997 demographic and patient origin data to calculate the projected need for those hospital beds across the State. The updated CON review standards resulted in a 32% Statewide reduction in the projected need for those beds. The CON review standards for nursing home/hospital long-term care and inpatient psychiatric care services also contain hospital bed need calculations that use similar demographic and patient origin data to project the need for those types of hospital beds. However, the CON review standards for those services were not addressed. The patient origin data for the nursing home/hospital long-term care bed need projection has not been updated since 1987, and the demographic data for nursing home/hospital long-term care and both types of data used in the inpatient psychiatric care bed need projections have not been updated since 1990. DCH informed us that similar revisions to update the demographic and patient origin data were not made to those CON review standards in part because the methodology that is used to calculate the bed need projections should be revised.

In addition, current CON review standards require health facilities with approved CON projects to complete and return a project implementation progress report (PIPR) within 10 days of 100% completion of the project. However, current DCH procedures only require initial follow-up on CON projects 11 months after they are approved. As a result, DCH does not enforce submission of PIPRs within 10 days of project completion if the projects are completed within the first 11 months after project approval (see Finding 3).

Through the CON review standards, the CON Commission has developed various quantified quality assurance requirements. However, these quality assurance requirements have not been incorporated into an overall evaluation process.

RECOMMENDATION

We recommend that DCH, in conjunction with the CON Commission, evaluate the CON Program in order to determine whether the CON Program is achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan.

AGENCY PRELIMINARY RESPONSE

DCH

DCH agrees with the recommendation and, in consultation with the CON Commission, will enhance existing processes in order to determine whether the CON Program is achieving its goal of balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan.

DCH will contract with an independent outside contractor to conduct a comprehensive evaluation of the CON Program. This study will assist DCH in determining more meaningful, quantifiable measures for assessing the CON Program. These measures will be incorporated in future iterations of the CON Program Annual Activity Report. Moreover, this comprehensive evaluation will assist the CON Commission in making recommendations to the Senate and House of Representatives committees regarding the CON Program, as required in Section 333.22215(1)(f) of the *Michigan Compiled Laws* .

The comprehensive evaluation will examine if the CON Program is meeting its stated goals and objectives and include a critical review of the relevance of current thresholds and standards. The evaluation will also provide recommendations to improve processes and alternative models to achieve the CON Program's stated goals and objectives.

DCH will provide to the CON Commission evaluation information and, when available, the findings and recommendations to assist in its report to the Legislature, as required in Section 333.22215(1)(f) of the *Michigan Compiled Laws* .

DCH will strengthen the CON Program Annual Activity Report, based in part from information gained through the comprehensive evaluation. This report is submitted annually to the CON Commission in order for it to assess the operations and effectiveness of the CON Program, as required in Section 333.22215(1)(e) of the

Michigan Compiled Laws . Report improvements will include additional output and outcome measurements that can be used to evaluate, monitor, and ensure compliance of the CON Program. DCH also will work with the Department of Management and Budget and, when appropriate, with the Department of Consumer and Industry Services to evaluate and develop a corrective action plan to improve the CON Program's current management information systems for tracking CON Program activity. In addition, DCH will work to improve its data information systems to ensure that appropriate, accurate, and up-to-date data are available to assess the ongoing effectiveness of the CON Program.

CON COMMISSION

The CON Commission agrees with the recommendation and believes that the lack of the statutorily required information from DCH staff on CON Program operations is a serious issue. The CON Commission is dependent on the information from DCH to fulfill its statutory responsibilities to provide both the annual review of CON Program operations and recommendations at least every five years to the Legislature on the future of the Program, including changing the list of covered services. The CON Commission informed us that recently, in order to still meet its responsibilities, it was able to convene a voluntary special task force, which resulted in the CON Commission recommending the deregulation of partial day psychiatric programs (which the Legislature has allowed to go forward) and the prioritization of needed changes in CON review standards. The CON Commission stated that the successful update process would have worked far better if DCH had been able to provide the periodic information on program performance, as required by statute, and hopes that can be done in the future.

The CON Commission informed us that having an independent outside contractor conduct a comprehensive evaluation of the CON Program has been suggested to it before, sometimes through public comment. The CON Commission hopes that the Legislature will support this idea of having such an evaluation done and thinks that it would be most valuable if the specifications of the contract were developed after consultation and agreement among the legislative health committees, DCH, and the CON Commission and after receiving public input. That would facilitate the outside contractor's report covering issues of particular concern to the Legislature, the CON Commission, DCH, and the public.

FINDING

2. Costs and Revenues of the CON Program and the Application Fee Structure

DCH needs to establish controls and procedures to ensure that the costs and revenues of the CON Program are accurately identified and reported to the CON Commission in order to ensure that CON application fees are established in accordance with State law.

DCH is responsible for accumulating the costs and revenues relating to the CON Program and reporting this data to the CON Commission. Section 333.22215(6) of the *Michigan Compiled Laws* requires the CON Commission to recommend revisions to CON application fees if the revenues collected from CON application fees are not within 10% of one half of DCH's cost to administer the CON Program.

We noted during our review that DCH could not document that CON Program costs and revenues were accurate. Our review disclosed:

a. DCH did not have a process in place to identify the total costs of the CON Program. The cost data provided to us by DCH did not contain the following costs for administering the CON Program: DCH indirect costs, certain DCH staff allocated payroll costs, and allocated payroll costs from the Administrative Tribunal, the Department of Consumer and Industry Services, and the Department of Attorney General. DCH informed us that these costs were relevant to the CON Program and that it had begun efforts to implement procedures to include these costs. However, these efforts came after we had completed our audit fieldwork.

b. DCH had not reported CON Program costs to the CON Commission in its fiscal year 1998-99 and 1999-2000 CON Program Annual Activity Reports. The fiscal year 2000-01 annual activity report had not yet been released at the time of our audit fieldwork. DCH informed us that it had last included CON Program costs in the fiscal year 1994-95 annual activity report.

c. The revenue amount from application fees that DCH reported to the CON Commission for fiscal year 1999-2000 ($608,750) was different from CON Program revenue amounts from application fees as recorded on the State's accounting system ($583,516). DCH staff could not explain the difference.

The current CON application fee structure has not been modified in over 10 years. Without an accurate reporting of the CON Program costs and revenues by DCH, the CON Commission cannot ensure that CON application fees are appropriate.

RECOMMENDATION

We recommend that DCH establish controls and procedures to ensure that the costs and revenues of the CON Program are accurately identified and reported to the CON Commission in order to ensure that CON application fees are established in accordance with State law.

AGENCY PRELIMINARY RESPONSE

DCH

DCH agrees with the recommendation and will establish controls and procedures to ensure that the costs and revenues of the CON Program are accurately identified and reported to the CON Commission.

DCH informed us that it has designed a comprehensive report of costs and revenues associated with the CON Program. This report will be issued from the DCH Budget and Finance Administration during the first quarter of each fiscal year and will contain information gathered from CON Program activities experienced during the preceding fiscal year.

This report will include federally approved DCH indirect administrative costs, any associated direct program costs experienced by other organizational components within DCH, and any direct CON costs reported to DCH by other elements of State government. Included in the report will be an annual testing of the ratio between costs and fees as required in Section 333.22215(6) of the *Michigan Compiled Laws*. DCH will regularly present this report to the CON Commission as a piece of business at the first meeting of each calendar year; this report will also be the basis of any cost and revenue information included in the CON Program Annual Activity Report.

CON COMMISSION

The CON Commission has been aware that it has the statutory responsibility to recommend fee changes so that applicants provide approximately half of the costs of CON Program operations. The CON Commission informed us that, for some

years, it has been concerned that it could not fulfill this statutory duty because it has not received needed information on CON Program costs and that the reporting of CON program costs was incomplete for fiscal years 2000-01, 1999-2000, and 1998-99. The CON Commission informed us that DCH staff forthrightly indicated that there were accounting problems at the different times when they were to provide the CON Commission with the cost information and that, without that data, the CON Commission could not fulfill its duty to ensure the statutory 50/50 balance for funding the program between fees and General Fund support.

CON APPLICATIONS

COMMENT

Background: DCH staff spend a significant amount of time administering the CON application process, which includes the assessment of each application for compliance with all applicable statutory requirements and CON review standards. DCH staff also provide assistance to individual applicants prior to and throughout the CON application process. When DCH approves an application for a CON project, DCH is required to perform follow-up procedures to determine that applicants are implementing their projects within allowed time frames and as approved in their CON.

According to DCH, the CON Reform Act of 1988 significantly reduced the types of projects subject to CON review. As a result, DCH's decisions on applications have decreased from 383 in fiscal year 1987-88 to 198 in fiscal year 2000-01. This 48% decrease reflects the intent of the CON Reform Act to reduce unnecessary review. During fiscal year 2000-01, the average number of days required to issue a nonsubstantive decision was 29 days, down 31% from 42 days in fiscal year 1989-90. Nonsubstantive reviews involve projects such as certain equipment replacements and changes in ownership and do not require a full review.

During the period October 1, 1998 through September 30, 2001, DCH received 676 CON applications and issued 552 (82%) final decisions. DCH had not rendered a final decision on 124 (18%) of the applications because some applicants had requested extensions on their applications or because a final decision was not yet due. In addition, applicants sometimes withdraw their applications before DCH makes a final decision or an applicant might appeal a proposed decision by DCH to deny the application.

Audit Objective: To assess DCH's effectiveness and efficiency in administering CON applications.

Conclusion: We concluded that DCH was generally effective and efficient in processing and issuing decisions on CON applications but generally was not effective or efficient in monitoring approved CON projects. Our audit disclosed one material condition. DCH had not sufficiently monitored projects that received an approved CON to help ensure that the projects were completed within the allowed time frames. Also, DCH did not ensure that facilities submitted required documentation relating to CON applications and project contracts on a timely basis.

Our audit also disclosed a reportable condition related to CON application fee refunds.

FINDING

3. Monitoring of Approved CON Projects

DCH had not sufficiently monitored projects that received an approved CON to help ensure that the projects were completed within the allowed time frames. Also, DCH did not ensure that facilities submitted required documentation relating to CON applications and project contracts on a timely basis.

Michigan Administrative Code R 325.9401(1) states that a CON shall be valid only as long as there is compliance with the provisions in the final or amended application, including project timetables. In addition, *Michigan Administrative Code* R 325.9403 states that a CON shall expire one year from its effective date, unless the project is 100% completed or meets certain other requirements. DCH has implemented procedures to follow up on approved projects using a series of form letters that request that the status of projects and other information be reported back to DCH within specified time frames.

DCH requires facilities to complete and return a project implementation progress report (PIPR) within 10 days of 100% completion of the project or no later than 11 months from the date of the approval of the CON, whichever occurs first. DCH uses PIPRs to help determine the status of a CON project and to help determine when facilities are required to submit additional information in order to satisfy the requirements of their CON. CON projects that are not 100% complete within 12 months after the approval of the CON must provide evidence that they have entered into an enforceable contract, which must be approved by DCH within 12

months from the CON approval date in order for the CON to remain valid. An extension of six months may be requested by an applicant and is granted by DCH if project activity is occurring to obtain an enforceable contract. CON projects that extend over a period of more than one year may be required to submit several PIPR forms.

DCH's automated database, used to track CON applications, generates a listing that identifies CON projects that need follow-up action to be taken. As of October 22, 2001, there were 256 CON projects on this listing. We selected 20 CON projects from the listing and 3 additional projects from DCH's automated database that were not on the listing and reviewed the procedures used by DCH to monitor the projects for compliance with the CON Program requirements. These 23 projects included 21 CONs approved for regular projects and 2 CONs originally approved for emergency projects.

Our review disclosed:

a. DCH had not ensured that the facilities for 11 (48%) of the 23 approved CONs submitted PIPRs within the required time frames. One of the 11 facilities submitted a final PIPR to DCH after the project was complete, but the PIPR was received 582 days after the reported project completion date (see item c.). Another facility submitted an interim PIPR 89 days after the established 11-month time frame which indicated that the project was 20% complete. Nine of the 11 facilities had not sent interim or final PIPRs. The CON applications for these projects had been approved between September 29, 1999 and November 2, 2000.

b. DCH had not followed up with the facilities for 3 (13%) of the 23 approved CONs in over 18 months. DCH last sent letters to 2 of the facilities requesting PIPRs in May 2000 and to the third facility in March 2000. Two of the facilities last submitted a PIPR in June 2000, and the third facility last submitted a PIPR in April 2000. The last PIPRs submitted for these 3 facilities indicated that the CON projects were 6%, 15%, and 99% complete, respectively.

c. DCH did not receive the final PIPRs from 6 facilities within 10 days of project completion, which is required by the CON review standards and is stated as a condition of approval for a CON project. These 6 facilities submitted their final PIPRs to DCH 24, 248, 312, 380, 398, and 582 days, respectively, after their

projects had been completed. DCH did not take enforcement action against these facilities, which includes revoking or suspending the CON when appropriate and/or imposing a civil fine.

d. DCH did not receive the formal application within 30 days for the 2 facilities that were originally approved with emergency CONs.

   Emergency CON applications are allowed when the applicants meet certain circumstances, which are defined in Section 333.22235 of the *Michigan Compiled Laws*. *Michigan Administrative Code* R 325.9227(2) requires applicants to submit a formal application for a CON within 30 days of the requested emergency review. The facilities we identified had submitted the formal applications 44 and 41 days, respectively, after the emergency CONs had been approved.

e. DCH did not ensure that 2 facilities, whose CON projects were not 100% complete, had enforceable contracts in place within 12 months of their CON approval date. DCH approved the contracts 94 and 263 days, respectively, after the 12-month deadline. In the instance in which DCH had approved the enforceable contract 94 days after the 12-month deadline, the facility had filed for a 6-month extension, which would normally eliminate the need to have an enforceable contract in place within one year of CON approval. However, the extension request was filed 50 days after the original CON expiration date.

Without appropriate follow-up on facilities' approved CONs within the required time frames, DCH lessens the effectiveness of the CON application approval process and increases the risk that facilities may not implement their CONs as approved or within the allowed time frames. DCH needs to enforce due dates for documentation of each project's completion so that it can effectively regulate facilities that are operating with approved CONs.

RECOMMENDATIONS

We recommend that DCH improve its efforts to monitor projects that received an approved CON to help ensure that the projects are completed within the allowed time frames.

We also recommend that DCH ensure that facilities submit required documentation relating to CON applications and project contracts on a timely basis.

AGENCY PRELIMINARY RESPONSE

DCH agrees with the recommendations and will improve and clarify procedures to monitor projects that received an approved CON to help ensure that the projects are completed within the allowed time frames. DCH will also ensure that facilities submit required documentation relating to CON applications and project contracts on a timely basis.

Currently, DCH notifies the applicant in the CON decision letter that it must provide the required notice within 10 days of completion or not later than 12 months from the date of the approval of the CON, whichever occurs first. DCH informed us that most applicants do not follow the 10-day completion notice requirement and, instead, respond to the letter sent to them by DCH during the 11th month. Consequently, DCH believes that noncompliance with the 10-day notice requirement should not warrant compliance action and that this requirement adds minimal value to the CON Program. Therefore, DCH will make a recommendation to the CON Commission at the next meeting scheduled in June 2002 to remove this provision in the standard. DCH will continue to initiate follow-up in the 11th month after CON approval.

Additionally, in order to minimize interpretation of terminology, DCH will clarify and define various terms in the applicable departmental form(s). Finally, DCH will establish formal written policies and procedures documenting appropriate follow-up activity that must occur and the methodology for each. These changes will be implemented by June 30, 2002.

FINDING

4. CON Application Fee Refunds

DCH should establish a formal procedure for issuing refunds of CON application fees.

During the period from October 1, 1998 through September 30, 2001, DCH reported revenues totaling approximately $1.9 million from 676 CON applications. DCH informed us that fees received from CON applicants may be refunded when

application fees are overpaid, when a CON applicant withdraws its application prior to DCH beginning its application review process, or upon written request from an applicant when DCH does not meet statutory time frames in the processing of an application. Although DCH has issued refunds since the establishment of the CON Program, DCH has not established a formal procedure for a refund process identifying those instances when a refund would be issued.

During the period October 1, 1998 through September 30, 2001, DCH issued refunds on 21 CON applications totaling $47,750. Our review disclosed that DCH issued:

a. Seven refunds (33%), totaling $15,750, because excess application fees were submitted or because DCH determined that projects were not subject to review.

b. Seven refunds (33%), totaling $8,750, because DCH did not meet the statutory time frame to issue proposed decisions.

   Section 333.22231(11) of the *Michigan Compiled Laws* allows for refunds of CON application fees upon the written request of an applicant if DCH exceeds specified time frames without good cause, as determined by the CON Commission, in the processing of an application. DCH did not obtain the CON Commission's approval to issue these refunds.

c. Six refunds (29%), totaling $20,500, after the CON applicants withdrew their applications.

d. One refund (5%) for $2,750 after the applicant submitted the fee along with a letter of intent to file a formal CON application, but never did actually submit a CON application.

DCH assesses application fees to help support the administrative costs of operating the CON Program. A formal procedure should specify the criteria under which full or partial refunds are allowed, including when DCH would offer refunds of application fees when applications are withdrawn at any time during the application process.

RECOMMENDATION

We recommend that DCH establish a formal procedure for issuing refunds of CON application fees.

AGENCY PRELIMINARY RESPONSE

DCH agrees with the recommendation and will establish a formal procedure for issuing refunds.

DCH informed us that it has instituted an approval process for all refunds, which requires CON Program director approval. Additionally, all processing of refunds will be documented by June 30, 2002 in formal written departmental policies and procedures to clarify to all CON Program staff the various circumstances in which refunds may occur, to clarify the process of CON Program director level approval for issuing such refunds, and to clearly designate circumstances in which involvement of the CON Commission is warranted.

COMPLIANCE WITH APPLICABLE CON PROVISIONS

COMMENT

Audit Objective: To assess DCH's effectiveness and efficiency in monitoring health care facilities' and service providers' compliance with applicable CON provisions.

Conclusion: We concluded that DCH was generally not effective or efficient in monitoring health care facilities' and service providers' compliance with applicable CON provisions. Our audit disclosed one material condition. DCH did not have effective policies and procedures in place to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in CON review standards. In addition, DCH had not taken appropriate remedial action for facilities identified as not being in compliance with quality assurance requirements.

FINDING

5. Monitoring Compliance With CON Review Standards

DCH did not have effective policies and procedures in place to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in CON review standards. In addition, DCH had not taken appropriate

remedial action for facilities identified as not being in compliance with quality assurance requirements.

One of the stated objectives of the CON Program is "promoting quality services by requiring compliance with standards developed by health experts." Section 333.22247 of the *Michigan Compiled Laws* gives DCH the authority to monitor compliance with CONs issued and requires DCH to investigate allegations of noncompliance with a CON. The CON Commission appoints ad hoc advisory committees, comprised of a majority of experts with professional competence in the subject matter of the proposed standard, to assist in the development of proposed CON review standards. Several of the CON review standards establish ongoing quality assurance requirements. Before becoming effective and binding, the proposed CON review standards are submitted to the Governor and the Legislature for approval. Section 333.22221 of the *Michigan Compiled Laws* requires DCH to administer and apply approved CON review standards.

Each year, DCH administers a hospital survey to request data from facilities that can be used to help monitor compliance with CON review standards. Section 333.20141(5) of the *Michigan Compiled Laws* requires health facilities to provide DCH with data and statistics required to enable DCH to carry out functions required by federal and State law and promulgated rules and regulations.

We reviewed the hospital survey document administered by DCH during fiscal year 1998-99 and determined that it did not capture all the data necessary to determine a facility's compliance with CON review standards. We noted deficiencies in the survey document that precluded DCH from making a determination of full compliance with the following CON review standards: open heart surgery*, cardiac catheterization*, lithotripsy*, transplants*, megavoltage radiation therapy*, and nursing home/hospital long-term care beds. For example, CON review standards for open heart surgery services require that physicians credentialed by a facility perform at least 50 open heart surgeries each year as the attending physician. DCH did not ask facilities to report the number of procedures performed by credentialed physicians on the hospital survey. DCH informed us that it did not have another process in place to identify the required information.

* *See glossary at end of report for definition.*

Several of the CON review standards include project delivery requirements that are intended to help ensure the quality of the services being provided. The hospital survey captures some of the data needed to determine a facility's compliance with the project delivery requirements. We reviewed reports compiled by DCH from the 1999 annual hospital surveys and identified several instances of noncompliance with project delivery requirements. As shown in the following table, a significant number of facilities were not meeting project delivery requirements:

CON Review Standard	Number of Facilities Reviewed	Number of Facilities Not Meeting Project Delivery Requirements	Percent
Surgical	217	58	27%
Cardiac catheterization	66	5	8%
Pancreas transplants	2	1	50%
Computed tomography*	188	27	14%
Megavoltage radiation therapy	49	7	14%

DCH had initiated a similar analysis with the survey data relating to the review standard for surgical services in February 2000 and had identified surgical facilities that were not meeting project delivery requirements. However, DCH did not pursue any corrective action. DCH informed us that it had not performed a similar analysis for the other review standards.

In addition, we obtained data for the reporting period January 1, 2000 through December 31, 2000 related to magnetic resonance imaging* (MRI) service utilization from DCH. MRI data is not captured in the annual hospital surveys, but rather is collected by the Division for Vital Records and Health Statistics. DCH does not routinely use this information to monitor compliance with quality assurance requirements.

It is imperative that DCH obtain relevant and reliable data from facilities so that it can meet its responsibility of administering and applying CON review standards. In addition, DCH should have a process in place to investigate and take timely, statutorily allowed enforcement action, when necessary, against facilities identified

* *See glossary at end of report for definition.*

as not meeting current CON review standards. Section 333.22247 of the *Michigan Compiled Laws* allows DCH to take appropriate action against facilities not in compliance with the terms of their CON that includes revoking or suspending the CON when appropriate and/or imposing a civil fine.

RECOMMENDATIONS

We recommend that DCH implement effective policies and procedures to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in CON review standards.

We also recommend that DCH take appropriate remedial action for facilities identified as not being in compliance with quality assurance requirements.

AGENCY PRELIMINARY RESPONSE

DCH

DCH agrees with the recommendations and will develop and implement effective policies and procedures to obtain relevant data needed to monitor facilities' compliance with quality assurance requirements contained in the CON review standards. When necessary, DCH will take appropriate remedial action for facilities identified as not being in compliance with quality assurance requirements.

DCH will ensure facility compliance through a three-pronged approach: 1) surveillance, 2) proactive compliance checks, and 3) compliance investigations. As part of the surveillance effort, DCH administers an annual hospital survey to request data that it uses to monitor compliance with the CON review standards' quality assurance requirements. DCH informed us that it has already initiated improvements to this surveillance tool to address missing data that has not been previously collected - open-heart surgery and cardiac catheterization. DCH informed us that this has been corrected as of March 2002 and that all relevant data needed to monitor the quality assurance requirements will be collected, as requested in the 2001 annual hospital survey. In addition, DCH will initiate formal written procedures to review and verify that current surveillance tools capture all relevant data needed for compliance verification when CON review standards are updated.

DCH informed us that it also monitors compliance with quality assurance requirements on a proactive basis and that this is done through its review of quality assurance requirements when a CON application is received, reviewed, and processed. If applicable quality assurance requirements are not met, the CON application is either denied or approved with conditions.

Additionally, DCH informed us that, as required by statute, compliance investigation always occurs when DCH receives a written complaint of potential noncompliance. If an applicant appears to be in noncompliance, DCH will initiate a desk audit and, if needed, assist the applicant to bring itself into compliance. If the desk audit appears to confirm noncompliance, a recommendation pursuant to statutory allowances will be forwarded to DCH's compliance officer.

DCH maintains a log of all compliance actions. Additionally, DCH informed us that, in January 2002, it instituted a tracking process for all desk audit activities. Finally, all quality assurance compliance processes will be documented by June 30, 2002 in formal written departmental policies and procedures. All compliance actions will be reported in aggregate form in the CON Program Annual Activity Report.

CON COMMISSION

The CON Commission agrees with the recommendations and informed us that it is keenly aware that staff shortages affect the possibility of post-approval monitoring of CON projects and that the ongoing monitoring of CON-approved projects has long been a particular concern of the CON Commission. The CON Commission believes that compliance information is critical to ensure that recipients of CON approvals are actually meeting the quality standards, not just in the first year but thereafter.

The CON Commission informed us that the 2000 annual hospital survey is not yet available to the CON Commission or the public and that the 2001 report is also still being processed. Without these ongoing reports, the CON Commission cannot begin to evaluate whether consumers are receiving the promise of quality that is part of the CON Program objectives, not to mention timely access to services. The CON Commission believes that the audit's specific suggestions for improving the annual survey were also quite helpful. The CON Commission informed us that it needs the revised annual hospital survey data, and other sources of follow-up information, to properly determine if changes should be made in the quality assurance requirements in future iterations of the CON review standards.

The CON Commission believes that providing this information on a timely basis is an objective that current DCH staff have not been able to fully meet because of staff shortages. The CON Commission informed us that the concern about monitoring of quality compliance is an issue that has been raised by the CON Commission for years. The CON Commission hopes that DCH can now institute processes to fulfill the quality monitoring and other deficiencies identified in the audit. The CON Commission's concern is how that responsibility will be fulfilled on an ongoing basis once these "processes" have been established.

SUPPLEMENTAL INFORMATION

Responses to Legislative Questions

Summary Overview

The following nine questions were included in the legislative request to audit the Certificate of Need (CON) Program. Each question is followed by our response.

Question 1: What are the CON Program's stated mission, goals, and objectives?

Response: The CON Program adopted the Department of Community Health's (DCH's) mission statement, which states that DCH strives for a healthier Michigan. To that end DCH will:

1. Promote access to the broadest possible range of quality services and supports.

2. Take steps to prevent disease, promote wellness and improve quality of life.

3. Strive for the delivery of those services and supports in a fiscally prudent manner.

The CON Program has a single goal, which is to balance cost, quality, and access issues and ensure that only needed services are developed in Michigan.

The CON Program has four objectives, which are:

1. Providing a cost-control mechanism to address overbedding and the oversupply of health care services and facilities.

2. Promoting access to certain health care services and facilities for all residents, particularly in rural areas and for the medically indigent.

3. Promoting quality services by requiring compliance with standards developed by health experts.

4. Providing a forum for public input and community involvement prior to the development of facilities and services.

Our audit resulted in a finding related to how DCH, in conjunction with the CON Commission, had not evaluated the CON Program in order to determine whether the CON Program was achieving its stated goal (see Finding 1). In addition, we surveyed health care providers who applied for a CON during the period October 1, 1998 through June 30, 2001 and inquired about the effectiveness of the CON Program in balancing cost, quality, and access issues and ensuring that only needed services are developed in Michigan (see Exhibit 8, Health Care Provider Survey Summary, question 34).

Question 2: What performance measurements exist for the CON Program?

Response: The CON Program had not developed performance measurements. We noted that DCH had not established quantifiable goals and objectives and, as a result, DCH did not have a basis for measuring specific Program performance (see Finding 1).

Question 3: Have Michigan's health care costs been compared to other states that have repealed or deregulated their CON programs?

Response: DCH, in conjunction with the CON Commission, informed us that it had not performed an analysis of Michigan's health care costs or compared them to other states that have repealed or deregulated their CON programs. Also, DCH, in conjunction with the CON Commission, informed us that it had not analyzed how the CON Program has impacted health care costs in Michigan (see Finding 1).

Question 4: How does the level of regulation in Michigan compare with other states that have CON programs?

Response: As reported in the *National Directory of Health Planning, Policy and Regulatory Agencies*, Twelfth Edition: January 31, 2002, in comparison to other states with CON programs, Michigan ranks in the middle for the level of regulation. According to this publication, as of January 31, 2002, 36 states plus the District of Columbia had CON programs regulating up to 30 different categories of medical services. The number of medical services regulated by any one state's CON program ranged from 1

to 27. Michigan's CON Program regulates 18 different categories of medical services. See Exhibit 7 for a summary of CON regulations by states as of January 2002. We surveyed health care providers who applied for a CON during the period October 1, 1998 through June 30, 2001 and inquired about the appropriateness of Michigan's current CON regulations (see Exhibit 8, Health Care Provider Survey Summary, questions 31 and 33).

Question 5: How does the CON Program determine and evaluate quality of care for Michigan hospitals and other health care providers?

Response: Quality assurance requirements are incorporated into several of the CON review standards. Health care facilities and/or providers who apply for CONs must demonstrate at the time of application that they can meet those requirements. If approved for the CON, the applicants must report, in DCH's annual hospital survey, data that DCH can use to monitor ongoing compliance with the quality assurance requirements. However, we noted that DCH's annual hospital survey does not require information that is necessary for DCH to monitor ongoing compliance with all of the quality assurance requirements in all of its CON review standards (see Finding 5).

Question 6: Has DCH assessed the CON Program's impact on the availability of and access to medical care?

Response: DCH, in conjunction with the CON Commission, informed us that it has not assessed the CON Program's impact on the availability and access to medical care (see Finding 1). However, the CON Commission formed several ad hoc committees during the period October 1, 1998 through January 31, 2002 to address the availability of certain medical services and access to medical care. CON review standards that were addressed by ad hoc committees during this period were: 1) hospital beds, 2) nursing home/hospital long-term care beds, 3) magnetic resonance imaging, 4) positron emission tomography (PET) scanner services, 5) lithotripsy services/units, and 6) megavoltage radiation therapy services.

The Science and Technology Division, Michigan Legislative Service Bureau, prepared maps of CON covered service locations in Michigan based on data DCH had provided to us during our audit fieldwork. The maps show the approximate geographic locations where CON regulated medical services are offered (see Exhibit 6).

Question 7: What are the costs of operating the CON Program?

Response: DCH reported CON Program costs totaling approximately $1.4 million, $1.25 million, and $1.1 million in fiscal years 2000-01, 1999-2000, and 1998-99, respectively. However, DCH did not have controls and procedures to ensure that CON Program costs were accurately identified and reported to the CON Commission (see Finding 2).

Question 8: Has DCH established a methodology for determining whether the CON Program is cost effective and efficient?

Response: DCH, in conjunction with the CON Commission, has not established a methodology for determining whether the CON Program is cost effective and efficient (see Finding 1).

Question 9: Does DCH monitor the costs to hospitals and other health care providers associated with going through the CON application process?

Response: DCH does not monitor the costs to hospitals and other health care providers associated with going through the CON application process. DCH informed us that most hospitals and health care providers who apply for a CON obtain the services of lawyers, consultants, etc., which significantly increase the costs associated with the application process. We surveyed health care providers who applied for a CON during the period October 1, 1998 through June 30, 2001 and inquired about the costs they incurred as a direct result of the CON application process (see Exhibit 8, Health Care Provider Survey Summary, questions 26 through 30).

Department of Community Health
Inventories of Hospital Beds and Bed Need Projections

Summary Overview

The certificate of need (CON) review standards require the Department of Community Health (DCH) to maintain and provide upon request a listing of the current inventories of hospital beds. DCH maintains these inventories plus corresponding projections of bed needs for each of the following general categories: acute medical care services, nursing home/hospital long-term care services, adult inpatient psychiatric care services, and child/adolescent inpatient psychiatric care services.

The following table shows DCH's inventory and bed need projection for each general category:

Category	Inventory of Existing Beds (a)	Bed Need Projection (b)
Acute Medical Care Services	28,114	17,311
Nursing Home/Hospital Long-Term Care Services	52,271	48,919
Adult Inpatient Psychiatric Care Services	2,681	2,823
Child/Adolescent Inpatient Psychiatric Care Services	505	454

(a) The figures in the inventory of existing beds column do not reflect any data regarding applications for beds under appeal or pending a final decision by DCH. The effective dates for the inventories for the general categories of hospital beds are: January 23, 2002 for acute medical care services; May 10, 2001 for nursing home/hospital long-term care services; and February 12, 2002 for adult and child/adolescent inpatient psychiatric care services. The instances in which the inventory of beds is greater than the bed need projection are due in part to some health facilities being granted hospital beds under past CON review standards or prior to the existence of CON review standards. A facility's existing bed capacity is not affected when DCH recalculates bed need projections.

(b) The bed need projections for acute medical care services; nursing home/hospital long-term care services and adult inpatient psychiatric care services; and child/adolescent inpatient psychiatric care services were last calculated by DCH in 2001, 1993, and 1995, respectively. DCH used 1997 patient origin and demographic data in the calculation for the acute medical care bed need projection, 1987 patient origin and 1990 demographic data in the calculation for the nursing home/hospital long-term care bed need projection, and 1990 demographic and patient origin data in the calculations for the inpatient psychiatric care (adult and child/adolescent) bed need projections.

Each health facility that provides services related to these categories is grouped together with other health facilities in regions across the State either based on the geographic location of the populations they serve (acute medical care services) or based on the geographic location of the facilities. These regions are defined in the CON review standards for each category. When a facility applies for additional hospital beds, DCH considers the bed need in the region that the facility is grouped and compares it with the capacity of existing facilities in that region. Applications for additional hospital beds in those regions where there is not a need would not be approved.

See the following pages for details on hospital bed inventories and bed need projections in each general category's designated regions.

UNAUDITED
Exhibit 2

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR ACUTE MEDICAL CARE SERVICES

DCH's inventories and bed need projections for acute medical care services are broken down into 8 healt service areas. Each health service area includes from 3 to 13 sub areas.

Health Service Area	Sub Area	Inventory of Existing Beds	Bed Need Projection
Southeast	Howell	199	69
	Pontiac	1,492	797
	Mount Clemens	770	455
	Port Huron	350	248
	Ann Arbor	1,574	1,224
	Monroe	217	121
	Wayne	855	429
	Dearborn-Wyandotte	1,561	833
	Northwest Detroit	2,671	2,319
	Northeast Detroit	1,975	1,167
	Central Detroit	3,116	1,514
Southeast Health Service Area Totals		14,780	9,176
Mid-Southern	Lansing	1,143	718
	Jackson	390	233
	Hillsdale	65	58
	Adrian	205	118
Mid-Southern Health Service Area Totals		1,803	1,127
Southwest	Hastings	89	77
	South Haven	82	19
	Kalamazoo	837	547
	Battle Creek	341	206
	Albion	70	28
	Benton Harbor	349	204
	Dowagiac	74	39
	Niles	89	57
	Three Rivers	60	45
	Sturgis	94	39
	Coldwater	102	63
Southwest Health Service Area Totals		2,187	1,324
West	Ludington	81	69
	Big Rapids	168	91
	Hart	24	13
	Fremont	67	36
	Muskegon	568	297
	Grand Rapids	1,738	1,133
	Greenville	90	44
	Holland	250	140
	Ionia	77	26
	Allegan	54	30
West Health Service Area Totals		3,117	1,879

Exhibit 2
(continued)

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR ACUTE MEDICAL CARE SERVICES

Health Service Area	Sub Area	Inventory of Existing Beds	Bed Need Projection
Genesee, Lapeer, Shiawassee (GLS)	Owosso	115	98
	Flint	1,241	843
	Lapeer	183	107
GLS Health Service Area Totals		1,539	1,048
East	West Branch	88	64
	Tawas City	60	38
	Mount Pleasant	182	99
	Midland	272	193
	Bay City	443	211
	Alma	191	126
	Saginaw	994	555
	Cass City	97	30
	Bad Axe	114	54
	Thumb	100	49
East Health Service Area Totals		2,541	1,419
Northern Lower	Cheboygan	46	41
	Petoskey	288	175
	Rogers City	36	22
	Gaylord	53	30
	Alpena	124	96
	Traverse City	393	271
	Cadillac	97	76
	Grayling	90	51
	Manistee	75	37
Northern Lower Health Service Area Totals		1,202	799
Upper Peninsula	Wakefield	54	39
	Ontonogan	25	8
	Crystal Falls	36	29
	L'anse	24	14
	Hancock	85	61
	Iron Mountain	96	68
	Marquette	358	179
	Menominee	0	0
	Escanaba	110	69
	Munising	25	7
	Manistique	25	11
	Newberry	25	13
	Sault Saint Marie	82	41
Upper Peninsula Health Service Area Totals		945	539
Statewide Totals		28,114	17,311

UNAUDITED
Exhibit 3

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR NURSING HOME/HOSPITAL LONG-TERM CARE SERVICES

DCH's inventories and bed need projections for nursing home/hospital long-term care services are broken down into 84 planning areas.

Planning Area	Inventory of Existing Beds	Bed Need Projection
Alcona	106	102
Alger	106	70
Allegan	565	474
Alpena	208	203
Antrim	113	134
Arenac	148	106
Baraga	87	72
Barry	252	262
Bay	668	638
Benzie	102	93
Berrien	867	969
Branch	283	241
Calhoun	866	805
Cass	222	272
Charlevoix	134	134
Cheboygan	162	154
Chippewa	173	193
Clare	200	173
Clinton	251	251
Crawford	160	85
Delta	292	260
Dickinson	256	230
Eaton	444	431
Emmet	230	167
Genesee	1,951	1,951
Gladwin	180	150
Gogebic	221	195
Grand Traverse	552	368
Gratiot	556	272
Hillsdale	262	262
Houghton/Keweenaw	335	314
Huron	313	278
Ingham	1,181	1,180
Ionia	248	275
Iosco	244	193
Iron	249	150
Isabella	309	214
Jackson	847	828
Kalamazoo	1,384	1,120
Kalkaska	88	76
Kent	2,761	2,566
Lake	89	78

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR NURSING HOME/HOSPITAL LONG-TERM CARE SERVICES

Planning Area	Inventory of Existing Beds	Bed Need Projection
Lapeer	272	291
Leelanau	97	111
Lenawee	497	497
Livingston	475	421
Luce	61	46
Mackinac	79	81
Macomb	4,056	3,636
Manistee	221	170
Marquette	441	361
Mason	202	197
Mecosta	232	184
Menominee	195	197
Midland	414	338
Missaukee	95	81
Monroe	696	619
Montcalm	285	285
Montmorency	84	89
Muskegon	945	904
Newaygo	245	222
Ottawa	970	874
Oakland	5,241	5,241
Oceana	113	130
Ogemaw	233	131
Ontonagon	110	76
Osceola	54	118
Oscoda	90	69
Otsego	154	111
Presque Isle	106	111
Roscommon	179	171
Saginaw	1,175	1,156
St. Clair	765	789
St. Joseph	369	355
Sanilac	267	269
Schoolcraft	75	72
Shiawassee	327	350
Tuscola	293	292
Van Buren	424	411
Washtenaw	1,360	1,032
Wexford	218	161
Northwest Wayne	3,181	3,166
Southwest Wayne	2,033	1,818
Detroit	6,277	6,297
Statewide Totals	52,271	48,919

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR ADULT INPATIENT PSYCHIATRIC CARE SERVICES

DCH's inventories and bed need projections for adult inpatient psychiatric care services are broken down into 55 planning areas.

Planning Area	Inventory of Existing Beds	Bed Need Projection
Detroit/Wayne	922 (a)	717
Livingston	0	39
Macomb	187	230
Monroe	21	22
Oakland	421	380
St. Clair	23	43
Washtenaw	87	103
Clinton-Eaton-Ingham	144	114
Jackson-Hillsdale	40	40
Lenawee	35 (b)	31
Barry	0	17
Berrien	30	30
Branch	16	14
Calhoun	56	47
Cass	0	17
Kalamazoo	40	44
St. Joseph	0	13
Van Buren	15	15
Allegan	9	9
Ionia	0	19
Kent	156	166
Lake	0	3
Mason	14	9
Montcalm	16	16
Muskegon	27	43
Newaygo	16	13
Oceana	0	8
Ottawa	12	20
Genesee	108	141
Lapeer	20	20
Shiawassee	16	24
Ausable Valley	0	20
Bay-Arenac	28	28
Central Michigan	19 (c)	14
Gratiot	12	12
Huron	0	12
Midland-Gladwin	20	20
Saginaw	55	71
Sanilac	0	14
Tuscola	0	19
Antrim-Kalkaska	0	11
Grand Traverse-Leelanau	14	14

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR ADULT INPATIENT PSYCHIATRIC CARE SERVICES

Planning Area	Inventory of Existing Beds	Bed Need Projection
Manistee-Benzie	0	12
North Central	20	20
Northeast Michigan	15	23
Northern Michigan	14	14
Alger-Marquette	37	28
Copper Country	0	20
Delta	0	13
Dickinson-Iron	0	14
Eastern Upper Peninsula	0	16
Gogebic	0	7
Luce	0	2
Menominee	16	9
Schoolcraft	0	3
Statewide Totals	2,681	2,823

(a) Inventory includes 135 inactive or "zero occupancy" licensed beds.
(b) Inventory includes 23 inactive or "zero occupancy" licensed beds.
(c) Inventory includes 19 inactive or "zero occupancy" licensed beds.

DEPARTMENT OF COMMUNITY HEALTH
INVENTORY OF HOSPITAL BEDS AND BED NEED PROJECTIONS
FOR CHILD/ADOLESCENT INPATIENT PSYCHIATRIC CARE SERVICES

DCH's inventories and bed need projections for child/adolescent inpatient psychiatric care services are broken down into 8 planning areas.

Planning Area	Inventory of Existing Beds	Bed Need Projection
Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, Wayne	241	217
Clinton, Eaton, Hillsdale, Ingham, Jackson, Lenawee	61	35
Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	55	39
Allegan, Ionia, Kent, Lake, Mason, Montcalm, Muskegon, Newaygo, Oceana, Ottawa	70	60
Genesee, Lapeer, Shiawassee	40	30
Arenac, Bay, Clare, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Mecosta, Ogemaw, Osceola, Oscoda, Saginaw, Sanilac, Tuscola	28 (a)	40
Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Roscommon, Wexford	0	18
Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonogan, Schoolcraft	10	15
Statewide Totals	505	454

(a) Inventory includes 14 inactive or "zero occupancy" licensed beds.

Maps of CON Covered Service Locations

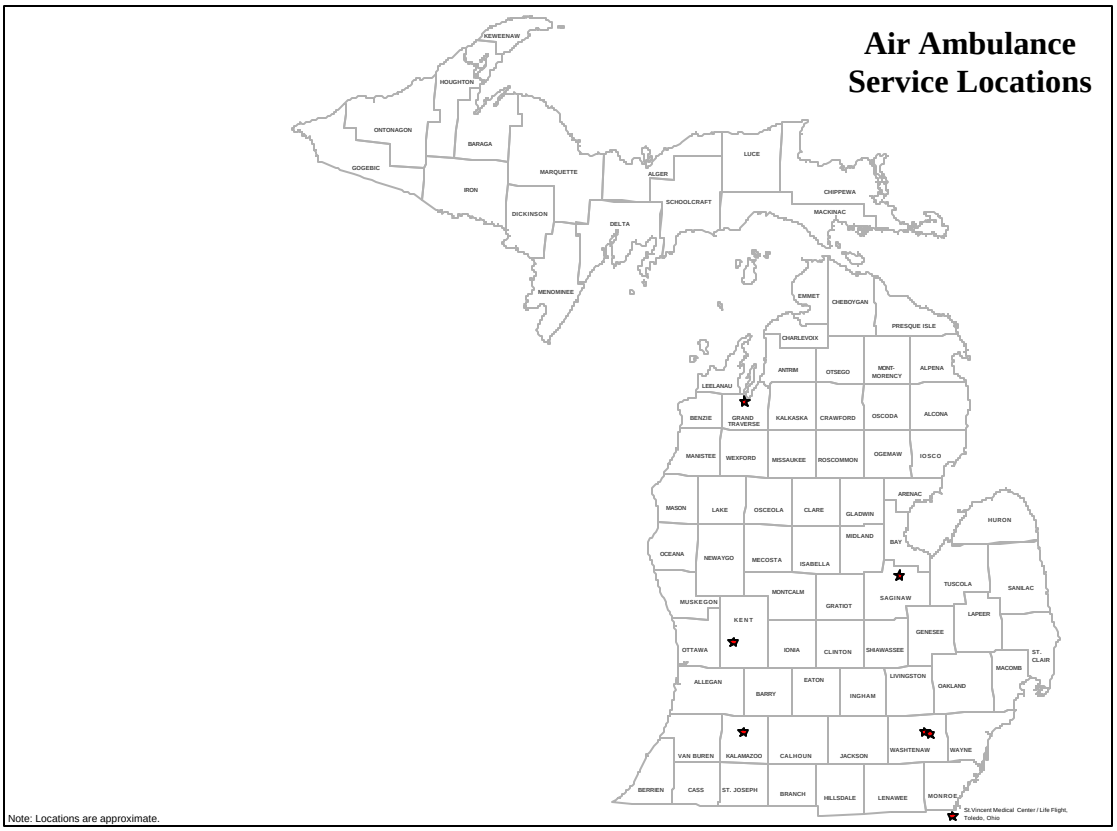
Summary Overview

The Science and Technology Division, Michigan Legislative Service Bureau, prepared maps of certificate of need (CON) covered service locations in Michigan based on data the Department of Community Health (DCH) had provided to us during our audit fieldwork. The maps show the approximate geographic locations where CON regulated medical services are offered**. The following service locations were mapped:

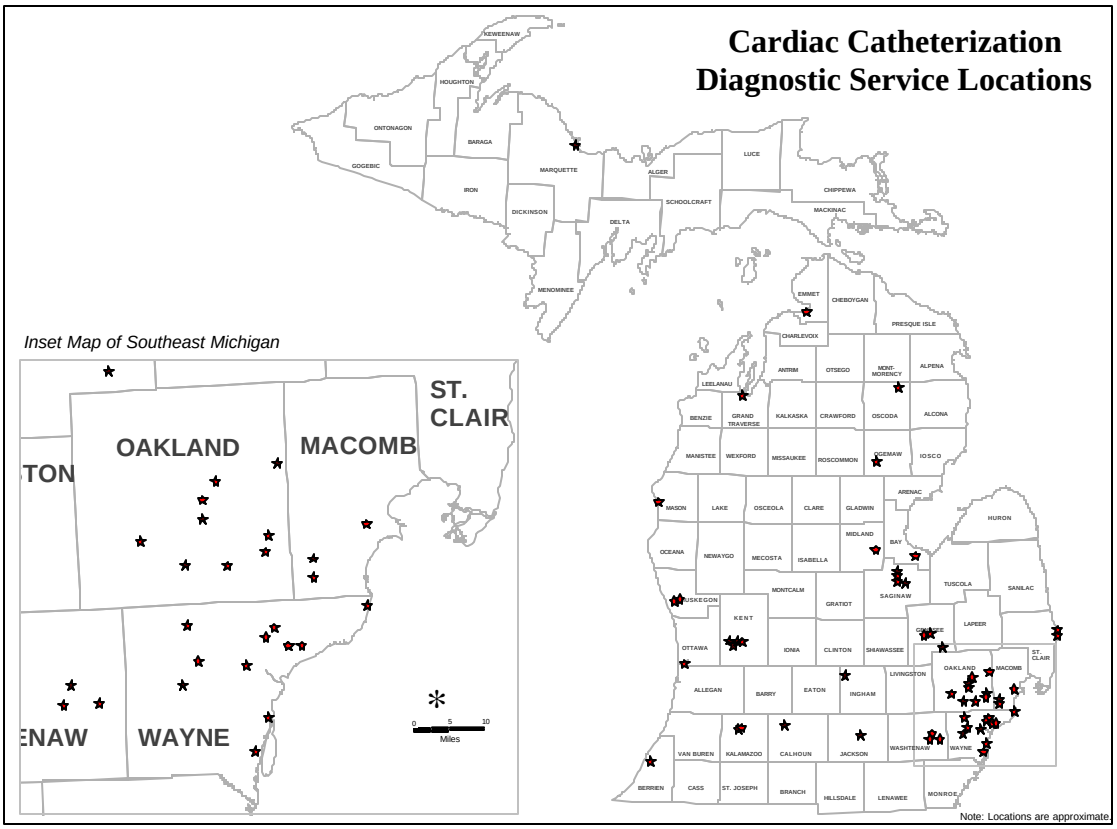
Air Ambulance*
Cardiac Catheterization* Diagnostic
Cardiac Catheterization Therapeutic and Open Heart Surgery*
Cardiac Catheterization - Mobile*
Computed Tomography* (CT) Scanner
CT Scanner - Mobile*
Inpatient Psychiatric Care
Lithotripsy* - Mobile and Stationary
Magnetic Resonance Imaging* (MRI)
MRI - Mobile*
Megavoltage Radiation Therapy* (MRT)
Michigan Hospital Locations
Neonatal Intensive Care Unit (NICU) and NICU Beds per County
Positron Emission Tomography* (PET) Scanner
Surgery (Inpatient, Outpatient, and Ambulatory/Free-Standing*)
Transplant*

* *See glossary at end of report for definition.*

** Some of the maps may not include all facilities that provide a certain service because some facilities offered CON regulated services prior to CON regulation and, therefore, have not had to go through the CON process.



Data from: Michigan Department of Community Health, Certificate of Need (CON) Program.
Map Prepared by the Michigan Legislative Service Bureau, Science and Technology Division.



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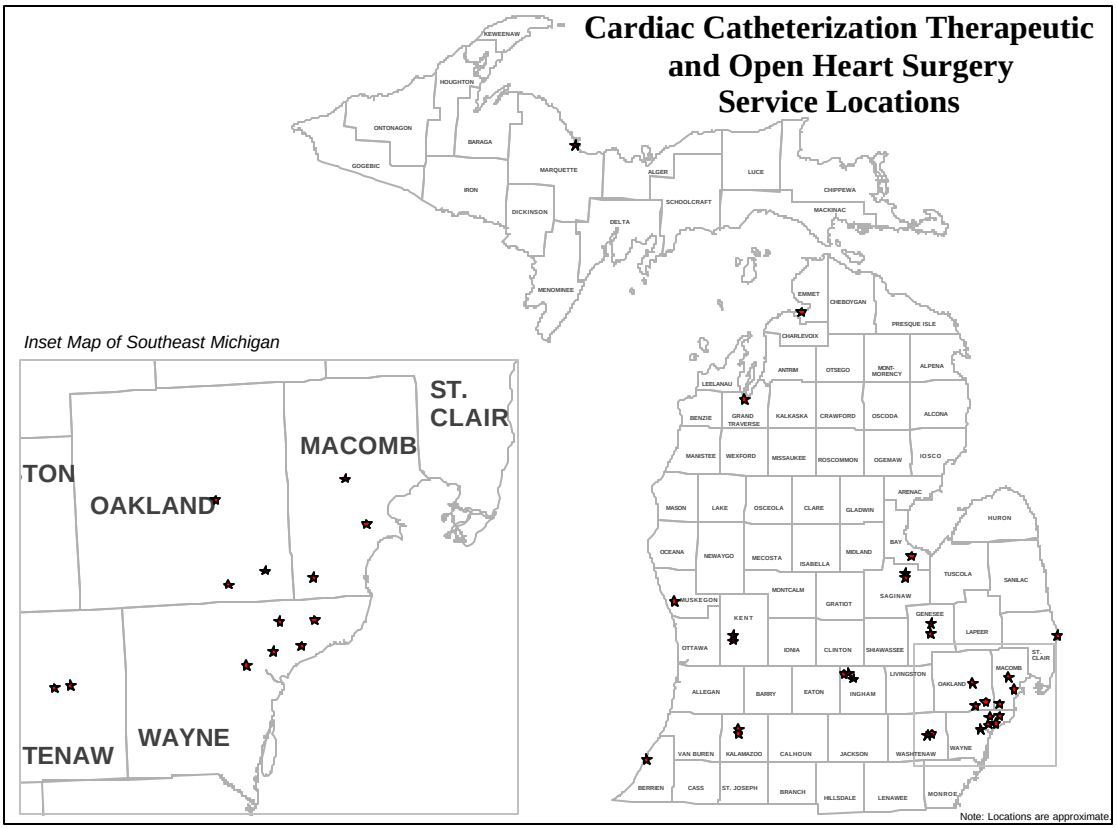

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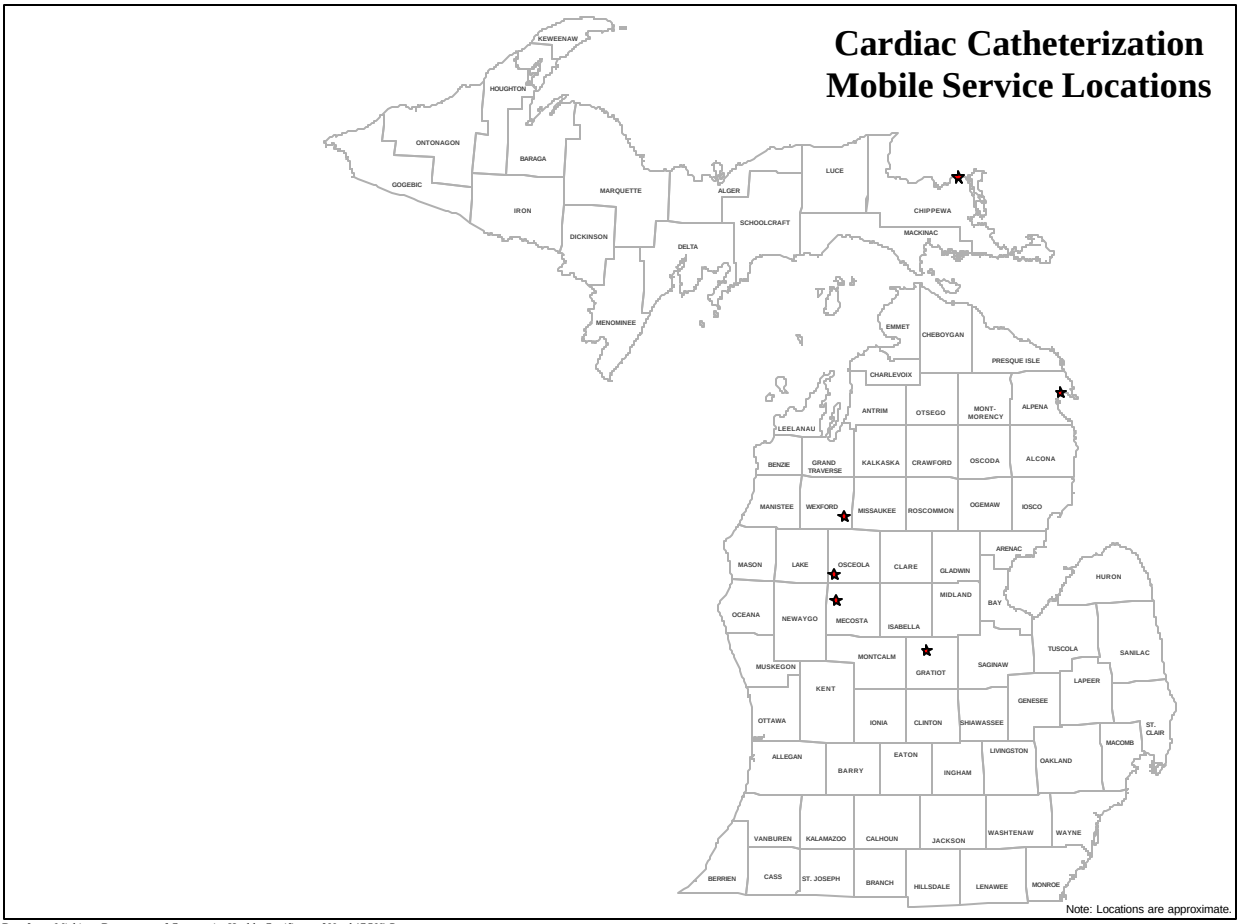

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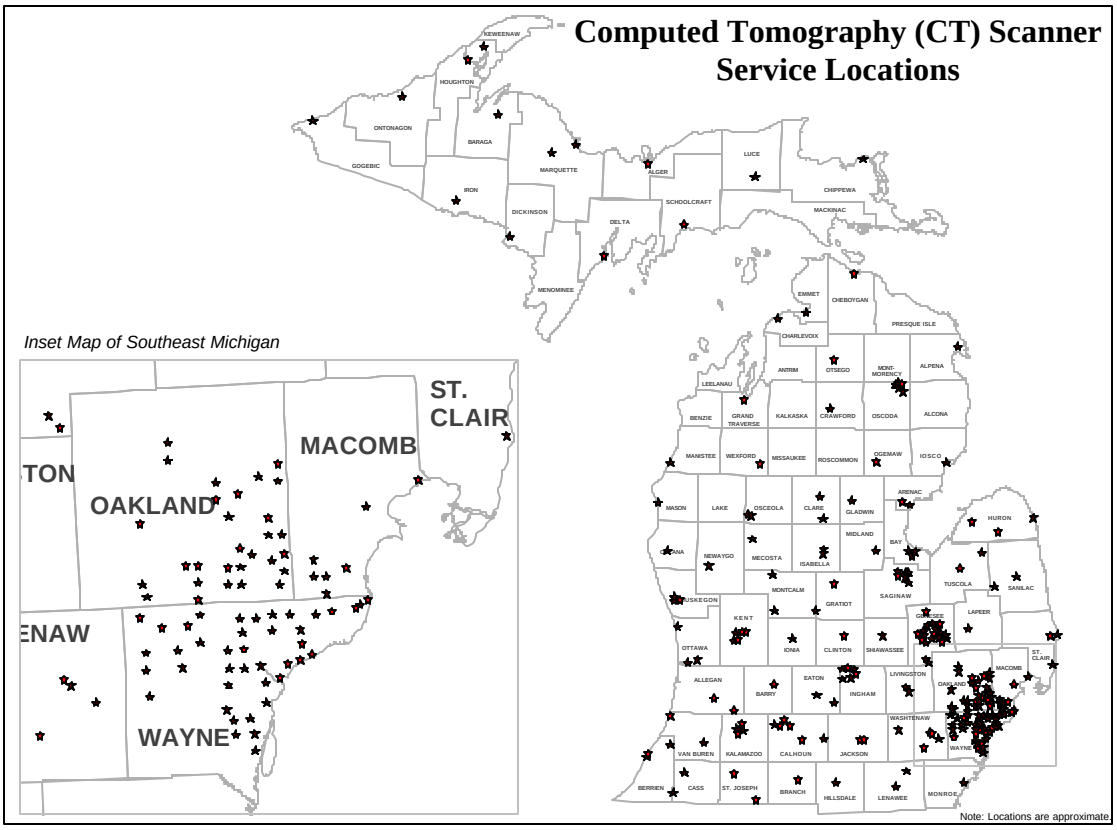

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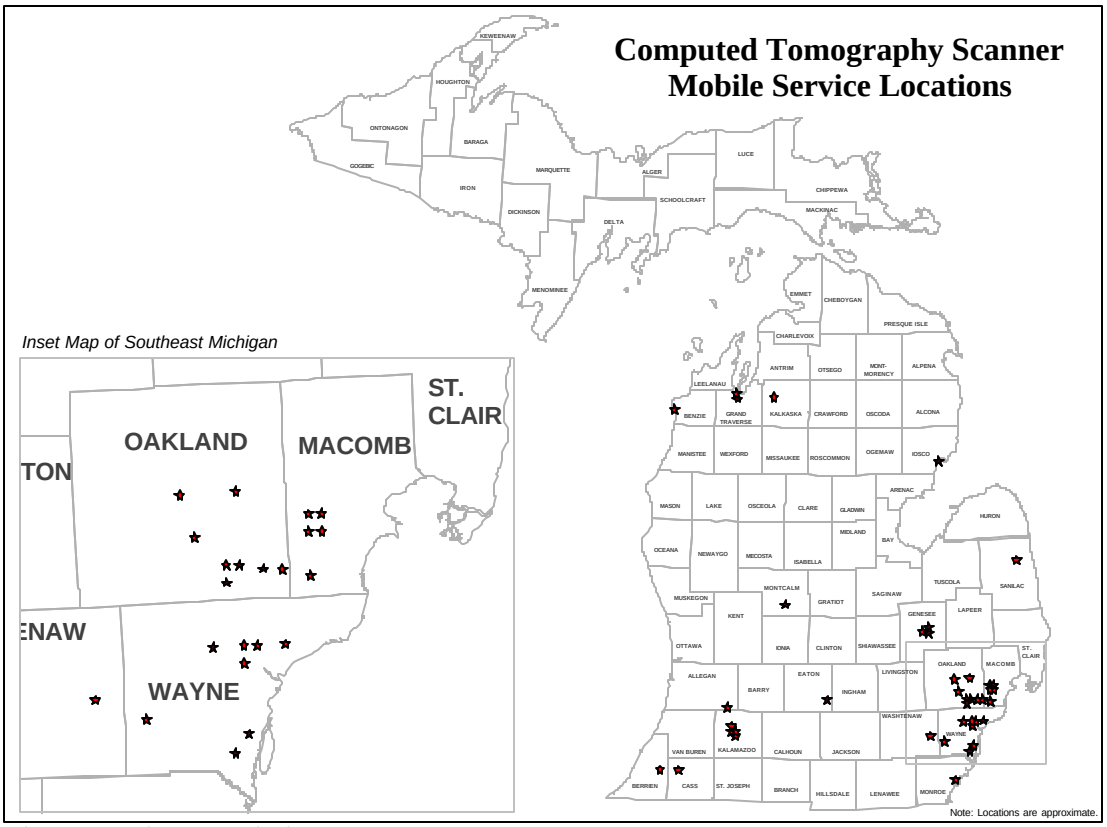

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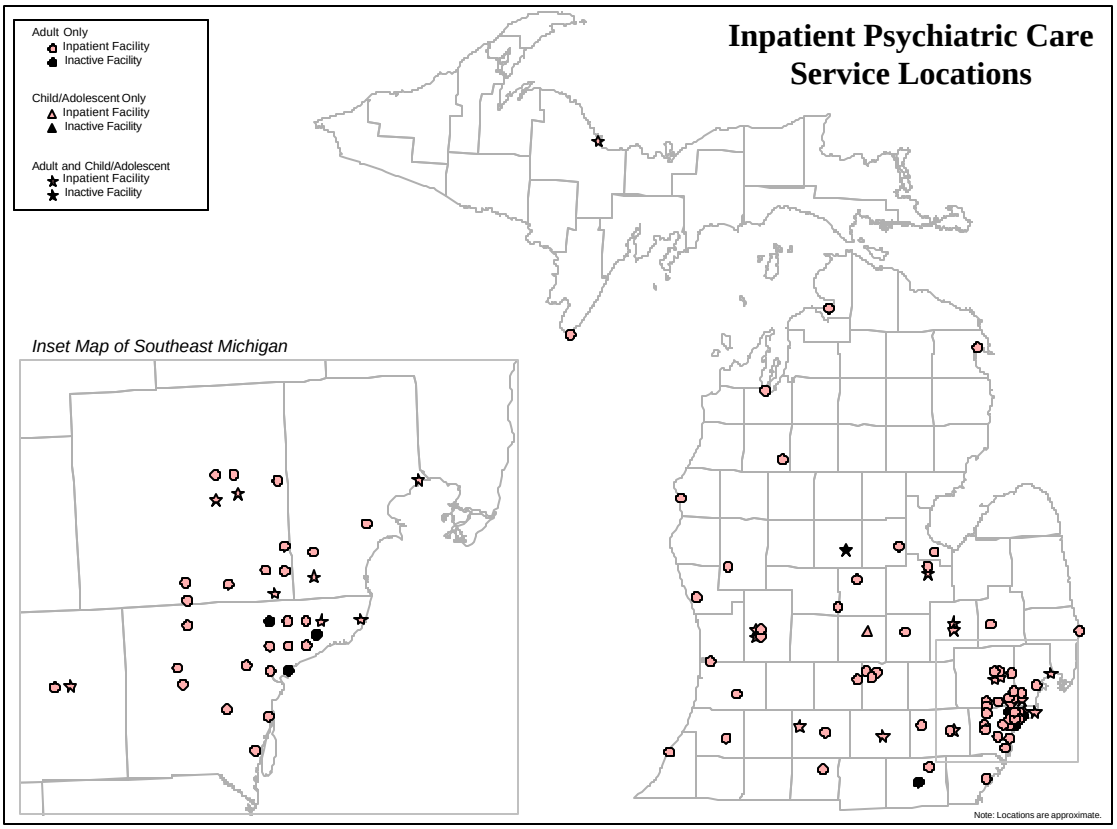

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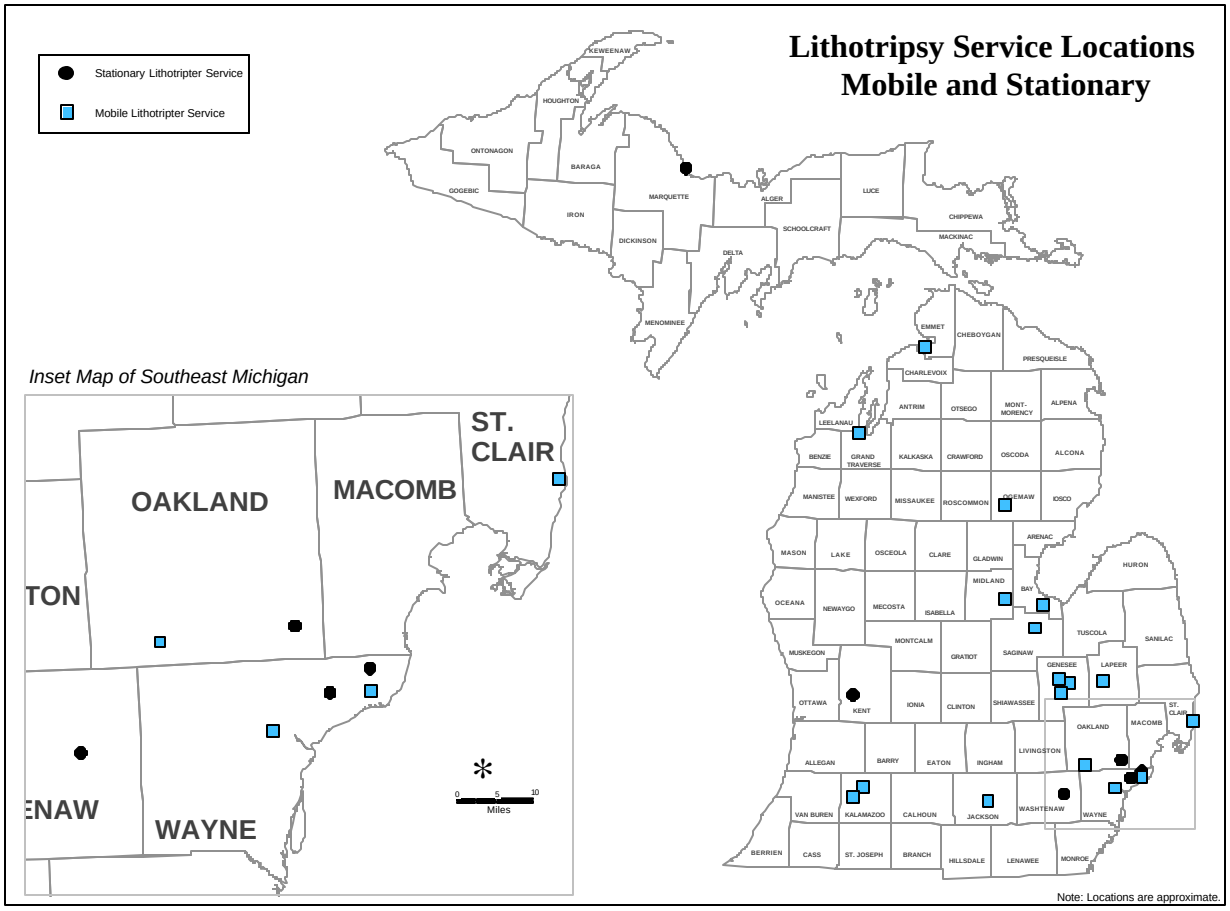

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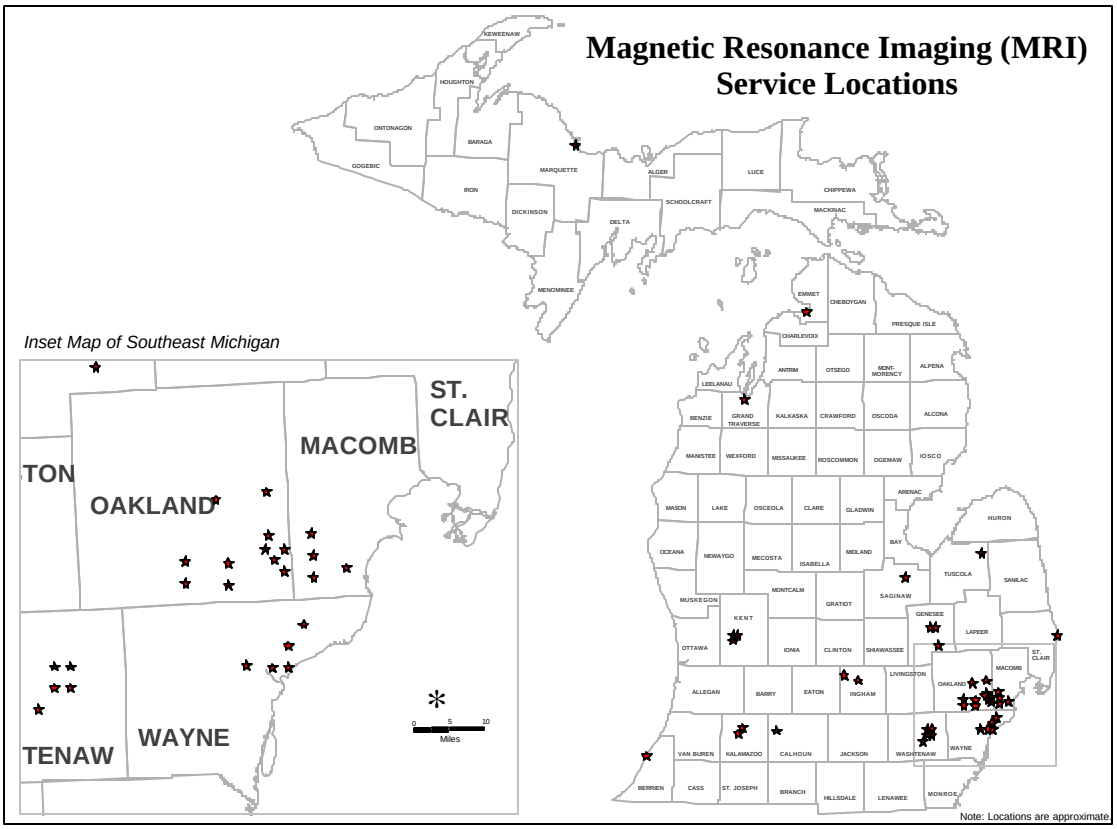

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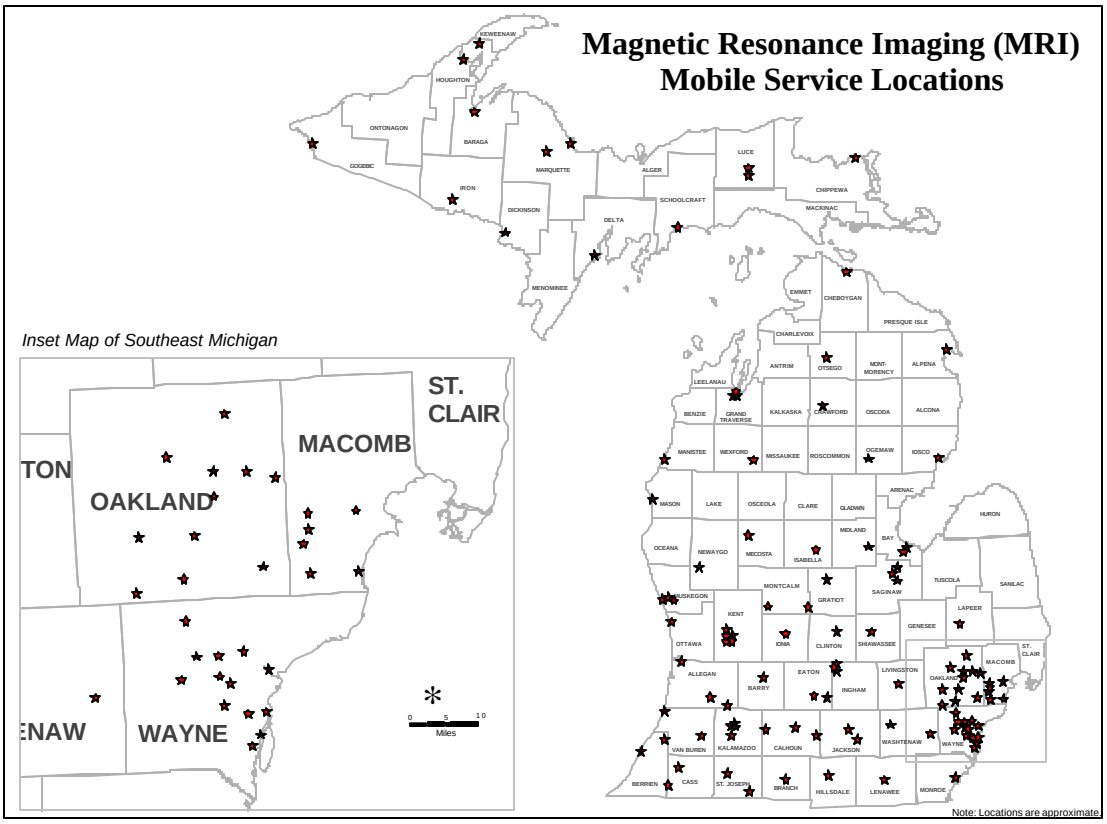

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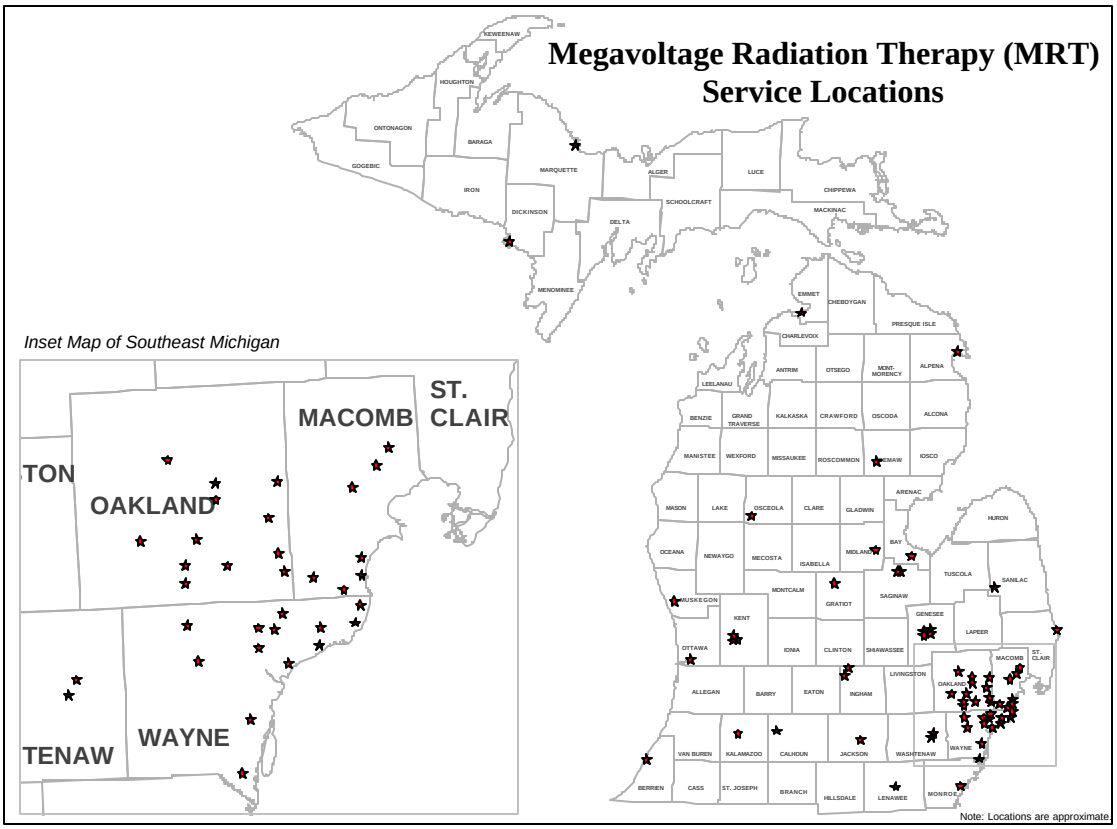

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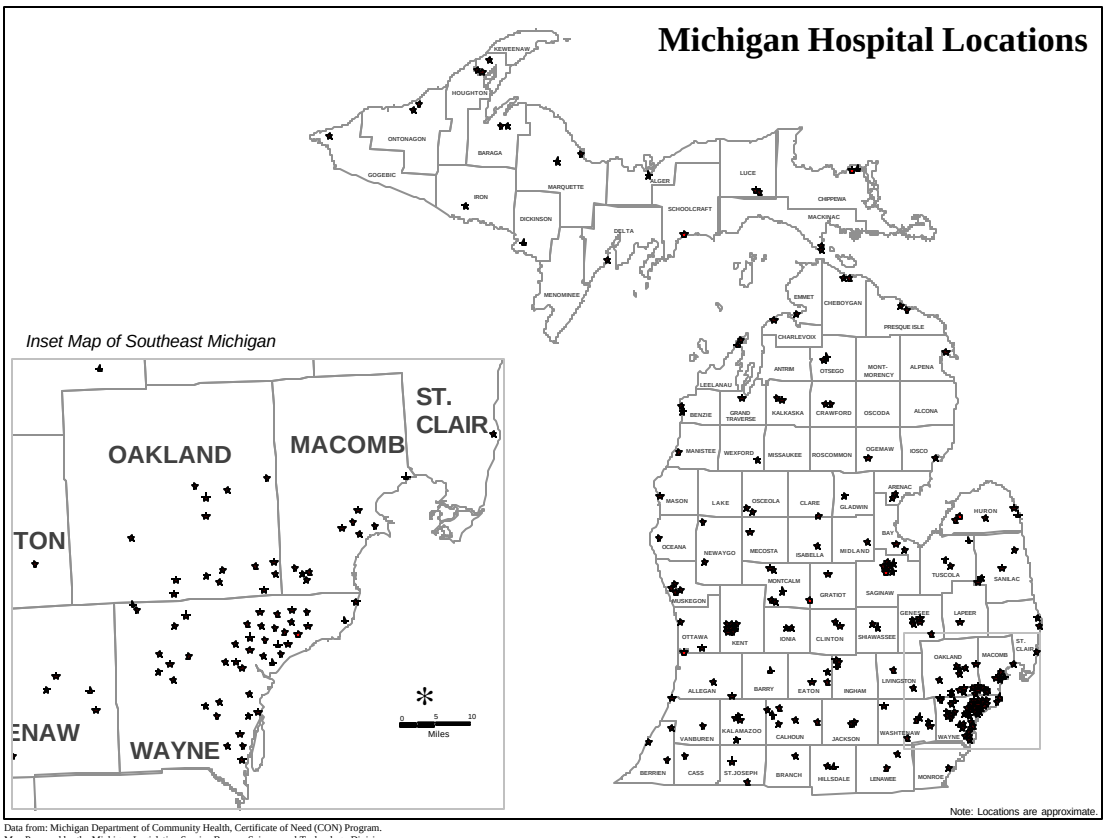

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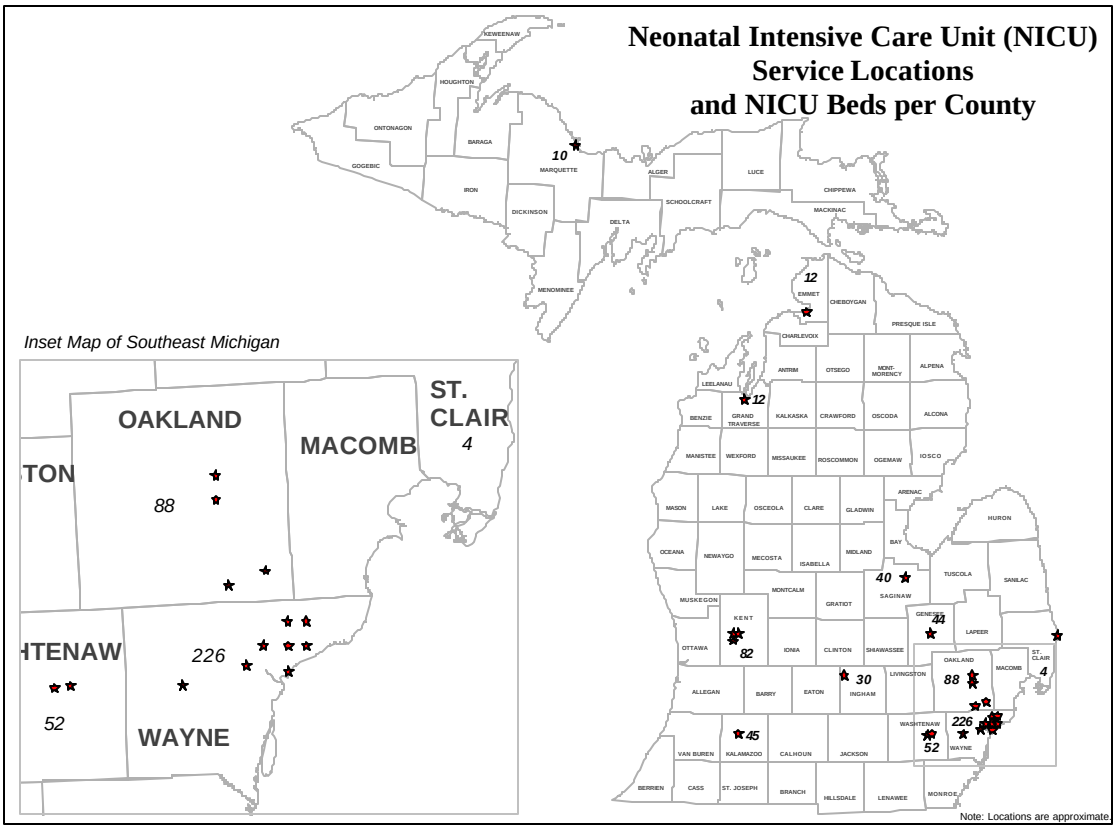

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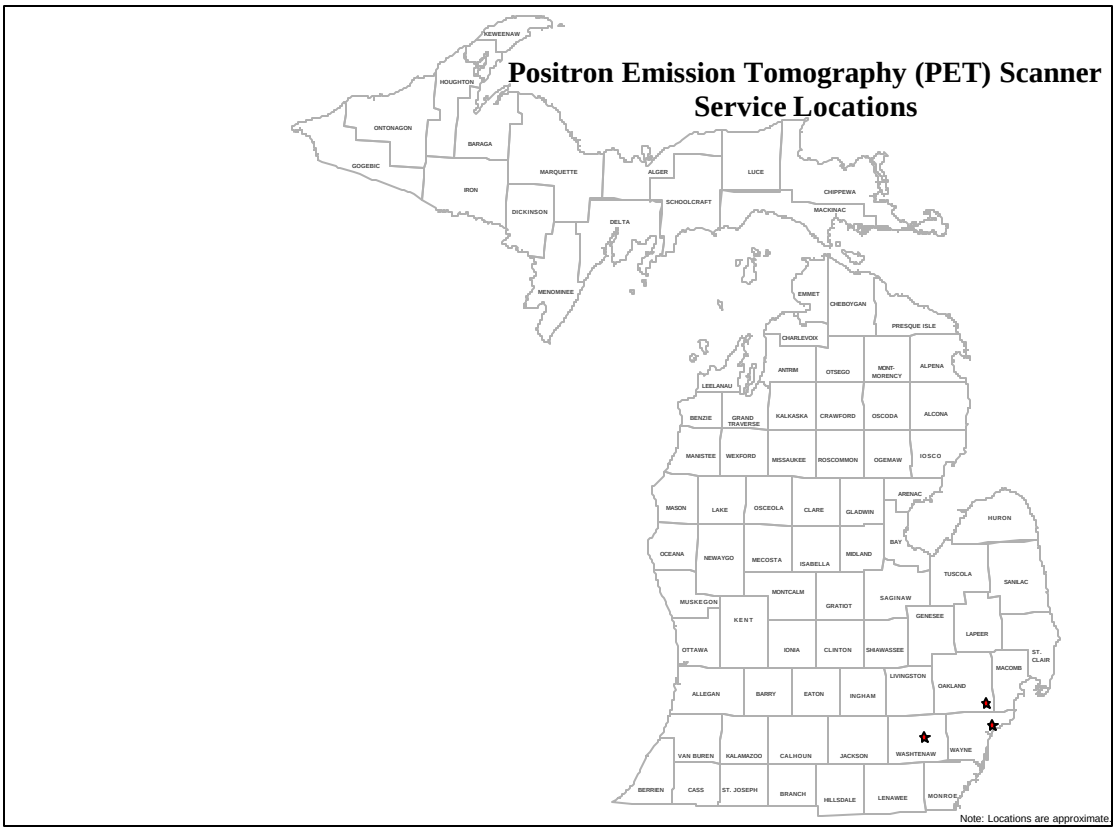

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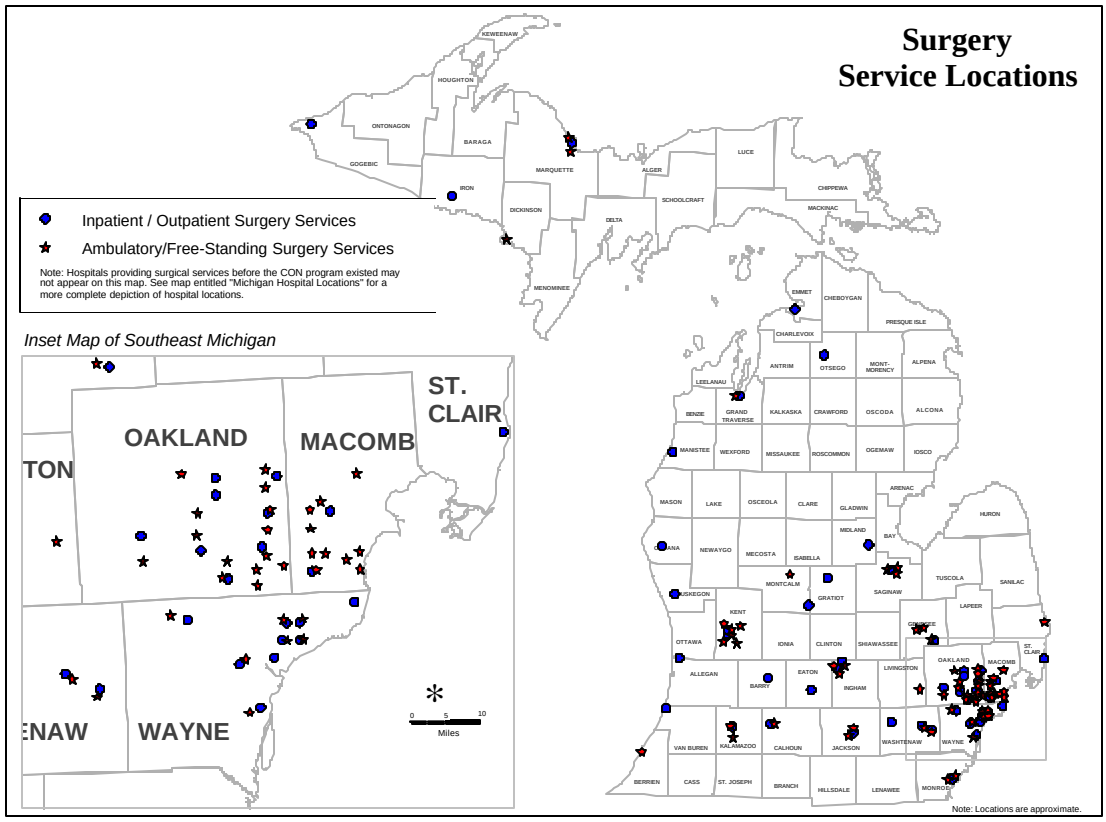

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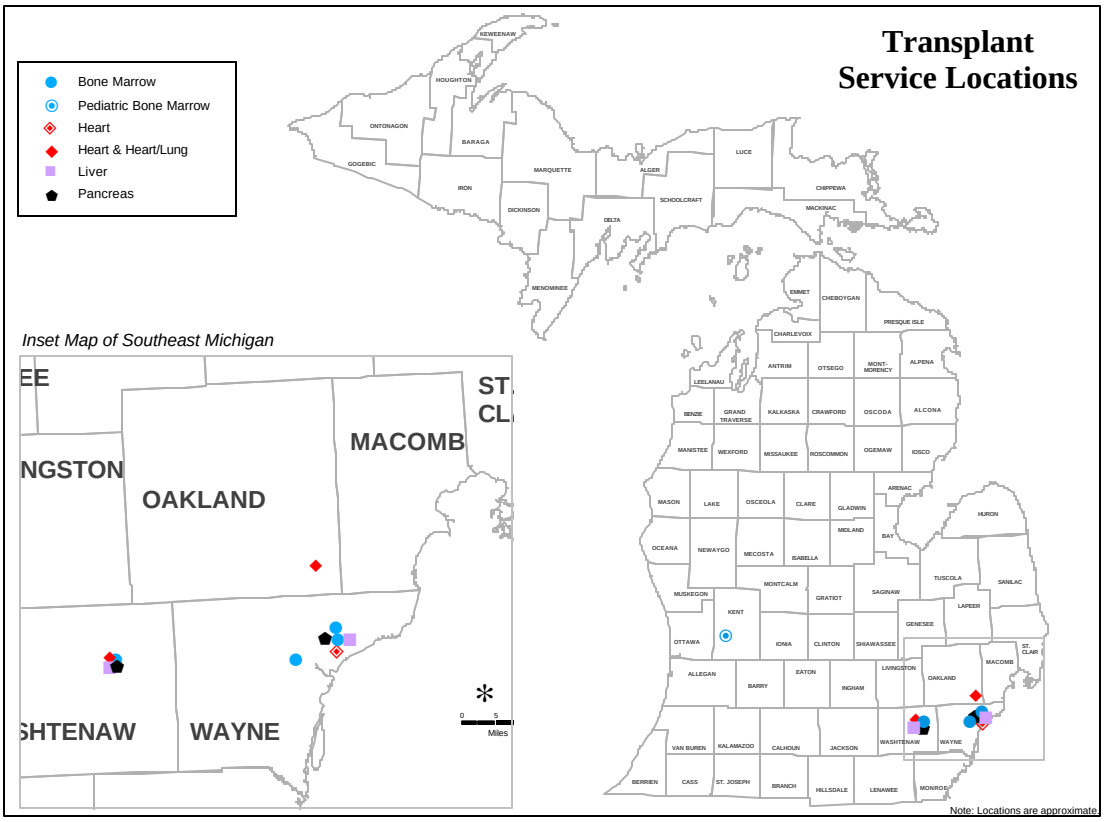

Data from: Michigan Department of Community Health, Certificate of Need (CON) Program.
Map Prepared by the Michigan Legislative Service Bureau, Science and Technology Division.

Summary of Nationwide CON Program Regulation

Overview

The American Health Planning Association publishes the *National Directory of Health Planning, Policy and Regulatory Agencies* annually. The Directory is intended to provide information about the Certificate of Need (CON) Program and health planning agencies throughout the United States.

According to the Directory, as of January 31, 2002, 36 states and the District of Columbia continue to administer, to varying degrees, a CON program to regulate health care. The Directory contains information on each of these CON programs, including the medical services being regulated, CON fees, and the relative scope and reviewability thresholds of CON covered services. The medical services being regulated by CON programs include capital additions, certain medical equipment purchases, and new services.

Medical Services Regulated by CON Programs

According to the American Health Planning Association, as of January 31, 2002, the 36 states plus the District of Columbia regulated approximately 30 different categories of medical services and medical equipment purchases. These included:

1. Acute Care*
2. Air Ambulance*
3. Ambulatory Surgical Centers*
4. Burn Care
5. Business Computers
6. Cardiac Catheterization*
7. Computed Tomography Scanners*
8. Gamma Knives*
9. Home Health
10. Intermediate Care Facility for the Mentally Retarded
11. Lithotripsy*
12. Long-Term Care*

13. Medical Office Building
14. Mobile Hi-Tech*
15. Mobile Resonance Imaging Scanners*
16. Neonatal Intensive Care*
17. Obstetric Services
18. Open Heart Services*
19. Organ Transplant*
20. PET Scanners*
21. Psychiatric Services*
22. Radiation Therapy*
23. Rehabilitation
24. Renal Dialysis
25. Residential Care Facility
26. Subacute
27. Substance Abuse
28. Swing Beds*
29. Ultra-sound
30. Other* (In Michigan, other services are: Hospice Nursing Home, Nursing Home Vent Beds, and Surgical Facilities.)

* Medical services that are regulated in Michigan.

The number of medical service categories regulated by individual states ranged from 1 to 27. Twenty-two states and the District of Columbia regulate 15 or more of these medical service categories. Fourteen states regulate from 1 to 14 of these medical service categories. **Michigan's CON Program regulates 18 different medical service categories.**

Reviewability Thresholds of CON Covered Services

Most states with CON programs have set "reviewability thresholds" for CON regulated medical services. These thresholds, which vary from state to state, determine which acquisitions of medical services are required to go through the

CON process. Some states have not established specific dollar thresholds, but instead require that the acquisition of any service regulated by CON be subject to CON review. For comparative purposes, we considered only those states that have established specific dollar thresholds.

For capital additions, the reviewability thresholds among the states with CON programs range from $500,000 to $9,841,075. **Michigan's reviewability thresholds for capital additions are $2,352,000 for clinical service areas and $3,639,000 for nonclinical service areas.**

For medical equipment, the reviewability thresholds among the states with CON programs range from $400,000 to $6,000,000. **Michigan's reviewability threshold requires any medical equipment regulated by the CON Program be subject to the CON process.**

For new services, the reviewability thresholds among the states with CON Programs range from $100,000 to $1,000,000. **Michigan's reviewability threshold requires any new clinical services regulated by the CON Program be subject to the CON process.**

Health Care Provider Survey Summary

In October 2001, we sent surveys to 100 health care providers that had applied for a certificate of need (CON) during the period October 1, 1998 through June 30, 2001. Three (3%) of the 100 surveys were returned to us as "undeliverable." We received 50 responses for a response rate of 52%.

Following is a copy of the survey that includes the number of responses received for each item. The total number of responses for each item may not agree with the number of responses reported above because some facilities provided more than one response to an item and other facilities did not respond to all of the items.

Survey of Health Care Providers Regarding the Certificate of Need (CON) Program

Background Information

1. Please indicate the type of facility you were associated with when you applied for a CON:

a.	39 (76%)	Hospital
b.	3 (6%)	Freestanding surgical outpatient facility
c.	5 (10%)	Nursing home
d.	0	Hospital long-term care unit
e.	0	Health maintenance organization (HMO)
f.	0	Psychiatric hospital
g.	0	Inpatient psychiatric unit
h.	0	Partial hospitalization psychiatric program
i.	4 (8%)	Other

2. Which of the following reasons explain why you applied for a CON:

a.	4 (8%)	Wanted to acquire an existing health facility
b.	5 (9%)	Wanted to make a change in the bed capacity of a health facility
c.	1 (2%)	Wanted to begin operation of a health facility at a site that was not currently licensed for that type of health facility
d.	30 (57%)	Wanted to initiate, replace, or expand a "covered clinical service"
e.	11 (21%)	Wanted to make a "covered capital expenditure"
f.	2 (4%)	Other

3. Please indicate which one of the following dollar amounts best estimates the cost of the project for which you applied for the CON:

a.	11 (23%)	$500,000 or less
b.	7 (15%)	Greater than $500,000 but not more than $1 million
c.	20 (42%)	Greater than $1 million but not more than $5 million
d.	3 (6%)	Greater than $5 million but not more than $10 million
e.	7 (15%)	Greater than $10 million

4. Which type of CON review was this project subject to?

a.	15 (31%)	Nonsubstantive
b.	23 (47%)	Substantive
c.	2 (4%)	Comparative
d.	9 (18%)	I do not know.

Application Process

5. Please indicate the amount of time it took for the Department of Community Health (DCH) to respond to the letter of intent that you submitted for your project:

a.	24 (49%)	1 to 15 calendar days
b.	15 (31%)	16 to 30 calendar days
c.	3 (6%)	More than 30 calendar days
d.	7 (14%)	I do not remember how long it took.

6. Please indicate the amount of time it took for DCH to provide you with a proposed decision on your application:

a.	5 (10%)	1 to 30 calendar days
b.	9 (18%)	31 to 60 calendar days
c.	5 (10%)	61 to 90 calendar days
d.	11 (22%)	91 to 120 calendar days
e.	10 (20%)	121 to 160 calendar days
f.	3 (6%)	More than 160 calendar days
g.	7 (14%)	I have not received a proposed decision on my application.

7. Please indicate the proposed decision DCH made regarding your CON application:

a.	38 (90%)	Approved
b.	0	Approved with conditions
c.	2 (5%)	Denied
d.	2 (5%)	Other

8. After you were notified of the proposed decision, which of the following time frames best describes how long it took DCH to inform you of the final decision regarding your CON application:

a.	22 (52%)	1 to 15 calendar days
b.	9 (21%)	16 to 30 calendar days
c.	4 (10%)	31 to 60 calendar days
d.	2 (5%)	61 to 90 calendar days
e.	2 (5%)	More than 90 calendar days
f.	1 (2%)	I have not received a final decision.
g.	2 (5%)	Not applicable

9. Please indicate what the final decision was on your CON application:

a.	37 (90%)	Approved
b.	0	Approved with conditions
c.	2 (5%)	Denied
d.	2 (5%)	Other

10. Please indicate the number of times you submitted additional information to DCH regarding your application or amended your original application prior to a proposed decision:

a.	7 (14%)	None
b.	17 (35%)	1
c.	13 (27%)	2
d.	4 (8%)	3
e.	8 (16%)	More than 3

11. If you had not submitted additional information or amended your original application, would your application have otherwise been denied?

a.	14 (33%)	Yes
b.	5 (12%)	No
c.	24 (56%)	I do not know.

12. Did DCH request it or did you voluntarily submit the additional or amended information?

a.	30 (70%)	DCH requested
b.	2 (5%)	Voluntarily submitted
c.	11 (26%)	Both

13. Please indicate the number of extension(s) you requested during the processing of your application:

a.	41 (84%)	None
b.	6 (12%)	1
c.	1 (2%)	2
d.	0	3
e.	1 (2%)	More than 3

14. Please indicate the number of days your application was extended as a result of your request(s):

a.	5 (45%)	1 to 30 days
b.	0	31 to 60 days
c.	1 (9%)	61 to 90 days
d.	5 (45%)	More than 90 days

15. Please indicate your level of satisfaction with the instructions on the CON application regarding how to fill it out and submit your request:

a.	21 (43%)	Very satisfied
b.	19 (39%)	Somewhat satisfied
c.	4 (8%)	Somewhat dissatisfied
d.	4 (8%)	Very dissatisfied
e.	1 (2%)	No opinion

16. Would you benefit from a training session offered by DCH on how to properly fill out and submit a CON application?

a.	27 (54%)	Yes
b.	13 (26%)	No
c.	10 (20%)	No opinion

17. Could DCH have done more to provide assistance to you during the application process?

a.	7 (14%)	Yes
b.	27 (54%)	No
c.	16 (32%)	No opinion

18. If you had contact with DCH staff during the application process, were they courteous?

a.	45 (87%)	Yes
b.	2 (4%)	No
c.	0	No opinion
d.	5 (10%)	I did not have contact with DCH staff.

19. Should the CON application process be changed?

a.	26 (51%)	Yes
b.	17 (33%)	No
c.	8 (16%)	No opinion

20. To the best of your knowledge, did DCH follow its own rules and State laws in reviewing your CON application?

a.	41 (82%)	Yes
b.	1 (2%)	No
c.	8 (16%)	I do not know.

Appeals Process

21. Did you file a request for a hearing to appeal the proposed decision on your CON application?

a.	1 (2%)	Yes
b.	44 (98%)	No

22. Why did you file a request for a hearing? (please select the most appropriate answer.)

a.	1 (100%)	CON application was denied.
b.	0	CON application was originally approved and then decision was reversed.
c.	0	Other

23. How soon after you received notice of the proposed disapproval or reversal did you file a request for a hearing?

a.	0	1 to 15 calendar days
b.	1 (100%)	Greater than 15 but not more than 30 calendar days
c.	0	Greater than 30 but not more than 60 calendar days
d.	0	Greater than 60 calendar days

24. How satisfied were you with the timeliness of the appeals process?

a.	1 (5%)	Very satisfied
b.	2 (10%)	Somewhat satisfied
c.	0	Somewhat dissatisfied
d.	0	Very dissatisfied
e.	18 (86%)	No opinion

25. If the outcome of your hearing was not in your favor, did DCH help you to understand why?

a.	1 (100%)	Yes
b.	0	No
c.	22 (N/A)	Not applicable

Costs Associated With the Application Process

26. Please indicate which one of the following most accurately describes the amount of the fee **assessed by DCH** when you applied for the CON:

a.	7 (15%)	$750
b.	18 (39%)	$2,750
c.	18 (39%)	$4,250
d.	3 (7%)	Other amount

27. Please check all of the following types of fees not assessed by DCH that you incurred as a direct result of the CON application process:

a.	23 (37%)	None
b.	14 (22%)	Legal fees
c.	5 (8%)	Authorized agent fee
d.	15 (24%)	Consultant fees
e.	6 (10%)	Other

28. Please indicate the estimated dollar amount of the fees indicated in question 27:

a.	16 (59%)	Greater than $1,000 but not more than $5,000
b.	7 (26%)	Greater than $5,000 but not more than $10,000
c.	4 (15%)	Greater than $10,000

29. Do you feel that it was necessary to incur these extra costs in order to obtain a CON?

a.	24 (62%)	Yes
b.	7 (18%)	No
c.	8 (21%)	No opinion

30. Given the type of project that was proposed, do you feel the costs associated with obtaining a CON were reasonable?

a.	25 (53%)	Yes
b.	13 (28%)	No
c.	9 (19%)	No opinion

Other

31. Do you believe the current CON regulations for health care services and facilities in Michigan are appropriate?

a.	25 (48%)	Yes
b.	22 (42%)	No
c.	5 (10%)	No opinion

32. Do you believe the current review standards by which CON applications are evaluated are reasonable?

a.	25 (51%)	Yes
b.	15 (31%)	No
c.	9 (18%)	No opinion

33. Has there been an instance(s) in which you did not undertake a project or pursue the purchase of specialized equipment because of a CON requirement(s)?

a.	26 (54%)	Yes
b.	22 (46%)	No

34. Do you believe the CON Program is effective in balancing cost, quality, and access issues and ensuring that only needed services and facilities are developed in Michigan?

a.	22 (46%)	Yes
b.	17 (35%)	No
c.	9 (19%)	No opinion

Glossary of Acronyms and Terms

air ambulance	The provision of emergency medical and air medical services by means of one or more air ambulances, which operate in conjunction with a base of operations.
ambulatory/free-standing surgery	Surgical services provided at either ambulatory surgical centers (ASCs) or free-standing surgical outpatient facilities (FSOFs). An ASC is any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. An FSOF is a health facility that does not include a surgical outpatient facility owned by, operated by, and licensed as part of a hospital at a licensed hospital site.
cardiac catheterization	A medical diagnostic or therapeutic procedure during which a catheter is inserted into a vein or artery in a patient and subsequently a physician is able to perform various diagnostic studies and/or therapeutic procedures in the heart. Because of the nature of cardiac catheterization therapeutic procedures, all facilities that perform therapeutic procedures also perform open heart surgeries.
cardiac catheterization - mobile	Mobile services include adult diagnostic-only cardiac catheterization services by a central service coordinator and two or more host facilities.
computed tomography (CT)	An imaging test used to examine the brain, chest, lungs, and other parts of the body for tumors, organ injury, and other problems.
CON	certificate of need.

CT scanner - mobile	A CT scanner and transporting equipment operated by a central service coordinator that must serve two or more host facilities.
DCH	Department of Community Health.
DPH	Department of Public Health.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical with the minimum amount of resources.
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
lithotripsy	Urinary extracorporeal shock wave lithotripsy (UESWL) is a procedure for the removal of kidney stones that involves focusing shock waves on kidney stones so that the stones are pulverized into sand-like particles, which then may be passed through the urinary tract. The shock waves for the UESWL procedures are produced by urinary lithotripters.
magnetic resonance imaging (MRI)	An imaging test that examines soft tissues in the body, such as cartilage and ligaments, or the spine.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
megavoltage radiation therapy (MRT)	A clinical modality in which patients with cancer, other tumors, or cerebrovascular system abnormalities are treated with radiation that is delivered by a megavoltage radiation therapy unit.

MRI - mobile	An MRI unit operating at two or more host sites that has a central service coordinator.
objectives	Specific outcomes that a program seeks to achieve its goals.
open heart surgery	Any form of cardiac surgery that requires the use of (outside of body) circulation and oxygenation during surgery in which the heart must be slowed down or stopped to perform the necessary surgery. During the open heart surgery, a heart/lung pump or its equivalent performs the work of the heart and lungs. The use of the pump during the procedure distinguishes "open heart" from other cardiac surgery.
outcomes	The actual impacts of the program.
outputs	The products or services produced by the program.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
performance indicators	Information of a quantitative or qualitative nature used to assess achievement of goals and/or objectives.
performance standards	A desired level of output or outcome.
PIPR	project implementation progress report.

positron emission tomography (PET)	An imaging test that can track biochemical changes and visualize any region of the body. Among other uses, PET can detect certain types of cancer, evaluate the amount of muscle damage after a heart attack, and assess the effectiveness of chemotherapy drugs on specific tissue.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
transplants	Medical transplant procedures that are regulated by Michigan's CON Program include bone marrow, pediatric bone marrow, heart and lung, liver, and pancreas transplants.