

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

Thursday December 15, 2011

**Capitol View Building
201 Townsend Street
MDCH Conference Center
Lansing, Michigan 48913**

APPROVED MINUTES

I. Call to Order & Introductions

Chairperson Falahee called the meeting to order @ 9:04 a.m.

A. Members Present:

James B. Falahee, Jr., JD, Chairperson
Bradley Cory
Kathleen Cowling, DO
Charles Gayney arrived @ 9:18 a.m.
Robert Hughes arrived @ 9:06 a.m.
Marc Keshishian, MD
Brian Klott arrived @ 9:07 a.m.
Gay L. Landstrom, RN
Suresh Mukherji, MD
Michael A. Sandler, MD

B. Members Absent:

Edward B. Goldman, Vice-Chairperson

C. Department of Attorney General Staff:

Joe Potchen

C. Michigan Department of Community Health Staff Present:

Melanie Brim
Jessica Austin
Scott Blakeney
Natalie Kellogg
Tania Rodriguez

Andrea Moore

II. Review of Agenda

Motion by Commissioner Landstrom and seconded by Commissioner Mukherji to accept the agenda as presented. Motion Carried.

III. Declaration of Conflicts of Interest

No conflicts declared.

IV. Review of Minutes

Motion by Commissioner Mukherji and seconded by Commissioner Hughes to accept the minutes as presented from the September 22, 2011 meeting, with the exception to review the vote count on the final failed motion for Cardiac Catheterization. Motion Carried.

V. Hospital Beds Standard Advisory Committee (HBSAC) Report

Mr. Casalou and Mr. Shortridge gave an overview of the HBSAC recommendations submitted to the Commission for proposed action (see attachments A).

A. Review of Proposed Language:

Ms. Rogers gave a brief overview of the proposed language (see Attachment B).

B. Public Comment:

Keith Proll, Oaklawn Hospital
Penny Crissman, Doctors Hospital of MI (see Attachment C)
Brie Hanlon, BCBS of Michigan (see Attachment D)
Greg Dobis, McLaren Health
Dennis McCafferty, Economic Alliance for Michigan (EAM)
Robert Casalou, St. Joseph Hospital/Trinity Health

C. Commission Discussion

Discussion followed.

D. Commission Final Action

Motion by Mr. Hughes and seconded by Commissioner Mukherji to approve the proposed language and move it forward for public hearing and JLC review. Motion Carried in a vote of 10- Yes, 0- No, 0- Abstained.

VI. Cardiac Catheterization Services- Public hearing Comments

Ms. Rogers gave a brief summary of the CC language submitted to the Commission for final action (see attachments E).

A. Public Comment

Rick McNamara, Spectrum health

B. Commission Discussion

Commissioner Keshishian inquired upon the trans-catheter aortic valve replacement procedure and the impact it may have upon the CC Standards.

Discussion followed.

C. Commission Final Action

Motion by Commissioner Sandler and seconded by Commissioner Mukherji to approve the proposed language and move it forward to the JLC and Governor for the 45-day review period. Motion Carried in a vote of 10- Yes, 0- No, and 0- Abstained.

VII. Computed Tomography (CT) Scanner Services - Public Hearing Comments

Ms. Rogers gave a brief summary of the proposed language submitted to the Commission for final action (see attachment F).

A. Public Comment

Michael Ketslark, National Diagnostic Services

B. Commission Discussion

Discussion followed.

C. Commission Final Action

Motion by Commissioner Keshishian and seconded by Commissioner Gayney to accept the proposed language and amendment to Section 12(3) and move it forward to the JLC and Governor for the 45-day review period.
Motion Carried in a vote of 7- Yes, 3- No, 0-Abstained.

Dr. Sandler recommended taking the CT Standards and the issue of mobile CT scanners out of the review cycle.

Break @ 10:50 a.m. - 11:08 a.m.

VIII. Surgical Services - Public Hearing Comments

Ms. Rogers gave a brief summary of the proposed language submitted to the Commission for final action (see attachment G).

A. Public Comment

Andrew Krass, Lifeline Vascular Access

B. Commission Discussion

Discussion followed.

C. Commission Proposed Action

Motion by Commissioner Keshishian and seconded by Commissioner Landstrom to accept the proposed language and move it forward to the JLC.
Motion Carried in a vote of 10-Yes, 0- No, and 0- Abstained.

Public Comment:

Robert Meeker, Spectrum Health

IX. Positron Emission Tomography (PET)/ Magnetic Resonance Imaging (MRI) - Update

Commissioner Keshishian gave a brief update on the PET/MR hybrid.

Discussion followed.

Motion by Commissioner Keshishian and seconded by Commissioner Sandler to form a workgroup with Commissioner Keshishian chairing, to further explore the PET/MR hybrid and draft language within the

PET standards for the Commission to review at the January Commission meeting. Motion Carried in a vote of 10-Yes, 0- No, and 0- Abstained.

X. MRI/Angiography- Update

Commissioner Keshishian gave a brief overview of the MR/Angio hybrid technology.

Discussion followed.

Motion by Commissioner Keshishian and seconded by Commissioner Mukherji to delegate the Department and a panel of experts to develop language specific to the MR/Angio hybrid for the Commission to review at either the January or March meeting. Motion carried in a vote of 10-Yes, 0- No, and 0- Abstained.

XI. Open Heart Surgery Services Charge for SAC

A. Review of Charge

B. Commission Discussion

Commissioner Keshishian expressed concern regarding requirements for facilities performing trans catheter aortic valve replacements.

C. Commission Action

Motion by Commissioner Sandler and seconded by Commissioner Klott to accept the charge and delegate the finalization to Chairperson Falahee. Motion carried in a vote of 10- Yes, 0- No, and 0- Abstained.

XII. Standing New Medical Technology Advisory Committee (NEWTAC)

Commissioner Keshishian advised there were no new updates.

XIII. Legislative Report

None.

XIV. Administrative Update

A. Health Policy Section Update

Ms. Brim gave a brief staffing update.

B. CON Evaluation Section Update

1. Compliance Report (Written Report – Attachment H).
2. Quarterly Performance Measures (Written Report – Attachment I).

XV. Legal Activity Report

Mr. Potchen gave a brief update of legal activity (see Attachment J).

XVI. Future Meeting Dates

- A. January 31, 2012 (Special Commission Meeting)
- C. March 29, 2012
- D. June 14, 2012
- E. September 27, 2012
- F. December 13, 2012

XVII. Public Comment

None.

XVIII. Review of Commission Work Plan

Ms. Rogers gave a brief summary of the work plan (see Attachment K).

- A. Commission Discussion
- B. Commission Action

Motion by Commissioner Hughes and seconded by Commissioner Mukherji to approve the work plan as amended at the meeting.
Motion Carried in a vote of 10- Yes, 0- No, and 0- Abstained.

XIX. Adjournment

Motion by Commissioner Sandler and seconded by Commissioner Gayney to adjourn the meeting @ 12:33 p.m. Motion Carried.

**FINAL REPORT AND SUMMARY OF
RECOMMENDATIONS**

**HOSPITAL BED STANDARDS
STANDARDS ADVISORY COMMITTEE (SAC)**

**Presented to the
STATE OF MICHIGAN
CERTIFICATE OF NEED COMMISSION
DECEMBER 15, 2011**

AGENDA

- **HBSAC Membership**
- **Overview of HBSAC Charge**
- **Organization of Work**
- **Recommendations For Charges 2-5**
- **Recommendations for Bed Need Methodology (Charge 1)**
- **Recommendations for Unused Beds (Charge 6)**
- **Alternative Proposal For Future Consideration**

Hospital Beds Standard Advisory Committee Members

- Robert Casalou, St. Joseph Mercy Hospitals/Trinity Health, Chair
- Jane Schelberg, Henry Ford Health System, Vice Chair
- James Ball, Michigan Manufacturer's Association
- Ron Bieber, United Auto Workers
- Heidi Gustine, Munson Healthcare
- David Jahn, War Memorial Hospital
- Patrick Lamberti, POH Regional Medical Center/McLaren
- Nancy List, Covenant Healthcare
- Conrad Mallett, Sinai Grace Hospital/Detroit Medical Center
- Robert Milewski, BCBSM
- Doug Rich, St. John Providence Health System/Ascension Health
- Kevin Splaine, Spectrum Health

HOSPITAL BEDS

STANDARD ADVISORY COMMITTEE CHARGE

(Approved by the CON Commission on January 26, 2011)

The Hospital Bed Standards SAC should review and recommend any necessary changes to the Hospital Bed Standards with consideration of the following:

- 1. Review and update, if necessary, the subarea methodology to determine current health care markets and needs including relevant demographic data. If needed, revise methodologies based on defined geographical areas for determining stable projection need.**
- 2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.**

HOSPITAL BEDS

STANDARD ADVISORY COMMITTEE CHARGE

(Approved by the CON Commission on January 26, 2011)

- 3. Review and update, if necessary, size requirement for replacement hospitals.**
- 4. Review possible elimination of existing Addendum for HIV Infected Individuals.**
- 5. Consider language similar to that in the nursing home standards requiring all outstanding debt obligations to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP) be paid prior to receiving or replacing hospital beds.**

HOSPITAL BEDS

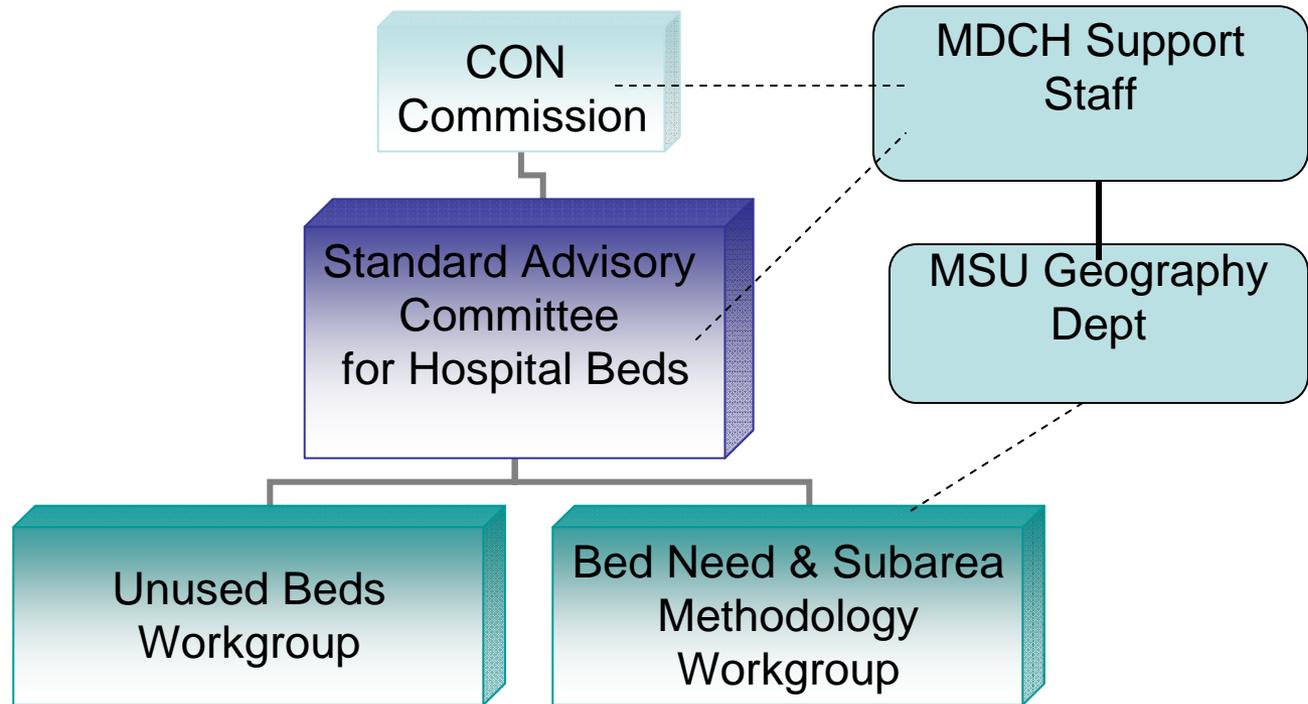
STANDARD ADVISORY COMMITTEE CHARGE

(Approved by the CON Commission on January 26, 2011)

- 6. Consider the proper number of beds for Michigan's population given demographic (aging and health of the population) concerns and consider concepts that link occupancy to inventory thereby allowing for reduction of "excess" beds. Example: Determine the "appropriate" occupancy, and if over a defined period of time bed capacity remains below that figure, unused beds must be released.**

- 7. Consider any necessary technical or other changes e.g. updates or modifications consistent with other CON review standards and the Public Health Code.**

Organization Chart



HBSAC RECOMMENDATIONS OF CHARGES 2 - 5

2. Review project delivery requirements to assure quality, measurability, and affordability for both the provider and consumer.

There were no substantive changes recommended by HBSAC for the project delivery requirements. The committee accepted language changes provided by MDCH staff to be consistent with other standards.

HBSAC RECOMMENDATIONS FOR CHARGES 2 – 5 (continued)

3. Review and update, if necessary, size requirement for replacement hospitals.

There were no substantive changes recommended by the HBSAC for the size requirement of replacement hospitals. The committee did accept language changes to incorporate “Hospital Group” name changes consistent with the proposed replacement for the subarea methodology to be discussed later in this presentation.

HBSAC RECOMMENDATIONS FOR CHARGES 2 – 5 (continued)

- 4. Review possible elimination of existing Addendum for HIV Infected Individuals.**

The HBSAC unanimously approved a recommendation to eliminate the existing Addendum for HIV Infected Individuals from the standards.

HBSAC RECOMMENDATIONS FOR CHARGES 2 – 5 (continued)

- 5. Consider language similar to that in the nursing home standards requiring all outstanding debt obligations to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP) be paid prior to receiving or replacing hospital beds.**

The HBSAC accepted QAAP/CMP language drafted by MDCH staff .

Hospital Subarea Methodology

Charge #1

Subarea Methodology Objectives

- Objective
- Replicable
- Sustainable

Subarea Methodology Process

Use most recent 3 year MIDB data to cluster hospitals based on patient days and location.

Consider potential subarea results with peak incremental “fit” scores.

Select final number of subareas based on:

- Cap the maximum number of hospitals in a subarea to 20 or less
- Of remaining options, select the one with the fewest single-hospital subareas
- If multiple options exist with the fewest single-hospital subareas, select the option with the largest number of subareas

Subarea Methodology Decisions

All hospitals reporting in MIDB will be included, regardless of whether they have 3 full years of data.

- Rationale: Persons running the methodology in the future will not have the benefit of a workgroup to advise them of hospital changes (new, closed, expanded, downsized) that occurred during the three-year period. The impacts are anticipated to be minimal.

Hospitals not reporting in MIDB will not be assigned to a subarea.

- Rationale: If their beds are not being counted in the bed need, they should not be included in the allocation of beds; hence they do not need to be included in a subarea.
- Note: There are very few of these cases. If one of these hospitals wished to file a CON, they would have to participate in the MIDB, as required under the existing project delivery requirements.

Subarea Methodology Decisions (continued)

If feasible, MSU Geography and MDCH will work together to create a methodology which will allow an applicant to see which hospital group the facility will likely fall into. A proposed new hospital will be grouped using only the location component of the grouping methodology. The method will use minimum average road distance to each hospital in the nearest hospital groups to make such a determination. To determine their hospital group assignment, an applicant can request that the methodology be run.

–Rationale: In other standards, an applicant can determine in advance whether or not their project meets the CON Review Standards. Running the location component of the methodology would allow an applicant to see where their hospital would be placed and whether a need exists in that subarea.

Subarea Recommendations

Rename “hospital subareas” as “hospital groups” and number 1-35 based on the sum of licensed beds in each group.

- Rationale: Since the hospital clusters are not geography-based, and since many cross Health Service Area (HSA) boundaries, they are no longer "subareas" within the HSAs.

Re-run methodology at least every 5 years, or sooner at the request of the CON Commission, following the availability of new MIDB data.

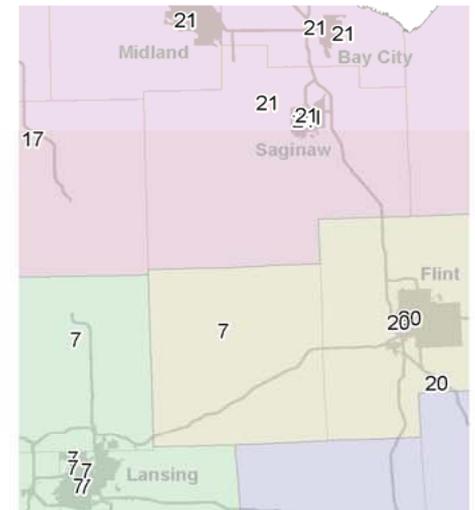
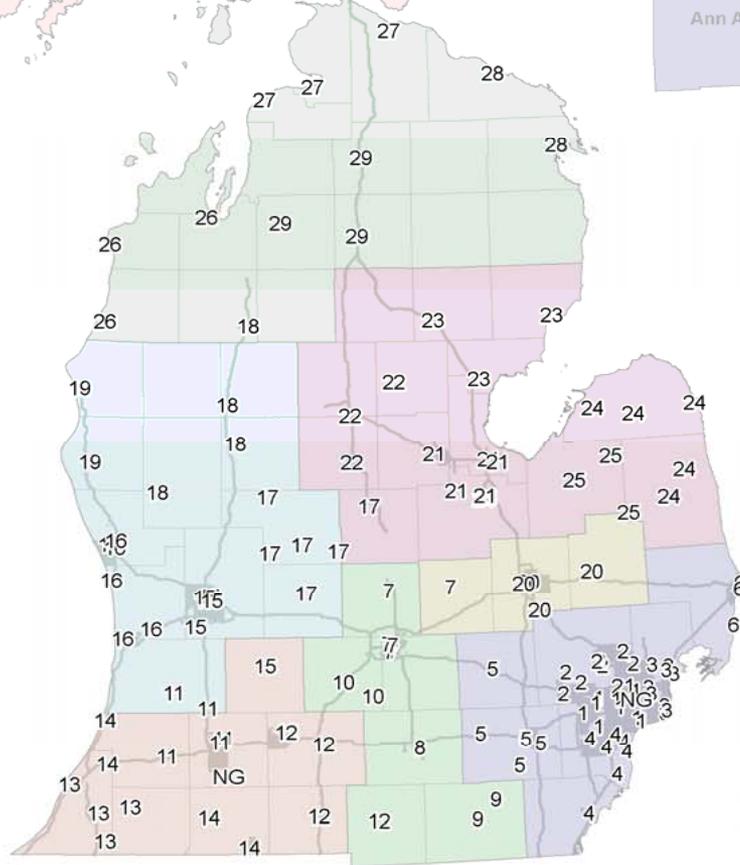
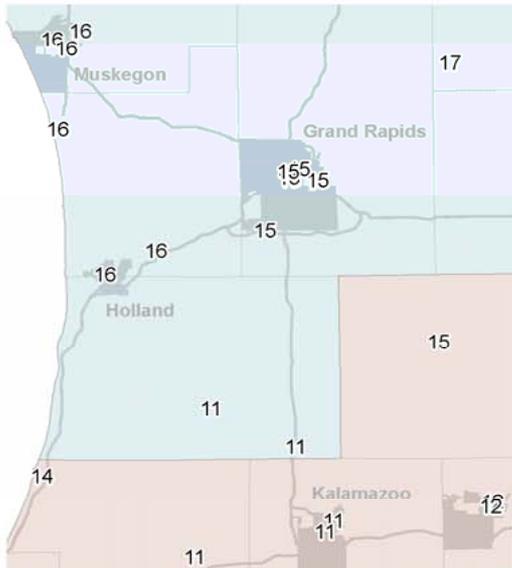
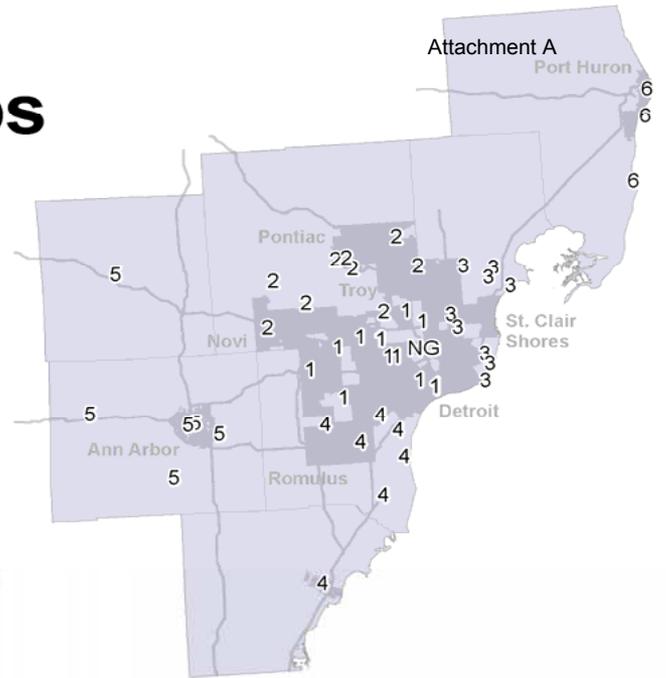
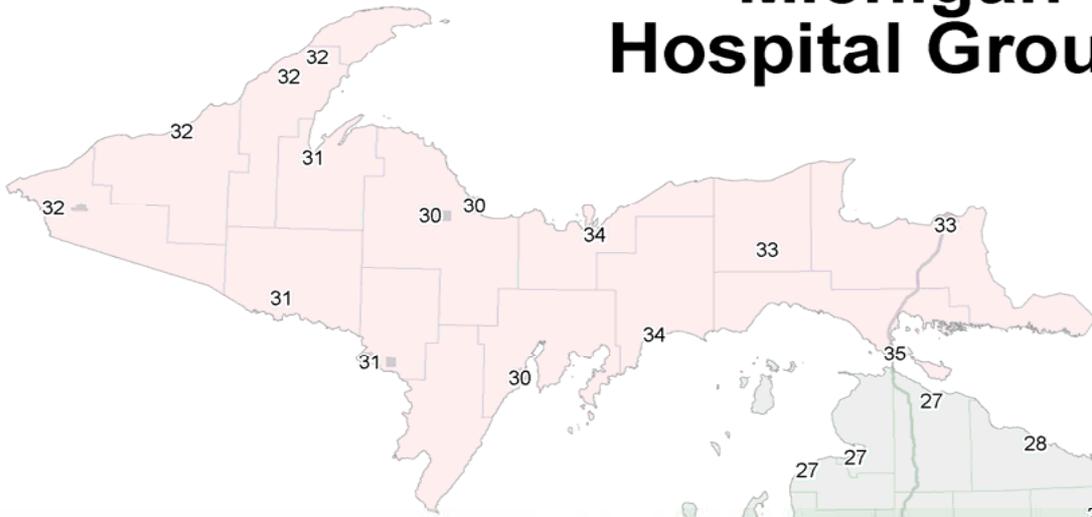
Hospital Group Impacts

For illustrative purposes, we applied the proposed methodology to the current MIDB data.

- Would reduce the number of Hospital Groups from 64 to 35
- Would reduce single-Hospital Groups from 32 to 1

Using 2009 final MIDB data, the following three slides illustrate the potential changes should the Commission adopt this methodology. If accepted, it will be calculated using the 2010 final MIDB data.

Michigan Hospital Groups



35 Hospital Groups

HG	Hospital Name	HG	Hospital Name	HG	Hospital Name	HG	Hospital Name
1	Sinai-Grace Hospital	5	St. Joseph Mercy Ann Arbor Hospital	15	Spectrum Health Blodgett Hospital	23	St. Joseph Health System - Tawas
1	Hutzel Women's Hospital	5	St. Joseph Mercy Saline Hospital	15	Spectrum Health Butterworth Hospital	23	West Branch Regional Medical Center
1	Botsford Hospital	5	Chelsea Community Hospital	15	Spectrum Health Kent Community Hospital	23	St. Mary's of Michigan Standish Hospital
1	Garden City Hospital	5	University of Michigan Hospitals	15	Metropolitan Hospital	24	Scheurer Hospital
1	St. Mary Mercy Livonia Hospital	5	St. Joseph Mercy Livingston Hospital	15	Saint Mary's Health Care	24	Harbor Beach Community Hospital
1	Rehabilitation Institute	5	Select Specialty Hospital - Ann Arbor	15	Pennock Hospital	24	Mckenzie Memorial Hospital
1	Harper University Hospital	6	St. John River District Hospital	15	Mary Free Bed Rehabilitation Hospital	24	Deckerville Community Hospital
1	Straith Hospital for Special Surgery	6	St. Joseph Mercy Port Huron Hospital	16	Holland Hospital	24	Huron Memorial Hospital
1	Children's Hospital of Michigan	6	Port Huron Hospital	16	North Ottawa Community Hospital	25	Hills & Dales General Hospital
1	Oakland Regional Hospital			16	Zeeland Community Hospital	25	Caro Community Hospital
1	Select Specialty Hospital - NW Detroit	7	Edward W Sparrow Hospital	16	Mercy Health Partners - General Campus	25	Marlette Regional Hospital
1	DMC Surgery Hospital	7	Sparrow Health System - St. Lawrence Campus	16	Mercy Health Partners - Mercy Campus		
1	Karmanos Cancer Center	7	Sparrow Specialty Hospital	16	Mercy Health Partners - Hackley Campus	26	Paul Oliver Memorial Hospital
1	Henry Ford Hospital	7	Ingham Regional Medical Center	16	Great Lakes Specialty Hospital - Hackley	26	Munson Medical Center
1	Providence Hospital and Medical Center	7	Ingham Regional Medical Center - Penn. Campus	17	Sparrow Ionia Hospital	26	West Shore Medical Center
1	St. John Macomb-Oakland Hosp (Oakland)	7	Memorial Healthcare	17	Spectrum Health United Memorial - Kelsey	27	Northern Michigan Regional Hospital
1	Detroit Receiving Hospital	7	Clinton Memorial Hospital	17	Gratiot Medical Center	27	Charlevoix Area Hospital
2	Doctors' Hospital of Michigan	8	Carelink of Jackson	17	Carson City Hospital	27	Cheboygan Memorial Hospital
2	POH Medical Center	8	Allegiance Health	17	Sheridan Community Hospital	28	Alpena Regional Medical Center
2	Crittenton Hospital Medical Center	9	Emma L. Bixby Medical Center	17	Spectrum Health United Memorial - United	28	Rogers City Rehabilitation Hospital
2	St. Joseph Mercy Oakland Hospital	9	Herrick Medical Center	18	Mecosta County Medical Center	29	Mercy Hospital - Grayling
2	Huron Valley-Sinai Hospital	10	Eaton Rapids Medical Center	18	Spectrum Health Reed City Hospital	29	Otsego Memorial Hospital
2	Providence Medical Center - Providence Park	10	Hayes Green Beach Memorial Hospital	18	Gerber Memorial Hospital	29	Kalkaska Memorial Health Center
2	Select Specialty Hospital - Pontiac			18	Mercy Hospital		
2	Henry Ford West Bloomfield Hospital	11	Allegan General Hospital	19	Memorial Medical Center of West Michigan	30	St. Francis Hospital
2	William Beaumont Hospital, Royal Oak	11	Bronson Methodist Hospital	19	Mercy Health Partners, Lakeshore Campus	30	Bell Memorial Hospital
2	William Beaumont Hospital, Troy	11	Borgess-Pipp Hospital			30	Marquette General Health System
3	Henry Ford Cottage Hospital	11	Borgess Medical Center	20	Mclaren Regional Medical Center	31	Northstar Health System
3	Mount Clemens Regional Medical Center	11	Bronson Vicksburg Hospital	20	Lapeer Regional Medical Center	31	Dickinson County Healthcare System
3	Henry Ford Macomb Hospital	11	Select Specialty Hospital - Kalamazoo	20	Hurley Medical Center	31	Baraga County Memorial Hospital
3	Henry Ford Macomb Hospital - Warren Campus	12	Battle Creek Health System	20	Genesys Regional Medical Center	32	Grand View Health System
3	St. John North Shores Hospital	12	Community Health Center of Branch County	20	Select Specialty Hospital - Flint	32	Aspirus Ontonagon Hospital
3	William Beaumont Hospital, Grosse Pointe	12	Hillsdale Community Health Center			32	Portage Hospital
3	Select Specialty Hospital - Grosse Pointe	12	Southwest Regional Rehabilitation Center	21	Bay Regional Medical Center	32	Aspirus Keweenaw Hospital
3	St. John Macomb-Oakland Hosp (Macomb)	12	Oaklawn Hospital	21	Bay Regional Medical Center (West Campus)	33	Chippewa County War Memorial Hospital
3	St. John Hospital & Medical Center	13	Lakeland Specialty Hospital	21	MidMichigan Medical Center-Midland	33	Helen Newberry Joy Hospital
3	Select Specialty Hospital - Macomb	13	Lakeland Hospital, Niles	21	Covenant Medical Center - Cooper	34	Schoolcraft Memorial Hospital
4	Oakwood Hospital And Medical Center	13	Lakeland Hospital, St. Joseph	21	Covenant Medical Center - Harrison	34	Munising Memorial Hospital
4	Mercy Memorial Hospital	13	Borgess-Lee Memorial Hospital	21	Covenant Medical Center - Northern Michigan	35	Mackinac Straits Health System, Inc.
4	Henry Ford Wyandotte Hospital	14	South Haven Community Hospital	21	St. Mary's of Michigan	NG	Southeast Michigan Surgical Hospital
4	Oakwood Annapolis Hospital	14	Sturgis Hospital	21	Healthsource Saginaw, Inc.	NG	Bronson Lakeview Hospital
4	Oakwood Southshore Medical Center	14	Three Rivers Health	21	Bay Special Care Hospital		
4	Oakwood Heritage Hospital	14	Community Hospital Watervliet	21	Select Specialty Hospital - Saginaw		
4	Select Specialty Hospital - Downriver			22	MidMichigan Medical Center - Gladwin		
4	Vibra of Southeastern Michigan			22	Central Michigan Community Hospital		
				22	MidMichigan Medical Center Clare		

Bed Need Methodology

Charge #1

Bed Need Methodology Objectives

- Objective
- Replicable
- Sustainable
- Easy to run (re-run every two years)

Bed Need Methodology: Projecting Demand

Projection of demand will be on a county-wide vs. zip code level.

- Rationale: Counties provide more robust rates and less volatility.

Projection of demand will model patient days per county directly using a 5-year regression model based on monthly data. If the regression model is not significant, a 3-year bed day average will be used.

- Rationale: This model eliminates the need for population projections, which added an additional margin for projection error. It is not advisable to use a trend model for prediction if there is no trend - the prediction is not meaningful and likely farther from the actual value than the 3-year average would be.

Bed Need Methodology: Projecting Demand (continued)

Modeling is done at the aggregate level, not by age brackets and bed type.

- Rationale: Modeling at the aggregate level produces statistically identical bed need projections as the projections done by age and type. Additionally, beds are no longer licensed separately as Med/Surg, OB, or Peds. For ease of running the model, the work group recommends eliminating this step.

Bed Need Methodology: Allocating Demand

The predicted patient days are then allocated to Hospital Groups and bed need is calculated.

- Use utilization rates from base year (most recent year of available MIDB data)
- Convert to average daily census
- Adjust using occupancy rate table

The existing occupancy adjustment tables were merged into one table, and the range was modified from 60%-85% to 60%-80%.

- Rationale: Merging the tables was appropriate since bed need projections would be made at the aggregate level, not at the bed-type level. The upper end of the range was adjusted so that bed need planning was consistent with the high-occupancy standard.

Bed Need Methodology: Allocating Demand (continued)

Hospitals that do not report in MIDB are not included in the allocation of bed need.

- Rationale: If their days are not reported in MIDB, they are not included in the bed need calculation, hence they cannot be included in the allocation of bed need.

VA and Psych Hospitals are no longer included.

- Rationale: These facilities are not subject to the CON Hospital Bed Need process so their inclusion would distort projections.

In-state residents visiting out-of-state hospitals will not be included in the methodology, however out-of-state residents visiting in-state hospitals are included.

- Rationale: This will ensure that future bed need predictions match the actual use of Michigan's hospitals.

Bed Need Recommendations

Re-run methodology every two years, following the availability of new MIDB data.

Bed Need Impact

- **The proposed methodology was applied to current MIDB data.**
- **No bed need identified in the State of Michigan**
- **In fact, there are more excess beds than previously identified with old methodology.**

Illustrative Bed Need Output

HG	ADC2009	PRED2014	Diff	PctChange	PRED2014	BEDS2010	BedNeed
1	3132	3192	60	1.92	3192	3906	714
2	2504	2642	138	5.51	2642	3412	770
3	1812	1885	73	4.03	1885	2452	567
4	1425	1448	23	1.61	1448	2019	571
5	1477	1490	13	0.88	1490	1707	217
6	266	260	-6	-2.26	260	350	90
7	830	862	32	3.86	862	1094	232
8	280	281	1	0.36	281	389	108
9	83	76	-7	-8.43	76	113	37
10	17	19	2	11.76	19	45	26
11	714	733	19	2.66	733	969	236
12	287	297	10	3.48	297	474	177
13	247	240	-7	-2.83	240	393	153
14	88	91	3	3.41	91	284	193
15	1343	1353	10	0.74	1353	1813	460
16	428	413	-15	-3.5	413	769	356
17	168	175	7	4.17	175	328	153
18	121	115	-6	-4.96	115	257	142
19	54	55	1	1.85	55	97	42
20	1142	1177	35	3.06	1177	1344	167
21	1175	1235	60	5.11	1235	1620	385
22	86	83	-3	-3.49	83	192	109
23	84	80	-4	-4.76	80	162	82
24	42	42	0	0	42	144	102
25	25	24	-1	-4	24	75	51
26	395	404	9	2.28	404	410	6
27	194	194	0	0	194	264	70
28	97	100	3	3.09	100	160	60
29	79	79	0	0	79	144	65
30	217	199	-18	-8.29	199	387	188
31	76	70	-6	-7.89	70	145	75
32	61	45	-16	-26.23	45	111	66
33	61	63	2	3.28	63	107	44
34	9	9	0	0	9	29	20
35	2	2	0	0	2	15	13
99	19021	19433	412	2.17	19433	26180	6747

In Summary

- When applied to current MIDB data, the proposed Hospital Group and Bed Need Methodologies do not project any areas of need within the state.
- The methodologies proposed are more replicable and are simplified, when compared to the current methodologies.
- The use of patient day projections at a county level will ensure that bed need will be responsive to the hospital needs of Michigan's population.

Hospital Bed Workgroup Charge #6

Recommendation

The HBSAC recommends (by a 9 to 3 super majority vote) that the CON standards be amended to incorporate a “low occupancy” standard by which “excess licensed beds” could potentially be reduced upon a CON request for the replacement, relocation or acquisition of hospital beds.

RATIONALE

- Excess Beds present a potential cost to the health care system and employers at the time they are replaced, relocated or put into use after an acquisition.
- A process is needed to begin reducing the number of excess beds in the State of Michigan.

RATIONALE

- The Low Occupancy Standard is enabled by the current availability of the High Occupancy Rule that provides a mechanism for hospitals to obtain additional beds if volumes grow.
- Reduces concern that hospital beds become a “commodity” that can be bought or sold regardless of whether they are in use.

Workgroup Process

- A workgroup chaired by HBSAC Vice-Chair, Jane Schelberg, met several times with input from a wide range of HBSAC and non-HBSAC members.
- The workgroup and HBSAC considered various proposals presented by the Economic Alliance of Michigan (EAM).

Definitions

Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone.

Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity unless otherwise provided in these Standards.

Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subarea or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.

Recommendations

Replacement

In order to obtain CON approval for replacement of acute care hospital beds, a hospital with average adjusted occupancy of below 40% during the most recent three (3) years, must de-license sufficient beds to raise its adjusted occupancy to 60%.

Recommendations

Acquisition

In order to obtain CON approval for acquisition of an acute care hospital with average adjusted occupancy of below 40% during the most recent three (3) years, an applicant (the new owner) must agree to de-license sufficient beds to raise its adjusted occupancy to 60%, if it fails to achieve at least 40% average adjusted occupancy in the third year after acquisition.

Recommendations

Relocation

In order to obtain CON approval for relocation of acute care hospital beds from a hospital with average adjusted occupancy of below 40% during the most recent three (3) years, the hospital (source hospital) must de-license the number of beds required for the source hospital to be at 60% adjusted occupancy after the relocations. A receiving hospital may not, after the relocations, have an adjusted occupancy below 40%. The source hospital may file multiple CONS at one time for relocations to more than one hospital.

RATIONALE FOR THRESHOLDS

(Replacement, Acquisition, Relocation)

- New standard will have some uncertainty so threshold set to initially minimize risk.
- The approach is sustainable with different thresholds over time if deemed appropriate by the CON Commission.
- Proposal supported by EAM as “a starting point” for this type of standard.

EXCLUSIONS/LIMITATION

(Replacement, Acquisition, Relocation)

EXCLUSIONS

- critical access hospitals
- rural county hospitals
- micropolitan county hospitals
- long term acute care hospitals (LTACH)
- hospitals with less than 25 beds
- Sole Community Hospital as designated by CMS

ADDITIONAL LIMITATION

- Standard would not allow bed reduction/right sizing to below 25 beds

ALTERNATIVE FOR FUTURE CONSIDERATION

- Proposal submitted to HBSAC by member Patrick Lamberti on behalf of McLaren Health Care as HBSAC proceedings were concluding at final meeting.
- Proposal was to simplify the Hospital Bed Standards and provide new criteria for relocating existing hospital beds.

McLaren Health Care Proposal

- Reduce restrictions on CON for relocating hospital beds to a new site. If a hospital elects to relocate beds to a new site it must demonstrate:
 - Financial viability with regards to the entire project
 - Conclusive positive community need assessment for both the proposed hospital site that is receiving beds and the hospital giving up beds:
 - Significant community benefit with a financially viable plan for reuse of the existing facility.
 - Existing facilities cannot close to move to a new facility.

McLaren Proposal (continued)

- No additional beds in Michigan
- Maintain existing payer contracts for at least five years.
- Delicense at least 10% of existing facility's beds
- Proposed new hospital site may not be approved within five miles of existing acute care hospitals, nor within the same county as single community providers.

McLaren Proposal Discussion

- Although the method and timing of this proposal was questionable, the HBSAC did take it under consideration and discussion.
- The following comments were put on the record during the discussion:
 - The proposal has elements that could be very useful as criteria in the CON standards.
 - Taken in isolation, this proposal would open up the potential for unchecked and unwarranted construction of new hospitals and excess capacity.

McLaren Proposal Discussion (cont)

- A proposed modification to this proposal was made to include the following:
 - That the criteria would be used in the event that a Bed Need was identified in a hospital grouping that triggered the ability for a new market entrant.
 - That if a bed need was identified that all applications for the new hospital site would be subject to comparative review. The “McLaren criteria” could be incorporated into the comparative review standards.
 - That the “five mile” from a new hospital site standard be replaced with the established “30-minute drive time” standard.

McLaren Proposal Discussion (cont)

- Member Lamberti did not accept any of these proposed modifications. The proposal was defeated by super-majority vote of the HBSAC.
- Please note that member Patrick Lamberti, representing McLaren, cast a roll call “yes” vote in favor of the new bed need and hospital grouping methodologies at the October 19, 2011 HBSAC meeting.

Questions & Answers

Thank you

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS

(By authority conferred on the CON Commission by sections 22215 and 22217 of Act No. 368 of the Public Acts of 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being sections 333.22215, 333.22217, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. (1) These standards are requirements for approval ~~and delivery of services for all projects approved and certificates of need issued~~ under Part 222 of the Code that involve (a) beginning operation of a new hospital ~~increasing licensed beds in a hospital licensed under Part 215~~ or (b) replacing beds in a hospital or physically relocating hospital beds from one licensed site to another geographic location or (c) increasing licensed beds in a hospital licensed under Part 215 ~~replacing beds in a hospital~~ or (d) acquiring a hospital ~~or (e) beginning operation of a new hospital.~~ PURSUANT TO PART 222 OF THE CODE.

~~—(2)AA~~ hospital licensed under Part 215 is a covered health facility ~~for purposes of Part 222 of the Code. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.~~

(~~3~~2) An increase in licensed hospital beds is a change in bed capacity for purposes of Part 222 of the Code.

(~~4~~3) The physical relocation of hospital beds from a licensed site to another geographic location is a change in bed capacity for purposes of Part 222 of the Code.

(~~5~~4) An increase in hospital beds certified for long-term care is a change in bed capacity for purposes of Part 222 of the Code and shall be subject to and reviewed under the CON Review Standards for Long-Term-Care Services.

~~—(6) The Department shall use sections 3, 4, 5, 6, 7, 8, 10, and 16 of these standards and Section 2 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.~~

~~—(7) The Department shall use Section 9 of these standards and Section 3 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.~~

Section 2. Definitions

Sec. 2. (1) As used in these standards:

(a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a licensed and operating hospital and which does not involve a change in bed capacity.

(b) "ADJUSTED PATIENT DAYS" MEANS THE NUMBER OF PATIENT DAYS WHEN CALCULATED AS FOLLOWS:

(I) COMBINE ALL PEDIATRIC PATIENT DAYS OF CARE AND OBSTETRICS PATIENT DAYS OF CARE PROVIDED DURING THE PERIOD OF TIME UNDER CONSIDERATION AND MULTIPLY THAT NUMBER BY 1.1.

(II) ADD THE NUMBER OF NON-PEDIATRIC AND NON-OBSTETRIC PATIENT DAYS OF CARE PROVIDED DURING THE SAME PERIOD OF TIME TO THE PRODUCT OBTAINED IN (I) ABOVE. THIS IS THE NUMBER OF ADJUSTED PATIENT DAYS FOR THE APPLICABLE PERIOD.

- 56 | (C) "Alcohol and substance abuse hospital" means a licensed hospital within a long-term (acute) care
57 | (LTAC) hospital that exclusively provides inpatient medical detoxification and medical stabilization and
58 | related outpatient services for persons who have a primary diagnosis of substance dependence covered
59 | by DRGs 433 - 437.
- 60 | (dD) "Base year" means the most recent year that final MIDB data is available to the Department
61 | unless a different year is determined to be more appropriate by the Commission.
- 62 | (dE) "Certificate of Need Commission" or "Commission" means the Commission created pursuant to
63 | Section 22211 of the code, being Section 333.22211 of the Michigan Compiled Laws.
- 64 | (eF) "Close a hospital" means an applicant will demonstrate to the satisfaction of the Department that
65 | a hospital licensed under Part 215, and whose licensed capacity for the most recent 24 months prior to
66 | submission of the application was at least 80 percent for acute care beds, will close and surrender its
67 | acute care hospital license upon completion of the proposed project.
- 68 | (fG) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et
69 | seq. of the Michigan Compiled Laws.
- 70 | (gH) "Common ownership or control" means a hospital that is owned by, is under common control of,
71 | or has a common parent as the applicant hospital.
- 72 | (hI) "Compare group" means the applications that have been grouped for the same type of project in
73 | the same subareaHOSPITAL GROUP and are being reviewed comparatively in accordance with the
74 | CON rules.
- 75 | (iJ) "Department" means the Michigan Department of Community Health (MDCH).
- 76 | (jK) "Department inventory of beds" means the current list maintained for each hospital
77 | subareaGROUP on a continuing basis by the Department of (i) licensed hospital beds and (ii) hospital
78 | beds approved by a valid CON issued under either Part 221 or Part 222 of the Code that are not yet
79 | licensed. The term does not include hospital beds certified for long-term-care in hospital long-term care
80 | units.
- 81 | ~~— (k) "Discharge relevance factor" (%R) means a mathematical computation where the numerator is~~
82 | ~~the inpatient hospital discharges from a specific zip code for a specified hospital subarea and the~~
83 | ~~denominator is the inpatient hospital discharges for any hospital from that same specific zip code.~~
- 84 | (l) "Disproportionate share hospital payments" means the most recent payments to hospitals in the
85 | special pool for non-state government-owned or operated hospitals to assure funding for costs incurred
86 | by public facilities providing inpatient hospital services which serve a disproportionate number of low-
87 | income patients with special needs as calculated by the Medical Services Administration within the
88 | Department.
- 89 | (m) "EXCLUDED HOSPITALS" MEANS HOSPITALS IN THE FOLLOWING CATEGORIES:
90 | (I) CRITICAL ACCESS HOSPITALS DESIGNATED BY CMS PURSUANT TO 42 CFR 485.606
91 | (II) HOSPITALS LOCATED IN RURAL OR MICROPOLITAN STATISTICAL AREA COUNTIES
92 | (III) LTAC HOSPITALS
93 | (IV) SOLE COMMUNITY HOSPITALS DESIGNATED BY CMS PURSUANT TO 42 CFR 412.92
94 | (V) HOSPITALS WITH 25 OR FEWER LICENSED BEDS
- 95 | (N) "Existing hospital beds" means, for a specific hospital subareaGROUP, the total of all of the
96 | following: (i) hospital beds licensed by the Department; (ii) hospital beds with valid CON approval but not
97 | yet licensed; (iii) proposed hospital beds under appeal from a final decision of the Department; and (iv)
98 | proposed hospital beds that are part of a completed application under Part 222 (other than the application
99 | under review) for which a proposed decision has been issued and which is pending final Department
100 | decision.
- 101 | (oQ) "Gross hospital revenues" means the hospital's revenues as stated on the most recent Medicare
102 | and Michigan Medicaid forms filed with the Medical Services Administration within the Department.
- 103 | (eP) "Health service area" OR "HSA" means the groups of counties listed in Section 18APPENDIX A.
- 104 | (pQ) "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital
105 | licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in
106 | Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.
- 107 | (qR) "Hospital" means a hospital as defined in Section 20106(5) of the Code being Section
108 | 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does
109 | not include a hospital or hospital unit licensed or operated by the Department of Mental Health.

- 110 (fS) "HOSPITAL GROUP" MEANS A CLUSTER OR GROUPING OF HOSPITALS BASED ON
 111 GEOGRAPHIC PROXIMITY AND HOSPITAL UTILIZATION PATTERNS. THE LIST OF HOSPITAL
 112 GROUPS AND THE HOSPITALS ASSIGNED TO EACH HOSPITAL GROUP WILL BE POSTED ON
 113 THE STATE OF MICHIGAN CON WEB SITE AND WILL BE UPDATED PURSUANT TO SECTION 3.
- 114 (T) "Hospital long-term-care unit" or "HLTCU" means a nursing care unit, owned or operated by and
 115 as part of a hospital, licensed by the Department, and providing organized nursing care and medical
 116 treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.
- 117 ~~—(s) "Hospital subarea" or "subarea" means a cluster or grouping of hospitals and the relevant portion~~
 118 ~~of the state's population served by that cluster or grouping of hospitals. For purposes of these standards,~~
 119 ~~hospital subareas and the hospitals assigned to each subarea are set forth in Appendix A.~~
- 120 (tU) "Host hospital" means a licensed and operating hospital, which delicenss hospital beds, and
 121 which leases patient care space and other space within the physical plant of the host hospital, to allow a n
 122 long-term (acute) careLTAC hospital, or alcohol and substance abuse hospital, to begin operation.
- 123 (uV) "Licensed site" means the location of the facility authorized by license and listed on that
 124 licensee's certificate of licensure.
- 125 (vW) "Limited access area" means those geographic-UNDERSERVED areas containing a population
 126 of 50,000 or more based on the planning year and not within 30 minutes drive time of an existing licensed
 127 acute care hospital with 24 hour/7 days a week emergency services utilizing the slowest route available
 128 as defined by the Michigan Department of Transportation (MDOT) WITH A PATIENT DAY DEMAND
 129 THAT MEETS OR EXCEEDS THE STATE-WIDE AVERAGE OF PATIENT DAYS USED PER 50,000
 130 RESIDENTS IN THE BASE YEAR and as identified in Appendix ED. Limited access areas shall be
 131 redetermined when a new hospital has been approved or an existing hospital closes.
- 132 (wX) "Long-term (acute) care hospital" OR "LTAC HOSPITAL" means a hospital has been approved to
 133 participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital
 134 in accordance with 42 CFR Part 412.
- 135 ~~—(x) "Market forecast factors" (%N) means a mathematical computation where the numerator is the~~
 136 ~~number of total inpatient discharges indicated by the market survey forecasts and the denominator is the~~
 137 ~~base year MIDB discharges.~~
- 138 (y) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and TO
 139 1396r-8G AND 1396I to 1396v1396U.
- 140 (z) "Medicaid volume" means the number of Medicaid recipients served at the hospital as stated on
 141 the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration
 142 within the Department.
- 143 ~~(aa) "Metropolitan statistical area county" means a county located in a metropolitan statistical area as~~
 144 ~~that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by~~
 145 ~~the statistical policy office of the office of information and regulatory affairs of the United States office of~~
 146 ~~management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.~~
- 147 ~~—(bb)—"Michigan Inpatient Data Base" or "MIDB" means the data base compiled by the Michigan Health~~
 148 ~~and Hospital Association or successor organization. The data base consists of inpatient discharge~~
 149 ~~records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for~~
 150 ~~a specific calendar year.~~
- 151 ~~—(cc) "Micropolitan statistical area county" means a county located in a micropolitan statistical area as~~
 152 ~~that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by~~
 153 ~~the statistical policy office of the office of information and regulatory affairs of the United States office of~~
 154 ~~management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.~~
- 155 (ddBB) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not
 156 currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one
 157 subareaHOSPITAL GROUP which are proposed for relocation in a different subareaHOSPITAL GROUP
 158 as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed
 159 hospital beds at a licensed site in one subareaHOSPITAL GROUP which are proposed for relocation to
 160 another geographic site which is in the same subareaHOSPITAL GROUP as determined by the
 161 Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that
 162 are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.
- 163 (eeCC) "New hospital" means one of the following: (i) the establishment of a new facility that shall be
 164 issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site

165 | that is not in the same hospital [subareaGROUP](#) as the currently licensed beds, (iii) currently licensed
 166 | hospital beds at a licensed site in one [subareaHOSPITAL GROUP](#) which are proposed for relocation to
 167 | another geographic site which is in the same [subareaHOSPITAL GROUP](#) as determined by the
 168 | Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are
 169 | proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.
 170 | (~~##DD~~) "Obstetrics patient days of care" means inpatient days of care for patients in the applicant's
 171 | Michigan Inpatient Data Base data ages 15 through 44 with drgs 370 through 375 (obstetrical
 172 | discharges).
 173 | (~~ggEE~~) "Overbedded [subareaHOSPITAL GROUP](#)" means a hospital [subareaGROUP](#) in which the total
 174 | number of existing hospital beds in that [subareaHOSPITAL GROUP](#) exceeds the [subareaHOSPITAL](#)
 175 | [GROUP](#) needed hospital bed supply ~~as set forth in Appendix C.~~
 176 | (~~hhFF~~) "Pediatric patient days of care" means inpatient days of care for patients in the applicant's
 177 | Michigan Inpatient Data Base data ages 0 through 14 excluding normal newborns.
 178 | (~~iiGG~~) "Planning year" means five years beyond the base year, established by the CON Commission,
 179 | for which hospital bed need is developed, unless a different year is determined to be more appropriate by
 180 | the Commission.
 181 | (~~jjHH~~) "Qualifying project" means each application in a comparative group which has been reviewed
 182 | individually and has been determined by the Department to have satisfied all of the requirements of
 183 | Section 22225 of the code, being section 333.22225 of the Michigan Compiled Laws and all other
 184 | applicable requirements for approval in the Code or these Standards.
 185 | ~~_(kk) "Relevance index" or "market share factor" (%Z) means a mathematical computation where the~~
 186 | ~~numerator is the number of inpatient hospital patient days provided by a specified hospital subarea~~
 187 | ~~GROUP from a specific zip code GEOGRAPHIC AREA and the denominator is the total number of~~
 188 | ~~inpatient hospital patient days provided by all hospitals to that specific zip code GEOGRAPHIC AREA~~
 189 | ~~using MIDB data.~~
 190 | (~~llll~~) "Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards,
 191 | means a change in the location of existing hospital beds from the existing licensed hospital site to a
 192 | different existing licensed hospital site within the same hospital [subareaGROUP](#) or HSA. This definition
 193 | does not apply to projects involving replacement beds in a hospital governed by Section 7 of these
 194 | standards.
 195 | (~~mmJJ~~) "Remaining patient days of care" means total inpatient days of care in the applicant's Michigan
 196 | Inpatient Data Base data minus obstetrics patient days of care and pediatric patient days of care.
 197 | (~~nnKK~~) "Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i)
 198 | an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at
 199 | which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for
 200 | replacement in new physical plant space being developed in new construction or in newly acquired space
 201 | (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the
 202 | replacement zone.
 203 | (~~ooLL~~) "Replacement zone" means a proposed licensed site that is (i) in the same [subareaHOSPITAL](#)
 204 | [GROUP](#) as the existing licensed site as determined by the Department in accord with Section 3 of these
 205 | standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing
 206 | licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on
 207 | a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a
 208 | population of less than 200,000.
 209 | ~~_(pp) "Rural county" means a county not located in a metropolitan statistical area or micropolitan~~
 210 | ~~statistical areas as those terms are defined under the "standards for defining metropolitan and~~
 211 | ~~micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of~~
 212 | ~~the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as~~
 213 | ~~shown in Appendix B.~~
 214 | (~~qqMM~~) "Uncompensated care volume" means the hospital's uncompensated care volume as stated on
 215 | the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration
 216 | within the Department.
 217 | (~~##NN~~) ["UNDERSERVED AREA" MEANS THOSE GEOGRAPHIC AREAS NOT WITHIN 30 MINUTES](#)
 218 | [DRIVE TIME OF AN EXISTING LICENSED ACUTE CARE HOSPITAL WITH 24 HOUR/7 DAYS A WEEK](#)

219 EMERGENCY SERVICES UTILIZING THE MOST DIRECT ROUTE USING THE LOWEST SPEED
 220 LIMITS POSTED AS DEFINED BY THE MICHIGAN DEPARTMENT OF TRANSPORTATION (MDOT).
 221 (OO) "Utilization rate" or "use Use rate" means the number of days of inpatient care per 1,000
 222 population during a one-year period.
 223 —(ss) "Zip code population" means the latest population estimates for the base year and projections for
 224 the planning year, by zip code.

225
 226 (2) The definitions in Part 222 shall apply to these standards.
 227

228 **Section 3. Hospital subareasGROUPS**

229
 230 Sec. 3. ~~(1)(a)~~ Each existing hospital is assigned to a hospital subareaGROUP as set forth in
 231 Appendix A B which is incorporated as part of these standards, until Appendix A B is revised pursuant to
 232 this subsection (1).

233 (i1) These hospital subareaGROUPs, and the assignments of hospitals to subareaHOSPITAL
 234 GROUPs, shall be updated BY THE DEPARTMENT EVERY FIVE YEARS OR, at the direction of the
 235 Commission, ~~starting in May 2003, to be completed no later than November 2003. Thereafter, at the~~
 236 ~~direction of the Commission, the updates shall occur no later than two years after the official date of the~~
 237 ~~federal decennial census, provided that:~~ THE METHODOLOGY DESCRIBED IN "A METHODOLOGY
 238 FOR DEFINING HOSPITAL GROUPS" BY PAUL L. DELAMATER, ASHTON M. SHORTRIDGE, AND
 239 JOSEPH P. MESSINA, 2011 SHALL BE USED AS FOLLOWS:

240 (AA) Population data at the federal zip code level, derived from the federal decennial census, are
 241 available; and final MIDB data are available to the Department for that same census year.FOR EACH
 242 HOSPITAL, CALCULATE THE PATIENT DAY COMMITMENT INDEX (%C – A MATHEMATICAL
 243 COMPUTATION WHERE THE NUMERATOR IS THE NUMBER OF INPATIENT HOSPITAL DAYS
 244 FROM A SPECIFIC GEOGRAPHIC AREA PROVIDED BY A SPECIFIED HOSPITAL AND THE
 245 DENOMINATOR IS THE TOTAL NUMBER OF PATIENT DAYS PROVIDED BY THE SPECIFIED
 246 HOSPITAL USING MIDB DATA) FOR ALL MICHIGAN ZIP CODES USING THE SUMMED PATIENT
 247 DAYS FROM THE MOST RECENT THREE YEARS OF MIDB DATA. INCLUDE ONLY THOSE ZIP
 248 CODES FOUND IN EACH YEAR OF THE MOST RECENT THREE YEARS OF MIDB DATA. ARRANGE
 249 OBSERVATIONS IN AN ORIGIN-DESTINATION TABLE SUCH THAT EACH HOSPITAL IS AN ORIGIN
 250 (ROW) AND EACH ZIP CODE IS A DESTINATION (COLUMN) AND INCLUDE ONLY HOSPITALS
 251 WITH INPATIENT RECORDS IN THE MIDB.

252 (b) ~~For an application involving a proposed new licensed site for a hospital (whether new or~~
 253 ~~replacement), the proposed new licensed site shall be assigned to an existing hospital subarea utilizing a~~
 254 ~~market survey conducted by the applicant and submitted with the application. The market survey shall~~
 255 ~~provide, at a minimum, forecasts of the number of inpatient discharges for each zip code that the~~
 256 ~~proposed new licensed site shall provide service. The forecasted numbers must be for the same year as~~
 257 ~~the base year MIDB data. The market survey shall be completed by the applicant using accepted~~
 258 ~~standard statistical methods. The market survey must be submitted on a computer media and in a format~~
 259 ~~pursuant to Section 15, shall be used by the Department to assign the proposed new site to an existing~~
 260 ~~subarea based on the methodology described by "The Specification of Hospital Service Communities in a~~
 261 ~~Large Metropolitan Area" by J. William Thomas, Ph.D., John R. Griffith, and Paul Durance, April 1979 as~~
 262 ~~follows:FOR EACH HOSPITAL, CALCULATE THE ROAD DISTANCE TO ALL OTHER HOSPITALS.~~
 263 ARRANGE OBSERVATIONS IN AN ORIGIN-DESTINATION TABLE SUCH THAT EACH HOSPITAL IS
 264 AN ORIGIN (ROW) AND EACH HOSPITAL IS ALSO A DESTINATION (COLUMN).

265
 266 (iC) ~~For the proposed new site, a discharge relevance factor for each of the zip codes identified in the~~
 267 ~~application will be computed. Zip codes with a market forecast factor of less than .05 will be deleted from~~
 268 ~~consideration.RESCALE THE ROAD DISTANCE ORIGIN-DESTINATION TABLE BY DIVIDING EVERY~~
 269 ENTRY IN THE ROAD DISTANCE ORIGIN-DESTINATION TABLE BY THE MAXIMUM DISTANCE
 270 BETWEEN ANY TWO HOSPITALS.

271 (iiD) ~~The base year MIDB data will be used to compute discharge relevance factors (%Rs) for each~~
 272 ~~hospital subarea for each of the zip codes identified in step (i) above. Hospital subareas with a %R of~~
 273 less than .10 for all zip codes identified in step (i) will be deleted from the computation.APPEND THE

274 ROAD DISTANCE ORIGIN-DESTINATION TABLE TO THE %C ORIGIN-DESTINATION TABLE (BY
 275 HOSPITAL) TO CREATE THE INPUT DATA MATRIX FOR THE CLUSTERING ALGORITHM.

276 (iiiE) The third step in the methodology is to calculate a population-weighted average discharge
 277 relevance factor \bar{R}_j for the proposed hospital and existing subareas. Letting:

278 ———— P_i = Population of zip code i.

279 ———— d_{ij} = Number of patients from zip code i treated at hospital j.

280 ———— $D_i = \sum_j d_{ij}$ = Total patients from zip code i.

281 ———— $I_j = \{i | (d_{ij}/D_i) \geq \alpha\}$, set of zip codes for which the individual relevance factor [%R from (i) and (ii)
 282 above) values (d_{ij}/D_i) of hospital j exceeds or equals α , where α is specified $0 \leq \alpha \leq 1$.

283 ———— $\sum_{i \in I_j} P_i (d_{ij}/D_i)$
 284 then $\bar{R}_j = \frac{\sum_{i \in I_j} P_i (d_{ij}/D_i)}{\sum_{i \in I_j} P_i}$

285 ———— $\sum_{i \in I_j} P_i$ GROUP HOSPITALS INTO CLUSTERS USING THE K-MEANS

286 CLUSTERING ALGORITHM WITH INITIAL CLUSTER CENTERS PROVIDED BY A WARDS
 287 HIERARCHICAL CLUSTERING METHOD. ITERATE OVER ALL CLUSTER SOLUTIONS FROM 2 TO
 288 THE NUMBER OF HOSPITALS (n) MINUS 1.

289 (iv) After \bar{R}_j is calculated for the applicant(s) and the included existing subareas, the
 290 hospital/subarea with the smallest \bar{R}_j ($S\bar{R}_j$) is grouped with the hospital/subarea having the greatest
 291 individual discharge relevance factor in the $S\bar{R}_j$'s home zip code. $S\bar{R}_j$'s home zip code is defined as
 292 the zip code from $S\bar{R}_j$'s with the greatest discharge relevance factor. FOR EACH CLUSTER
 293 SOLUTION, RECORD THE GROUP MEMBERSHIP OF EACH HOSPITAL, THE CLUSTER CENTER
 294 LOCATION FOR EACH OF THE CLUSTERS, THE r^2 VALUE FOR THE OVERALL CLUSTER
 295 SOLUTION, THE NUMBER OF SINGLE HOSPITAL CLUSTERS, AND THE MAXIMUM NUMBER OF
 296 HOSPITALS IN ANY CLUSTER.

297 (II) "K-MEANS CLUSTERING ALGORITHM" MEANS A METHOD FOR PARTITIONING
 298 OBSERVATIONS INTO A USER-SPECIFIED NUMBER OF GROUPS. IT IS A STANDARD ALGORITHM WITH
 299 A LONG HISTORY OF USE IN ACADEMIC AND APPLIED RESEARCH. THE APPROACH IDENTIFIES
 300 GROUPS OF OBSERVATIONS SUCH THAT THE SUM OF SQUARES FROM POINTS TO THE ASSIGNED
 301 CLUSTER CENTERS IS MINIMIZED, I.E., OBSERVATIONS IN A CLUSTER ARE MORE SIMILAR TO ONE
 302 ANOTHER THAN THEY ARE TO OTHER CLUSTERS. SEVERAL K-MEANS IMPLEMENTATIONS HAVE BEEN
 303 PROPOSED: THE BED NEED METHODOLOGY USES THE WIDELY-ADOPTED HARTIGAN-WONG
 304 ALGORITHM. ANY CLUSTERING OR DATA MINING TEXT WILL DISCUSS K-MEANS: ONE EXAMPLE IS B.S.
 305 EVERITT, S. LANDAU, M. LEESE, & D. STAHL (2011) CLUSTER ANALYSIS, 5TH EDITION. WILEY, 346 P.

306 (III) "WARDS HIERARCHICAL CLUSTERING METHOD" MEANS A METHOD FOR CLUSTERING
 307 OBSERVATIONS INTO GROUPS. THIS METHOD USES A BINARY TREE STRUCTURE TO SEQUENTIALLY
 308 GROUP DATA OBSERVATIONS INTO CLUSTERS, SEEKING TO MINIMIZE OVERALL WITHIN-GROUP
 309 VARIANCE. IN THE BED NEED METHODOLOGY, THIS METHOD IS USED TO IDENTIFY THE STARTING
 310 CLUSTER LOCATIONS FOR K-MEANS. ANY CLUSTERING TEXT WILL DISCUSS HIERARCHICAL CLUSTER
 311 ANALYSIS, INCLUDING WARD'S METHOD: ONE EXAMPLE IS: G. GAN, C. MA, & J. WU (2007) DATA
 312 CLUSTERING: THEORY, ALGORITHMS, AND APPLICATIONS (ASA-SIAM SERIES ON STATISTICS AND
 313 APPLIED PROBABILITY). SOCIETY FOR INDUSTRIAL AND APPLIED MATHEMATICS (SIAM), 466 P.

314 (vF) If there is only a single applicant, then the assignment procedure is complete. If there are
 315 additional applicants, then steps (iii), and (iv) must be repeated until all applicants have been assigned to
 316 an existing subarea. CALCULATE THE INCREMENTAL F SCORE (F_{inc}) FOR EACH CLUSTER
 317 SOLUTION (i) BETWEEN 3 AND $n-1$ LETTING:

318 ———— $r^2_j = r^2$ OF SOLUTION i

319 ———— $r^2_{j-1} = r^2$ OF SOLUTION i-1

320 ———— $k_i =$ NUMBER OF CLUSTERS IN SOLUTION i

321 ———— $k_{i-1} =$ NUMBER OF CLUSTERS IN SOLUTION i-1

322 ———— $n =$ TOTAL NUMBER OF HOSPITALS

323 WHERE:
$$F_{inc,i} = \frac{\left(\frac{r_i^2 - r_{i-1}^2}{k_i - k_{i-1}} \right)}{\left(\frac{1 - r_i^2}{n - (k_i - 1)} \right)}$$

- 324 (G) SELECT CANDIDATE SOLUTIONS BY FINDING THOSE WITH PEAK VALUES IN F_{inc}
 325 SCORES SUCH THAT $F_{inc,i}$ IS GREATER THAN BOTH $F_{inc,i-1}$ AND $F_{inc,i+1}$.
 326 (H) REMOVE ALL CANDIDATE SOLUTIONS IN WHICH THE LARGEST SINGLE CLUSTER
 327 CONTAINS MORE THAN 20 HOSPITALS.
 328 (I) IDENTIFY THE MINIMUM NUMBER OF SINGLE HOSPITAL CLUSTERS FROM THE
 329 REMAINING CANDIDATE SOLUTIONS. REMOVE ALL CANDIDATE SOLUTIONS CONTAINING A
 330 GREATER NUMBER OF SINGLE HOSPITAL CLUSTERS THAN THE IDENTIFIED MINIMUM.
 331 (J) FROM THE REMAINING CANDIDATE SOLUTIONS, CHOOSE THE SOLUTION WITH THE
 332 LARGEST NUMBER OF CLUSTERS (k). THIS SOLUTION (k CLUSTERS) IS THE RESULTING
 333 NUMBER AND CONFIGURATION OF THE HOSPITAL GROUPS.
 334 (K) RENAME HOSPITAL GROUPS AS FOLLOWS:
 335 (I) FOR EACH HOSPITAL GROUP, IDENTIFY THE HSA IN WHICH THE MAXIMUM NUMBER OF
 336 HOSPITALS ARE LOCATED. IN CASE OF A TIE, USE THE HSA NUMBER THAT IS LOWER.
 337 (II) FOR EACH HOSPITAL GROUP, SUM THE NUMBER OF CURRENT LICENSED HOSPITAL
 338 BEDS FOR ALL HOSPITALS.
 339 (III) ORDER THE GROUPS FROM 1 TO k BY FIRST SORTING BY HSA NUMBER, THEN
 340 SORTING WITHIN EACH HSA BY THE SUM OF BEDS IN EACH HOSPITAL GROUP. THE HOSPITAL
 341 GROUP NAME IS THEN CREATED BY APPENDING NUMBER IN WHICH IT IS ORDERED TO "HG"
 342 (E.G., HG1, HG2, ... HG k).
 343 (IV) HOSPITALS THAT DO NOT HAVE PATIENT RECORDS IN THE MIDB - IDENTIFIED IN
 344 SUBSECTION (1)(A) - ARE DESIGNATED AS "NG" FOR NON-GROUPABLE HOSPITALS.
 345
 346
 347 (2) FOR AN APPLICATION INVOLVING A PROPOSED NEW LICENSED SITE FOR A HOSPITAL
 348 (WHETHER NEW OR REPLACEMENT), THE PROPOSED NEW LICENSED SITE SHALL BE
 349 ASSIGNED TO AN EXISTING HOSPITAL GROUP UTILIZING THE METHODOLOGY DESCRIBED IN
 350 "A METHODOLOGY FOR DEFINING HOSPITAL GROUPS" BY PAUL L. DELAMATER, ASHTON M.
 351 SHORTRIDGE, AND JOSEPH P. MESSINA, 2011 AS FOLLOWS:
 352 (A) CALCULATE THE ROAD DISTANCE FROM PROPOSED NEW SITE (s) TO ALL EXISTING
 353 HOSPITALS, RESULTING IN A LIST OF n OBSERVATIONS (s_n).
 354 (B) RESCALE s_n BY DIVIDING EACH OBSERVATION BY THE MAXIMUM ROAD DISTANCE
 355 BETWEEN ANY TWO HOSPITALS IDENTIFIED IN SUBSECTION (1)(C).
 356 (C) FOR EACH HOSPITAL GROUP, SUBSET THE CLUSTER CENTER LOCATION IDENTIFIED IN
 357 SUBSECTION (1)(E)(I) TO ONLY THE ENTRIES CORRESPONDING TO THE ROAD DISTANCE
 358 BETWEEN HOSPITALS. FOR EACH HOSPITAL GROUP, THE RESULT IS A LIST OF n
 359 OBSERVATIONS THAT DEFINE EACH HOSPITAL GROUP'S CENTRAL LOCATION IN RELATIVE
 360 ROAD DISTANCE.
 361 (D) CALCULATE THE DISTANCE ($D_{k,s}$) BETWEEN THE PROPOSED NEW SITE AND EACH
 362 EXISTING HOSPITAL GROUP
 363 WHERE: $d_{k,s} = \sqrt{(HG_{k,1} - s_1)^2 + (HG_{k,2} - s_2)^2 + (HG_{k,3} - s_3)^2 + \dots + (HG_{k,n} - s_n)^2}$
 364 (E) ASSIGN THE PROPOSED NEW SITE TO THE CLOSEST HOSPITAL GROUP (HG k) BY
 365 SELECTING THE MINIMUM VALUE OF $d_{k,s}$.
 366 (F) IF THERE IS ONLY A SINGLE APPLICANT, THEN THE ASSIGNMENT PROCEDURE IS
 367 COMPLETE. IF THERE ARE ADDITIONAL APPLICANTS, THEN STEPS (A-E) MUST BE REPEATED
 368 UNTIL ALL APPLICANTS HAVE BEEN ASSIGNED TO AN EXISTING HOSPITAL GROUP.
 369

370 (3) The Commission DEPARTMENT shall amend Appendix A- THE HOSPITAL GROUPS to reflect:
 371 (a) approved new licensed site(s) assigned to a specific hospital subareaGROUP; (b) hospital closures;
 372 and (c) licensure action(s) as appropriate.
 373

374 (34) As directed by the Commission, new sub-areaHOSPITAL GROUP assignments established
 375 according to subsection (1)(a)(i) shall supersede Appendix A- THE PREVIOUS SUBAREA/HOSPITAL
 376 GROUP ASSIGNMENTS and shall be included as an amended appendix to these standardsPOSTED
 377 ON THE STATE OF MICHIGAN CON WEB SITE effective on the date determined by the Commission.
 378

379 **Section 4. Determination of the needed hospital bed supply**

380
 381 Sec. 4. (1) The determination of the needed hospital bed supply for a limited access area and a
 382 hospital subareaGROUP for a planning year shall be made using the MIDB and population estimates and
 383 projections by zip code in the following methodology DETAILED IN "A METHODOLOGY FOR
 384 DETERMINING NEEDED HOSPITAL BED SUPPLY" BY PAUL L. DELAMATER, ASHTON M.
 385 SHORTRIDGE, AND JOSEPH P. MESSINA, 2011 AS FOLLOWS:

386 (a) All hospital discharges for normal newborns (DRG 391 PRIOR TO 2008, DRG 795
 387 THEREAFTER) and psychiatric patients (ICD-9-CM codes 290 through 319 as a principal diagnosis) will
 388 be excluded.

389 (b) For each discharge from the selected zip codes for a limited access area or each hospital
 390 subarea discharge, as applicable, calculate the number of patient days (take the patient days for each
 391 discharge and accumulate it within the respective age group) for the following age groups: ages 0
 392 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44
 393 (DRGs 370 through 375 — obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75
 394 and older. Data from non-Michigan residents are to be included for each specific age group. For limited
 395 access areas, proceed to section 4(1)(c)FOR EACH COUNTY, COMPILE THE MONTHLY PATIENT
 396 DAYS USED BY COUNTY RESIDENTS FOR THE PREVIOUS FIVE YEARS (BASE YEAR PLUS
 397 PREVIOUS FOUR YEARS). COMPILE THE MONTHLY PATIENT DAYS USED BY NON-MICHIGAN
 398 RESIDENTS IN MICHIGAN HOSPITALS FOR THE PREVIOUS FIVE YEARS AS AN "OUT-OF-STATE"
 399 UNIT. THE OUT-OF-STATE PATIENT DAYS UNIT IS CONSIDERED AN ADDITIONAL COUNTY
 400 THEREAFTER. PATIENT DAYS ARE TO BE ASSIGNED TO THE MONTH IN WHICH THE PATIENT
 401 WAS DISCHARGED. FOR PATIENT RECORDS WITH AN UNKNOWN COUNTY OF RESIDENCE,
 402 ASSIGN PATIENT DAYS TO THE COUNTY OF THE HOSPITAL WHERE THE PATIENT RECEIVED
 403 SERVICE.

404 (c) For each hospital subarea, calculate the relevance index (%Z) for each zip code and for each of
 405 the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through
 406 44, female ages 15 through 44 (DRGs 370 THROUGH 375 — obstetrical discharges), ages 45 through
 407 64, ages 65 through 74, and ages 75 and olderFOR EACH COUNTY, CALCULATE THE MONTHLY
 408 PATIENT DAYS FOR ALL MONTHS IN THE PLANNING YEAR. FOR EACH COUNTY, CONSTRUCT
 409 AN ORDINARY LEAST SQUARES LINEAR REGRESSION MODEL USING MONTHLY PATIENT DAYS
 410 AS THE DEPENDENT VARIABLE AND MONTHS (1-60) AS THE INDEPENDENT VARIABLE. IF THE
 411 LINEAR REGRESSION MODEL IS SIGNIFICANT AT A 90% CONFIDENCE LEVEL (F-SCORE, TWO
 412 TAILED p VALUE < 0.1), PREDICT PATIENT DAYS FOR MONTHS 109-120 USING THE MODEL
 413 COEFFICIENTS. IF THE LINEAR REGRESSION MODEL IS NOT SIGNIFICANT AT A 90%
 414 CONFIDENCE LEVEL (F-SCORE, TWO TAILED p VALUE > 0.1), CALCULATE THE PREDICTED
 415 MONTHLY PATIENT DAY DEMAND IN THE PLANNING YEAR BY FINDING THE MONTHLY
 416 AVERAGE OF THE THREE PREVIOUS YEARS (MONTHS 25-60).

417 (d) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective base
 418 year zip code and age group specific year population. The result will be the zip code allocations by age
 419 group for each subareaFOR EACH COUNTY, CALCULATE THE PREDICTED YEARLY PATIENT DAY
 420 DEMAND IN THE PLANNING YEAR. FOR COUNTIES WITH A SIGNIFICANT REGRESSION MODEL,
 421 SUM THE MONTHLY PREDICTED PATIENT DAYS FOR THE PLANNING YEAR. FOR COUNTIES
 422 WITH A NON-SIGNIFICANT REGRESSION MODEL, MULTIPLY THE THREE YEAR MONTHLY
 423 AVERAGE BY 12.

424 (e) ~~For each limited access area or hospital subarea, as applicable, calculate the subarea base year~~
 425 ~~population by age group by adding together all zip code population allocations calculated in (d) for each~~
 426 ~~specific age group in that subarea. For a limited access area, add together the age groups identified for~~
 427 ~~the limited access area. The result will be six population age groups for each limited access area or~~
 428 ~~subarea, as applicable.~~ FOR EACH COUNTY, CALCULATE THE BASE YEAR PATIENT DAY
 429 COMMITMENT INDEX (%C) TO EACH HOSPITAL GROUP. SPECIFICALLY, DIVIDE THE BASE YEAR
 430 PATIENT DAYS FROM EACH COUNTY TO EACH HOSPITAL GROUP BY THE TOTAL NUMBER OF
 431 BASE YEAR PATIENT DAYS FROM EACH COUNTY.

432 (f) ~~For each limited access area or hospital subarea, as applicable, calculate the patient day use~~
 433 ~~rates for ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15~~
 434 ~~through 44 (DRGs 370 through 375 — obstetrical discharges), ages 45 through 64, ages 65 through 74,~~
 435 ~~and ages 75 and older by dividing the results of (b) by the results of (e).~~ FOR EACH COUNTY,
 436 ALLOCATE THE PLANNING YEAR PATIENT DAYS TO THE HOSPITAL GROUPS BY MULTIPLYING
 437 THE PLANNING YEAR PATIENT DAYS BY THE %C TO EACH HOSPITAL GROUP FROM
 438 SUBSECTION (E).

439 (g) ~~For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective planning~~
 440 ~~year zip code and age group specific year population. The results will be the projected zip code~~
 441 ~~allocations by age group for each subarea. For a limited access area, multiply the population projection~~
 442 ~~for the plan year by the proportion of the zip code that is contained within the limited access area for each~~
 443 ~~zip code age group. The results will be the projected zip code allocations by age group for each zip code~~
 444 ~~within the limited access area.~~ FOR EACH HOSPITAL GROUP, SUM THE PLANNING YEAR PATIENT
 445 DAYS ALLOCATED FROM EACH COUNTY.

446 (h) ~~For each hospital subarea, calculate the subarea projected year population by age group by~~
 447 ~~adding together all projected zip code population allocations calculated in (g) for each specific age group.~~
 448 ~~For a limited access area, add together the zip code allocations calculated in (g) by age group identified~~
 449 ~~for the limited access area. The result will be six population age groups for each limited access area or~~
 450 ~~subarea, as applicable.~~ FOR EACH HOSPITAL GROUP, CALCULATE THE AVERAGE DAILY CENSUS
 451 (ADC) FOR THE PLANNING YEAR BY DIVIDING THE PLANNING YEAR PATIENT DAYS BY 365.
 452 ROUND EACH ADC VALUE UP TO THE NEAREST WHOLE NUMBER.

453 (i) ~~For each limited access area or hospital subarea, as applicable, calculate the limited access area~~
 454 ~~or hospital subarea, as applicable, projected patient days for each age group by multiplying the six~~
 455 ~~projected populations by age group calculated in step (h) by the age specific use rates identified in step~~
 456 ~~(f).~~ FOR EACH HOSPITAL GROUP, SELECT THE APPROPRIATE OCCUPANCY RATE FROM THE
 457 OCCUPANCY TABLE IN APPENDIX C.

458 (j) ~~For each limited access area or hospital subarea, as applicable, calculate the adult~~
 459 ~~medical/surgical limited access area or hospital subarea, as applicable, projected patient days by adding~~
 460 ~~together the following age group specific projected patient days calculated in (i): ages 15 through 44,~~
 461 ~~ages 45 through 64, ages 65 through 74, and ages 75 and older. The 0 (excluding normal newborns)~~
 462 ~~through 14 (pediatric) and female ages 15 through 44 (DRGs 370 through 375 — obstetrical discharges)~~
 463 ~~age groups remain unchanged as calculated in (i).~~ FOR EACH HOSPITAL GROUP, CALCULATE THE
 464 PLANNING YEAR BED NEED BY DIVIDING THE PLANNING YEAR ADC BY THE APPROPRIATE
 465 OCCUPANCY RATE. ROUND EACH BED NEED VALUE UP TO THE NEAREST WHOLE NUMBER.

466 (k) ~~For each limited access area or hospital subarea, as applicable, calculate the limited access area~~
 467 ~~or hospital subarea, as applicable, projected average daily census (ADC) for three age groups: Ages 0~~
 468 ~~(excluding normal newborns) through 14 (pediatric), female ages 15 through 44 (DRGs 370 through 375~~
 469 ~~— obstetrical discharges), and adult medical surgical by dividing the results calculated in (j) by 365 (or 366~~
 470 ~~if the planning year is a leap year). Round each ADC to a whole number. This will give three ADC~~
 471 ~~computations per limited access area or subarea, as applicable.~~

472 (l) ~~For each limited access area or hospital subarea, as applicable, and age group, select the~~
 473 ~~appropriate occupancy rate from the occupancy rate table in Appendix D.~~

474 (m) ~~For each limited access area or hospital subarea, as applicable, and age group, calculate the~~
 475 ~~limited access area or subarea, as applicable, projected bed need number of hospital beds for the limited~~
 476 ~~access area or subarea, as applicable, by age group by dividing the ADC calculated in (k) by the~~
 477 ~~appropriate occupancy rate determined in (l). To obtain the total limited access area or hospital, as~~

478 ~~applicable, bed need, add the three age group bed projections together. Round any part of a bed up to a~~
 479 ~~whole bed.~~

480
 481 (2) THE DETERMINATION OF THE NEEDED HOSPITAL BED SUPPLY FOR A LIMITED ACCESS
 482 AREA SHALL BE MADE USING THE MIDB AND THE METHODOLOGY DETAILED IN "A
 483 METHODOLOGY FOR DETERMINING NEEDED HOSPITAL BED SUPPLY" BY PAUL L. DELAMATER,
 484 ASHTON M. SHORTRIDGE, AND JOESPH P. MESSINA, 2011 AS FOLLOWS:

485 (A) ALL HOSPITAL DISCHARGES FOR NORMAL NEWBORNS (DRG 391 PRIOR TO 2008, DRG
 486 795 THEREAFTER) AND PSYCHIATRIC PATIENTS (ICD-9-CM CODES 290 THROUGH 319 AS A
 487 PRINCIPAL DIAGNOSIS) WILL BE EXCLUDED.

488 (B) CALCULATE THE AVERAGE PATIENT DAY USE RATE OF MICHIGAN RESIDENTS. SUM
 489 TOTAL PATIENT DAYS OF MICHIGAN RESIDENTS IN THE BASE YEAR AND DIVIDE BY ESTIMATED
 490 BASE YEAR POPULATION FOR THE STATE (POPULATION DATA AVAILABLE FROM US CENSUS
 491 BUREAU).

492 (C) CALCULATE THE MINIMUM NUMBER OF PATIENT DAYS FOR DESIGNATION OF A LIMITED
 493 ACCESS AREA BY MULTIPLYING THE AVERAGE PATIENT DAY USE RATE BY 50,000. ROUND UP
 494 TO THE NEAREST WHOLE NUMBER.

495 (D) FOLLOW STEPS OUTLINED IN SECTION 4(1)(B) – (D) TO PREDICT PLANNING YEAR
 496 PATIENT DAYS FOR EACH UNDERSERVED AREA. ROUND UP TO THE NEAREST WHOLE
 497 NUMBER. THE PATIENT DAYS FOR EACH UNDERSERVED AREA ARE DEFINED AS THE SUM OF
 498 THE ZIP CODES CORRESPONDING TO EACH UNDERSERVED AREA.

499 (E) FOR EACH UNDERSERVED AREA, COMPARE THE PLANNING YEAR PATIENT DAYS TO
 500 THE MINIMUM NUMBER OF PATIENT DAYS FOR DESIGNATION OF A LIMITED ACCESS AREA
 501 CALCULATED IN (C). ANY UNDERSERVED AREA WITH A PLANNING YEAR PATIENT DAY
 502 DEMAND GREATER THAN OR EQUAL TO THE MINIMUM IS DESIGNATED AS A LIMITED ACCESS
 503 AREA.

504 (F) FOR EACH LIMITED ACCESS AREA, CALCULATE THE PLANNING YEAR BED NEED USING
 505 THE STEPS OUTLINED IN SECTION 4(1)(H) – (J). FOR THESE STEPS, USE THE PLANNING YEAR
 506 PATIENT DAYS FOR EACH LIMITED ACCESS AREA.

507 **Section 5. Bed Need**

508
 509
 510 Sec. 5. (1) The bed-need numbers ~~incorporated as part of these standards as Appendix C~~ shall apply
 511 to projects subject to review under these standards, except where a specific CON review standard states
 512 otherwise.

513
 514 (2) ~~The Commission shall direct the Department, effective November 2004 and SHALL re-calculate~~
 515 ~~the acute care bed need methodology in Section 4 every two years, thereafter OR AS DIRECTED BY~~
 516 ~~THE COMMISSION, to re-calculate the acute care bed need methodology in Section 4, within a specified~~
 517 ~~time frame.~~

518
 519 (3) The Commission shall designate the base year and the future planning year which shall be
 520 utilized in applying the methodology pursuant to subsection (2).

521
 522 (4) ~~When the Department is directed by the Commission to apply the methodology pursuant to~~
 523 ~~subsection (2), t~~The effective date of the bed-need numbers shall be established by the Commission.

524
 525 (5) ~~As directed by the Commission, n~~New bed-need numbers established by subsections (2) and (3)
 526 shall supersede ~~the PREVIOUS~~ bed-need numbers ~~shown in Appendix C~~ and shall be ~~included as an~~
 527 ~~amended appendix to these standards~~ POSTED ON THE STATE OF MICHIGAN CON WEB SITE AS
 528 PART OF THE HOSPITAL BED INVENTORY.

529
 530 (6) MODIFICATIONS MADE BY THE COMMISSION PURSUANT TO THIS SECTION SHALL NOT
 531 REQUIRE STANDARD ADVISORY COMMITTEE ACTION, A PUBLIC HEARING, OR SUBMITTAL OF

532 | THE STANDARD TO THE LEGISLATURE AND THE GOVERNOR IN ORDER TO BECOME
 533 | EFFECTIVE.

534 |
 535 | **Section 6. Requirements for approval -- new beds in a hospital**
 536 |

537 | Sec. 6. (1) An applicant proposing new beds in a hospital, except an applicant meeting the
 538 | requirements of subsection 2, 3, 4, or 5 shall demonstrate that it meets all of the following:

539 | (a) The new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan
 540 | statistical area county or ~~50-25~~ beds in a rural or micropolitan statistical area county. This subsection
 541 | may be waived by the Department if the Department determines, in its sole discretion, that a smaller
 542 | hospital is necessary or appropriate to assure access to health-care services.

543 | (b) The total number of existing hospital beds in the ~~subarea~~HOSPITAL GROUP to which the new
 544 | beds will be assigned does not currently exceed the needed hospital bed supply ~~as set forth in Appendix~~
 545 | ~~C~~. The Department shall determine the ~~subarea~~HOSPITAL GROUP to which the beds will be assigned
 546 | in accord with Section 3 of these standards.

547 | (c) Approval of the proposed new beds in a hospital shall not result in the total number of existing
 548 | hospital beds, in the ~~subarea~~HOSPITAL GROUP to which the new beds will be assigned, exceeding the
 549 | needed hospital bed supply ~~as set forth in Appendix C~~. The Department shall determine the
 550 | ~~subarea~~HOSPITAL GROUP to which the beds will be assigned in accord with Section 3 of these
 551 | standards.
 552 |

553 | (2) An applicant proposing to begin operation as a new ~~long-term (acute) care~~LTAC hospital or
 554 | alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it
 555 | meets all of the requirements of this subsection:

556 | (a) If the ~~long-term (acute) care~~LTAC hospital applicant described in this subsection does not meet
 557 | the Title XVIII requirements of the Social Security Act for exemption from PPS as a ~~N long-term (acute)~~
 558 | ~~care~~LTAC hospital within 12 months after beginning operation, then it may apply for a six-month
 559 | extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII
 560 | requirements for PPS exemption as a ~~N long-term (acute) care~~LTAC hospital within the 12 or 18-month
 561 | period, then the CON granted pursuant to this section shall expire automatically.

562 | (b) The patient care space and other space to establish the new hospital is being obtained through a
 563 | lease arrangement and renewal of a lease between the applicant and the host hospital. The initial,
 564 | renewed, or any subsequent lease shall specify at least all of the following:

565 | (i) That the host hospital shall delicense the same number of hospital beds proposed by the
 566 | applicant for licensure in the new hospital or any subsequent application to add additional beds.

567 | (ii) That the proposed new beds shall be for use in space currently licensed as part of the host
 568 | hospital.

569 | (iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued
 570 | under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project
 571 | delivery requirements or any other applicable requirements of these standards, the beds licensed as part
 572 | of the new hospital must be disposed of by one of the following means:

573 | (A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the
 574 | ~~long-term (acute) care~~LTAC hospital. In the event that the host hospital applies for a CON to acquire the
 575 | ~~long-term (acute) care~~LTAC hospital [including the beds leased by the host hospital to the ~~long-term~~
 576 | ~~(acute) care~~LTAC hospital] within six months following the termination of the lease with the ~~long-term~~
 577 | ~~(acute) care~~LTAC hospital, it shall not be required to be in compliance with the hospital bed supply ~~set~~
 578 | ~~forth in Appendix C~~ if the host hospital proposes to add the beds of the ~~long-term (acute) care~~LTAC
 579 | hospital to the host hospital's medical/surgical licensed capacity and the application meets all other
 580 | applicable project delivery requirements. The beds must be used for general medical/surgical purposes.
 581 | Such an application shall not be subject to comparative review and shall be processed under the
 582 | procedures for non-substantive review (as this will not be considered an increase in the number of beds
 583 | originally licensed to the applicant at the host hospital);

584 | (B) Delicensure of the hospital beds; or

585 | (C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and
 586 | that entity must meet and shall stipulate to the requirements specified in Section 6(2).

587 (c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently,
 588 for CON approval to initiate any other CON covered clinical services; provided, however, that this section
 589 is not intended, and shall not be construed in a manner which would prevent the licensee from
 590 contracting and/or billing for medically necessary covered clinical services required by its patients under
 591 arrangements with its host hospital or any other CON approved provider of covered clinical services.

592 (d) The new licensed hospital shall remain within the host hospital.

593 (e) The new hospital shall be assigned to the same subareaHOSPITAL GROUP as the host hospital.

594 (f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute
 595 a change in bed capacity under Section 1(32) of these standards.

596 (g) The lease will not result in an increase in the number of licensed hospital beds in the
 597 subareaHOSPITAL GROUP.

598 (h) Applications proposing a new hospital under this subsection shall not be subject to comparative
 599 review.

600

601 (3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under
 602 Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be
 603 required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application
 604 meets all other applicable CON review standards and agrees and assures to comply with all applicable
 605 project delivery requirements.

606 (a) The approval of the proposed new hospital beds shall not result in an increase in the number of
 607 licensed hospital beds as follows:

608 (i) In the subareaHOSPITAL GROUP PURSUANT TO SECTION 8(2)(A), or

609 (ii) in the HSA pursuant to Section 8(2)(b).

610 ~~(A) The receiving hospital shall meet the requirements of section 6(4)(b) of these standards.~~

611 (b) AN APPLICANT PROPOSING TO ADD NEW LICENSED BEDS AS THE RECEIVING
 612 HOSPITAL WHERE THE SOURCE HOSPITAL WAS SUBJECT TO SECTION 8(3)(B) SHALL MEET
 613 THE FOLLOWING REQUIREMENTS:

614 (I) THE NUMBER OF BEDS TO BE ADDED SHALL BE NO MORE THAN THE NUMBER, WHICH,
 615 WHEN ADDED TO THE NUMBER OF LICENSED BEDS PRIOR TO THE ADDITION, WOULD RESULT
 616 IN THE ADJUSTED OCCUPANCY RATE FOR THE RECEIVING HOSPITAL TO BE AT LEAST 40
 617 PERCENT.

618 (II) FOR THE PURPOSES OF SUBSECTION (I) ABOVE, THE REVISED NUMBER OF LICENSED
 619 BEDS AT THE RECEIVING HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

620 (A) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 621 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 622 DEPARTMENT.

623 (B) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN SUBSECTION (A)
 624 ABOVE BY .40 TO DETERMINE LICENSED BED DAYS AT 40 PERCENT OCCUPANCY.

625 (C) DIVIDE THE RESULT OF SUBSECTION (B) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP
 626 YEAR) AND ROUND THE QUOTIENT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM
 627 NUMBER OF BEDS THAT CAN BE LICENSED AT THE RECEIVING HOSPITAL AFTER THE
 628 ACCEPTANCE OF THE NEW BEDS, OR 25 WHICHEVER IS LARGER.

629 (C) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

630 (D) The proposed project to add new hospital beds, under this subsection, shall constitute a change
 631 in bed capacity under Section 1(32) of these standards.

632 (eE) Applicants proposing to add new hospital beds under this subsection shall not be subject to
 633 comparative review.

634

635 (4) An applicant may apply for the addition of new beds if all of the following subsections are met.
 636 Further, an applicant proposing new beds at an existing licensed hospital site shall not be required to be
 637 in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all
 638 other applicable CON review standards and agrees and assures to comply with all applicable project
 639 delivery requirements.

640 (a) The beds are being added at the existing licensed hospital site.

641 (b) The hospital at the existing licensed hospital site has operated at an adjusted occupancy rate of
 642 80 percent or above for the previous, consecutive 24 months based on its licensed and approved hospital
 643 bed capacity. The adjusted occupancy rate shall be calculated as follows:

644 (i) ~~Combine all pediatric patient days of care and obstetrics patient days of care provided during the~~
 645 ~~most recent, consecutive 24-month period for which verifiable data are available to the Department and~~
 646 ~~multiply that number by 1.1.~~

647 ~~(ii) Add remaining patient days of care provided during the most recent, consecutive 24-month~~
 648 ~~period for which verifiable data are available to the Department to the number calculated in (i) above.~~
 649 ~~This is the adjusted patient days.~~ CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING
 650 THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE
 651 AVAILABLE TO THE DEPARTMENT.

652 (iii) Divide the number calculated in (ii) above by the total possible patient days [licensed and
 653 approved hospital beds multiplied by 730 (or 731 if including a leap year)]. This is the adjusted
 654 occupancy rate.

655 (c) The number of beds that may be approved pursuant to this subsection shall be the number of
 656 beds necessary to reduce the adjusted occupancy rate for the hospital to 75 percent. The number of
 657 beds shall be calculated as follows:

658 (i) Divide the number of adjusted patient days calculated in subsection (b)(ii) by .75 to determine
 659 licensed bed days at 75 percent occupancy.

660 (ii) Divide the result of step (i) by 730 (or 731 if including a leap year) and round the result up to the
 661 next whole number.

662 (iii) Subtract the number of licensed and approved hospital beds as documented on the "Department
 663 Inventory of Beds" from the result of step (ii) and round the result up to the next whole number to
 664 determine the maximum number of beds that may be approved pursuant to this subsection.

665 (d) A licensed acute care hospital that has relocated its beds, after the effective date of these
 666 standards, shall not be approved for hospital beds under this subsection for five years from the effective
 667 date of the relocation of beds.

668 (e) Applicants proposing to add new hospital beds under this subsection shall not be subject to
 669 comparative review.

670 (f) Applicants proposing to add new hospital beds under this subsection shall demonstrate to the
 671 Department that they have pursued a good faith effort to relocate acute care beds from other licensed
 672 acute care hospitals within the HSA. At the time an application is submitted to the Department, the
 673 applicant shall demonstrate that contact was made by one certified mail return receipt for each
 674 organization contacted.

675
 676 (5) An applicant proposing a new hospital in a limited access area shall not be required to be in
 677 compliance with the needed hospital bed supply ~~set forth in Appendix C~~ if the application meets all other
 678 applicable CON review standards, agrees and assures to comply with all applicable project delivery
 679 requirements, and all of the following subsections are met.

680 (a) The proposed new hospital, unless a critical access hospital, shall have 24 hour/7 days a week
 681 emergency services, obstetrical services, surgical services, and licensed acute care beds.

682 (b) The Department shall assign the proposed new hospital to an existing ~~subarea~~HOSPITAL
 683 GROUP based on the current market use patterns of existing ~~subarea~~HOSPITAL GROUPs.

684 (c) Approval of the proposed new beds in a hospital in a limited access area shall not exceed the
 685 bed need for the limited access area as determined by the bed need methodology in Section 4 and as set
 686 forth in Appendix ED.

687 (d) The new beds in a hospital in a limited access area shall result in a hospital of at least 100 beds
 688 in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. If the
 689 bed need for a limited access area, as shown in Appendix ED, is less, then that will be the minimum
 690 number of beds for a new hospital under this provision. If an applicant for new beds in a hospital under
 691 this provision simultaneously applies for status as a critical access hospital, the minimum hospital size
 692 shall be that number allowed under state/federal critical access hospital designation.

693 (e) Applicants proposing to create a new hospital under this subsection shall not be approved, for a
 694 period of five years after beginning operation of the facility, of the following covered clinical services: (i)
 695 open heart surgery, (ii) therapeutic cardiac catheterization, (iii) fixed positron emission tomography (PET)

696 services, (iv) all transplant services, (v) neonatal intensive care services/beds, and (vi) fixed urinary
 697 extracorporeal shock wave lithotripsy (UESWL) services.

698 (f) Applicants proposing to add new hospital beds under this subsection shall be prohibited from
 699 relocating the new hospital beds for a period of 10 years after beginning operation of the facility.

700 (g) An applicant proposing to add a new hospital pursuant to this subsection shall locate the new
 701 hospital as follows:

702 (i) In a metropolitan statistical area county, an applicant proposing to add a new hospital pursuant to
 703 this subsection shall locate the new hospital within the limited access area and serve a population of
 704 50,000 or more inside the limited access area and within 30 minutes drive time from the proposed new
 705 hospital.

706 (ii) In a rural or micropolitan statistical area county, an applicant proposing to add a new hospital
 707 pursuant to this subsection shall locate the new hospital within the limited access area and serve a
 708 population of 50,000 or more inside the limited access area and within 60 minutes drive time from the
 709 proposed new hospital.

711 **Section 7. Requirements for approval -- replacement beds in a hospital in a replacement zone**

712
 713 Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing
 714 replacement beds in a hospital in the replacement zone shall demonstrate that the new beds in a hospital
 715 shall result in a hospital of at least 200 beds in a metropolitan statistical area county or ~~50-25~~ beds in a
 716 rural or micropolitan statistical area county. This subsection may be waived by the Department if the
 717 Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to
 718 assure access to health-care services.

719
 720 (2) In order to be approved, the applicant SHALL DEMONSTRATE THAT THE new licensed site is in
 721 the replacement zone.

722
 723 (3) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING
 724 REQUIREMENTS, AS APPLICABLE:

725 (A) THE APPLICANT shall propose to (i) replace an equal or lesser number of beds currently
 726 licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii)
 727 that the proposed new licensed site is in the replacement zone. IF THE HOSPITAL AT THE EXISTING
 728 LICENSED HOSPITAL SITE HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF
 729 40 PERCENT OR ABOVE FOR THE PREVIOUS, CONSECUTIVE 36 MONTHS, BASED ON ITS
 730 LICENSED AND APPROVED HOSPITAL BED CAPACITY, THE AVERAGE ADJUSTED OCCUPANCY
 731 RATE SHALL BE CALCULATED AS FOLLOWS:

732 (i) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 733 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 734 DEPARTMENT.

735 (ii) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (i) ABOVE BY 1095
 736 (OR 1096 IF INCLUDING A LEAP YEAR).

737 (B) IF THE HOSPITAL AT THE EXISTING LICENSED HOSPITAL SITE HAS OPERATED AT AN
 738 AVERAGE ADJUSTED OCCUPANCY RATE LESS THAN 40 PERCENT FOR THE PREVIOUS,
 739 CONSECUTIVE 36 MONTHS, IN ORDER TO BE APPROVED, THE REVISED NUMBER OF BEDS AT
 740 THE LICENSED SITE SHALL BE NO MORE THAN THE NUMBER OF BEDS WHICH WOULD RESULT
 741 IN AN ADJUSTED OCCUPANCY RATE FOR THE HOSPITAL OF 60 PERCENT. THE REVISED
 742 NUMBER OF LICENSED BEDS AT THE HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

743 (i) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 744 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 745 DEPARTMENT.

746 (ii) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (i) ABOVE BY .60 TO
 747 DETERMINE LICENSED BED DAYS AT 60 PERCENT OCCUPANCY.

748 (iii) DIVIDE THE RESULT OF SUBSECTION (ii) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP
 749 YEAR) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM

750 NUMBER OF BEDS THAT CAN BE LICENSED AT THE EXISTING LICENSED HOSPITAL SITE AFTER
 751 THE REPLACEMENT, OR 25 WHICHEVER IS LARGER.

752 (C) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

753
 754 (34) An applicant proposing replacement beds in the replacement zone shall not be required to be in
 755 compliance with the needed hospital bed supply ~~set forth in Appendix C~~ if the application meets all other
 756 applicable CON review standards and agrees and assures to comply with all applicable project delivery
 757 requirements.

758
 759 **Section 8. Requirements for approval of an applicant proposing to relocate existing licensed**
 760 **hospital beds**

761
 762 Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in
 763 bed capacity under Section 1(43) of these standards.

764
 765 (2) Any existing licensed acute care hospital may relocate all or a portion of its beds to another
 766 existing licensed acute care hospital as follows:

- 767 (a) The licensed acute care hospitals are located within the same ~~subarea~~ HOSPITAL GROUP, or
 768 (b) the licensed acute care hospitals are located within the same HSA if the receiving hospital meets
 769 the requirements of Section 6(4)(b) of these standards.

770
 771 (3) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING
 772 REQUIREMENTS, AS APPLICABLE:

773 (A) ANY EXISTING LICENSED ACUTE CARE HOSPITAL MAY RELOCATE ALL OR A PORTION
 774 OF ITS BEDS TO ANOTHER EXISTING LICENSED ACUTE CARE HOSPITAL(S) IF THE EXISTING
 775 LICENSED HOSPITAL HAS OPERATED AT AN AVERAGE ADJUSTED OCCUPANCY RATE OF 40
 776 PERCENT OR ABOVE FOR THE PREVIOUS, CONSECUTIVE 36 MONTHS, BASED ON ITS
 777 LICENSED AND APPROVED HOSPITAL BED CAPACITY. THE AVERAGE ADJUSTED OCCUPANCY
 778 RATE SHALL BE CALCULATED AS FOLLOWS:

779 (I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 780 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 781 DEPARTMENT.

782 (II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 1095
 783 (OR 1096 IF INCLUDING A LEAP YEAR).

784 (B) IF THE EXISTING LICENSED HOSPITAL SITE HAS OPERATED AT AN AVERAGE ADJUSTED
 785 OCCUPANCY RATE OF LESS THAN 40 PERCENT FOR THE PREVIOUS, CONSECUTIVE 36
 786 MONTHS, IN ORDER TO BE APPROVED, THE FOLLOWING REQUIREMENTS MUST BE MET:

787 (I) UPON COMPLETION OF THE RELOCATION(S), THE REVISED NUMBER OF BEDS AT THE
 788 EXISTING LICENSED HOSPITAL ("SOURCE HOSPITAL") SHALL BE NO MORE THAN THE NUMBER
 789 OF BEDS WHICH WOULD RESULT IN AN ADJUSTED OCCUPANCY RATE FOR THE SOURCE
 790 HOSPITAL OF 60 PERCENT.

791 (II) MULTIPLE RELOCATIONS CAN BE REQUESTED AT THE SAME TIME AND CAN BE
 792 COMBINED TO MEET THE CRITERIA OF (I) ABOVE. A SEPARATE CON MUST BE SUBMITTED
 793 FOR EACH RELOCATION AND MULTIPLE APPLICATIONS FILED ON THE SAME APPLICATION
 794 DATE SHALL BE CONSIDERED TOGETHER TO MEET THIS CRITERION.

795 (C) FOR THE PURPOSES OF SUBSECTION (3)(B)(I), THE REVISED NUMBER OF LICENSED
 796 BEDS AT THE SOURCE HOSPITAL SHALL BE CALCULATED AS FOLLOWS:

797 (I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 798 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 799 DEPARTMENT.

800 (II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY .60 TO
 801 DETERMINE LICENSED BED DAYS AT 60 PERCENT OCCUPANCY.

802 (III) DIVIDE THE RESULT OF SUBSECTION (II) ABOVE BY 1095 (OR 1096 IF INCLUDING A LEAP
 803 YEAR) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM

NUMBER OF BEDS THAT CAN BE LICENSED AT THE EXISTING LICENSED HOSPITAL SITE AFTER THE RELOCATION, OR 25 WHICHEVER IS LARGER.

(D) SUBSECTION (3)(B) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

(4) The hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

(45) The relocated beds shall be licensed to the receiving hospital and will be counted in the inventory for the applicable ~~subarea~~HOSPITAL GROUP.

(56) The relocation of beds under this section shall not be subject to a mileage limitation.

Section 9. Project delivery requirements -- terms of approval for all applicants

Sec. 9. ~~(4)~~ An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(a1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(A) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(3) COMPLIANCE WITH THE FOLLOWING ACCESS TO CARE REQUIREMENTS:

(A) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(B) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:

(i) Not deny services to any individual based on ability to pay or source of payment.

(ii) Maintain information by source of payment to indicate the volume of care from each payor and non-payor source provided annually.

(iii) Provide services to any individual based on clinical indications of need for the services.

(4) COMPLIANCE WITH THE FOLLOWING MONITORING AND REPORTING REQUIREMENTS:

(A) An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75 percent over the last 12-month period in the three years after the new beds are put into operation, and for each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a minimum of 75 percent average annual occupancy for the revised licensed bed complement.

(B) The applicant must submit documentation acceptable and reasonable to the Department, within 30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-month period after the new beds are put into operation and for each subsequent calendar year, within 30 days after the end of the year.

(D) The applicant shall participate in a data collection SYSTEM established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information, OPERATING SCHEDULES, THROUGH-PUT SCHEDULES, and demographic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site; in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(E) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(F) The applicant shall provide the Department with ~~a notice stating the date the hospital beds are placed in operation and such~~ TIMELY notice shall be submitted to the Department ~~OF THE PROPOSED PROJECT IMPLEMENTATION~~ consistent with applicable statute and promulgated rules.

~~(b)~~ Compliance with applicable operating standards.

- 858 ~~—(i) An applicant approved pursuant to Section 6(4) must achieve a minimum occupancy of 75~~
859 ~~percent over the last 12-month period in the three years after the new beds are put into operation, and for~~
860 ~~each subsequent calendar year, or the number of new licensed beds shall be reduced to achieve a~~
861 ~~minimum of 75 percent average annual occupancy for the revised licensed bed complement.~~
862 ~~—(ii) The applicant must submit documentation acceptable and reasonable to the Department, within~~
863 ~~30 days after the completion of the 3-year period, to substantiate the occupancy rate for the last 12-~~
864 ~~month period after the new beds are put into operation and for each subsequent calendar year, within 30~~
865 ~~days after the end of the year.~~
866 ~~—(c) Compliance with the following quality assurance standards:~~
867 ~~—(i) The applicant shall provide the Department with a notice stating the date the hospital beds are~~
868 ~~placed in operation and such notice shall be submitted to the Department consistent with applicable~~
869 ~~statute and promulgated rules.~~
870 ~~—(ii) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201~~
871 ~~of the Michigan Compiled Laws.~~
872 ~~—(iii) The applicant shall participate in a data collection network established and administered by the~~
873 ~~Department or its designee. The data may include, but is not limited to, annual budget and cost~~
874 ~~information and demographic, diagnostic, morbidity, and mortality information, as well as the volume of~~
875 ~~care provided to patients from all payor sources. The applicant shall provide the required data on a~~
876 ~~separate basis for each licensed site; in a format established by the Department, and in a mutually~~
877 ~~agreed upon media. The Department may elect to verify the data through on-site review of appropriate~~
878 ~~records.~~
879 ~~—(A) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The~~
880 ~~data shall be submitted to the Department or its designee.~~
881 ~~—(iv) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years~~
882 ~~of operation and continue to participate annually thereafter.~~
883 ~~—(d) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:~~
884 ~~—(i) Not deny services to any individual based on ability to pay or source of payment.~~
885 ~~—(ii) Maintain information by source of payment to indicate the volume of care from each payor and~~
886 ~~non-payor source provided annually.~~
887 ~~—(iii) Provide services to any individual based on clinical indications of need for the services.~~

889 (25) The agreements and assurances required by this section shall be in the form of a certification
890 agreed to by the applicant or its authorized agent.

891

892 **Section 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan** 893 **counties**

894

895 Sec. 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties, for
896 purposes of these standards, are incorporated as part of these standards as Appendix B. The
897 Department may amend Appendix B as appropriate to reflect changes by the statistical policy office of the
898 office of information and regulatory affairs of the United States office of management and budget.

899

900 **Section 11. Department inventory of beds**

901

902 Sec. 11. The Department shall maintain and provide on request a listing of the Department inventory
903 of beds for each ~~subarea~~HOSPITAL GROUP.

904

905 **Section 12. Effect on prior planning policies; comparative reviews**

906

907 Sec. 12. (1) These CON review standards supersede and replace the CON standards for hospital
908 beds approved by the CON Commission on December ~~129, 2006-2008~~ and effective March ~~82,~~
909 ~~2007-2009~~.

910

911 (2) Projects reviewed under these standards shall be subject to comparative review except those
912 projects meeting the requirements of Section 7 involving the replacement of beds in a hospital within the

913 replacement zone and projects involving acquisition (including purchase, lease, donation or comparable
914 arrangements) of a hospital.

915

916 **Section 13. Additional requirements for applications included in comparative reviews**

917

918 Sec. 13. (1) Except for those applications for limited access areas, any application for hospital beds,
919 that is subject to comparative review under Section 22229 of the Code, being Section 333.22229 of the
920 Michigan Compiled Laws, or under these standards shall be grouped and reviewed comparatively with
921 other applications in accordance with the CON rules.

922

923 (2) Each application in a comparative review group shall be individually reviewed to determine
924 whether the application is a qualifying project. If the Department determines that two or more competing
925 applications are qualifying projects, it shall conduct a comparative review. The Department shall approve
926 those qualifying projects which, when taken together, do not exceed the need, as defined in Section
927 22225(1) of the Code, and which have the highest number of points when the results of subsection (3)
928 are totaled. If two or more qualifying projects are determined to have an identical number of points, then
929 the Department shall approve those qualifying projects that, when taken together, do not exceed the need
930 in the order in which the applications were received by the Department based on the date and time stamp
931 placed on the applications by the department in accordance with rule 325.9123.

932

933 (3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's
934 uncompensated care volume and as measured by percentage of gross hospital revenues as set forth in
935 the following table. The applicant's uncompensated care volume will be the cumulative of all currently
936 licensed Michigan hospitals under common ownership or control with the applicant that are located in the
937 same health service area as the proposed hospital beds. If a hospital under common ownership or
938 control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of
939 zero. The source document for the calculation shall be the most recent Cost Report filed with the
940 Department for purposes of calculating disproportionate share hospital payments.

941

942	<u>Percentile Ranking</u>	<u>Points Awarded</u>
943	90.0 – 100	25 pts
944	80.0 – 89.9	20 pts
945	70.0 – 79.9	15 pts
946	60.0 – 69.9	10 pts
947	50.0 – 59.9	5 pts

948

949 Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to
950 be closed shall be excluded from this calculation.

951 (b) A qualifying project will be awarded points based on the health service area percentile rank of the
952 applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the
953 following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all
954 currently licensed Michigan hospitals under common ownership or control with the applicant that are
955 located in the same health service area as the proposed hospital beds. If a hospital under common
956 ownership or control with the applicant has not filed a Cost Report, then the related applicant shall
957 receive a score of zero. The source document for the calculation shall be the most recent Cost Report
958 filed with the department for purposes of calculating disproportionate share hospital payments.

959

960	<u>percentile rank</u>	<u>points awarded</u>
961	87.5 – 100	20 pts
962	75.0 – 87.4	15 pts
963	62.5 – 74.9	10 pts
964	50.0 – 61.9	5 pts

965 less than 50.0 0 pts

966
967 Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to
968 be closed shall be excluded from this calculation.

969 (c) A qualifying project shall be awarded points as set forth in the following table in accordance with
970 its impact on inpatient capacity. If an applicant proposes to close a hospital(s), points shall only be
971 awarded if (i) closure of that hospital(s) does not create a bed need in any subarea**HOSPITAL GROUP**
972 as a result of its closing; (ii) the applicant stipulates that the hospital beds to be closed shall not be
973 transferred to another location or facility; and (iii) the utilization (as defined by the average daily census
974 over the previous 24-month period prior to the date that the application is submitted) of the hospital to be
975 closed is at least equal to 50 percent of the size of the proposed hospital (as defined by the number of
976 proposed new licensed beds).

<u>Impact on Capacity</u>	<u>Points Awarded</u>
Closure of hospital(s)	25 pts
Closure of hospital(s) which creates a bed need	-15 pts

983 (d) A qualifying project will be awarded points based on the percentage of the applicant's
984 historical market share of inpatient discharges of the population in an area which will be defined
985 as that area circumscribed by the proposed hospital locations defined by all of the applicants in
986 the comparative review process under consideration. This area will include any zip code
987 completely within the area as well as any zip code which touches, or is touched by, the lines
988 that define the area included within the figure that is defined by the geometric area resulting
989 from connecting the proposed locations. In the case of two locations or one location or if the
990 exercise in geometric definition does not include at least ten zip codes, the market area will be
991 defined by the zip codes within the county (or counties) that includes the proposed site (or
992 sites). Market share used for the calculation shall be the cumulative market share of the
993 population residing in the set of above-defined zip codes of all currently licensed Michigan
994 hospitals under common ownership or control with the applicant, which are in the same health
995 service area.

<u>Percent</u>	<u>Points Awarded</u>
% of market share	% of market share served x 30 (total pts. awarded)

1000
1001 The source for calculations under this criterion is the MIDB.

1002
1003 **Section 14. Review standards for comparative review of a limited access area**

1004
1005 Sec. 14. (1) Any application subject to comparative review, under Section 22229 of the Code, being
1006 Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and
1007 reviewed comparatively with other applications in accordance with the CON rules.

1008
1009 (2) Each application in a comparative group shall be individually reviewed to determine whether the
1010 application has satisfied all the requirements of Section 22225 of the Code, being Section 333.22225 of
1011 the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these
1012 standards. If the Department determines that two or more competing applications satisfy all of the
1013 requirements for approval, these projects shall be considered qualifying projects. The Department shall
1014 approve those qualifying projects which, when taken together, do not exceed the need, as defined in
1015 Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws, and which
1016 have the highest number of points when the results of subsection (3) are totaled. If two or more
1017 qualifying projects are determined to have an identical number of points, then the Department shall
1018 approve those qualifying projects, when taken together, that do not exceed the need, as defined in

1019 Section 22225(1) in the order in which the applications were received by the Department based on the
1020 date and time stamp placed on the application by the Department when the application is filed.

1021
1022 (3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's
1023 uncompensated care volume as measured by percentage of gross hospital revenues as set forth in the
1024 following table. For purposes of scoring, the applicant's uncompensated care will be the cumulative of all
1025 currently licensed Michigan hospitals under common ownership or control with the applicant. The source
1026 document for the calculation shall be the most recent Cost Report submitted to MDCH for purposes of
1027 calculating disproportionate share hospital payments. If a hospital under common ownership or control
1028 with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

1029	<u>Percentile Ranking</u>	<u>Points Awarded</u>
1030		
1031	90.0 – 100	25 pts
1032	80.0 – 89.9	20 pts
1033	70.0 – 79.9	15 pts
1034	60.0 – 69.9	10 pts
1035	50.0 – 59.9	5 pts

1036
1037 Where an applicant proposes to close a hospital as part of its application, data from the closed hospital
1038 shall be excluded from this calculation.

1039 (b) A qualifying project will be awarded points based on the statewide percentile rank of the
1040 applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the
1041 following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all
1042 currently licensed Michigan hospitals under common ownership or control with the applicant. The source
1043 documents for the calculation shall be the Cost Report submitted to MDCH for purposes of calculating
1044 disproportionate share hospital payments. If a hospital under common ownership or control with the
1045 applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

1046	<u>Percentile Rank</u>	<u>Points Awarded</u>
1047		
1048	87.5 – 100	20 pts
1049	75.0 – 87.4	15 pts
1050	62.5 – 74.9	10 pts
1051	50.0 – 61.9	5 pts
1052	Less than 50.0	0 pts

1053
1054 Where an applicant proposes to close a hospital as part of its application, data from the closed hospital
1055 shall be excluded from this calculation.

1056 (c) A qualifying project shall be awarded points as set forth in the following table in accordance with
1057 its impact on inpatient capacity in the health service area of the proposed hospital site.

1058	<u>Impact on Capacity</u>	<u>Points Awarded</u>
1059		
1060	Closure of hospital(s)	15 pts
1061	Move beds	0 pts
1062	Adds beds (net)	-15 pts
1063	or	
1064	Closure of hospital(s)	
1065	or delicensure of beds	
1066	which creates a bed need	
1067	or	
1068	Closure of a hospital	
1069	which creates a new Limited Access Area	

1070 (d) A qualifying project will be awarded points based on the percentage of the applicant's market
 1071 share of inpatient discharges of the population in the limited access area as set forth in the following
 1072 table. Market share used for the calculation shall be the cumulative market share of Michigan hospitals
 1073 under common ownership or control with the applicant.

1074	<u>Percent</u>	<u>Points Awarded</u>
1075	% of market share	% of market share served x 15
1076		(total pts awarded)

1077
 1078
 1079 The source for calculations under this criterion is the MIDB.

1080 (e) A qualifying project will be awarded points based on the percentage of the limited access area's
 1081 population within a 30 minute travel time of the proposed hospital site if in a metropolitan statistical area
 1082 county, or within 60 minutes travel time if in a rural or micropolitan statistical area county as set forth in
 1083 the following table.

1084	<u>Percent</u>	<u>Points Awarded</u>
1085	% of population within	% of population
1086	30 (or 60) minute travel	covered x 15 (total pts
1087	time of proposed site	awarded)

1088
 1089
 1090 (f) All applicants will be ranked in order according to their total project costs as stated in the CON
 1091 application divided by its proposed number of beds in accordance with the following table.

1092	<u>Cost Per Bed</u>	<u>Points Awarded</u>
1093	Lowest cost	10 pts
1094	2nd Lowest cost	5 pts
1095	All other applicants	0 pts

1096 **Section 15. Documentation of market survey**

1097
 1098
 1099
 1100 ~~—Sec. 15. An applicant required to conduct a market survey under Section 3 shall specify how the~~
 1101 ~~market survey was developed. This specification shall include a description of the data source(s) used,~~
 1102 ~~assessments of the accuracy of these data, and the statistical method(s) used. Based on this~~
 1103 ~~documentation, the Department shall determine if the market survey is reasonable.~~

1104 **Section 4615. Requirements for approval -- acquisition of a hospital**

1105
 1106
 1107 Sec. 4615. (1) An applicant proposing to acquire a hospital shall not be required to be in compliance
 1108 with the needed hospital bed supply ~~set forth in Appendix C~~ for the ~~subarea~~HOSPITAL GROUP in which
 1109 the hospital subject to the proposed acquisition is assigned if the applicant demonstrates that all of the
 1110 following are met:

- 1111 (a) the acquisition will not result in a change in bed capacity,
- 1112 (b) the licensed site does not change as a result of the acquisition,
- 1113 (c) the project is limited solely to the acquisition of a hospital with a valid license, and
- 1114 (d) if the application is to acquire a hospital, which was proposed in a prior application to be
 1115 established as a ~~N long-term (acute) care~~LTAC hospital (~~LTAC~~) and which received CON approval, the
 1116 applicant also must meet the requirements of Section 6(2). Those hospitals that received such prior
 1117 approval are so identified ~~in Appendix A~~ON THE DEPARTMENT INVENTORY OF BEDS.

1118
 1119 **(2) IN ORDER TO BE APPROVED, THE APPLICANT SHALL COMPLY WITH THE FOLLOWING**
 1120 **REQUIREMENTS, AS APPLICABLE:**

1121 **(A) THE EXISTING LICENSED HOSPITAL HAS OPERATED AT AN AVERAGE ADJUSTED**
 1122 **OCCUPANCY RATE OF AT LEAST 40 PERCENT FOR THE PREVIOUS CONSECUTIVE 36 MONTHS**
 1123 **BASED ON ITS LICENSED AND APPROVED HOSPITAL BED CAPACITY. AVERAGE ADJUSTED**
 1124 **OCCUPANCY SHALL BE CALCULATED AS FOLLOWS:**

- 1125 (I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 1126 CONSECUTIVE 36-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 1127 DEPARTMENT.
- 1128 (II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 1095
 1129 (OR 1096 IF INCLUDING A LEAP YEAR).
- 1130 (B) IF THE EXISTING LICENSED HOSPITAL HAS OPERATED AT AN AVERAGE ADJUSTED
 1131 OCCUPANCY RATE OF LESS THAN 40 PERCENT FOR THE PREVIOUS CONSECUTIVE 36
 1132 MONTHS, AS CALCULATED IN (A) ABOVE, IN ORDER TO BE APPROVED, THE APPLICANT SHALL
 1133 AGREE TO ALL OF THE FOLLOWING:
- 1134 (I) THE HOSPITAL TO BE ACQUIRED WILL ACHIEVE AN ADJUSTED ANNUAL OCCUPANCY
 1135 OF AT LEAST 40% DURING ANY CONSECUTIVE 12-MONTH PERIOD BY THE END OF THE THIRD
 1136 YEAR OF OPERATION AFTER COMPLETION OF THE ACQUISITION. AVERAGE ADJUSTED
 1137 OCCUPANCY SHALL BE CALCULATED AS FOLLOWS:
- 1138 (A) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 1139 CONSECUTIVE 12-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 1140 DEPARTMENT.
- 1141 (B) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN (I) ABOVE BY 365
 1142 (OR 366 IF A LEAP YEAR).
- 1143 (II) IF THE HOSPITAL TO BE ACQUIRED DOES NOT ACHIEVE AN ADJUSTED ANNUAL
 1144 OCCUPANCY OF AT LEAST 40 PERCENT, AS CALCULATED IN (B) ABOVE, DURING ANY
 1145 CONSECUTIVE 12-MONTH PERIOD BY THE END OF THE THIRD YEAR OF OPERATION AFTER
 1146 COMPLETION OF THE ACQUISITION, THE APPLICANT SHALL RELINQUISH SUFFICIENT BEDS AT
 1147 THE EXISTING HOSPITAL TO RAISE ITS ADJUSTED OCCUPANCY TO 60 PERCENT. THE
 1148 REVISED NUMBER OF LICENSED BEDS AT THE HOSPITAL SHALL BE CALCULATED AS
 1149 FOLLOWS:
- 1150 (I) CALCULATE THE NUMBER OF ADJUSTED PATIENT DAYS DURING THE MOST RECENT,
 1151 CONSECUTIVE 12-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE
 1152 DEPARTMENT.
- 1153 (II) DIVIDE THE NUMBER OF ADJUSTED PATIENT DAYS CALCULATED IN SUBSECTION (I)
 1154 ABOVE BY .60 TO DETERMINE LICENSED BED DAYS AT 60 PERCENT OCCUPANCY.
- 1155 (III) DIVIDE THE RESULT OF STEPSUBSECTION (II) ABOVE BY 365 (OR 366 IF A LEAP YEAR)
 1156 AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER. THIS IS THE MAXIMUM NUMBER
 1157 OF LICENSED BEDS. THE NUMBER OF LICENSED BEDS PERMITTED FOR THE LICENSED
 1158 HOSPITAL SHALL BE THE MAXIMUM NUMBER OF LICENSED BEDS, OR 25, WHICHEVER IS
 1159 LARGER.
- 1160 (C) SUBSECTION (2) SHALL NOT APPLY TO EXCLUDED HOSPITALS.

1161
 1162 **Section 4716. Requirements for approval – all applicants**

1163
 1164 Sec. 4716. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a
 1165 new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be
 1166 provided to the Department within six (6) months from the offering of services if a CON is approved.
 1167

1168 (2) THE APPLICANT CERTIFIES ALL OUTSTANDING DEBT OBLIGATIONS OWED TO THE
 1169 STATE OF MICHIGAN FOR QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) OR CIVIL
 1170 MONETARY PENALTIES (CMP) HAVE BEEN PAID IN FULL.
 1171

1172 (3) THE APPLICANT CERTIFIES THAT THE HEALTH FACILITY FOR THE PROPOSED PROJECT
 1173 HAS NOT BEEN CITED FOR A STATE OR FEDERAL CODE DEFICIENCY WITHIN THE 12 MONTHS
 1174 PRIOR TO THE SUBMISSION OF THE APPLICATION. IF A STATE CODE DEFICIENCY HAS BEEN
 1175 ISSUED, THE APPLICANT SHALL CERTIFY THAT A PLAN OF CORRECTION FOR CITED STATE
 1176 DEFICIENCIES AT THE HEALTH FACILITY HAS BEEN SUBMITTED AND APPROVED BY THE
 1177 BUREAU OF HEALTH SYSTEMS WITHIN THE DEPARTMENT OF LICENSING AND REGULATORY
 1178 AFFAIRS. IF A FEDERAL CODE DEFICIENCY HAS BEEN ISSUED, THE APPLICANT SHALL
 1179 CERTIFY THAT A PLAN OF CORRECTION FOR CITED FEDERAL DEFICIENCIES AT THE HEALTH

1180 | FACILITY HAS BEEN SUBMITTED AND APPROVED BY THE CENTERS FOR MEDICARE AND
1181 | MEDICAID SERVICES. IF CODE DEFICIENCIES INCLUDE ANY UNRESOLVED DEFICIENCIES
1182 | STILL OUTSTANDING WITH THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS OR
1183 | THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THAT ARE THE BASIS FOR THE
1184 | DENIAL, SUSPENSION, OR REVOCATION OF AN APPLICANT'S HEALTH FACILITY LICENSE,
1185 | POSES AN IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENTS, OR MEETS A
1186 | FEDERAL CONDITIONAL DEFICIENCY LEVEL, THE PROPOSED PROJECT CANNOT BE
1187 | APPROVED WITHOUT APPROVAL FROM THE BUREAU OF HEALTH SYSTEMS OR, IF
1188 | APPLICABLE, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

APPENDIX A

1189 |
 1190 |
 1191 | **Section 18. Health service areas**

1192 |
 1193 | ~~Sec. 18.~~ Counties assigned to each ~~of the~~ health service areas are as follows:

HSA	COUNTIES		
1 - Southeast	Livingston	Monroe	St. Clair
	Macomb	Oakland	Washtenaw
	Wayne		
2 - Mid-Southern	Clinton	Hillsdale	Jackson
	Eaton	Ingham	Lenawee
3 - Southwest	Barry	Calhoun	St. Joseph
	Berrien	Cass	Van Buren
	Branch	Kalamazoo	
4 - West	Allegan	Mason	Newaygo
	Ionia	Mecosta	Oceana
	Kent	Montcalm	Osceola
	Lake	Muskegon	Ottawa
5 - GLS	Genesee	Lapeer	Shiawassee
6 - East	Arenac	Huron	Roscommon
	Bay	Iosco	Saginaw
	Clare	Isabella	Sanilac
	Gladwin	Midland	Tuscola
	Gratiot	Ogemaw	
7 - Northern Lower	Alcona	Crawford	Missaukee
	Alpena	Emmet	Montmorency
	Antrim	Gd Traverse	Oscoda
	Benzie	Kalkaska	Otsego
	Charlevoix	Leelanau	Presque Isle
	Cheboygan	Manistee	Wexford
8 - Upper Peninsula	Alger	Gogebic	Mackinac
	Baraga	Houghton	Marquette
	Chippewa	Iron	Menominee
	Delta	Keweenaw	Ontonagon
	Dickinson	Luce	Schoolcraft

**CON REVIEW STANDARDS
 FOR HOSPITAL BEDS**

HOSPITAL SUBAREA ASSIGNMENTS
 Revised 11/19/08

Health

Service — Sub

Area — Area — Hospital Name — City

1 - Southeast

1247	1A	North Oakland Med Center (Fac #63-0110)	Pontiac
1248	1A	Pontiac Osteopathic Hospital (Fac #63-0120)	Pontiac
1249	1A	St. Joseph Mercy — Oakland (Fac #63-0140)	Pontiac
1250	1A	Select Specialty Hospital — Pontiac (LTAC - Fac #63-0172)*	Pontiac
1251	1A	Crittenton Hospital (Fac #63-0070)	Rochester
1252	1A	Huron Valley — Sinai Hospital (Fac #63-0014)	Commerce Township
1253	1A	Wm Beaumont Hospital (Fac #63-0030)	Royal Oak
1254	1A	Wm Beaumont Hospital — Troy (Fac #63-0160)	Troy
1255	1A	Providence Hospital & Medical Center (Fac #63-0130)	Southfield
1256	1A	Oakland Regional Hospital (Fac #63-0013)	Southfield
1257	1A	Straith Hospital for Special Surg (Fac #63-0150)	Southfield
1258	1A	MI Orthopaedic Specialty Hospital (Fac #63-0060)	Madison Heights
1259	1A	St. John Macomb — Oakland Hospital — Oakland (Fac #63-0080)	Madison Heights
1260	1A	Southeast Michigan Surgical Hospital (Fac #50-0100)	Warren
1261	1A	Henry Ford West Bloomfield Hospital (Fac #63-0176)	West Bloomfield
1262	1A	Providence Med Ctr-Providence Park (Fac #63-0177)	Novi
1264	1B	Henry Ford Bi-County Hospital (Fac #50-0020)	Warren
1265	1B	St. John Macomb — Oakland Hospital — Macomb (fac #50-0070)	Warren
1267	1C	Oakwood Hospital and Medical Center (Fac #82-0120)	Dearborn
1268	1C	Garden City Hospital (Fac #82-0070)	Garden City
1269	1C	Henry Ford — Wyandotte Hospital (Fac #82-0230)	Wyandotte
1270	1C	Select Specialty Hosp — Downriver (LTAC - Fac #82-0272)*	Wyandotte
1271	1C	Oakwood Annapolis Hospital (Fac #82-0010)	Wayne
1272	1C	Oakwood Heritage Hospital (Fac #82-0250)	Taylor
1273	1C	Riverside Osteopathic Hospital (Fac #82-0160)	Trenton
1274	1C	Oakwood Southshore Medical Center (Fac #82-0170)	Trenton
1275	1C	Vibra of Southeastern Michigan (Fac #82-0130)	Lincoln Park
1277	1D	Sinai-Grace Hospital (Fac #83-0450)	Detroit
1278	1D	Rehabilitation Institute of Michigan (Fac #83-0410)	Detroit
1279	1D	Harper University Hospital (Fac #83-0220)	Detroit
1280	1D	Henry Ford Hospital (Fac #83-0190)	Detroit
1281	1D	St. John Hospital & Medical Center (Fac #83-0420)	Detroit
1282	1D	Children's Hospital of Michigan (Fac #83-0080)	Detroit
1283	1D	Detroit Receiving Hospital & Univ Hlth (Fac #83-0500)	Detroit
1284	1D	Karmanos Cancer Center (Fac #83-0520)	Detroit
1285	1D	Triumph Hospital Detroit (LTAC - Fac #83-0521)*	Detroit
1286	1D	Detroit Hope Hospital (Fac #83-0390)	Detroit

*This is a hospital that must meet the requirement(s) of Section 16(1)(d) - LTAC.

APPENDIX A (continued)

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Health**Service — Sub****Area — Area — Hospital Name — City****1—Southeast (continued)**

	1D	Hutzel Women's Hospital (Fac #83-0240)	Detroit
	1D	Select Specialty Hosp—NW Detroit (LTAC - Fac #83-0523)*	Detroit
	1D	Beaumont Hospital, Grosse Pointe (Fac #82-0030)	Grosse Pointe
	1D	Henry Ford Cottage Hospital (Fac #82-0040)	Grosse Pointe Farm
	1D	Select Specialty Hospital—Grosse Pointe (LTAC - Fac #82-0276)*	Grosse Pointe
	1E	Botsford Hospital (Fac #63-0050)	Farmington Hills
	1E	St. Mary Mercy Hospital (Fac #82-0190)	Livonia
	1F	Mount Clemens Regional Medical Center (Fac #50-0060)	Mt. Clemens
	1F	Select Specialty Hosp—Macomb Co. (Fac #50-0111)*	Mt. Clemens
	1F	St. John North Shores Hospital (Fac #50-0030)	Harrison Twp.
	1F	Henry Ford Macomb Hospital (Fac #50-0110)	Clinton Township
	1F	Henry Ford Macomb Hospital - Mt. Clemens (Fac #50-0080)	Mt. Clemens
	1G	Mercy Hospital (Fac #74-0010)	Port Huron
	1G	Port Huron Hospital (Fac #74-0020)	Port Huron
	1H	St. Joseph Mercy Hospital (Fac #81-0030)	Ann Arbor
	1H	University of Michigan Health System (Fac #81-0060)	Ann Arbor
	1H	Select Specialty Hosp—Ann Arbor (LTAC - Fac #81-0081)*	Ypsilanti
	1H	Chelsea Community Hospital (Fac #81-0080)	Chelsea
	1H	Saint Joseph Mercy Livingston Hosp (Fac #47-0020)	Howell
	1H	Saint Joseph Mercy Saline Hospital (Fac #81-0040)	Saline
	1H	Forest Health Medical Center (Fac #81-0010)	Ypsilanti
	1H	Brighton Hospital (Fac #47-0010)	Brighton
	1I	St. John River District Hospital (Fac #74-0030)	East China
	1J	Mercy Memorial Hospital System (Fac #58-0030)	Monroe

2--Mid-Southern

	2A	Clinton Memorial Hospital (Fac #49-0010)	St. Johns
	2A	Eaton Rapids Medical Center (Fac #23-0010)	Eaton Rapids
	2A	Hayes Green Beach Memorial Hosp (Fac #23-0020)	Charlotte
	2A	Ingham Regional Medical Center (Greenlawn) (Fac #33-0020)	Lansing
	2A	Ingham Regional Orthopedic Hospital (Fac #33-0010)	Lansing
	2A	Edward W. Sparrow Hospital (Fac #33-0060)	Lansing
	2A	Sparrow Health System—St. Lawrence Campus (Fac #33-0050)	Lansing
	2A	Sparrow Specialty Hospital (LTAC - FAC #33-0061)*	Lansing
	2B	Carelink of Jackson (LTAC Fac #38-0030)*	Jackson
	2B	Allegiance Health (Fac #38-0010)	Jackson

*This is a hospital that must meet the requirement(s) of Section 16(1)(d) - LTAC.

1345	Health				
1346	Service	Sub			
1347	Area	Area	Hospital Name		City
1348	=====				
1349	2—Mid-Southern (continued)				
1350	-----				
1351		2C	Hillsdale Community Health Center (Fac #30-0010)		Hillsdale
1352					
1353		2D	Emma L. Bixby Medical Center (Fac #46-0020)		Adrian
1354					
1355		2D	Herrick Memorial Hospital (Fac #46-0052)		Tecumseh
1356					
1357					
1358	3—Southwest				
1359					
1360		3A	Borgess Medical Center (Fac #39-0010)		Kalamazoo
1361		3A	Bronson Methodist Hospital (Fac #39-0020)		Kalamazoo
1362		3A	Borgess-Pipp Health Center (Fac #03-0031)		Plainwell
1363		3A	Bronson Lakeview Hospital (Fac #80-0030)		Paw Paw
1364		3A	Bronson Vicksburg Hospital (Fac #39-0030)		Vicksburg
1365		3A	Pennock Hospital (Fac #08-0010)		Hastings
1366		3A	Three Rivers Health (Fac #75-0020)		Three Rivers
1367		3A	Sturgis Hospital (Fac #75-0010)		Sturgis
1368		3A	Select Specialty Hospital — Kalamazoo (LTAC - Fac #39-0032)*		Kalamazoo
1369					
1370		3B	Battle Creek Health System (Fac #13-0031)		Battle Creek
1371		3B	SW Regional Rehabilitation Center (Fac #13-0100)		Battle Creek
1372		3B	Oaklawn Hospital (Fac #13-0080)		Marshall
1373					
1374		3C	Community Hospital (Fac #11-0040)		Watervliet
1375		3C	Lakeland Hospital, St. Joseph (Fac #11-0050)		St. Joseph
1376		3C	Lakeland Specialty Hospital (LTAC - Fac #11-0080)*		Berrien Center
1377		3C	South Haven Community Hospital (Fac #80-0020)		South Haven
1378					
1379		3D	Lakeland Hospital, Niles (Fac #11-0070)		Niles
1380		3D	Borgess-Lee Memorial Hospital (A) (Fac #14-0010)		Dowagiac
1381					
1382		3E	Community Health Center of Branch County (Fac #12-0010)		Coldwater
1383					
1384	4—WEST				
1385					
1386		4A	Memorial Medical Center of West MI (Fac #53-0010)		Ludington
1387					
1388		4B	Spectrum Health United Memorial — Kelsey (A) (Fac #59-0050)		Lakeview
1389		4B	Mecosta County Medical Center (Fac #54-0030)		Big Rapids
1390					
1391		4C	Spectrum Health-Reed City Campus (Fac #67-0020)		Reed City
1392					
1393		4D	Lakeshore Community Hospital (Fac #64-0020)		Shelby
1394					
1395		4E	Gerber Memorial Hospital (Fac #62-0010)		Fremont
1396					
1397	*This is a hospital that must meet the requirement(s) of Section 16(1)(d) - LTAC.				
1398	(A) This is a hospital that has state/federal critical access hospital designation.				
1399					
1400					

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1403	Health			1403
1404	Service	Sub		
1405	Area	Area	Hospital Name	City
1406	=====			
1407	4--West (continued)			
1408				
1409	4F		Carson City Hospital (Fac #59-0010)	Carson City
1410	4F		Gratiot Medical Center (Fac #29-0010)	Alma
1411				
1412	4G		Hackley Hospital (Fac #61-0010)	Muskegon
1413	4G		Mercy General Health Partners (Sherman) (Fac #61-0020)	Muskegon
1414	4G		Mercy General Health Partners (Oak) (Fac #61-0030)	Muskegon
1415	4G		Lifecare Hospitals of Western MI (LTAC - Fac #61-0052)*	Muskegon
1416	4G		Select Specialty Hospital - Western MI (LTAC - Fac #61-0051)*	Muskegon
1417	4G		North Ottawa Community Hospital (Fac #70-0010)	Grand Haven
1418				
1419	4H		Spectrum Health - Blodgett Campus (Fac #41-0010)	E. Grand Rapids
1420	4H		Spectrum Health Hospitals (Fac #41-0040)	Grand Rapids
1421	4H		Spectrum Health - Kent Community Campus (Fac #41-0090)	Grand Rapids
1422	4H		Mary Free Bed Hospital & Rehab Ctr (Fac #41-0070)	Grand Rapids
1423	4H		Metro Health Hospital (Fac #41-0060)	Wyoming
1424	4H		Saint Mary's Health Care (Fac #41-0080)	Grand Rapids
1425				
1426	4I		Sheridan Community Hospital (A) (Fac #59-0030)	Sheridan
1427	4I		Spectrum Health United Memorial - United Campus (Fac #59-0060)	Greenville
1428				
1429	4J		Holland Community Hospital (Fac #70-0020)	Holland
1430	4J		Zeeland Community Hospital (Fac #70-0030)	Zeeland
1431				
1432	4K		Ionia County Memorial Hospital (A) (Fac #34-0020)	Ionia
1433				
1434	4L		Allegan General Hospital (A) (Fac #03-0010)	Allegan
1435				
1436	5--GLS			
1437				
1438	5A		Memorial Healthcare (Fac #78-0010)	Owosso
1439				
1440	5B		Genesys Regional Medical Center - Health Park (Fac #25-0072)	Grand Blanc
1441	5B		Hurley Medical Center (Fac #25-0040)	Flint
1442	5B		Mclaren Regional Medical Center (Fac #25-0050)	Flint
1443	5B		Select Specialty Hospital-Flint (LTAC - Fac #25-0071)*	Flint
1444				
1445	5C		Lapeer Regional Medical Center (Fac #44-0010)	Lapeer
1446				
1447	6--East			
1448				
1449	6A		West Branch Regional Medical Center (Fac #65-0010)	West Branch
1450	6A		Tawas St. Joseph Hospital (Fac #35-0010)	Tawas City
1451				
1452	6B		Central Michigan Community Hospital (Fac #37-0010)	Mt. Pleasant
1453				
1454	*This is a hospital that must meet the requirement(s) of Section 16(1)(d) - LTAC.			
1455				
1456	(A) This is a hospital that has state/federal critical access hospital designation.			

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Health

Service Sub

Area Area Hospital Name City

6—East (continued)

6C	MidMichigan Medical Center - Clare	(Fac #18-0010)	Clare
6D	Mid-Michigan Medical Center - Gladwin (A)	(Fac #26-0010)	Gladwin
6D	Mid-Michigan Medical Center - Midland	(Fac #56-0020)	Midland
6E	Bay Regional Medical Center	(Fac #09-0050)	Bay City
6E	Bay Regional Medical Center - West	(Fac #09-0020)	Bay City
6E	Bay Special Care	(LTAC - Fac #09-0010)*	Bay City
6E	St. Mary's Standish Community Hospital (A)	(Fac #06-0020)	Standish
6F	Select Specialty Hospital - Saginaw	(LTAC - Fac #73-0062)*	Saginaw
6F	Covenant Medical Center - Cooper	(Fac #73-0040)	Saginaw
6F	Covenant Medical Center - N Michigan	(Fac #73-0030)	Saginaw
6F	Covenant Medical Center - N Harrison	(Fac #73-0020)	Saginaw
6F	Healthsource Saginaw	(Fac #73-0060)	Saginaw
6F	St. Mary's of Michigan Medical Center	(Fac #73-0050)	Saginaw
6F	Care Community Hospital	(Fac #79-0010)	Care
6F	Hills and Dales General Hospital	(Fac #79-0030)	Cass City
6G	Harbor Beach Community Hospital (A)	(Fac #32-0040)	Harbor Beach
6G	Huron Medical Center	(Fac #32-0020)	Bad Axe
6G	Scheurer Hospital (A)	(Fac #32-0030)	Pigeon
6H	Deckerville Community Hospital (A)	(Fac #76-0010)	Deckerville
6H	Mckenzie Memorial Hospital (A)	(Fac #76-0030)	Sandusky
6I	Marlette Regional Hospital	(Fac #76-0040)	Marlette

7-- Northern Lower

7A	Cheboygan Memorial Hospital	(Fac #16-0020)	Cheboygan
7B	Charlevoix Area Hospital	(Fac #15-0020)	Charlevoix
7B	Mackinac Straits Hospital (A)	(Fac #49-0030)	St. Ignace
7B	Northern Michigan Hospital	(Fac #24-0030)	Petoskey
7C	Rogers City Rehabilitation Hospital	(Fac #71-0030)	Rogers City
7D	Otsego Memorial Hospital	(Fac #69-0020)	Gaylord
7E	Alpena General Hospital	(Fac #04-0010)	Alpena
7F	Kalkaska Memorial Health Center (A)	(Fac #40-0020)	Kalkaska

*This is a hospital that must meet the requirement(s) of Section 16(1)(d) - LTAC.

(A) This is a hospital that has state/federal critical access hospital designation.

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Health

Service Sub

Area Area Hospital Name City

7-- Northern Lower (continued)

7F	Munson Medical Center	(Fac #28-0010)	Traverse City
7F	Paul Oliver Memorial Hospital (A)	(Fac #10-0020)	Frankfort
7G	Mercy Hospital	Cadillac (Fac #84-0010)	Cadillac
7H	Mercy Hospital	Grayling (Fac #20-0020)	Grayling
7I	West Shore Medical Center	(Fac #51-0020)	Manistee

8-- Upper Peninsula

8A	Grand View Hospital	(Fac #27-0020)	Ironwood
8B	Aspirus Ontonagon Hospital, Inc. (A)	(Fac #66-0020)	Ontonagon
8C	Iron County Community Hospital	(Fac #36-0020)	Iron River
8D	Baraga County Memorial Hospital (A)	(Fac #07-0020)	L'anse
8E	Keweenaw Memorial Medical Center	(Fac #31-0010)	Laurium
8E	Portage Health Hospital	(Fac #31-0020)	Hancock
8F	Dickinson County Memorial Hospital	(Fac #22-0020)	Iron Mountain
8G	Bell Memorial Hospital	(Fac #52-0010)	Ishpeming
8G	Marquette General Hospital	(Fac #52-0050)	Marquette
8H	St. Francis Hospital	(Fac #21-0010)	Escanaba
8I	Munising Memorial Hospital (A)	(Fac #02-0010)	Munising
8J	Schoolcraft Memorial Hospital (A)	(Fac #77-0010)	Manistique
8K	Helen Newberry Joy Hospital (A)	(Fac #48-0020)	Newberry
8L	Chippewa County War Memorial Hospital	(Fac #17-0020)	Sault Ste Marie

(A) This is a hospital that has state/federal critical access hospital designation.

APPENDIX B

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**CON REVIEW STANDARDS
FOR HOSPITAL BEDS**

1573 Rural Michigan counties are as follows:

1574			
1575	Alcona	Hillsdale	Ogemaw
1576	Alger	Huron	Ontonagon
1577	Antrim	Iosco	Osceola
1578	Arenac	Iron	Oscoda
1579	Baraga	Lake	Otsego
1580	Charlevoix	Luce	Presque Isle
1581	Cheboygan	Mackinac	Roscommon
1582	Clare	Manistee	Sanilac
1583	Crawford	Mason	Schoolcraft
1584	Emmet	Montcalm	Tuscola
1585	Gladwin	Montmorency	
1586	Gogebic	Oceana	

1587

1588 Micropolitan statistical area Michigan counties are as follows:

1589			
1590	Allegan	Gratiot	Mecosta
1591	Alpena	Houghton	Menominee
1592	Benzie	Isabella	Midland
1593	Branch	Kalkaska	Missaukee
1594	Chippewa	Keweenaw	St. Joseph
1595	Delta	Leelanau	Shiawassee
1596	Dickinson	Lenawee	Wexford
1597	Grand Traverse	Marquette	

1598

1599 Metropolitan statistical area Michigan counties are as follows:

1600			
1601	Barry	Ionia	Newaygo
1602	Bay	Jackson	Oakland
1603	Berrien	Kalamazoo	Ottawa
1604	Calhoun	Kent	Saginaw
1605	Cass	Lapeer	St. Clair
1606	Clinton	Livingston	Van Buren
1607	Eaton	Macomb	Washtenaw
1608	Genesee	Monroe	Wayne
1609	Ingham	Muskegon	

1610

1611 Source:

1612

1613 65 F.R., p. 82238 (December 27, 2000)

1614 Statistical Policy Office

1615 Office of Information and Regulatory Affairs

1616 United States Office of Management and Budget

**CON REVIEW STANDARDS
FOR HOSPITAL BEDS**

The hospital bed need for purposes of these standards, effective March 2, 2009, and until otherwise changed by the Commission are as follows:

Health Service Area	SA No.	Bed Need
1 - SOUTHEAST		
	1A	2946
	1B	480
	1C	1481
	1D	2979
	1E	495
	1F	700
	1G	267
	1H	1648
	1I	53
	1J	177
2 - MID-SOUTHERN		
	2A	889
	2B	306
	2C	59
	2D	117
3 - SOUTHWEST		
	3A	890
	3B	281
	3C	282
	3D	89
	3E	71
4 - WEST		
	4A	65
	4B	52
	4C	19
	4D	13
	4E	38
	4F	133
	4G	373
	4H	1400
	4I	48
	4J	157
	4K	18
	4L	30
5 - GLS		
	5A	78
	5B	1163
	5C	109

1672	Health		
1673	Service	SA	Bed
1674	Area	No.	Need
1675	6 - EAST		
1676		6A	96
1677		6B	62
1678		6C	42
1679		6D	184
1680		6E	324
1681		6F	820
1682		6G	48
1683		6H	16
1684		6I	22
1685	7 - NORTHERN LOWER		
1686		7A	38
1687		7B	200
1688		7C	19
1689		7D	35
1690		7E	102
1691		7F	392
1692		7G	64
1693		7H	59
1694		7I	36
1695	8 - UPPER PENINSULA		
1696		8A	30
1697		8B	12
1698		8C	22
1699		8D	12
1700		8E	54
1701		8F	93
1702		8G	226
1703		8H	53
1704		8I	7
1705		8J	9
1706		8K	14
1707		8L	54
1708			
1709			
1710			
1711			
1712			
1713			

1714
1715
1716

OCCUPANCY RATE TABLE

Adult Medical/Surgical					Pediatric Beds				
HOSPITAL GROUP PROJECTED BED ADC			ADJUSTED BedsBed RANGE		Beds				
ADC	ADC	Occup	StartBE	StopBE	ADC	ADC	Occup	Start	Stop
>= LO	ADC<= HIGH		DS LO	DS HIGH	>	<=			
W	W		W	H					<=50
30	3031	0.60%	50	5052		30	0.50		
		0.6061							
3432	3235	%	5253	5258	30	33	0.50	61	66
		0.6462							
3236	3439	%	5359	5653	34	40	0.51	67	79
		0.6263							
3540	3745	%	5764	6072	41	46	0.52	80	88
		0.6364							
3846	4450	%	6472	6579	47	53	0.53	89	100
		0.6465							
4251	4658	%	6679	7290	54	60	0.54	101	111
		0.6566							
4759	5067	%	7390	77102	61	67	0.55	112	121
		0.6667							
5468	5677	%	78102	85115	68	74	0.56	122	131
		0.6768							
5778	6388	%	86115	94130	75	80	0.57	132	139
		0.6869							
6489	70101	%	95129	103147	81	87	0.58	140	149
		0.6970							
74102	79117	%	104146	114168	88	94	0.59	150	158
		0.7071							
80118	89134	%	115167	126189	95	101	0.60	159	167
		0.7172							
90135	100154	%	127188	140214	102	108	0.61	168	175
		0.7273							
104155	114176	%	141213	157242	109	114	0.62	176	182
		0.7374							
115177	130204	%	158240	177276	115	121	0.63	183	190
		0.7475							
134205	149258	%	178274	200344	122	128	0.64	191	198
		0.7576							
150259	172327	%	201341	227431	129	135	0.65	199	206
		0.7677							
173328	200424	%	228426	261551	136	142	0.66	207	213
		0.7778							
204425	234561	%	262545	301720	143	149	0.67	214	220
		0.7879							
235562	276760	%	302712	350963	150	155	0.68	221	226
		0.7980							
277761	327895	%	351952	4101119	156	162	0.69	227	232
		0.80							
328	394	0.80	411	484	163	169	0.70	233	239
		0.81							
392	473	0.81	485	578	170	176	0.71	240	245
		0.82							
474	577	0.82	579	696	177	183	0.72	246	252

578	713	0.83	697	850	184	189	0.73	253	256	Attachment B
714	894	0.84	851	894	190	196	0.74	257	262	
895		0.85	>=1054		197		0.75	>=263		

Obstetric Beds

Obstetric Beds-cont.

Obstetric Beds					Obstetric Beds-cont.				
ADC>	ADC<=	Occup	Beds		ADC>	ADC<=	Occup	Beds	
			Start	Stop				Start	Stop
	30	0.50		<=50	115	121	0.63	183	190
30	33	0.50	61	66	122	128	0.64	191	198
34	40	0.51	67	79	129	135	0.65	199	206
41	46	0.52	80	88	136	142	0.66	207	213
47	53	0.53	89	100	143	149	0.67	214	220
54	60	0.54	101	111	150	155	0.68	221	226
61	67	0.55	112	121	156	162	0.69	227	232
68	74	0.56	122	131	163	169	0.70	233	239
75	80	0.57	132	139	170	176	0.71	240	245
81	87	0.58	140	149	177	183	0.72	246	252
88	94	0.59	150	158	184	189	0.73	253	256
95	101	0.60	159	167	190	196	0.74	257	262
102	108	0.61	168	175	197		0.75	>=263	
109	114	0.62	176	182					

1717

LIMITED ACCESS AREAS

Limited access areas and the hospital bed need, effective ~~March 2, 2009~~ (INSERT EFFECTIVE DATE), for each of those areas are identified below. The hospital bed need for limited access areas shall be changed by the department in accordance with section 2(1)(~~vv~~) of these standards, and this appendix shall be updated accordingly.

<u>HEALTH SERVICE AREA</u>	<u>LIMITED ACCESS AREA</u>	<u>BED NEED</u>	<u>POPULATION FOR PLANNING YEAR</u>
<u>7</u>	<u>Alpena/Plus 0808</u>	<u>358</u>	<u>66,946</u>
<u>8</u>	<u>Upper Peninsula 0808</u>	<u>415</u>	<u>135,215</u>

(NEEDS TO BE UPDATED WHEN BED NEED IS RUN.)

Sources:

- 1) Michigan State University
Department of Geography
Hospital Site Selection Final Report
November 3, 2004, as amended
- 2) Section 4 of these standards
- 3) Michigan State University
Department of Geography
2011 Planning Year Hospital Bed Need Calculations
August 28, 2008

(SOURCES MAY NEED UPDATING)

**CON REVIEW STANDARDS FOR HOSPITAL BEDS
--ADDENDUM FOR PROJECTS FOR HIV INFECTED INDIVIDUALS--**

(By authority conferred on the CON Commission by sections 22215 and 22217 of Act No. 368 of the Public Acts of 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being sections 333.22215, 333.2217, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability; definitions

—Sec. 1. (1) This addendum supplements the CON Review Standards for Hospital Beds and may be used for determining the need for projects established to meet the needs of HIV infected individuals.

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

—(3) The definitions that apply to the CON Review Standards for Hospital Beds apply to these standards.

—(4) "HIV infected" means that term as defined in Section 5101 of the Code.

—(5) Planning area for projects for HIV infected individuals means the State of Michigan.

Section 2. Requirements for approval; change in bed capacity

—Sec. 2. (1) A project which, if approved, will increase the number of licensed hospital beds in an overbedded subarea or will result in the total number of existing hospital beds in a subarea exceeding the needed hospital bed supply as determined under the CON Review Standards for Hospital Beds may, nevertheless, be approved pursuant to subsection (3) of this addendum.

—(2) Hospital beds approved as a result of this addendum shall be included in the Department inventory of existing beds in the subarea in which the hospital beds will be located. Increases in hospital beds approved under this addendum shall cause subareas currently showing a current surplus of beds to have that surplus increased.

—(3) In order to be approved under this addendum, an applicant shall demonstrate all of the following:

—(a) The Director of the Department has determined that action is necessary and appropriate to meet the needs of HIV infected individuals for quality, accessible and efficient health care.

—(b) The hospital will provide services only to HIV infected individuals.

—(c) The applicant has obtained an obligation, enforceable by the Department, from existing licensed hospital(s) in any subarea of this state to voluntarily delicense a number of hospital beds equal to the number proposed in the application. The effective date of the delicensure action will be the date the beds approved pursuant to this addendum are licensed. The beds delicensed shall not be beds already subject to delicensure under a bed reduction plan.

—(d) The application does not result in more than 20 beds approved under this addendum in the State.

—(4) In making determinations under Section 22225(2)(a) of the Code, for projects under this addendum, the Department shall consider the total cost and quality outcomes for overall community health systems for services in a dedicated portion of an existing facility compared to a separate aids facility and has determined that there exists a special need, and the justification of any cost increases in terms of important quality/access improvements or the likelihood of future cost reductions, or both.

Section 3. Project delivery requirements--additional terms of approval for projects involving HIV infected individuals approved under this addendum.

1812 ~~—Sec. 3. (1) An applicant shall agree that, if approved, the services provided by the beds for HIV~~
1813 ~~infected individuals shall be delivered in compliance with the following terms of CON approval:~~
1814 ~~—(a) The license to operate the hospital will be limited to serving the needs of patients with the clinical~~
1815 ~~spectrum of HIV infection and any other limitations established by the Department to meet the purposes~~
1816 ~~of this addendum.~~
1817 ~~—(b) The hospital shall be subject to the general license requirements of Part 215 of the Code except~~
1818 ~~as waived by the Department to meet the purposes of this addendum.~~
1819 ~~—(c) The applicant agrees that the Department shall revoke the license of the hospital if the hospital~~
1820 ~~provides services to inpatients other than HIV infected individuals.~~

1821
1822 **Section 4. Comparative reviews**

1823
1824 ~~Sec. 4. (1) Projects proposed under Section 3 shall be subject to comparative review.~~



DOCTORS'
HOSPITAL
OF MICHIGAN

461 West Huron St.
Pontiac, MI 48341
Tel: (248) 857-7200
www.dhofm.com

December 15, 2011

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

Dear Certificate of Need Commission:

I am writing this letter to strongly oppose the Bed Need Standard Advisory Committee's (HBSAC) recommendation on a bed reduction methodology. Doctors' Hospital of Michigan is a privately owned hospital facility where dedicated physicians are working diligently to provide for the medical and health care needs of the residents of the Pontiac area.

Doctors' Hospital was created when a group of physicians purchased the 321 bed hospital and other assets of North Oakland Medical Center in November of 2008. Our physicians are determined to keep the hospital operational and growing. We have been in a recovery mode following the bankruptcy by the previous owners. There has been a complete change in leadership and a new plan of action for growth and community service is in place.

As Doctors Hospital recovers and grows, it will be necessary to seek CON approval under the Bed Need Standards for renovations and updates. The proposal before you will drastically diminish our ability to fully utilize the hospital facility that we have purchased. Under the 40% occupancy trigger with only the ability to utilize 60 percent of beds above the previous 3 year occupancy level will leave us with only a 61 bed hospital and a nearly empty building. The formula does not have any scientific basis and is arbitrary.

The few beds that could incrementally be added back to the hospital under the high occupancy standard are not sufficient for our expected future needs. It would require countless CON applications at a cost that is prohibitive.

Doctors Hospital is a purchased asset and under the recommendations of the HBSAC, you would be taking that asset away from us without due process and without due compensation. As a for profit hospital, we pay property taxes to the City of Pontiac. Under the proposal, Doctors' Hospital would be paying property taxes on a building and land that could not be utilized to its full potential. You would also be limiting our ability to hire additional staff during a time when every job is vital to the economic recovery of Michigan.

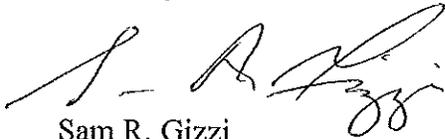
Page 2

December 15, 2011

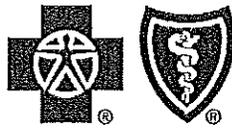
Empty hospital beds are not a cost to healthcare. They are not a liability to the state, to purchasers of health insurance or providers. There is really no economic need for this bed reduction proposal. As a result, I strongly urge the Certificate of Need Commission to vote down the bed reduction proposal. In the alternative, I urge you to exclude for-profit-hospitals as there is a value to the purchased beds.

Your consideration of my request will be greatly appreciated.

Sincerely,

A handwritten signature in cursive script, appearing to read "S. R. Gizzi".

Sam R. Gizzi
President and Chief Executive Officer



Testimony
Blue Cross Blue Shield of Michigan/Blue Care Network
CON Commission Meeting: Proposed Hospital Bed Standards
December 15, 2011

Thank you for the opportunity to provide testimony on behalf of Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN). BCBSM/BCN supports the proposed hospital bed standards which have been submitted for Commission consideration by the Hospital Bed SAC. The proposed standards reflect months of deliberative discussions and ensure that the needs and realities of the health care marketplace in Michigan are the central tenet of the standards.

Hospital Group and Bed Need Methodology

The proposed methodologies developed by the workgroup and approved by the SAC were developed over a period of five months with the participation of multiple stakeholders and the assistance of the MSU Department of Geography. The workgroup focused on the goal of developing objective, replicable, and sustainable standards which could be utilized now and into the future.

The standards developed through the workgroup process accomplish these goals in the following manner:

- The proposed hospital group methodology groups hospitals based on location and utilization patterns. **This methodology will more logically group hospitals than the groupings provided by the existing methodology.**
- The demand for bed need will be based on modeling of trends based on the previous five years of county-wide patient day data. The previous methodology relied on zip-code level data and often inaccurate population projections. **The proposed methodology will capture trends in bed day rates more effectively than the current methodology, will avoid the errors that are encountered when using small data sets, and will require the collection of dramatically less data.**
- According to MSU Geography, which has been contracted to run this data for the Department in previous years, **the methodologies “can be executed within a short time frame, using open-source code, and produces replicable results.”**

When considering the tenets of cost, quality, and access, the proposed methodologies show that the current number of hospitals and hospital beds in the state are more than adequately serving the demands of Michigan's population. When run illustratively for the workgroup using 2009 MIDB data, the proposed methodologies found no areas of hospital bed need in the state and an overall excess of 6,747 hospital beds state-wide. Should patient population and utilization trends change in the future, the methodologies are equipped to reflect such changes.

Hospital Bed Reduction

BCBSM supports the proposals that emerged from the hospital bed reduction work group as a valuable first step in addressing the excess bed capacity in Michigan's hospitals. The proposals



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Detroit, Michigan 48226-2998

adopted by the SAC will limit the financial incentive for hospitals to use large amounts of excess beds as a bargaining tool for their purchase. Additionally, the proposals will promote the development of capital projects that will be more reflective of a hospital's average occupancy, which could provide cost savings in the future. While BCBSM believes that the proposal is a step in the right direction, continued efforts must address excess hospital capacity on a larger scale in order to truly make a more significant impact on excess costs within the health care system.

Conclusion

BCBSM/BCN supports the Hospital Bed Standards recommended by the Hospital Bed SAC to the CON Commission. The thorough review of these standards over the past six months has resulted in significant improvements to the standards that will ensure appropriate hospital access and reflect the health care needs of the state's population for years to come.

12/15/11

Attach
D

Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date: November 10, 2011
TO: Brenda Rogers
FROM: Natalie Kellogg
RE: Summary of Public Hearing Comments on Cardiac Catheterization
(CC) Services Standards and MDCH Policy Staff Analysis

Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the CC Standards at its September 22, 2011 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed CC Standards on November 3, 2011. Written testimony was accepted for an additional 7 days after the hearing via an electronic link on the Commission's website. Testimony was received from six organizations and is summarized as follows:

Steven Szelag, University of Michigan Health System (UMHS)

UMHS strongly supports the proposed revisions of the CC services standards but, would like to provide additional information pertaining to the necessity of a 0.5 inventory adjustment factor for an Operating Room (OR) and CC Lab used in a hybrid configuration. Data shows that the progressive trend for therapy for Cardiovascular Disease (CVD) is using percutaneous endovascular therapy with or without combined open repair. Those cases without combined open repair will require surgical backup and therefore all cases will necessitate a hybrid OR/CCL. UMHS indicates that the estimated case distribution in a typical hybrid OR/CCL is 60% catheter-based, 30% open surgery and 10% true hybrid (*2010 Vascular and Hybrid Suite Benchmarking Survey*). It is based on this finding that UMHS is proposing 0.5 inventory adjustment for both the OR and CCL used in a hybrid configuration.

Robert Meeker, Spectrum Health

Spectrum supports the proposed revisions of the CC services standards, particularly the continued requirement that elective angiography procedures can only be performed at hospitals with open-heart surgery back-up. Maintenance of

requirements that restrict the addition of unneeded angioplasty programs in Michigan is good public policy. There are two provisions of the proposed standards which merit further consideration, specifically 1) requirements for replacement of cardiac catheterization units, and 2) requirements of primary angioplasty programs.

In regards to requirements for replacement, Spectrum contends need for the equipment to be replaced should be demonstrated, and such a requirement could be less than the volume required for initiation, perhaps 50% but substantially greater than zero.

Concerning the requirements for primary angioplasty, the SAC recommended reductions in the initiation requirements for primary angioplasty, both the minimum volume of diagnostic cardiac catheterization procedures actually performed and the volume of primary angioplasty projected at the proposed new site. Spectrum Health recommends adjusting the diagnostic CC requirement to 600 procedure equivalents (which would retain the current requirement of 400 procedures) and maintaining the projected volume of 48 emergency PCI procedures. Another issue the Commission may wish to discuss is the "75% rule," specifically the program section sanctions for providers which perform below 75% of the minimum volume requirements.

Daniel Witt, Metro Health

Metro Health asks that the definition of diagnostic cardiac catheterization procedures be modified to incorporate the right side ablation procedures because the procedure was discussed by the SAC and it was determined that they are safely performed in the Cath Lab setting. The right sided catheter ablation procedures were omitted from the definition when the elective PCI language was removed at the prior Commission meeting.

Patrick O'Donovan, Beaumont Health System

Beaumont supports the CC Standards that were approved for public comment by the Commission at the September 22, 2011 meeting. While Beaumont supports the SAC recommendation to allow (under certain conditions) elective PCI without on-site open heart surgery availability, they do not wish to delay the remaining recommendations. Furthermore Beaumont supports an expedited review of this issue by the Commission at whatever point the ACC guidelines change.

Dennis McCafferty, the Economic Alliance for Michigan (EAM)

EAM, for the most part, supports the proposed changes to the CC standards. EAM feels that the existing 33 sites that are able to perform elective PCI are well distributed across the state, and by concentrating the declining elective PCI volume in fewer sites helps assure higher quality and lower probability that

marginally necessary procedures are being performed. This means lower costs by avoiding capital and staff expense of establishing more elective PCI programs to treat the same population of patients.

EAM did have concerns related specifically to the decrease of annual volume from 48 to 36. The MDCH CON staff does not take corrective action until a provider has dropped below 75% of the CON standards minimum annual volume. The enforceable minimum is now 27, far below the national standards for patient safety. EAM recommends that the Commission consider revisiting this decision, and increase the annual minimum volume for emergency PCI back to 48.

Sallie Flanders, CON Evaluation Section, MDCH

The Standards do not provide clear guidance on how to calculate procedure equivalents when several types of procedures are performed within one session, e.g. diagnostic procedure followed by a therapeutic procedure. Should the provider apply the higher weight (2.7 for adult therapeutic) or does one combine the weights (1.5 for adult diagnostic or 2.7 for adult therapeutic)?

Bart Buxton, Lapeer Regional

Mr. Buxton is concerned that the Commission chose to ignore the CCSACs recommendation and is even more concerned that the Commission chose to pay no heed to the CON process. He states that as an expert appointed to the SAC, the Committee members and the Department spent countless hours putting together industry information on allowing elective PCI without on-site surgical back-up and the impact it would have upon health care communities in Michigan. The Committee deliberated and ultimately recommended that the Commission adopt language providing for elective PCI without open heart back up under clearly articulated safety guidelines outlined and included as an attachment (American College of Cardiology Guidelines for Percutaneous Coronary Intervention published November 9, 2011). Mr. Buxton further states that he plans to raise concerns with the Joint Legislative Review Committee in addition to local legislators.

Karen Kippen, Henry Ford Health System (HFHS)

HFHS supports the CON Standards for CC Services that received initial approval from the Commission on September 22, 2011. HFHS continues to believe that there are additional cost savings and patient care improvements for Michigan that can be achieved by de-linking the angioplasty (PCI) from open heart surgery, but recognize that the discussion will be more productive once guidelines from the American College of Cardiology have been publicly released. Lastly, HFHS fully supports the Commission's decision to reduce the number of procedures required to obtain and maintain primary PCI.

Michigan Department of Community Health (MDCH or Department)
MEMORANDUM
Lansing, MI

Date: November 22, 2011
TO: Brenda Rogers
FROM: Natalie Kellogg
RE: Summary of Public Hearing Comments on Surgical Services (SS)
Standards and MDCH Policy Staff Analysis

Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the SS Standards at its September 22, 2011 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed SS Standards on November 3, 2011. Written testimony was accepted for an additional 7 days after the hearing via an electronic link on the Commission's website. Testimony was received from three organizations and is summarized as follows:

Steven Szelag, University of Michigan Health System (UMHS)

UMHS strongly supports the proposed revisions of the Surgical Services Standards but would like to provide additional information pertaining to the necessity of a 0.5 inventory adjustment factor for an Operating Room (OR) and Cardiac Catheterization Lab (CCL) used in a hybrid configuration. Data shows that the progressive trend for therapy for Cardiovascular Disease (CVD) is using percutaneous endovascular therapy with or without combined open repair. Those cases without combined open repair will require surgical backup and therefore all cases will necessitate a hybrid OR/CCL. UMHS indicates that the estimated case distribution in a typical hybrid OR/CCL is 60% catheter-based, 30% open surgery and 10% true hybrid (*2010 Vascular and Hybrid Suite Benchmarking Survey*.) It is based on this finding that UMHS is proposing 0.5 inventory adjustment for both the OR and CCL used in a hybrid configuration.

Dennis McCafferty, Economic Alliance for Michigan (EAM)

EAM supports the proposed changes to the Surgical Services Standards, including the exemption for emergency room (ER) for trauma care and the new definition for hybrid operating room/cardiac cath labs. EAM also noted with

interest the issues raised by the Vascular Access Centers to be re-classified as ambulatory surgical centers, specifically so they are able to bill an additional facility fee to Medicare, thereby reversing the reduction in Medicare reimbursement. EAM is concerned that the procedures performed within the Vascular Access centers are not considered to be surgical procedures, nor the treatment rooms to be considered operating rooms. EAM is further concerned that if a CON were granted, this would allow an exemption for a non-surgical service. The precedent of using CON standards to address reimbursement reductions by Medicare for a specific type of provider could have far-reaching and unanticipated consequences, and recommends excluding this change in the proposed standards.

Robert Meeker, Spectrum Health

Spectrum Health is supportive of the proposed changes to the Surgical Services standards, particularly the revisions allowing dedicated trauma room and defining hybrid OR/CCLs.

The modification for trauma rooms would allow a trauma center to operate a dedicated trauma OR, without counting either the room or the surgical cases performed therein, in the OR need calculation. Providing the option for a busy trauma center to operate a truly dedicated trauma room acknowledges this loss of capacity and allows for a fully-equipped OR ready for trauma patients at all times.

The proposed revisions for hybrid OR/CCLs provides regulatory acknowledgement of the increasing complexity of contemporary surgical procedures. Procedures and cases previously requiring open surgery are able to be performed using approaches previously employed in cardiac catheterization labs and special radiologic procedure rooms. The proposed changes specify requirements for CON approval for the hybrid room(s) and allows the hospital to count each hybrid OR/CCL as either a surgical procedure or a cath lab procedure, as long as they are not counted more than once. They will also allow major referral centers in Michigan to upgrade their cardiac cath and surgical capabilities with the latest equipment. Furthermore, the proposed provisions will insure that hybrid OR/CCLs are only approved at established centers with CON compliant cardiac cath and open-heart surgery programs.

CERTIFICATE OF NEED
4th Quarter Compliance Report to the CON Commission
 October 1, 2010 through September 30, 2011 (FY 2011)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients as required by Section 22247 of the Public Health Code.

MCL 333.22247

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

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

(a) Revoke or suspend the certificate of need.

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

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

(d) Request enforcement action under section 22253.

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

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

(g) Take any other action as determined appropriate by the department.

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

Activity Report

Follow Up: In accordance with Administrative Rules 325.9403 and 325.9417, the Department tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

Activity	4 th Quarter	Year-to-Date
Approved projects requiring 1-year follow up	90	341
Approved projects contacted on or before anniversary date	61	229
Approved projects completed on or before 1-year follow up	68%	
CON approvals expired due to noncompliance with Part 222	14	80
Total follow up correspondence sent	136	726
Total approved projects still ongoing	364	

Compliance: The Evaluation Section continues to conduct statewide compliance checks based on 2010 annual survey data.

CERTIFICATE OF NEED
4th Quarter Program Activity Report to the CON Commission
 October 1, 2010 through September 30, 2011 (FY 2011)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

Activity	4 th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Letters of Intent Received	94	N/A	441	N/A
Letters of Intent Processed within 15 days	92	98%	438	99%
Letters of Intent Processed Online	94	100%	439	99%

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

Activity	4 th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Applications Received	54	N/A	318	N/A
Applications Processed within 15 Days	52	96%	315	99%
Applications Incomplete/More Information Needed	26	48%	148	46%
Applications Filed Online*	54	100%	269	98%
Application Fees Received Online*	15	28%	69	25%

* Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

Activity	4 th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Nonsubstantive Applications	36	100%	179	100%
Substantive Applications	50	100%	129	100%
Comparative Applications	23	100%	34	100%

Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.

Measures – continued

Administrative Rule R325.9227 requires the Department to determine if an emergency application will be reviewed pursuant to Section 22235 of the Public Health Code within 10 working days upon receipt of the emergency application request.

Activity	4 th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Emergency Applications Received	1	N/A	2	N/A
Decisions Issued within 10 workings Days	1	100%	2	100%

Administrative Rule R325.9413 requires the Department to process amendment requests within the same review period as the original application.

Activity	4 th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Amendments	18	100%	75	98%

Section 22231(10) of the Public Health Code requires the Department to issue a refund of the application fee, upon written request, if the Director exceeds the time set forth in this section for a final decision for other than good cause as determined by the Commission.

Activity	4 th Quarter	Year-to-Date
Refunds Issued Pursuant to Section 22231	0	0

Other Measures

Activity	4 th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
FOIA Requests Received	45	N/A	122	N/A
FOIA Requests Processed on Time	45	100%	122	100%
Number of Applications Viewed Onsite	2	N/A	8	N/A

FOIA – Freedom of Information Act.

CERTIFICATE OF NEED LEGAL ACTION
(12.15.11)

<u>Case Name</u>	<u>Date Opened</u>	<u>Case Description</u>	<u>Status</u>
<p><i>Medilodge of Howell v MDCH and Trilogy— Howell Health Campus</i></p> <p>Livingston County Circuit Court No: 11-25961-AV</p>	04/22/11	Application for Leave to Appeal relating to DCH's decision to remand a comparative review involving nursing home beds.	After the Circuit Court granted DCH's motion to dismiss, Medilodge filed an application for leave to appeal with the Michigan Court of Appeals. The COA has not ruled on the application.
<p><i>Metro Health Hospital – CON Application: 10-1026 MAHS</i></p>	01/07/11	Metro Health requested a hearing relating to DCH's 11/20/10 proposed decision to deny Metro Health's application for open heart surgery services and cardiac and catheterization services.	DCH's Motion for Summary Disposition filed and Metro Health's Response is due by December 15, 2011.
<p><i>Monroe County – Compare Group #95-0216</i></p> <p><u>Includes:</u> <i>Mercy Memorial – CON App # 11-0039 Fountain View – CON App # 11-0018 Medilodge of Monroe – CON App # 11-0030</i></p>	11/14/11	Monroe County – Comparative Review of nursing home beds – Administrative Appeal The three applicants are: (1) Mercy Memorial (denied applicant); (2) Fountain View (denied applicant); (3) Medilodge of Monroe (approved applicant)	Pre-hearing conference held on 11/23/11. Dates for discovery and motions set.

CERTIFICATE OF NEED LEGAL ACTION
(12.15.11)

<u>Case Name</u>	<u>Date Opened</u>	<u>Case Description</u>	<u>Status</u>
<p><i>Oakland County – Compare Group #95-0217</i></p> <p><u>Includes:</u> <i>Medilodge of Oxford – CON App # 11-0045</i> <i>Medilodge of Clarkston – CON App # 11-0043</i> <i>Medilodge of Square Lk – CON App # 11-0041</i> <i>Regency on the Lk – CON App # 11-0033</i> <i>Manor of Farm. Hills – CON App # 11-0024</i> <i>Bloomfield Orchard – CON App # 11-0028</i> <i>Sen. Com. Of Auburn Hills – CON App # 11-0023</i> <i>Sen. Com. Of Prov. Pk. – CON App # 11-0022</i></p>	11/1/11	<p>Oakland County – Comparative Review of nursing home beds – Administrative Appeal</p> <p>The eight applicants are: (1) Medilodge of Oxford (denied applicant); (2) Medilodge of Clarkston (denied applicant); (3) Medilodge of Square Lake (denied applicant); (4) Regency on the Lake (denied applicant); (5) Manor of Farmington Hills (approved applicant); (6) Bloomfield Orchard Villa (approved applicant); (7) Senior Community Of Auburn Hills (approved applicant); (8) Senior Community of Providence Park (approved applicant)</p>	Pre-hearing conference held on 12/1/11. Dates for discovery and motions set.
<p><i>Livingston County – Compare Group #95-0214</i></p> <p><u>Includes:</u> <i>Medilodge of Livingston – CON App # 11-0044</i> <i>Livingston Care Center – CON App # 11-0021</i></p>	11/1/11	<p>Livingston County – Comparative Review of nursing home beds – Administrative Appeal</p> <p>The two applicants are: (1) Medilodge of Livingston (denied applicant); (2) Livingston Care Center (approved applicant)</p>	Pre-hearing conference held on 12/6/11. Dates for discovery and motions set.
<p><i>St. Clair County – Compare Group #95-0219</i></p> <p><u>Includes:</u> <i>Medilodge of St. Clair – CON App # 11-0032</i> <i>Regency on Lk- Ft. Gratiot – CON App # 11-0034</i></p>	11/1/11	<p>St. Clair County – Comparative Review of nursing home beds – Administrative Appeal</p> <p>The two applicants are: (1) Medilodge of St. Clair (denied applicant); (2) Regency on the Lake-Fort Gratiot (approved applicant)</p>	Pre-hearing conference held on 12/13/11. Dates for discovery and motions set.

CERTIFICATE OF NEED LEGAL ACTION
(12.15.11)

<u>Case Name</u>	<u>Date Opened</u>	<u>Case Description</u>	<u>Status</u>
<i>Ausable Valley Continuing Care – CON App # 11-0017</i>	11/19/11	Oscoda County –Administrative Appeal relating to denial of CON application seeking 13 nursing home beds.	Pre-hearing conference is scheduled for 12/20/11.

<u>Case Name</u>	<u>Date Opened</u>	<u>Case Description</u>	<u>Status</u>
<i>Medilodge of Pickney – CON App # 11-0189</i>	11/19/11	Livingston County – Administrative Appeal relating to denial of CON application seeking 56 nursing home beds.	Pre-hearing conference held on 1/12/12. Dates for discovery and motions set.

CON Leg Action; report 12.15.11

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2011												2012											
	J*	F	M*	A	M	J*	J	A	S*	O	N	D*	J*	F	M*	A	M	J*	J	A	S*	O	N	D*
Bone Marrow Transplantation Services										PH			•R											
Cardiac Catheterization Services	■	■	■	■	■	•R—	•	•	—	•	•P	•▲F												
Computed Tomography (CT) Scanner Services	■	•	—	•	•P	•▲		•	•	•	•P	•▲F												
Heart/Lung and Liver Transplantation Services										PH			•R											
Hospital Beds and Addendum for HIV Infected Individuals	•R	•S	•S	•S		■	■	■	■	■	■	•R—	•	•P	•▲F									
Magnetic Resonance Imaging (MRI) Services	•	•	•R	•	•	•R—	•P	•	•▲F	PH•	•	•	•R											
Open Heart Surgery Services	•R	Pending CCSAC							D	•	•	•												
Pancreas Transplantation Services										PH			•R											
Psychiatric Beds and Services										PH			•R											
Surgical Services	•R	•	•	•	•	•	•	•	•R—	•	•P	•▲F												
Renewal of "Guiding Principles for Determining Whether a Clinical Service should Require Certificate of Need (CON) Review"																								
New Medical Technology Standing Committee	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M	•M
Commission & Department Responsibilities			M			M			M			M			M			M			M			M
CON Annual Activity Report FY 2011												•	•	•	•R									

- KEY**
- - Receipt of proposed standards/documents, proposed Commission action
 - * - Commission meeting
 - - Staff work/Standard advisory committee meetings
 - ▲ - Consider Public/Legislative comment
 - ** - Current in-process standard advisory committee or Informal Workgroup
 - - Staff work/Informal Workgroup/Commission Liaison Work/Standing Committee Work
 - A - Commission Action
 - C - Consider proposed action to delete service from list of covered clinical services requiring CON approval
 - D - Discussion
 - F - Final Commission action, Transmittal to Governor/Legislature for 45-day review period
 - M - Monitor service or new technology for changes
 - P - Commission public hearing/Legislative comment period
 - PH - Public Hearing for initial comments on review standards
 - R - Receipt of report
 - S - Solicit nominations for standard advisory committee or standing committee membership

For Approval December 15, 2011

Updated December 7, 2011

The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings, contact the Michigan Department of Community Health, Health Policy & Regulation Administration, CON Policy Section, 7th Floor Capitol View Bldg., 201 Townsend St., Lansing, MI 48913, 517-335-6708, www.michigan.gov/con.

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

Standards	Effective Date	Next Scheduled Update**
Air Ambulance Services	August 12, 2010	2013
Bone Marrow Transplantation Services	December 3, 2010	2012
Cardiac Catheterization Services	February 25, 2008	2014
Computed Tomography (CT) Scanner Services	June 20, 2008	2013
Heart/Lung and Liver Transplantation Services	May 28, 2010	2012
Hospital Beds and Addendum for HIV Infected Individuals	March 2, 2009	2014
Magnetic Resonance Imaging (MRI) Services	November 21, 2011	2012
Megavoltage Radiation Therapy (MRT) Services/Units	November 21, 2011	2014
Neonatal Intensive Care Services/Beds (NICU)	August 12, 2010	2013
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	March 11, 2011	2013
Open Heart Surgery Services	February 25, 2008	2014
Pancreas Transplantation Services	November 5, 2009	2012
Positron Emission Tomography (PET) Scanner Services	November 21, 2011	2014
Psychiatric Beds and Services	November 5, 2009	2012
Surgical Services	June 20, 2008	2014
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	February 25, 2008	2013

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

**A Public Hearing will be held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. If it is determined that changes are necessary, then the standards can be deferred to a standard advisory committee (SAC), workgroup, or the Department for further review and recommendation to the CON Commission. If no changes are determined, then the standards are scheduled for review in another three years.