**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)**
**HOSPITAL BEDS**
**STANDARD ADVISORY COMMITTEE (HBSAC) MEETING**

Thursday, October 26, 2017

South Grand Building
333 S. Grand Ave,
1st Floor, Grand Conference Room
Lansing, MI 48933

**APPROVED MINUTES**

## I. Call to Order

Chairperson Turner-Bailey called the meeting to order at 9:47 a.m.

A. Members Present:

Renee Turner-Bailey, Chairperson
Stephen L. Anderson
T. Anthony Denton (arrived at 9:51 a.m.)
Jeffrey Garber
Richard C. Lindsey, Jr. A
Thomas Mee
Patrick O'Donovan
Jane Schelberg
Shannon D. Striebich (arrived at 10:11 a.m.)

B. Members Absent:

Robert R. Camp, M.D.
Joel S. Clark
Jennifer Groseclose
Margaret Klobucar

C. Michigan Department of Health and Human Services Staff present:

Tulika Bhattacharya
Joette Laseur
Amber Myers
Beth Nagel
Tania Rodriguez
Brenda Rogers

## II. Review of Agenda

Motion by Mr. Garber and seconded by Mr. Mee to accept the agenda as modified moving Charge #2 to Item VII. Motion carried.

## III. Declaration of Conflicts of Interests

No conflicts were declared.

## IV. Review and Approval of September 28, 2017 Minutes

Motion by Mr. O'Donovan and seconded by Mr. Anderson to accept the minutes as presented. Motion carried.

## V. Charge #3 "Review and update, if necessary, the space lease and lease renewal at hospitals"

Chairperson Turner-Bailey provided an update. (See Attachment A)

Discussion followed.

Motion by Mr. Garber, seconded by Mr. O'Donovan to accept the space lease and lease renewal at hospitals language as drafted.

Motion carried in a vote of 9- Yes, 0- No, and 0- Abstained.

## VI. Charge 4 "Review the concept of replacing and relocating inpatient rehabilitation beds and update the standard, if necessary"

Mr. Denton provided a presentation. (See Attachment B)

Discussion followed.

Public Comment

Melissa Cupp, RWC Advocacy

Recessed at 11:25 a.m. & reconvened at 11:42 a.m.

## VII. Charge #2 Review and update, if necessary, the language throughout section 12, titled "Additional requirements for applications included in comparative reviews"

Ms. Striebach provided an update of the subcommittee. (See Attachment C)

Discussion followed.

## VIII. Next Steps

The SAC discussed next steps as follows:

- Charge #4: The subcommittee will continue its review for the next meeting along with draft language.
- Charge #2: The subcommittee will continue its review for the next meeting along with draft language.
- The Department will provide the working draft document to the subcommittees for their use.

## IX. Future Meeting Dates – November 30, 2017; December 14, 2017; & January 11, 2018

## X. Public Comment

None.

## XI. Adjournment

Motion by Mr. Denton and seconded by Mr. Garber to adjourn at 12:29 p.m. Motion Carried.

**MICHIGAN DEPARTMENT OF ~~COMMUNITY~~ HEALTH AND HUMAN SERVICES**

**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 under Part 222 of the Code that involve (a) beginning operation of a new hospital 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 or (d) acquiring a hospital . Pursuant to Part 222 of the Code, a hospital licensed under Part 215 is a covered health facility. 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.

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

(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.

(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.

**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, excluding psychiatric patient days, 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.

(c) "Alcohol and substance abuse hospital" means a licensed hospital within a long-term (acute) care (LTAC) hospital that exclusively provides inpatient medical detoxification and medical stabilization and related outpatient services for persons who have a primary diagnosis of substance dependence covered by DRGs 433 - 437.

(d) "Average adjusted occupancy rate" shall be calculated as follows:

(i) Calculate the number of adjusted patient days during the most recent, consecutive 36-month period, as of the date of the application, for which verifiable data are available to the Department.

(ii) Calculate the total licensed bed days for the same 36-month period as in (i) above by multiplying the total licensed beds by the number of days they were licensed.

(iii) Divide the number of adjusted patient days calculated in (i) above by the total licensed bed days calculated in (ii) above, then multiply the result by 100.

(d) "Base year" means the most recent year that final MIDB data is available to the Department.

(e) "Certificate of Need Commission" or "Commission" means the Commission created pursuant to Section 22211 of the code, being Section 333.22211 of the Michigan Compiled Laws.

(f) "Close a hospital" means an applicant will demonstrate to the satisfaction of the Department that a hospital licensed under Part 215, and whose licensed capacity for the most recent 24 months prior to submission of the application was at least 80 percent for acute care beds, will close and surrender its acute care hospital license upon completion of the proposed project.

(g) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et seq. of the Michigan Compiled Laws.

(h) "Common ownership or control" means a hospital that is owned by, is under common control of, or has a common parent as the applicant hospital.

(i) "Compare group" means the applications that have been grouped for the same type of project in the same hospital group and are being reviewed comparatively in accordance with the CON rules.

(j) "Department" means the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES (MD~~C~~HHS).

(k) "Department inventory of beds" means the current list maintained for each hospital group on a continuing basis by the Department of (i) licensed hospital beds and (ii) hospital beds approved by a valid CON issued under either Part 221 or Part 222 of the Code that are not yet licensed. The term does not include hospital beds certified for long-term-care in hospital long-term care units.

(l) "Disproportionate share hospital payments" means the most recent payments to hospitals in the special pool for non-state government-owned or operated hospitals to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs as calculated by the Medical Services Administration within the Department.

(m) "Excluded hospitals" means hospitals in the following categories:

(i) Critical access hospitals designated by CMS pursuant to 42 CFR 485.606

(ii) Hospitals located in rural or micropolitan statistical area counties

(iii) LTAC and Inpatient Rehabilitation Facility (IRF) hospitals

(iv) Sole community hospitals designated by CMS pursuant to 42 CFR 412.92

(v) Hospitals with 25 or fewer licensed beds

(n) "Existing hospital beds" means, for a specific hospital group, the total of all of the following: (i) hospital beds licensed by the Department of Licensing and Regulatory Affairs (LARA)or its successor; (ii) hospital beds with valid CON approval but not yet licensed; (iii) proposed hospital beds under appeal from a final decision of the Department; and (iv) proposed hospital beds that are part of a completed application under Part 222 (other than the application under review) for which a proposed decision has been issued and which is pending final Department decision.

(o) "Gross hospital revenues" means the hospital's revenues as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(p) "Health service area" or "HSA" means the groups of counties listed in Appendix A.

(q) "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.

(r) "Hospital" means a hospital as defined in Section 20106(5) of the Code being Section 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does not include a hospital or hospital unit licensed or operated by the Department of Mental Health.

(s) "Hospital group" means a cluster or grouping of hospitals based on geographic proximity and hospital utilization patterns. The list of hospital groups and the hospitals assigned to each hospital group will be posted on the State of Michigan CON web site and will be updated pursuant to Section 3.

(t) "Hospital long-term-care unit" or "HLTCU" means a nursing care unit, owned or operated by and as part of a hospital, licensed by the Department, and providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

(u) "Host hospital" means a licensed and operating hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow an LTAC hospital, IRF hospital, or alcohol and substance abuse hospital, to begin operation.

(v) "Inpatient Rehabilitation Facility hospital" or "IRF hospital" means a hospital that has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt Inpatient Rehabilitation Hospital in accordance with 42 CFR Part 412 Subpart P.

(w) "Licensed site" means the location of the facility authorized by license and listed on that licensee's certificate of licensure.

(x) "Limited access area" means those underserved areas with a patient day demand that meets or exceeds the state-wide average of patient days used per 50,000 residents in the base year and as identified in Appendix D. Limited access areas shall be redetermined when a new hospital has been approved or an existing hospital closes.

(y) "Long-term (acute) care hospital" or "LTAC hospital" means a hospital has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital in accordance with 42 CFR Part 412 Subpart O.

(z) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396 to 1396g and 1396i to 1396u.

(aa) "Medicaid volume" means the number of Medicaid recipients served at the hospital as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(bb) "Michigan Inpatient Data Base" or "MIDB" means the data base compiled by the Michigan Health and Hospital Association or successor organization. The data base consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.

(cc) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation in a different hospital group as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation to another geographic site which is in the same hospital group as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.

(dd) "New hospital" means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site that is not in the same hospital group as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one hospital group which are proposed for relocation to another geographic site which is in the same hospital group as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.

(ee) "Obstetrics patient days of care" means inpatient days of care for patients in the applicant's Michigan Inpatient Data Base data ages 15 through 44 with DRGs 370 through 375 (obstetrical discharges).

(ff) "Overbedded hospital group" means a hospital group in which the total number of existing hospital beds in that hospital group exceeds the hospital group needed hospital bed supply.

(gg) "Pediatric patient days of care" means inpatient days of care for patients in the applicant's Michigan Inpatient Data Base data ages 0 through 14 excluding normal newborns.

(hh) "Planning year" means five years beyond the base year for which hospital bed need is developed.

(ii) "Qualifying project" means each application in a comparative group which has been reviewed individually and has been determined by the Department to have satisfied all of the requirements of Section 22225 of the code, being section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code or these Standards.

(jj) "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 group or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.

(kk) "Remaining patient days of care" means total inpatient days of care in the applicant's Michigan Inpatient Data Base data minus obstetrics patient days of care and pediatric patient days of care.

(ll) "RENEWAL OF LEASE" MEANS EXECUTION OF A LEASE BETWEEN THE LICENSEE AND A REAL PROPERTY OWNER IN WHICH THE TOTAL LEASE COSTS EXCEED THE CAPITAL EXPENDITURE THRESHOLD.

(mm) "Replace beds" means a change in the location of the licensed hospital, the replacement of a portion of the licensed beds at the same licensed site, or the one-time replacement of less than 50% of the licensed beds to a new site within 250 yards of the building on the licensed site containing more than 50% of the licensed beds, which may include a new site across a highway(s) or street(s) as defined in MCL 257.20 and excludes a new site across a limited access highway as defined in MCL 257.26. The hospital beds will be in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.) within the replacement zone.

(~~mm~~nn) "Replacement zone" means a proposed licensed site that is (i) in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

(~~nn~~oo) "Uncompensated care volume" means the hospital's uncompensated care volume as stated on the most recent Medicare and Michigan Medicaid forms filed with the Medical Services Administration within the Department.

(~~oo~~pp) "Underserved area" means those geographic areas not within 30 minute drive time of an existing licensed acute care hospital with 24 hour/7 days a week emergency room services utilizing the most direct route using the lowest speed limits posted as defined by the Michigan Department of Transportation (MDOT).

(~~pp~~qq) "Use rate" means the number of days of inpatient care per 1,000 population during a one-year period.

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

**Section 3. Hospital groups**

Sec. 3. Each existing hospital is assigned to a hospital group pursuant to subsection (1).

(1) These hospital groups and the assignments of hospitals to hospital groups shall be updated by the Department every five years or at the direction of the Commission. The methodology described in "New Methodology for Defining Hospital Groups" by Paul l. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 shall be used as follows:

(a) For each hospital, calculate the patient day commitment index (%C – a mathematical computation where the numerator is the number of inpatient hospital days from a specific geographic area provided by a specified hospital and the denominator is the total number of patient days provided by the specified hospital using MIDB data) for all Michigan zip codes using the summed patient days from the most recent three years of MIDB data. Include only those zip codes found in each year of the most recent three years of MIDB data. Arrange observations in an origin-destination table such that each hospital is an origin (row) and each zip code is a destination (column) and include only hospitals with inpatient records in the MIDB.

(b) For each hospital, calculate the road distance to all other hospitals. Arrange observations in an origin-destination table such that each hospital is an origin (row) and each hospital is also a destination (column).

(c) Rescale the road distance origin-destination table by dividing every entry in the road distance origin-destination table by the maximum distance between any two hospitals.

(d) Append the road distance origin-destination table to the %C origin-destination table (by hospital) to create the input data matrix for the clustering algorithm.

(e) Group hospitals into clusters using the k-means clustering algorithm with initial cluster centers provided by a wards hierarchical clustering method. Iterate over all cluster solutions from 2 to the number of hospitals (*n*) minus 1.

(i) For each cluster solution, record the group membership of each hospital, the cluster center location for each of the clusters, the $r^2$ value for the overall cluster solution, the number of single hospital clusters, and the maximum number of hospitals in any cluster.

(ii) "k-means clustering algorithm" means a method for partitioning observations into a user-specified number of groups. It is a standard algorithm with a long history of use in academic and applied research. The approach identifies groups of observations such that the sum of squares from points to the assigned cluster centers is minimized, i.e., observations in a cluster are more similar to one another than they are to other clusters. Several k-means implementations have been proposed; the bed need methodology uses the widely-adopted Hartigan-Wong algorithm. Any clustering or data mining text will discuss k-means; one example is B.S. Everitt, S. Landau, M. Leese, & D. Stahl (2011) Cluster Analysis, 5th Edition. Wiley, 346 p.

(iii) "Wards hierarchical clustering method" means a method for clustering observations into groups. This method uses a binary tree structure to sequentially group data observations into clusters, seeking to minimize overall within-group variance. In the bed need methodology, this method is used to identify the starting cluster locations for k-means. Any clustering text will discuss hierarchical cluster analyis, including Ward's method; one example is: G. Gan, C. Ma, & J. Wu (2007) Data Clustering: Theory, Algorithms, and Applications (Asa-Siam Series on Statistics and Applied Probability). Society for Industrial and Applied Mathematics (Siam), 466 p.

(f) Calculate the incremental F score ($F_{inc}$) for each cluster solution (i) between 3 and $n$-1 letting:

$r^2_i = r^2$ of solution i

$r^2_{i-1} = r^2$ of solution i-1

$k_i$ = number of clusters in solution i

$k_{i-1}$ = number of clusters in solution i-1

$n$ = total number of hospitals

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

(g) Select candidate solutions by finding those with peak values in $f_{inc}$ scores such that $f_{inc,\,i}$ is greater than both $f_{inc,\,i-1}$ and $f_{inc,\,i+1}$.

(h) Remove all candidate solutions in which the largest single cluster contains more than 20 hospitals.

(i) Identify the minimum number of single hospital clusters from the remaining candidate solutions. Remove all candidate solutions containing a greater number of single hospital clusters than the identified minimum.

(j) From the remaining candidate solutions, choose the solution with the largest number of clusters (*k*). This solution (*k* clusters) is the resulting number and configuration of the hospital groups.

(k) Rename hospital groups as follows:

(i) For each hospital group, identify the HSA in which the maximum number of hospitals are located. In case of a tie, use the HSA number that is lower.

(ii) For each hospital group, sum the number of current licensed hospital beds for all hospitals.

(iii) Order the groups from 1 to *k* by first sorting by HSA number, then sorting within each HSA by the sum of beds in each hospital group. The hospital group name is then created by appending number in which it is ordered to "hg" (e.g., hg1, hg2, … hg*k*).

(iv) Hospitals that do not have patient records in the MIDB - identified in subsection (1)(a) - are designated as "ng" for non-groupable hospitals.

(2) For an application involving a proposed new licensed site for a hospital (whether new or replacement), the proposed new licensed site shall be assigned to an existing hospital group utilizing the methodology described in "A Methodology for Defining Hospital Groups" by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) Calculate the road distance from proposed new site (*s*) to all existing hospitals, resulting in a list of *n* observations ($s_n$).

(b) Rescale $s_n$ by dividing each observation by the maximum road distance between any two hospitals identified in subsection (1)(c).

(c) For each hospital group, subset the cluster center location identified in subsection (1)(e)(i) to only the entries corresponding to the road distance between hospitals. For each hospital group, the result is a list of *n* observations that define each hospital group's central location in relative road distance.

(d) Calculate the distance ($d_{K,S}$) between the proposed new site and each existing hospital group

where: $d_{k,s} = \sqrt{\left(HG_{k,1} - s_1\right)^2 + \left(HG_{k,2} - s_2\right)^2 + \left(HG_{k,3} - s_3\right)^2 + ... + \left(HG_{k,n} - s_n\right)^2}$

(e) Assign the proposed new site to the closest hospital group (HG*k*) by selecting the minimum value of $d_{k,s}$.

(f) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (a) – (e) must be repeated until all applicants have been assigned to an existing hospital group.

(3) The Department shall amend the hospital groups to reflect: (a) approved new licensed site(s) assigned to a specific hospital group; (b) hospital closures; and (c) licensure action(s) as appropriate.

(4) As directed by the Commission, new hospital group assignments established according to subsection (1) shall supersede the previous subarea/hospital group assignments and shall be posted on the State of Michigan CON web site effective on the date determined by the Commission.

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

Sec. 4. (1) The determination of the needed hospital bed supply for a hospital group for a planning year shall be made using the MIDB and the methodology detailed in "New Methodology for Determining Needed Hospital Bed Supply" by Paul L. Delamater, Ashton M. Shortridge, and Joseph P. Messina, 2011 as follows:

(a) All hospital discharges for normal newborns (DRG 391 prior to 2008, DRG 795 thereafter) and psychiatric patients (ICD-9-CM codes 290 through 319, see Appendix E for ICD-10-CM Codes, as a principal diagnosis) will be excluded.

(b) For each county, compile the monthly patient days used by county residents for the previous five years (base year plus previous four years). Compile the monthly patient days used by non-Michigan residents in Michigan hospitals for the previous five years as an "out-of-state" unit. The out-of-state patient days unit is considered an additional county thereafter. Patient days are to be assigned to the month in which the patient was discharged. For patient records with an unknown county of residence, assign patient days to the county of the hospital where the patient received service.

(c) For each county, calculate the monthly patient days for all months in the planning year. For each county, construct an ordinary least squares linear regression model using monthly patient days as the dependent variable and months (1-60) as the independent variable. If the linear regression model is significant at a 90% confidence level (F-score, two tailed *p* value $\leq$ 0.1), predict patient days for months 109-120 using the model coefficients. If the linear regression model is not significant at a 90% confidence level (F-score, two tailed *p* value > 0.1), calculate the predicted monthly patient day demand in the planning year by finding the monthly average of the three previous years (months 25-60).

(d) For each county, calculate the predicted yearly patient day demand in the planning year. For counties with a significant regression model, sum the monthly predicted patient days for the planning year. For counties with a non-significant regression model, multiply the three year monthly average by 12.

(e) For each county, calculate the base year patient day commitment index (%c) to each hospital group. Specifically, divide the base year patient days from each county to each hospital group by the total number of base year patient days from each county.

(f) For each county, allocate the planning year patient days to the hospital groups by multiplying the planning year patient days by the %c to each hospital group from subsection (e).

(g) For each hospital group, sum the planning year patient days allocated from each county.

(h) For each hospital group, calculate the average daily census (ADC) for the planning year by dividing the planning year patient days by 365. Round each ADC value up to the nearest whole number.

(i) For each hospital group, select the appropriate occupancy rate from the occupancy table in Appendix C.

(j) For each hospital group, calculate the planning year bed need by dividing the planning year ADC by the appropriate occupancy rate. Round each bed need value up to the nearest whole number.

(2) The determination of the needed hospital bed supply for a limited access area shall be made using the MIDB and the methodology detailed in "A Methodology for Determining Needed Hospital Bed Supply" by Paul L. Delamater, Ashton M. Shortridge, And Joesph P. Messina, 2011 as follows:

(a) All hospital discharges for normal newborns (DRG 391 prior to 2008, DRG 795 thereafter) and psychiatric patients (ICD-9-CM codes 290 through 319, see Appendix E for ICD-10-CM Codes, as a principal diagnosis) will be excluded.

(b) Calculate the average patient day use rate of Michigan residents. Sum total patient days of Michigan residents in the base year and divide by estimated base year population for the state (population data available from US Census Bureau).

(c) Calculate the minimum number of patient days for designation of a limited access area by multiplying the average patient day use rate by 50,000. Round up to the nearest whole number.

(d) Follow steps outlined in Section 4(1)(b) – (d) to predict planning year patient days for each underserved area. Round up to the nearest whole number. The patient days for each underserved area are defined as the sum of the zip codes corresponding to each underserved area.

(e) For each underserved area, compare the planning year patient days to the minimum number of patient days for designation of a limited access area calculated in (c). Any underserved area with a planning year patient day demand greater than or equal to the minimum is designated as a limited access area.

(f) For each limited access area, calculate the planning year bed need using the steps outlined in Section 4(1)(h) – (j). For these steps, use the planning year patient days for each limited access area.

**Section 5. Bed Need**

Sec. 5. (1) The bed-need numbers shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise.

(2) The Department shall re-calculate the acute care bed need methodology in Section 4 every two years, or as directed by the Commission.

(3) The effective date of the bed-need numbers shall be established by the Commission.

(4) New bed-need numbers established by subsections (2) and (3) shall supersede PREVIOUS bed-need numbers and shall be posted on the State Of Michigan CON web site as part of the hospital bed inventory.

(5) Modifications made by the Commission pursuant to this section shall not require standard advisory committee action, a public hearing, or submittal of the standard to the legislature and the governor in order to become effective.

**Section 6. Requirements for approval -- new beds in a hospital**

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

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

(b) The total number of existing hospital beds in the hospital group to which the new beds will be assigned does not currently exceed the needed hospital bed supply. The Department shall determine the hospital group to which the beds will be assigned in accord with Section 3 of these standards.

(c) Approval of the proposed new beds in a hospital shall not result in the total number of existing hospital beds, in the hospital group to which the new beds will be assigned, exceeding the needed hospital bed supply. The Department shall determine the hospital group to which the beds will be assigned in accord with Section 3 of these standards.

(2) An applicant proposing to begin operation as a new LTAC hospital, IRF hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection:

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

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

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

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

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

(A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the LTAC or IRF hospital. In the event that the host hospital applies for a CON to acquire the LTAC or IRF hospital [including the beds leased by the host hospital to the LTAC or IRF hospital] within six months following the termination of the lease with the LTAC or IRF hospital, it shall not be required to be in compliance with the hospital bed supply if the host hospital proposes to add the beds of the LTAC or IRF hospital to the host hospital's medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital);

(B) Delicensure of the hospital beds; or

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

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

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

(e) The new hospital shall be assigned to the same hospital group as the host hospital.

(f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

(g) The lease will not result in an increase in the number of licensed hospital beds in the hospital group.

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

(3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be

in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

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

(i) In the hospital group pursuant to Section 8(2)(a), or

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

(b) Where the source hospital was subject to Section 8(3)(b), the receiving hospital shall have an average adjusted occupancy rate of 40 percent or above.

(c) Where the source hospital was subject to Section 8(3)(b), the addition of the proposed new hospital beds at the receiving hospital shall not exceed the number determined by the following calculation:

(i) As of the date of the application, calculate the adjusted patient days for the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .40.

(ii) Divide the result of subsection (i) by 1095 (or 1096, if the 36-month period includes a leap year) and round up to next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the receiving hospital.

(iii) Subtract the receiving hospital's total number of licensed beds and approved beds from the result of subsection (ii). This is the maximum number of beds that can be added to the receiving hospital.

(d) Where the source hospital was subject to Section 8(3)(b), the receiving hospital's average adjusted occupancy rate must not be less than 40 percent after the addition of the proposed new hospital beds.

(e) Subsection (3)(b), (c), and (d) shall not apply to excluded hospitals.

(f) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

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

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

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

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

(i) Calculate the number of adjusted patient days during the most recent, consecutive 24-month period for which verifiable data are available to the Department.

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

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

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

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

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

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

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

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

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

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

(b) The Department shall assign the proposed new hospital to an existing hospital group based on the current market use patterns of existing hospital groups.

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

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

(e) Applicants proposing to create a new hospital under this subsection shall not be approved, for a period of five years after beginning operation of the facility, of the following covered clinical services: (i) open heart surgery, (ii) therapeutic cardiac catheterization, (iii) fixed positron emission tomography (PET) services, (iv) all transplant services, (v) neonatal intensive care services/beds, and (vi) fixed urinary extracorporeal shock wave lithotripsy (UESWL) services.

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

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

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

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

**Section 7. Requirements for approval to replace beds**

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

(2) The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, to replace a portion of the licensed beds at the existing licensed site, or the one-time replacement of less than 50% of the licensed beds to a new site within 250 yards of the building on the licensed site containing more than 50% of the licensed beds, which may include a new site across a

highway(s) or street(s) as defined in MCL 257.20 and excludes a new site across a limited access highway as defined in MCL 257.26.

(3) The applicant shall demonstrate that the new licensed site is in the replacement zone.

(4) The applicant shall comply with the following requirements, as applicable:
(a) The applicant's hospital shall have an average adjusted occupancy rate of 40 percent or above.
(b) If the applicant hospital does not have an average adjusted occupancy rate of 40 percent or above, then the applicant hospital shall reduce the appropriate number of licensed beds to achieve an average adjusted occupancy rate of 60 percent or above. The applicant hospital shall not exceed the number of beds calculated as follows:
(i) As of the date of the application, calculate the number of adjusted patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.
(ii) Divide the result of subsection (i) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the licensed hospital site after the replacement.
(c) Subsection (4)(a) and (b) shall not apply to excluded hospitals.

(5) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

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

Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(3) of these standards.

(2) Any existing licensed acute care hospital (source hospital) may relocate all or a portion of its beds to another existing licensed acute care hospital as follows:
(a) The licensed acute care hospitals are located within the same hospital group, or
(b) the licensed acute care hospitals are located within the same HSA if the receiving hospital meets the requirements of Section 6(4)(b) of these standards.

(3) The applicant shall comply with the following requirements, as applicable:
(a) The source hospital shall have an average adjusted occupancy rate of 40 percent or above.
(b) If the source hospital does not have an average adjusted occupancy rate of 40 percent or above, then the source hospital shall reduce the appropriate number of licensed beds to achieve an average adjusted occupancy rate of 60 percent or above upon completion of the relocation(s). The source hospital shall not exceed the number of beds calculated as follows:
(i) As of the date of the application, calculate the number of adjusted patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.
(ii) Divide the result of subsection (i) by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the source hospital site after the relocation.
(c) Subsections (3)(a) and (b) shall not apply to excluded hospitals.

(4) A source hospital shall apply for multiple relocations on the same application date, and the applications can be combined to meet the criteria of (3)(b) above. A separate application shall be submitted for each proposed relocation.

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

(6) The relocated beds shall be licensed to the receiving hospital and will be counted in the inventory for the applicable hospital group.

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

(1) 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.
(c) 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.
(d) 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.
(e) The applicant shall provide the Department with timely notice of the proposed project implementation consistent with applicable statute and promulgated rules.

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

**Section 10. Department inventory of beds**

Sec. 10. The Department shall maintain and provide on request a listing of the Department inventory of beds for each hospital group.

**Section 11. Effect on prior planning policies; comparative reviews**

Sec. 11. (1) These CON review standards supersede and replace the CON standards for hospital beds approved by the CON Commission on ~~March 18, 2014~~DECEMBER 11, 2014 and effective ~~June 2, 2014~~MARCH 20, 2015.

(2) Projects reviewed under these standards shall be subject to comparative review except those projects meeting the requirements of Section 7 involving the replacement of beds in a hospital within the replacement zone and projects involving acquisition (including purchase, lease, donation or comparable arrangements) of a hospital.

**Section 12. Additional requirements for applications included in comparative reviews**

Sec. 12. (1) Except for those applications for limited access areas, any application for hospital beds, that is subject to comparative review under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

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

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

| Percentile Ranking | Points Awarded |
|---|---|
| 90.0 – 100 | 25 pts |
| 80.0 – 89.9 | 20 pts |
| 70.0 – 79.9 | 15 pts |
| 60.0 – 69.9 | 10 pts |
| 50.0 – 59.9 | 5 pts |

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

(b) A qualifying project will be awarded points based on the health service area percentile rank of the applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are

located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the department for purposes of calculating disproportionate share hospital payments.

| percentile rank | points awarded |
|---|---|
| 87.5 – 100 | 20 pts |
| 75.0 – 87.4 | 15 pts |
| 62.5 – 74.9 | 10 pts |
| 50.0 – 61.9 | 5 pts |
| less than 50.0 | 0 pts |

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

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

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

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

| Percent | Points Awarded |
|---|---|
| % of market share | % of market share served x 30 (total pts. awarded) |

The source for calculations under this criterion is the MIDB.

**Section 13. Review standards for comparative review of a limited access area**

Sec. 13. (1) Any application subject to comparative review, under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) Each application in a comparative group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code, being Section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these standards. If the Department determines that two or more competing applications satisfy all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws, and which have the highest number of points when the results of subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects, when taken together, that do not exceed the need, as defined in Section 22225(1) in the order in which the applications were received by the Department based on the date and time stamp placed on the application by the Department when the application is filed.

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

| Percentile Ranking | Points Awarded |
|---|---|
| 90.0 – 100 | 25 pts |
| 80.0 – 89.9 | 20 pts |
| 70.0 – 79.9 | 15 pts |
| 60.0 – 69.9 | 10 pts |
| 50.0 – 59.9 | 5 pts |

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

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

| Percentile Rank | Points Awarded |
|---|---|
| 87.5 – 100 | 20 pts |
| 75.0 – 87.4 | 15 pts |
| 62.5 – 74.9 | 10 pts |
| 50.0 – 61.9 | 5 pts |
| Less than 50.0 | 0 pts |

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

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

| Impact on Capacity | Points Awarded |
|---|---|
| Closure of hospital(s) | 15 pts |
| Move beds | 0 pts |
| Adds beds (net) | -15 pts |
| or | |
| Closure of hospital(s) or delicensure of beds which creates a bed need | |
| or | |
| Closure of a hospital which creates a new Limited Access Area | |

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

| Percent | Points Awarded |
|---|---|
| % of market share | % of market share served x 15 (total pts awarded) |

The source for calculations under this criterion is the MIDB.

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

| Percent | Points Awarded |
|---|---|
| % of population within 30 (or 60) minute travel time of proposed site | % of population covered x 15 (total pts awarded) |

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

| Cost Per Bed | Points Awarded |
|---|---|
| Lowest cost | 10 pts |
| 2nd Lowest cost | 5 pts |
| All other applicants | 0 pts |

**Section 14. Requirements for approval -- acquisition of AN EXISTING hospital OR RENEW THE LEASE OF AN EXISTING HOSPITAL**

Sec. 14. AN APPLICANT PROPOSING TO ACQUIRE AN EXISTING HOSPITAL OR RENEW THE LEASE OF AN EXISTING HOSPITAL MUST MEET THE FOLLOWING AS APPLICABLE:

(1) An applicant proposing to acquire a hospital shall not be required to be in compliance with the needed hospital bed supply for the hospital group in which the hospital subject to the proposed acquisition is assigned if the applicant demonstrates that all of the following are met:

(a) the acquisition will not result in a change in bed capacity,

(b) the licensed site does not change as a result of the acquisition,

(c) the project is limited solely to the acquisition of a hospital with a valid license, and

(d) if the application is to acquire a hospital, which was proposed in a prior application to be established as an LTAC or IRF hospital and which received CON approval, the applicant also must meet

the requirements of Section 6(2). Those hospitals that received such prior approval are so identified on the Department inventory of beds.

(2) The applicant shall comply with the following requirements, as applicable:

(a) The existing licensed hospital shall have an average adjusted occupancy rate of 40 percent or above.

(b) If the existing licensed hospital does not have an average adjusted occupancy rate of 40 percent or above, the applicant shall agree to all of the following:

(i) The hospital to be acquired will achieve an annual adjusted occupancy of at least 40% during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition. Annual adjusted occupancy shall be calculated as follows:

(a) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period for which verifiable data is available to the Department.

(b) Divide the number of adjusted patient days calculated in (a) above by 365 (or 366 if a leap year).

(c) If the hospital to be acquired does not achieve an annual adjusted occupancy of at least 40 percent, as calculated in (b) above, during any consecutive 12-month period by the end of the third year of operation after completion of the acquisition, the applicant shall relinquish sufficient beds at the existing hospital to raise its adjusted occupancy to 60 percent. The revised number of licensed beds at the hospital shall be calculated as follows:

(i) Calculate the number of adjusted patient days during the most recent, consecutive 12-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) above by 365 (or 366 if the 12-month period includes a leap year) and round up to the next whole number or 25, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed hospital site after acquisition.

(d) Subsection (2) shall not apply to excluded hospitals OR TO THOSE APPLICANTS APPLYING UNDER SECTION 14(3).

(3) AN APPLICANT PROPOSING TO RENEW THE LEASE FOR AN EXISTING HOSPITAL SHALL NOT BE REQUIRED TO BE IN COMPLIANCE WITH THE NEEDED HOSPITAL BED SUPPLY FOR THE HOSPITAL GROUP IN WHICH THE HOSPITAL IS LOCATED, IF ALL OF THE FOLLOWING REQUIREMENTS ARE MET:

(a) THE LEASE RENEWAL WILL NOT RESULT IN A CHANGE IN BED CAPACITY.

(b) THE LICENSED SITE DOES NOT CHANGE AS A RESULT OF THE LEASE RENEWAL.

(4) SECTION 14(3) DOES NOT APPLY TO RENEWAL OF LEASE FOR LTAC HOSPITAL, IRF HOSPITAL OR ALCOHOL AND SUBSTANCE ABUSE HOSPITAL WITHIN AN EXISTING LICENSED, HOST HOSPITAL UNDER SECTION 6(2).

**Section 15. Requirements for approval – all applicants**

Sec. 15. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

(2) The applicant certifies all outstanding debt obligations owed to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP) have been paid in full.

(3) The applicant certifies that the health facility for the proposed project has not been cited for a state or federal code deficiency within the 12 months prior to the submission of the application. If a state code deficiency has been issued, the applicant shall certify that a plan of correction for cited state deficiencies at the health facility has been submitted and approved by the Bureau of COMMUNITY AND Health Systems within ~~the Department of Licensing and Regulatory Affairs~~LARA. If a federal code deficiency has been issued, the applicant shall certify that a plan of correction for cited federal deficiencies at the health

facility has been submitted and approved by the Centers for Medicare and Medicaid Services. If code deficiencies include any unresolved deficiencies still outstanding with ~~the Department of Licensing and Regulatory Affairs~~LARA or the Centers for Medicare and Medicaid Services that are the basis for the denial, suspension, or revocation of an applicant's health facility license, poses an immediate jeopardy to the health and safety of patients, or meets a federal conditional deficiency level, the proposed project cannot be approved without approval from the Bureau of COMMUNITY AND Health Systems or, if applicable, the Centers for Medicare and Medicaid Services.

(4) THE APPLICANT CERTIFIES THAT THE REQUIREMENTS FOR HOSPITALS FOUND IN THE MINIMUM DESIGN STANDARDS FOR HEALTH CARE FACILITIES OF MICHIGAN, REFERENCED IN SECTION 20145 (6) OF THE PUBLIC HEALTH CODE, ACT 368 OF 1978, AS AMENDED, OR ANY FUTURE VERSIONS, AND ARE PUBLISHED BY THE DEPARTMENT, WILL BE MET WHEN THE ARCHITECTURAL BLUEPRINTS ARE SUBMITTED FOR REVIEW AND APPROVAL BY THE DEPARTMENT.

## APPENDIX A

Counties assigned to each health service area 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 |

Rural Michigan counties are as follows:

| | | |
|---|---|---|
| Alcona | Gogebic | Ogemaw |
| Alger | Huron | Ontonagon |
| Antrim | Iosco | Osceola |
| Arenac | Iron | Oscoda |
| Baraga | Lake | Otsego |
| Charlevoix | Luce | Presque Isle |
| Cheboygan | Mackinac | Roscommon |
| Clare | Manistee | Sanilac |
| Crawford | Montmorency | Schoolcraft |
| Emmet | Newaygo | Tuscola |
| Gladwin | Oceana | |

Micropolitan statistical area Michigan counties are as follows:

| | | |
|---|---|---|
| Allegan | Hillsdale | Mason |
| Alpena | Houghton | Mecosta |
| Benzie | Ionia | Menominee |
| Branch | Isabella | Missaukee |
| Chippewa | Kalkaska | St. Joseph |
| Delta | Keweenaw | Shiawassee |
| Dickinson | Leelanau | Wexford |
| Grand Traverse | Lenawee | |
| Gratiot | Marquette | |

Metropolitan statistical area Michigan counties are as follows:

| | | |
|---|---|---|
| Barry | Jackson | Muskegon |
| Bay | Kalamazoo | Oakland |
| Berrien | Kent | Ottawa |
| Calhoun | Lapeer | Saginaw |
| Cass | Livingston | St. Clair |
| Clinton | Macomb | Van Buren |
| Eaton | Midland | Washtenaw |
| Genesee | Monroe | Wayne |
| Ingham | Montcalm | |

Source:

75 F.R., p. 37245 (June 28, 2010)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

## OCCUPANCY RATE TABLE

| HOSPITAL GROUP PROJECTED BED ADC | | | ADJUSTED BED RANGE | |
|---|---|---|---|---|
| ADC _LOW | ADC_HIGH | OCCUPANCY RATE | BEDS_LOW | BED S_HIGH |
| 30 | 31 | 60% | 50 | 52 |
| 32 | 35 | 61% | 53 | 58 |
| 36 | 39 | 62% | 59 | 53 |
| 40 | 45 | 63% | 64 | 72 |
| 46 | 50 | 64% | 72 | 79 |
| 51 | 58 | 65% | 79 | 90 |
| 59 | 67 | 66% | 90 | 102 |
| 68 | 77 | 67% | 102 | 115 |
| 78 | 88 | 68% | 115 | 130 |
| 89 | 101 | 69% | 129 | 147 |
| 102 | 117 | 70% | 146 | 168 |
| 118 | 134 | 71% | 167 | 189 |
| 135 | 154 | 72% | 188 | 214 |
| 155 | 176 | 73% | 213 | 242 |
| 177 | 204 | 74% | 240 | 276 |
| 205 | 258 | 75% | 274 | 344 |
| 259 | 327 | 76% | 341 | 431 |
| 328 | 424 | 77% | 426 | 551 |
| 425 | 561 | 78% | 545 | 720 |
| 562 | 760 | 79% | 712 | 963 |
| 761 | 895 | 80% | 952 | 1119 |

## LIMITED ACCESS AREAS

Limited access areas and the hospital bed need, effective November 1, 2014, 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)(x) of these standards, and this appendix shall be updated accordingly.

| LIMITED ACCESS AREA | BED NEED | PREDICTED PATIENT DAYS |
|---|---|---|
| 1 Upper Peninsula | 196 | 51,102 |
| 2 West Northern Lower Peninsula | 310 | 84,639 |
| 3 East/Central Northern Lower Peninsula | 127 | 31,383 |

Sources:

1) Michigan State University
   Department of Geography
   Acute Care Hospital Bed Need and Limited Access Areas – 2014 Update
   August 6, 2014

2) Section 4 of these standards

## ICD-9-CM TO ICD-10-CM Code Translation

| ICD-9 CODE | Description | ICD-10 Code | Description |
|---|---|---|---|
| 290 through 319 | Psychiatric Patients | F01.50-F99 | Mental, Behavioral, and Neurodevelopmental Disorders |

"ICD-9-CM Code" means the disease codes and nomenclature found in the International Classification of Diseases - 9th Revision - Clinical Modification, prepared by the Commission on Professional and Hospital Activities for the U.S. National Center for Health Statistics.

"ICD-10-CM Code" means the disease codes and nomenclature found in the International Classification of Diseases - 10th Revision - Clinical Modification, National Center for Health Statistics.

# Inpatient Rehabilitation Facilities & Beds: Proposed CoN Standards Discussion

Hospital Beds CoN Standards Advisory Committee

T. Anthony Denton, Senior Vice-President and COO
University of Michigan Health System

October 26, 2017

# Proposed IRF Principles for CoN Hospital Bed Standards

- Any amendment specific to IRF “should not compromise” the overall integrity of the Hospital Bed Standards.
- Geographic separation of IRF beds would be applicable to only those “organizations approved by Medicare to participate as an exempt Inpatient Rehabilitation Hospital”.
- CoN Standards for Hospital Beds should follow the distinct levels of care per regulatory definition.
- Provide accessible, high quality, acute rehabilitation care in an appropriate setting, responsive to patient needs.

# Sections of CoN Standards Which Would Require Amendments

**Section 2 - Definitions:** New and revised definitions that specifically recognize IRF beds and their distinct level of care separate from acute medical-surgical.

**Section 7 - Requirements for Approval to Replace Beds:** Include Standards that allow for the non-contiguous separation of these two distinct types of beds.

**Section 9 - Project Delivery Requirements:** Additional Compliance Standards must be a part of the proposal to assure that any non-contiguous replacement of IRF Beds ensures that relocated IRF Beds are only used for their intended purpose at the new non-contiguous site.

# Section 2: Definitions

**Existing Definition**: "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.

**Proposed New Definition**: **"Inpatient Rehabilitation Facility bed" or "IRF bed" means a licensed hospital bed within an IRF hospital or unit that has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt Inpatient Rehabilitation Hospital in accordance with 42 CFR Part 412 Subpart P.**

# Section 2: Definitions (continued)

**Existing Definition:** "Replace beds" means a change in the location of the licensed hospital, the replacement of a portion of the licensed beds at the same licensed site, or the one-time replacement of less than 50% of the licensed beds to a new site within 250 yards of the building on the licensed site containing more than 50% of the licensed beds, which may include a new site across a highway(s) or street(s) as defined in MCL 257.20 and excludes a new site across a limited access highway as defined in MCL 257.26. The hospital beds will be in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.) within the replacement zone.

**Proposed New Definition:** **"Replace IRF beds" means a change in the location of all IRF beds from an existing site to a new site within the replacement zone for IRF beds.**

# Section 2: Definitions (continued)

**Revised Definition:** "Replacement zone" means a proposed licensed site that is (i) in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles **(5 miles for IRF beds)** of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles **(10 miles for IRF beds)** of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

# Section 7: Requirements for Approval to Replace Beds

**Existing Standard:** If the application involves the development of a new licensed site, an applicant proposing to replace beds in a hospital within the replacement zone shall demonstrate that the new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 25 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

**Equivalent Standard for Inpatient Rehabilitation Facilities on the following slide.**

# Section 7: Requirements for Approval to Replace Beds (continued)

**Proposed New Standard**: If the application involves the development of a new licensed IRF hospital site, an applicant proposing to replace IRF beds within the replacement zone shall demonstrate that it meets or agrees to all of the requirements of this subsection:

a. The new IRF hospital will have at least 40 IRF beds.

b. The applicant has demonstrated, at the time of the CON filing, it is operating under high occupancy as governed by Section 6(4) of these standards.

c. The proposed site has at least three approved and operational CON covered services. (options to consider)

   1. Leave subsection as drafted

   2. Identify specific covered services

# Section 7: Requirements for Approval to Replace Beds (continued)

d. If the IRF hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as an IRF hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as an IRF hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically.

e. The proposed project to begin operation of a new site, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

# Section 7: Requirements for Approval to Replace Beds (continued)

f. The new IRF hospital shall be assigned to the same hospital group as the hospital where the IRF beds originated.

g. The hospital where the IRF beds originated shall delicense the same number of hospital beds proposed by the applicant for licensure in the new IRF hospital.

h. Applicants proposing a new IRF hospital under this subsection shall not be subject to comparative review.

i. If the IRF hospital ceases operation…

**Please refer to the following slide for subcommittee recommendations.**

# Section 7(i)
# Subcommittee Recommendation

The subcommittee believes that if the relocated IRF beds will no longer be used for IRF beds at the new site (either because the System goes out of the IRF business, the IRF designation is lost, there is a natural disaster that makes the site unusable, etc) the system should be able to either move the entire rehab unit to another site or return the beds to the original site as either med surg beds or IRF beds.

If the IRF beds will be used as IRF beds at a new site or at the "mother ship," the system should be able to move all of the beds being used as IRF bed including the number of beds replaced and any additional beds acquired due to high occupancy, or.

If the IRF beds will be moved back to the "mother ship" as med surg beds, the system should only be able to move the number of beds replaced and any additional beds that were acquired due to high occupancy would be de-licensed.

If the SAC approves of these concepts, the subcommittee will work with the Department to properly draft the language.

# Section 7: Requirements for Approval to Replace Beds (continued)

**Proposed Standard Revision:** The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, **the replacement of all of the licensed IRF beds to a new site**, to replace a portion of the licensed beds at the existing licensed site, or the one-time replacement of less than 50% of the licensed beds to a new site within 250 yards of the building on the licensed site containing more than 50% of the licensed beds, which may include a new site across a highway(s) or street(s) as defined in MCL 257.20 and excludes a new site across a limited access highway as defined in MCL 257.26.

# Section 9: Project Delivery Requirements Terms of Approval for All Applicants

**Proposed New Project Delivery Requirement: (6) An applicant approved for the replacement of IRF beds to a new site shall be in compliance with the following:**

(a) **The replaced IRF beds shall maintain their PPS exempt Inpatient Rehabilitation Hospital status.**

# Discussion

# C.O.N. Review Standards for Hospital Beds
# Comparative Review Criteria (Section 12)
# Discussion Document
# October 26, 2017

Attachment C

| Category | Metric | Description | Existing/ Proposed | Preliminary Recommendation | Current Weight (Max Pts) |
|---|---|---|---|---|---|
| Access | Uncompensated care volume | Uncompensated care as % of gross hospital revenues | Existing | Delete- Covered by Medicaid criterion (below) | 25 pts |
| Access | Medicaid volume | Medicaid as % of gross hospital revenues | Existing | Keep | 20 pts |
| Cost | Hospital closure | Applicant closes hosp. & doesn't create bed need anywhere else | Existing | Keep | 25 pts |
| Access | Market share | Applicant current mkt share in service area | Existing | Keep | 30 pts |
| Cost | Cost per bed | Total project costs divided by beds | Proposed (but in LAA (sec. 13) | Add | TBD (10 in LAA) |
| Quality | CMS Star ratings via Hospital Compare | Hospitals rated 1-5 stars by CMS (64 quality measures) | Proposed | Add | TBD |

# Review of Comparative Review Section for Hospital Beds

- Subcommittee reviewed and had several discussions regarding current language and methodology of comparative review for hospital beds
- Items for review today:
  - Plus/delta of current language
  - Recommendations for review and feedback
    - Review of suggestion for Quality metric
- Note: Likelihood of a comparative review occurring for hospital beds is fairly slim given over-bedded status of the State of Michigan

# Highlights: Assessment of Current Comparative Review

- Issues of cost and access are addressed
- MIDB data is still relevant for comparative purpose as a proxy for inpatient market share

- Quality is not addressed
- Utilizing both Medicaid and uncompensated care as proxy for access may be duplicative
- Cost per bed not addressed (but is addressed elsewhere in CON)
- Weights of each section may need to be addressed

# C.O.N. Review Standards for Hospital Beds
# Comparative Review Criteria (Section 12)
# Discussion Document
# October 26, 2017

Attachment C

| Category | Metric | Description | Existing/ Proposed | Preliminary Recommendation | Current Weight (Max Pts) |
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| Access | Medicaid volume | Medicaid as % of gross hospital revenues | Existing | Keep | 20 pts |
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| Access | Market share | Applicant current mkt share in service area | Existing | Keep | 30 pts |
| Cost | Cost per bed | Total project costs divided by beds | Proposed (but in LAA (sec. 13) | Add | TBD (10 in LAA) |
| Quality | CMS Star ratings via Hospital Compare | Hospitals rated 1-5 stars by CMS (64 quality measures) | Proposed | Add | TBD |

# CMS' Overall Hospital Quality Star Rating

# Background

- The Overall Hospital Quality Star Rating System was developed to: Provide consumers with information about multiple dimensions of quality in a single score
- Provide a methodology for generating a summary Five-Star rating for each hospital using existing measures on *Hospital Compare*
- The Overall Hospital Quality Star Ratings is a separate star ratings system distinct from the HCAHPS star rating.
- The Star Ratings does not replace reporting of any individual quality measures

Note:
- CMS uses the Star ratings in other programs (i.e. Dialysis Facilities, Nursing Homes, & Home Health.
- CMS unveiled the Overall Hospital Quality Rating on its Hospital Compare website in 2016

# Measures included in the Star Rating

as of Oct 2017

- 7 measure groups
- 57 measures*

| Measure Group | Number of Measures | Measure Group Weight |
|---|---|---|
| Mortality | 7 | 22.0% |
| Readmission | 8 | 22.0% |
| Safety of Care | 8 | 22.0% |
| Patient Experience | 11 | 22.0% |
| Efficient Use of Medical Imaging | 5 | 4.0% |
| Timeliness of Care | 7 | 4.0% |
| Effectiveness of Care | 11 | 4.0% |

*Number of measures varies over time

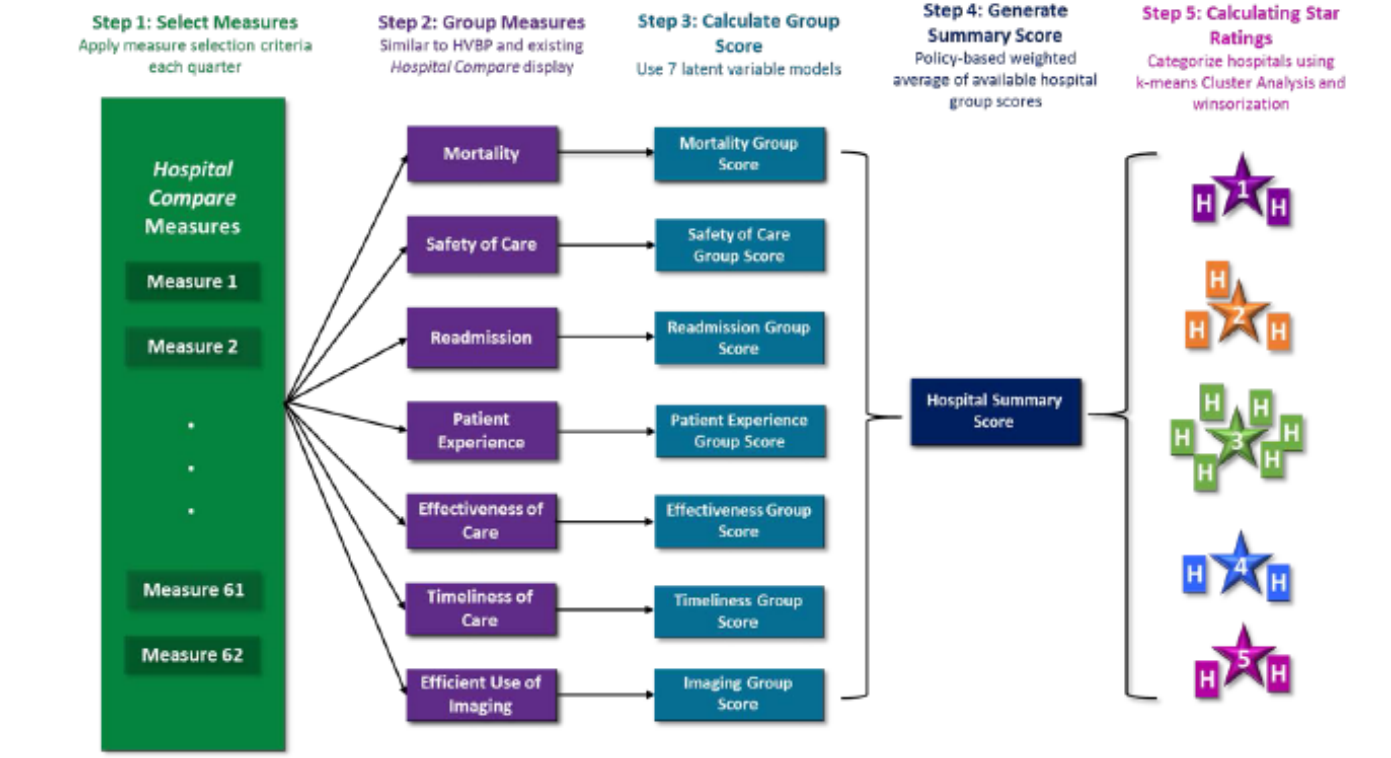
# Star Rating Methodology

# Star Rating
## Methodology

- Developed by Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) under contract to CMS.
- 5 Star rating

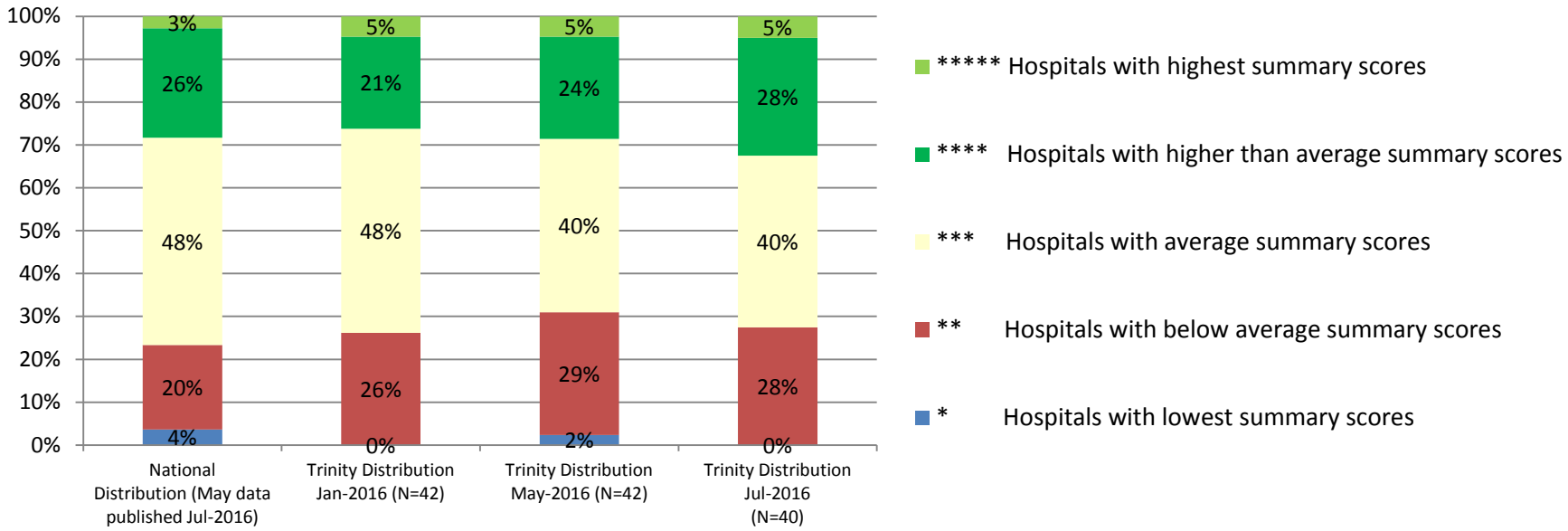
| Star | Description |
|---|---|
| ★★★★★ | Cluster of hospitals with the highest summary scores |
| ★★★★ | Cluster of hospitals with higher than average summary scores |
| ★★★ | Cluster of hospitals with average summary scores |
| ★★ | Cluster of hospitals with below average summary scores |
| ★ | Cluster of hospitals with lowest summary scores |

# Star Ratings Calculation Steps



# Distribution - Hospital Quality Star Ratings

National distribution as reported by CMS based on May-2016 data published to Hospital Compare Jul-2016



# Discussion

- Reaction/feedback regarding:
  - Elimination of uncompensated care metric?
  - Addition of a metric to compare Quality?
    - CMS star rating
    - Others to consider?
  - Addition of cost per bed?
- Additional feedback for consideration

# Appendix/Additional Information

# Methodology

The methodology takes a five-step approach to calculating the Star Ratings

1. Measures are selected based on their relevance and importance and then standardized
2. Measures are then organized into seven groups
3. For each group a latent variable model is used to estimate a group score for each hospital reporting measures in that group.
4. Calculation of hospital summary scores as a weighted average of group scores
5. Application of clustering algorithm to categorize summary scores into Star Ratings

In addition to the Star Ratings, CMS also organizes hospitals into one of three group performance categories (above, same as, and below the national average)

# Methodology

## Calculation of Latent Variable Model (LVM) Group Scores

CMS uses LVM to estimate a group score

LVM is a statistical model that assumes each measure reflects information about an underlying, unobserved dimension of quality

LVM accounts for the relationship (correlation) between measures for a single hospital

- Measures that are more consistent with each other and measures that have larger denominators have a greater influence on the latent variable
- Each model estimates, for each hospital, the value of a single latent variable representing the underlying dimension of quality; this estimate is the hospital's group score

# FAQ

**Q. How often will CMS update the Overall Hospital Quality Star Rating?**

**A.** CMS updates the overall rating with each quarterly refresh of *Hospital Compare* data. The frequency of updates may change in the future. We welcome feedback and input on the update frequency

# Latest from CMS

## CMS will not update Hospital Compare Star Ratings Data in October 2017

**September 29, 2017**

The Centers for Medicare & Medicaid Services (CMS) will not update the Overall Hospital Quality Star Ratings for October 2017, as previously scheduled. CMS decided not to proceed with the October update to continue its examination of potential changes to the Star Rating methodology based on public feedback. As part of this process, CMS sought feedback from a multi-disciplinary Technical Expert Panel and a Provider Leadership Workgroup. CMS is also seeking feedback via an ongoing Public Comment Period.

Hospitals should know:

- CMS will not publish the data from the October Star Ratings Preview Reports on *Hospital Compare*.
- CMS will post the next SAS Pack with the December 2017 *Hospital Compare* release.
- Star Ratings released in December 2016 will remain on *Hospital Compare* until the next update.

AHANEWS

American Hospital Association

## CMS releases hospital star ratings

*AHA News*
Jul 27, 2016

Over the strong objections of the hospital field, the Centers for Medicare & Medicaid Services (CMS) today released its new star ratings for hospitals on the *Hospital Compare* website.

"The new CMS star ratings program is confusing for patients and families trying to choose the best hospital to meet their health care needs," said AHA President and CEO Rick Pollack. "Health care consumers making critical decisions about their care cannot be expected to rely on a rating system that raises far more questions than answers. And it adds yet another to a long list of conflicting rating and ranking systems … We want to work with CMS and the Congress to fix the hospital star ratings so that it is helpful and useful to both patients and the hospitals that treat them."

The star ratings, released for more than 3,500 hospitals, came after a three-month delay due to concerns raised by hospitals and members of Congress about the program and methodology used. The ratings are based on more than 64 quality measurements. The grading system gives hospitals a rating of one to five stars.

Reps. Jim Renacci, R-Ohio, and Kathleen Rice, D-N.Y., July 25 introduced a bill to delay for at least one year the introduction of the Centers for Medicare & Medicaid Services' (CMS) new hospital star ratings to ensure the ratings are fair and reliable.

The Hospital Quality Rating Transparency Act would delay the release of the hospital star ratings until no earlier than July 31, 2017 and require CMS to accept comments for 60 days on its methodology and the data used. In addition, it asks that the methodology and data be validated by a third party.

The bill also would require the agency to remove the star ratings from the Hospital Compare website if they are posted prior to the bill's enactment.

"Patients need clear, meaningful information to make important health care decisions," said AHA Executive Vice President Tom Nickels in support of the legislation. "We continue to urge CMS to work with hospitals and health systems to provide patients with a rating system that accurately reflects the quality of care provided at their facilities, and will work with Reps. Renacci and Rice to move this legislation forward."

On July 22, CMS released data on the national distribution of overall hospital quality star ratings and by hospital characteristics, including bed size, teaching status, safety-net status, eligibility for Disproportionate Share Hospital payments and critical access hospital status.

Earlier this month, the AHA, Association of American Medical Colleges, America's Essential Hospitals, and Federation of American Hospitals urged CMS to share additional information with hospitals and the public about how accurately its overall hospital quality star ratings portray hospital performance, and to work with hospitals to validate the methodology or continue to withhold publication of the ratings.

A bipartisan group of House and Senate lawmakers have weighed in with the agency as well. In recent letters to CMS, 225 representatives and 60 senators urged CMS to delay the release of the ratings "to provide the necessary time to more closely examine the star rating methodology, analyze its impact on different types of hospitals, and provide more transparent information regarding the calculation of the ratings to determine accuracy."

A recent analysis by an expert in econometrics found several shortcomings in CMS's approach to the ratings.

"The data continues to raise questions and concerns, as it may unfairly penalize teaching hospitals and those serving the poor," said Ashley Thompson, the AHA's senior vice president for public policy analysis and development.

PDF

AHA News 7-27-16