MICHIGAN DEPARTMENT OF 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 or comparative review group" means the applications, other than applications applying under Section 6(5), 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. For applications applying under Section 6(5), compare group or comparative review group means applications that have been grouped for the same type of project and are proposing sites within a 60-minute travel time and are being reviewed comparatively in accordance with the CON rules.

(j) "Department" means the Michigan Department of Health and Human Services (MDHHS).

(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) "Geographically underserved area" means those geographic areas that are more than 30-minutes drive time from an existing licensed acute care hospital with 24 hour/7 days a week emergency room services using Esri's online network analyst services (or a comparable source).

(p) "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.

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

(r) "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.

(s) "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.

(t) "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.

(u) "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.

(v) "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.

(w) “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.

(x) “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.

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

(z) "Limited access area" or “LAA” means a potential hospital location both with a bed need of 10 beds or more and an underserved population percent of 50% or more, as identified on the state of Michigan CON web site. Limited access areas shall be redetermined in the following circumstances:

(i) each time the bed need methodology is redetermined,

(ii) when a new hospital has been approved, or

(iii) when an existing hospital closes.

(aa) "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.

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

(cc) "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.

(dd) "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.

(ee) "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.

(ff) "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.

(gg) "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).

(hh) "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.

(ii) "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.

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

(kk) “Potential hospital location” means a 1km hexagon region. The center point of which is located both in a geographically underserved area and on land (not water).

(ll) "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.

(mm) "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.

(nn) "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.

(oo) “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.

(pp) "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.

(qq) “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.

(rr) "Replacement zone" means a proposed licensed site that (i) is in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards and is 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 or (ii) qualifies as an enhanced replacement zone.

(ss) "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.

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

(uu) “Verifiable data” means data (patient days) from the most recent annual survey or more recent data that can be validated by the Department.

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

(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 hospital bed need and limited access areas

Sec. 4. (1) The determination of the hospital bed need 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 D 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 limited access areas and their hospital bed need shall be made using the methodology detailed in "A Methodology for Determining Limited Access Areas" by Paul L. Delamater, 2021, which methodology is summarized as follows:

(a) Calculate the average yearly patient day use rate of Michigan residents in the base year as follows:

(i) Sum all patient days from all hospital discharges for Michigan residents in the base year, excluding 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 D for ICD-10-CM Codes, as a principal diagnosis).

(ii) Acquire the estimated Michigan population in the base year from the US Census Bureau.

(iii) Divide the summed patient days calculated in (i) by the estimated Michigan population acquired in (ii) to calculate the average yearly patient day use rate.

(b) Identify geographically underserved areas as follows:

(i) Using Esri's online network analyst services (or a comparable source), create 30-minute drive time service areas around each existing licensed acute care hospital with 24 hour/7 days a week emergency room services.

(ii) Identify regions greater than a 30-minute drive from the nearest existing hospital by removing the 30-minute service areas from the state geographic footprint. The remaining regions are the geographically underserved areas.

(c) Identify potential hospital locations as follows:

(i) Create a hexagon tessellation over the entire state with 1km distance between the center point of every hexagon.

(ii) Subset the hexagons to include only those hexagons with a center point that is located within a geographically underserved area and on land. For purposes of this subsection, on land means those US Census block groups that are not 100% covered by water. The set of remaining hexagons are the potential hospital locations.

(d) For each potential hospital location, calculate the bed need and the underserved population percent as follows:

(i) Using Esri's online network analyst services (or a comparable source), create a 30-minute drive time service area around the hexagon center point.

(ii) Identify the number of people residing within the 30-minute service area using US Census block centroids with updated population information.

(iii) Assign each population as currently underserved or currently served by geographically overlaying the US Census block centroids (with updated population information) used in (ii) with the geographically

underserved areas identified in (b). Sum the number of people in both groups to determine the total population.

(iv) Multiply the underserved population total by the average yearly patient day use rate of Michigan residents in the base year as calculated in Section 4(2)(a) to calculate the expected number of yearly patient days. Follow the steps in Section 4(1)(h) – (j) to calculate the bed need for the hospital location.

(v) Divide the underserved population total by the total population as determined in (iii), and multiply by 100 to calculate the underserved population percent.

(e) Remove all potential hospital locations with a bed need of less than 10 beds or with an underserved population percent of less than 50%. The remaining potential hospital locations are the limited access areas.

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 or are being replaced to a new IRF hospital site being created under Section 7(6) as part of the same CON application.

(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.

(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, surgical services, and licensed acute care beds.

(b) The Department shall assign the proposed new hospital to an existing hospital group using the methodology in Section 3(2).

(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 in Section 4(2)(d)(iv) and as set forth on the State of Michigan CON web site.

(d) 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.

(e) 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.

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 all 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.

(3) The applicant shall demonstrate that the new licensed site is in the replacement zone or in the enhanced replacement zone. To qualify as an enhanced replacement zone, the following requirements shall be met:

(a) The existing licensed site shall:

(i) be located in a county with a population of 200,000 or less, and

(ii) be the only licensed hospital site in that county that reported providing emergency services on the most recent CON Annual Survey as of the date of the application; and

(b) the proposed licensed site shall:

(i) be in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards,

(ii) be on a site within 10 miles of the existing licensed site,

(iii) be on a site within the same county as the existing licensed site or in an adjacent county that does not currently have a licensed hospital site that offers emergency services, and

(iv) be on a site 10 or more miles from all other licensed hospital sites that offer emergency services.

(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.

(6) 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 all of the requirements of this subsection:

(a) The new license created by the proposed project shall only be utilized for inpatient rehabilitation beds.

(b) The applicant hospital 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 applicant has demonstrated, at the time of CON filing, that the beds to be replaced are either IRF beds that meet the Title XVIII requirements of the Social Security Act for exemption from PPS as an IRF hospital, or high occupancy beds being requested under Section 6(4) as part of the same CON application.

(d) The new IRF hospital will have at least 40 IRF beds if located in a county with a population of 200,000 or more; or at least 25 IRF beds if located in a county with a population of less than 200,000.

(e) As part of the phasing of the replacement of IRF beds to the new site, the applicant may retain, for 36-months from the time of activation of the new site, up to eight IRF beds at the existing hospital site. Any IRF beds at the existing site that have not been transitioned to the new site within the 36-month time period shall not be utilized for inpatient rehabilitation and shall revert back to acute medical-surgical hospital beds.

(f) 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.

(g) The existing hospital site shall delicense the same number of IRF 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) The new IRF hospital shall be assigned to the same hospital group as the hospital where the IRF beds originated.

(j) If the IRF hospital approved under this subsection ceases operation as an IRF hospital, the beds licensed as part of the new IRF hospital must be disposed of by one of the following means:

(i) relocate the replaced IRF beds back to the site of origin;

(ii) relocate all IRF beds approved under high occupancy to the site of origin in subsection (i) if they are to be utilized as an IRF bed; or

(iii) delicense any IRF beds approved under high occupancy if they are not to be utilized as an IRF bed.

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) An applicant approved for the replacement of IRF beds under Section 7(6) to a new non-contiguous site shall be in compliance with the following:

(a) The replaced IRF beds shall maintain their PPS exempt inpatient rehabilitation hospital status.

(b) The new license created by the proposed project will only be utilized for inpatient rehabilitation beds.

(6) An applicant approved pursuant to Section 6(5) shall not exceed the number of approved beds unless it also receives approval under sections 6(3) or 6(4).

(7) 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 June 14, 2018 and effective November 28, 2018.

(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) 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 same type of applications (limited access area or non-limited access area) 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 applicant's CMS Star Ratings via Hospital Compare as of the date of application as follows:

A qualifying project will be awarded points based on the applicant's quality of care as measured by the overall Star Ratings available through CMS' Hospital Compare. For purposes of evaluating this criterion, an average shall be calculated based on the overall Star Ratings of the applicant and 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. Applicants shall be ranked in order according to this calculated overall Star Rating average.

STAR RATING	POINTS AWARDED
Applicant with highest average star rating	20 points
All other applicants	Applicant's average Star Rating divided by the highest applicant's Star Rating, then multiplied by 15
Example: The highest applicant has an average Star Rating of 3.4	20 points
Applicant with Star Rating of 3.1	(3.1 ÷ 3.4) x 15 = 13.7 is 14 points
Applicant with Star Rating of 3.0	(3.0 ÷ 3.4) x 15 = 13.2 is 13 points

For purposes of evaluating this criterion, applicants shall submit the overall CMS Star Rating available at the time of the submission of the CON application for the applicant and each currently licensed hospital under common ownership or control located in the same health service area as the proposed hospital beds. 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. Star Ratings shall be rounded to the nearest 1/10, and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(b) A qualifying project will be awarded points based on the ranking of the applicant's uninsured days as measured as a percentage of total days as set forth in the following table. The applicant's uninsured percentage will be the cumulative of all uninsured inpatient med/surg and uninsured inpatient rehab days divided by the cumulative of all inpatient med/surg and inpatient rehab days at 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. For purposes of evaluating this criterion, an applicant shall submit the most recent reviewed and accepted Medicaid Cost Report for each currently licensed hospital under common ownership or control within the same health service area. If a hospital under common ownership or control with the applicant has not filed a MEDICAID Cost Report, then the related applicant shall receive a score of zero.

UNINSURED DAYS	POINTS AWARDED
Applicant with highest percent of uninsured days	10 points
All other applicants	Applicant's percent of uninsured days divided by the highest applicant's percent of uninsured days, then multiplied by 7
Example: The highest applicant has 5.3% uninsured days	10 points
Applicant with 5.0% days	(5.0 ÷ 5.3) x 7 = 6.6 is 7 points
Applicant with 3.0% days	(3.0 ÷ 5.3) x 7 = 4.0 is 4 points

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. Percentages of days shall be rounded to the nearest 1/10 (e.g. 5.3%), and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(c) A qualifying project will be awarded points based on the ranking of the applicant's Medicaid days as measured as a percentage of total days as set forth in the following table. For purposes of scoring, the applicant's Medicaid percentage will be the cumulative of all Title XIX and Healthy Michigan inpatient med/surg and inpatient rehab days divided by the cumulative of all inpatient med/surg and inpatient rehab days at 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. For purposes of evaluating this criterion, an applicant shall submit the most recent reviewed and accepted Medicaid Cost Report for each currently licensed hospital under common ownership or control within the same health service area. If a hospital under common ownership or control with the applicant has not filed a MEDICAID Cost Report, then the related applicant shall receive a score of zero.

MEDICAID DAYS	POINTS AWARDED
Applicant with highest percent of Medicaid days	20 points
All other applicants	Applicant's percent of Medicaid days divided by the highest applicant's percent of Medicaid days, then multiplied by 15
Example: the highest applicant has 15.3% Medicaid days	20 points
Applicant with 15.0% days	(15.0 ÷ 15.3) x 15 = 14.7 is 15 points
Applicant with 12.2% days	(12.2 ÷ 15.3) x 15 = 12.0 is 12 points

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. Percentages of days shall be rounded to the nearest 1/10 (e.g. 5.3%), and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(d) 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)	15 pts
Closure of hospital(s) which creates a bed need	5 pts

(e) A qualifying project will be awarded points based on the applicant's total project costs per hospital bed. For purposes of this criterion, total project costs shall be defined as the total costs for construction and renovation, site work, architectural/engineering and consulting fees, contingencies, fixed equipment, construction management and permits. The proposed project must include space for inpatient care, and, if not already available at the proposed site, space to provide 24 hour/7 days a week surgical, emergency and imaging services. Points shall be awarded in accordance with the table below:

COST PER BED	POINTS AWARDED
Applicant with lowest cost per bed	15 points
All other applicants	The lowest cost per bed in the compare group divided by the applicant's cost per bed, then multiplied by 10
Example: the lowest cost applicant has $698,000 per bed	15 points
Applicant with $710,000 per bed	($698,000 ÷ 710,000) x 10 = 9.8 is 10 points
Applicant with $975,000 per bed	($698,000 ÷ 975,000) x 10 = 7.2 is 7 points

Points shall not be awarded under this section for any project that proposes to add beds at a leased facility. Costs shall be rounded to the nearest whole dollar, and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(f) A qualifying project will be awarded points based on the percentage of the applicant's historical market share of inpatient days 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 of the market area's patient days served by the applicant and all currently licensed Michigan hospitals under common ownership and control divided by the market area's total patient days for the 12-month period most recently available through the Michigan inpatient database.

MARKET SHARE	POINTS AWARDED
Applicant with highest market share	10 pts
All other applicants	Applicant's market share divided by the highest applicant's market share in the compare group, then multiplied by 7
Example: the highest applicant has 22.5% of population	10 points
Applicant with 20.0% market share	(20.0 ÷ 22.5) x 7 = 6.2 is 6 points
Applicant with 15.6% market share	(15.6 ÷ 22.5) x 7 = 4.9 is 5 points

For purposes of evaluating this criterion, an applicant shall submit patient days by zip code for each currently licensed Michigan hospital under common ownership or control using the most recent 12-months of data available through the MIDB at the time of the submission of the CON application. 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. Market share percentages shall be rounded to the nearest 1/10 (e.g. 5.3%), and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(4) If the comparative review group involves limited access area(s), each qualifying project will be awarded points based on the bed need of each applicant's chosen limited access area. The applicant proposing to locate a hospital in a limited access area with the highest bed need shall receive 10 points. All other applicants shall receive points as set forth in the following table.

BED NEED	POINTS AWARDED
Applicant in LAA with highest bed need	10 pts
All other applicants	Bed need of the applicant's project divided by the bed need of the applicant with the highest bed need, then multiplied by 10
Example: The highest applicant proposes project in LAA allowing 22 beds	10 points
Applicant proposes project in LAA allowing 15 beds	(15 ÷ 22) x 10 = 6.8 is 7 points
Applicant proposes project in LAA allowing 10 beds	(10 ÷ 22) x 10 = 4.5 is 5 points

Points shall be rounded to the nearest whole number.

Section 13. Requirements for approval -- acquisition of an existing hospital or renew the lease of an existing hospital

Sec. 13. 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 13(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 13(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 14. Requirements for approval – all applicants

Sec. 14. (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 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 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 LARA, will be met when the architectural blueprints are submitted for review and approval by LARA.

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

APPENDIX B

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

APPENDIX C

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

APPENDIX D

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.