HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Tuesday, July 18, 2006

Capitol View Building
201 Townsend Street
MDCH Conference Room B/C
Lansing, MI 48913

APPROVED MINUTES

I. Call to Order.

Chairperson Ball called the meeting to order at 9:10 a.m.

a. Members Present and Organizations Represented:

Robert Asmussen, St. John Health System (arrived at 9:13 a.m.)
James Ball, Michigan Manufacturers Association
Wayne Cass, Michigan State AFL-CIO (Arrived at 9:07 p.m.)
Tim Cook, Blue Cross Blue Shield of Michigan (Alternate)
Gregory Dobis, McLaren Health Care Corporation (Alternate, arrived at 9:38 a.m.)
James Falahee, Jr., Bronson Healthcare Group
Gary Kushner, Small Business Association of Michigan (left at 11:55 a.m.)
Mark Mailloux, University of Michigan Health System (via teleconference)
Patrick O'Donovan, Beaumont Hospitals
Patricia Richards, Health Alliance Plan
William Rietscha, Spectrum Health
Mary Zuckerman, Detroit Medical Center
Lody Zwarensteyn, Alliance for Health (Alternate)

b. Members Absent and Organizations Represented:

Barton P. Buxton, McLaren Health Care
Connie Cronin, H.F. Health System
Dr. Douglas Edema, Trinity Health
A. Michael LaPenna, Alliance for Health
Dale Steiger, Blue Cross Blue Shield of Michigan

c. Staff Present:

Lakshmi Amarnath
Jan Christensen
Bill Hart
Irma Lopez
Andrea Moore
Taleitha Pytlowanyj
Brenda Rogers

II. Conflicts of Interests.

No conflicts were noted.

III. Review of Agenda.

Mr. Steiger's Charge One Workgroup will not be giving a report at this time.

Motion by Mr. Kushner, seconded by Ms. Zuckerman, to approve the agenda as modified. Motion Carried.

IV. Review of Minutes – June 28, 2006.

Motion by Mr. O'Donovan, seconded by Mr. Asmussen, to accept the minutes as presented. Motion Carried.

V. Workgroup Reports.

A. Charges Two/Five Workgroup – High Occupancy; Occupancy Levels and Fluctuation Over Time.

Mr. Mailloux provided additional information and answered questions of the Committee. The Committee was presented with Draft Language (Attachment A) for High Occupancy. Discussion followed.

For the August 2nd meeting, it was requested that the Department do a historical search for language that had been proposed in past years regarding delicensure of beds if not meeting a certain level of occupancy.

Public Comment:

Robert Meeker, Spectrum Health

C. Charge Three Workgroup – Comparative Review Criteria.

Mr. O'Donovan provided a written (Attachment B) and oral report of the Workgroup's status. He reported that the Workgroup had met a couple times via the web and once in person. In addition, he provided a case study example (Attachment C). Discussion followed.

After discussion, it was requested that the Department provide to the SAC members a copy of the summary regarding the comparative review criteria for limited access areas that had been prepared by the CON Program Section and previously provided to the workgroup.

Public Comment:

Melissa Cupp, Wiener Associates
Terry Gerald, Detroit Medical Center

Break from 11:17 a.m. to 11:29 a.m.

D. Charges Four/Six Workgroup – Replacement Zone.

Mr. Asmussen reported that the Workgroup had met a total of five times. A sub-workgroup had also met a total of four times. Mr. Asmussen presented a PowerPoint presentation and a written report (Attachment D). The Committee requested that the Department provide the interpretation of MCL 333.22229(2) from the Attorney General's office at the August 2, 2006 Meeting. Discussion followed.

Public Comment:

Ken Trester, Oakwood

Terance Thomas, St. John Health
Barb Jackson, Economic Alliance of Michigan

VI. Next Step.

For the August 2nd meeting, in addition to the previously mentioned items, the SAC would like input from the Department on quality criteria that might be applied for comparative review and on any foreseeable implementation concerns.

VII. Future Meetings:

August 2, 2006
August 22, 2006

VIII. Public Comment.

None.

IX. Adjournment.

Motion by Mr. Falahee, seconded by Mr. Cass, to adjourn the meeting at 12:50 p.m. Motion Carried.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS

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

Section 1. Applicability

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

(2) A hospital licensed under Part 215 is a covered health facility for purposes of Part 222 of the Code.

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

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

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

(6) The Department shall use sections 3, 4, 5, 6, 7, 8, 10, 16, and 17 of these standards and Section 2 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.

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

Section 2. Definitions

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

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

(b) "Alcohol and substance abuse hospital," for purposes of these standards, means a licensed hospital within a long-term (acute) care 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.

(c) "Base year" means the most recent year that final MIDB data is available to the Department unless a different year is determined to be more appropriate by the Commission.

(d) "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.

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

(f) "Department" means the Michigan Department of Community Health (MDCH).

(g) "Department inventory of beds" means the current list maintained for each hospital subarea 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.

(h) “Discharge relevance factor” (%R) means a mathematical computation where the numerator is the inpatient hospital discharges from a specific zip code for a specified hospital subarea and the denominator is the inpatient hospital discharges for any hospital from that same specific zip code.

(i) "Existing hospital beds" means, for a specific hospital subarea, the total of all of the following: (i) hospital beds licensed by the Department; (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.

(j) "Health service area" OR "HSA" means the groups of counties listed in Section 18.

(k) "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.

(l) "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.

(m) "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.

(n) "Hospital subarea" or "subarea" means a cluster or grouping of hospitals and the relevant portion of the state's population served by that cluster or grouping of hospitals. For purposes of these standards, hospital subareas and the hospitals assigned to each subarea are set forth in Appendix A.

(o) “Host hospital,” for purposes of these standards, means an existing licensed hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation.

(p) "Licensed site" means either (i) in the case of a single site hospital, the location of the facility authorized by license and listed on that licensee's certificate of licensure or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure.

(q) "Limited access area" means those geographic areas containing a population of 50,000 or more based on the planning year and not within 30 minutes drive time of an existing licensed acute care hospital with 24 hour/7 days a week emergency services utilizing the slowest route available as defined by the Michigan Department of Transportation (MDOT) and as identified in Appendix E. Limited access areas shall be redetermined when a new hospital has been approved or an existing hospital closes.

(r) "Long-term (acute) care hospital," for purposes of these standards, 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.

(s) “Market forecast factors” (%N) means a mathematical computation where the numerator is the number of total inpatient discharges indicated by the market survey forecasts and the denominator is the base year MIDB discharges.

(t) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and1396r-8 to 1396v.

(u) "Metropolitan statistical area county” means a county located in a metropolitan statistical area as that term is defined under the “standards for defining metropolitan and micropolitan statistical areas” by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(v) "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.

(w) "Micropolitan statistical area county" means a county located in a micropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(x) "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 subarea which are proposed for relocation in a different subarea as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea 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.

(y) "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 subarea as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea 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.

(z) "OBSTETRICS PATIENT DAYS OF CARE" MEANS INPATIENT DAYS OF CARE FOR PATIENTS IN THE APPLICANT'S MICHIGAN INPATIENT DATABASE DATA AGES 15 THROUGH 44 WITH DRGS 370 THROUGH 375 (OBSTETRICAL DISCHARGES).

(AA) "Overbedded subarea" means a hospital subarea in which the total number of existing hospital beds in that subarea exceeds the subarea needed hospital bed supply as set forth in Appendix C.

(BB) "PEDIATRIC PATIENT DAYS OF CARE" MEANS INPATIENT DAYS OF CARE FOR PATIENTS IN THE APPLICANT'S MICHIGAN INPATIENT DATABASE DATA AGES 0 THROUGH 14 EXCLUDING NORMAL NEWBORNS.

(~~aa~~CC) "Planning year" means five years beyond the base year, established by the CON Commission, for which hospital bed need is developed, unless a different year is determined to be more appropriate by the Commission.

(~~bb~~DD) "Relevance index" or "market share factor" (%Z) means a mathematical computation where the numerator is the number of inpatient hospital patient days provided by a specified hospital subarea from a specific zip code and the denominator is the total number of inpatient hospital patient days provided by all hospitals to that specific zip code using MIDB data.

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

(FF) "REMAINING PATIENT DAYS OF CARE" MEANS TOTAL INPATIENT DAYS OF CARE IN THE APPLICANT'S MICHIGAN INPATIENT DATABASE DATA MINUS OBSTETRICS PATIENT DAYS OF CARE AND PEDIATRIC PATIENT DAYS OF CARE.

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

(~~ee~~HH) "Replacement zone" means a proposed licensed site that is (i) in the same subarea 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.

(~~ff~~II) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and

micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(~~gg~~JJ) "Utilization rate" or "use rate" means the number of days of inpatient care per 1,000 population during a one-year period.

(~~hh~~KK) "Zip code population" means the latest population estimates for the base year and projections for the planning year, by zip code.

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

Section 3. Hospital subareas

Sec. 3. (1)(a) Each existing hospital is assigned to a hospital subarea as set forth in Appendix A which is incorporated as part of these standards, until Appendix A is revised pursuant to this subsection.

(i) These hospital subareas, and the assignments of hospitals to subareas, shall be updated, at the direction of the Commission, starting in May 2003, to be completed no later than November 2003. Thereafter, at the direction of the Commission, the updates shall occur no later than two years after the official date of the federal decennial census, provided that:

(A) Population data at the federal zip code level, derived from the federal decennial census, are available; and final MIDB data are available to the Department for that same census year.

(b) 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 subarea utilizing a market survey conducted by the applicant and submitted with the application. The market survey shall provide, at a minimum, forecasts of the number of inpatient discharges for each zip code that the proposed new licensed site shall provide service. The forecasted numbers must be for the same year as the base year MIDB data. The market survey shall be completed by the applicant using accepted standard statistical methods. The market survey must be submitted on a computer media and in a format specified by the Department. The market survey, if determined by the Department to be reasonable pursuant to Section 15, shall be used by the Department to assign the proposed new site to an existing subarea based on the methodology described by "The Specification of Hospital Service Communities in a Large Metropolitan Area" by J. William Thomas, Ph.D., John R. Griffith, and Paul Durance, April 1979 as follows:

(i) For the proposed new site, a discharge relevance factor for each of the zip codes identified in the application will be computed. Zip codes with a market forecast factor of less than .05 will be deleted from consideration.

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

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

P_i = Population of zip code i.

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

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

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

$$\text{then } \overline{R}_{j=} \frac{\sum_{i \varepsilon Ij} P_i (d_{ij}/D_i)}{\sum_{i \varepsilon Ij} P_i}$$

(iv) After $\overline{R}_j$ is calculated for the applicant(s) and the included existing subareas, the hospital/subarea with the smallest $\overline{R}_j$ ($S\overline{R}_j$) is grouped with the hospital/subarea having the greatest individual discharge

relevance factor in the S $\overline{R}$ j's home zip code. S $\overline{R}$ j's home zip code is defined as the zip code from S $\overline{R}$ j's with the greatest discharge relevance factor.

(v) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (iii), and (iv) must be repeated until all applicants have been assigned to an existing subarea.

(2) The Commission shall amend Appendix A to reflect: (a) approved new licensed site(s) assigned to a specific hospital subarea; (b) hospital closures; and (c) licensure action(s) as appropriate.

(3) As directed by the Commission, new sub-area assignments established according to subsection (1)(a)(i) shall supersede Appendix A and shall be included as an amended appendix to these standards 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 limited access area and a hospital subarea for a planning year shall be made using the MIDB and population estimates and projections by zip code in the following methodology:

(a) All hospital discharges for normal newborns (DRG 391) and psychiatric patients (ICD-9-CM codes 290 through 319 as a principal diagnosis) will be excluded.

(b) For each discharge from the selected zip codes for a limited access area or each hospital subarea discharge, as applicable, calculate the number of patient days (take the patient days for each discharge and accumulate it within the respective age group) for the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 through 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older. Data from non-Michigan residents are to be included for each specific age group. Data from non-Michigan residents are to be included for each specific age group. For limited access areas, proceed to section 4(1)(e).

(c) For each hospital subarea, calculate the relevance index (%Z) for each zip code and for each of the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 THROUGH 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older.

(d) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective base year zip code and age group specific year population. The result will be the zip code allocations by age group for each subarea.

(e) For each limited access area or hospital subarea, as applicable, calculate the subarea base year population by age group by adding together all zip code population allocations calculated in (d) for each specific age group in that subarea. For a limited access area, add together the age groups identified for the limited access area. The result will be six population age groups for each limited access area or subarea, as applicable.

(f) For each limited access area or hospital subarea, as applicable, calculate the patient day use rates for ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 THROUGH 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older by dividing the results of (b) by the results of (e).

(g) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective planning year zip code and age group specific year population. The results will be the projected zip code allocations by age group for each subarea. For a limited access area, multiply the population projection for the plan year by the proportion of the zip code that is contained within the limited access area for each zip code age group. The results will be the projected zip code allocations by age group for each zip code within the limited access area.

(h) For each hospital subarea, calculate the subarea projected year population by age group by adding together all projected zip code population allocations calculated in (g) for each specific age group. For a limited access area, add together the zip code allocations calculated in (g) by age group identified for the limited access area. The result will be six population age groups for each limited access area or subarea, as applicable.

(i) For each limited access area or hospital subarea, as applicable, calculate the limited access area or hospital subarea, as applicable, projected patient days for each age group by multiplying the six projected populations by age group calculated in step (h) by the age specific use rates identified in step (f).

(j) For each limited access area or hospital subarea, as applicable, calculate the adult medical/surgical limited access area or hospital subarea, as applicable, projected patient days by adding together the following age group specific projected patient days calculated in (i): ages 15 through 44, ages 45 through 64, ages 65 through 74, and ages 75 and older. The 0 (excluding normal newborns) through 14 (pediatric) and female ages 15 through 44 (DRGs 370 through 375 – obstetrical discharges) age groups remain unchanged as calculated in (i).

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

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

(m) For each limited access area or hospital subarea, as applicable, and age group, calculate the limited access area or subarea, as applicable, projected bed need number of hospital beds for the limited access area or subarea, as applicable, by age group by dividing the ADC calculated in (k) by the appropriate occupancy rate determined in (l). To obtain the total limited access area or hospital, as applicable, bed need, add the three age group bed projections together. Round any part of a bed up to a whole bed.

Section 5. Bed Need

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

(2) The Commission shall direct the Department, effective November 2004 and every two years thereafter, to re-calculate the acute care bed need methodology in Section 4, within a specified time frame.

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

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

(5) As directed by the Commission, new bed-need numbers established by subsections (2) and (3) shall supersede the bed-need numbers shown in Appendix C and shall be included as an amended appendix to these standards.

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 50 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 subarea to which the new beds will be assigned does not currently exceed the needed hospital bed supply as set forth in Appendix C. The Department

shall determine the subarea 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 subarea to which the new beds will be assigned, exceeding the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subarea 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 long-term (acute) care 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 long-term (acute) care hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as a long-term (acute) care 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 a long-term (acute) care 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 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.

(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 long-term (acute) care hospital. In the event that the host hospital applies for a CON to acquire the long-term (acute) care hospital [including the beds leased by the host hospital to the long-term (acute) care hospital] within six months following the termination of the lease with the long-term (acute) care hospital, it shall not be required to be in compliance with the hospital bed supply set forth in Appendix C if the host hospital proposes to add the beds of the long-term (acute) care 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 subarea 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(3) of these standards.

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

(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 set forth in Appendix C 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 subarea, or

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

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

(b) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards.

(c) 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 set forth in Appendix C 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 ~~as follows~~ AT AN ADJUSTED OCCUPANCY RATE OF 80% OR ABOVE for the previous, consecutive ~~12~~ 24 months based on its ~~existing~~ licensed AND APPROVED hospital bed capacity. ~~as documented on the most recent reports of the "Annual Hospital Statistical Questionnaire" or more current verifiable data:~~ THE ADJUSTED OCCUPANCY RATE SHALL BE CALCULATED AS FOLLOWS:

~~Number of Licensed Hospital Beds~~	~~Average Occupancy~~
~~Fewer than 300~~	~~80% and above~~
~~300 or more~~	~~85% and above~~

(I) COMBINE ALL PEDIATRIC PATIENT DAYS OF CARE AND OBSTETRICS PATIENT DAYS OF CARE PROVIDED DURING THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT AND MULTIPLY THAT NUMBER BY 1.1.

(II) ADD REMAINING PATIENT DAYS OF CARE PROVIDED DURING THE MOST RECENT, CONSECUTIVE 24-MONTH PERIOD FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT TO THE NUMBER CALCULATED IN (I) ABOVE. THIS IS THE ADJUSTED PATIENT DAYS.

(III) DIVIDE THE NUMBER CALCULATED IN (II) 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 ~~80 75percent for hospitals with licensed beds of 300 or more and to 75 percent for hospitals with licensed beds of fewer than 300~~. The number of beds shall be calculated as follows:

(i) Divide the ~~actual~~ number of ADJUSTED patient days CALCULATED IN SUBSECTION (B)(II)~~of care provided during the most recent, consecutive 12-month period for which verifiable data are available to the department by .80 for hospitals with licensed beds of 300 or more and~~ by .75 f~~or hospitals with licensed beds of fewer than 300~~ to determine licensed bed days at ~~80 percent occupancy or~~ 75 percent occupancy ~~as applicable~~;

(ii) Divide the result of step (i) by ~~365~~ 730 (or ~~366~~ 731 ~~for~~ IF INCLUDING A leap year~~s~~) 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 set forth in Appendix C 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 subarea based on the current market use patterns of existing subareas.

(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 E.

(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 E, 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 -- replacement beds in a hospital in a replacement zone

Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital in 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 50 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) In order to be approved, the applicant shall propose to (i) replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii) that the proposed new licensed site is in the replacement zone.

(3) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C 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(4) of these standards.

(2) Any existing licensed acute care 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 subarea, 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 hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

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

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

(a) Compliance with these standards

(b) Compliance with applicable operating standards

(c) Compliance with the following quality assurance standards:

(i) The applicant shall provide the Department with a notice stating the date the hospital beds are placed in operation and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

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

(iii) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information and demographic, diagnostic, 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.

(A) 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.

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

(d) 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.

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

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

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

Section 11. Department inventory of beds

Sec. 11. The Department shall maintain and provide on request a listing of the Department inventory of beds for each subarea. Hospitals that have state/federal critical access hospital designation are excluded from the bed inventory.

Section 12. Effect on prior planning policies; comparative reviews

Sec. 12. (1) These CON review standards supersede and replace the CON standards for hospital beds approved by the CON Commission on March ~~98~~, ~~2004~~ 2005 and effective ~~June 4, 2004~~MAY 27, 2005.

(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 13. Additional requirements for applications included in comparative reviews

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 these standards shall be grouped and reviewed with other applications in accordance with the CON rules applicable to comparative reviews.

(2) Each application in a comparative review 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 one or more of the competing applications satisfies all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, taken together, do not exceed the need, as defined in Section 22225(1), in the order the Department determines the projects most fully promote the availability of quality health services at reasonable cost.

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

Sec. 14. (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 owned by, under common control of, or having as a common parent the applicant. The source document for the calculation shall be the most recent Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital owned by, under common control of, or having a common parent 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 owned by, under common control of, or having a common parent with the applicant. The source documents for the calculation shall be the Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital owned by, under common control of, or having a common parent 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 owned by, under common control of, or having a common parent 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 15. Documentation of market survey

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

Section 16. Requirements for approval -- acquisition of a hospital

Sec. 16. (1) An applicant proposing to acquire a hospital shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C for the subarea 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 a long-term (acute) care hospital (LTAC) 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 in Appendix A.

X. Section 17. Requirements for approval – all applicants

Sec. 17. An applicant shall provide verification of Medicaid participation at the time the application is submitted to the Department. An applicant that is a new provider not currently enrolled in Medicaid shall provide a signed affidavit stating 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. If the required documentation is not submitted with the application on the designated application date, the application will be deemed filed on the first applicable designated application date after all required documentation is received by the Department.

Section 18. Health service areas

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

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

CON REVIEW STANDARDS
FOR HOSPITAL BEDS

HOSPITAL SUBAREA ASSIGNMENTS

Health Service Area	Sub Area	Hospital Name	City
1 - Southeast			
	1A	North Oakland Med Centers (Fac #63-0110)	Pontiac
	1A	Pontiac Osteopathic Hospital (Fac #63-0120)	Pontiac
	1A	St. Joseph Mercy – Oakland (Fac #63-0140)	Pontiac
	1A	Select Specialty Hospital - Pontiac (LTAC - FAC #63-0172)*	Pontiac
	1A	Crittenton Hospital (Fac #63-0070)	Rochester
	1A	Huron Valley – Sinai Hospital (Fac #63-0014)	Commerce Township
	1A	Wm Beaumont Hospital (Fac #63-0030)	Royal Oak
	1A	Wm Beaumont Hospital – Troy (Fac #63-0160)	Troy
	1A	Providence Hospital (Fac #63-0130)	Southfield
	1A	Great Lakes Rehabilitation Hospital (Fac #63-0013)	Southfield
	1A	Straith Hospital for Special Surg (Fac #63-0150)	Southfield
	1A	The Orthopaedic Specialty Hospital (Fac #63-0060)	Madison Heights
	1A	St. John Oakland Hospital (Fac #63-0080)	Madison Heights
	1A	Southeast Michigan Surgical Hospital (Fac #50-0100)	Warren
	1B	Bi-County Community Hospital (Fac #50-0020)	Warren
	1B	St. John Macomb Hospital (Fac #50-0070)	Warren
	1C	Oakwood Hosp And Medical Center (Fac #82-0120)	Dearborn
	1C	Garden City Hospital (Fac #82-0070)	Garden City
	1C	Henry Ford –Wyandotte Hospital (Fac #82-0230)	Wyandotte
	1C	Select Specialty Hosp Wyandotte (LTAC - Fac #82-0272)*	Wyandotte
	1C	Oakwood Annapolis Hospital (Fac #82-0010)	Wayne
	1C	Oakwood Heritage Hospital (Fac #82-0250)	Taylor
	1C	Riverside Osteopathic Hospital (Fac #82-0160)	Trenton
	1C	Oakwood Southshore Medical Center (Fac #82-0170)	Trenton
	1C	Kindred Hospital – Detroit (Fac #82-0130)	Lincoln Park
	1D	Sinai-Grace Hospital (Fac #83-0450)	Detroit
	1D	Rehabilitation Institute of Michigan (Fac #83-0410)	Detroit
	1D	Harper University Hospital (Fac #/83-0220)	Detroit
	1D	St. John Detroit Riverview Hospital (Fac #83-0034)	Detroit
	1D	Henry Ford Hospital (Fac #83-0190)	Detroit
	1D	St. John Hospital & Medical Center (Fac #83-0420)	Detroit
	1D	Children's Hospital of Michigan (Fac #83-0080)	Detroit
	1D	Detroit Receiving Hospital & Univ Hlth (Fac #83-0500)	Detroit
	1D	St. John Northeast Community Hosp (Fac #83-0230)	Detroit
	1D	Kindred Hospital–Metro Detroit (Fac #83-0520)	Detroit
	1D	SCCI Hospital-Detroit (LTAC - Fac #83-0521)*	Detroit
	1D	Greater Detroit Hosp–Medical Center (Fac #83-0350)	Detroit
	1D	Renaissance Hosp & Medical Centers (Fac #83-0390)	Detroit
	1D	United Community Hospital (Fac #83-0490)	Detroit

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

Health Service Area	Sub Area	Hospital Name	City
1 – Southeast (continued)			
	1D	Harper-Hutzel Hospital (Fac #83-0240)	Detroit
	1D	Select Specialty Hosp–NW Detroit (LTAC - Fac #83-0523)*	Detroit
	1D	Bon Secours Hospital (Fac #82-0030)	Grosse Pointe
	1D	Cottage Hospital (Fac #82-0040)	Grosse Pointe Farm
	1E	Botsford General Hospital (Fac #63-0050)	Farmington Hills
	1E	St. Mary Mercy Hospital (Fac #82-0190)	Livonia
	1F	Mount Clemens General Hospital (Fac #50-0060)	Mt. Clemens
	1F	Select Specialty Hosp – Macomb Co. (FAC #50-0111)*	Mt. Clemens
	1F	St. John North Shores Hospital (Fac #50-0030)	Harrison Twp.
	1F	St. Joseph's Mercy Hosp & Hlth Serv (Fac #50-0110)	Clinton Township
	1F	St. Joseph's Mercy Hospital & Health (Fac #50-0080)	Mt. Clemens
	1G	Mercy Hospital (Fac #74-0010)	Port Huron
	1G	Port Huron Hospital (Fac #74-0020)	Port Huron
	1H	St. Joseph Mercy Hospital (Fac #81-0030)	Ann Arbor
	1H	University Of Michigan Health System (Fac #81-0060)	Ann Arbor
	1H	Select Specialty Hosp–Ann Arbor (Ltac - Fac #81-0081)*	Ann Arbor
	1H	Chelsea Community Hospital (Fac #81-0080)	Chelsea
	1H	Saint Joseph Mercy Livingston Hosp (Fac #47-0020)	Howell
	1H	Saint Joseph Mercy Saline Hospital (Fac #81-0040)	Saline
	1H	Forest Health Medical Center (Fac #81-0010)	Ypsilanti
	1H	Brighton Hospital (Fac #47-0010)	Brighton
	1I	St. John River District Hospital (Fac #74-0030)	East China
	1J	Mercy Memorial Hospital (Fac #58-0030)	Monroe
2 - Mid-Southern			
	2A	Clinton Memorial Hospital (Fac #19-0010)	St. Johns
	2A	Eaton Rapids Medical Center (Fac #23-0010)	Eaton Rapids
	2A	Hayes Green Beach Memorial Hosp (Fac #23-0020)	Charlotte
	2A	Ingham Reg Med Cntr (Greenlawn) (Fac #33-0020)	Lansing
	2A	Ingham Reg Med Cntr (Pennsylvania) (Fac #33-0010)	Lansing
	2A	Edward W. Sparrow Hospital (Fac #33-0060)	Lansing
	2A	Sparrow – St. Lawrence Campus (Fac #33-0050)	Lansing
	2B	Carelink of Jackson (Ltac Fac #38-0030)*	Jackson
	2B	W. A. Foote Memorial Hospital (Fac #38-0010)	Jackson
	2C	Hillsdale Community Health Center (Fac #30-0010)	Hillsdale
	2D	Emma L. Bixby Medical Center (Fac #46-0020)	Adrian
	2D	Herrick Memorial Hospital (Fac #46-0030)	Tecumseh

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

Health Service Area	Sub Area	Hospital Name	City
3 – Southwest			
	3A	Borgess Medical Center (Fac #39-0010)	Kalamazoo
	3A	Bronson Methodist Hospital (Fac #39-0020)	Kalamazoo
	3A	Borgess-Pipp Health Center (Fac #03-0031)	Plainwell
	3A	Lakeview Community Hospital (Fac #80-0030)	Paw Paw
	3A	Bronson – Vicksburg Hospital (Fac #39-0030)	Vicksburg
	3A	Pennock Hospital (Fac #08-0010)	Hastings
	3A	Three Rivers Area Hospital (Fac #75-0020)	Three Rivers
	3A	Sturgis Hospital (Fac #75-0010)	Sturgis
	3A	Sempercare Hospital at Bronson (LTAC - Fac #39-0032)*	Kalamazoo
	3B	Fieldstone Ctr of Battle Crk. Health (Fac #13-0030)	Battle Creek
	3B	Battle Creek Health System (Fac #13-0031)	Battle Creek
	3B	Select Spec Hosp–Battle Creek (Ltac - Fac #13-0111)*	Battle Creek
	3B	SW Michigan Rehab. Hosp. (Fac #13-0100)	Battle Creek
	3B	Oaklawn Hospital (Fac #13-0080)	Marshall
	3C	Community Hospital (Fac #11-0040)	Watervliet
	3C	Lakeland Hospital, St. Joseph (Fac #11-0050)	St. Joseph
	3C	Lakeland Specialty Hospital (LTAC - Fac #11-0080)*	Berrien Center
	3C	South Haven Community Hospital (Fac #80-0020)	South Haven
	3D	Lakeland Hospital, Niles (Fac #11-0070)	Niles
	3D	Lee Memorial Hospital (A) (Fac #14-0010)	Dowagiac
	3E	Community Hlth Ctr Of Branch Co (Fac #12-0010)	Coldwater
4 – WEST			
	4A	Memorial Medical Center Of West MI (Fac #53-0010)	Ludington
	4B	Kelsey Memorial Hospital (Fac #59-0050)	Lakeview
	4B	Mecosta County General Hospital (Fac #54-0030)	Big Rapids
	4C	Spectrum Hlth-Reed City Campus (Fac #67-0020)	Reed City
	4D	Lakeshore Community Hospital (Fac #64-0020)	Shelby
	4E	Gerber Memorial Hospital (Fac #62-0010)	Fremont
	4F	Carson City Hospital (Fac #59-0010)	Carson City
	4F	Gratiot Community Hospital (Fac #29-0010)	Alma

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) This is a hospital that has state/federal critical access hospital designation (see Section 11).

Health Service Area	Sub Area	Hospital Name	City
4 – West (continued)			
	4G	Hackley Hospital (Fac #61-0010)	Muskegon
	4G	Mercy Gen Hlth Partners–(Sherman) (Fac #61-0020)	Muskegon
	4G	Mercy Gen Hlth Partners–(Oak) (Fac #61-0030)	Muskegon
	4G	Lifecare Hospitals of Western MI (LTAC - Fac #61-0052)*	Muskegon
	4G	Select Spec Hosp–Western MI (LTAC - Fac #61-0051)*	Muskegon
	4G	North Ottawa Community Hospital (Fac #70-0010)	Grand Haven
	4H	Spectrum Hlth–Blodgett Campus (Fac #41-0010)	E. Grand Rapids
	4H	Spectrum Hlth–Butterworth Campus (Fac #41-0040)	Grand Rapids
	4H	Spectrum Hlth–Kent Comm Campus (Fac #41-0090)	Grand Rapids
	4H	Mary Free Bed Hospital & Rehab Ctr (Fac #41-0070)	Grand Rapids
	4H	Metropolitan Hospital (Fac #41-0060)	Grand Rapids
	4H	Saint Mary's Mercy Medical Center (Fac #41-0080)	Grand Rapids
	4I	Sheridan Community Hospital (A) (Fac #59-0030)	Sheridan
	4I	United Memorial Hospital & LTCU (Fac #59-0060)	Greenville
	4J	Holland Community Hospital (Fac #70-0020)	Holland
	4J	Zeeland Community Hospital (Fac #70-0030)	Zeeland
	4K	Ionia County Memorial Hospital (Fac #34-0020)	Ionia
	4L	Allegan General Hospital (Fac #03-0010)	Allegan
5 – GLS			
	5A	Memorial Healthcare (Fac #78-0010)	Owosso
	5B	Genesys Reg Med Ctr–Hlth Park (Fac #25-0072)	Grand Blanc
	5B	Hurley Medical Center (Fac #25-0040)	Flint
	5B	Mclaren Regional Medical Center (Fac #25-0050)	Flint
	5B	Select Specialty Hospital-Flint (LTAC - Fac #25-0071)*	Flint
	5C	Lapeer Regional Hospital (Fac #44-0010)	Lapeer
6 – East			
	6A	West Branch Regional Medical Cntr (Fac #65-0010)	West Branch
	6A	Tawas St Joseph Hospital (Fac #35-0010)	Tawas City
	6B	Central Michigan Community Hosp (Fac #37-0010)	Mt. Pleasant
	6C	Mid-Michigan Medical Center-Clare (Fac #18-0010)	Clare

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) This is a hospital that has state/federal critical access hospital designation (see Section 11).

Health Service Area	Sub Area	Hospital Name	City
6 – East (continued)			
	6D	Mid-Michigan Medical Cntr - Gladwin (Fac #26-0010)	Gladwin
	6D	Mid-Michigan Medical Cntr - Midland (Fac #56-0020)	Midland
	6E	Bay Regional Medical Center (Fac #09-0050)	Bay City
	6E	Bay Regional Medical Ctr-West (Fac #09-0020)	Bay City
	6E	Samaritan Health Center (Fac #09-0051)	Bay City
	6E	Bay Special Care (LTAC - Fac #09-0010)*	Bay City
	6E	Standish Community Hospital (A) (Fac #06-0020)	Standish
	6F	Select Specialty Hosp–Saginaw (LTAC - Fac #73-0062)*	Saginaw
	6F	Covenant Medical Centers, Inc (Fac #73-0061)	Saginaw
	6F	Covenant Medical Cntr–N Michigan (Fac #73-0030)	Saginaw
	6F	Covenant Medical Cntr–N Harrison (Fac #73-0020)	Saginaw
	6F	Healthsource Saginaw (Fac #73-0060)	Saginaw
	6F	St. Mary's Medical Center (Fac #73-0050)	Saginaw
	6F	Caro Community Hospital (Fac #79-0010)	Caro
	6F	Hills And Dales General Hospital (Fac #79-0030)	Cass City
	6G	Harbor Beach Community Hosp (A) (Fac #32-0040)	Harbor Beach
	6G	Huron Medical Center (Fac #32-0020)	Bad Axe
	6G	Scheurer Hospital (A) (Fac #32-0030)	Pigeon
	6H	Deckerville Community Hospital (A) (Fac #76-0010)	Deckerville
	6H	Mckenzie Memorial Hospital (A) (Fac #76-0030)	Sandusky
	6I	Marlette Community Hospital (Fac #76-0040)	Marlette
7 - Northern Lower			
	7A	Cheboygan Memorial Hospital (Fac #16-0020)	Cheboygan
	7B	Charlevoix Area Hospital (Fac #15-0020)	Charlevoix
	7B	Mackinac Straits Hospital (A) (Fac #49-0030)	St. Ignace
	7B	Northern Michigan Hospital (Fac #24-0030)	Petoskey
	7C	Rogers City Rehabilitation Hospital (Fac #71-0030)	Rogers City
	7D	Otsego Memorial Hospital (Fac #69-0020)	Gaylord
	7E	Alpena General Hospital (Fac #04-0010)	Alpena
	7F	Kalkaska Memorial Health Center (A) (Fac #40-0020)	Kalkaska
	7F	Leelanau Memorial Health Center (A) (Fac #45-0020)	Northport
	7F	Munson Medical Center (Fac #28-0010)	Traverse City
	7F	Paul Oliver Memorial Hospital (A) (Fac #10-0020)	Frankfort

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) This is a hospital that has state/federal critical access hospital designation (see Section 11).

Health Service Area	Sub Area	Hospital Name	City
7 - Northern Lower (continued)			
	7G	Mercy Hospital - Cadillac (Fac #84-0010)	Cadillac
	7H	Mercy Hospital - Grayling (Fac #20-0020)	Grayling
	7I	West Shore Medical Center (Fac #51-0020)	Manistee
8 - Upper Peninsula			
	8A	Grand View Hospital (Fac #27-0020)	Ironwood
	8B	Ontonagon Memorial Hospital (A) (Fac #66-0020)	Ontonagon
	8C	Iron County General Hospital (Fac #36-0020)	Iron River
	8D	Baraga County Memorial Hospital (A) (Fac #07-0020)	L'anse
	8E	Keweenaw Memorial Medical Center (Fac #31-0010)	Laurium
	8E	Portage Health System (Fac #31-0020)	Hancock
	8F	Dickinson County Memorial Hospital (Fac #22-0020)	Iron Mountain
	8G	Bell Memorial Hospital (Fac #52-0010)	Ishpeming
	8G	Marquette General Hospital (Fac #52-0050)	Marquette
	8H	St. Francis Hospital (Fac #21-0010)	Escanaba
	8I	Munising Memorial Hospital (A) (Fac #02-0010)	Munising
	8J	Schoolcraft Memorial Hospital (A) (Fac #77-0010)	Manistique
	8K	Helen Newberry Joy Hospital (A) (Fac #48-0020)	Newberry
	8L	Chippewa Co. War Memorial Hosp (Fac #17-0020)	Sault Ste Marie

(A) This is a hospital that has state/federal critical access hospital designation (see Section 11).

APPENDIX B

CON REVIEW STANDARDS FOR HOSPITAL BEDS

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

65 F.R., p. 82238 (December 27, 2000)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

APPENDIX C

CON REVIEW STANDARDS

FOR HOSPITAL BEDS

The hospital bed need for purposes of these standards until otherwise changed by the Commission are as follows:

Health Service Area	SA No.	Bed Need
1 - SOUTHEAST		
	1A	2693
	1B	415
	1C	1372
	1D	3098
	1E	451
	1F	636
	1G	275
	1H	1431
	1I	50
	1J	149
2 - MID-SOUTHERN		
	2A	866
	2B	293
	2C	48
	2D	98
3 – SOUTHWEST		
	3A	763
	3B	282
	3C	261
	3D	85
	3E	59
4 – WEST		
	4A	57
	4B	63
	4C	17
	4D	11
	4E	38
	4F	136
	4G	391
	4H	1240
	4I	47
	4J	153
	4K	21
	4L	24
5 - GLS		
	5A	79
	5B	1120
	5C	119

APPENDIX C (Continued)

Health Service Area	SA No.	Bed Need
6 - EAST		
	6A	99
	6B	55
	6C	47
	6D	216
	6E	299
	6F	765
	6G	43
	6H	13
	6I	24
7 - NORTHERN LOWER		
	7A	43
	7B	203
	7C	0
	7D	27
	7E	99
	7F	349
	7G	62
	7H	53
	7I	40
8 - UPPER PENINSULA		
	8A	24
	8B	7
	8C	21
	8D	11
	8E	50
	8F	88
	8G	228
	8H	57
	8I	4
	8J	7
	8K	9
	8L	52

1243
1244
1245

OCCUPANCY RATE TABLE

Adult Medical/Surgical

ADC >=	ADC<	Occup	Beds Start	Stop
	30	0.60		<=50
31	32	0.60	52	52
32	34	0.61	53	56
35	37	0.62	57	60
38	41	0.63	61	65
42	46	0.64	66	72
47	50	0.65	73	77
51	56	0.66	78	85
57	63	0.67	86	94
64	70	0.68	95	103
71	79	0.69	104	114
80	89	0.70	115	126
90	100	0.71	127	140
101	114	0.72	141	157
115	130	0.73	158	177
131	149	0.74	178	200
150	172	0.75	201	227
173	200	0.76	228	261
201	234	0.77	262	301
235	276	0.78	302	350
277	327	0.79	351	410
328	391	0.80	411	484
392	473	0.81	485	578
474	577	0.82	579	696
578	713	0.83	697	850
714	894	0.84	851	894
895		0.85	>=1054	

Pediatric Beds

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

Obstetric Beds

ADC >	ADC<=	Occup	Beds Start	Stop
	30	0.50		<=50
30	33	0.50	61	66
34	40	0.51	67	79
41	46	0.52	80	88
47	53	0.53	89	100
54	60	0.54	101	111
61	67	0.55	112	121
68	74	0.56	122	131
75	80	0.57	132	139
81	87	0.58	140	149
88	94	0.59	150	158
95	101	0.60	159	167
102	108	0.61	168	175
109	114	0.62	176	182
115	121	0.63	183	190

Obstetric Beds cont.

ADC >	ADC<=	Occup	Beds Start	Stop
122	128	0.64	191	198
129	135	0.65	199	206
136	142	0.66	207	213
143	149	0.67	214	220
150	155	0.68	221	226
156	162	0.69	227	232
163	169	0.70	233	239
170	176	0.71	240	245
177	183	0.72	246	252
184	189	0.73	253	256
190	196	0.74	257	262
197		0.75	>=263	

APPENDIX E

LIMITED ACCESS AREAS

Limited access areas and the hospital bed need 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)(q) of these standards, and this appendix shall be updated accordingly.

HEALTH SERVICE AREA	LIMITED ACCESS AREA	BED NEED	POPULATION FOR PLANNING YEAR
7	Alpena/Plus 1204	135	59,422
8	Upper Peninsula 1204	179	108,917

Sources:

1) Michigan State University
   Department of Geography
   Hospital Site Selection Final Report
   November 3, 2004, as amended

2) Section 4 of these standards

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH AND MEDICAL AFFAIRS

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

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

XI. Section 1. Applicability; definitions

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

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

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

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

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

Section 2. Requirements for approval; change in bed capacity

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

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

(3) In order to be approved under this addendum, an applicant shall demonstrate all of the following:
(a) The Director of the Department has determined that action is necessary and appropriate to meet the needs of HIV infected individuals for quality, accessible and efficient health care.
(b) The hospital will provide services only to HIV infected individuals.
(c) The applicant has obtained an obligation, enforceable by the Department, from existing licensed hospital(s) in any subarea of this state to voluntarily delicense a number of hospital beds equal to the number proposed in the application. The effective date of the delicensure action will be the date the beds approved pursuant to this addendum are licensed. The beds delicensed shall not be beds already subject to delicensure under a bed reduction plan.
(d) The application does not result in more than 20 beds approved under this addendum in the State.

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

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

Sec. 3. (1) An applicant shall agree that, if approved, the services provided by the beds for HIV infected individuals shall be delivered in compliance with the following terms of CON approval:

(a) The license to operate the hospital will be limited to serving the needs of patients with the clinical spectrum of HIV infection and any other limitations established by the Department to meet the purposes of this addendum.

(b) The hospital shall be subject to the general license requirements of Part 215 of the Code except as waived by the Department to meet the purposes of this addendum.

(c) The applicant agrees that the Department shall revoke the license of the hospital if the hospital provides services to inpatients other than HIV infected individuals.

Section 4. Comparative reviews

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

Memorandum

To: Hospital Beds Standards Advisory Committee

From: Michael LaPenna

Subject: **DRAFT** - "Comparative Review" Subcommittee Results

Date: July 17, 2006

The Subcommittee charge, as we understand it from the work papers, is as follows:

> ***"Consider the use of the comparative review criteria developed for limited access areas as a foundation for development of comparative review criteria for any hospital bed under review."***

The Subcommittee has discussed this formally and informally, and it has met in WEB Conference and in person to address this matter. Subcommittee members have reviewed the work product of the previous SAC and discussed the issues with former members of the panel that addressed this issue. We have also discussed the issue with staff, and we have met with Mr. Nash to better understand issues relating to market share. We have also polled the Committee in an attempt to better understand the philosophies of our colleagues related to the issue of DISH and uncompensated care in this matter. In this process, we have considered material offered by hospitals that have a specific interest in the outcome of this matter and who have offered public comment in the past.

We are in agreement, and we feel that the Committee is in general support of the following question being answered positively.

> ***Should comparative review be extended to all bed review processes?***

We would respectfully ask that the Committee consider this question and affirm our suggestion.

> **MOTION FORM:** ***It is recommended that any request for the creation or addition of hospital beds, in whatever form, be submitted for comparative review before the application is acted upon by the Department and that the results of the comparative review process be a determining factor in the approval/denial of the request.***

Assuming that this is endorsed in some form by the Committee, we have additional suggestions and observations on the present standards and their application to the issue of the review of any bed-need application, as well as, the revision/update of the present standards reflected in the LAA criteria.

The La Penna Group, Inc.
Grand Rapids, Michigan

Phone (800) 527-3662
Fax (616) 281-0573

These have been incorporated within language suggested by Department staff with comments on each section included within the suggested language. We would remind the Committee that factors such as quality, ethnic diversity, cultural competency, etc. were rejected for consideration due to the inability to quantify standards.

NOTE: Committee comments and background information has been added in bold and italics and is bracketed to allow the reader to distinguish proposed language from discussion comments.

Section 13. Review standards for comparative review

(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, 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 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.

[COMMENTARY - THIS SECTION HAS BEEN REVISED TO INCORPORATE DEPARTMENT LANGUAGE TO CLARIFY THE LAA REGULATIONS FOR THE PURPOSES OF ADDRESSING BED NEED REQUESTS.]

(3)

(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's uncompensated care volume, as defined by the Department, and 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 owned by, under common control of, or having as a common parent with the applicant. The source document for the calculation shall be the most recent Cost Report submitted to the Department for purposes of calculating disproportionate share hospital payments. If a hospital owned by, under common control of, or having a common parent 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.

[Per Department Staff - "Uncompensated Care" is currently defined by the Department using the Indigent Volume section of the Michigan Medicaid Form (MMF), and it currently includes: Uninsured – Charity Care Charges, Uninsured – Patient Pay Charges, Uninsured – State of Local Government Charges, Uninsured Charges – Prisoners, and Bad Debts. The computation is generally two years old. This language allows a system to identify all commonly owned hospitals in the calculation, and the Department will rank them accordingly. The survey of the Committee agreed that service to the uninsured/uncompensated care category was strongly supported, and this criteria and point system preserves the LAA ranking process for this indicator.]

(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 owned by, under common control of, or having a common parent with the applicant. The source documents for the calculation shall be the Cost Report submitted to the Department for purposes of calculating disproportionate share hospital payments. If a hospital owned by, under common control of, or having a common parent 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.

[The Committee is reminded that Medicaid data is two years old. This ranking is also consistent with that found in the LAA section. This may be the most appropriate place to address DISH and Medicare offsets, if that is the Committee's intention. This is an area on which the Subcommittee did not reach consensus; however, the survey of the Committee did produce results that suggested that some form of recognition of DISH payments should be incorporated within the process to correct for funds received to offset care to Medicaid patients. The Committee survey did not endorse the same acknowledgement of the inclusion of some factor for a hospital that served high proportions of Medicare patients at some kind of margin that reflects a loss for that population.

> ***Suggestion: Address the MEDICARE factor as a Committee and confirm the survey results by rejecting the issue as a component of comparative review for the purposes of ranking projects.***
>
> ***MOTION: The Committee declines to utilize margin related to MEDICARE patients as a factor in comparing hospitals and hospital systems for comparative review as it pertains to applications for new bed construction.***

The matter of DISH payments may or may not come up in a CON application process; however, the survey conducted among Committee members suggests support for factoring in this feature, and the MEDICAID ranking section may be the best place to do this. There may be a challenge in using DISH payments as a general comparison among all hospitals and as a ranking feature (as MEDICAID payments are done).

Some suggestions that would include the "DISH factor":

1. ***Require each applicant to report their DISH payments for the years for which MEDICAID is being considered for the ranking process.***
2. ***Allow any applicant to inquire of the Department the DISH payments reported for each competing applicant on the project for which they wish to have DISH offset considered.***
3. ***If there is a request by any candidate for the DISH factor to be considered as part of the comparative review process, simply take the candidate's MEDICAID revenues, subtract the DISH payments received (MEDICAID only), and inspect the ranking to see if this changes the primacy of one institution over another. That is, if the DISH adjustment shows that one institution in the applicant pool would have gained its MEDICAID ranking, but would have incurred less expense (loss or cost shifting) for the provision of these services than another competing institution for the same project, then DISH played a role in the application process under study. If this cannot be shown, ignore the DISH payments. If it can be demonstrated, then move the top ranked hospital applicant down one level in the rankings to reflect the DISH factor.***

This approach was not vetted through the Subcommittee process. It is merely offered as a way to move the process forward without changing the overall criteria in any substantial fashion, but with the reality that DISH will be a feature that contributes to the final approval/denial. One would assume that the competing project applicants would provide staff support to justify their hospital's position on DISH.]

(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. (Table deleted – NA)

[This point addresses impact on capacity and is not relevant for inclusion into a statewide review because it is assumed that applicants are applying within an area that has a recognized hospital bed need. In final language, it would be removed.]

(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 sub area as set forth in Appendix A. Market share used for the calculation shall be the cumulative market share of the population in the sub area of all currently licensed Michigan hospitals owned by, under common control of, or having a common parent with the applicant.

Percent	Points Awarded
% of market share	*% of market share served x 15* (Total pts. awarded)

(e) A qualifying project will be awarded points based on the percentage of the sub area's population, based on the most recent decennial census available to the department, 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

[The Subcommittee recognizes market share and the need to protect existing institutions in an area as crucial to common sense health care development and community development. It would suggest that these point systems be increased from a multiplicative factor of 15 to 20 in order to provide extra weighting that would offset the potential that a local community based provider would be displaced by an applicant from a competing urban area.]

(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

[Cost per bed is an elusive concept when long-term facility leases and land leases are considered. The Subcommittee would suggest that each applicant be required to present their costs per bed in a form that reflects true cost of ownership. In other words, if there is a non-capitalizing lease, the applicant will be asked to convert the costs in the project to reflect the same project as if it were to be an outright purchase. This would require transparency on land acquisition and on construction costs. For any applicant that cannot perform under this criteria, the points awarded under this category would be zero.]

Comparative Review Case Study Example

Case: Two hospital organizations want to build hospitals in the "Alpena plus" limited access area

Comparative review applicants are:
Alpena Hospital
Monroe Hospital

Comparative Review Scoring:	Alpena measure	Alpena points	Monroe measure	Monroe points
Uncompensated care percentile ranking	79	15	90	25
Medicaid volume percentile ranking	74	10	88	20
Reduce capacity	move	0	move	0
Market share	67%	10.1	2%	0.3
% of population covered	60%	9	40%	6
Cost/bed	lowest	10	2nd lowest	5
Total points		54.1		56.3

Monroe gets the hospital

concomparativereviewcasestudy4-28-06.xls

TO: James Ball, Chairman, Hospital Bed Standard Advisory Committee
James Falahee, Vice Chairman
Members of the Hospital Bed SAC

FROM: Robert Asmussen, Chairman, Charges 4 and 6 Workgroup

SUBJECT: Final Report of the Charges 4&6 Workgroup

DATE: 7/13/2006

The Workgroup was asked to review and recommend changes, if any, to standard language related to the following charges specified by the Certificate of Need Commission:

1) Charge 4: Review the current replacement zone for existing hospitals considering the replacement of aging physical plants.
2) Charge 6: Consider multiple site licenses under common ownership as appropriate.

The Workgroup spent an extensive amount of time on its assignment, meeting 5 times beginning in March and concluding June 28, 2006. A subgroup also met 4 times to attempt to work through details of various alternatives that the Workgroup might endorse.

Unfortunately, the Workgroup was unable to reach a consensus on a preferred alternative to the current standard language for replacement zone. (Charge 4) This report will conclude with two options which received significant support but not a majority. Only a minority of the Workgroup supported changes to the replacement zone which would take into account ownership by a system (hospitals under common ownership) of the hospital to be replaces. (Charge 6)

CHARGE 4, REPLACEMENT ZONE

The current language in the Public Health Code states: on the same site, on a contiguous site, or on a site within two 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 five miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

The Workgroup began its work by reviewing how other CON states handled replacement zones. The Oregon model appeared to come closest to something that might work in Michigan. The replacement zone in Oregon is 7 miles plus it has to be in the hospital's service area, which is defined to include those zip codes from which either 10% or more of the hospital's discharges originate or in which it has at least a 20% market share.

The Metropolitan Hospital, Grand Rapids, replacement zone pilot project language was examined to determine if it might provide some direction for this assignment. It was decided that the pilot was narrowly developed to cover the Metropolitan request for replacement and would not be applicable across the board as replacement zone policy.

Most of the effort of the Workgroup focused on attempting to find a methodology which would not focus on mileage as the only criterion for defining the replacement zone. The Workgroup, in so doing, was sensitive to the fact that there is a CON standard for relocation which requires bed need and comparative review. Creating a broad definition of replacement zone could be construed as really a relocation. Thus, much attention was placed on assuring that the hospital to be replaced remained within its own market if the replacement zone was to be significantly broadened.

In the course of the Workgroup deliberations other potential criteria were discussed beyond mileage and market share definition. These included:

- Travel time methodology (e.g. 30 minutes)
- Age of facility to be replaced, or age of original "footprint"
- Hospital to be replaced should not abandon the underserved populations
- Should the replacement hospital be allowed to build in the same market as a competitor (e.g. 5 mile restriction)
- State border or lake effect on replacement zone
- Population growth/shift
- Community support
- Right sizing provision to assure the bed license of the replacement hospital fits the needs of the community
- Need to replace dictated by establishing that retrofitting exceeds plant's market value
- Some % of existing staff live in the area
- Need to have a tertiary care presence in the area
- Require an X% of affiliated physician signatures
- Should a specified number of years of ownership be required of hospital to be replaced
- Should financing be in place for approval to replace
- Access to transportation infrastructure (main roads)
- Availability of suitable property at a reasonable market place price
- Allow any hospital to replace itself within a geographic area where the hospitals sub-area discharges are greater than other hospital sub-areas aggregate discharges
- Methodologies using hospitals in the sub-area occur within contiguous zip codes of the replacement site

Very thorough discussion occurred with regard to the value of including one or more of the criteria above into a recommendation on replacement zone. There was no consensus or a majority opinion registered on any of these additional criteria.

Rather the Workgroup preferred to focus on a mileage limitation and/or a mileage limitation with a market share test.

As a result the two following alternatives are presented to the SAC for consideration: Add exception language Section 7 subsection 4:

An applicant proposing to replace existing licensed hospital beds beyond the replacement zone as defined in Section 2(ee) shall supersede the replacement zone if the applicant can demonstrate satisfactorily to the Department the following:

Option 1
(I) the existing licensed site closes and;
(ii) the replaced beds are located at a new licensed site within 10 miles from the existing licensed hospital site and;
(iii) the proposed site is located in a zip code area that meets one of the following criteria:

a. the existing hospital had at least 15% of the total inpatient discharges originating from that zip code, according to the most recent data available to the department, or;

b. the number of inpatient discharges at the existing hospital from that zip code and all contiguous zip codes comprised at least 25% of the total inpatient discharges for the existing hospital, according to the most recent data available to the department. If the proposed replacement project results in the complete closure of two (2) or more existing licensed hospitals, the replacement zone may be determined using any combination of the discharge data of the existing hospitals to be closed to meet the requirements of Section 7(4)(ii)(b).

Option 2
(I) the existing licensed site closes and;
(ii) the replaced beds are located at a new licensed site within 5 miles from the existing hospital site.

CHARGE 6, COMMON OWNERSHIP CONSIDERATION

The Workgroup, after consultation with the Department and the member of the CON Commission who requested Charge 6, interpreted it to mean that the Workgroup should consider whether or not a hospital under common ownership (system), which is being replaced, should have different requirements as it relates to the replacement zone. Only a minority of the Workgroup supported recognition of system ownership in the application of the replacement zone criteria. One example of such a potential alteration would be the substitution of system market share for individual hospital market share in the area where the replacement hospital is to be built. Since only a minority of the Workgroup endorses a system modification to the options identified above, the Workgroup makes no recommendation with regard to Charge 6.