MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
CERTIFICATE OF NEED (CON) COMMISSION MEETING

Thursday, June 15, 2017

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

APPROVED MINUTES

I. Call to Order & Introductions

Chairperson Mukherji called the meeting to order at 9:34 a.m.

A. Members Present:

Suresh Mukherji, MD, Chairperson
Thomas Mittelbrun, Vice-Chairperson
Denise Brooks-Williams (participated via phone)
Gail J. Clarkson, RN
James B. Falahee, Jr., JD
Debra Guido-Allen, RN
Robert Hughes
Marc Keshishian, MD
Luis Tomatis, MD

B. Members Absent:

None.

C. Department of Attorney General Staff:

Joseph Potchen

D. Michigan Department of Health and Human Services Staff Present:

Tulika Bhattacharya
Amber Myers
Beth Nagel
Tania Rodriguez
Brenda Rogers

II. Review of Agenda

Motion by Commissioner Falahee, seconded by Commissioner Guido-Allen, to approve the agenda as presented. Motion carried.

III. Declaration of Conflicts of Interests

None.

IV. Review of Minutes of March 16, 2017

Motion by Commissioner Mittlebrun, seconded by Commissioner Falahee, to approved the minutes as presented. Motion carried.

V. Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services – Draft Language & Public Hearing Report

Ms. Rogers gave an overview of the public hearing (Attachment A), the draft language (Attachment B), and the Department's recommendations.

A. Public Comment

1. John Shaski and Carrie Linderoth, Sparrow Health System
2. Robert Meeker, Greater Michigan Lithotripsy
3. Jorgen Madsen, Great Lakes Lithotripsy

B. Commission Discussion

Discussion followed.

C. Commission Action

Motion by Commissioner Falahee, seconded by Commissioner Clarkson to take proposed action on the language presented today including the amendment and move to Public Hearing and forward to the Joint Legislative Committee (JLC). Motion carried in a vote of 8 - Yes, 0 - No, and 0 - Abstained.

VI. Nursing Home and Hospital Long-Term-Care Unit (NH-HLTCU) Beds – Final Report & Draft Language

Ms. Rogers gave an overview of the public hearing (Attachment C), the draft language (Attachment D), and the Department's recommendations.

A. Public Comment

1. David Stobb, Ciena Healthcare – comment card read for the record stating support for the changes to the standards

2. Pat Anderson, Health Care Association of Michigan (HCAM)

B. Commission Discussion

Discussion followed.

C. Commission Action

Motion by Commissioner Clarkson, seconded by Commissioner Falahee to take final action on the draft language as presented and forward to the JLC and the Governor for the 45-day review period. Motion carried in a vote of 8 - Yes, 0 - No, and 0 - Abstained.

VII. Surgical Services Draft Language

Ms. Rogers gave an overview of the draft language (see Attachment E).

A. Public Comment

1. David Walker, Spectrum Health

B. Discussion followed.

C. Commission Action

Motion by Commissioner Falahee, seconded by Commissioner Mittlebrun to take proposed action on the language presented today and move to Public Hearing and forward to the JLC. Motion carried in a vote of 8 - Yes, 0 - No, and 0 - Abstained.

VIII. Psychiatric Beds and Services – Re-calculation of Bed Need Numbers – Setting the Effective Date (Written Report from Paul Delamater)

Ms. Rogers gave an overview (see Attachment F).

Motion by Commissioner Falahee, seconded by Commissioner Keshishian to set July 3, 2017 as the effective date for the updated bed need methodology. Motion carried in a vote of 8 - Yes, 0 - No, and 0 - Abstained.

IX. Legislative Report

None.

X. Administrative Update

A. Planning & Access to Care Section Update

Ms. Nagel provided an update.

B. CON Evaluation Section Update

Ms. Bhattacharya provided an update on the following items:

1. Compliance Report (see Attachment G)
2. Quarterly Performance Measures (see Attachment H)

XI. Legal Activity Report

Mr. Potchen provided an update on the CON legal activity.

XII. Future Meeting Dates: September 21, 2017 & December 7, 2017

XIII. Public Comment

None.

XIV. Review of Commission Work Plan

Ms. Rogers provided an overview of the changes to the Work Plan (see Attachment I).

A. Commission Discussion

Discussion followed.

B. Commission Action

Motion by Commissioner Tomatis, seconded by Commissioner Keshishian to accept the Work Plan as presented with updates from today's meeting. Motion carried in a vote of 8 - Yes, 0- No, and 0- Abstained

XV. Adjournment

Motion by Commissioner Mittlebrun, seconded by Commissioner Falahee, to adjourn the meeting at 11:06 a.m. Motion Carried in a vote of 8 - Yes, 0 - No, and 0 - Abstained.

Michigan Department of Health and Human Services (MDHHS or Department)
MEMORANDUM
Lansing, MI

Date: May 16, 2017

TO: The Certificate of Need (CON) Commission

FROM: Brenda Rogers, Special Assistant to the CON Commission, Office of Planning, CON Policy, MDHHS

RE: Summary of Public Hearing Comments on Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services Standards

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Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the UESWL Services Standards at its March 16, 2017 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed UESWL Services Standards on May 2, 2017. Written testimony was accepted for an additional seven days after the hearing. Testimony was received from three organizations.

Written Testimony:

1.) Jorgen Madsen, Great Lakes Lithotripsy

- Supports the draft language except for the provision in the standard that would allow conversion from a mobile to a fixed UESWL unit. They state the following:
  - "If you allow for high volume sites to convert to fixed service, and leave just the lower volume sites on the mobile routes, the current system becomes jeopardized."
  - "The mobile service provides the technologist to operate the unit (including all of the expenses associated with any employee), insurance, maintenance, service contracts, etc.)"
  - "In order for this proposal to be consistent with the other standards that allow for this concept, the host site volume would need to reach 1,000 procedures per year to qualify."
  - Additional accreditation/certification requirements should be considered if new entrants are allowed into the market.

2.) Alan Buergenthal, Greater Michigan Lithotripsy

- Does not support the language that would allow conversion from a mobile to a fixed UESWL service. They state the following:

- “Mobile host sites receive a comprehensive service package from their central service provider. Not only does this comprehensive mobile lithotripsy service include state-of-the-art equipment with constant upgrades, but it also provides trained, experienced, and certified technologists; at least quarterly preventive maintenance; local and national quality assurance and review; appropriate insurance; compliance oversight; non-OEM proprietary upgrades; and annual certification. The value of these important support functions is more than half a million dollars a year for each mobile machine.”
- “To be consistent with other CON Standards, the volume requirement for converting to a fixed lithotripsy service should be at least as high as that for mobile.”
- “…allowing fixed lithotripters, even in the highest volume facilities, would result in greatly underutilized lithotripters.”
- “The higher volume sites on mobile routes are analogous to "anchor stores" in a shopping mall. By providing the highest percentage of the volume performed by the mobile unit, they enable the route to serve smaller facilities, permitting access for patients in more remote communities. If the "anchor" sites leave the route, the other sites would be unable to sustain the machine, causing the route to fall below CON minimum volumes and increasing costs for the other sites, which then would have to cover the fixed costs over fewer procedures. Costs for the remaining host sites on a route losing a high-volume host site would only increase.”
- “…allowing conversion to fixed lithotripsy with lower projected volume would be counter-productive. By diluting existing volume over more machines, costs would increase for existing host sites. Moreover, technologist proficiency and quality would be compromised with the proliferation of machines, because fixed site lithotripsy technologists will perform fewer procedures than those currently employed by the mobile providers. Likely, this effect would cascade to technologists on the mobile routes as well, due to anticipated lower volumes. Additionally, access could be constrained if existing providers need to consolidate the existing mobile routes in response to reduced volumes resulting from the loss of high-volume host sites.”

3.) John Shaski, Sparrow Hospital

- Supports the draft language. They state “The fixed unit's cost is $575,000 plus $60,000 annually for a service contract-contrasted with annual mobile lease costs of at least $750,000.”

Department Recommendation:

The Department supports the language as presented at the March 16, 2017 CON Commission meeting including the language for conversion from a mobile to a fixed service as well as increasing the number of procedures required from 500 to 1,000

procedures. 1,000 procedures is the required initiation level for mobile service and the maintenance level for both fixed and mobile UESWL services.

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

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR URINARY EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (UESWL) SERVICES

(By authority conferred on the CON Commission by Section 22215 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, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. These standards are requirements for approval to initiate, replace, expand, or acquire an UESWL service/unit under Part 222 of the Code. Urinary extracorporeal shock wave lithotripsy is a covered clinical service for purposes of Part 222 of the Code. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

Sec. 2. (1) For purposes of these standards:

(a) "Central service coordinator" OR "CSC" means the organizational unit that has operational responsibility for a mobile UESWL service and its unit(s) and that is a legal entity authorized to do business in the state of Michigan.

(b) "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.

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

(d) "Complicated stone disease treatment capability" means the expertise necessary to manage all patients during the treatment of kidney stone disease. This includes, but is not limited to:

(i) A urology service that provides skilled and experienced ureteroscopic stone removal procedures and

(ii) Experienced interventional radiologic support.

(e) "Department" means the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES (~~MDCH~~MDHHS).

(f) "Existing mobile UESWL unit" means a CON-approved and operational UESWL unit and transporting equipment operated by a central service coordinator that provides UESWL services to two or more host sites.

(g) "Existing UESWL service" means the utilization of a CON-approved and operational UESWL unit(s) at one site in the case of a fixed UESWL service or at each host site in the case of a mobile UESWL service.

(h) "Existing UESWL unit" means the utilization of a CON-approved and operational UESWL unit.

(i) "Hospital" means a health facility licensed under Part 215 of the Code.

(j) "Host site" means the site at which a mobile UESWL unit is authorized to provide UESWL services.

(k) "Licensed site" means either of the following:

(i) In the case of a single site health facility, the location of the facility authorized by license and listed on that licensee's Certificate of Licensure.

(ii) In the case of a health facility with multiple sites, the location of each separate and distinct health facility as authorized by license and listed on that licensee's Certificate of Licensure.

(l) "Michigan Inpatient Database" or "MIDB" means the database that is compiled by the Michigan Health and Hospital Association or successor organization. The database consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.

(m) "Mobile UESWL unit" means a UESWL unit and transporting equipment operated by a central service coordinator that provides UESWL services to two or more host sites.

(n) "Planning area" means the state of Michigan.
(o) “Region” means the geographic areas set forth in Appendix B.
(p) “Renewal of a lease” means extending the effective period of a lease for an existing UESWL unit that does not involve either the replacement/upgrade of a UESWL unit, as defined in Section 4, or a change in the parties to the lease.
(q) “Retreatment” means a UESWL procedure performed on the same side of the same patient within 6 months of a previous UESWL procedure performed at the same UESWL service. In the case of a mobile service, the term includes a retreatment performed at a different host site if the initial treatment was performed by the same service.
(r) "Ureteroscopic stone removal procedure" means a stone removal procedure conducted in the ureter by means of an endoscope that may or may not include laser technology.
(s) "Urinary extracorporeal shock wave lithotripsy" or "UESWL" means a procedure for the removal of kidney stones that involves focusing shock waves on kidney stones so that the stones are pulverized into sand-like particles, which then may be passed through the urinary tract.
(t) “UESWL service” means either the CON-approved utilization of a UESWL unit(s) at one site in the case of a fixed UESWL service or at each host site in the case of a mobile UESWL service.
(u) "UESWL unit" means the medical equipment that produces the shock waves for the UESWL procedure.

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

Section 3. Requirements to initiate a urinary extracorporeal shock wave lithotripsy service

Sec. 3. Initiate a UESWL service means to begin operation of a UESWL unit, whether fixed or mobile, at a site that does not offer (or has not offered within the last consecutive 12-month period) approved UESWL services. The term does not include the acquisition or replacement of an existing UESWL service or the renewal of a lease.

(1) An applicant proposing to initiate a UESWL service shall demonstrate each of the following:
(a) The capability to provide complicated stone disease treatment on-site.
(b) At least 1,000 procedures are projected pursuant to the methodology set forth in Section 10(1).
(c) The proposed UESWL service shall be provided at a site that provides, or will provide, each of the following:
(i) On-call availability of an anesthesiologist and a surgeon.
(ii) On-site Advanced Cardiac Life Support (ACLS)-certified personnel and nursing personnel.
(iii) EITHER ~~O~~on-site OR THROUGH A CONTRACTUAL AGREEMENT WITH ANOTHER HEALTH FACILITY, IV supplies and materials for infusions and medications, blood and blood products, and pharmaceuticals, including vasopressor medications, antibiotics, and fluids and solutions.
(iv) On-site general anesthesia, EKG, cardiac monitoring, blood pressure, pulse oximeter, ventilator, general radiography and fluoroscopy, cystoscopy, and laboratory services.
(v) On-site crash cart.
(vi) On-site cardiac intensive care unit or a written transfer agreement with a hospital that has a cardiac intensive care unit.
(vii) EITHER ~~O~~on-site OR THROUGH A CONTRACTUAL AGREEMENT WITH ANOTHER HEALTH FACILITY, A 23-hour holding unit.

(2) AN APPLICANT PROPOSING TO INITIATE A FIXED UESWL SERVICE THAT MEETS THE FOLLOWING REQUIREMENTS SHALL NOT BE REQUIRED TO BE IN COMPLIANCE WITH SUBSECTION (1)(B):
(a) THE APPLICANT IS CURRENTLY AN EXISTING MOBILE UESWL HOST SITE.
(b) THE APPLICANT HAS PERFORMED AT LEAST ~~500~~1000 PROCEDURES ANNUALLY FOR THE PAST THREE YEARS PRIOR TO SUBMITTING AN APPLICATION.
(c) THE APPLICANT SHALL INSTALL AND OPERATE THE FIXED UESWL UNIT AT THE SAME SITE AS THE EXISTING HOST SITE.

(d) THE APPLICANT SHALL CEASE OPERATION AS A HOST SITE AND NOT BECOME A HOST SITE FOR AT LEAST 12 MONTHS FROM THE DATE THE FIXED SERVICE BECOMES OPERATIONAL.

Section 4. Requirements to replace an existing UESWL unit(s)

Sec. 4. Replace an existing UESWL unit means an equipment change of an existing UESWL unit, other than an upgrade, proposed by an applicant that results in that applicant operating the same number of UESWL units before and after the project completion. The term does not include an upgrade of an existing UESWL unit, changing a mobile UESWL unit to a fixed UESWL unit, or changing a fixed UESWL unit to a mobile UESWL unit. Replacement also means a change in the location of a fixed UESWL unit(s) from the existing site to a different site, OR a change in the geographic location of an existing fixed UESWL service and its unit(s) from an existing site to a different site.

(1) "Upgrade an existing UESWL unit" means any equipment change, other than a replacement, that involves a capital expenditure of $125,000 or less in any consecutive 24-month period.

(2) An applicant proposing to replace an existing UESWL unit(s) shall demonstrate the following:
(a) Each existing UESWL unit of the service proposing to replace a UESWL unit has averaged at least 1,000 UESWL procedures per unit during the most recent continuous 12-month period for which the Department has verifiable data.
(b) Each UESWL unit of the service proposing to replace a UESWL unit is projected to perform at least 1,000 UESWL procedures per unit per year pursuant to the methodology set forth in Section 10.

(3) An applicant proposing to replace a UESWL unit shall demonstrate one or more of the following:
(a) The existing equipment clearly poses a threat to the safety of the public.
(b) The proposed replacement UESWL unit offers technological improvements that enhance quality of care, increase efficiency, or reduce operating costs and patient charges.
(c) The existing equipment is fully depreciated according to generally accepted accounting principles.

(4) An applicant that demonstrates that it meets the requirements in this subsection shall not be required to demonstrate compliance with Section 4(2):
(a) The proposed project involves replacing 1 existing fixed UESWL unit with 1 mobile UESWL unit.
(b) The proposed mobile unit will serve at least 1 host site that is located in a region other than the region in which the fixed UESWL unit proposed to be replaced is located currently.
(c) At least 100 UESWL procedures are projected in each region in which the proposed mobile UESWL unit is proposed to operate when the results of the methodology in Section 10 are combined for the following, as applicable:
(i) All licensed hospital sites committing MIDB data pursuant to Section 11, as applicable, that are located in the region identified in subsection (c).
(ii) All sites that receive UESWL services from an existing UESWL service and propose to receive UESWL services from the proposed mobile unit and that are located in the region identified in subsection (c).
(d) A separate application from each host site is filed at the same time the application to replace a fixed unit is submitted to the Department.
(e) The proposed mobile UESWL unit is projected to perform at least 1,000 procedures annually pursuant to the methodology set forth in Section 10.

(5) An applicant proposing to ~~relocate~~ REPLACE ~~its~~ AN existing FIXED UESWL service and its unit(s) TO A NEW SITE shall demonstrate that the proposed project meets all of the following:
(a) ~~The UESWL service and its unit(s) to be relocated is a fixed UESWL unit(s).~~
~~(b)~~ The UESWL service to be ~~relocated~~ REPLACED has been in operation for at least 36 months as of the date an application is submitted to the Department UNLESS THE APPLICANT MEETS THE REQUIREMENT IN SUBSECTION (d)(i) OR (ii).

(~~c~~b) The site to which the UESWL service will be ~~relocated~~ REPLACED meets the requirements of Section 3(1)(c).

(~~d~~c) The proposed new site is in the state of Michigan and within a 25-mile radius of the existing site of the UESWL service to be ~~relocated~~REPLACED.

(~~e~~d) The UESWL service and its unit(s) to be ~~relocated~~ REPLACED performed an average of at least 1,000 procedures per unit in the most recent 12-month period for which the Department has verifiable data UNLESS ONE OF THE FOLLOWING REQUIRMENTS ARE MET:~~.~~

(i) THE OWNER OF THE BUILDING WHERE THE SITE IS LOCATED HAS INCURRED A FILING FOR BANKRUPTCY UNDER CHAPTER SEVEN (7) WITHIN THE LAST THREE YEARS;

(ii) THE OWNERSHIP OF THE BUILDING WHERE THE SITE IS LOCATED HAS CHANGED WITHIN 24 MONTHS OF THE DATE OF THE SERVICE BEING OPERATIONAL; OR

(iii) THE UESWL SERVICE BEING REPLACED IS PART OF THE REPLACEMENT OF AN ENTIRE HOSPITAL TO A NEW GEOGRAPHIC SITE AND HAS ONLY ONE (1) UESWL UNIT.

(~~f~~e) The applicant agrees to operate the UESWL service and its unit(s) in accordance with all applicable project delivery requirements set forth in Section 9 of these standards.

(6) An applicant proposing to ~~relocate~~ REPLACE a fixed UESWL unit(s) of an existing UESWL service shall demonstrate that the proposed project meets all of the following:

(a) The existing UESWL service from which the UESWL unit(s) is to be ~~relocated~~ REPLACED has been in operation for at least 36 months as of the date an application is submitted to the Department.

(b) The site to which the UESWL unit(s) will be ~~relocated~~ REPLACED meets the requirements of Section 3(1)(c).

(c) The proposed new site is in the state of Michigan and within a 25-mile radius of the existing site of the fixed UESWL unit to be ~~relocated~~REPLACED.

(d) Each existing UESWL unit(s) at the service from which a unit is to be ~~relocated~~ REPLACED performed at least an average of 1,000 procedures per fixed unit in the most recent 12-month period for which the Department has verifiable data.

(e) The applicant agrees to operate the UESWL unit(s) in accordance with all applicable project delivery requirements set forth in Section 9 of these Standards.

(f) For volume purposes, the new site shall remain associated with the existing UESWL service for a minimum of three years.

(7) Equipment that is replaced shall be removed from service and disposed of or rendered considerably inoperable on or before the date that the replacement equipment becomes operational.

Section 5. Requirements for approval to expand an existing UESWL service

Sec. 5. Expand an existing UESWL service means the addition of one UESWL unit at an existing UESWL service. An applicant proposing to expand an existing UESWL service, whether fixed or mobile, unless otherwise specified, shall demonstrate the following:

(1) All of the applicant's existing UESWL units, both fixed and mobile, at the same geographic location as the proposed additional UESWL unit, have performed an average of at least 1,800 procedures per UESWL unit during the most recent 12-month period for which the Department has verifiable data. In computing this average, the Department will divide the total number of UESWL procedures performed by the applicant's total number of UESWL units, including both operational and approved but not operational fixed and mobile UESWL units.

(2) The applicant shall project an average of at least 1,000 procedures for each existing and proposed fixed and mobile UESWL unit(s) as a result from the application of the methodology in Section 10 of these standards for the second 12-month period after initiation of operation of each additional UESWL unit whether fixed or mobile.

(3) An applicant proposing to expand an existing mobile UESWL service must provide a copy of the existing or revised contracts between the central service coordinator and each host site(s) that includes the same stipulations as specified in Section 7(1)(c).

Section 6. Requirements to acquire an existing UESWL service or an existing UESWL unit(s)

Sec. 6. Acquisition of an existing UESWL service or existing UESWL unit(s)" means obtaining possession or control of an existing fixed or mobile UESWL service or existing UESWL unit(s) by purchase, lease, donation, or other comparable arrangement.

(1) ~~An~~ THE applicant ~~proposing to acquire an existing fixed or mobile UESWL service and its unit(s)~~ shall not be required to be in compliance with the volume requirement applicable to the seller/lessor on the date the acquisition occurs ~~demonstrate that A~~IF THE proposed project meets ~~all~~ ONE of the following:

(a) ~~For an application for the proposed~~IT IS THE first acquisition of ~~an~~ THE existing fixed or mobile UESWL service~~,~~ for which a final decision has not been issued after May 2, 1998~~, an existing UESWL service to be acquired shall not be required to be in compliance with the volume requirement applicable to the seller/lessor on the date the acquisition occurs~~. ~~The UESWL service and its unit(s) shall be operating at the applicable volume requirements set forth in Section 9 of these standards in the second 12 months after the date the service and its unit(s) is acquired, and annually thereafter.~~

(b) THE EXISTING FIXED OR MOBILE UESWL SERVICE IS OWNED BY, IS UNDER COMMON CONTROL OF, OR HAS A COMMON PARENT AS THE APPLICANT, AND THE UESWL SERVICE SHALL REMAIN AT THE SAME SITE.

(2) For any application for proposed acquisition of an existing fixed or mobile UESWL service, except ~~the first~~ AN application approved pursuant to subsection (~~a~~1), ~~for which a final decision has not been issued after May 2, 1998~~, an applicant shall be required to demonstrate that the UESWL service and its unit(s) to be acquired performed an average of at least 1,000 procedures per unit in the most recent 12-month period for which the Department has verifiable data.

(~~2~~3) An applicant proposing to acquire an existing fixed or mobile UESWL unit(S) of an existing UESWL service shall demonstrate that the proposed project meets all of the following:

(a) For any application for proposed acquisition of an existing fixed or mobile UESWL unit(s), an applicant shall be required to demonstrate that the UESWL unit(s) to be acquired performed an average of at least 1,000 procedures per unit in the most recent 12-month period for which the Department has verifiable data.

(b) The requirements of Section 3(1)(c) have been met.

(4) The UESWL service and its unit(s) shall be operating at the applicable volume requirements set forth in Section 9 of these standards in the second 12 months after the date the service and its unit(s) is acquired, and annually thereafter.

Section 7. Additional requirements for approval for mobile UESWL services

Sec. 7. (1) An applicant proposing to begin operation of a mobile UESWL service in Michigan shall demonstrate that it meets all of the following:

(a) At least 100 UESWL procedures are projected in each region in which the proposed mobile UESWL unit is proposing to operate when the results of the methodology in Section 10 are combined for the following, as applicable:

(i) All licensed hospital sites committing MIDB data pursuant to Section 11, as applicable, that are located in the region identified in subsection (b).

(ii) All sites that receive UESWL services from an existing UESWL unit and propose to receive UESWL services from the proposed mobile unit are located in the region(s) identified in subsection (b).

(b) The normal route schedule, the procedures for handling emergency situations, and copies of all potential contracts related to the mobile UESWL service and its unit(s) shall be included in the CON application submitted by the central service coordinator.

(2) The requirements of sections 3, 4, and subsection (1)(a) shall not apply to an applicant that proposes to add a Michigan site as a host site if the applicant demonstrates that the mobile UESWL service and its unit(s) operates predominantly outside of Michigan and all of the following requirements are met:

(a) The proposed host site is located in a rural or micropolitan statistical area county.

(b) All existing and approved Michigan UESWL service and its unit(s) locations (whether fixed or mobile) are in excess of 50 miles from the proposed host site and within a region currently served by a UESWL mobile service operating predominantly outside of Michigan.

(c) A separate CON application has been submitted by the CSC and each proposed host site.

(3) A central service coordinator proposing to add, or an applicant proposing to become, a host site on either an existing or a proposed mobile UESWL service shall demonstrate that it meets the requirements of Section 3(1)(C).

(4) A central service coordinator proposing to add, or an applicant proposing to become, a host site on an existing mobile UESWL service in a region not currently served by that service shall demonstrate that at least 100 UESWL procedures are projected in each region in which the existing mobile UESWL service is proposing to add a host site when the results of the methodology in Section 10 are combined for the following, as applicable:

(a) All licensed hospital sites committing MIDB data pursuant to Section 11, as applicable, are located in that region(s).

(b) All sites that receive UESWL services from an existing UESWL service and its unit(s) and propose to receive UESWL services from the proposed mobile service and its unit(s) are located in that region(s).

Section 8. Requirements for Medicaid participation

Sec. 8. An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of service if a CON is approved.

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

Sec 9. An applicant shall agree that, if approved, UESWL services, including all existing and approved UESWL units, shall be delivered in compliance with the following:

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(a) The medical staff and governing body shall receive and review at least annual reports describing activities of the UESWL service, including complication rates, morbidity data, and retreatment rates.

(b) An applicant shall accept referrals for UESWL services from all appropriately licensed health care practitioners.

(c) An applicant shall develop and utilize a standing medical staff and governing body rule that provides for the medical and administrative control of the ordering and utilization of UESWL services.

(d) An applicant shall require that each urologist serving as a UESWL surgeon shall have completed an approved training program in the use of the lithotripter at an established facility with UESWL services.

(e) An applicant shall establish a process for credentialing urologists who are authorized to perform UESWL procedures at the applicant facility. This shall not be construed as a requirement to establish specific credentialing requirements for any particular hospital or UESWL site.

(f) A urologist who is not an active medical staff member of an applicant facility shall be eligible to apply for limited staff privileges to perform UESWL procedures. Upon request by the Department, an applicant shall provide documentation of its process that will allow a urologist who is not an active medical staff member to apply for medical staff privileges for the sole and limited purpose of performing UESWL procedures. In order to be granted staff privileges limited to UESWL procedures, a urologist shall demonstrate that he or she meets the same requirements, established pursuant to the provisions of subsection (e), that a urologist on an applicant facility's active medical staff must meet in order to perform UESWL procedures.

(g) An applicant shall provide UESWL program access to approved physician residency programs for teaching purposes.

(3) Compliance with the following access to care requirements:

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

(i) Not deny any UESWL services to any individual based on inability to pay or source of payment,

(ii) Provide all UESWL services to any individual based on clinical indications of need for the services, and

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

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

(c) The operation of and referral of patients to the UESWL service shall be in conformance with 1978 PA 368, Sec. 16221, as amended by 1986 PA 319; MCL 333.16221; MSA 14.15 (16221).

Compliance with selective contracting requirements shall not be construed as a violation of this term.

(4) Compliance with the following monitoring and reporting requirements:

(a) Each UESWL unit, whether fixed or mobile, shall perform at least an average of 1,000 procedures per unit per year in the second 12 months of operation and annually thereafter. The central service coordinator shall demonstrate that a mobile UESWL unit approved pursuant to these standards performed at least 100 procedures in each region that is served by the mobile unit. For purposes of this requirement, the number of UESWL procedures performed at all host sites in the same region shall be combined.

(b) 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; operating schedules; and demographic, diagnostic, morbidity and mortality information; primary diagnosis code; whether the procedure was a first or retreatment UESWL procedure; what other treatment already has occurred; outpatient or inpatient status; complications; and whether follow-up procedures (e.g., percutaneous nephrotomy) were required, as well as the volume of care provided to patients from all payor sources. An applicant shall provide the required data on a separate basis for each host site or 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.

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

(5) Compliance with the following mobile UESWL requirements, if applicable:

(a) The volume of UESWL procedures performed at each host site shall be reported to the Department by the central service coordinator.

(b) An applicant with an approved CON for a mobile UESWL service shall notify the Department and the local CON review agency, if any, at least 30 days prior to dropping an existing host site.

(c) Each mobile UESWL service shall establish and maintain an Operations Committee consisting of the central service coordinator's medical director and members representing each host site and the central service coordinator. This committee shall oversee the effective and efficient use of the UESWL unit, establish the normal route schedule, identify the process by which changes are to be made to the schedule, develop procedures for handling emergency situations, and review the ongoing operations of the mobile UESWL service and its unit(s) on at least a quarterly basis.

(d) The central service coordinator shall arrange for emergency repair services to be available 24 hours each day for the mobile UESWL unit equipment and the vehicle transporting the equipment.

(e) If the host site will not be performing the lithotripsy procedures inside the facility, it must provide a properly prepared parking pad for the mobile UESWL unit of sufficient load-bearing capacity to support the vehicle, a waiting area for patients, and a means for patients to enter the vehicle without going outside (such as a canopy or enclosed corridor). Each host site also must provide the capability for maintaining the confidentiality of patient records. A communication system must be provided between the mobile vehicle and each host site to provide for immediate notification of emergency medical situations.

(f) A mobile UESWL service shall operate under a contractual agreement that includes the provision of UESWL services at each host site on a regularly scheduled basis.

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

Section 10. Methodology for projecting UESWL procedures

Sec. 10. (1) The methodology set forth in this subsection shall be used for projecting the number of UESWL procedures at a site or sites that do not provide UESWL services as of the date an application is submitted to the Department. In applying the methodology, actual inpatient discharge data, as specified in the most recent Michigan Inpatient Database available to the Department on the date an application is deemed complete shall be used for each licensed hospital site for which a signed data commitment form has been provided to the Department in accordance with the provisions of Section 11. In applying inpatient discharge data in the methodology, each inpatient record shall be used only once and the following steps shall be taken in sequence:

(a) The number of inpatient records with a diagnosis, either principal or nonprincipal, of ICD-9-CM codes 592.0, 592.1, or 592.9 (see Appendix D for ICD-10-CM Codes) shall be counted.

(b) The result of subsection (a) shall be multiplied by the factor specified in Appendix A for each licensed hospital site that is committing its inpatient discharge data to a CON application. If more than one licensed hospital site is committing inpatient discharge data in support of a CON application, the products from the application of the methodology for each licensed hospital site shall be summed.

(c) The result of subsection (b) is the total number of projected UESWL procedures for an application that is proposing to provide fixed or mobile UESWL services at a site, or sites in the case of a mobile service, that does not provide UESWL service, either fixed or mobile, as of the date an application is submitted to the Department.

(2) For a site or sites that provide UESWL services as of the date an application is submitted to the Department, the actual number of UESWL procedures performed at each site, during the most recent continuous 12-month period for which the Department has verifiable data, shall be the number used to project the number of UESWL procedures that will be performed at that site or sites.

(3) For a proposed UESWL unit, except for initiation, the results of subsections (1) and (2), as applicable, shall be summed and the result is the projected number of UESWL procedures for the proposed UESWL unit for purposes of the applicable sections of these standards.

(4) An applicant that is projecting UESWL procedures pursuant to subsection (1) shall provide access to verifiable hospital-specific data and documentation using a format prescribed by the Department.

Section 11. Requirements for MIDB data commitments

Sec. 11. (1) In order to use MIDB data in support of an application for UESWL services, an applicant shall demonstrate or agree to, as applicable, all of the following.

(a) A licensed hospital site whose MIDB data is used in support of a CON application for a UESWL service shall not use any of its MIDB data in support of any other application for a UESWL service for 5 years following the date the UESWL service to which the MIDB data are committed begins to operate.

The licensed hospital site shall be required to commit 100% of its inpatient discharge data to a CON application.

(b) The licensed hospital site, or sites, committing MIDB data to a CON application has completed the departmental form(s) that agrees to or authorizes each of the following:

(i) The Michigan Health and Hospital Association may verify the MIDB data for the Department.

(ii) An applicant shall pay all charges associated with verifying the MIDB data.

(iii) The commitment of the MIDB data remains in effect for the period of time specified in subsection (1)(a).

(c) A licensed hospital site that is proposing to commit MIDB data to an application is admitting patients regularly as of the date the director makes the final decision on that application under Section 22231(9) of the Code, being Section 333.22231(9) of the Michigan Compiled Laws.

(2) The Department shall consider an MIDB data commitment in support of an application for a UESWL service from a licensed hospital site that meets all of the following:

(a) The licensed hospital site proposing to commit MIDB data to an application does not provide, or does not have a valid CON to provide, UESWL services, either fixed or mobile, as of the date an application is submitted to the Department.

(b) The licensed hospital site proposing to commit MIDB data is located in a region in which a proposed fixed UESWL service is proposed to be located or, in the case of a mobile unit, has at least one host site proposed in that region.

(c) The licensed hospital site meets the requirements of subsection (1), as applicable.

Section 12. Effect on prior planning policies; comparative reviews

Sec. 12. (1) These CON review standards supersede and replace the CON review standards for urinary extracorporeal shock wave lithotripsy (UESWL) services approved by the CON Commission on ~~March 18~~SEPTEMBER 25, 2014 and effective on ~~June~~ DECEMBER 22, 2014.

(2) Projects reviewed under these standards shall not be subject to comparative review.

APPENDIX A

Factor For Calculating Projected UESWL Procedures

(1) Until changed by the Department, the factor to be used in Section 10(1)(b) used for calculating the projected number of UESWL procedures shall be 1.~~09~~104.

(2) The Department may amend Appendix A by revising the factor in subsection (1) in accordance with the following steps:

(a) Steps for determining statewide UESWL adjustment factor:

(i) Determine the total statewide number of inpatient records with a diagnosis, either principal or nonprincipal, of ICD-9-CM codes 592.0, 592.1, or 592.9 (see Appendix D for ICD-10-CM Codes) for the most recent year for which Michigan Inpatient Database information is available to the Department.

(ii) Determine the total number of UESWL procedures performed in the state using the Department's Annual Hospital Questionnaire for the same year as the MIDB being used in subsection (i) above.

(iii) Divide the number of UESWL procedures determined in subsection (ii) above by the number of inpatient records determined in subsection (i) above.

(b) Steps for determining "urban/rural" adjustment factor:

(i) For each hospital, assign urban/rural status based on the ~~2000 census~~COUNTY CLASSIFICATIONS FOUND IN APPENDIX C. "Metropolitan statistical area counties" will be assigned "urban" status, and "micropolitan statistical area" and "rural" counties will be assigned "rural" status.

(ii) Aggregate the records from step (a)(i) by zip code "urban/rural" status.

(iii) Identify the zip codes in which all records are either "urban" status or "rural" status. Aggregate the number of records and zip code populations separately by "urban/rural" status.

(iv) For zip codes having records in both "urban" and "rural" status, Calculate the proportion of records in "urban" and "rural" by dividing the respective number of records by the total number of records for that zip code. Multiply the population of each zip code by its respective "urban" and "rural" proportions.

(v) Aggregate the records and populations from step (b)(iv) separately by "urban/rural" status.

(vi) The sub-totals from step (v) will then be added to the sub-totals from step (iii) to produce totals for "urban" & "rural" separately. Calculate the "urban" and "rural" discharge rates per 10,000 (DRU and DRR, respectively) by dividing the total number of records by the total population for each status, then multiplying by 10,000.

(vii) Divide the urban discharge rate by the rural discharge rate (DRU/DRR) to calculate the "urban/rural" adjustment factor. Multiply the statewide adjustment factor identified in step (a)(iii) by the "urban/rural" adjustment factor. The result is the revised factor for calculating UESWL procedures.

(3) The Department shall notify the Commission when this revision is made and the effective date of the revision.

APPENDIX B

Counties assigned to each region are as follows:

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

APPENDIX C

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

APPENDIX D

ICD-9-CM TO ICD-10-CM CODE TRANSLATION

ICD-9 CODE	DESCRIPTION	ICD-10 CODE	DESCRIPTION
592.0	Calculus of Kidney	N20.0	Calculus of Kidney
		N20.2	Calculus of Kidney with Calculus of Ureter
592.1	Calculus of Ureter	N20.1	Calculus of Ureter
		N20.2	Calculus Of Kidney with Calculus of Ureter
592.9	Urinary Calculus	N20.9	Urinary Calculus, Unspecified
		N22	Calculus of Urinary Tract in Diseases Classified Elsewhere

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

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

Michigan Department of Health and Human Services (MDHHS or Department)
MEMORANDUM
Lansing, MI

Date: May 16, 2017

TO: The Certificate of Need (CON) Commission

FROM: Brenda Rogers, Special Assistant to the CON Commission, Office of Planning, CON Policy, MDHHS

RE: Summary of Public Hearing Comments on Nursing Home and Hospital Long-Term-Care Unit (NH-HLTCU) Beds Standards

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Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the NH-HLTCU Beds Standards at its March 16, 2017 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed NH-HLTCU Beds Standards on May 2, 2017. Written testimony was accepted for an additional seven days after the hearing. Testimony was received from one organization.

Written Testimony:

1.) *Pat Anderson, Health Care Association of Michigan (HCAM)*
- Supports the draft language. They state the following:
  - "…recommend that the bed need for nursing homes be updated based on the changes to the methodology." *(The bed need is scheduled to be run this summer.)*
  - "…continue to have a concern regarding the CON requirement and related fees for renewal of leases with no change to either party to the lease."

Department Recommendation:

The Department supports the language as presented at the March 16, 2017 CON Commission meeting.

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

CERTIFICATE OF NEED (CON) REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT (HLTCU) BEDS

(By authority conferred on the CON Commission by Section 22215 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, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. (1) These standards are requirements for approval under Part 222 of the Code that involve a) beginning operation of a new nursing home/HLTCU, (b) replacing beds in a nursing home/HLTCU or physically relocating nursing home/HLTCU beds from one licensed site to another geographic location, (c) increasing licensed beds in a nursing home/HLTCU licensed under Part 217 and a HLTCU defined in Section 20106(6), or (d) acquiring a nursing home/HLTCU. Pursuant to the Code, a nursing home/HLTCU is a covered health facility. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

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

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

Section 2. Definitions

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

(a) "Acquisition of an existing nursing home/HLTCU" means the issuance of a new nursing home/HLTCU license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangement) of an existing licensed and operating nursing home/HLTCU and which does not involve a change in bed capacity of that health facility.

(b) "ADC adjustment factor" means the factor by which the average daily census (ADC), derived during the bed need methodology calculation set forth in Section 3(2)(d) for each planning area, is divided. ~~For planning areas with an ADC of less than 100, t~~The ADC adjustment factor is 0.90 ~~and~~ for ALL planning areas ~~with an ADC of 100 or more, the ADC adjustment factor is 0.95~~.

(c) "Applicant's cash" means the total unrestricted cash, designated funds, and restricted funds reported by the applicant as the source of funds in the application. If the project includes space lease costs, the applicant's cash includes the contribution designated for the project from the landlord.

(d) "Base year" means 1987 or the most recent year for which verifiable data collected as part of the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES Annual Survey of Long-Term-Care Facilities or other comparable ~~MDCH~~MDHHS survey instrument are available.

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

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

(g) "Common ownership or control" means a nursing home, regardless of the state in which it is located, that is owned by, is under common control of, or has a common parent as the applicant nursing

home pursuant to the definition of common ownership or control utilized by the Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Care Services.

(h) "Comparative group" means the applications which have been grouped for the same type of project in the same planning area or statewide special pool group and which are being reviewed comparatively in accordance with the CON rules.

(i) "Converted space" means existing space in a health facility that is not currently licensed as part of the nursing home/HLTCU and is proposed to be licensed as nursing home or HLTCU space. An example is proposing to license home for the aged space as nursing home space.

(j) "Department" means the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES (~~MDCH~~MDHHS).

(k) "Department inventory of beds" means the current list, for each planning area maintained on a continuing basis by the Department: (i) licensed nursing home beds and (ii) nursing home beds approved by a valid CON issued under Part 222 of the Code which are not yet licensed. It does not include (a) nursing home beds approved from the statewide pool and (b) short-term nursing care program beds approved pursuant to Section 22210 of the Code, being Section 333.22210 of the Michigan Compiled Laws.

(l) "Existing nursing home beds" means, for a specific planning area, the total of all nursing home beds located within the planning area including: (i) licensed nursing home beds, (ii) nursing home beds approved by a valid CON issued under Part 222 of the Code which are not yet licensed, (iii) proposed nursing home beds under appeal from a final Department decision made under Part 222 or pending a hearing from a proposed decision issued under Part 222 of the Code, and (iv) proposed nursing home beds that are part of a completed application under Part 222 of the Code which is pending final Department decision. (a) Nursing home beds approved from the statewide pool are excluded; and (b) short-term nursing care program beds approved pursuant to Section 22210 of the Code, being Section 333.22210 of the Michigan Compiled Laws, are excluded.

(m) "Health service area" or "HSA" means the geographic area established for a health systems agency pursuant to former Section 1511 of the Public Health Service Act and set forth in ~~Section 14~~APPENDIX A.

(n) "Hospital long-term-care unit" or "HLTCU" means a nursing care facility, owned and operated by and as part of a hospital, that provides organized nursing care and medical treatment to seven (7) or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

(o) "Licensed only facility" means a licensed nursing home that is not certified for Medicare or Medicaid.

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

(q) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396 to 1396g and1396i to 1396u.

(r) "New design model" means a nursing home/HLTCU built in accordance with specified design requirements as identified in the applicable sections.

(s) "Nursing home" means a nursing care facility, including a county medical care facility, but excluding a hospital or a facility created by Act No. 152 of the Public Acts of 1885, as amended, being sections 36.1 to 36.12 of the Michigan Compiled Laws, that provides organized nursing care and medical treatment to seven (7) or more unrelated individuals suffering or recovering from illness, injury, or infirmity. This term applies to the licensee only and not the real property owner if different than the licensee.

(t) "Nursing home bed" means a bed in a health facility licensed under Part 217 of the Code or a licensed bed in a hospital long-term-care unit. The term does not include short-term nursing care program beds approved pursuant to Section 22210 of the Code being Section 333.22210 of the Michigan Compiled Laws or beds in health facilities listed in Section 22205(2) of the Code, being Section 333.22205(2) of the Michigan Compiled Laws.

(u) "Occupancy rate" means the percentage which expresses the ratio of the actual number of patient days of care provided divided by the total number of patient days. Total patient days is calculated by summing the number of licensed and/or CON approved but not yet licensed beds and multiplying these beds by the number of days that they were licensed and/or CON approved but not yet licensed. This shall include nursing home beds approved from the statewide pool. Occupancy rates shall be calculated using verifiable data from the actual number of patient days of care for 12 continuous months of data from the CON Annual Survey or other comparable ~~MDCH~~ MDHHS survey instrument.

(v) "Planning area" means the geographic boundaries of each county in Michigan with the exception of: (i) Houghton and Keweenaw counties, which are combined to form one planning area and (ii) Wayne County which is divided into three planning areas. Section 12 identifies the three planning areas in Wayne County and the specific geographic area included in each.

(w) "Planning year" means 1990 or the year in the future, at least three (3) years but no more than seven (7) years, for which nursing home bed needs are developed. The planning year shall be a year for which official population projections, from the Department of Management and Budget or U.S. Census, data are available.

(x) "Proposed licensed site" means the physical location and address (or legal description of property) of the proposed project or within 250 yards of the physical location and address (or legal description of property) and within the same planning area of the proposed project that will be authorized by license and will be listed on that licensee's certificate of licensure.

(y) "Relocation of existing nursing home/HLTCU beds" means a change in the location of existing nursing home/HLTCU beds from the licensed site to a different existing licensed site within the planning area.

(z) "Renewal of lease" means execution of a lease between the licensee and a real property owner in which the total lease costs exceed the capital expenditure threshold.

(aa) "Replacement bed" means a change in the location of the licensed nursing home/HLTCU, the replacement of a portion of the licensed beds at the same licensed site, or the replacement of a portion of the licensed beds pursuant to the new model design. The nursing home/HLTCU beds will be in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.) within the replacement zone.

(bb) "Replacement zone" means a proposed licensed site that is,

(i) for a rural or micropolitan statistical area county, within the same planning area as the existing licensed site.

(ii) for a county that is not a rural or micropolitan statistical area county,

(A) within the same planning area as the existing licensed site and

(B) within a three-mile radius of the existing licensed site.

(cc) "Use rate" means the number of nursing home and hospital long-term-care unit days of care per 1,000 population during a one-year period.

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

Section 3. Determination of needed nursing home bed supply

Sec. 3 (1)(a) The age specific use rates for the planning year shall be the actual statewide age specific nursing home use rates using data from the base year.

(b) The age cohorts for each planning area shall be: (i) age 0 - 64 years, (ii) age 65 - 74 years, (iii) age 75 - 84 years, and (iv) age 85 and older.

(c) Until the base year is changed by the Commission in accord with Section 4(3) and Section 5, the use rates for the base year PER 1000 POPULATION for each corresponding age cohort, established in accord with subsection (1)(b), are ~~set forth in Appendix B~~POSTED ON THE STATE OF MICHIGAN CON WEB SITE.

(2) The number of nursing home beds needed in a planning area shall be determined by the following formula:

(a) Determine the population for the planning year for each separate planning area in the age cohorts established in subsection (1)(b).

(b) Multiply each population age cohort by the corresponding use rate ~~established in Appendix B~~ WHICH IS POSTED ON THE STATE OF MICHIGAN CON WEB SITE.

(c) Sum the patient days resulting from the calculations performed in subsection (b). The resultant figure is the total patient days.

(d) Divide the total patient days obtained in subsection (c) by 365 (or 366 for leap years) to obtain the projected average daily census (ADC).

(e) ~~The following shall be known as the ADC adjustment factor. (i) If the ADC determined in subsection (d) is less than 100, d~~Divide the ADC DETERMINED IN SUBSECTION (d) by 0.90. ~~(ii) If the ADC determined in subsection (d) is 100 or greater, divide the ADC by 0.95.~~

(f) The number determined in subsection (e) represents the number of nursing home beds needed in a planning area for the planning year.

Section 4. Bed need

Sec. 4. (1) The bed need numbers shall apply to project applications subject to review under these standards, except where a specific CON standard states otherwise.

(2) The Department shall apply the bed need methodology in Section 3 on a biennial basis.

(3) The base year and the planning year that shall be utilized in applying the methodology pursuant to subsection (2) shall be set according to the most recent data available to the Department.

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

(5) New bed need numbers established by subsections (2) and (3) shall supersede previous bed need numbers and shall be posted on the state of Michigan CON web site as part of the Nursing Home/HLTCU Bed Inventory.

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

Section 5. Modification of the age specific use rates by changing the base year

Sec. 5. (1) The base year shall be modified based on data obtained from the Department and presented to the Commission. The Department shall calculate use rates for each of the age cohorts set forth in Section 3(1)(b) and biennially present the revised use rates based on 2006 information, or the most recent base year information available biennially after 2006, to the CON Commission.

(2) The Commission shall establish the effective date of the modifications made pursuant to subsection (1).

(3) Modifications made by the Commission pursuant to subsection (1) shall not require standard advisory committee action, a public hearing, or submittal of the standard to the Legislature and the Governor in order to become effective.

Section 6. Requirements for approval to increase beds in a planning area

Sec. 6. An applicant proposing to increase the number of nursing home beds in a planning area must meet the following as applicable:

(1) An applicant proposing to increase the number of nursing home beds in a planning area by beginning operation of a new nursing home/HLTCU or increasing the number of beds to an existing licensed nursing home/HLTCU shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

(d) The proposed increase, if approved, will not result in the total number of existing nursing home beds in that planning area exceeding the needed nursing home bed supply, unless one of the following is met:

(i) An applicant may request and be approved for up to a maximum of 20 beds if, when the total number of "existing nursing home beds" is subtracted from the bed need for the planning area, the difference is equal to or more than 1 and equal to or less than 20. This subsection is not applicable to projects seeking approval for beds from the statewide pool of beds.

(ii) ~~An exception to the number of beds may be approved, if the applicant facility has experienced an average occupancy rate of 97% for three years based on the CON Annual Survey. The number of beds that may be approved in excess of the bed need for each planning area is set forth in subsection (A).~~

~~(A) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the occupancy rate for the planning area in which the additional beds are proposed to the ADC adjustment factor for that planning area as shown in Appendix C. The number of beds shall be calculated by (1) dividing the actual number of patient days of care provided during the most recent 12-month period for which verifiable data are available to the Department provided by all nursing home (including HLTCU) beds in the planning area, including patient days of care provided in beds approved from the statewide pool of beds and dividing that result by 365 (or 366 for leap years); (2) dividing the result of step (1) by the ADC adjustment factor for the planning area in which the beds are proposed to be added; (3) rounding the result of step (2) up to the next whole number; and (4) subtracting the total number of beds in the planning area including beds approved from the statewide pool of beds from the result of step (3). If the number of beds necessary to reduce the planning area occupancy rate to the ADC adjustment factor for that planning area is equal to or more than 20, the number of beds that may be approved pursuant to this subsection shall be up to that number of beds. If the number of beds necessary to reduce the planning area occupancy rate to the ADC adjustment factor for that planning area is less than 20, the number of additional beds that may be approved shall be that number of beds or up to a maximum of 20 beds.~~

~~(iii)~~ An applicant may request and be approved for up to a maximum of 20 beds if the following requirements are met:

(A) ~~The planning area in which the beds will be located shall have a population density of less than 28 individuals per square mile based on the 2010 U.S. Census figures as set forth in Appendix E.~~

~~(B)~~ The applicant facility has experienced an average occupancy rate of 92% for the most recent ~~two years~~12 CONSECUTIVE MONTHS AND 90% OR ABOVE FOR THE PRIOR 12 MONTHS AS VERIFIABLE BY THE DEPARTMENT AS OF THE DATE AN APPLICATION IS SUBMITTED TO THE DEPARTMENT~~ based on the CON Annual Survey~~.

(B) THE APPLICANT FACILITY HAS NOT DECREASED THE NUMBER OF LICENSED BEDS WITHIN THE 24 MONTHS PRECEDING THE APPLICATION DATE.

(C) THE APPLICANT FACILITY SHALL PROPOSE NO MORE THAN TWO BEDS PER RESIDENT ROOM AND SHALL ELIMINATE ALL THREE AND/OR FOUR BED WARDS WITHIN THE EXISTING FACILITY, IF APPLICABLE, AS PART OF THE PROPOSED PROJECT.

(D) THE APPLICANT FACILITY SHALL CERTIFY THE NEW BEDS FOR BOTH MEDICARE AND MEDICAID.

(E) THE APPLICANT FACILITY SHALL NOT RELOCATE ANY BEDS FROM THE FACILITY OR REPLACE A PORTION OF BEDS TO A NEW SITE PURSUANT TO SECTION 7(3)(d), FOLLOWING CON APPROVAL AND FOR AT LEAST 24 MONTHS FROM THE DATE OF THE LICENSURE OF THE NEW BEDS AT THE FACILITY.

(2) An applicant proposing to increase the number of nursing home beds in a planning area by beginning operation of a new nursing home/HLTCU or increasing the number of beds to an existing licensed nursing home/HLTCU pursuant to the new design model shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) The proposed project results in no more than 100 beds per new design model and meets the following design standards:

(i) For inpatient facilities that are not limited to group resident housing of 10 beds or less, the construction standards shall be those applicable to nursing homes in the document entitled Minimum Design Standards for Health Care Facilities in Michigan and incorporated by reference in Section 20145(6) of the Public Health Code, being Section 333.20145(6) of the Michigan Compiled Laws or any future versions.

(ii) For small resident housing units of 10 beds or less that are supported by a central support inpatient facility, the construction standards shall be those applicable to hospice residences providing an inpatient level of care, except that:

(A) at least 100% of all resident sleeping rooms shall meet barrier free requirements;

(B) electronic nurse call systems shall be required in all facilities;

(C) handrails shall be required on both sides of patient corridors; and

(D) ceiling heights shall be a minimum of 7 feet 10 inches.

(iii) The proposed project shall comply with applicable life safety code requirements and shall be fully sprinkled and air conditioned.

(iv) The Department may waive construction requirements for new design model projects if authorized by law.

(c) The proposed project shall include at least 80% single occupancy resident rooms with an adjoining toilet room containing a sink, water closet, and bathing facility and serving no more than two residents in both the central support inpatient facility and any supported small resident housing units.

(d) The proposed increase, if approved, will not result in the total number of existing nursing home beds in that planning area exceeding the needed nursing home bed supply, unless the following is met:

(i) An approved project involves replacement of a portion of the beds of an existing facility at a geographic location within the replacement zone that is not physically connected to the current licensed site. If a portion of the beds are replaced at a location that is not the current licensed site, a separate license shall be issued to the facility at the new location.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

Section 7. Requirements for approval to replace beds

Sec. 7. An applicant proposing to replace beds must meet the following as applicable.

(1) An applicant proposing to replace beds within the replacement zone shall not be required to be in compliance with the needed nursing home bed supply if all of the following requirements are met:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUS and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) The proposed project is either to replace the licensed nursing home/HLTCU to a new proposed licensed site or replace a portion of the licensed beds at the existing licensed site.

(c) The proposed licensed site is within the replacement zone.

(d) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

(2) An applicant proposing to replace a licensed nursing home/HLTCU outside the replacement zone shall demonstrate all of the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) The total number of existing nursing home beds in that planning area is equal to or less than the needed nursing home bed supply.

(c) The number of beds to be replaced is equal to or less than the number of currently licensed beds at the nursing home/HLTCU at which the beds proposed for replacement are currently located.

(d) The applicant certifies that the requirements found in the Minimum Design Standards for Health Care Facilities of Michigan, referenced in Section 20145 (6) of the Public Health Code, Act 368 of 1978, as amended and are published by the Department, will be met when the architectural blueprints are submitted for review and approval by the Department.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

(3) An applicant proposing to replace beds with a new design model shall not be required to be in compliance with the needed nursing home bed supply if all of the following requirements are met:

(a) The proposed project results in no more than 100 beds per new design model and meets the following design standards:

(i) For inpatient facilities that are not limited to group resident housing of 10 beds or less, the construction standards shall be those applicable to nursing homes in the document entitled Minimum Design Standards for Health Care Facilities in Michigan and incorporated by reference in Section 20145(6) of the Public Health Code, being Section 333.20145(6) of the Michigan Compiled Laws or any future versions.

(ii) For small resident housing units of 10 beds or less that are supported by a central support inpatient facility, the construction standards shall be those applicable to hospice residences providing an inpatient level of care, except that:

(a) at least 100% of all resident sleeping rooms shall meet barrier free requirements;

(b) electronic nurse call systems shall be required in all facilities;

(c) handrails shall be required on both sides of patient corridors; and

(d) ceiling heights shall be a minimum of 7 feet 10 inches.

(iii) The proposed project shall comply with applicable life safety code requirements and shall be fully sprinkled and air conditioned.

(iv) The Department may waive construction requirements for new design model projects if authorized by law.

(b) The proposed project shall include at least 80% single occupancy resident rooms with an adjoining toilet room containing a sink, water closet, and bathing facility and serving no more than two residents in both the central support inpatient facility and any supported small resident housing units. If the proposed project is for replacement/renovation of an existing facility and utilizes only a portion of its currently licensed beds, the remaining rooms at the existing facility shall not exceed double occupancy.

(c) The proposed project shall be within the replacement zone unless the applicant demonstrates all of the following:

(i) the proposed licensed site for the replacement beds is in the same planning area,

(ii) the applicant shall provide a signed affidavit or resolution from its governing body or authorized agent stating that the proposed licensed site will continue to provide service to the same market, and

(iii) the current patients of the facility/beds being replaced shall be admitted to the replacement beds when the replacement beds are licensed, to the extent that those patients desire to transfer to the replacement facility/beds.

(d) An approved project may involve replacement of a portion of the beds of an existing facility at a geographic location within the replacement zone that is not physically connected to the current licensed site. If a portion of the beds are replaced at a location that is not the current licensed site, a separate license shall be issued to the facility at the new location. IF BEDS HAVE BEEN ADDED PURSUANT TO

SECTION 6(1)(d)(ii), THEN THE APPLICANT FACILITY SHALL NOT RELOCATE ANY BEDS FROM THE FACILITY OR REPLACE A PORTION OF BEDS TO A NEW SITE FOLLOWING CON APPROVAL AND FOR AT LEAST 24 MONTHS FROM THE DATE OF THE LICENSURE OF THE NEW BEDS AT THE FACILITY.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

Section 8. Requirements for approval to relocate existing nursing home/HLTCU beds

Sec. 8. (1) An applicant proposing to relocate existing nursing home/HLTCU beds shall not be required to be in compliance with the needed nursing home bed supply if all of the following requirements are met:

(a) There shall not be any ownership relationship requirements between the nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds.

(b) The relocated beds shall be placed in the same planning area.

(c) The relocated beds shall be licensed to the receiving nursing home/HLTCU and will be counted in the inventory for the applicable planning area.

(d) At the time of transfer to the receiving facility, patients in beds to be relocated must be given the choice of remaining in another bed in the nursing home/HLTCU from which the beds are being transferred or to the receiving nursing home/HLTCU. Patients shall not be involuntary discharged to create a vacant bed.

(e) Relocation of beds shall not increase the rooms with three (3) or more bed wards in the receiving facility.

(f) IF BEDS HAVE BEEN ADDED PURSUANT TO SECTION 6(1)(d)(ii), THEN THE APPLICANT FACILITY SHALL NOT RELOCATE ANY BEDS FROM THE FACILITY OR REPLACE A PORTION OF BEDS TO A NEW SITE FOLLOWING CON APPROVAL AND FOR AT LEAST 24 MONTHS FROM THE DATE OF THE LICENSURE OF THE NEW BEDS AT THE FACILITY.

(2) An applicant proposing to add new nursing home/HLTCU beds, as the receiving existing nursing home/HLTCU under subsection (1), shall not be required to be in compliance with the needed nursing home bed supply if all of the following requirements are met:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) The approval of the proposed new nursing home/HLTCU beds shall not result in an increase in the number of nursing home beds in the planning area.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

Section 9. Requirements for approval to acquire an existing nursing home/HLTCU or renew the lease of an existing nursing home/HLTCU

Sec. 9. An applicant proposing to acquire an existing nursing home/HLTCU or renew the lease of an existing nursing home/HLTCU must meet the following as applicable:

(1) An applicant proposing to acquire an existing nursing home/HLTCU shall not be required to be in compliance with the needed nursing home bed supply for the planning area in which the nursing home or HLTCU is located if all of the following requirements are met:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the state of Michigan including, but not limited to, quality assurance assessment program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or civil monetary penalties (CMP).

(b) The acquisition will not result in a change in bed capacity.

(c) The licensed site does not change as a result of the acquisition.

(d) The project is limited solely to the acquisition of a nursing home/HLTCU with a valid license.

(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with the Department, and

(f) The applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health Care Services within LARA, and shall post the annual report in the facility if the facility being acquired has met any of conditions in subsections (a)(i), (ii), (iii), (iv), (v), or (vi).

(g) IF THE APPLICANT IS A NEW ENTITY WITH NO PRIOR NH-HLTCU HISTORY, THE APPLICANT SHALL SUBMIT PROOF THAT:

(i) THE NURSING HOME/HLTCU TO BE ACQUIRED IS NO LONGER LISTED AS A SPECIAL FOCUS NURSING HOME BY THE CENTER FOR MEDICARE AND MEDICAID SERVICES, OR THE APPLICANT SHALL PARTICIPATE IN A QUALITY IMPROVEMENT PROGRAM, APPROVED BY THE DEPARTMENT, FOR FIVE YEARS AND PROVIDE AN ANNUAL REPORT TO THE MICHIGAN STATE LONG-TERM-CARE OMBUDSMAN, BUREAU OF HEALTH CARE SERVICES WITHIN LARA, AND SHALL POST THE ANNUAL REPORT IN THE FACILITY; AND

(ii) ALL DELINQUENT DEBT OBLIGATIONS TO THE STATE OF MICHIGAN INCLUDING, BUT NOT LIMITED TO, QAAP, PASARR OR CMPs HAVE BEEN PAID.

(2) An applicant proposing to acquire an existing nursing home/HLTCU approved pursuant to the new design model shall demonstrate the following:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

Type of Applicant	Reporting Requirement
Applicant with only Michigan nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control
Applicant with 10 or more Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan nursing homes/HLTCUs under common ownership or control

Applicant with fewer than 10 Michigan nursing homes/HLTCUs and out of state nursing homes/HLTCUs	All Michigan and out of state nursing homes/HLTCUs under common ownership or control

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Delinquent debt obligation to the State of Michigan including, but not limited to, Quality Assurance Assessment Program (QAAP), Preadmission Screening and Annual Resident Review (PASARR) or Civil Monetary Penalties (CMP).

(b) An applicant will continue to operate the existing nursing home/HLTCU pursuant to the new design model requirements.

(c) The applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health of Health Care Services within LARA, and shall post the annual report in the facility if the facility being acquired has met any of conditions in subsections (a)(i), (ii), (iii), (iv), (v), or (vi).

(d) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

(e) IF THE APPLICANT IS A NEW ENTITY WITH NO PRIOR NH-HLTCU HISTORY, THE APPLICANT SHALL SUBMIT PROOF THAT:

(i) THE NURSING HOME/HLTCU TO BE ACQUIRED IS NO LONGER LISTED AS A SPECIAL FOCUS NURSING HOME BY THE CENTER FOR MEDICARE AND MEDICAID SERVICES, OR THE APPLICANT SHALL PARTICIPATE IN A QUALITY IMPROVEMENT PROGRAM, APPROVED BY THE DEPARTMENT, FOR FIVE YEARS AND PROVIDE AN ANNUAL REPORT TO THE MICHIGAN STATE LONG-TERM-CARE OMBUDSMAN, BUREAU OF HEALTH CARE SERVICES WITHIN LARA, AND SHALL POST THE ANNUAL REPORT IN THE FACILITY; AND

(ii) ALL DELINQUENT DEBT OBLIGATIONS TO THE STATE OF MICHIGAN INCLUDING, BUT NOT LIMITED TO, QAAP, PASARR OR CMPs HAVE BEEN PAID.

(3) An applicant proposing to renew the lease for an existing nursing home/HLTCU shall not be required to be in compliance with the needed nursing home bed supply for the planning area in which the nursing home/HLTCU is located, if all of the following requirements are met:

(a) The lease renewal will not result in a change in bed capacity.

(b) The licensed site does not change as a result of the lease renewal.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with LARA.

Section 10. Review standards for comparative review

Sec. 10. (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) The degree to which each application in a comparative group meets the criterion set forth in Section 22230 of the Code, being Section 333.22230 of the Michigan Compiled Laws, shall be determined based on the sum of points awarded under subsections (a) and (b).

(a) A qualifying project will be awarded points as follows:

(i) For an existing nursing home/HLTCU, the current percentage of patient days of care reimbursed by Medicaid for the most recent 12 months of operation.

(ii) For a new nursing home/HLTCU, the proposed percentage of patient days of care to be reimbursed by Medicaid in the second 12 months of operation following project completion.

Percentage of Medicaid Patient Days (calculated using total patient days for all existing and proposed beds at the facility)	Points Awarded	
	Existing	Proposed
50 – 69%	4	3
70 – 100%	8	7

(b) A qualifying project will be awarded 10 points if all beds in the proposed project will be dually certified for both Medicare and Medicaid services by the second 12 months of operation.

(3) A qualifying project will have 15 points deducted if the applicant has any of the following at the time the application is submitted:

(a) has been a special focus nursing home/HLTCU within the last three (3) years;

(b) has had more than eight (8) substandard quality of care citations; immediate harm citations, and/or immediate jeopardy citations in the three (3) most recent standard survey cycles (includes intervening abbreviated surveys, standard surveys, and revisits);

(c) has had an involuntary termination or voluntary termination at the threat of a medical assistance provider enrollment and trading partner agreement within the last three (3) years;

(d) has had a state enforcement action resulting in a reduction in license capacity or a ban on admissions within the last three (3) years; or

(e) has any delinquent debt obligation to the state of Michigan including, but not limited to, quality assurance assessment program (QAAP), civil monetary penalties (CMP), Medicaid level of care determination (LOCD), or preadmission screening and annual resident review (PASARR).

(4) A qualifying project will be awarded three (3) points if the applicant provides documentation that it participates or if it proposes to participate in a culture change model, which contains person centered care, ongoing staff training, and measurements of outcomes. An additional five (5) points will be awarded if the culture change model, either currently used or proposed, is a model approved by the Department.

(5) A qualifying project will be awarded points based on the proposed percentage of the "Applicant's cash" to be applied toward funding the total proposed project cost as follows:

Percentage "Applicant's Cash"	Points Awarded
Over 20%	5
10 – 20%	3
5 – 9%	2

(6) A qualifying project will be awarded four (4) points if the entire existing and proposed nursing home/HLTCU is fully equipped with air conditioning. Fully equipped with air conditioning means meeting the design temperatures in table 6b of the minimum design standards for health care facilities in Michigan and capable of maintaining a temperature of 71 – 81 degrees for the resident unit corridors.

(7) A qualifying project will be awarded six (6) or four (4) points based on only one of the following:
(a) Six (6) points if the proposed project has 100% rooms with dedicated toilet room containing a sink, water closet, and bathing facility or
(b) Four (4) points if the proposed project has 80% private rooms with dedicated toilet room containing a sink, water closet and bathing facility.

(8) A qualifying project will be awarded 10 points if it results in a nursing home/HLTCU with 150 or fewer beds in total.

(9) A qualifying project will be awarded five (5) points if the proposed beds will be housed in new construction.

(10) A qualifying project will be awarded 10 points if the entire existing nursing home/HLTCU and its proposed project will have no more than double occupancy rooms at completion of the project.

(11) A qualifying project will be awarded two (2) points if the existing or proposed nursing home/HLTCU is on or readily accessible to an existing or proposed public transportation route.

(12) A qualifying project will be awarded points for technological innovation as follows:

INNOVATIONS	Points Awarded
The proposed project will have wireless nurse call/paging system including wireless devices carried by direct care staff	1
Wireless internet with resident access to related equipment/device in entire facility	1
An integrated electronic medical records system with point-of-service access capability (including wireless devices) for all disciplines including pharmacy, physician, nursing, and therapy services at the entire existing and proposed nursing home/HLTCU	4
The proposed project will have a backup generator supporting all functions with an on-site or piped-in fuel supply and be capable of providing at least 48 hours of service at full load	4

(13) A qualifying project will be awarded three (3) points if the proposed project includes bariatric rooms as follows: project using 0 – 49 beds will result in at least one (1) bariatric room or project using 50

or more beds will result in at least two (2) bariatric rooms. Bariatric room means the creation of patient room(s) included as part of the CON project, and identified on the architectural schematics, that are designed to accommodate the needs of bariatric patients weighing over ~~400~~ 350 pounds. The bariatric patient rooms shall have a larger ENTRANCE WIDTH FOR THE ROOM ~~room~~ and bathroom ~~entrance width~~ to accommodate over-sized equipment, and shall include a minimum of a bariatric bed, bariatric toilet, bariatric wheelchair, and a device to assist resident movement (such as a portable or build in lift). If an in-room shower is not included in the bariatric patient room, the main/central shower room that is located on the same floor as the bariatric patient room(s) shall include at least one (1) shower stall that has an opening width and depth that is larger than minimum MI code requirements.

(14) Submission of conflicting information in this section may result in a lower point award. If an application contains conflicting information which could result in a different point value being awarded in this section, the Department will award points based on the lower point value that could be awarded from the conflicting information. For example, if submitted information would result in 6 points being awarded, but other conflicting information would result in 12 points being awarded, then 6 points will be awarded. If the conflicting information does not affect the point value, the Department will award points accordingly. For example, if submitted information would result in 12 points being awarded and other conflicting information would also result in 12 points being awarded, then 12 points will be awarded.

(15) 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 subsections (2) through (12) 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 which, when taken together, 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 on the application when the application is filed.

Section 11. Project delivery requirements and terms of approval

Sec. 11. An applicant shall agree that, if approved, the nursing home/HLTCU services shall be delivered in compliance with the following terms of approval:

(1) Compliance with these standards, including the requirements of Section 10. If an applicant is awarded beds pursuant to Section 10 and representations made in that section, the Department shall monitor compliance with those statements and representations and shall determine actions for non-compliance.

(2) Compliance with the following applicable quality assurance standards:

(a) Compliance with Section 22230 of the Code shall be based on the nursing home's/HLTCU's actual Medicaid participation within the time periods specified in these standards. Compliance with Section 10(2)(a) of these standards shall be determined by comparing the nursing home's/HLTCU's actual patient days reimbursed by Medicaid, as a percentage of the total patient days, with the applicable schedule set forth in Section 10(2)(a) for which the applicant had been awarded points in the comparative review process. If any of the following occurs, an applicant shall be required to be in compliance with the range in the schedule immediately below the range for which points had been awarded in Section 10(2)(a), instead of the range of points for which points had been awarded in the comparative review in order to be found in compliance with Section 22230 of the Code: (i) the average percentage of Medicaid recipients in all nursing homes/HLTCUs in the planning area decreased by at least 10 percent between the second 12 months of operation after project completion and the most recent 12-month period for which data are available, (ii) the actual rate of increase in the Medicaid program per diem reimbursement to the applicant nursing home/HLTCU is less than the annual inflation index for nursing homes/HLTCUs

as defined in any current approved Michigan State Plan submitted under Title XIX of the Social Security Act which contains an annual inflation index, or (iii) the actual percentage of the nursing home's/HLTCU's patient days reimbursed by Medicaid (calculated using total patient days for all existing and proposed nursing home beds at the facility) exceeds the statewide average plus 10 percent of the patient days reimbursed by Medicaid for the most recent year for which data are available from the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES [subsection (iii) is applicable only to Section 10(2)(a)]. In evaluating subsection (ii), the Department shall rely on both the annual inflation index and the actual rate increases in per diem reimbursement to the applicant nursing home/HLTCU and/or all nursing homes/HLTCUs in the HSA.

(b) For projects involving the acquisition of a nursing home/HLTCU, the applicant shall agree to maintain the nursing home's/HLTCU's level of Medicaid participation (patient days and new admissions) for the time periods specified in these standards, within the ranges set forth in Section 10(2)(a) for which the seller or other previous owner/lessee had been awarded points in a comparative review.

(c) For projects involving replacement of an existing nursing home/HLTCU, the current patients of the facility/beds being replaced shall be admitted to the replacement beds when the replacement beds are licensed, to the extent that those patients desire to transfer to the replacement facility/beds.

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

(3) Compliance with the following access to care requirements:

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

(i) not deny services to any individual based on payor source.

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

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

(4) Compliance with the following monitoring and reporting requirements:

(a) 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; operating schedules; 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 an individual 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.

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

(5) An applicant shall agree that, if approved, and material discrepancies are later determined within the reporting of the ownership and citation history of the applicant facility and all nursing homes under common ownership and control that would have resulted in a denial of the application, shall surrender the CON. This does not preclude an applicant from reapplying with corrected information at a later date.

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

Section 12. Department inventory of beds

Sec. 12. The Department shall maintain a listing of the Department Inventory of Beds for each planning area.

Section 13. Wayne County planning areas

Sec. 13. (1) For purposes of these standards the cities and/or townships in Wayne County are assigned to the planning areas as follows:

Planning Area 84/Northwest Wayne

Canton Township, Dearborn, Dearborn Heights, Garden City, Inkster, Livonia, Northville (part), Northville Township, Plymouth, Plymouth Township, Redford Township, Wayne, Westland

Planning area 85/Southwest Wayne

Allen Park, Belleville, Brownstown Township, Ecorse, Flat Rock, Gibraltar, Grosse Ile Township, Huron Township, Lincoln Park, Melvindale, River Rouge, Riverview, Rockwood, Romulus, Southgate, Sumpter Township, Taylor, Trenton, Van Buren Township, Woodhaven, Wyandotte

Planning area 86/Detroit

Detroit, Grosse Pointe, Grosse Pointe Township, Grosse Pointe Farms, Grosse Pointe Park, Grosse Pointe Woods, Hamtramck, Harper Woods, Highland Park

Section 14. Effect on prior CON review standards, comparative reviews

Sec. 14. (1) These CON review standards supersede and replace the CON Standards for Nursing Home and Hospital Long-Term-Care Unit (HLTCU) Beds approved by the CON Commission on December ~~15~~11, ~~2010~~ 2014 and effective on March ~~11~~20, ~~2011~~2015.

(2) Projects reviewed under these standards involving a change in bed capacity shall be subject to comparative review except as follows:

(a) replacement of an existing nursing home/HLTCU being replaced in ~~a rural county~~THE REPLACEMENT ZONE;

(b) replacement of an existing nursing home/HLTCU ~~in a micropolitan or metropolitan statistical area county that is within two miles of the existing nursing home/HLTCU~~ PURSUANT TO SECTION 7(3) AND WITHIN THE SAME PLANNING AREA AS THE EXISTING LICENSED SITE;

(c) relocation of existing nursing home/HLTCU beds; or

(d) an increase in beds pursuant to Section 6(1)(d)(ii) ~~or (iii)~~.

(3) Projects reviewed under these standards that relate solely to the acquisition of an existing nursing home/HLTCU or the renewal of a lease shall not be subject to comparative review.

APPENDIX A

Counties assigned to each of the HSAs are as follows:

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

APPENDIX B

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT BEDS

The use rate per 1000 population for each age cohort, for purposes of these standards, effective August MARCH 16, 20132016, and until otherwise changed by the Commission, is as follows.

(i) Age 0 - 64: 200 195 days of care

(ii) Age 65 - 74: 2,6382,380 days of care

(iii) Age 75 - 84: 9,3798,091 days of care

(iv) Age 85 +: 34,00929,408 days of care

APPENDIX C

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM-CARE UNIT BEDS

The ADC adjustment factor, for purposes of these standards, effective August 1, 2013, and until otherwise changed by the Commission, are as follows:

Planning Area	ADC Adjustment Factor
Alcona	0.90
Alger	0.90
Allegan	0.95
Alpena	0.95
Antrim	0.95
Arenac	0.90
Baraga	0.90
Barry	0.95
Bay	0.95
Benzie	0.95
Berrien	0.95
Branch	0.95
Calhoun	0.95
Cass	0.95
Charlevoix	0.95
Cheboygan	0.95
Chippewa	0.95
Clare	0.95
Clinton	0.95
Crawford	0.90
Delta	0.95
Dickinson	0.95
Eaton	0.95
Emmet	0.95
Genesee	0.95
Gladwin	0.95
Gogebic	0.95
Gd. Traverse	0.95
Gratiot	0.95
Hillsdale	0.95
Houghton/Keweenaw	0.95
Huron	0.95

~~APPENDIX C - continued~~

Planning Area	ADC Adjustment Factor
Ingham	0.95
Ionia	0.95
Iosco	0.95
Iron	0.90
Isabella	0.95
Jackson	0.95
Kalamazoo	0.95
Kalkaska	0.90
Kent	0.95
Lake	0.90
Lapeer	0.95
Leelanau	0.95
Lenawee	0.95
Livingston	0.95
Luce	0.90
Mackinac	0.90
Macomb	0.95
Manistee	0.95
Marquette	0.95
Mason	0.95
Mecosta	0.95
Menominee	0.95
Midland	0.95
Missaukee	0.90
Monroe	0.95
Montcalm	0.95
Montmorency	0.90
Muskegon	0.95
Newaygo	0.95
Oakland	0.95
Oceana	0.95
Ogemaw	0.95
Ontonagon	0.90
Osceola	0.95
Oscoda	0.90
Otsego	0.95
Ottawa	0.95

~~**APPENDIX B - continued**~~

Planning Area	ADC Adjustment Factor
Presque Isle	0.95
Roscommon	0.95
Saginaw	0.95
St. Clair	0.95
St. Joseph	0.95
Sanilac	0.95
Schoolcraft	0.90
Shiawassee	0.95
Tuscola	0.95
Van Buren	0.95
Washtenaw	0.95
Wexford	0.95
NW Wayne	0.95
SW Wayne	0.95
Detroit	0.95

APPENDIX ~~DB~~

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

APPENDIX E

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS

Michigan nursing home planning areas with a population density of less than 28 individuals per square mile based on 2010 U.S. Census figures.

Planning Area	Population Density Per Square Mile
Ontonagon	5.11
Schoolcraft	6.95
Luce	7.16
Baraga	9.67
Iron	9.76
Alger	10.25
Mackinac	10.45
Gogebic	14.35
Oscoda	15.12
Alcona	15.76
Montmorency	17.36
Presque Isle	19.53
Lake	20.11
Chippewa	21.29
Menominee	22.86
Houghton/Keweenaw	24.17
Crawford	25.00
Missaukee	25.90

Source: Michigan Department of Management and Budget and The U.S. Bureau of the Census

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

CON REVIEW STANDARDS
FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS
--ADDENDUM FOR SPECIAL POPULATION GROUPS

(By authority conferred on the CON Commission by Section 22215 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, 24.207 and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability; definitions

Sec. 1. (1) This addendum supplements the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds and shall be used for determining the need for projects established to better meet the needs of special population groups within the long-term care and nursing home populations.

(2) Except as provided in sections 2, 3, 4, 5, 6, 7, and 8 of this addendum, these standards supplement, and do not supersede, the requirements and terms of approval required by the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(3) The definitions which apply to the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds shall apply to these standards.

(4) For purposes of this addendum, the following terms are defined:

(a) "BARIATRIC PATIENT" MEANS A PATIENT WEIGHTING OVER 350 POUNDS.

(b) "BARIATRIC ROOM" MEANS THE CREATION OF PATIENT ROOM(S) INCLUDED AS PART OF THE CON PROJECT, AND IDENTIFIED ON THE ARCHITECTURAL SCHEMATICS, THAT ARE DESIGNED TO ACCOMMODATE THE NEEDS OF BARIATRIC PATIENTS WEIGHING OVER 350 POUNDS. THE BARIATRIC PATIENT ROOMS SHALL HAVE A LARGER ENTRANCE WIDTH FOR THE ROOM AND BATHROOM TO ACCOMMODATE OVER-SIZED EQUIPMENT, AND SHALL INCLUDE A MINIMUM OF A BARIATRIC BED, BARIATRIC TOILET, BARIATRIC WHEELCHAIR, AND A DEVICE TO ASSIST RESIDENT MOVEMENT (SUCH AS A PORTABLE OR BUILD IN LIFT). IF AN IN-ROOM SHOWER IS NOT INCLUDED IN THE BARIATRIC PATIENT ROOM, THE MAIN/CENTRAL SHOWER ROOM THAT IS LOCATED ON THE SAME FLOOR AS THE BARIATRIC PATIENT ROOM(S) SHALL INCLUDE AT LEAST ONE (1) SHOWER STALL THAT HAS AN OPENING WIDTH AND DEPTH THAT IS LARGER THAN MINIMUM MI CODE REQUIREMENTS.

(c) "Behavioral patient" means an individual that exhibits a history of chronic behavior management problems such as aggressive behavior that puts self or others at risk for harm, or an altered state of consciousness, including paranoia , delusions, and acute confusion.

~~(b) "Hospice" means a health care program licensed under Part 214 of the Code, being Section 333.21401 et seq.~~

(~~c~~d) "Infection control program," means a program that will reduce the risk of the introduction of communicable diseases into a ventilator-dependent unit, provide an active and ongoing surveillance program to detect the presence of communicable diseases in a ventilator-dependent unit, and respond to the presence of communicable diseases within a ventilator-dependent unit so as to minimize the spread of a communicable disease.

(~~d~~e) "Licensed hospital" means either a hospital licensed under Part 215 of the Code; or a psychiatric hospital or unit licensed pursuant to Act 258 of the Public Acts of 1974, as amended, being sections 330.1001 to 330.2106 of the Michigan Compiled Laws.

(~~e~~f) "Private residence", means a setting other than a licensed hospital; or a nursing home including a nursing home or part of a nursing home approved pursuant to Section 6.

(~~f~~g) "Traumatic brain injury (TBI)/spinal cord injury (SCI) patient" means an individual with TBI or SCI that is acquired or due to a traumatic insult to the brain and its related parts that is not of a degenerative or congenital nature. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial adjustment.

(~~g~~h) "Ventilator-dependent patient," means an individual who requires mechanical ventilatory assistance.

Section 2. Requirements for approval -- applicants proposing to increase nursing home beds -- special use exceptions

Sec. 2. A project to increase nursing home beds in a planning area which, if approved, would otherwise cause the total number of nursing home beds in that planning area to exceed the needed nursing home bed supply or cause an increase in an existing excess as determined under the applicable CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds, may nevertheless be approved pursuant to this addendum.

Section 3. Statewide pool for the needs of special population groups within the long-term care and nursing home populations

Sec. 3. (1) A statewide pool of additional nursing home beds of 1,958 beds needed in the state is established to better meet the needs of special population groups within the long-term care and nursing home populations. Beds in the pool shall be allocated as follows:

(a) These categories shall be allocated 1,~~109~~039 beds and distributed as follows and shall be reduced/redistributed in accordance with subsection (c):

(i) TBI/SCI beds will be allocated 400 beds.

(ii) Behavioral beds will be allocated 400 beds.

(iii) ~~Hospice~~ BARIATRIC beds will be allocated ~~130~~60 beds.

(iv) Ventilator-dependent beds will be allocated 179 beds.

(b)The following historical categories have been allocated ~~849~~919 beds. Additional beds shall not be allocated to these categories. If the beds within any of these categories are delicensed, the beds shall be eliminated and not be returned to the statewide pool for special population groups.

(i) Alzheimer's disease has 384 beds.

(ii) Health care needs for skilled nursing care has 173 beds.

(iii) Religious has 292 beds.

(iv) Hospice beds has 70 beds.

(c) ~~The number of beds set aside from the total statewide pool established for categories in subsection (1)(a) for a special population group shall be reduced if there has been no CON activity for that special population group during at least 6 consecutive application periods.~~

~~(i) The number of beds in a special population group shall be reduced to the total number of beds for which a valid CON has been issued for that special population group.~~

~~(ii) The number of beds reduced from a special population group pursuant to this subsection shall revert to the total statewide pool established for categories in subsection (1)(a).~~

~~(iii) The Department shall notify the Commission of the date when action to reduce the number of beds set aside for a special population group has become effective and shall identify the number of beds that reverted to the total statewide pool established for categories in subsection (1)(a).~~

~~(iv) For purposes of this subsection, "application period" means the period of time from one designated application date to the next subsequent designated application date.~~

~~(v) For purposes of this subsection, "CON activity" means one or more of the following:~~

~~(A) CON applications for beds for a special population group have been submitted to the Department for which either a proposed or final decision has not yet been issued by the Department.~~

~~(B) Administrative hearings or appeals to court of decisions issued on CON applications for beds for a special population group are pending resolution.~~

~~(C) An approved CON for beds for each special population group has expired for lack of appropriate action by an applicant to implement an approved CON.~~ THE COMMISSION MAY ADJUST/REDISTRIBUTE THE NUMBER OF BEDS AVAILABLE IN THE STATEWIDE POOL FOR THE NEEDS OF SPECIAL POPULATION GROUPS IN SUBSECTION (1)(a) CONCURRENT WITH THE BIENNIAL RECALCUATION OF THE STATEWIDE NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BED NEED. MODIFYING THE NUMBER OF BEDS AVAILABLE IN THE STATEWIDE POOL FOR THE NEEDS OF SPECIAL POPULATION GROUPS IN SUBSECTION (1)(a) PURSUANT TO THIS SECTION SHALL NOT REQURE A PUBLIC HEARING OR SUBMITTAL OF THE STANDARD TO THE LEGISLATURE AND THE GOVERNOR IN ORDER TO BECOME EFFECTIVE.

(d) By setting aside these beds from the total statewide pool, the Commission's action applies only to applicants seeking approval of nursing home beds pursuant to sections 4, 5, 6, and 7. It does not preclude the care of these patients in units of hospitals, hospital long-term care units, nursing homes, or other health care settings in compliance with applicable statutory or certification requirements.

(2) Increases in nursing home beds approved under this addendum for special population groups shall not cause planning areas currently showing an unmet bed need to have that need reduced or planning areas showing a current surplus of beds to have that surplus increased.

Section 4. Requirements for approval for beds from the statewide pool for special population groups allocated to TBI/SCI patients

Sec. 4. The CON Commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of TBI/SCI patients as compared to serving these needs in general nursing home unit(s).

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate with credible documentation to the satisfaction of the Department each of the following:

(a) The beds will be operated as part of a specialized program exclusively for TBI/SCI patients. At the time an application is submitted, the applicant shall demonstrate that it operates:

(i) A continuum of outpatient treatment, rehabilitative care, and support services for TBI/SCI patients; and

(ii) A transitional living program or contracts with an organization that operates a transitional living program and rehabilitative care for TBI/SCI patients.

(b) The applicant shall submit evidence of accreditation of its existing outpatient and/or residential programs by the Commission on Accreditation of Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for rehabilitative care and services.

(c) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another nationally-recognized accreditation organization for the nursing home beds proposed under this subsection.

(d) A floor plan for the proposed physical plant space to house the nursing home beds allocated under this subsection that provides for:

(i) Individual units consisting of 20 beds or less per unit, not to be more than 40 beds per facility.

(ii) Day/dining area within, or immediately adjacent to, the unit(s), which is solely for the use of TBI/SCI patients.

(iii) Direct access to a secure outdoor or indoor area at the facility appropriate for supervised activity.

(e) The applicant proposes programs to promote a culture within the facility that is appropriate for TBI/SCI patients of various ages.

(2) Beds approved under this subsection shall not be converted to OR UTILIZED AS general nursing home use without a CON for nursing home and hospital long-term care unit beds under the CON review standards for nursing home and hospital long-term care unit beds and shall not be offered to individuals other than TBI/SCI patients.

Section 5. Requirements for approval for beds from the statewide pool for special population groups allocated to behavioral patients

Sec. 5. The CON Commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of behavioral patients as compared to serving these needs in general nursing home unit(s).

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate with credible documentation to the satisfaction of the Department each of the following:

(a) Individual units shall consist of 20 beds or less per unit.

(b) The facility shall not be awarded more than 40 beds.

(c) The proposed unit shall have direct access to a secure outdoor or indoor area for supervised activity.

(d) The unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the behavioral patients.

(e) The physical environment of the unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(f) Staff will be specially trained in treatment of behavioral patients.

(2) Beds approved under this subsection shall not be converted to OR UTILIZED AS ~~-~~general nursing home use without a CON for nursing home and hospital long-term care unit beds under the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(3) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 6. Requirements for approval for beds from the statewide pool for special population groups allocated to ~~hospice patients~~ BARIATRIC PATIENTS

Sec. 6. The CON Commission determines there is a need for beds for ~~patients requiring both hospice and long-term nursing care services within the long-term care and nursing home populations~~APPLICATIONS DESIGNED TO DETERMINE THE EFFICIENCY AND EFFECTIVENESS OF SPECIALIZED PROGRAMS FOR THE CARE AND TREATMENT OF BARIATRIC PATIENTS AS COMPARED TO SERVING THESE NEEDS IN GENERAL NURSING HOME UNIT(S).

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate, with credible documentation to the satisfaction of the Department, each of the following:

~~(a) An applicant shall be a hospice certified by Medicare pursuant to the Code of Federal Regulations, Title 42, Chapter IV, Subpart B (Medicare programs), Part 418 and shall have been a Medicare certified hospice for at least 24 continuous months prior to the date an application is submitted to the Department.~~

(~~b~~a) ~~An applicant shall demonstrate that, during the most recent 12-month period prior to the date an application is submitted to the Department for which verifiable data are available to the Department, at least 64% of the total number of hospice days of care provided to all of the clients of the applicant hospice were provided in a private residence~~THE FACILITY SHALL NOT BE AWARDED MORE THAN 10 BEDS.

(~~c~~b) ~~An application shall propose 30 beds or less~~THE FACILITY MAY PLACE BEDS THROUGHOUT THE FACILITY FOR A FLEXIBLE AND SEAMLESS INCLUSIVE RESIDENT DESIGN.

(c) ~~An applicant for beds from the special statewide pool of beds shall not be approved if any application for beds in that same planning area has been approved from the special statewide pool of beds allocated for hospice~~THE PROPOSED BEDS SHALL HAVE ADEQUATE ACCESS TO AN OUTDOOR OR INDOOR AREA FOR ACTIVITIES WITH APPROPRIATE EQUIPMENT.

(d) THE PHYSICAL ENVIRONMENT OF ANY UNIT CONTAINING BARIATRIC BEDS SHALL BE DESIGNED TO FACILITATE VISITORS.

(e) THE UNIT/BEDS SHALL HAVE AVAILABLE SPECIALTY EQUIPMENT TO ASSIST STAFF IN PROVIDING CARE.

(f) THE BEDS SHALL BE LOCATED ON A GROUND FLOOR AND EMERGENCY EGRESS WILL NOT REQUIRE STAIRWAYS OR ELEVATORS TO EXIT-.

(g) THE BEDS SHALL BE ESTABLISHED IN EITHER SINGLE OR DOUBLE OCCUPANCY ROOMS, THERE SHALL BE NO ROOMS WITH MORE THAN TWO BEDS.

(2) BEDS APPROVED UNDER THIS SUBSECTION SHALL NOT BE CONVERTED TO OR UTILIZED FOR GENERAL NURSING HOME USE WITHOUT A CON FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS.

(3) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 7. Requirements for approval for beds from the statewide pool for special population groups allocated to ventilator-dependent patients

Sec. 7. The CON Commission determines there is a need for beds for ventilator-dependent patients within the long-term care and nursing home populations

(1) An applicant proposing to begin operation of a new nursing home/HLTCU or add beds to an existing nursing home/HLTCU under this section shall demonstrate, with credible documentation to the satisfaction of the Department, each of the following:

(a) An applicant proposes a program for caring for ventilator-dependent patients in licensed nursing home beds.

(b) An application proposes no more than 40 beds that will be licensed as nursing home beds.

(c) The proposed unit will serve only ventilator-dependent patients.

(2) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(3) BEDS APPROVED UNDER THIS SUBSECTION SHALL NOT BE CONVERTED TO OR UTILIZED FOR GENERAL NURSING HOME USE WITHOUT A CON FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS.

Section 8. Acquisition of nursing home/HLTCU beds approved pursuant to this addendum

Sec. 8. (1) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to religious shall meet the following:

(a) The applicant is a part of, closely affiliated with, controlled, sanctioned or supported by a recognized religious organization, denomination or federation as evidenced by documentation of its federal tax exempt status as a religious corporation, fund, or foundation under section 501(c)(3) of the United States Internal Revenue Code.

(b) The applicant's patient population includes a majority of members of the religious organization or denomination represented by the sponsoring organization.

(c) The applicant's existing services and/or operations are tailored to meet certain special needs of a specific religion, denomination or order, including unique dietary requirements, or other unique religious needs regarding ceremony, ritual, and organization which cannot be satisfactorily met in a secular setting.

(d) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(2) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to TBI/SCI shall meet the following:

(a) The beds will be operated as part of a specialized program exclusively for TBI/SCI patients. At the time an application is submitted, the applicant shall demonstrate that it operates:

(i) a continuum of outpatient treatment, rehabilitative care, and support services for TBI/SCI patients; and

(ii) a transitional living program or contracts with an organization that operates a transitional living program and rehabilitative care for TBI/SCI patients.

(b) The applicant shall submit evidence of accreditation of its existing outpatient and/or residential programs by the Commission on Accreditation of Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for rehabilitative care and services.

(c) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another nationally-recognized accreditation organization for the nursing home beds proposed under this subsection.

(d) A floor plan for the proposed physical plant space to house the nursing home beds allocated under this subsection that provides for:

(i) Individual units consisting of 20 beds or less per unit, not to be more than 40 beds per facility.

(ii) Day/dining area within, or immediately adjacent to, the unit(s), which is solely for the use of TBI/SCI patients.

(iii) Direct access to a secure outdoor or indoor area at the facility appropriate for supervised activity.

(e) The applicant proposes programs to promote a culture within the facility that is appropriate for TBI/SCI patients of various ages.

(3) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to Alzheimer’s disease shall meet the following:

(a) The beds are part of a specialized program for Alzheimer's disease which will admit and treat only patients which require long-term nursing care and have been appropriately classified as a patient on the Global Deterioration Scale (GDS) for age-associated cognitive decline and Alzheimer's disease as a level 4 (when accompanied by continuous nursing needs), 5, or 6.

(b) The specialized program will participate in the state registry for Alzheimer's disease.

(c) The specialized program shall be attached or geographically adjacent to a licensed nursing home and be no larger than 20 beds in size.

(d) The proposed Alzheimer's unit shall have direct access to a secure outdoor or indoor area at the health facility, appropriate for unsupervised activity.

(e) The Alzheimer's unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the Alzheimer's unit patients.

(f) The physical environment of the Alzheimer's unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(g) Staff will be specially trained in Alzheimer's disease treatment.

(h) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(4) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to behavioral patients shall meet the following:

(a) Individual units shall consist of 20 beds or less per unit.

(b) The facility shall not be awarded more than 40 beds.

(c) The proposed unit shall have direct access to a secure outdoor or indoor area for supervised activity.

(d) The unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the behavioral patients.

(e) The physical environment of the unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(f) Staff will be specially trained in treatment of behavioral patients.

(g) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(5) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to hospice shall meet the following:

(a) An applicant shall be a hospice certified by Medicare pursuant to the code of Federal Regulations, Title 42, Chapter IV, Subpart B (Medicare Programs), Part 418 and shall have been a Medicare certified hospice for at least 24 continuous months prior to the date an application is submitted to the Department.

(b) An applicant shall demonstrate that, during the most recent 12-month period prior to the date an application is submitted to the Department for which verifiable data are available to the Department, at least 64% of the total number of hospice days of care provided to all of the clients of the applicant hospice were provided in a private residence.

(c) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

(6) AN APPLICANT PROPOSING TO ACQUIRE NURSING HOME/HLTCU BEDS FROM THE STATEWIDE POOL FOR SPECIAL POPULATION GROUPS ALLOCATED TO BARIATRIC PATIENTS SHALL MEET THE FOLLOWING:

(a) THE FACILITY SHALL NOT BE AWARDED MORE THAN 10 BEDS.

(b) THE FACILITY MAY PLACE BEDS THROUGHOUT THE FACILITY FOR A FLEXIBLE AND SEAMLESS INCLUSIVE RESIDENT DESIGN.

(c) THE PROPOSED BEDS SHALL HAVE ADEQUATE ACCESS TO AN OUTDOOR OR INDOOR AREA FOR ACTIVITIES WITH APPROPRIATE EQUIPMENT.

(d) THE PHYSICAL ENVIRONMENT OF ANY UNIT CONTAINING BARIATRIC BEDS SHALL BE DESIGNED TO FACILITATE VISITORS.

(e) THE BEDS SHALL HAVE AVAILABLE SPECIALTY EQUIPMENT TO ASSIST STAFF IN PROVIDING CARE.

(f) THE BEDS SHALL BE LOCATED ON A GROUND FLOOR AND EMERGENCY EGRESS WILL NOT REQUIRE STAIRWAYS OR ELEVATORS TO EXIT.

(g) BEDS APPROVED UNDER THIS SUBSECTION SHALL NOT BE CONVERTED TO OR UTILIZED AS GENERAL NURSING HOME USE WITHOUT A CON FOR NURSING HOME AND HOSPITAL LONG-TERM CARE UNIT BEDS UNDER THE CON REVIEW STANDARDS.

(h) ALL BEDS APPROVED PURSUANT TO THIS SUBSECTION SHALL BE DUALLY CERTIFIED FOR MEDICARE AND MEDICAID.

(7) An applicant proposing to acquire nursing home/HLTCU beds from the statewide pool for special population groups allocated to ventilator-dependent patients shall meet the following:

(a) An applicant proposes a program for caring for ventilator-dependent patients in licensed nursing home beds.

(b) An application proposes no more than 40 beds that will be licensed as nursing home beds.

(c) The proposed unit will serve only ventilator-dependent patients.

(d) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

Section 9. Project delivery requirements -- terms of approval for all applicants seeking approval under Section 3(1) of this addendum

Sec. 9. (1) An applicant shall agree that if approved, the services shall be delivered in compliance with the terms of approval required by the CON Review Standards for Nursing Home and Hospital Long-term Care Unit Beds.

(2) An applicant for beds from the statewide pool for special population groups allocated to religious shall agree that, if approved, the services provided by the specialized long-term care beds shall be delivered in compliance with the following term of CON approval:

(a) The applicant shall document, at the end of the third year following initiation of beds approved an annual average occupancy rate of 95 percent or more. If this occupancy rate has not been met, the applicant shall delicense a number of beds necessary to result in a 95 percent occupancy based upon its average daily census for the third full year of operation.

(3) An applicant for beds from the statewide pool for special population groups allocated to Alzheimer's disease shall agree that if approved:

(a) The beds are part of a specialized program for Alzheimer's disease which will admit and treat only patients which require long-term nursing care and have been appropriately classified as a patient on the Global Deterioration Scale (GDS) for age-associated cognitive decline and Alzheimer's disease as a level 4 (when accompanied by continuous nursing needs), 5, or 6.

(b) The specialized program will participate in the state registry for Alzheimer's disease.

(c) The specialized program shall be attached or geographically adjacent to a licensed nursing home and be no larger than 20 beds in size.

(d) The proposed Alzheimer's unit shall have direct access to a secure outdoor or indoor area at the health facility, appropriate for unsupervised activity.

(e) The Alzheimer's unit shall have within the unit or immediately adjacent to it a day/dining area which is solely for the use of the Alzheimer's unit patients.

(f) The physical environment of the Alzheimer's unit shall be designed to minimize noise and light reflections to promote visual and spatial orientation.

(g) Staff will be specially trained in Alzheimer's disease treatment.

(4) An applicant for beds from the statewide pool for special population groups allocated to hospice shall agree that, if approved, all beds approved pursuant to that subsection shall be operated in accordance with the following CON terms of approval.

(a) An applicant shall maintain Medicare certification of the hospice program and shall establish and maintain the ability to provide, either directly or through contractual arrangements, hospice services as outlined in the Code of Federal Regulations, Title 42, Chapter IV, Subpart B, Part 418, hospice care.

(b) The proposed project shall be designed to promote a home-like atmosphere that includes accommodations for family members to have overnight stays and participate in family meals at the applicant facility.

(c) An applicant shall not refuse to admit a patient solely on the basis that he/she is HIV positive, has AIDS or has AIDS related complex.

(d) An applicant shall make accommodations to serve patients that are HIV positive, have AIDS or have AIDS related complex in nursing home beds.

(e) An applicant shall make accommodations to serve children and adolescents as well as adults in nursing home beds.

(f) Nursing home beds shall only be used to provide services to individuals suffering from a disease or condition with a terminal prognosis in accordance with Section 21417 of the Code, being Section 333.21417 of the Michigan Compiled Laws.

(g) An applicant shall agree that the nursing home beds shall not be used to serve individuals not meeting the provisions of Section 21417 of the Code, being Section 333.21417 of the Michigan Compiled Laws, unless a separate CON is requested and approved pursuant to applicable CON review standards.

(h) An applicant shall be licensed as a hospice program under Part 214 of the Code, being Section 333.21401 et seq. of the Michigan Compiled Laws.

(i) An applicant shall agree that at least 64% of the total number of hospice days of care provided by the applicant hospice to all of its clients will be provided in a private residence.

(5) An applicant for beds from the statewide pool for special population groups allocated to ventilator-dependent patients shall agree that, if approved, all beds approved pursuant to that subsection shall be operated in accordance with the following CON terms of approval.

(a) An applicant shall staff the proposed ventilator-dependent unit with employees that have been trained in the care and treatment of ventilator-dependent patients and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of ventilator-dependent patients.

(ii) A program director that is a registered nurse.

(b) An applicant shall make provisions, either directly or through contractual arrangements, for at least the following services:

(i) respiratory therapy.

(ii) occupational and physical therapy.

(iii) psychological services.

(iv) family and patient teaching activities.

(c) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the ventilator-dependent unit. At a minimum, the criteria shall address the amount of mechanical ventilatory dependency, the required medical stability, and the need for ancillary services.

(ii) The transfer of patients requiring care at other health care facilities.

(iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.

(iv) Patient rights and responsibilities in accordance with Sections 20201 and 20202 of the Code, being Sections 333.20201 and 333.20202 of the Michigan Compiled Laws.

(v) The type of ventilatory equipment to be used on the unit and provisions for back-up equipment.

(d) An applicant shall establish and maintain an organized infection control program that has written policies for each of the following:

(i) use of intravenous infusion apparatus, including skin preparation, monitoring skin site, and frequency of tube changes.

(ii) placement and care of urinary catheters.

(iii) care and use of thermometers.

(iv) care and use of tracheostomy devices.

(v) employee personal hygiene.

(vi) aseptic technique.

(vii) care and use of respiratory therapy and related equipment.

(viii) isolation techniques and procedures.

(e) An applicant shall establish a multi-disciplinary infection control committee that meets on at least a monthly basis and includes the director of nursing, the ventilator-dependent unit program director, and representatives from administration, dietary, housekeeping, maintenance, and respiratory therapy. This subsection does not require a separate committee, if an applicant organization has a standing infection control committee and that committee's charge is amended to include a specific focus on the ventilator-dependent unit.

(f) The proposed ventilator-dependent unit shall have barrier-free access to an outdoor area in the immediate vicinity of the unit.

(g) An applicant shall agree that the beds will not be used to service individuals that are not ventilator-dependent unless a separate CON is requested and approved by the Department pursuant to applicable CON review standards.

(h) An applicant shall provide data to the Department that evaluates the cost efficiencies that result from providing services to ventilator-dependent patients in a hospital.

(6) An applicant for beds from the statewide pool for special population groups allocated to TBI/SCI patients shall agree that if approved:

(a) An applicant shall staff the proposed unit for TBI/SCI patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of TBI/SCI patients.

(ii) A program director that is a registered nurse.

(iii) Other professional disciplines required for a multi-disciplinary team approach to care.

(b) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the unit for TBI/SCI patients. At a minimum, the criteria shall address the required medical stability and the need for ancillary services, including dialysis services.

(ii) The transfer of patients requiring care at other health care facilities, including a transfer agreement with one or more acute-care hospitals in the region to provide emergency medical treatment to any patient who requires such care.

(iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge, including support services to be provided by transitional living programs or other outpatient programs or services offered as part of a continuum of care to TBI patients by the applicant.

(iv) Utilization review, which shall consider the rehabilitation necessity for the service, quality of patient care, rates of utilization and other considerations generally accepted as appropriate for review.

(v) Quality assurance and assessment program to assure that services furnished to TBI/SCI patients meet professional recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the TBI patient receiving such services.

(7) An applicant for beds from the statewide pool for special population groups allocated to behavioral patients shall agree that if approved:

(a) An applicant shall staff the proposed unit for behavioral patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:

(i) A medical director with specialized knowledge, training, and skills in the care of behavioral patients.

(ii) A program director that is a registered nurse.

(iii) Other professional disciplines required for a multi-disciplinary team approach to care.

(b) An applicant shall establish and maintain written policies and procedures for each of the following:

(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the unit for behavioral patients.

(ii) The transfer of patients requiring care at other health care facilities, including a transfer agreement with one or more acute-care hospitals in the region to provide emergency medical treatment to any patient who requires such care.

(iii) Utilization review, which shall consider the rehabilitation necessity for the service, quality of patient care, rates of utilization and other considerations generally accepted as appropriate for review.

(iv) quality assurance and assessment program to assure that services furnished to behavioral patients meet professional recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the behavioral patient receiving such services.

(v) Orientation and annual education/competencies for all staff, which shall include care guidelines, specialized communication, and patient safety.

(8) AN APPLICANT FOR BEDS FROM THE STATEWIDE POOL FOR SPECIAL POPULATION GROUPS ALLOCATED TO BARIATRIC PATIENTS SHALL AGREE THAT IF APPROVED:

(a) THE FACILITY SHALL NOT BE AWARDED MORE THAN 10 BEDS.

(b) THE FACILITY MAY PLACE BEDS THROUGHOUT THE FACILITY FOR A FLEXIBLE AND SEAMLESS INCLUSIVE RESIDENT DESIGN.

(c) THE PROPOSED BEDS SHALL HAVE ADEQUATE ACCESS TO AN OUTDOOR OR INDOOR AREA FOR ACTIVITIES WITH APPROPRIATE EQUIPMENT.

(d) THE PHYSICAL ENVIRONMENT OF ANY UNIT CONTAINING BARIATRIC BEDS SHALL BE DESIGNED TO FACILITATE VISITORS.

(e) THE BEDS SHALL HAVE AVAILABLE SPECIALTY EQUIPMENT TO ASSIST STAFF IN PROVIDING CARE.

(f) THE BEDS SHALL BE LOCATED ON A GROUND FLOOR AND EMERGENCY EGRESS WILL NOT REQUIRE STAIRWAYS OR ELEVATORS TO EXIT.

(g) THE BEDS SHALL BE ESTABLISHED IN EITHER SINGLE OR DOUBLE OCCUPANCY ROOMS. THERE SHALL BE NO ROOMS WITH MORE THAN TWO BEDS.

(h) ALL BEDS APPROVED PURSUANT TO THIS SUBSECTION SHALL BE DUALLY CERTIFIED FOR MEDICARE AND MEDICAID.

Section 10. Comparative reviews, effect on prior CON review standards

Sec. 10. (1) Projects proposed under Section 4 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(2) Projects proposed under Section 5 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(3) Projects proposed under Section 6 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(4) Projects proposed under Section 7 shall be considered a distinct category and shall be subject to comparative review on a statewide basis.

(5) These CON review standards supercede and replace the CON Review Standards for Nursing Home and Long-term Care Unit Beds--Addendum for Special Population Groups approved by the Commission on ~~April 30~~DECEMBER 11, ~~2008~~ 2014 and effective on ~~June~~ MARCH 20, ~~2008~~2015.

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

CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR SURGICAL SERVICES

(By authority conferred on the CON Commission by Section 22215 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, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. These standards are requirements for the approval of the initiation, replacement, expansion, or acquisition of a surgical service provided in a surgical facility and the delivery of these services under Part 222 of the Code. Surgical services provided in a freestanding surgical outpatient facility, an ambulatory surgery center certified under title XVIII, or a surgical department of a hospital licensed under Part 215 of the Code and offering inpatient or outpatient surgical services are covered clinical services . The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

Sec. 2. For purposes of these standards:

(a) "Ambulatory surgical center" or "ASC" means any distinct entity certified by Medicare as an ASC under the provisions of Title 42, Part 416 that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(b) "Burn care" means surgical services provided to burn patients in a licensed hospital site that has been verified as meeting the "Guidelines for Development and Operation of Burn Centers" issued by the American Burn Association in March 1988, or equivalent standards for a burn center.

(c) "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.

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

(e) "Cystoscopy" means direct visual examination of the urinary tract with a cystoscope.

(f) "Cystoscopy case" means a single visit to an operating room during which one or more cystoscopic procedures are performed.

(g) “Dedicated endoscopy or cystoscopy operating room” means a room used exclusively for endoscopy or cystoscopy cases.

(h) "Department" means the Michigan Department of ~~Community~~ Health AND HUMAN SERVICES (~~MDCH~~MDHHS).

(i) “Emergency Room” means a designated area in a licensed hospital and recognized by the Department as having met the staffing and equipment requirements for the treatment of emergency patients.

(j) "Endoscopy" means visual inspection of any portion of the body by means of an endoscope.

(k) "Endoscopy case" means a single visit to an operating room during which one or more endoscopic procedures are performed.

(l) "Existing surgical service" means a surgical facility that, on the date an application is submitted to the Department, is part of a licensed hospital site, a licensed freestanding surgical outpatient facility, or a certified ASC.

(m) "Freestanding surgical outpatient facility" or "FSOF" means a health facility licensed under Part 208 of the Code. It does not include a surgical outpatient facility owned and operated as a part of a licensed hospital site. A freestanding surgical outpatient facility is a health facility for purposes of Part 222 of the Code.

(n) "Hospital" means a health facility licensed under Part 215 of the Code.

(o) "Hours of use" means the actual time in hours, and parts thereof, an operating room is used to provide surgical services. It is the time from when a patient enters an operating room until that same patient leaves that same room. It excludes any pre- or post-operative room set-up or clean-up preparations, or any time a patient spends in pre- or post-operative areas including a recovery room.

(p) "Licensed hospital site" means either:

(i) in the case of a single site hospital, the location of the hospital 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 site as authorized by licensure.

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

(r) "Offer" means to perform surgical services.

(s) "Operating room" or "OR" means a room in a surgical facility constructed and equipped to perform surgical cases and located on a sterile corridor. The term also includes a room constructed and equipped to perform surgical cases on a nonsterile corridor if the room is located in an FSOF or ASC that is used exclusively for endoscopy or cystoscopy cases. This term does not include procedure rooms.

(t) "Operating suite," for purposes of these standards, means an area in a surgical facility that is dedicated to the provision of surgery. An operating suite includes operating rooms, pre- and post-operative patient areas, clean and soiled utility and linen areas, and other support areas associated with the provision of surgery.

(u) "Outpatient surgery" means the provision of surgical services performed in a hospital, FSOF, or ASC, requiring anesthesia or a period of post-operative observation, or both, to patients whose admission to a hospital for an overnight stay is not anticipated as being medically necessary.

(v) “Procedure room” means a room in a surgical facility constructed and equipped to perform surgical procedures and not located on a sterile corridor.

(w) "Renovate an existing surgical service or one or more operating rooms" means a project that:

(i) involves the renovation, remodeling, or modernization of an operating suite of a hospital, FSOF, or ASC;

(ii) does not involve new construction;

(iii) does not involve a change in the physical location within the surgical facility at the same site; and

(iv) does not result in an increase in the number of operating rooms at an existing surgical facility.

Renovation of an existing surgical service or one or more operating rooms may involve a change in the number of square feet allocated to an operating suite. The renovation of an existing surgical service or one or more operating rooms shall not be considered the initiation, expansion, replacement, or acquisition of a surgical service or one or more operating rooms.

(x) "Sterile corridor" means an area of a surgical facility designated primarily for surgical cases and surgical support staff. Access to this corridor is controlled and the corridor is not used by the general public or personnel of the surgical facility whose primary work station is not in the operating suite(s) or whose primary work tasks do not require them to be in the operating suite(s) of a surgical facility. Examples of personnel who would normally use sterile corridors include physicians, surgeons, operating room nurses, laboratory or radiology personnel, and central supply or housekeeping personnel. Other terms commonly used to represent "sterile" in describing access areas include "restricted," "controlled," "limited access," or "clean."

(y) "Surgical case" means a single visit to an operating room during which one or more surgical procedures are performed.

(ii) "Surgical facility" means either:

(i) a licensed FSOF;

(ii) a certified ASC; or

(iii) a licensed hospital site authorized to provide inpatient or outpatient surgery.

(jj) "Surgical service" means performing surgery in a surgical facility.

(z) "Trauma care," for purposes of these standards, means surgical services provided to a trauma patient in a licensed hospital site that has been verified as meeting the standards of the American College of Surgeons for a Level I or II trauma center, or equivalent standards.

(aa) "Verifiable data" means surgical data (cases and/or hours) from the most recent Annual Survey or more recent data that can be validated by the Department.

(2) Terms defined in the Code have the same meanings when used in these standards.

Section 3. Inventory of operating rooms used to perform surgical services; surgical cases, or hours of use; and evaluating compliance with minimum volume requirements

Sec. 3. (1) The Department shall use the number of operating rooms and verifiable data pursuant to subsection (2) to determine the number of surgical cases, hours of use, or both, as applicable, pursuant to subsection (3) for purposes of evaluating compliance with the actual and proposed volume requirements set forth in the applicable sections of these standards. Compliance with CON minimum volume requirements established by these standards shall be determined based on the average number of surgical cases, hours of use, or both, per operating room of the surgical service as permitted by these standards.

(2) The number of operating rooms for each type of surgical facility shall be determined as follows:

(a) In a licensed hospital site, all operating rooms in which surgery is or will be performed excluding:

(i) A delivery room(s) if that room is located in an area of a licensed hospital site designated primarily for obstetrical services.

(ii) An operating room that is or will be used exclusively for endoscopy or cystoscopy cases.

(iii) An operating room in which a fixed lithotripter is or will be located and utilized. A mobile lithotripter shall not be considered as an operating room.

(iv) An operating room that is or will be used, though not exclusively, to provide surgical services to patients requiring burn care or trauma care, as those terms are defined in these standards. No more than 0.5 burn care and 0.5 trauma care operating rooms shall be excluded pursuant to this subdivision, and precludes the use of the room in subsection (2)(a)(v).

(v) An operating room that is or will be used exclusively to provide surgical services to patients requiring burn care or trauma care, as those terms are defined in these standards. No more than 1 burn care and 1 trauma care operating room shall be excluded pursuant to this subdivision, and precludes the use of the room in subsection (2)(a)(iv).

(vi) A hybrid ORCCL shall have 0.5 excluded for each room meeting the requirements of section of these standards. A surgical facility will not be limited to the number of hybrid ORCCLS within a single licensed facility.

(b) In an FSOF or ASC that is or will be used exclusively for endoscopy or cystoscopy cases, all rooms in which endoscopy or cystoscopy cases are or will be performed.

(c) In an FSOF or ASC that is not or will not be used exclusively for endoscopy or cystoscopy cases, all operating rooms in which surgery is or will be performed, excluding any operating rooms used exclusively for endoscopy or cystoscopy cases.

(3) The number of surgical cases, or hours of use, shall be determined as follows:

(a) In a licensed hospital site, all surgical cases, or hours of use, performed in operating rooms, including surgical cases, or hours of use, performed in an operating room identified in subsectionS (2)(a)(iv), (v), AND (vi) but excluding the surgical cases, or hours of use, performed in operating rooms identified in subsection (2)(a)(i), (ii), and (iii).

(b) In an FSOF or ASC that is or will be used exclusively for endoscopy or cystoscopy cases, all endoscopy or cystoscopy cases, or hours of use, performed in the operating rooms identified in subsection (2)(b).

(c) In an FSOF or ASC that is not or will not be used exclusively for endoscopy or cystoscopy cases, all surgical cases, or hours of use, performed in the operating rooms identified in subsection (2)(c). Cases, or

hours of use, performed in any operating room used exclusively for endoscopy or cystoscopy cases, shall be excluded.

Section 4. Requirements to initiate a surgical service

Sec. 4. To initiate a surgical service means to begin operation of a surgical facility at a site that has not offered surgical services within the 12-month period immediately preceding the date an application is submitted to the Department. An applicant proposing to initiate a surgical service shall demonstrate the following, as applicable to the proposed project.

(1) Each proposed operating room shall perform an average of at least 1,128 surgical cases per year per operating room in the second 12 months of operation.

(2) Subsection (1) shall not apply if the proposed project involves the initiation of a surgical service with 1 or 2 operating rooms at a licensed hospital site located in a rural or micropolitan statistical area county that does not offer surgical services as of the date an application is submitted to the Department.

(3) An applicant shall demonstrate that it meets the requirements of Section ~~10~~11(2) for the number of surgical cases projected under subsection (1).

(a) SECTION 11(2)(d) SHALL NOT APPLY IF THE PROPOSED PROJECT INVOLVES THE INITIATION OF A SURGICAL SERVICE AT A NEW FSOF OR A NEW ASC AT A NEW GEOGRAPHICAL SITE UTILIZING THE HISTORICAL SURGICAL CASES OF THE APPLICANT AND THE NEW SERVICE IS OWNED BY THE SAME APPLICANT.

Section 5. Requirements to replace a surgical service

Sec. 5. To replace a surgical service or one or more operating rooms, means the development of new space (whether through new construction, purchase, lease or similar arrangement) to house one or more operating rooms operated by an applicant at the same site as the operating room(s) to be replaced. This also includes designating an OR as a dedicated endoscopy or cystoscopy OR. The term also includes relocating an existing surgical facility or one or more operating rooms to a new geographic location of an existing surgical facility or one or more operating rooms to a different location currently offering surgical services. The term does not include the renovation of an existing surgical service or one or more operating rooms. An applicant requesting to replace an existing surgical service shall demonstrate each of the following, as applicable to the proposed project.

(1) An applicant proposing to replace shall demonstrate:

(a) All existing operating rooms in the existing surgical facility have performed an average of at least:

(i) 1,042 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room for which verifiable data is available to the Department, or

(iii) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient hours divided by 1,125. (For example: Using 375 inpatient hours and 844 outpatient hours would equate to 375/1,500 + 844/1,125 = 0.25 + 0.75 = 1.00 OR.), or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient cases divided by 1,042. (For example: Using 375 inpatient hours and 785 outpatient cases would equate to 375/1,500 + 785/1,042 = 0.25 + 0.75 = 1.00 OR.)

(b) All operating rooms, existing and replaced, are projected to perform an average of at least:

(i) 1,042 surgical cases per year per operating room in the second twelve months of operation, and annually thereafter, or

(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room in the second twelve months of operation, and annually thereafter, or

(iii) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room in the second twelve months of operation, and annually thereafter and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient hours divided by 1,125. (For example: Using 375 inpatient hours and 844 outpatient hours would equate to 375/1,500 + 844/1,125 = 0.25 + 0.75 = 1.00 OR.), or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room in the second twelve months of operation, and annually thereafter and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient cases divided by 1,042. (For example: Using 375 inpatient hours and 785 outpatient cases would equate to 375/1,500 + 785/1,042 = 0.25 + 0.75 = 1.00 OR.)

(2) An applicant proposing to replace one or more operating rooms at a licensed hospital and is located in a rural or micropolitan county or the applicant is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as defined by the most recent federal decennial census shall demonstrate each of the following:

(a) The applicant has three, four, or five ORs at the licensed hospital.

(b) All existing operating rooms have performed an average of at least:

(i) 839 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,200 hours of use per year per operating room for which verifiable data is available to the Department.

(c) All operating rooms, existing and replaced, are projected to perform an average of at least:

(i) 839 surgical cases per year per operating room in the second twelve months of operation, and annually thereafter, or

(ii) 1,200 hours of use per year per operating room in the second twelve months of operation, and annually thereafter.

(3) Subsections (1) and (2) shall not apply if the proposed project involves replacing one or more operating rooms at the same licensed hospital site if the surgical facility is located in a rural or micropolitan statistical area county and has one or two operating rooms.

(4) Subsections (1) and (2) shall not apply to those hospitals licensed under Part 215 of PA 368 of 1978, as amended that had fewer than 70 licensed beds on December 1, 2002 provided the number of ORs at the surgical service has not increased as of March 31, 2003, and the location does not change.

(5) An applicant proposing to designate an OR as a dedicated endoscopy or cystoscopy OR shall submit notification to the Department on a form provided by the Department. An applicant under this subsection shall not be required to comply with subsections (1) and (2).

(6) An applicant proposing to relocate an existing surgical service or one or more operating rooms shall demonstrate each of the following, as applicable:

(a) The proposed new site is within a 10-mile radius of the site at which an existing surgical service is located if an existing surgical service is located in a metropolitan statistical area county, or a 20-mile radius if an existing surgical service is located in a rural or micropolitan statistical area county.

(b) All existing operating rooms in the surgical facility from which one or more ORs are proposed to be relocated have performed an average of at least:

(i) 1,042 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room for which verifiable data is available to the Department, or,

(iii) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient hours divided by 1,125. (For example: Using 375 inpatient hours and 844 outpatient hours would equate to 375/1,500 + 844/1,125 = 0.25 + 0.75 = 1.00 OR.), or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient cases divided by 1,042. (For example: Using 375 inpatient hours and 785 outpatient cases would equate to 375/1,500 + 785/1,042 = 0.25 + 0.75 = 1.00 OR.)

(c) All operating rooms, existing and relocated, are projected to perform an average of at least:

(i) 1,042 surgical cases per year per operating room in the second twelve months of operation or

(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room in the second twelve months of operation, and annually thereafter, or

(iii) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room in the second twelve months of operation, and annually thereafter and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient hours divided by 1,125. (For example: Using 375 inpatient hours and 844 outpatient hours would equate to 375/1,500 + 844/1,125 = 0.25 + 0.75 = 1.00 OR.) or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room in the second twelve months of operation, and annually thereafter and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient cases divided by 1,042. (For example: Using 375 inpatient hours and 785 outpatient cases would equate to 375/1,500 + 785/1,042 = 0.25 + 0.75 = 1.00 OR.)

(7) Subsection (6) shall not apply if the proposed project involves relocating one or two operating rooms within a 20-mile radius if the surgical facility is located in a rural or micropolitan statistical area county.

(8) An applicant proposing to relocate one or more operating rooms from one licensed hospital site to another licensed hospital site and is located in a rural or micropolitan county or the applicant is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as defined by the most recent federal decennial census shall demonstrate each of the following:

(a) The applicant has three, four, or five ORs at the licensed hospital.

(b) All existing operating rooms have performed an average of at least:

(i) 839 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,200 hours of use per year per operating room for which verifiable data is available to the Department.

(c) All operating rooms, existing and relocated, are projected to perform an average of at least:

(i) 839 surgical cases per year per operating room in the second twelve months of operation or

(ii) 1,200 hours of use per year per operating room in the second twelve months of operation,.

(9) An applicant shall demonstrate that it meets the requirements of Section ~~10~~11(2) for the number of surgical cases, or hours of use, projected under subsection (1), (2), (6), and (8).

Section 6**. Requirements to expand an existing surgical service**

Sec. 6. To expand a surgical service means the addition of one or more operating rooms at an existing surgical service. This term also includes the change from a dedicated endoscopy or cystoscopy OR to a non-dedicated OR. An applicant proposing to add one or more operating rooms at an existing surgical service shall demonstrate each of the following as applicable, to the proposed project.

(1) An applicant shall demonstrate the following:

(a) All existing operating rooms in the existing surgical facility have performed an average of at least:

(i) 1,216 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,313 hours of use in a facility that performs only outpatient surgery per year per operating room for which verifiable data is available to the Department, or

(iii) a licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,750 plus the outpatient hours divided by 1,313. (For example: Using 438 inpatient hours and 985 outpatient hours would equate to 438/1,750 + 985/1,313 = 0.25 + 0.75 = 1.00 OR), or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room for which verifiable data is available to the Department and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,750 plus the outpatient cases divided by 1,216. (For example: Using 438 inpatient hours and 912 outpatient cases would equate to 438/1,750 + 912/1,216 = 0.25 + 0.75 = 1.00 OR.)

(b) All proposed operating rooms are projected to perform an average of at least:

(i) 1,042 surgical cases per year per operating room in the second twelve months of operation, or

(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room in the second twelve months of operation, or

(iii) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of inpatient hours of use and outpatient hours of use as billed by the facility per year per operating room in the second twelve months of operation, and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient hours divided by 1,125. (For example: Using 375 inpatient hours and 844 outpatient hours would equate to 375/1,500 + 844/1,125 = 0.25 + 0.75 = 1.00 OR.), or

(iv) A licensed hospital that provides both inpatient and outpatient surgery may use a weighted average of hours of use (inpatient surgical volume) and surgical cases (outpatient surgical volume) as billed by the facility per year per operating room in the second twelve months of operation, and calculated as follows:

(A) The number of operating rooms shall be the sum of the inpatient hours of use divided by 1,500 plus the outpatient cases divided by 1,042. (For example: Using 375 inpatient hours and 785 outpatient cases would equate to 375/1,500 + 785/1,042 = 0.25 + 0.75 = 1.00 OR.)

(2) An applicant proposing to add one or more operating rooms at a licensed hospital and is located in a rural or micropolitan county or the applicant is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as defined by the most recent federal decennial census shall demonstrate each of the following:

(a) The applicant has two, three, or four ORs at the licensed hospital.

(b) All existing operating rooms have performed an average of at least:

(i) 979 surgical cases per year per operating room for which verifiable data is available to the Department, or

(ii) 1,400 hours of use per year per operating room for which verifiable data is available to the Department.

(c) All proposed operating rooms are projected to perform an average of at least:

(i) 839 surgical cases per year per operating room in the second twelve months of operation, or

(ii) 1,200 hours of use per year per operating room in the second twelve months of operation.

(3) Subsections (1) and (2) shall not apply if the proposed project involves adding a second operating room in a licensed hospital site located in a rural or micropolitan statistical area county that currently has only one operating room.

(4) An applicant shall demonstrate that it meets the requirements of Section ~~10~~11(2) for the number of surgical cases, or hours of use, projected under subsections (1) and (2).

Section 7. Requirements to acquire an existing surgical service

Sec. 7. Acquisition of a surgical service means a project involving the issuance of a new license for a hospital or a freestanding surgical outpatient facility or a new certification as an ambulatory surgical center as the result of the acquisition (including purchase, lease, donation, or other comparable arrangement) of an existing surgical service. An applicant proposing to acquire an existing surgical service shall demonstrate each of the following, as applicable to the proposed project.

(1) An applicant agrees and assures to comply with all applicable project delivery requirements.

(2) For the first application proposing to acquire an existing surgical service, for which a final decision has not been issued, on or after January 27, 1996, the existing surgical service shall not be required to be in compliance with the applicable volume requirements set forth in these standards. The surgical service shall be operating at the applicable volume requirements in the second 12 months after the effective date of the acquisition.

(3) For any application proposing to acquire an existing surgical service except the first application, for which a final decision has not been issued, on or after January 27, 1996, the existing surgical service shall be required to be in compliance with the applicable volume requirements on the date the application is submitted to the Department.

(4) Subsection (3) shall not apply to those hospitals licensed under Part 215 of PA 368 of 1978, as amended that had fewer than 70 licensed beds on December 1, 2002 provided the number of ORs at the surgical service has not increased as of March 31, 2003, and the location does not change.

Section 8. Requirements for a Hybrid Operating Room/Cardiac Catheterization Laboratory (OR/CCL)

Sec. 8. A hybrid or/ccl means an operating room located on a sterile corridor and equipped with an angiography system permitting minimally invasive procedures of the heart and blood vessels with full anesthesia capabilities. An applicant proposing to add one or more hybrid OR/CCLS at an existing surgical service shall demonstrate each of the following:

(1) The applicant operates an open heart surgery service which is in full compliance with the current con review standards for open heart surgery services.

(2) If the hybrid OR/CCL(s) represents an increase in the number of licensed operating rooms at the facility, the applicant is in compliance with Section 6 of these standards.

(3) If the hybrid OR/CCL(s) represents conversion of an existing operating room(s), the applicant is in compliance with the provisions of Section 5, if applicable.

(4) The applicant meets the applicable requirements of the CON review standards for cardiac catheterization services.

(5) Each case performed in a hybrid OR/CCL shall be included either in the surgical volume or the therapeutic cardiac catheterization volume of the facility. No case shall be counted more than once.

Section 9. Requirements for Medicaid Participation

Sec. 9. An applicant shall provide Verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

Section 10. Project delivery requirements terms of approval for all applicants

Sec. 10. An applicant shall agree that, if approved, the surgical services shall be delivered in compliance with the following terms of approval:

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(i) The designation of ORs as defined by the standards shall not be changed without prior notification to the Department.

(ii) Surgical facilities shall have established policies for the selection of patients and delineate procedures which may be performed in that particular facility.

(iii) Surgical facilities shall have provisions for handling all types of in-house emergencies, including cardiopulmonary resuscitation.

(iv) Surgical facilities performing outpatient surgery shall have policies which allow for hospitalization of patients when necessary. All surgeons who perform surgery within the facility shall have evidence of admitting privileges or of written arrangements with other physicians for patient admissions at a local hospital. The surgical facility shall have an established procedure, including a transfer agreement that provides for the immediate transfer of a patient requiring emergency care beyond the capabilities of the surgical facility to a hospital that is capable of providing the necessary inpatient services and is located within 30 minutes of the surgical facility. If no hospital is located within 30 minutes of the surgical facility, an applicant shall have a transfer agreement with the nearest hospital having such capability.

(v) An applicant shall have written policies and procedures regarding the administration of a surgical facility.

(vi) An applicant shall have written position descriptions which include minimum education, licensing, or certification requirements for all personnel employed at the surgical facility.

(vii) An applicant shall have a process for credentialing individuals authorized to perform surgery or provide anesthesia services at a surgical facility. An applicant's credentialing process shall insure that the selection and appointment of individuals to the staff of a surgical facility does not discriminate on the basis of licensure, registration, or professional education as doctors of medicine, osteopathic medicine and surgery, podiatric medicine and surgery, or dentistry.

(viii) An applicant shall provide laboratory, diagnostic imaging, pathology and pharmacy (including biologicals) services, either on-site or through contractual arrangements.

(ix) An applicant shall have written policies and procedures for advising patients of their rights.
(x) An applicant shall develop and maintain a system for the collection, storage, and use of patient records.
(xi) Surgical facilities shall have separate patient recovery and non-patient waiting areas.
(xii) Surgical facilities shall provide a functionally safe and sanitary environment for patients, personnel, and the public. Each facility shall incorporate a safety management program to maintain a physical environment free of hazards and to reduce the risk of human injury.
(B) For purposes of evaluating subsection (A), the Department shall consider it prima facie evidence as to compliance with the applicable requirements if an applicant surgical facility is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Hospital Association, or the Accreditation Association for Ambulatory Health Care, or certified by Medicare as an ambulatory surgical center.
(C) The operation of and referral of patients to the surgical facility shall be in conformance with 1978 PA 368, Sec. 16221, as amended by 1986 PA 319; MCL 333.16221; MSA 14.15 (16221).

(3) Compliance with the following access to care requirements:
(a) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:
(b) not deny surgical services to any individual based on ability to pay or source of payment;
(c) provide surgical services to any individual based on the clinical indications of need for the service.
(d) maintain information by payer and non-paying sources to indicate the volume of care from each source provided annually. Compliance with selective contracting requirements shall not be construed as a violation of this term.
(e) An applicant shall participate in Medicaid or in Medicaid managed care products at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter or attest that the applicant has been unable to contract with Medicaid managed care products at current Medicaid rates.

(4) Compliance with the following monitoring and reporting requirements:
(a) Existing operating rooms shall perform an average of at least:
(i) 1,042 surgical cases per year per operating room verifiable by the Department, or
(ii) 1,125 hours of use in a facility that performs only outpatient surgery per year per operating room verifiable by the Department, or
(iii) Be in compliance using the applicable weighted averages under Section 5.
(b) Existing operating rooms, located in a rural or micropolitan county, or within a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as defined by the most recent Federal decennial census in a surgical service that has three, four, or five OR'S shall perform an average of at least:
(i) 839 surgical cases per year per operating room verifiable by the Department or
(ii) 1,200 hours of use per year per operating room verifiable by the Department.
(c) The applicant shall participate in a data collection System established and administered by the Department. The data may include, but is not limited to, hours of use of operating rooms, annual budget and cost information, operating schedules, and demographic, diagnostic, morbidity and mortality information, as well as the volume of care provided to patients from all payer sources. An applicant shall provide the required data on a separate basis for each licensed or certified site, in a format established by the department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.
(d) The surgical service shall provide the Department with timely notice of the proposed project implementation consistent with applicable statute and promulgated rules.

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

Section 11. Documentation of projections

Sec. 11. (1) An applicant required to project volumes of service shall specify how the volume projections were developed and shall include only those surgical cases performed in an OR.

(a) The applicant shall include a description of the data source(s) used as well as an assessment of the accuracy of these data used to make the projections. Based on this documentation, the Department shall determine if the projections are reasonable.

(b) The Department shall subtract any previous commitment, pursuant to subsection 2(d).

(2) If a projected number of surgical cases, or hours of use, under subsection (1) includes surgical cases, or hours of use, performed at another existing surgical facility(s), an applicant shall demonstrate, with documentation satisfactory to the Department, that the utilization of the existing surgical facility(s) is in compliance with the volume requirements applicable to that facility, and will continue to be in compliance with the volume requirements (cases and/or hours) applicable to that facility subsequent to the initiation, expansion, or replacement of the surgical services proposed by an applicant. In demonstrating compliance with this subsection, an applicant shall provide each of the following:

(a) The name of each physician that performed surgical cases to be transferred to the applicant surgical facility.

(b) The number of surgical cases each physician, identified in subdivision (a), performed during the most recent 12-month period for which verifiable data is available.

(c) The location(s) at which the surgical cases to be transferred were performed, including evidence that the existing location and the proposed location are within 20 miles of each other.

(d) A written commitment from each physician, identified in subdivision (a), that he or she will perform at least the volume of surgical cases to be transferred to the applicant surgical facility for no less than 3 years subsequent to the initiation, expansion, or replacement of the surgical service proposed by an applicant.

(e) SUBSECTION 11(2)(d) SHALL NOT APPLY IF THE PROPOSED PROJECT INVOLVES THE INITIATION OF A SURGICAL SERVICE AT A NEW FSOF OR A NEW ASC AT A NEW GEOGRAPHICAL SITE UTILIZING THE HISTORICAL SURGICAL CASES OF THE APPLICANT AND THE NEW SERVICE IS OWNED BY THE SAME APPLICANT. THE APPLICANT FACILITY COMMITTING SURGICAL DATA HAS COMPLETED THE DEPARTMENTAL FORM THAT CERTIFIES THE SURGICAL CASES WERE PERFORMED AT THE COMMITTING FACILITY AND THE SURGICAL CASES WILL BE TRANSFERRED TO THE PROPOSED SURGICAL FACILITY FOR NO LESS THAN THREE YEARS SUBSEQUENT TO THE INITIATION OF THE SURGICAL SERVICE PROPOSED BY THE APPLICANT.

(~~e~~f) The number of surgical cases performed, at the existing surgical facility from which surgical cases will be transferred, during the most recent 12-month period prior to the date an application is submitted to the Department for which verifiable annual survey data is available.

(3) An applicant, other than an applicant proposing to initiate a surgical service, may utilize hours of use in documenting compliance with the applicable sections of these standards, if an applicant provides documentation, satisfactory to the Department, from the surgical facility from which the hours of use are being transferred.

Section 12. Effect on prior CON review standards; comparative reviews

Sec. 12. Proposed projects reviewed under these standards shall not be subject to comparative review. These CON review standards supercede and replace the CON Review Standards for Surgical Facilities approved by the CON Commission on ~~December 15, 2011~~SEPTEMBER 25, 2014 and effective on ~~February 27, 2012~~DECEMBER 22, 2014.

APPENDIX A

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

Psychiatric Bed Need: 2017 Update

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1 Summary

The psychiatric bed need was implemented using the methodology found in the current Review Standards (12/9/16) and three key datasets: projected population data for 2020 (acquired from the State Demographer), observed population data from 2015 (from the US Census Bureau), and CON Survey data from 2014 and 2015. The two appendices (A and B) in the Review Standards were also updated using the 2015 survey and population data. This report contains the updated values for Appendix A and Appendix B, and psychiatric bed need projections for 2020, as well as information from the previous updates (for comparative purposes).

2 Appendix A

The number of psychiatric hospital beds per 10,000 adults (aged 18+) is reported as a table in Appendix A of the Review Standards. The appendix was updated using 2015 annual survey data and 2015 county population data (see Table 1). In this update, bed/population rate fell in five of the eight planning areas (HSAs 1, 2, 3, 6, 7) and for the state overall. However, these drops were not substantial. The bed/population rate increased for HSAs 4, 5, and 8; however, as was the case for the decreases, these changes do not appear to be substantial. Overall, the bed/population rates appear to be quite stable (outside of HSA 7 in the previous update, which was due to the removal of 14 beds from service).

Table 1. Psychiatric hospital beds per 10,000 adults for Appendix A of the Standards. The years in the column headings represent the year from which the data were derived (e.g., 2015 contains the new values).

HSA	2010	2012	2015
1	3.0808	3.0914	3.0399
2	2.4282	2.4060	2.3735
3	2.4604	2.4446	2.3411
4	2.5284	2.3917	2.5981
5	3.0698	3.0791	3.0818
6	1.5558	1.7505	1.6770
7	1.2570	0.8384	0.8263
8	2.2756	2.2665	2.2847
STATE	*2.6633*	*2.6428*	*2.6324*

3 Appendix B

The Review Standards report the pediatric use rate (patient days per 1,000 children and adolescents aged 0–17) in Appendix B. The value increased from 25.6645 in the previous update to 29.8912 using the 2015 recent data. The raw data (patient days and population) can be found in Table 2 for the most recent calculations. It clearly shows that the use rate has increased over the previous five years, which has been due to both a larger raw number of patient days and a decreased pediatric and adolescent population.

Table 2. Pediatric use rate per 1,000 children/adolescents for Appendix B of the Standards. The years in the column headings represent the year from which the data were derived (e.g., 2015 contains the new values).

	2010	**2012**	**2015**
Patient Days	53,479	58,242	65,979
Population	2,344,068	2,269,365	2,207,304
Use Rate	22.8146	25.6644	29.8912

4 Pediatric Bed Need

The pediatric and adolescent psychiatric bed need was implemented as detailed in Section 3 of the Standards using 2015 as the base year and 2020 as the planning year, along with the updated pediatric use rate value from Appendix B. The updated bed need is provided in Table 3, along with the results from the previous two updates. The bed need figures increased slightly in half of the planning areas (HSAs 1, 2, 3, 4) and was the same in the other half (HSAs 5, 6, 7, 8). The overall increase in the number of pediatric beds required stems from the increase in the pediatric use rate (as noted above), but appears to be somewhat tempered by a likely decrease in the projected number of adolescents in the state in 2020.

Table 3. Pediatric Bed Need. The years in the column headings represent the planning year (e.g., 2020 contains the new values).

HSA	**2015**	**2017**	**2020**
1	113	114	122
2	15	16	18
3	17	19	20
4	32	35	40
5	12	13	13
6	14	16	16
7	8	9	9
8	6	7	7
STATE	*217*	*229*	*245*

5 Adult Bed Need

The adult psychiatric bed need was implemented as detailed in Section 3 of the Standards using 2015 as the base year and 2020 as the planning year, along with the updated values from Appendix A. The results are provided in Table 4. Statewide, the number of adult beds needed increased in the most recent update: five of eight planning areas (HSAs 1, 2, 3, 4, 8) had an increase, two (HSAs 5, 6) had slight decreases, and one (HSA 7) was unchanged. The observed changes do not appear to be substantial, and the overall adult psychiatric bed need appears to be relatively stable throughout the most recent updates.

Table 4. Adult Bed Need. The years in the column headings represent the planning year (e.g., 2020 contains the new values).

HSA	**2015**	**2017**	**2020**
1	1,084	1,044	1,051
2	169	163	187
3	188	179	183
4	300	289	324
5	143	144	140
6	95	110	106
7	48	30	30
8	64	62	77
STATE	*2,091*	*2,021*	*2,098*

CERTIFICATE OF NEED

2nd Quarter Compliance Report to the CON Commission

October 1, 2016 through September 30, 2017 (FY 2017)

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

MCL 333.22247

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

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

(a) Revoke or suspend the certificate of need.

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

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

(d) Request enforcement action under section 22253.

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

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

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

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

Activity Report

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

Activity	2nd Quarter	Year-to-Date
Approved projects requiring 1-year follow up	67	146
Approved projects contacted on or before anniversary date	15	53
Approved projects completed on or before 1-year follow up	52	
CON approvals expired	30	38
Total follow up correspondence sent	343	465
Total approved projects still ongoing	323	

Compliance: In accordance with Section 22247 and Rule 9419, the Department performs compliance checks on approved and operational Certificates of Need to determine if projects have been implemented, or if other applicable requirements have been met, in accordance with Part 222 of the Code.

- The Department is conducting statewide compliance reviews for Cardiac Catheterization Services and Megavoltage Radiation Therapy Services/Units utilizing 2015 CON Annual Survey data. After evaluating the annual survey data, review standards' requirements, and responses to additional questionnaire, the Department has identified the CON approved facilities for compliance investigations. The Department is in the process of completing compliance conference calls with each of these identified facilities. The finding of the statewide compliance reviews will be reported to the CON Commission at a later date.

- Crittenton Hospital Medical Center – During an application review, it was noted that the facility had operated a 3rd cardiac catheterization laboratory (CCL) without CON approval whereas they were approved for two (2) CCLs. The facility was required to immediately stop operating the 3rd CCL and establish an internal process to ensure that CON covered equipment receives approval prior to start of operations, and involve management level education about CON processes and requirements. The facility is required to pay a civil fine of $23,162.

- Karmanos Cancer Center – During the follow-up review of an approved CON, it was noted that the facility utilized a temporary fixed CT scanner unit without CON approval while awaiting the delivery of their CON-approved second fixed CT scanner at the hospital. The facility was required to establish an internal process to ensure that CON covered equipment receives approval prior to start of operations and involve management level education about CON processes and requirements. The facility submitted an amendment request to secure approval and paid a civil fine of $3,000.

Deregulation of Dental CT Scanner Service: On September 21, 2016, the CON Commission took final action on the CON Review Standards for CT Scanner Services and de-regulated dental CT scanner services. These Review Standards became effective on December 9, 2016. There were 49 dental CT scanner projects approved by CON but not 100% complete and the Department closed out these files without further follow-up required. There were four (4) CON applications in the review process and the Department waived review. Additionally, facilities with dental CT scanner service only, are no longer required to submit CON Annual Survey data.

Source: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

CERTIFICATE OF NEED

2nd Quarter Program Activity Report to the CON Commission

October 1, 2016 through September 30, 2017 (FY 2017)

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

Measures

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

Activity	2nd Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Letters of Intent Received	84	N/A	166	N/A
Letters of Intent Processed within 15 days	84	100%	165	99%
Letters of Intent Processed Online	84	100%	166	100%

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

Activity	2nd Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Applications Received	71	N/A	152	N/A
Applications Processed within 15 Days	70	98%	149	98%
Applications Incomplete/More Information Needed	47	66%	107	70%
Applications Filed Online*	57	100%	134	100%
Application Fees Received Online*	23	40%	37	28%

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

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

Activity	2nd Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Nonsubstantive Applications	51	100%	93	100%
Substantive Applications	28	100%	28	100%
Comparative Applications	0	N/A	0	N/A

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

Measures – continued

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

Activity	2nd Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Emergency Applications Received	0	N/A	0	N/A
Decisions Issued within 10 workings Days	0	N/A	0	N/A

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

Activity	2nd Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Amendments	14	100%	31	100%

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

Activity	2nd Quarter	Year-to-Date
Refunds Issued Pursuant to Section 22231	0	0

Other Measures

Activity	2nd Quarter		Year-to-Date	
	No.	Percent	No.	Percent
FOIA Requests Received	42	N/A	77	N/A
FOIA Requests Processed on Time *	42	100%	77	100%
Number of Applications Viewed Onsite	0	N/A	2	N/A

FOIA – Freedom of Information Act.

*Request processed within 5 days or an extension filed.

Source: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

Note: New or revised standards may include the provision that make the standard applicable, as of its effective date, to all CON applications for which a final decision has not been issued.

Attachment I

DRAFT CERTIFICATE OF NEED (CON) COMMISSION WORK PLAN

	2017											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Commission Meetings	Special Meeting		Meeting			Meeting			Meeting			Meeting
Bone Marrow Transplantation (BMT) Services										Public Comment for 2018 Review		
Cardiac Catheterization Services	Discussion	SAC Nomination & Selection Period					SAC Meeting	SAC Meeting	SAC Meeting/ Report	SAC Meeting	SAC Meeting	SAC Meeting/ Report
Heart/Lung and Liver Transplantation Services										Public Comment for 2018 Review		
Hospital Beds	Discussion		Discussion	SAC Nomination & Selection Period			SAC Meeting	SAC Meeting	SAC Meeting/ Report	SAC Meeting	SAC Meeting	SAC Meeting/ Report
Magnetic Resonance Imaging (MRI) Services										Public Comment for 2018 Review		
Nursing Home & Hospital Long-Term Care Unit (NH-HLTCU) Beds			Proposed Action		Public Hearing	Report/ Potential Final Action						
Open Heart Surgery (OHS)	Discussion											Report/ Draft Language Presented/Potential Proposed Action
Psychiatric Beds and Services										Public Comment for 2018 Review		
Surgical Services	Discussion					Report/ Draft Language Presented/Potential Proposed Action		Public Hearing	Report/ Potential Final Action			
Urinary Extracorporeal Shock Wave Lithotripsy Services		Public Hearing	Proposed Action		Public Hearing	Report/ Potential Final Action						
New Medical Technology Standing Committee	Department Monitoring					Department Monitoring				Department Monitoring		
FY2017 CON Annual Report												Present to Commission

For Approval June 15, 2017

The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings, contact the Michigan Department of Health and Human Services (MDHHS), Policy, Planning & Legislative Services, Office of Planning, 5th Floor South Grand Bldg., 333 S. Grand Ave., Lansing, MI 48933, 517-335-6708, **www.michigan.gov/con**.

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

Standards	Effective Date	Next Scheduled Update**
Air Ambulance Services	June 2, 2014	2019
Bone Marrow Transplantation Services	September 29, 2014	2018
Cardiac Catheterization Services	September 14, 2015	2017
Computed Tomography (CT) Scanner Services	December 9, 2016	2019
Heart/Lung and Liver Transplantation Services	September 28, 2012	2018
Hospital Beds	March 20, 2015	2017
Magnetic Resonance Imaging (MRI) Services	October 21, 2016	2018
Megavoltage Radiation Therapy (MRT) Services/Units	September 14, 2015	2020
Neonatal Intensive Care Services/Beds (NICU)	December 9, 2016	2019
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	March 20, 2015	2019
Open Heart Surgery Services	June 2, 2014	2017
Positron Emission Tomography (PET) Scanner Services	September 14, 2015	2020
Psychiatric Beds and Services	December 9, 2016	2018
Surgical Services	December 22, 2014	2017
Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	December 22, 2014	2019

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

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