

Michigan Certificate of Need Psychiatric Bed Workgroup  
Charges and Recommendations  
March 7, 2019

1. *Determine if modifications are necessary to Section 2(1)(s) to consider adding Nurse Practitioners and Physician Assistants individually to the definition of "Mental Health Professional" and include as part of "Mental Health Professional" in Section 15(1) – Project delivery requirements – additional terms of approval for child/adolescent service.*

**Recommendation:** The Workgroup noted that the way the standard is written, it appears that adding advanced practice providers (NP/PA) to the definition of "Mental Health Professional" would require facilities to have this type of provider on staff. That does not seem to be the intent of the standard but changing the definition may have unintended consequences for facilities and requirements. At this point, we would not recommend making this change. We would, however, respectfully suggest that all the regulatory bodies within the State of Michigan strive toward a consistent standard for what advanced practice providers are able to do (especially as stated in the Michigan Mental Health Code).

2. *Review potential options for flexibility to transfer beds and/or create units with existing child/adolescent and adult beds.*

**Recommendation:** The Workgroup understands that a proposal to allow for transfer of child/adolescent beds to facilities without an existing child/adolescent unit (but with an emergency department) was heard at the Certificate of Need Commission. The Workgroup endorses that proposal.

3. *Review the methodology for determining the inpatient psychiatric bed need in the state, including the proper percentage of psychiatric beds that should be allocated to the special pool for psychiatric beds.*

**Recommendations:** The Workgroup spent a considerable amount of time reviewing the potential methodology options for determining need for psychiatric beds in the state of Michigan. We reviewed a number of challenges, including the fact that the need for psychiatric services in the state has increased at a much higher rate in the past 5 years than in the past (which rendered past predictions inaccurate). Going forward, the Workgroup has recommended the following:

- We recommend that the current methodologies for predicting inpatient psychiatric bed need for both adult and child/adolescent beds be retired. We propose a new bed need methodology that incorporates a time series approach to predict future patient days and a normative approach to distribute those patient days to the HSAs (Health Service Areas).

The proposed methodology can be used for both adult and child/adolescent beds. While the proposed methodology is not without flaws, we believe that it is a more justifiable approach and potentially more accurate than the methodologies currently in place. We also recommend that the CON Commission and MDHHS work with the current psychiatric facilities in an effort to collect additional data via the CON Annual Survey or MIDB. [[Attachment 1 – Recommendation for Psychiatric Bed Need Methodology](#)]

- Increase of the Special Pool Bed number to 7.5% of the total bed need in the state for existing categories of Developmentally Disabled, Geriatric Psychiatry, Med-Psych. Add a new category of High Acuity that would be 10% of the total bed need in the state. Change the minimum for all of the categories that can include child/adolescent beds to 50.

*4. Review the comparative review criteria.*

**Recommendations:** A subgroup of the Psychiatric Bed Need Workgroup did a detailed analysis of the specific criteria for comparative review and proposed significant changes. These include more emphasis on facilities' providing access to indigent and high acuity populations. These revisions are in line with the identified need for patients who have been difficult to place throughout the state. [[Attachment 2 – Psych Beds Comparative Review Criteria](#)]

*5. Review criteria for the special pool beds.*

**Recommendations:** The Workgroup agreed that the special pool beds offered a useful mechanism to allow facilities to address needs within the state and their areas. The recommendation was to increase the percentage of the state bed need formula to increase the number of special pool beds. The group also recommended a revision of the standard for med-psych beds, as well as a new category of special pool bed: the high acuity unit. [[Attachment 3 – CON Review Standards for Special Population](#)]

*6. Add clarifying language, as appropriate, in each subsection of Section 9 to assist in understanding which subsection(s) apply under what circumstances (e.g., adding new beds from dept. inventory, adding new beds under high occupancy, relocate beds, etc).*

**Recommendation:** The Workgroup reviewed this language with MDHHS professionals and have submitted modifications. [[Attachment 4](#)]

*7. Add minimum occupancy requirements in last 12-months prior to application submission, as in hospital beds standards, for the existing psych hospital/unit before a new entity can acquire the facility, replace the facility, or relocate beds.*

**Recommendation:** The Workgroup recommended adding minimum occupancy requirements of 60% for adult beds and 40% for child beds. [[Attachment 4](#)]

8. *Consider any technical or other changes from the Department, e.g., updates or modifications consistent with other CON review standards and the Public Health Code.*

**Recommendation:** Throughout this process, the Workgroup consistently came up against issues around provider availability, continuum of care gaps, and inadequate reimbursement for many patients' hospitalizations. The Workgroup recommends continuing work in these areas on the state level.

# **ATTACHMENT 1**

## Recommendation for Psychiatric Bed Need Methodology

## **Recommendation for Psychiatric Bed Need Methodology**

March 1, 2019

Written by Paul Delamater on behalf of the Bed Need Methodology Subgroup

### Subgroup Participants

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Arlene Elliott (Arbor Advisors)	Ashton Shortridge (MSU)
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### Meeting Dates

January 4, 2019; January 29, 2019; February 22, 2019

## **Executive Summary**

We recommend that the current methodologies for predicting inpatient psychiatric bed need for both adult and child/adolescent beds be retired. We propose a new bed need methodology that incorporates a time series approach to predict future patient days and a normative approach to distribute those patient days to the HSAs (Health Service Areas). The proposed methodology can be used for both adult and child/adolescent beds. While the proposed methodology is not without flaws, we believe that it is a more justifiable approach and potentially more accurate than the methodologies currently in place. We also recommend that the CON Commission and MDHHS work with the current psychiatric facilities in an effort to collect additional data via the CON Annual Survey or MIDB.

## **Introduction**

The Psychiatric Beds and Services Workgroup formed a Bed Need Methodology Subgroup to develop and evaluate modifications of or replacements for the bed need methodologies currently in place in the Review Standards, per Charge #3 by the CON Commission on February 8, 2018. Given the general consensus in the workgroup that the current methodologies were inadequate, the subgroup emphasized new approaches. The subgroup met three times between January 4<sup>th</sup> and February 22<sup>nd</sup>. While many topics were discussed, the subgroup meetings largely focused on three main topics, 1) the role the bed need methodology plays (and does not play) in potential access to inpatient psychiatric services, 2) whether the bed need methodology should attempt to capture the future need of residents of each region or the future need of facilities in each region, and 3) detailed methodological approaches to predict future need for psychiatric services.

## **Recommendations**

The subgroup recommends that the current bed need methodologies be replaced with the new methodology proposed in this report. This proposed methodology was discussed on multiple occasions (including benefits and drawbacks), evaluated empirically, and agreed upon by the subgroup (although no official votes were taken, there were no objections to moving forward with this recommendation). The proposed methodology is detailed in this report.

The subgroup also recommends that the CON Commission and MDHHS work with the current psychiatric facilities in an effort to collect additional data via the CON Annual Survey or via reporting to the MIDB.

Part of the reason that developing a bed need methodology was a difficult process was that the group was working in a “data poor” environment; the most glaring absence was information on the residential location of patients visiting inpatient psychiatric facilities, which required a model-based approach to estimate these values in the proposed methodology. Specifically, we recommend that facilities report the sum of yearly visits and patient days aggregated by county of patient residence via the CON Annual Survey or that facilities report to the MIDB.

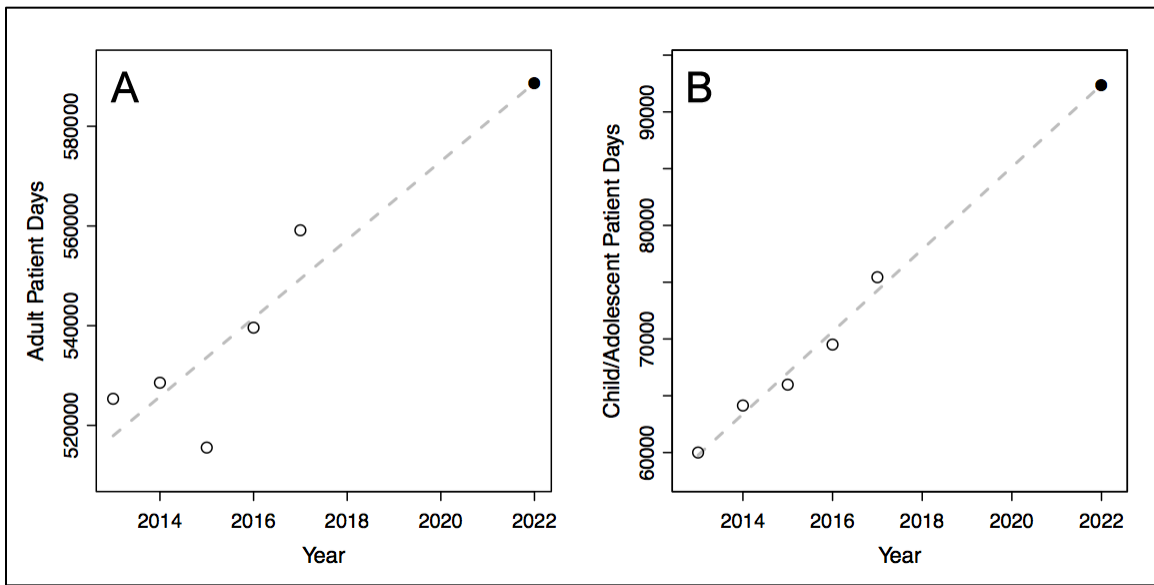
## **Methodology**

We recommend that the proposed methodology be implemented for both the adult (for people aged 18+ years) and child/adolescent (for people aged 0-17 years) bed need. We recommend the continued use of Michigan’s HSAs as the planning units. The proposed methodology has four stages: 1) predict patient day utilization in the planning year, 2) allocate planning year patient days to the HSAs, 3) adjust the planning year patient days to account for occupancy constraints, and 4) for each HSA, compare the future need for beds to the current number of beds to determine a surplus or deficit. These stages are detailed below.

### Predict planning year patient day utilization

The first stage of the proposed methodology predicts the total patient days in the planning year for the entire state. A temporal linear regression model is used for this prediction with the statewide patient days reported in the CON Annual Survey as the Y (dependent) variable and the year as the X (independent variable). The most recent five years of data are used in this model (base year plus previous four years). If there is a detectable temporal trend in the yearly patient days, the model parameters are used to predict the expected statewide patient days in the planning year (generally, five years from the year of the most recent data). If the data show no detectable temporal trend, expected statewide patient days in the planning year will be calculated using the average number from the most recent three years. The basic reasoning for this approach is that 1) if there is an overall increase or decrease in patient day utilization over time, the prediction will reflect that and 2) if there is limited evidence of an overall increase or decrease over time, the prediction will be conservative in its estimate. We suggest using a minimum  $R^2$  (a measure of model fit) of 0.5 to determine whether or not to use the regression results to predict future patient days.

This approach is illustrated in Figure 1, using the most recent five years of data (2013-17) to predict patient day utilization for both adult and child/adolescent psychiatric patient days 2022. In both cases, a temporal trend was detected. For adult patient days, the model  $R^2 = 0.56$  resulting in a prediction of 588,706 patient days in 2022, and for child/adolescent patient days, the model  $R^2 = 0.97$  resulting in a prediction of 92,390 patient days in 2022.



**Figure 1. Patient day predictions for 2022 for Adult (A) and Child/Adolescent (B) psychiatric services using the time series regression model approach.**

### Allocate Patient Days

Because the first stage of the proposed methodology predicts the total patient days in the planning year for the entire state, there needs to be a mechanism to assign those patient days to the HSAs. The second stage of the proposed methodology uses a normative approach for this task. A normative approach assumes that the underlying populations' need for psychiatric services is invariant from place to place and can be captured via the statewide utilization rate. To implement this approach, the statewide patient days for the planning year are divided by the predicted statewide population in the planning year to produce a statewide patient day utilization rate (in the planning year). The utilization rate is then multiplied by the predicted population in each HSA, which provides the planning year patient days for each HSA. Calculations for the adult and child/adolescent patient days in 2022 are provided below, and the resulting HSA-level predictions of patient days are provided in Table 1.

#### **Adult (in planning year)**

588,706 patient days / 8,163,955 adults = 0.0721 patient days per person

#### **Child/adolescent (in planning year)**

92,390 patient days / 2,088,266 children/adolescents = 0.0442 patient days per person

HSA	Adult		Child/Adolescent	
	Population	Patient Days	Population	Patient Days
1	3,922,102	282,824	989,467	43,776
2	652,779	47,072	160,621	7,106
3	686,756	49,522	182,513	8,075
4	1,308,312	94,343	361,713	16,003
5	452,054	32,598	115,928	5,129
6	584,425	42,143	143,607	6,354
7	329,335	23,748	82,203	3,637
8	228,193	16,455	52,214	2,310

**Table 1. HSA-level patient day predictions for 2022 for Adult and Child/Adolescent psychiatric services using the normative assignment approach.**

### Occupancy Adjustment

The third stage of the proposed methodology predicts the number of beds required to accommodate the patient days in the planning year by adjusting for expected occupancy (under the assumption that facilities are not expected to operate at full capacity). The proposed methodology uses a two-level occupancy adjustment that is based on the average number of beds for facilities in each HSA and the current requirements to add beds under the “high occupancy” provision in the Review Standards (75% for facilities with 19 beds or less and 80% for facilities with 20 beds or more). In this case, we propose an occupancy adjustment factor of 65% for HSAs with an average facility size less than 20 beds and 70% for HSAs with an average facility size of 20 or more beds (using the number of licensed beds in the base year). These values are 10% under the required occupancy to be considered high occupancy. To perform the occupancy adjustment, first calculate the average number of beds per facility in each HSA by dividing the HSA sum of licensed beds by the number of facilities. Next, divide the patient days in the planning year by the appropriate occupancy adjustment factor. Finally, divide the result by 365 to convert from patient days to beds.

### Compare to Current Supply

The final stage of the proposed methodology is simply to compare the predicted number of beds to meet the need of each HSAs population to the current number of beds in each HSA. The predicted number of beds is subtracted from the current number of beds. A positive value (or 0) represents that an HSA currently has more beds than required (or enough) to meet the future need of its residents, while a negative value represents that an HSA does not have enough beds to meet the future need of its residents (a need for additional beds). The results of the proposed methodology are presented in Tables 2 (Adult) and 3 (Child/Adolescent). A map of Michigan’s HSAs is provided in Figure 2.

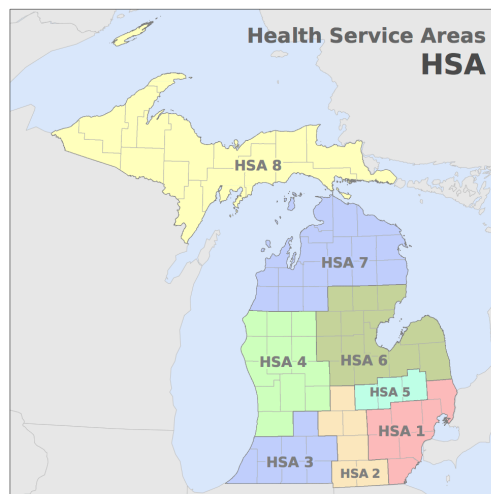


HSA	BEDS (avg)	OCC Adj	Patient Days	BEDS (pred)	BEDS (curr)	DIFF
1	42.6	0.7	282,824	1107	1,273	166
2	27.2	0.7	47,072	185	176	-9
3	25.3	0.7	49,522	194	152	-42
4	51.7	0.7	94,343	370	362	-8
5	33.8	0.7	32,598	128	135	7
6	29.3	0.7	42,143	165	117	-48
7	14.5	0.65	23,748	101	32	-69
8	28.5	0.7	16,455	65	57	-8

**Table 2. HSA-level results of bed need using the proposed methodology (base year 2017, planning year 2022) for Adult psychiatric services.** BEDS (avg) is the average number of beds per facility (in the base year), OCC Adj is the occupancy adjustment value. Patient Days is the predicted number of patient days in the planning year. BEDS (pred) is the predicted number of beds in the planning year. BEDS (curr) is the current department inventory (number of beds). DIFF is the difference between the predicted number of beds and current number of beds.

HSA	BEDS (avg)	OCC Adj	Patient Days	BEDS (pred)	BEDS (curr)	DIFF
1	29	0.7	43,776	173	148	-25
2	16	0.65	7,106	30	16	-14
3	6	0.65	8,075	35	6	-29
4	33	0.7	16,003	61	79	18
5	0	0.65	5,129	25	0	-25
6	33	0.7	6,354	26	33	7
7	0	0.65	3,637	17	0	-17
8	6	0.65	2,310	10	6	-4

**Table 3. HSA-level results of bed need using the proposed methodology (base year 2017, planning year 2022) for Child/Adolescent psychiatric services.** BEDS (avg) is the average number of beds per facility (in the base year), OCC Adj is the occupancy adjustment value. Patient Days is the predicted number of patient days in the planning year. BEDS (pred) is the predicted number of beds in the planning year. BEDS (curr) is the current department inventory (number of beds). DIFF is the difference between the predicted number of beds and current number of beds.



**Figure 2. Michigan’s Health Service Areas (HSAs)**

## Discussion

### Time-series Approach (Stage 1)

The time-series approach for predicting statewide patient days appears to provide reasonable predictions under the assumption that past temporal trends will continue into the future. Because this approach uses aggregated state data, it does not appear to be subject to large year-to-year fluctuations in utilization. This approach only requires utilization data (does not require population data). Another advantage of this approach is that it is similar to the time-series approach used in the acute care hospital bed need methodology. One disadvantage of the time-series approach is that it assumes past trends will continue into the future. Thus, if overall state-level utilization deviates from past trends in the period after the observed data used in the prediction (e.g., begins to plateau or reverse direction), the approach can produce values that are quite inaccurate. However, it appears that this approach will perform better than the other methods tested and we had high agreement that it was a capable component of a replacement methodology.

### Normative Patient Day Distribution (Stage 2)

The lack of data regarding patient origins (county of residence) in the CON Annual Survey data complicated efforts to predict the number of future beds for the HSAs because we only know the HSA of where services were used. We identified two theoretical approaches to solve this issue, which are facility-based and population-based (and are summarized below). We also discussed problems with data limitations. Currently some, but not all, inpatient psychiatric facilities submit patient record data to the Michigan Inpatient Database. MIDB patient data includes basic information like date of admission, stay length, diagnosis code, patient age, and county and ZIP code of residence. This data can provide detailed information about geographic and temporal patterns of access that would advance the State's knowledge about inpatient psychiatric care and contribute to better models of future bed need. We recommend requiring all inpatient psychiatric facilities to provide this data to the MIDB.

A facility-based approach attempts to predict the future need of the facilities in each HSA, regardless of where the patients using those facilities reside. If the methodology was based on HSA-level utilization data from the CON Annual Survey, the approach would essentially be facility-based in that it would predict the need of the facilities that provide the services, not the population that needs the services. This approach can be a concern in cases where there is a current misallocation of resources such that people are traveling outside of their HSA to access services, which we believe to be an issue with both adult and child/adolescent services (given the Working Group discussions and analysis of MIDB data for available facilities). This misallocation has the potential to be reinforced over time via the bed need methodology; for example, if facilities in an HSA are providing services for a large and increasing population that does not reside in that HSA, a facility-based approach will simply continue to allocate beds to that HSA to meet the detected increase in need. However, since (in the example) the need is originating outside of the HSA, we could consider this as a misallocation of resources because the need is allocated to a different HSA than where it is originating (and contradicts the purpose of using the HSAs as a planning unit).

One approach to remedy this issue when data are lacking on the residence of patients is to assume that there is an underlying level of need in the population that does not vary from place to place. An example of this would be to assume that the level of utilization needed by the population is expressed via the statewide utilization of patient days, and that the normative utilization rate is simply the statewide patient days divided by the statewide population. While this is a very strong assumption, we do not

believe that it is any worse than 1) assuming the patient day utilization based on the facility data adequately capture the true underlying need of the HSAs' residents or 2) continuing to misallocate resources due to cross-HSA utilization. A normative approach attempts to capture the need of each HSAs' resident population. We also examined a potential adjustment for each HSA's mix of publicly- and privately-insured population and varying psychiatric service utilization rates for these two groups. This approach did modify the resulting predictions of future bed need; however, the magnitude of these differences were quite small and did not justify the added complexity, data requirements, and additional assumption required for implementation.

The proposed normative approach for predicting HSA-level patient days appears to provide reasonable predictions for adult and child/adolescent patient day utilization, given the assumption of a constant underlying need for inpatient psychiatric services across HSAs. An advantage to this approach is that it is population-based, in that it attempts to predict the bed need for the residents of each HSA. The largest disadvantage of this approach is that the assumption of a constant underlying need for inpatient psychiatric services from region to region in the state is likely erroneous, as need will vary with social, economic, and demographic factors. Another disadvantage is that this approach requires predictions of HSA-level adult and child/adolescent populations in the planning year. Despite these limitations, we feel that this proposed approach is acceptable and offers an improvement over the current methodologies.

### Occupancy Adjustment (Stage 3)

The bed need methodologies currently in place use an expected occupancy adjustment of 75%, regardless of facility size (number of beds). Per the Review Standards, a facility operating at 75% occupancy would signal that the facility was operating at a "high occupancy" level (for facilities with less than 20 beds). We did not feel that the occupancy adjustment portion of the proposed bed need methodology should assume some facilities would be expected to operate at this threshold in the future. The two-level occupancy adjustment was agreed upon because it is a simple, sensible approach that takes into account the difference in larger and smaller facilities per the high occupancy standard. We also examined a variable occupancy scale that ranged from 60% for HSAs with an average facility size of 10 (or less) beds to 75% for HSAs with an average facility size of 40 (or more) beds. However, there was less justification for this approach, and we deemed the simple approach as more appropriate.

The proposed methodology does not include a "low occupancy" adjustment, which is a feature of the current adult and child/adolescent bed need methodologies. This adjustment appears to build in a buffer for facilities operating at 60% occupancy or less to account for temporal fluctuations in bed need that cannot be captured in the yearly time scale in which the bed need methodology considers. However, an examination of the low occupancy adjustment showed that it may not be having the desired effect. Specifically, it carries forward beds that are currently not being occupied and relabels them as "need" in the future. We thought that this approach was not appropriate, especially given the evidence from the Working Group that unutilized beds (or facilities operating under 60% occupancy) are likely a function of lack of staffing or resources, rather than natural temporal fluctuations in the population need for psychiatric services.

### **Appendix 1: Psychiatric Bed Need Methodology Subgroup Documents**

This document contains the materials produced (and used) by the Subgroup in determining their recommendation.

## **Appendix 1: Psychiatric Bed Need Methodology Subgroup Documents**

<b>Psychiatric Bed Need Methodology working document</b>	<b>January 25, 2019</b>	<b>Pages 2 – 33</b>
<b>Psychiatric Bed Need Comparative Results</b>	<b>February 19 2019</b>	<b>Page 34</b>
<b>Occupancy Adjustment Email Text</b>	<b>February 19 2019</b>	<b>Page 35</b>

Paul L. Delamater

# Psychiatric Bed Need Methodology working document

## DATA SOURCES

Patient day utilization: CON Annual Survey (facility-level)  
Population (observed): US Census (county-level)  
Population (predicted): Eric Guthrie (county-level)  
Medicaid / Healthy Michigan Program data (observed)

### **1. Time-series model to predict state-level number of patient days.**

**Summary:** Aggregate patient days to state total for each year. Use linear regression with five years of observed data to fit “trend line.” Use regression parameters (trend line) to predict patient day utilization 5 years into future, e.g., use data from 2013-17 to predict utilization in 2022. This approach is similar to that used in the Acute Care Hospital Bed Need Methodology.

I implemented the time-series model with all available data from the CON Annual Survey. In this case, data from 2009-13 was used to predict patient day utilization in 2018, 2010-14 was used to predict utilization in 2019, and so on. Because of the 5-year data requirement and the 5-year forecast window, the accuracy of this approach could not be tested by using past data to predict current utilization.

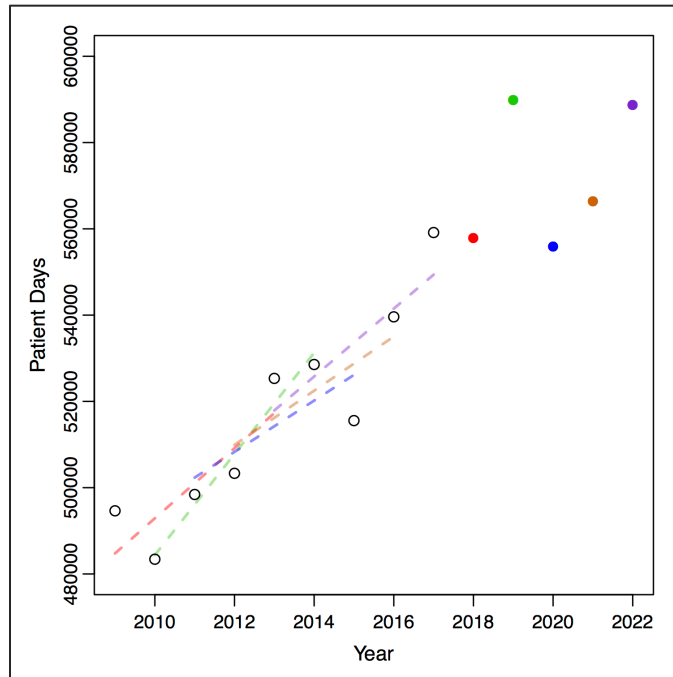
#### 1.1 ADULT

The linear regression models’ fit ( $R^2$ ) for adult patient day utilization are provided in Table 1, which demonstrates a good model fit for the first two 5-year windows and a decent model fit for the final three 5-year windows. The  $p$ -values (statistical significance of the model) are quite low despite that there are only five observations included in each the model; however,  $p$ -values are not extremely useful for this purpose given  $n=5$  for each model (a low number of observations). Figure 1 shows the observed data, the trend line from each of the regressions and the resulting predictions of statewide patient days using this approach.

Years	$R^2$	$p$ -value
2009-13	0.693	0.080
2010-14	0.953	0.004
2011-15	0.506	0.178
2012-16	0.523	0.167
2013-17	0.559	0.147

**Table 1. State-level time-series model statistics for adult psychiatric patient days.**  $R^2$  describes model fit;  $p$ -value describes statistical significance of the model (but is not highly useful in this case because  $n=5$ )

Figure 1 shows that the time series approach captures the general increase in adult patient day utilization observed over the previous nine years. The future predictions of the statewide patient days appear reasonable; e.g., if this methodology was implemented with the most recent data (2013-17), it predicts a statewide adult utilization of 588,706 patient days in 2022 (planning year), which represents a 5.3% increase from the 559,143 patient days from the base year 2017 (roughly 1% increase per year).



**Figure 1. State-level time-series models and predictions of adult psychiatric patient days.** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

### 1.2 PEDIATRIC

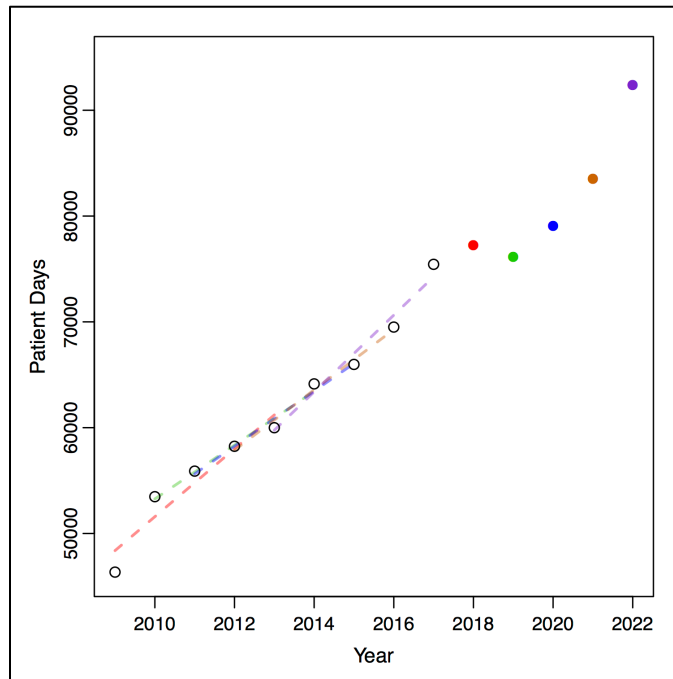
The linear regression models' fit ( $R^2$ ) with the statewide pediatric patient days are provided in Table 2, which demonstrates an extremely good model fit for each 5-year window. Figure 2 shows the observed data, the trend line from each of the regressions and the resulting predictions of statewide patient days using this approach. Notably, the Figure 2 shows the steady increase in patient day utilization over the previous nine years and the models' continuation of that trend into the future.

Years	$R^2$	$p$ -value
2009-13	0.908	0.012
2010-14	0.979	0.001
2011-15	0.982	0.001
2012-16	0.985	0.001
2013-17	0.968	0.002

**Table 1. State-level time-series model statistics for pediatric psychiatric patient days.**  $R^2$  describes model fit;  $p$ -value describes statistical significance of the model (but is not highly useful in this case because  $n=5$ )

### 1.3 PROS AND CONS

**Pros:** The time-series approach for predicting statewide patient days for both adult and pediatric utilization appears to provide reasonable predictions, under the assumption that past temporal trends will continue into the future. Because this approach uses aggregated state data, it does not appear to be subject to large year-to-year fluctuations in utilization. This approach can be used for both the adult and pediatric bed need methodologies. This approach only requires utilization data (does not require population data). Another advantage of this approach is that it is similar to the time-series approach used in the acute care hospital bed need methodology.



**Figure 2. State-level time-series models and predictions of pediatric psychiatric patient days.** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

**Cons:** This approach assumes past trends will continue into the future, thus if overall state-level utilization deviates from past trends in the period after the observed data used in the prediction (e.g., in this case, begins to plateau or decline), the approach can produce values that are highly inaccurate. The approach may need an additional step if there’s no strong trend (and a way to evaluate whether there is a strong trend). Also, because this approach uses aggregated state data, it requires an additional mechanism to distribute or allocate the predicted patient days to the Planning Areas (or Health Service Areas, HSAs).

**Recommendation:** The time-series approach using state-level data should be considered as a potential “piece” of a proposed bed need methodology given that the results appear to be quite reasonable and utilization appears to be on a consistent incline.

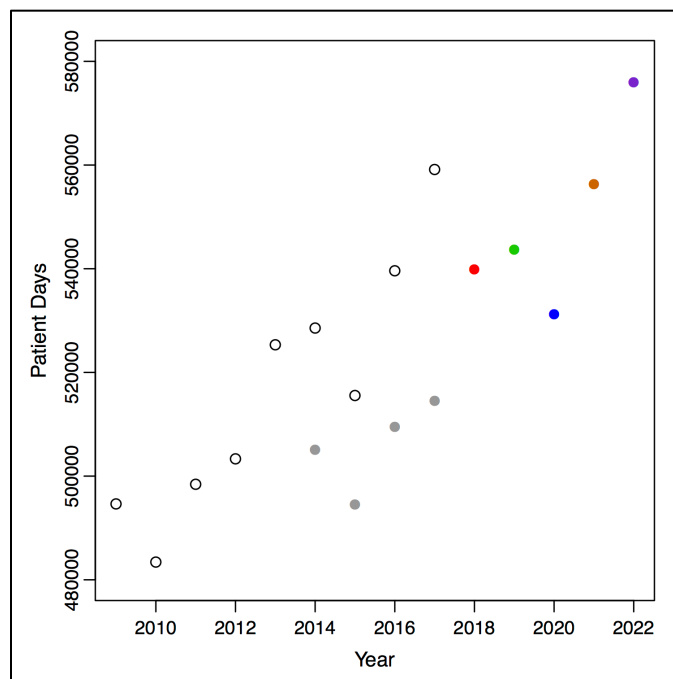
## 2. Population/utilization model to predict state-level number of patient days.

**Summary:** Aggregate patient days and population to state total for each year. Divide state-level patient days by state-level population to establish a utilization rate in the base year. Multiply the utilization rate by population in the planning year. This approach is similar to that used in the current Pediatric Psychiatric Bed Need Methodology.

I implemented the population/utilization model with all available data from the CON Annual Survey. In this case, utilization data from 2009-17 was used to predict day utilization in 2014-22. Because this approach only uses a single year of data, the results from 2014-17 can be compared to actual data. For the observed data calculations, the estimated state-level population data from 2014-2017 were used. Predicted population data were used to make the 2018-22 predictions.

### 2.1 ADULT

The predicted statewide patient days are found in Figure 3. The predictions for 2014 to 2017 (grey dots) represent what this approach would have predicted for those years, if the predictions were made five years prior (2009 to 2012) with observed population data as the “predicted” population data. The predictions for 2018 to 2022 use predicted population data.



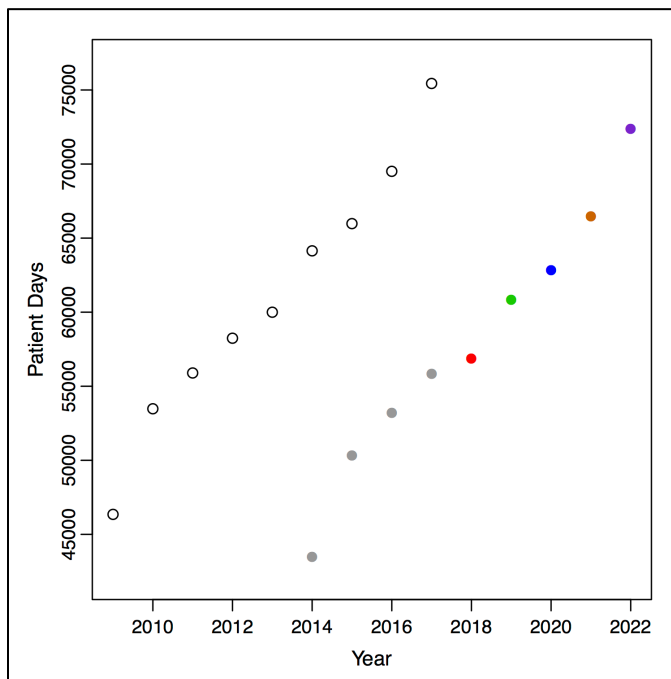
**Figure 3. State-level population/utilization predictions of adult psychiatric patient days.** Hollow (observed data), Grey (2009, 2014; 2010, 2015; 2011, 2016; 2012, 2017), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022).

Figure 3 shows that the population/utilization approach is highly dependent upon the utilization rate in the base year, as population changes at the state level are relatively small. For example, note that the difference between the observed patient days in 2017 and 2022; the increase in patient days is due to the expected increase in population over this time period. In general, it appears that the predicted values have generally just been shifted forward in time and slightly upward (note the pattern of the hollow points is extremely similar to the filled points). One issue with this approach is also apparent in Figure 3, which shows that the predictions can be quite erroneous when (in this case) utilization rates increase *and* population increases (note the large difference in the prediction and observed data for 2017).



## 2.2 PEDIATRIC

Figure 4 shows the results of the population/utilization approach when applied to the pediatric patient days. Similar to the previous figure, grey dots show what this approach would have predicted for 2014 to 2017, if this approach was implemented using data from 2009 to 2012. The predictions in Figure 4 demonstrate a scenario in which this approach performs quite poorly, when utilization rates are increasing dramatically in a steadily shrinking population, as the predictions for 2014 to 2017 are highly erroneous (compared to observed data) and the predictions from 2018 to 2022 do not appear to be very reasonable given recent data.



**Figure 4. State-level population/utilization predictions of pediatric psychiatric patient days.** Hollow (observed data), Grey (2009, 2014; 2010, 2015; 2011, 2016; 2012, 2017), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022).

## 2.3 PROS AND CONS

**Pros:** The population/utilization approach for predicting statewide patient days appears to provide reasonable predictions for adult patient day utilization. This approach can be used for both the adult and pediatric bed need methodologies. It uses a similar theoretical approach to the methodology currently used in the pediatric psychiatric bed need.

**Cons:** The population/utilization approach for predicting statewide patient days appears to provide unreasonable predictions for recent and future pediatric patient day utilization. Because this approach uses aggregated state data, it requires an additional mechanism to distribute or allocate the predicted patient days to the Planning Areas (or Health Service Areas, HSAs).

**Recommendation:** The population/utilization approach to predict state-level utilization data should probably not be considered as a potential “piece” of a proposed bed need methodology, given that patient day utilization rates appear to be (and have been) shifting quite dramatically. Notably, the expectation that utilization rates five years in the future will be similar to they are today appears to be unreasonable.

### 3. Time-series model to predict HSA-level number of patient days.

**Summary:** Aggregate patient days by HSA for each year. Use linear regression with five years of observed data to fit “trend line” for each HSA. Use regression parameters to predict patient day utilization 5 years into future, e.g., use data from 2013-17 to predict utilization in 2022. This approach is very similar to that used in the Acute Care Hospital Bed Need Methodology (which uses counties, not HSA).

I implemented the time-series model with all available data. In this case, data from 2009-13 was used to predict patient day utilization in 2018, 2010-14 was used to predict utilization in 2019, and so on. Similar to the state-level approach, the accuracy of this approach could not be tested using past data given available data. An important note regarding time-series model to predict HSA-level utilization is the “sum” of the predictions are equal to the state-level utilization predictions (from #1 above). Thus, this approach does not require a separate mechanism to allocate patient days to the HSAs.

#### 3.1 ADULT

The fit of the linear regression models are provided in Table 2, which shows an extremely large variation among the years and HSAs. Figure 5 shows the observed data, the trend line from each of the regressions and the resulting predictions of the HSA-level patient days using this approach.

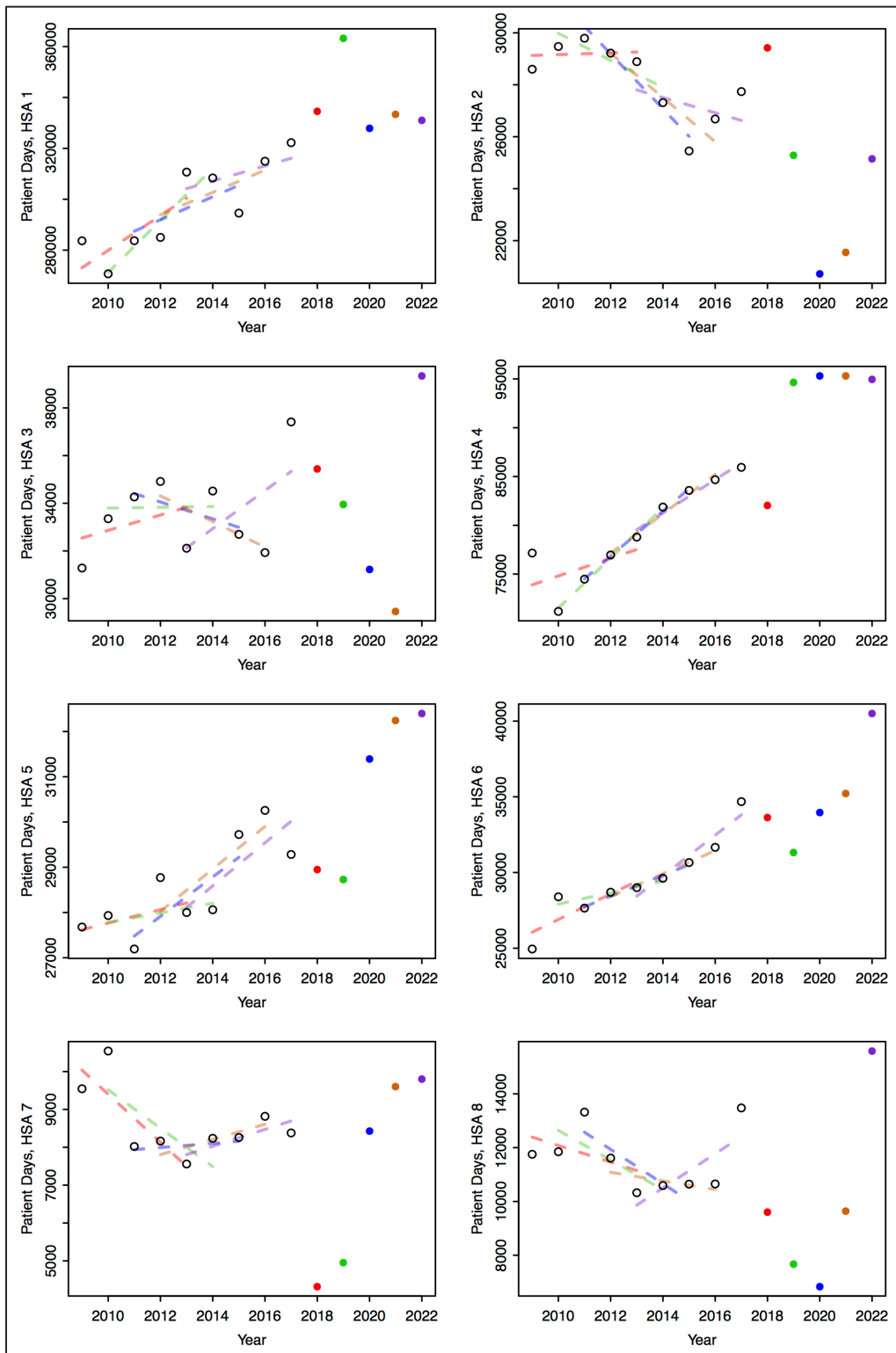
As Figure 5 shows, the HSA-level yearly patient day utilization is much more variable from year-to-year than the state-level utilization. This is expected, because the number of facilities and people in each unit is smaller than the state total. In some cases, the resulting predictions appear reasonable, but in others they appear unreasonable. One of the drawbacks of using a time-series approach with somewhat instable data is very apparent in the predictions for HSA 2. Specifically, the prediction for 2020 is extremely low given the sharp downward trend in patient day utilization from 2011-15. However, utilization rebounded and began increasing in 2016. Further, although utilization increased again in 2017 in HSA 2, the decreases occurring during 2013-15 continue to influence the patient day predictions for 2020.

	HSA1	HSA2	HSA3	HSA4	HSA5	HSA6	HSA7	HSA8
Years	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>
2009-13	0.55	0.01	0.12	0.23	0.17	0.66	0.66	0.21
2010-14	0.88	0.73	0.00	0.99	0.09	0.68	0.47	0.54
2011-15	0.32	0.91	0.21	0.99	0.52	0.97	0.09	0.67
2012-16	0.31	0.74	0.38	0.97	0.55	0.96	0.50	0.26
2013-17	0.21	0.13	0.30	0.95	0.56	0.90	0.60	0.59

**Table 2. HSA-level time-series model fit for adult psychiatric patient days.** R<sup>2</sup> describes model fit; *p*-values are not provided because they are not highly useful in this scenario (*n*=5).

#### 3.2 PEDIATRIC

The fit of the HSA-level linear regression models for pediatric patient days are provided in Table 3. Notably, this approach can only be used on HSAs 1, 3, 4, 6, and 8. This is because HSA 2 only had reported patient days in 2017 (five years of data are necessary), while HSAs 5 and 7 do not have facilities. Figure 6 shows the observed data, the trend line from each of the regressions and the resulting predictions of HSA-level patient days using this approach.

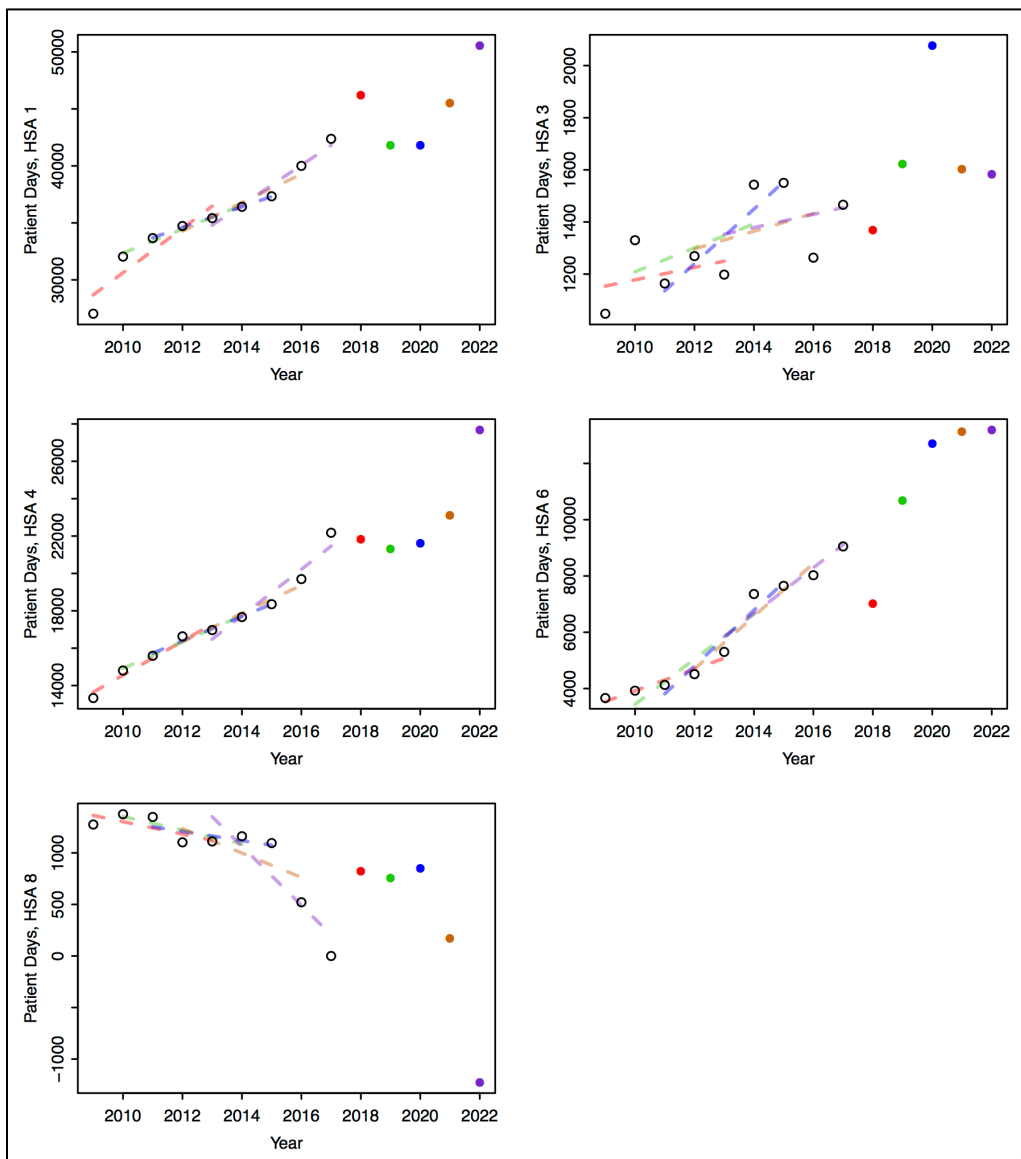


**Figure 5. HSA-level time-series predictions of adult psychiatric patient days.** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

For pediatric patient days, the HSA-level time series models have quite a good fit in HSAs 1, 4, and 6 over each 5-year period. HSA 8 has moderate fit. HSA 3 has poor model fit in 4 of 5 of the 5-year periods. Figure 6 shows that for all HSAs except HSA 8, this approach appears to provide reasonable results. A major issue is encountered in the prediction for patient days in HSA 8, where the time-series model predicts negative patient days (due to the decreasing utilization and the 0 observed patient days in 2017).

	HSA1	HSA3	HSA4	HSA6	HSA8
Years	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>	R <sup>2</sup>
2009-13	0.84	0.12	0.96	0.92	0.54
2010-14	0.98	0.24	0.98	0.83	0.63
2011-15	>0.99	0.77	0.98	0.93	0.44
2012-16	0.92	0.10	0.95	0.90	0.48
2013-17	0.95	0.06	0.92	0.88	0.80

**Table 3. HSA-level time-series model fit for pediatric psychiatric patient days.** R<sup>2</sup> describes model fit; *p*-values are not provided because they are not highly useful in this scenario (*n*=5).



**Figure 6. HSA-level time-series predictions of pediatric psychiatric patient days.** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

### 3.3 PROS AND CONS

**Pros:** The time-series approach for predicting HSA-level patient days appears to provide reasonable predictions for some HSAs in both adult and pediatric utilization. This approach can be used for both the adult and pediatric bed need methodologies (with caveat below). This approach only requires utilization data (does not require population data). Another advantage of this approach is that it is similar to the time-series approach used in the acute care hospital bed need methodology.

**Cons:** The time-series approach for predicting HSA-level patient days provided what appear to be unreasonable predictions for some HSAs in both adult and pediatric utilization (especially in 2022 for pediatric utilization in HSA 8). This approach assumes past trends will continue into the future, thus if overall utilization deviates from past trends in the period after the observed data used in the prediction (e.g., in this case, begins to plateau or decline), the approach can produce values that are highly inaccurate. The approach may need an additional step if there's no strong trend (and a way to evaluate whether there is a strong trend). Reinforces the potential misdistribution of resources. Also, because there are no facilities in some of the HSAs for pediatric beds, this approach would assume there is 0 need.

**Recommendation:** The time-series approach for predicting HSA-level patient days should probably not be considered as a potential "piece" of a proposed bed need methodology. The HSA-level data appear to be highly variable over time (in some HSAs) resulting in predictions that appear unreasonable.

#### 4. Population/utilization model to predict HSA-level number of patient days.

**Summary:** Aggregate patient days and population by HSA for each year. Divide patient days by population to establish a utilization rate in each HSA in the base year. Multiply the base year utilization rate by population in the planning year. This approach is similar to that used in the current Pediatric Psychiatric Bed Need Methodology.

I implemented the population/utilization model with all available data from the CON Annual Survey. In this case, utilization data from 2009-17 was used to predict day utilization in 2014-22. Because this approach only uses a single year of data, the results from 2014-17 can be compared to observed data. For the observed data calculations, the estimated state-level population data from 2014-2017 were used. Predicted population data were used to make the 2018-22 predictions.

##### 4.1 ADULT

Figure 7 shows the predicted statewide patient days for each HSA using the HSA-level population/utilization approach. The predictions for 2014 to 2017 (grey dots) represent what this approach would have predicted for those years, if the predictions were made five years prior (2009 to 2012) with observed population data as the “predicted” population data. The predictions for 2018 to 2022 use predicted population data.

As the figure shows, this approach appears to provide reasonable predictions of HSA-level patient day utilization for some HSAs, but not all. Similar to the state-level approach (#2), this approach is quite dependent on the population projections. For example, in HSA the increase in patient days (i.e., after 2017) stems from the population projection showing an increase in the number of people in HSA 1, as the utilization rates are from five years prior.

##### 4.2 PEDIATRIC

The results of the HSA-level population/utilization approach when applied to the pediatric patient days can be found in Figure 8. Similar to the previous figure, grey dots show what this approach would have predicted for 2014 to 2017, if this approach was implemented using data from 2009 to 2012.

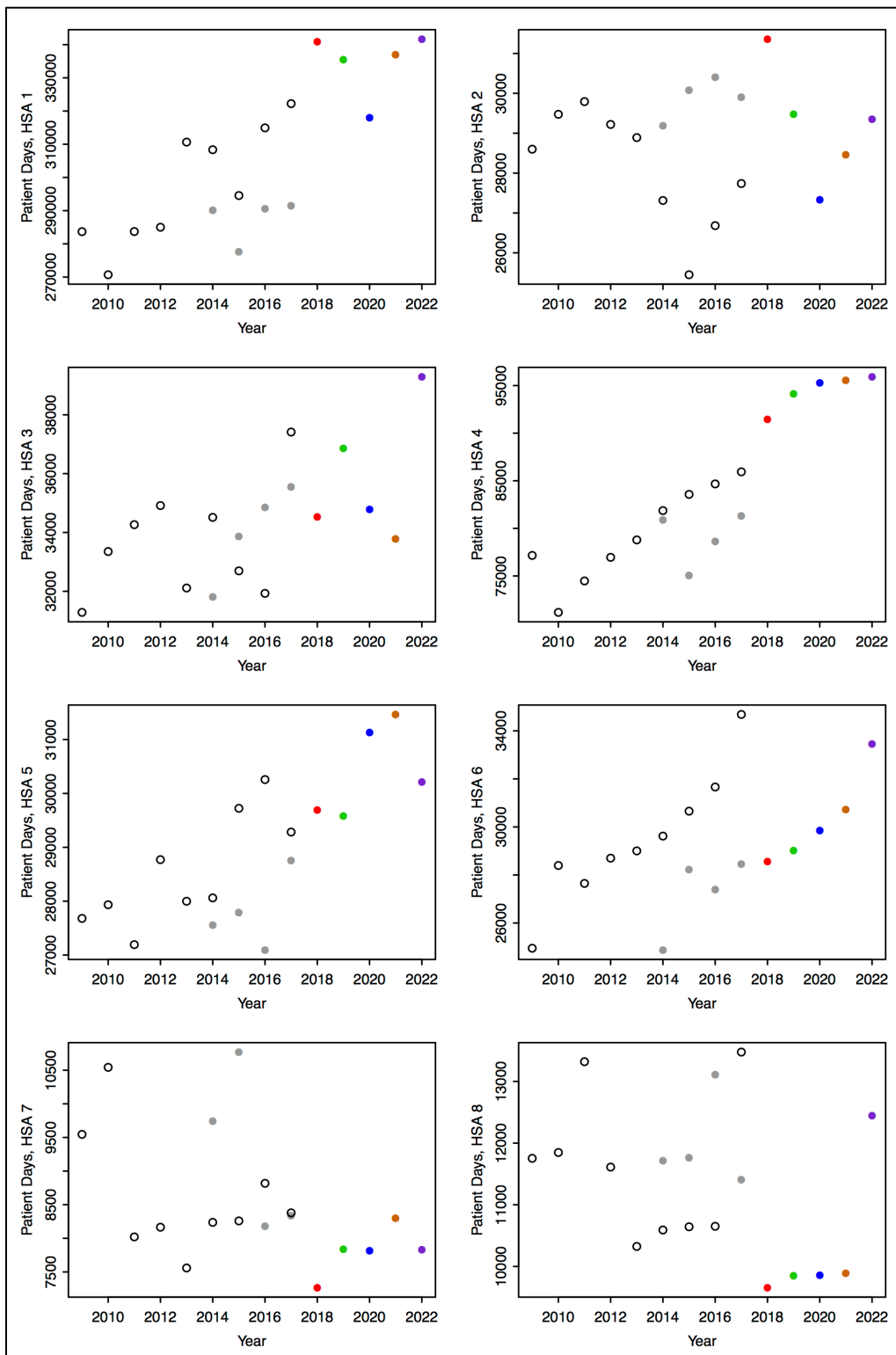
Notably, the HSA-level predictions of the pediatric patient days appear to suffer from the exact same issue as the state-level predictions using the population/utilization approach. Specifically, when the population is expected to stay roughly the same size (or decrease), the predictions appear to be past utilization simply shifted into the future. As with the state-level data, this can cause major error when utilization (rates) are increasing rapidly from year-to-year, as is the case with pediatric psychiatric services.

##### 4.3 PROS AND CONS

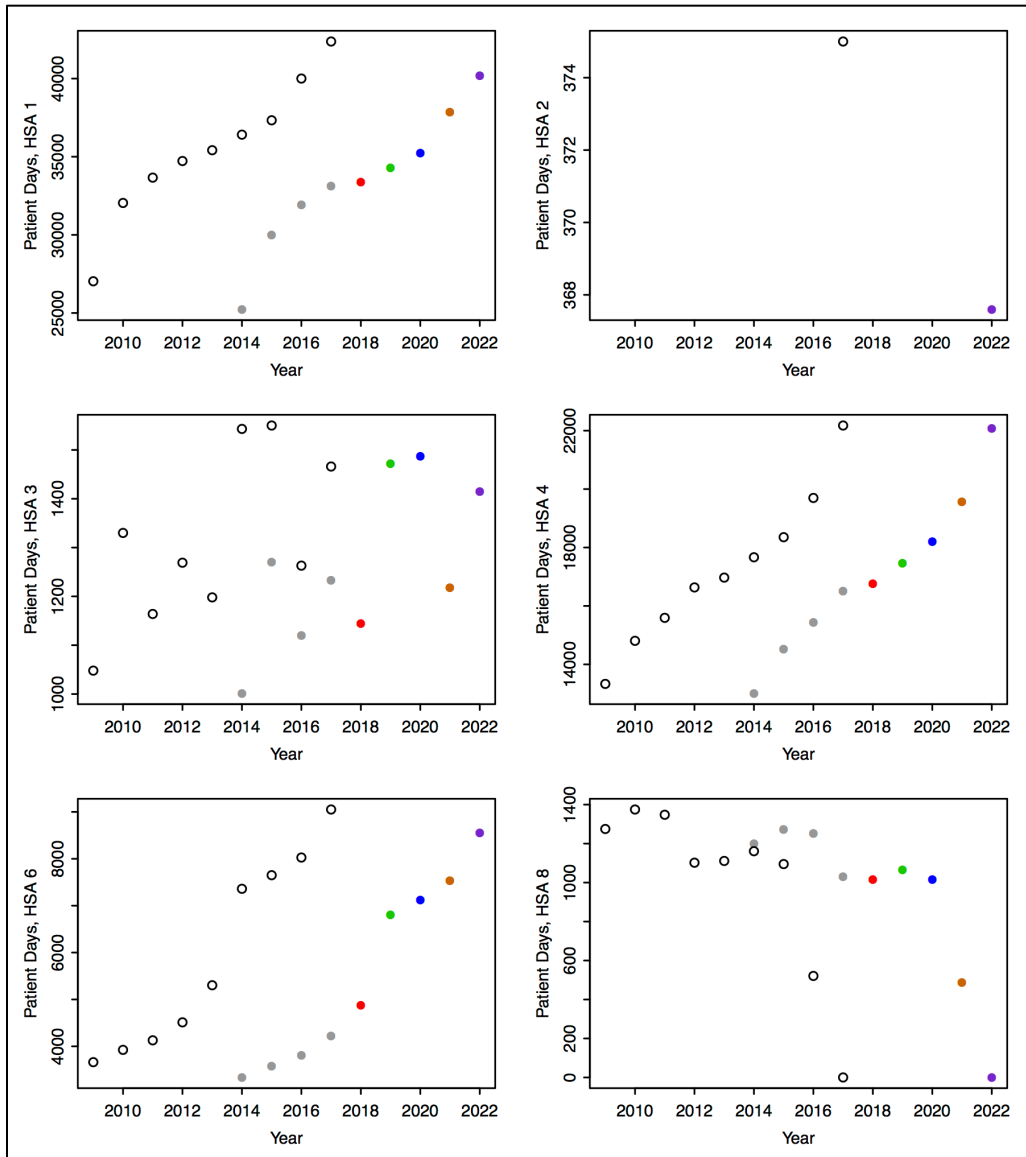
**Pros:** The HSA-level population/utilization approach for predicting patient days appears to provide reasonable predictions for adult patient day utilization in some HSAs. This approach can be used for both the adult and pediatric bed need methodologies. It uses a similar theoretical approach to the methodology currently used in the pediatric psychiatric bed need.

**Cons:** The HSA-level population/utilization approach for predicting patient days appears to provide unreasonable predictions for recent and future pediatric patient day utilization (for all HSAs) and for adult patient day utilization (in some HSAs). The approach is very reliant on accurate predictions of future populations at the HSA level (which is difficult). Reinforces the potential misdistribution of resources. Also, because there are no facilities in some of the HSAs for pediatric beds, this approach would assume there is 0 need.

**Recommendation:** The population/utilization approach to predict HSA-level utilization data should probably not be considered as a potential “piece” of a proposed bed need methodology, given that patient day utilization rates appear to be (and have been) shifting quite dramatically. Notably, the expectation that utilization rates five years in the future will be similar to they are today appears to be unreasonable.



**Figure 7. HSA-level population/utilization predictions of adult psychiatric patient days.** Hollow (observed data), Grey (2009, 2014; 2010, 2015; 2011, 2016; 2012, 2017), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022).



**Figure 8. HSA-level population/utilization predictions of pediatric psychiatric patient days.** Hollow (observed data), Grey (2009, 2014; 2010, 2015; 2011, 2016; 2012, 2017), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022).



## 5. Use relative distribution of patient day utilization among HSAs to allocate patient days.

**Summary:** Given a statewide prediction of total patient days (e.g., #1 above), use the proportion of use among the HSAs to allocate future patient days to the HSAs. For example, if HSA 1 provided 50% of all statewide patient days in 2017, we would expect HSA 1 to provide 50% of all patient days in 2022.

I implemented this approach using the statewide predictions from #1 above. I used three different calculations for the relative distribution of patient days among the HSAs to examine how they would affect the results. The first was to use a single year of data (base year) to calculate the relative distribution. For example, if HSA 1 provided 50% of all statewide patient days in 2017, we would expect HSA 1 to provide 50% of all patient days in 2022. The second was to use a 3-year average of data (aggregate data from base year plus two previous years) to calculate the relative distribution. For example, if HSA 1 provided 52% of all statewide patient days over 2015-17, we would expect HSA 1 to provide 52% of all patient days in 2022. The third was to use a 5-year average of data (aggregate data from base year plus four previous years) to calculate the relative distribution. For example, if HSA 1 provided 55% of all statewide patient days over 2013-17, we would expect HSA 1 to provide 55% of all patient days in 2022.

Because the first two calculations use less than five years of data, they can be evaluated using past data (and compared to observed data). To do this, I used the actual number of statewide patient days as the “prediction” and allocated them to the HSA based on relative distributions in the past. This allowed me to compare the predicted patient days per HSA (using the relative distribution approach) to the observed patient days.

### 5.1 ADULT

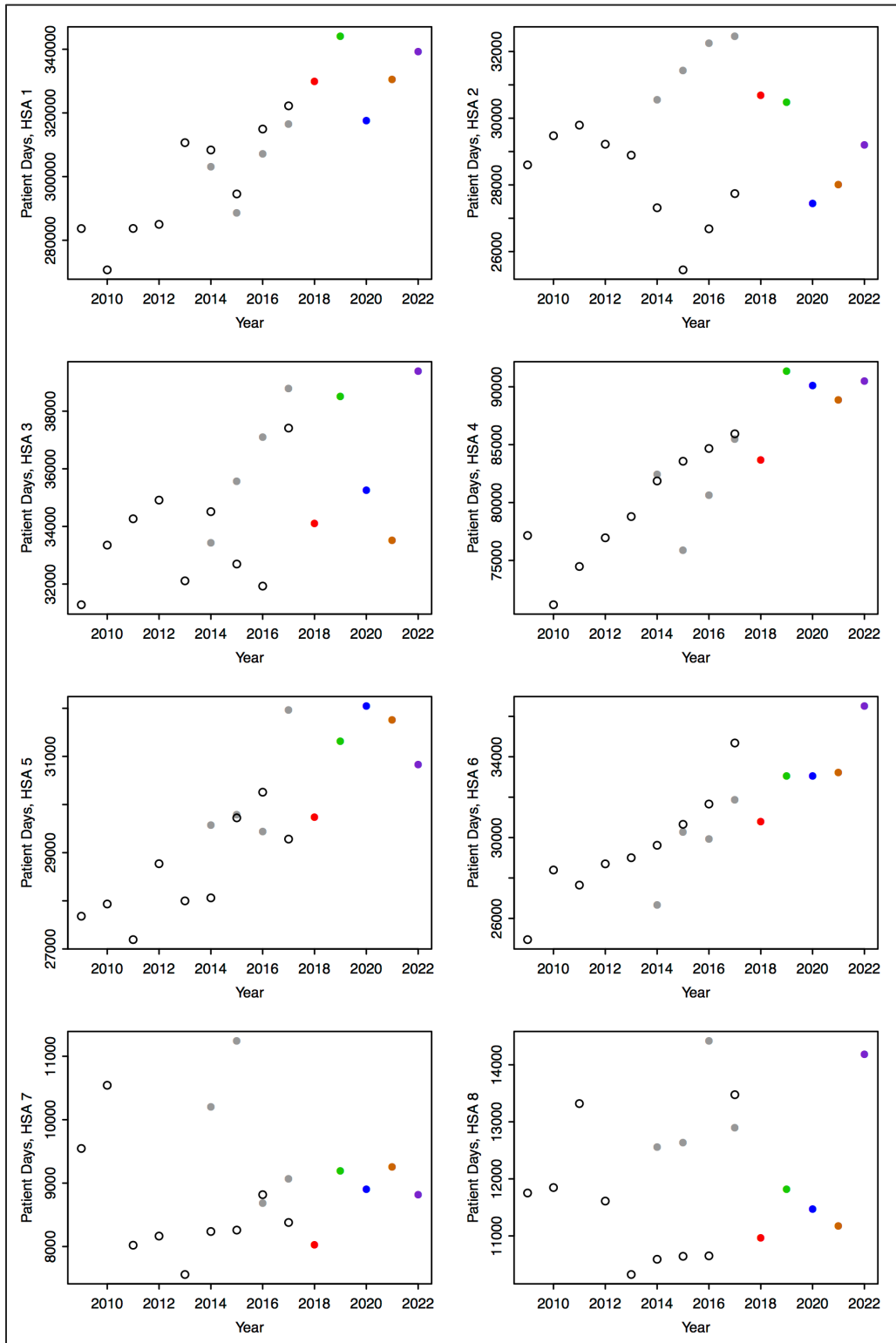
The relative distribution of adult psychiatric patient days among the HSAs is provided in Table 4 in percent form. For each year, all available data are provided. For example, for 2009 and 2010 only the 1-year observed relative distribution is available. For 2011 and 2012, the 1- and 3-year relative distributions are available. For 2013 to 2017, the 1-, 3-, and 5-year relative distributions are available. For comparative purposes, in instances when data from 5 years prior are available, these are also presented in Table 4 to illustrate how change over time may affect this approach if used in a bed need methodology (which would require predicting five years into the future). For example, the data in 2014 (1 yr pred) are exactly the same as the relative distribution of patient days using the 2009 (1 yr) data.

The results show that the relative distribution of patient days is somewhat stable over time, but there are instances that one or more HSAs has a large increase or decrease from year to year. The use of the temporally aggregated data (both 3- and 5-year) appears to smooth some of this variation. Further, comparison of the predicted relative distribution appears to provide reasonable results in the years with predictions.

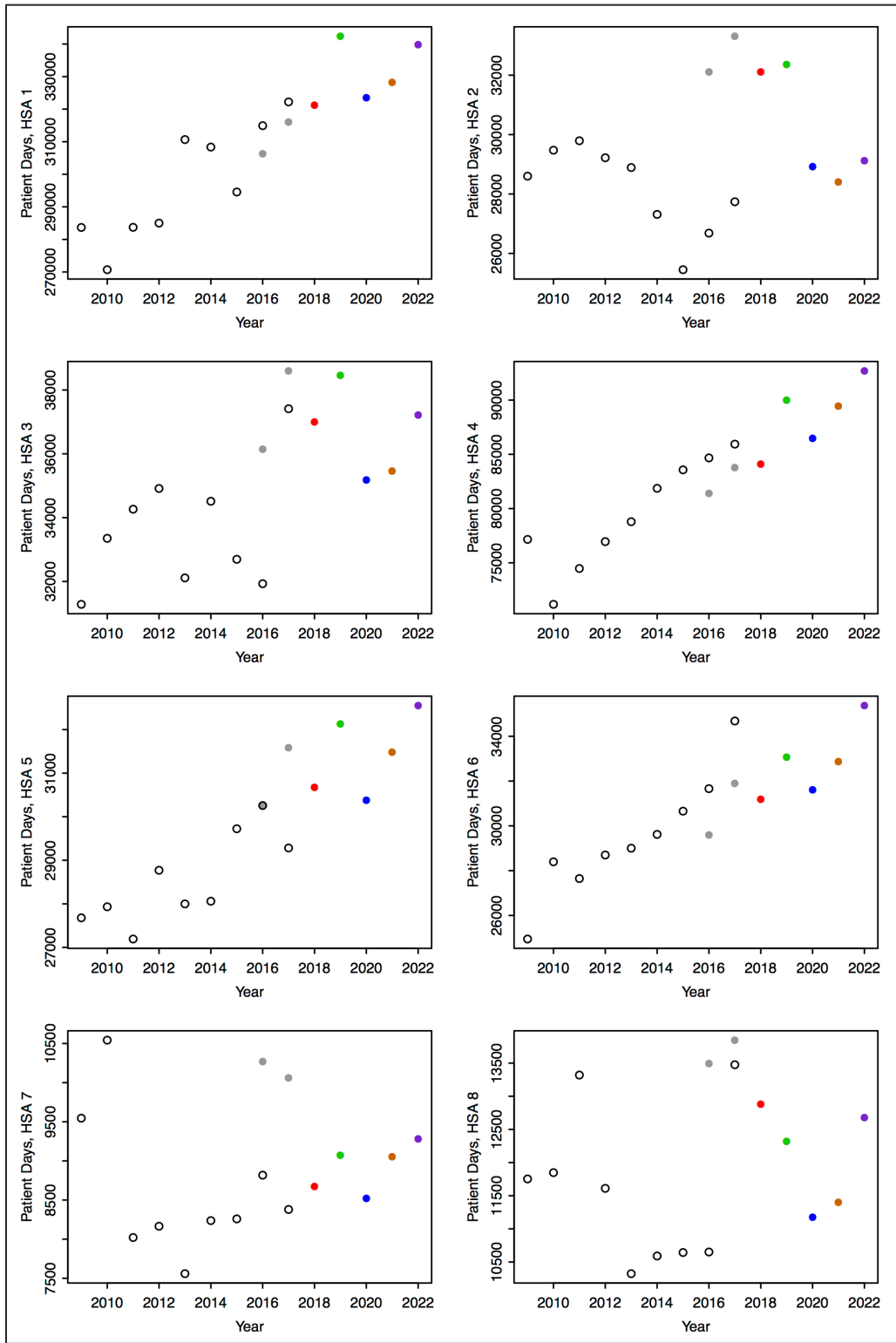
The results from the relative distribution calculation using a single year of data to calculate the patient days in each HSA are found in Figure 9. The results from the 3-year average calculation are in Figure 10, and the results from the 5-year average calculation are in Figure 11. Overall, this approach appears to provide reasonable results using past data and when extended to predicting future utilization in each HSA. The variation in the resulting predictions appears to get smaller as more years are used for the relative distribution calculation (e.g., predictions using five years of data are less variable than those using one year of data); the use of multiple years smooths out some of the year-to-year fluctuations in relative percent of patient days provided among the HSAs.

Year	HSA1	HSA2	HSA3	HSA4	HSA5	HSA6	HSA7	HSA8
2009 (1 yr)	57.35%	5.78%	6.32%	15.60%	5.60%	5.04%	1.93%	2.38%
2010 (1 yr)	56.00%	6.10%	6.90%	14.72%	5.78%	5.87%	2.18%	2.45%
2011 (1 yr)	56.92%	5.98%	6.87%	14.94%	5.46%	5.55%	1.61%	2.67%
2011 (3 yr)	56.76%	5.95%	6.70%	15.09%	5.61%	5.49%	1.90%	2.50%
2012 (1 yr)	56.62%	5.81%	6.94%	15.29%	5.72%	5.70%	1.62%	2.31%
2012 (3 yr)	56.52%	5.96%	6.90%	14.99%	5.65%	5.71%	1.80%	2.48%
2013 (1 yr)	59.14%	5.50%	6.11%	15.00%	5.33%	5.52%	1.44%	1.97%
2013 (3 yr)	57.58%	5.76%	6.63%	15.08%	5.50%	5.59%	1.55%	2.31%
2013 (5 yr)	57.23%	5.83%	6.62%	15.11%	5.57%	5.54%	1.75%	2.35%
2014 (1 yr)	58.34%	5.17%	6.53%	15.49%	5.31%	5.60%	1.56%	2.00%
2014 (3 yr)	58.05%	5.49%	6.52%	15.26%	5.45%	5.61%	1.54%	2.09%
2014 (5 yr)	57.44%	5.70%	6.66%	15.09%	5.51%	5.65%	1.67%	2.27%
2014 (1 yr pred)	57.35%	5.78%	6.32%	15.60%	5.60%	5.04%	1.93%	2.38%
2015 (1 yr)	57.13%	4.94%	6.34%	16.21%	5.77%	5.95%	1.60%	2.06%
2015 (3 yr)	58.21%	5.20%	6.33%	15.56%	5.47%	5.69%	1.53%	2.01%
2015 (5 yr)	57.65%	5.47%	6.55%	15.39%	5.51%	5.66%	1.57%	2.20%
2015 (1 yr pred)	56.00%	6.10%	6.90%	14.72%	5.78%	5.87%	2.18%	2.45%
2016 (1 yr)	58.36%	4.94%	5.92%	15.69%	5.61%	5.87%	1.63%	1.97%
2016 (3 yr)	57.96%	5.02%	6.26%	15.79%	5.56%	5.81%	1.60%	2.01%
2016 (5 yr)	57.94%	5.27%	6.36%	15.54%	5.54%	5.73%	1.57%	2.06%
2016 (1 yr pred)	56.92%	5.98%	6.87%	14.94%	5.46%	5.55%	1.61%	2.67%
2016 (3 yr pred)	56.76%	5.95%	6.70%	15.09%	5.61%	5.49%	1.90%	2.50%
2017 (1 yr)	57.63%	4.96%	6.69%	15.37%	5.24%	6.20%	1.50%	2.41%
2017 (3 yr)	57.72%	4.95%	6.32%	15.75%	5.53%	6.01%	1.58%	2.15%
2017 (5 yr)	58.12%	5.10%	6.32%	15.55%	5.45%	5.83%	1.55%	2.09%
2017 (1 yr pred)	56.62%	5.81%	6.94%	15.29%	5.72%	5.70%	1.62%	2.31%
2017 (3 yr pred)	56.52%	5.96%	6.90%	14.99%	5.65%	5.71%	1.80%	2.48%

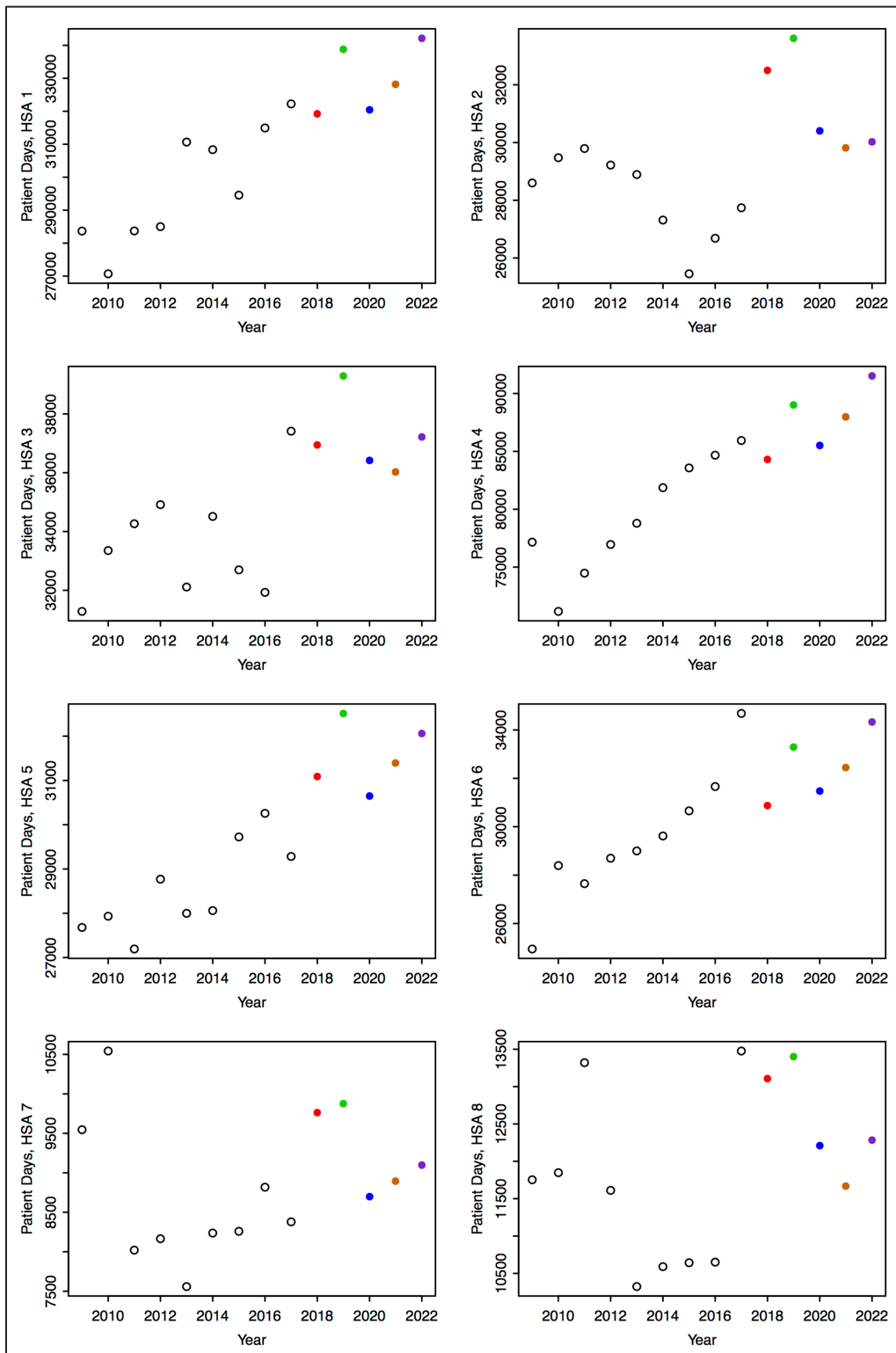
**Table 4. Relative distribution of adult patient days among HSAs (percent of all patient days) from 2009 to 2017.** 1 yr used a single year of observed data. 3 yr used three years of data (e.g., for 2011, used 2009-2011). 5 yr used five years of data (e.g., for 2013, used 2009-2013). 1 yr pred is data from a single year, five years prior; for example, the values for 2014 (1 yr pred) are the observed data from 2009 (1 yr). 3 yr pred is data from 3 years aggregated, five years prior; for example, the values for 2016 (3 yr pred) are the observed data from 2011 (3 yr).



**Figure 9. HSA-level time-series predictions of adult psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on single year of data, 5 years prior).** Hollow (observed data), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022), Grey (used observed number of patient days in year and relative allocation to HSAs).



**Figure 10. HSA-level time-series predictions of adult psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on 3-year average of data, 5 years prior).** Hollow (observed data), Red (2011-2013, 2018), Green (2012-2014, 2019), Blue (2013-2015, 2020), Orange (2014-2016, 2021), Purple (2015-2017, 2022), Grey (used observed number of patient days in year and relative allocation to HSAs).



**Figure 11. HSA-level time-series predictions of adult psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on 5-year average of data, 5 years prior).** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

## 5.2 PEDIATRIC

Table 5 contains the relative distribution of pediatric psychiatric patient days among the HSAs in percent form. For each year, all available data are provided. For example, for 2009 and 2010 only the 1-year observed relative distribution is available. For 2011 and 2012, the 1- and 3-year relative distributions are available. For 2013 to

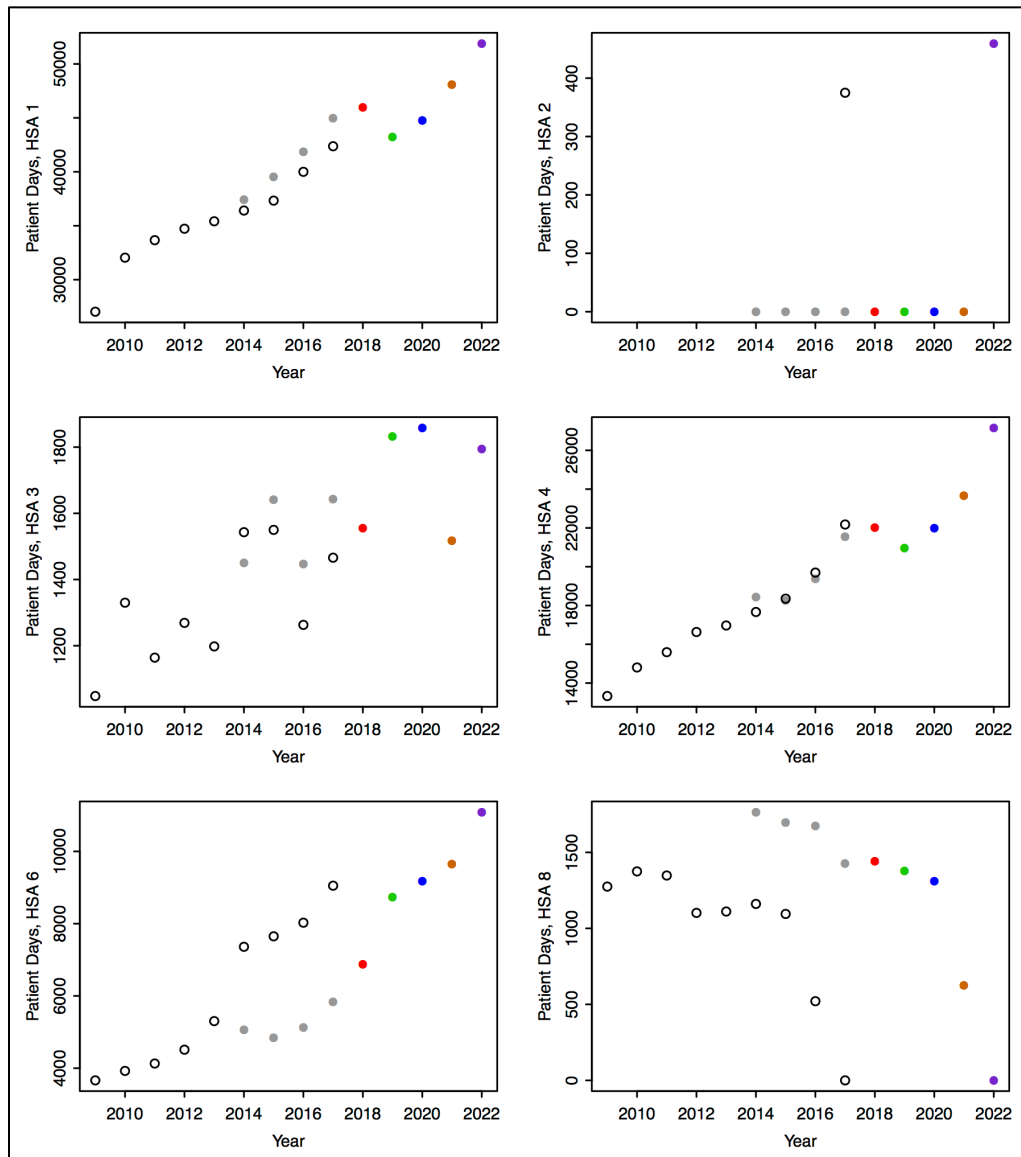
2017, the 1-, 3-, and 5-year relative distributions are available. For comparative purposes, in instances when data from 5 years prior are available, these are also presented in Table 5 to illustrate how change over time may affect this approach if used in a bed need methodology (which would require predicting five years into the future). For example, the data in 2014 (1 yr pred) are exactly the same as the relative distribution of patient days using the 2009 (1 yr) data.

Unlike the relative distribution of adult patient day utilization, the results for pediatric utilization show that the relative distribution of patient days is quite variable, especially when considering HSA 2 (new facility opened), HSA 6 (high variation from year-to-year), and HSA 8 (did not treat psychiatric patients in 2018). The use of the temporally aggregated data (both 3- and 5-year) appears to smooth some of this variation. Further, comparison of the predicted relative distribution appears to provide reasonable results in the years with predictions.

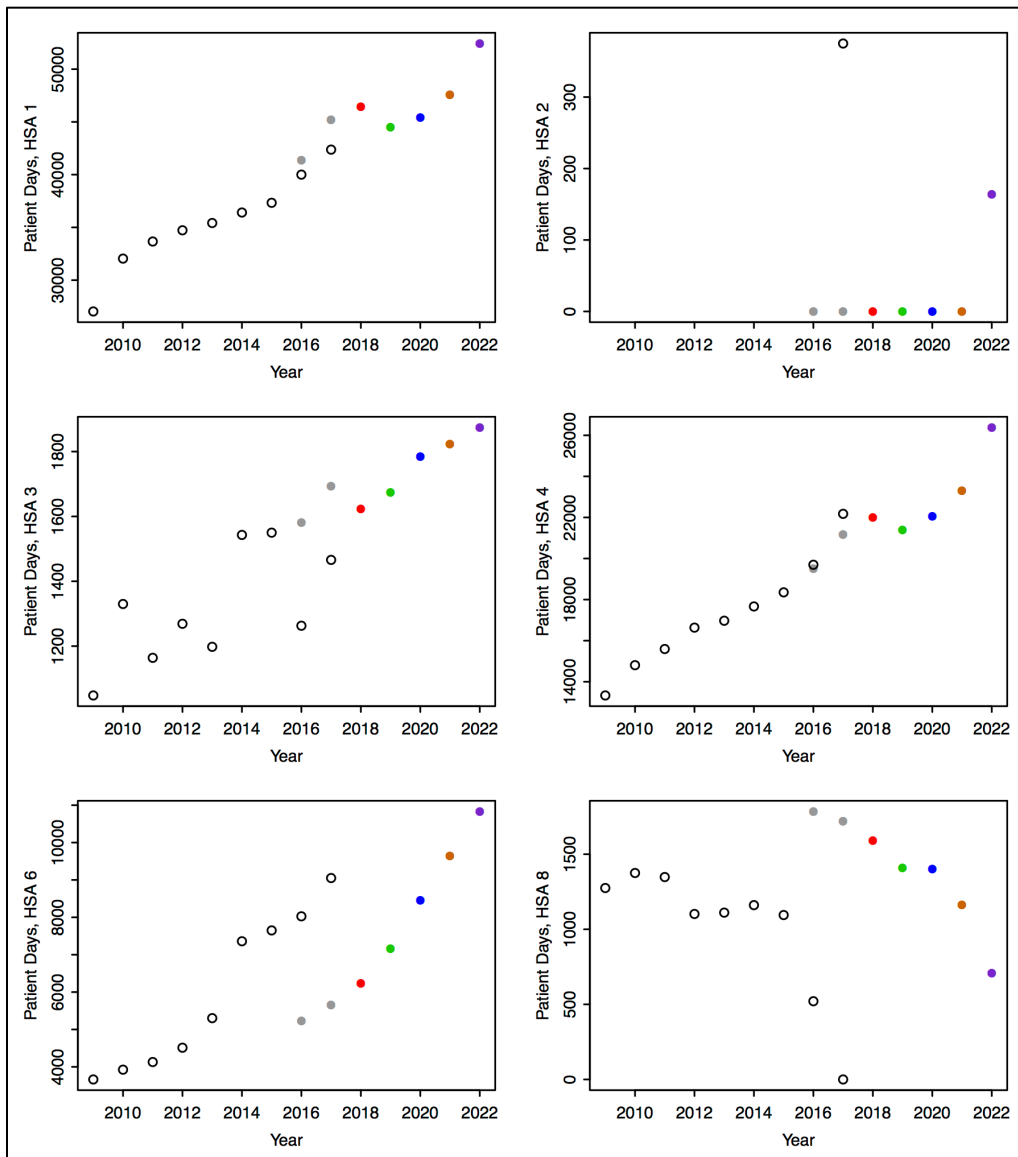
Year	HSA1	HSA2	HSA3	HSA4	HSA6	HSA8
2009 (1 yr)	58.32%	0.00%	2.26%	28.76%	7.90%	2.75%
2010 (1 yr)	59.92%	0.00%	2.49%	27.69%	7.34%	2.57%
2011 (1 yr)	60.22%	0.00%	2.08%	27.90%	7.39%	2.41%
2011 (3 yr)	59.55%	0.00%	2.27%	28.08%	7.52%	2.57%
2012 (1 yr)	59.62%	0.00%	2.18%	28.56%	7.75%	1.89%
2012 (3 yr)	59.92%	0.00%	2.24%	28.06%	7.50%	2.28%
2013 (1 yr)	59.03%	0.00%	2.00%	28.28%	8.84%	1.85%
2013 (3 yr)	59.61%	0.00%	2.09%	28.25%	8.01%	2.04%
2013 (5 yr)	59.45%	0.00%	2.19%	28.23%	7.86%	2.27%
2014 (1 yr)	56.77%	0.00%	2.41%	27.54%	11.47%	1.81%
2014 (3 yr)	58.42%	0.00%	2.20%	28.11%	9.42%	1.85%
2014 (5 yr)	59.04%	0.00%	2.23%	27.99%	8.65%	2.09%
2014 (1 yr pred)	58.32%	0.00%	2.26%	28.76%	7.90%	2.75%
2015 (1 yr)	56.58%	0.00%	2.35%	27.82%	11.59%	1.66%
2015 (3 yr)	57.42%	0.00%	2.26%	27.87%	10.68%	1.77%
2015 (5 yr)	58.35%	0.00%	2.21%	28.01%	9.52%	1.91%
2015 (1 yr pred)	59.92%	0.00%	2.49%	27.69%	7.34%	2.57%
2016 (1 yr)	57.55%	0.00%	1.82%	28.34%	11.55%	0.75%
2016 (3 yr)	56.98%	0.00%	2.18%	27.91%	11.54%	1.39%
2016 (5 yr)	57.85%	0.00%	2.15%	28.10%	10.34%	1.57%
2016 (1 yr pred)	60.22%	0.00%	2.08%	27.90%	7.39%	2.41%
2016 (3 yr pred)	59.55%	0.00%	2.27%	28.08%	7.52%	2.57%
2017 (1 yr)	56.17%	0.50%	1.94%	29.40%	12.00%	0.00%
2017 (3 yr)	56.75%	0.18%	2.03%	28.55%	11.72%	0.77%
2017 (5 yr)	57.16%	0.11%	2.10%	28.31%	11.16%	1.16%
2017 (1 yr pred)	59.62%	0.00%	2.18%	28.56%	7.75%	1.89%
2017 (3 yr pred)	59.92%	0.00%	2.24%	28.06%	7.50%	2.28%

**Table 5. Relative distribution of pediatric patient days among HSAs (percent of all patient days) from 2009 to 2017.** 1 yr used a single year of observed data. 3 yr used three years of data (e.g., for 2011, used 2009-2011). 5 yr used five years of data (e.g., for 2013, used 2009-2013). 1 yr pred is data from a single year, five years prior; for example, the values for 2014 (1 yr pred) are the observed data from 2009 (1 yr). 3 yr pred is data from 3 years aggregated, five years prior; for example, the values for 2016 (3 yr pred) are the observed data from 2011 (3 yr).

The results from the relative distribution calculation using a single year of data to calculate the pediatric patient days in each HSA are found in Figure 12. The results from the 3-year average calculation are in Figure 13, and the results from the 5-year average calculation are in Figure 14. Overall, this approach appears to provide reasonable results using past data and when extended to predicting future utilization in HSAs 1, 3, and 4. The results for HSA 6 are not great. Notably, the issues with HSA 2 (new facility) and HSA 8 are very apparent. Similar to the adult data, for pediatric utilization, the variation in the resulting predictions appears to get smaller as more years are used for the relative distribution calculation (e.g., predictions using five years of data are less variable than those using one year of data); the use of multiple years smooths out some of the year-to-year fluctuations in relative percent of patient days provided among the HSAs; however, this does not appear to improve the predictions substantially.



**Figure 12. HSA-level time-series predictions of pediatric psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on single year of data, 5 years prior).** Hollow (observed data), Red (2013, 2018), Green (2014, 2019), Blue (2015, 2020), Orange (2016, 2021), Purple (2017, 2022), Grey (used observed number of patient days in year and relative allocation to HSAs).



**Figure 13. HSA-level time-series predictions of pediatric psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on 3-year average of data, 5 years prior).** Hollow (observed data), Red (2011-2013, 2018), Green (2012-2014, 2019), Blue (2013-2015, 2020), Orange (2014-2016, 2021), Purple (2015-2017, 2022), Grey (used observed number of patient days in year and relative allocation to HSAs).

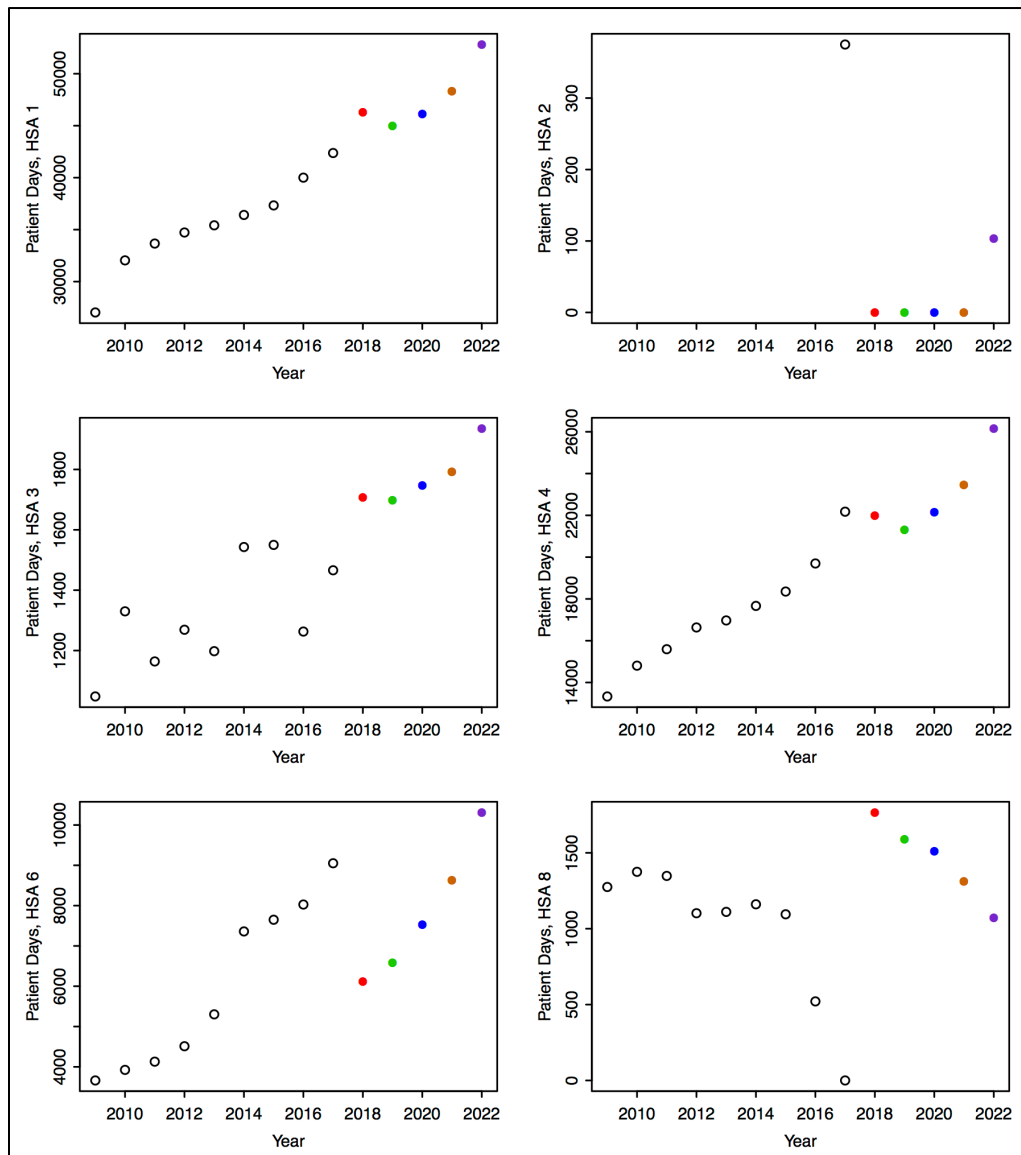
### 5.3 PROS AND CONS

**Pros:** The relative distribution approach for predicting HSA-level patient days appears to provide reasonable predictions for adult patient day utilization in general and in some HSAs for pediatric utilization. This approach can be used for both the adult and pediatric bed need methodologies (with caveat below). This approach only requires utilization data (does not require population data) and can be modified to consider a certain number of years of data to establish the relative distribution of patient days.

**Cons:** The relative distribution approach for predicting HSA-level patient days provided what appear to be unreasonable predictions for some HSAs in pediatric utilization (especially regarding opening/closing of facilities). This approach requires an additional method to provide the predictions of future state-level patient day utilization (e.g., #1 above). The use of pooled data (across years) may deemphasize current trends. Reinforces the potential misdistribution of resources. Also, because there are no facilities in some of the HSAs for pediatric beds, this approach would assume there is 0 need.



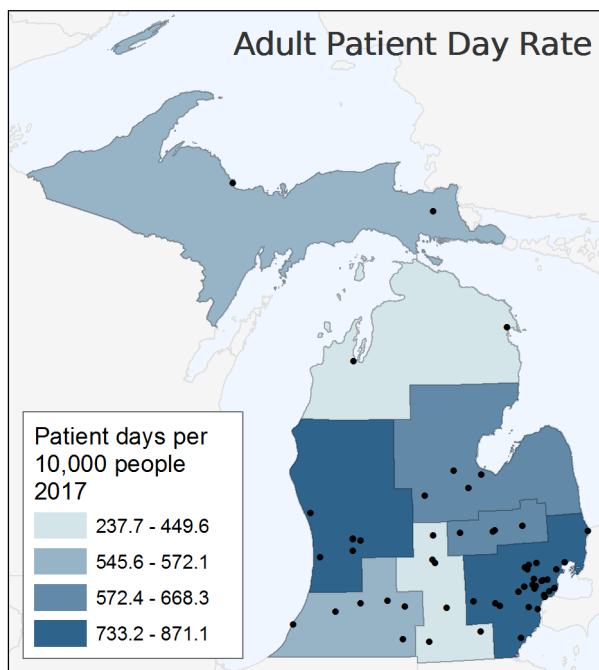
**Recommendation:** The relative distribution approach for predicting HSA-level patient days could be considered as a potential piece of a proposed bed need methodology. However, this would require making a decision on how many years of data to pool to calculate the relative distributions. Further, the approach would need to be modified to potentially account for HSAs that begin or cease providing services (e.g., HSAs 2 and 8 for pediatric services).



**Figure 14. HSA-level time-series predictions of pediatric psychiatric patient days using state-level predictions of patient days and relative distribution approach among HSAs (based on 5-year average of data, 5 years prior).** Hollow (observed data), Red (2009-2013, 2018), Green (2010-2014, 2019), Blue (2011-2015, 2020), Orange (2012-2016, 2021), Purple (2013-2017, 2022).

**6. Normative need/utilization summary.** One issue when dealing with data such as the CON Annual Survey data is that the origin (residence) of the people visiting the facilities within each HSA is unknown, and we only know the destination. Preliminary analysis of the MIDB data (which contains this information from some facilities) and anecdotal reports suggest that many patients cross HSA boundaries to access inpatient psychiatric services. As a result of this data limitation, the previous approaches are facility-based in that they consider bed need as a function of the facilities that provide the services, not the population that needs the services. This approach can be a concern, as it tends to be self-reinforcing over time; for example, if facilities in HSA 1 are providing services for a large and increasing population that does not reside in HSA 1, the previous methods will simply continue to allocate beds to facilities in HSA to meet the detected increase in need. However, since (in this example) the need is originating outside of HSA 1, we could almost consider this as a misallocation of resources. We might want to consider an approach that attempts to allocate resources to the facilities in the HSAs where the patients live, not where they access services.

The potential effects of this issue can be seen in the adult patient day utilization rate map in Figure 15. Notably, to calculate these utilization rates, I divided the patient days of all facilities located in each HSA by the population residing in each HSA. A large range in utilization rates is noticeable in the results, as there is nearly a four-fold difference in utilization rates between the HSAs having the lowest and highest rates. This large variation among places is not likely due to true differences in the underlying need (indication) for these services. This issue is exacerbated for pediatric psychiatric services, as some HSAs do not have any facilities, therefore report 0 patient days (and have 0 as their utilization rate).



**Figure 15. Adult psychiatric patient day utilization rates (per 10,000 people) in 2017.**

One approach to remedy this issue is to assume that there is an underlying level of need in the population that does not vary from place to place. An example of this would be to assume that the level of utilization needed by the population is expressed via the statewide utilization of patient days, and that the normative utilization rate is simply the statewide patient days divided by the statewide population (note: this is the current approach used in the methodology for pediatric psychiatric beds). While this is a very strong assumption, I do not believe that it is worse than 1) assuming the patient day utilization rates in Figure 15 adequately capture the true underlying need or 2) continuing to misallocate resources based on cross-HSA utilization.

I implemented a test with 2017 utilization data to evaluate the differences among expected utilization, actual utilization, current supply under the normative assumption. I calculated the statewide utilization rate for people age 18+ and multiplied this rate by the age 18+ population for each HSA, which produced the expected patient days for each HSA. I then divided by 365 (to convert from patient days to beds) and divided that result by 0.75 to account for occupancy limitations (assuming facilities can operate at 75% occupancy). This resulted in the number of beds that would be required to provide services for the population of each HSA, under the assumption that everyone in the state needs inpatient services at the same rate and facilities could operate at 75% capacity. I then subtracted this total from the current number of beds to calculate the difference (either excess or need) of beds at the current time under these assumptions. The results for this calculation using data from 2017 are in Table 6.

	Actual Util 2017	Expected Util 2017	Diff Util	Beds 2017	Expected Beds 2017	Diff Beds
HSA1	322,231	265,655	56,576	1,151	971	180
HSA2	27,739	44,307	-16,568	163	162	1
HSA3	37,413	46,962	-9,549	152	172	-20
HSA4	85,939	84,179	1,760	310	308	2
HSA5	29,283	31,470	-2,187	135	115	20
HSA6	34,683	43,518	-8,835	117	159	-42
HSA7	8,379	25,312	-16,933	29	93	-64
HSA8	13,476	17,739	-4,263	57	65	-8

**Table 6. Actual and expected utilization and beds for adult psychiatric services.** Actual Util 2017 is the patient day utilization at facilities within each HSA. Expected Util 2017 is the expected day utilization in 2017 based on the population of each HSA and a statewide rate of 718.2 patient days per 10,000 people. Diff Util is the difference between Actual and Expected; positive values represent instances where actual utilization is higher than expected (based on higher need within the HSA, utilization of facilities by non-HSA residents, or a combination of both) and negative values represent the opposite. Beds 2017 is the number of licensed beds as of 2017. Expected Beds 2017 is the number of beds required to meet the Expected Utilization in 2017 if facilities ran at 75% average occupancy. Diff Beds is the difference between actual and expected beds; positive values represent instances where the current number of beds is more than enough to meet the resident population demand (if utilizing services at the statewide rate) and negative values are instances where there is a need for additional beds (under the same assumption).

The results in Table 6 demonstrate that there are some extremely large differences in Actual vs Expected utilization under the assumption of a normative statewide utilization rate of psychiatric services for adults. Notably, HSAs 1 and 4 are the only ones with actual utilization higher than the expected utilization. These HSAs contain the two largest cities in the state, thus are likely drawing patients from outside the HSA. Interestingly, two of the HSAs (2 and 5) with expected utilization values higher than actual utilization currently have the bed capacity to meet the need of their population under this assumption. However, in HSAs 3, 6, 7, and 8, if residents needed services at the statewide rate and only sought out services at facilities within the HSA, the current supply of beds would not be able to meet the populations' needs.

## 7. Simple normative need/utilization approach.

**Summary:** Given a statewide prediction of total patient days (e.g., from #1 above) and total population in the planning year, calculate a statewide utilization rate. Multiply the rate by the predicted population in each HSA to produce predicted patient days for residents of that HSA.

I implemented this approach using the statewide patient day predictions from #1 above (time series) and with the predicted population for years 2018 to 2022. For reference, I also used this approach to calculate the results for 2009 to 2017 (e.g., see #6 above).

### 7.1 ADULT

The results of the adult patient day predictions using the statewide normative utilization approach are provided in Figure 16. Notably, and to be expected given the results provided in Table 6, the predicted patient days for residents of each HSA in 2009 to 2017 are quite different from the observed data (because this approach attempts to remove potential cross-HSA utilization). The predictions from 2018 to 2022 based on the state-level patient days and normative utilization appear to be reasonable (under the assumption that the model is accurately characterizing true underlying population need in each HSA).

### 7.2 PEDIATRIC

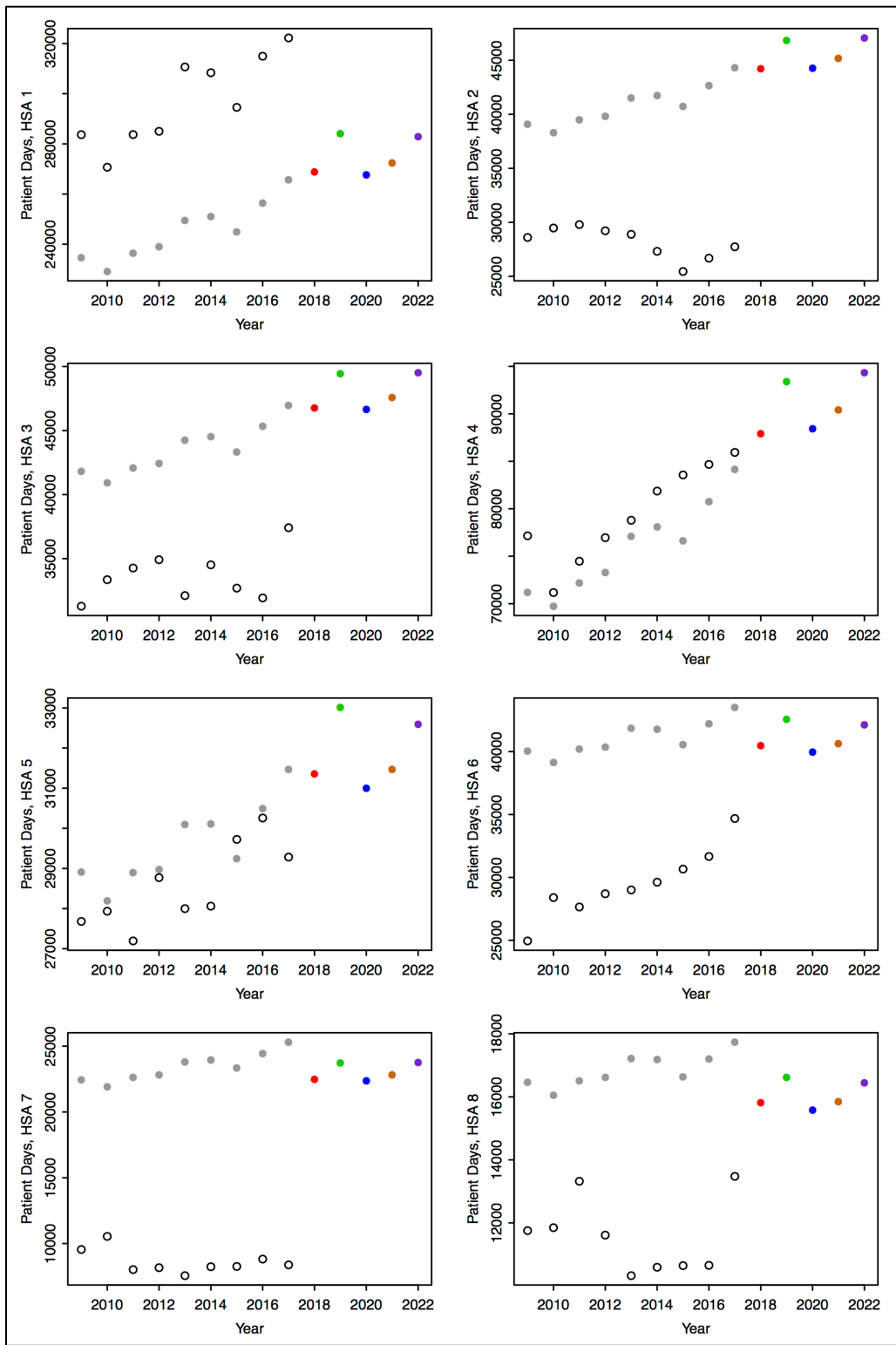
Figure 17 contains the results of the pediatric patient day predictions using the statewide normative utilization approach. The implications of using this approach are much more visible in the pediatric results, as two HSAs do not have any utilization from 2009 to 2017, one HSA had zero utilization in 2017, and one HSA only began having utilization in 2017. Notably, this approach appears to be relatively unaffected by openings and closings of facilities, as these are all combined into the state-level calculation of utilization rates.

### 7.3 PROS AND CONS

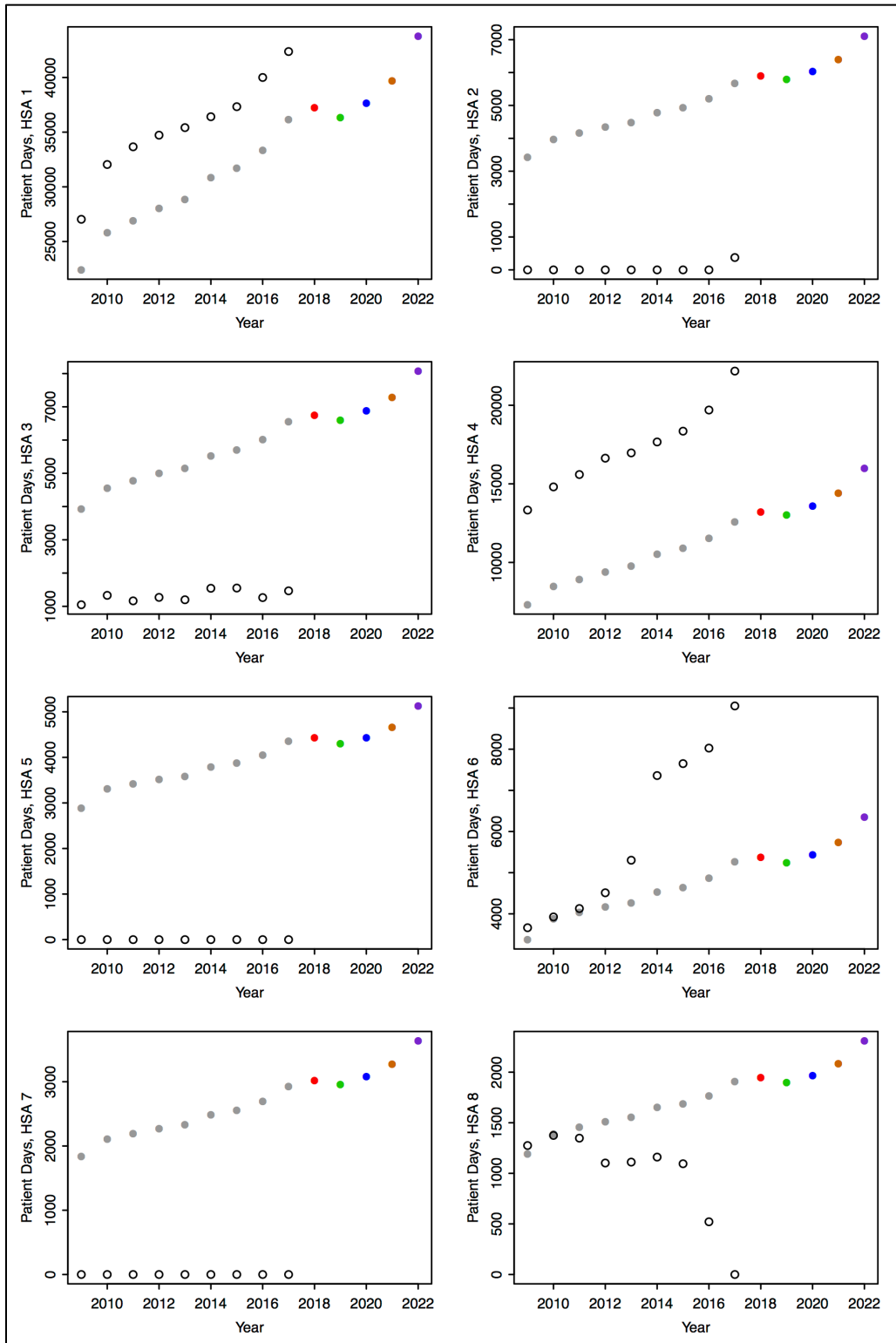
**Pros:** The normative approach for predicting HSA-level patient days appears to provide reasonable predictions for adult and pediatric patient day utilization, given the assumption of a constant underlying need for inpatient psychiatric services from region to region in the state. This approach can be used for both the adult and pediatric bed need methodologies. This approach is population-based, in that it attempts to predict the bed need of the residents of each HSA (not the utilization of facilities in each HSA, which contains patients living in other HSAs).

**Cons:** The assumption of a constant underlying need for inpatient psychiatric services from region to region in the state is likely erroneous, as need will vary with social, economic, and demographic factors. This approach requires an additional method to provide the predictions of future state-level patient day utilization (e.g., #1 above). This method requires future predictions of HSA-level adult and pediatric populations.

**Recommendation:** The normative approach for predicting HSA-level patient days could be considered as a potential piece of a proposed bed need methodology. However, this approach has the very strong assumption of invariant underlying need from place to place, which we know is wrong (but in my mind is better than what is currently in use, especially for the adult methodology).



**Figure 16. HSA-level predictions of adult psychiatric patient days using state-level predictions of patient days and population, and a normative utilization rate approach. Hollow (observed data), Red (2018), Green (2019), Blue (2020), Orange (2021), Purple (2022), Grey (2009-2017).**



**Figure 17. HSA-level predictions of pediatric psychiatric patient days using state-level predictions of patient days and population, and a normative utilization rate approach.** Hollow (observed data), Red (2018), Green (2019), Blue (2020), Orange (2021), Purple (2022), Grey (2009-2017).

## 8. Modified normative need/utilization approach (integrate Medicaid / Healthy Michigan Program data).

**Summary:** One problem with the normative approach detailed above (#7) is that it assumes that people in each region have the exact same underlying need for inpatient psychiatric services. One potential approach to account for varying need in the population from HSA to HSA is to examine the differences in populations and utilization broken down by Public (Medicaid and Healthy Michigan Program) and Private payors (including Private insurance and Medicare for those aged 65+); the psychiatric methodology subgroup considered this to be a potentially informative approach that accounts for variations in need of the residents of each HSA.

Get statewide prediction of total patient days (e.g., from #1 above) for Public patients and Private patients and total Public and Private population in the planning year. Use these to calculate a statewide utilization rates for Public population and Private population. Multiply the rates by the corresponding predicted Public and Private population of each HSA to produce predicted patient days for residents of that HSA (adjusted for the differences in the Public/Private population composition of each).

I implemented this approach using the statewide patient day predictions from #1 above (time series) and with the predicted population for years 2018 to 2022. For reference, I also used this approach to calculate the results for 2013 to 2017 (to compare to observed utilization). The detailed methods are provided below.

### 8.0 METHOD

The average monthly number of people with Public insurance (Medicaid or the Healthy Michigan Program) is available by county for Michigan for the years 2013 to 2017. These data are not broken down into the age groups used for psychiatric services, thus county-level data for pediatric and adult populations had to be estimated. First, I divided the number of people with public insurance by the total number of people eligible for these programs based on age (0 – 64 years). This produced a proportion of each county’s age-eligible population with Public insurance. I then multiplied this proportion by each county’s 0 – 17 years population and 18 – 64 years population to estimate the number of people in each age group with Public insurance (and used this value to estimate the number with Private insurance). An example calculation for Alcona County in 2017 is provided below:

Residents with Public insurance	= 2,427
Residents aged 0 – 64	= 6,636
Proportion of residents aged 0 – 64 with Public insurance	= $2,427 / 6,636 = 0.3657$
Residents aged 0 – 17	= 1,307
Estimated residents aged 0 – 17 with Public insurance	= $1,307 * 0.3657 = 478$
Estimated residents aged 0 – 17 with Private insurance	= $1,307 - 478 = 829$
Residents aged 18 – 64	= 5,329
Estimated residents aged 18 – 64 with Public insurance	= $5,329 * 0.3657 = 1,949$
Estimated residents aged 18 – 64 with Private insurance	= $5,329 - 1,949 = 3,380$
Residents aged 65+ (assumed Private insurance)	= 3,715

This set of calculations resulted in the following values for each county, Public pop 0 – 17, Private pop 0 – 17, Public pop 18 – 64, Private pop 18 – 64, and (Private) pop 65+. The data were aggregated to both the state level and HSA level.

The Public and Private patient days for 2013 to 2017 for each facility (broken down by pediatric and adult) are available from the CON Annual Survey. I summed these data to the state level, broken down by Public/Private and pediatric/adult. I calculated the statewide utilization rates for the Public and Private populations separately for pediatric and adult populations. For pediatric, this was accomplished by 1. dividing the statewide Public patient days (0 – 17) by the statewide estimate of Public population aged 0 – 17 and 2. dividing the statewide Private patient days (0 – 17) by the statewide estimate of Private population aged 0 –

17. For adults, I first summed the statewide estimate of Private population aged 18 – 64 and the population aged 65+ to create a statewide estimate of Private population aged 18+. To calculate the statewide utilization rates for adult Public and Private populations, I 1. divided the statewide Public patient days (18+) by the statewide estimate of Public population aged 18+ and 2. divided the statewide Private patient days (18+) by the statewide estimate of Public population aged 18+. Example calculations for adults in 2017 are provided below and show that the utilization rates for Public and Private populations are quite different. The resulting calculations for both pediatric and adult for 2013 to 2017 are provided in Table 7.

Adult (18+) Public Patient Days = 251,865  
 Adult (18+) Private Patient Days = 307,278  
 Adult (18 – 64) Public Population = 1,801,864  
 Adult (18 – 64) Private Population = 4,316,602  
 Adult (65+) Population = 1,667,196  
 Adult (18+) Private Population = 4,316,602 + 1,667,196 = 5,983,798  
 Adult Public Utilization Rate = 251,865 (patient days) / 1,801,864 (people) = 0.1398  
 Adult Private Utilization Rate = 307,278 (patient days) / 5,983,798 (people) = 0.0514

YEAR	Pediatric		Adult	
	Public	Private	Public	Private
2013	0.0672	0.0158	0.1867	0.0445
2014	0.0404	0.0251	0.1335	0.0536
2015	0.0373	0.0270	0.1265	0.0500
2016	0.0568	0.0215	0.1434	0.0482
2017	0.0547	0.0261	0.1398	0.0514

**Table 6. Statewide Public and Private psychiatric utilization rates (patient days per person) for pediatric and adult populations, 2013 - 2017.**

For the years 2013 to 2017, I implemented this approach to estimate the need of residents in each HSA based on the statewide utilization rates of Public and Private patients and each HSA’s Public and Private population. This is essentially the same operation explained in #6 above, but instead of using a single utilization rate, this adjusts for differential utilization of Public and Private people and differential Public/Private population compositions among the HSAs.

To predict the HSA level need in 2018 to 2022, I used the predicted statewide patient days produced by the time-series method (#1). I then segmented the predicted patient days in each year into predicted public patient days and predicted private patient days using the observed data from five years prior (to emulate the five year window used in the methodology, 2013 > 2018, 2014 > 2019, etc.). For example, to predict adult patient days in 2018,

I first calculated the statewide proportions of public and private patient days in 2013 by dividing 242,403 public patient days by 525,333 total patient days, which equals 0.46 (the converse of this is 0.54 for proportion of private patient days). I then multiplied the estimated total statewide patient days in 2018 (557,939) by these proportions, which resulted in 257,448 predicted public patient days and 300,491 predicted private patient days.

I then multiplied the statewide prediction of the adult population in 2018 by the statewide proportion of the adult public and private population in 2013. This provided a prediction of the public and private adult population in 2018.



I then calculated the statewide predicted utilization rates for Public and Private adult populations by dividing the predicted patient days by predicted population (for each category).

To calculate the HSA-level estimates, I first estimated the Public and Private population of each HSA in 2018 using the proportions from 2013 (e.g., proportion of HSA population with Public Insurance), e.g., if 50% of an HSA's population had Public insurance in 2013, we would expect half to have Public insurance in 2018. I multiplied these proportions by the predicted adult population in 2018 for each HSA. I then multiplied each HSA's Public population in 2018 by the predicted Public utilization rate in 2018 which provided a prediction of the public patient days in 2018 for that HSA. This was also completed for Private patient days. The HSA's Public and Private patient days were then summed to calculate the total predicted patient days in 2018.

## 8.1 ADULT

Figure 18 shows the results of the normative need/utilization approach for adult psychiatric utilization that attempts to adjust for the differences in Public vs Private need and HSA-level population composition. The results appear to be quite similar to those provided by the prior approach (#7, normative with no integration of Public and Private patients/population). The predictions from 2018 to 2022 based on the state-level patient days and normative utilization appear to be reasonable (under the assumption that the model is accurately characterizing true underlying population need in each HSA).

## 8.2 PEDIATRIC

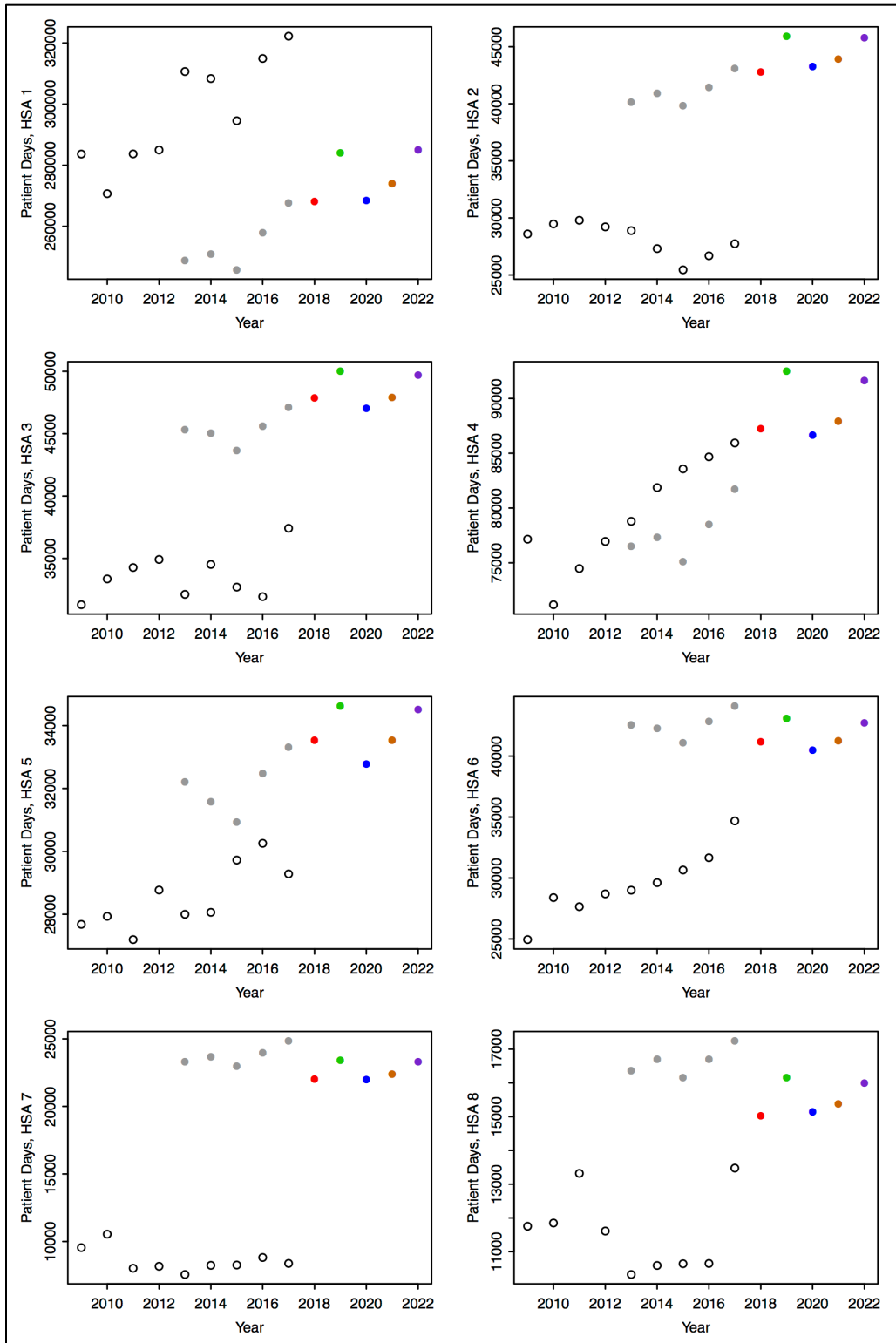
The results of the adult patient day predictions using the the normative need/utilization approach with adjustment for the differences in Public vs Private need and HSA-level population composition are provided in Figure 19. Again, these results appear highly similar to those from #7.

## 8.3 PROS AND CONS

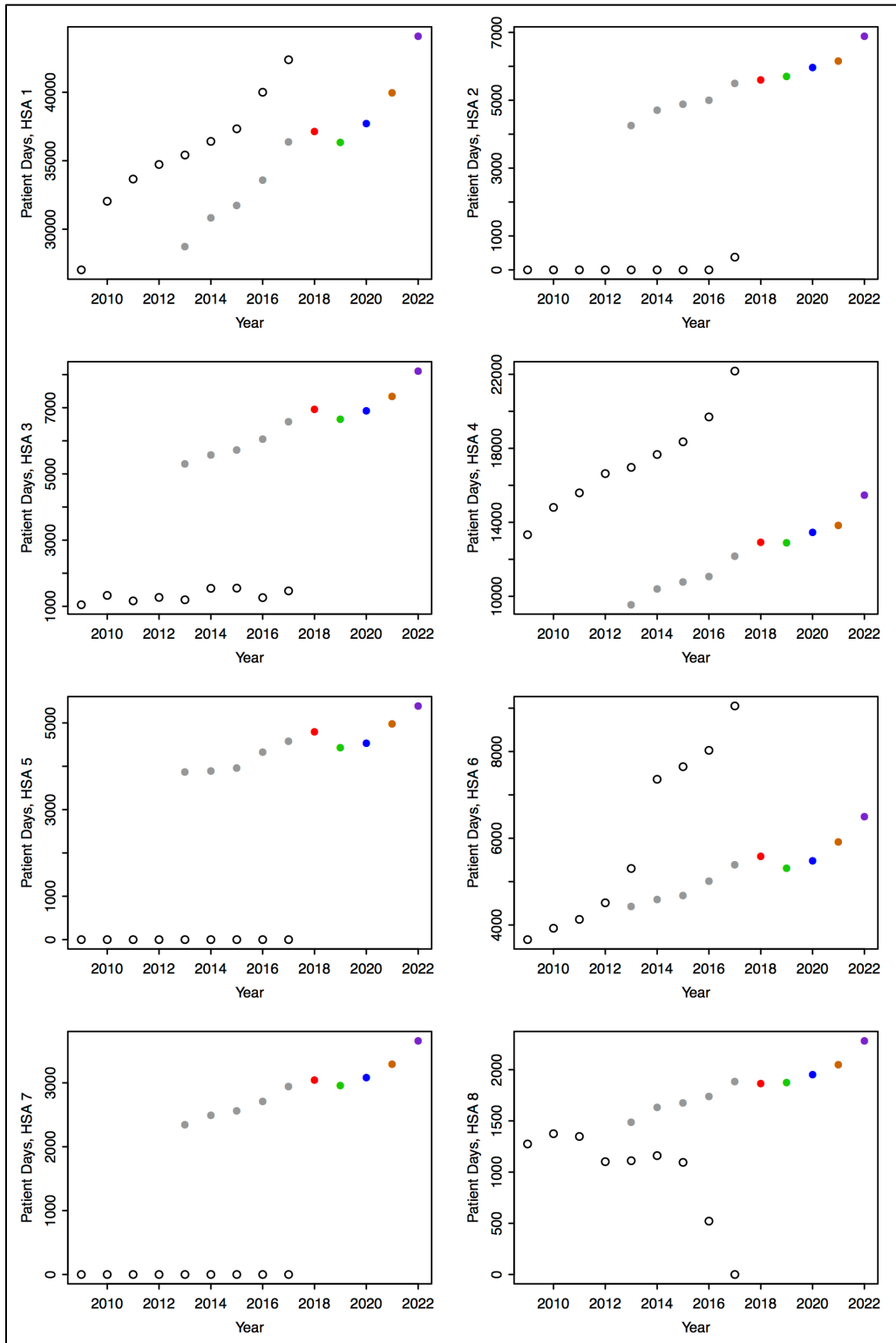
**Pros:** The normative approach for predicting HSA-level patient days appears to provide reasonable predictions for adult and pediatric patient day utilization, given the assumption of a constant underlying need for Public and Private pay inpatient psychiatric services from region to region in the state. This approach can be used for both the adult and pediatric bed need methodologies. This approach is population-based, in that it attempts to predict the bed need of the residents of each HSA (not the utilization of facilities in each HSA, which contains patients living in other HSAs) and attempts to account for the differing populations in each HSA.

**Cons:** The assumption of a constant underlying need for inpatient psychiatric services from region to region in the state is likely erroneous, even when adjusting for Public and Private insurance differences. This approach requires an additional method to provide the predictions of future state-level patient day utilization (e.g., #1 above). This method requires future predictions of HSA-level adult and pediatric populations. This method requires data on Public population and requires estimating those populations in the future. This approach is more complex and requires numerous estimations.

**Recommendation:** The normative need/utilization approach that accounts for differences in Public and Private utilization and composition among HSAs could be considered as a potential piece of a proposed bed need methodology. However, this approach has very strong assumptions and requires numerous estimations with semi-complex models. It is difficult to determine whether this increased complexity is worth the effort. The results of the predictions from 2018 – 2022 for each HSA using both #7 and #8 (normative and normative with adjustment) are provided in Tables 7 and 8.



**Figure 18. HSA-level predictions of adult psychiatric patient days using state-level predictions of patient days and population, and a normative utilization rate approach that adjusts for differences in utilization among Public and Private insured populations and HSA population composition. Hollow (observed data), Red (2018), Green (2019), Blue (2020), Orange (2021), Purple (2022), Grey (2009-2017).**



**Figure 19. HSA-level predictions of pediatric psychiatric patient days using state-level predictions of patient days and population, and a normative utilization rate approach that adjusts for differences in utilization among Public and Private insured populations and HSA population composition. Hollow (observed data), Red (2018), Green (2019), Blue (2020), Orange (2021), Purple (2022), Grey (2009-2017).**

2018			2019		2020		2021		2022	
HSA	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)
1	268,904	268,222	284,181	284,082	267,610	268,464	272,400	274,073	282,824	284,997
2	44,234	42,816	46,866	45,926	44,262	43,280	45,195	43,912	47,072	45,805
3	46,755	47,880	49,445	50,024	46,638	47,025	47,584	47,913	49,522	49,704
4	87,911	87,245	93,394	92,502	88,440	86,677	90,443	87,944	94,343	91,635
5	31,352	33,542	33,013	34,625	30,995	32,786	31,473	33,536	32,598	34,512
6	40,482	41,190	42,583	43,082	39,971	40,487	40,638	41,269	42,143	42,729
7	22,477	22,011	23,739	23,439	22,371	22,007	22,822	22,379	23,748	23,324
8	15,823	15,033	16,618	16,160	15,582	15,143	15,855	15,385	16,455	16,001

**Table 7. Predicted adult psychiatric patient day utilization for 2018 to 2022 using normative utilization rates (NORM) (#7) and normative utilization rates adjusted for Public and Private utilization and HSA composition (NORM (ADJ)) (#8).**

2018			2019		2020		2021		2022	
HSA	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)	NORM	NORM (ADJ)
1	37,264	37,125	36,345	36,334	37,653	37,702	39,673	39,948	43,776	44,092
2	5,896	5,607	5,791	5,703	6,040	5,972	6,402	6,152	7,106	6,888
3	6,743	6,949	6,603	6,653	6,882	6,907	7,284	7,346	8,075	8,107
4	13,213	12,923	13,013	12,886	13,605	13,457	14,419	13,846	16,003	15,468
5	4,431	4,792	4,303	4,426	4,435	4,534	4,660	4,981	5,129	5,393
6	5,380	5,586	5,243	5,308	5,434	5,485	5,742	5,918	6,354	6,501
7	3,017	3,041	2,954	2,963	3,081	3,086	3,271	3,293	3,637	3,658
8	1,945	1,864	1,897	1,877	1,967	1,954	2,083	2,050	2,310	2,282

**Table 8. Predicted pediatric psychiatric patient day utilization for 2018 to 2022 using normative utilization rates (NORM) (#7) and normative utilization rates adjusted for Public and Private utilization and HSA composition (NORM (ADJ)) (#8).**

## Psychiatric Bed Need Comparative Results

**DEPT\_INV:** Current inventory of beds (January, 2019)

**BN\_2020:** Results of previous bed need calculation (made in 2017, base year: 2015, planning year: 2020)

**BN\_2022:** Result of bed need calculation using current methodology (base year: 2017, planning year: 2022)

**Norm Pub/Priv BN\_2022:** Result of bed need calculation using state-level time series method and normalized distribution of patient days with public/private payor adjustment (base year: 2017, planning year: 2022); See Sections #1, #6, and #8 from Psych\_Bed\_Need\_Methodology\_Delamater\_190125.docx

**Normalized BN\_2022:** Result of bed need calculation using state-level time series method and normalized distribution of patient days (base year: 2017, planning year: 2022); See Sections #1, #6, and #7 from Psych\_Bed\_Need\_Methodology\_Delamater\_190125.docx

**Rel Dist BN\_2022:** Result of bed need calculation using state-level time series method and relative distribution of patient days based on 3-year average utilization among HSAs (base year: 2017, planning year: 2022) ; See Sections #1, #5, and #6 from Psych\_Bed\_Need\_Methodology\_Delamater\_190125.docx

*Note: The current methodology uses a 75% occupancy adjustment in the pediatric bed need methodology, but no adjustment in the adult bed need methodology (because it is bed-based). The current methodology (for both adult and pediatric) include a low-occupancy adjustment. The proposed methods implemented a sliding scale occupancy adjustment and no additional adjustment for low occupancy.*

### Adult Psychiatric Beds

HSA	DEPT_INV	BN_2020	BN_2022	Norm Pub/Priv BN_2022	Normalized BN_2022	Rel Dist BN_2022
1	1,273	1,051	1,130	1,042	1,034	1,242
2	176	187	224	184	189	117
3	152	183	175	202	202	152
4	362	324	347	335	345	339
5	135	140	142	132	125	124
6	117	106	113	169	167	140
7	32	30	28	104	105	42
8	57	77	63	64	66	51

### Pediatric Psychiatric Beds

HSA	DEPT_INV	BN_2020	BN_2022	Norm Pub/Priv BN_2022	Normalized BN_2022	Rel Dist BN_2022
1	148	122	126	173	172	206
2	16	18	35	30	31	1
3	6	20	24	38	37	9
4	79	40	46	59	61	101
5	0	13	15	25	24	0
6	33	16	19	25	25	42
7	0	9	11	17	17	0
8	6	7	12	11	11	4

## Occupancy Adjustment Email Text

I came across a question about Occupancy Adjustment. A 2-second primer for this is: we do not expect facilities to run at full capacity for an entire year. Since we predict patient days in the future based on utilization, we build in a “buffer” when converting expected patient days to the number of beds needed to care for those patients. For example, if we predict 3650 patient days, that equals 10 Beds. We then divide the value by the occupancy adjustment (e.g., 0.75 or 75%) to get,  $10 / 0.75 = 13.3$  beds required to accommodate that number of patient days.

The actual occupancy adjustment value(s) should be based on a rational “expected” occupancy for facilities to operate at over the course of a year. I believe that we usually set the occupancy value somewhere below the threshold for the “high occupancy” provision in the standards (a bit less).

Currently, the pediatric bed need methodology uses a blanket occupancy adjustment value of 75% (regardless of the number of beds in an HSA). The current adult methodology does not do this because it is already predicting beds.

Currently, the high occupancy provision for Psychiatric Beds is 75% for facilities with less than 20 beds and 80% for facilities with 20 or more beds. Thus, we would say a facility qualifies to add beds at this level, regardless of their HSA’s bed need.

I propose that we develop a sliding scale occupancy adjustment based on the Average facility size for each HSA. We do something very similar in the Acute Care Hospital bed need methodology. The rationale (based on previous discussions on this topic) is that it is more difficult for small facilities to consistently run at a high capacity over the course of an entire year and thus this approach also builds in a buffer for short term “spikes” in admissions.

I’ve attached the proposed scale (OCC\_table\_avebedsize.xlsx), which is a linear increase from 60% (10 bed average in HSA) to 75% (40 bed average in HSA). I’ve also included the data for each HSA based on their beds in 2017 and the occupancy adjustment we would use (Occupancy.examples.2017.HSA.xlsx).

One more thing. Currently, both the adult and pediatric bed need methodologies have an “adjustment” for low occupancy facilities (those under 60%). This is an artificial inflation of the final bed need that “pads” the numbers based on low occupancy facilities. I cannot, for the life of me, understand why this is necessary or a good idea because it’s adding “empty” beds in the present to the future need (seems like the antithesis of what constitutes a bed “need”). I would like to do away with this provision entirely, especially if we implement the sliding scale occupancy adjustment (which should account for lower occupancy in some places).

# **ATTACHMENT 2**

## **Psych Bed Comparative Review Criteria**

Sec. 12. (1) Any application subject to comparative review under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

(2) Each application in a comparative group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code being Section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these standards. If the Department determines that two or more competing applications satisfy all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1) of the Code, and which have the highest number of points when the results of subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects which, when taken together, do not exceed the need, in the order in which the applications were received by the Department, based on the date and time stamp placed on the applications by the Department in accordance with rule 325.9123.

(3)(a) A qualifying project application will be awarded 5 points if, within six months of beginning operation and annually thereafter, 100% of the licensed psychiatric beds (both existing and proposed) at the facility will be Medicaid certified.

~~(b) A qualifying project will have 4 points deducted if, on or after November 26, 1995, the records maintained by the Department document that the applicant was required to enter into a contract with either the Department or a CMH to serve the public patient and did not do so.~~

~~(c) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records maintained by the Department document that the applicant entered into a contract with MDCH or CMH but never admitted any public patients referred pursuant to that contract.~~

~~(d) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records maintained by the Department document that an applicant agreed to serve patients with an involuntary commitment status but has not admitted any patients referred with an involuntary commitment status.~~

~~(e) A qualifying project will be awarded 3 points if the applicant presents, in its application, a plan, acceptable to the Department, for the treatment of patients requiring long term treatment. For purposes of this subsection, long-term treatment is defined to mean an inpatient length of stay in excess of 45 days.~~

(b) A qualifying project will be awarded 3 points if the applicant currently provides a partial hospitalization psychiatric program, outpatient psychiatric services, or psychiatric aftercare services **OR TRANSPORTATION ASSISTANCE TO PATIENTS WHO REQUIRE THESE SERVICES. AN APPLICANT PROPOSING A NEW FACILITY WILL BE AWARDED THREE POINTS IF IT SUBMITS SITE PLANS OR SERVICE CONTRACTS TO DEMONSTRATE IT WILL INCLUDE ANY OF THESE SERVICES AS PART OF ITS PROPOSED**



~~PROJECT~~ , or the applicant includes any of these services as part of their proposed project, as demonstrated by site plans and service contracts.

(c) A qualifying project will have 4 points deducted if the Department has issued, within three years prior to the date on which the CON application was deemed submitted, a ~~temporary permit or provisional license due to a pattern of licensure deficiencies~~ at any psychiatric hospital or unit owned or operated by the applicant in this state.

(d) A qualifying project will have points awarded based on the ~~percentage of the hospital's indigent volume as set forth in the following table.~~ **RANKING OF THE APPLICANT'S MEDICAID DAYS AS MEASURED AS A PERCENTAGE OF TOTAL DAYS AS SET FORTH IN THE FOLLOWING TABLE. FOR PURPOSES OF SCORING, THE APPLICANT'S MEDICAID PERCENTAGE WILL BE THE CUMULATIVE OF ALL TITLE XIX AND HEALTHY MICHIGAN INPATIENT PSYCHIATRIC DAYS DIVIDED BY THE CUMULATIVE OF ALL INPATIENT PSYCHIATRIC DAYS AT ALL CURRENTLY LICENSED MICHIGAN HOSPITALS UNDER COMMON OWNERSHIP OR CONTROL WITH THE APPLICANT. FOR PURPOSES OF EVALUATING THIS CRITERION, AN APPLICANT SHALL SUBMIT THE MOST RECENT REVIEWED AND ACCEPTED MEDICAID COST REPORT FOR EACH CURRENTLY LICENSED HOSPITAL UNDER COMMON OWNERSHIP OR CONTROL IN MICHIGAN.**

Hospital Indigent Volume	Points Awarded
<del>0</del> <6%	<del>1</del>
<del>6</del> <11%	<del>2</del>
<del>11</del> <16%	<del>3</del>
<del>16</del> <21%	<del>4</del>
<del>21</del> <26%	<del>5</del>
<del>26</del> <31%	<del>6</del>
<del>31</del> <36%	<del>7</del>
<del>36</del> <41%	<del>8</del>
<del>41</del> <46%	<del>9</del>
46%+	10

~~For purposes of this subsection, indigent volume means the ratio of a hospital's indigent charges to its total charges expressed as a percentage as determined by the Department pursuant to Chapter VIII of the Medical Assistance Program manual. The indigent volume data being used for rates in effect at the time the application is deemed submitted will be used by the Department in determining the number of points awarded to each qualifying project.~~

MEDICAID DAYS	POINTS AWARDED
APPLICANT WITH HIGHEST PERCENT OF MEDICAID DAYS	10 POINTS
ALL OTHER APPLICANTS	APPLICANT'S PERCENT OF MEDICAID DAYS DIVIDED BY THE HIGHEST APPLICANT'S PERCENT OF MEDICAID DAYS, THEN MULTIPLIED BY 10
EXAMPLE: THE HIGHEST APPLICANT HAS 58.3% MEDICAID DAYS	10 POINTS
APPLICANT WITH 55.3% DAYS	$(.553 \div .583) \times 10 = 9$ POINTS

APPLICANT WITH 51.3% DAYS	$(.513 \div .583) \times 10 = 9$ POINTS
---------------------------	---

PERCENTAGES OF DAYS SHALL BE ROUNDED TO THE NEAREST 1/1000 (E.G. 5.3%) AND POINTS AWARDED SHALL BE ROUNDED TO THE NEAREST WHOLE NUMBER.

(e) A qualifying project will have points deducted based on the applicant's record of compliance with applicable safety and operating standards for any psychiatric hospital or unit owned and/or operated by the applicant in this state. Points shall be deducted in accordance with the following schedule if, on or after November 26, 1995, the Department records document any non-renewal or revocation of license for cause or non-renewal or termination of certification for cause of any psychiatric hospital or unit owned or operated by the applicant in this state.

<u>Psychiatric Hospital/Unit</u>	<u>Compliance Action Points Deducted</u>
Non-renewal or revocation of license	4
Non-renewal or termination of:	
Certification - Medicare	4
Certification - Medicaid	4

(FJ) A QUALIFYING PROJECT WILL BE AWARDED POINTS BASED ON THE APPLICANT'S TOTAL PROJECT COSTS PER BED. FOR PURPOSES OF THIS CRITERION, TOTAL PROJECT COSTS SHALL BE DEFINED AS THE TOTAL COSTS FOR CONSTRUCTION AND RENOVATION, SITE WORK, ARCHITECTURAL/ ENGINEERING AND CONSULTING FEES, CONTINGENCIES, FIXED EQUIPMENT, CONSTRUCTION MANAGEMENT AND PERMITS. POINTS SHALL BE AWARDED IN ACCORDANCE WITH THE TABLE BELOW:

COST PER BED	POINTS AWARDED
APPLICANT WITH LOWEST COST PER BED	7 POINTS
ALL OTHER APPLICANTS	APPLICANT'S COST PER BED DIVIDED BY THE LOWEST COST APPLICANT'S COST PER BED IN THE COMPARE GROUP, THEN MULTIPLIED BY 7
EXAMPLE: THE LOWEST COST APPLICANT HAS \$698,000 PER BED	7 POINTS
APPLICANT WITH \$710,000	$(\$698,000 \div 710,000) \times 7 = 7$ POINTS
APPLICANT WITH \$975,000 PER BED	$(\$698,000 \div 975,000) \times 7 = 5$ POINTS

POINTS SHALL NOT BE AWARDED UNDER THIS SECTION FOR ANY PROJECT THAT PROPOSES TO ADD BEDS AT A LEASED FACILITY. COSTS SHALL BE ROUNDED TO THE NEAREST WHOLE DOLLAR AND POINTS AWARDED SHALL BE ROUNDED TO THE NEAREST WHOLE NUMBER.

(g) A QUALIFYING PROJECT WILL BE AWARDED 1 POINT FOR EACH DESIGN FEATURE IN THIS SUBSECTION (MAXIMUM OF 3 POINTS) THAT APPLICANT PROPOSES TO INCLUDE IN THE PROPOSED PROJECT TO REDUCE STRESS, FOSTER DIMINISHED AGGRESSION, AND REDUCE PATIENT RISK:

(i) DESIGN FEATURES AS SHOWN ON THE FLOOR PLAN SUBMITTED WITH THE CON APPLICATION TO ALLOW THE APPLICANT TO CREATE ONE OR MORE SUBUNITS WITHIN A LARGER UNIT FOR CLINICAL OR PROGRAMMATIC PURPOSES, INCLUDING DOOR OR WALL SYSTEMS PERMITTED UNDER THE

MINIMUM DESIGN STANDARDS FOR HEALTHCARE FACILITIES IN MICHIGAN TO SUBDIVIDE INPATIENT PSYCHIATRIC SPACE ON A TEMPORARY OR FLEXIBLE BASIS;

(II) GARDENS OR OTHER OUTDOOR AREAS TO ALLOW INPATIENTS DIRECT DAILY ACCESS TO OUTDOOR SPACE AND DAYLIGHT; AND

(III) A FLOOR PLAN DESIGNED TO HELP REDUCE PATIENT RISK BY OPTIMIZING OBSERVATION OF PATIENTS IN THE FACILITY IN COMMUNAL AREAS, HALLWAYS, AND PATIENT ROOMS. FOR PURPOSES OF THIS CRITERIA, APPLICANTS SHALL SUBMIT PROPOSED FLOOR PLANS THAT SHOW UNOBSTRUCTED SIGHT LINES FROM NURSE STATIONS OR THE EQUIVALENT TO ALL PATIENT ROOM CORRIDORS AND ALL COMMON AREAS UTILIZED FOR PATIENT CARE.

(h) A QUALIFYING PROJECT WILL BE AWARDED 3 POINTS IF THE APPLICANT HAS OR PROPOSES TO DEVELOP A TELEHEALTH AND/OR TELEMEDICINE PROGRAM TO FACILITATE INPATIENT ADMISSION OF PSYCHIATRIC PATIENTS OR TO ASSIST IN THE DIAGNOSIS, TREATMENT OR PROVISION OF OTHER INPATIENT SUPPORT AND SERVICES NECESSARY AND APPROPRIATE FOR THE ADMISSION OR RETENTION OF A PSYCHIATRIC HOSPITAL INPATIENT WITH THE FOLLOWING FEATURES:

(I) THE EXISTING OR PROPOSED TELEHEALTH AND/OR TELEMEDICINE PROGRAM COMPLIES OR WILL COMPLY WITH MICHIGAN COMPILED LAWS SECTION 333.16283 TO 333.16288;

(II) THE PROPOSED PROJECT INCLUDES INFRASTRUCTURE NECESSARY OR APPROPRIATE FOR THE PSYCHIATRIC TELEHEALTH AND/OR TELEMEDICINE SERVICES INCLUDING HIGH-SPEED INTERNET CONNECTIONS, INTEGRATION OF THE TELEHEALTH AND/OR TELEMEDICINE SERVICES WITH THE ELECTRONIC HEALTH RECORD OF THE PSYCHIATRIC INPATIENT, AND PHYSICAL PLANT DESIGN ELEMENTS NECESSARY OR APPROPRIATE FOR COMPLIANCE WITH APPLICABLE STATE AND FEDERAL PRIVACY LAWS; AND

(III) THE APPLICANT HAS OR PROPOSES A PLAN TO FACILITATE WORKFORCE TRAINING AND TECHNICAL ASSISTANCE TO SUPPORT OPERATION OF THE TELEHEALTH AND/OR TELEMEDICINE PROGRAM.

(i) A QUALIFYING PROJECT WILL BE AWARDED 3 POINTS IF THE APPLICANT ALREADY HAS, OR THE PROPOSED PROJECT WILL HAVE COMPREHENSIVE PSYCHIATRIC CRISIS SERVICES FOR THE PURPOSE OF DIVERTING PATIENTS TO A LOWER ACUITY SETTING INCLUDING ANY OF: 24-HOUR PATIENT/FAMILY CRISIS TELEPHONE LINES, WALK-IN CRISIS SERVICES, OR A CRISIS STABILIZATION UNIT. AN APPLICANT SHALL SUBMIT SITE PLANS OR CONTRACTS TO DEMONSTRATE IT CURRENTLY HAS OR WILL INCLUDE ANY OF THESE SERVICES AS PART OF ITS PROPOSED PROJECT.

(J) A QUALIFYING PROJECT WILL BE AWARDED POINTS BASED ON THE GEOGRAPHIC LOCATION OF THE PROJECT IN ACCORDANCE WITH THE FOLLOWING TABLE. FOR PURPOSES OF EVALUATION, THIS CRITERIA WILL CONSIDER THE PROXIMITY OF THE PROPOSED PROJECT TO EXISTING BEDS OF THE SAME TYPE AS THOSE PROPOSED IN THE APPLICATION, INCLUDING BOTH OPERATING AND CON-APPROVED BUT NOT YET OPERATIONAL BEDS ON THE DATE OF APPLICATION.

PROXIMITY	POINTS
LESS THAN 30 MILES	0
BETWEEN 30-60 MILES	1
BETWEEN 60-90 MILES	2
GREATER THAN 90 MILES	3

FOR PURPOSES OF SCORING THIS CRITERIA, THE APPLICANT SHALL SUBMIT DATA USING THE MSU GEOCODER SERVICE AND MDHH’S PUBLISHED BED INVENTORY AT THE TIME THE APPLICATION IS DEEMED SUBMITTED.

(k) A QUALIFYING PROJECT THAT PROPOSES BEDS UNDER THE ADDENDUM FOR SPECIAL POPULATION GROUPS, SECTION 6 FOR HIGH ACUITY PSYCHIATRIC PATIENTS, WILL BE AWARDED POINTS BASED ON THE PERCENTAGE OF BEDS LOCATED IN PRIVATE ROOMS PROPOSED AS PART OF THE PROJECT, SUPPORTED BY THE FLOOR PLANS PROVIDED IN THE APPLICATION, IN ACCORDANCE WITH THE TABLE BELOW:

PERCENTAGE OF BEDS LOCATED IN PRIVATE ROOMS	POINTS AWARDED
APPLICANT WITH HIGHEST PERCENTAGE OF BEDS LOCATED IN PRIVATE ROOMS	7 POINTS
ALL OTHER APPLICANTS	APPLICANT’S PERCENT OF BEDS LOCATED IN PRIVATE ROOMS DIVIDED BY THE HIGHEST APPLICANT’S PERCENT OF BEDS LOCATED IN PRIVATE ROOMS, THEN MULTIPLIED BY 7
EXAMPLE: THE APPLICANT WITH THE HIGHEST PERCENTAGE OF BEDS IN PRIVATE ROOMS IS 90.0%	7 POINTS
APPLICANT WITH 80.0% BEDS IN PRIVATE ROOMS	$(.800/.900) \times 7 = 6$ POINTS
APPLICANT WITH 70.5% BEDS IN PRIVATE ROOMS	$(.705/.900) \times 7 = 5$ POINTS

PERCENTAGES SHALL BE ROUNDED TO THE NEAREST 1/1000 (E.G. 55.3%) AND POINTS AWARDED SHALL BE ROUNDED TO THE NEAREST WHOLE NUMBER. THE CALCULATION SHALL NOT INCLUDE EXISTING BEDS, JUST THOSE BEDS PROPOSED IN THIS APPLICATION.

(4) 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.

SECTION 14. PROJECT DELIVERY REQUIREMENTS – TERMS OF APPROVAL FOR ALL APPLICANTS

INSERT NEW REQUIREMENT AS FOLLOWS:

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

(B)

(IV) ADOPT AND MAINTAIN A POLICY THAT INCLUDES A PLAN FOR PROVIDING INPATIENT PSYCHIATRIC SERVICES TO EXISTING OR POTENTIAL PSYCHIATRIC INPATIENTS WHOSE LENGTH OF STAY AT APPLICANT'S PSYCHIATRIC HOSPITAL EXCEEDS, OR MAY EXCEED, 45 CONSECUTIVE INPATIENT DAYS IN ACCORDANCE WITH APPLICABLE MEDICARE, MEDICAID, CMH, OR OTHER THIRD PARTY PAYOR MEDICAL NECESSITY CRITERIA FOR INPATIENT PSYCHIATRIC ADMISSIONS AND AN APPROPRIATE CARE PLAN FOR THE INPATIENT.

# **ATTACHMENT 3**

## **CON Review Standards for Special Populations**

1 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

2  
3 CON REVIEW STANDARDS  
4 FOR PSYCHIATRIC BEDS AND SERVICES  
5 --ADDENDUM FOR SPECIAL POPULATION GROUPS  
6

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

10  
11 **Section 1. Applicability; definitions**

12  
13 Sec. 1. (1) This addendum supplements the CON review standards for psychiatric beds and services  
14 and shall be used for determining the need for projects established to better meet the needs of special  
15 population groups within the mental health populations.

16  
17 (2) Except as provided in sections 2, 3, 4, 5, 6, 7 and 78 of this addendum, these standards  
18 supplement, and do not supersede, the requirements and terms of approval required by the CON Review  
19 Standards for Psychiatric Beds and Services.

20  
21 (3) The definitions which apply to the CON Review Standards for Psychiatric Beds and Services shall  
22 apply to these standards.

23  
24 (4) For purposes of this addendum, the following terms are defined:

25 (a) "Developmental disability unit" means a unit designed for psychiatric patients (adult or  
26 child/adolescent as applicable) who have been diagnosed with a severe, chronic disability as outlined in  
27 Section 102, 42 USC 15002, of the Developmental Disabilities Assistance and Bill of Rights Act of 2000  
28 (DD Act) and its update or future guideline changes.

29 (b) "Geriatric psychiatric unit" means a unit designed for psychiatric patients aged 65 and over.

30 (c) "HIGH ACUITY PSYCHIATRIC UNIT" MEANS A DISTINCT PSYCHIATRIC UNIT FOR  
31 INDIVIDUALS WHO ARE CURRENTLY EXHIBITING TWO OR MORE OF THE FOLLOWING:  
32 CONFUSION, IRRITABILITY, BOISTEROUSNESS, POOR IMPULSE CONTROL,  
33 UNCOOPERATIVENESS, HOSTILITY, VERBAL THREATS, PHYSICAL THREATS, ATTACKING  
34 OBJECTS. THIS TERM ALSO INCLUDES PATIENTS WHO ARE UNWILLING OR UNABLE TO STOP  
35 ATTEMPTS AT SELF HARM OR SUICIDE OR PATIENTS WHO HAVE A HISTORY OF VIOLENCE ON  
36 AN INPATIENT PSYCHIATRIC UNIT.

37 (d) "Medical psychiatric unit" means a unit designed for psychiatric patients (adult or child/adolescent  
38 as applicable) who have also been diagnosed with a medical illness requiring hospitalization, e.g.,  
39 patients who may be on dialysis, require wound care or need intravenous or tube feeding.

40  
41 **Section 2. Requirements for approval -- applicants proposing to increase psychiatric beds --**  
42 **special use exceptions**

43  
44 Sec. 2. A project to increase psychiatric beds in a planning area which, if approved, would otherwise  
45 cause the total number of psychiatric beds in that planning area to exceed the needed psychiatric bed  
46 supply or cause an increase in an existing excess as determined under the applicable CON review  
47 standards for psychiatric beds and services, may nevertheless be approved pursuant to this addendum.  
48

49 **Section 3. Statewide pool for the needs of special population groups within the mental health**  
50 **populations**

51  
52 Sec. 3. (1) A statewide pool of additional psychiatric beds consists of 850 ~~370~~ beds needed in the  
53 state is established to better meet the needs of special population groups within the mental health  
54 populations. The number of beds in the DEVELOPMENTAL DISABILITY, GERIATRIC AND MEDICAL

55 PSYCHIATRIC pools ~~is~~ARE based on ~~five~~SEVEN AND A HALF percent of the statewide bed need for  
56 psychiatric inpatient beds rounded up to the next ten WITH A MINIMUM OF 50 CHILD/ADOLESCENT  
57 BEDS IN EACH SPECIAL POOL, AS APPLICABLE. THE NUMBER OF BEDS IN THE HIGH ACUITY  
58 POOL IS BASED ON TEN PERCENT OF THE STATEWIDE BED NEED FOR PSYCHIATRIC  
59 INPATIENT BEDS ROUNDED UP TO THE NEXT TEN WITH A MINIMUM OF 50 CHILD/ADOLESCENT  
60 BEDS. Beds in the pool shall be distributed as follows and shall be reduced in accordance with  
61 subsection (2):

62 (a) Developmental disability beds will be allocated ~~440~~160 adult beds and ~~20~~50 child/adolescent  
63 beds.

64 (b) Geriatric psychiatric beds will be allocated ~~440~~160 adult beds.

65 (c) HIGH ACUITY PSYCHIATRIC BEDS WILL BE ALLOCATED 220 ADULT BEDS AND 50  
66 CHILD/ADOLESCENT BEDS.

67 (d) Medical psychiatric beds will be allocated ~~440~~160 adult beds and ~~20~~50 child/adolescent beds.  
68

69 (2) By setting aside these beds from the total statewide pool, the Commission's action applies only to  
70 applicants seeking approval of psychiatric beds pursuant to sections 4, 5, 6, and ~~6~~7. It does not preclude  
71 the care of these patients in units of hospitals, psychiatric hospitals, or other health care settings in  
72 compliance with applicable statutory or certification requirements.  
73

74 (3) Increases in psychiatric beds approved under this addendum for special population groups shall  
75 not cause planning areas currently showing an unmet bed need to have that need reduced or planning  
76 areas showing a current surplus of beds to have that surplus increased.  
77

78 (4) The Commission may adjust the number of beds available in the statewide pool for the needs of  
79 special population groups within the mental health populations concurrent with the biennial recalculation  
80 of the statewide psychiatric inpatient bed need. Modifying the number of beds available in the statewide  
81 pool for the needs of special population groups within the mental health populations pursuant to this  
82 section shall not require a public hearing or submittal of the standard to the Legislature and the Governor  
83 in order to become effective.  
84

85 (5) BEDS APPROVED UNDER SUBSECTION 4, 5, 6, AND 7 SHALL NOT BE CONVERTED TO  
86 OR UTILIZED AS GENERAL PSYCHIATRIC BEDS.  
87

#### 88 **Section 4. Requirements for approval for beds from the statewide pool for special population** 89 **groups allocated to developmental disability patients**

90  
91 Sec. 4. The CON commission determines there is a need for beds for applications designed to  
92 determine the efficiency and effectiveness of specialized programs for the care and treatment of  
93 developmental disability patients as compared to serving these needs in general psychiatric unit(s).  
94

95 (1) An applicant proposing to begin operation of a new adult or child/adolescent psychiatric service or  
96 add beds to an existing adult or child/adolescent psychiatric service under this section shall demonstrate  
97 with credible documentation to the satisfaction of the Department each of the following:

98 (a) The applicant shall submit evidence of accreditation as follows:

99 (i) Documentation of its existing developmental disability program by the National Association for the  
100 Dually Diagnosed (NADD) or another nationally-recognized accreditation organization for developmental  
101 disability care and services; or

102 (ii) within 24-months of accepting its first patient, the applicant shall obtain NADD or another  
103 nationally-recognized accreditation organization for the developmental disability beds proposed under this  
104 subsection.

105 (b) The applicant proposes programs to promote a culture within the facility that is appropriate for  
106 developmental disability patients.

107 (c) Staff will be specially trained in treatment of developmental disability patients.



108 (d) The proposed beds will serve only developmental disability patients.

109  
110 (2) All beds approved pursuant to this subsection shall be certified for Medicaid.

111  
112 **Section 5. Requirements for approval for beds from the statewide pool for special population**  
113 **groups allocated to geriatric psychiatric patients**

114  
115 Sec. 5. The CON commission determines there is a need for beds for applications designed to  
116 determine the efficiency and effectiveness of specialized programs for the care and treatment of geriatric  
117 psychiatric patients as compared to serving these needs in general psychiatric unit(s).

118  
119 (1) An applicant proposing to begin operation of a new adult psychiatric service or add beds to an  
120 existing adult psychiatric service under this section shall demonstrate with credible documentation to the  
121 satisfaction of the Department each of the following:

122 (a) The applicant shall submit evidence of accreditation as follows:

123 (i) Documentation of its existing geriatric psychiatric program by the Commission on Accreditation of  
124 Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for geriatric  
125 psychiatric care and services; or

126 (ii) within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
127 nationally-recognized accreditation organization for the geriatric psychiatric beds proposed under this  
128 subsection.

129 (b) The applicant proposes programs to promote a culture within the facility that is appropriate for  
130 geriatric psychiatric patients.

131 (c) Staff will be specially trained in treatment of geriatric psychiatric patients.

132 (d) The proposed beds will serve only geriatric psychiatric patients.

133  
134 (2) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.

135  
136 **Section 6. REQUIREMENTS FOR APPROVAL FOR BEDS FROM THE STATEWIDE POOL FOR**  
137 **SPECIAL POPULATIONS GROUPS ALLOCATED TO HIGH ACUITY PSYCHIATRIC PATIENTS**

138  
139 SEC 6. THE CON COMMISSION DETERMINES THERE IS A NEED FOR BEDS FOR  
140 APPLICATIONS DESIGNED TO DETERMINE THE EFFICIENCY AND EFFECTIVENESS OF  
141 SPECIALIZED PROGRAMS FOR THE CARE AND TREATMENT OF HIGH ACUITY PSYCHIATRIC  
142 PATIENTS AS COMPARED TO SERVING THESE NEEDS IN A GENERAL PSYCHIATRIC UNIT(S).

143  
144 (1) AN APPLICANT PROPOSING TO BEGIN OPERATION OF A NEW ADULT OR  
145 CHILD/ADOLESCENT PSYCHIATRIC SERVICE OR ADD BEDS TO AN EXISTING ADULT OR  
146 CHILD/ADOLESCENT PSYCHIATRIC SERVICE UNDER THIS SECTION SHALL DEMONSTRATE  
147 WITH CREDIBLE DOCUMENTATION TO THE SATISFACTION OF THE DEPARTMENT EACH OF THE  
148 FOLLOWING:

149 (a) THE BEDS WILL BE OPERATED AS PART OF A SPECIALIZED PROGRAM EXCLUSIVELY  
150 FOR ADULT OR CHILD/ADOLESCENT PATIENTS CLASSIFIED AS HIGH ACUITY.

151 (b) THE APPLICANT SHALL SUBMIT EVIDENCE OF THE FOLLOWING:

152 (i) THE PROPOSED UNIT SHALL CONSIST OF A MAJORITY OF PRIVATE ROOMS AND MUST  
153 INCLUDE ENVIRONMENTAL SAFETY MEASURES THAT MEET STANDARDS FROM THE JOINT  
154 COMMISSION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THROUGHOUT  
155 THE ENTIRE UNIT.

156 (ii) THE PROPOSED UNIT SHALL HAVE A PHYSICAL ENVIRONMENT DESIGNED TO MINIMIZE  
157 NOISE AND LIGHT REFLECTIONS TO PROMOTE VISUAL AND SPATIAL ORIENTATION.

158 (iii) THE PROPOSED UNIT'S STAFF SHALL BE SPECIALLY TRAINED IN THE TREATMENT OF  
159 HIGH ACUITY PATIENTS WITH NON-VIOLENT INTERVENTION MODALITIES SUCH AS NON-  
160 ABUSLIVE PSYCHOLOGICAL AND PHYSICAL INTERVENTION, CRISIS INTERVENTION INSTITUTE  
161 TRAINING OR SIMILAR PROGRAMS.-

162 (iv) THE PROPOSED UNITY MUST DEMONSTRATE A PLAN FOR THE SAFE MANAGEMENT OF  
163 AGITATED OR AGGRESSIVE PATIENTS.

164 (c) THE PROPOSED BEDS WILL SERVE ONLY HIGH ACUITY PSYCHIATRIC PATIENTS.  
165

166 (2) ALL BEDS APPROVED PURSUANT TO THIS SUBSECTION SHALL BE CERTIFIED FOR  
167 MEDICAID.  
168

169 **Section 7. Requirements for approval for beds from the statewide pool for special population**  
170 **groups allocated to medical psychiatric patients**  
171

172 Sec. 67. The CON commission determines there is a need for beds for applications designed to  
173 determine the efficiency and effectiveness of specialized programs for the care and treatment of medical  
174 psychiatric patients as compared to serving these needs in general psychiatric unit(s).  
175

176 (1) An applicant proposing to begin operation of a new adult or child/adolescent psychiatric service or  
177 add beds to an existing adult or child/adolescent psychiatric service under this section shall demonstrate  
178 with credible documentation to the satisfaction of the Department each of the following:

179 (a) The beds will be operated as part of a specialized program exclusively for adult or  
180 child/adolescent medical psychiatric patients, as applicable, within ONE OF THE FOLLOWING  
181 SETTINGS:

182 (i) a licensed hospital licensed under part 215 of the code, OR

183 (ii) AN ADULT OR CHILD/ADOLESCENT PSYCHIATRIC SERVICE OR UNIT WITH A WRITTEN  
184 COLLABORATIVE AGREEMENT WITH A LICENSED HOSPITAL LICENSED UNDER PART 215 OF  
185 THE CODE THAT IS PROVIDED AS PART OF THE APPLICATION AND INCLUDES ALL OF THE  
186 FOLLOWING:

187 (A)- PROCEDURES FOR JOINT CREDENTIALING CRITERIA AND RECOMMENDATIONS FOR  
188 PHYSICIANS APPROVED TO TREAT MEDICAL PSYCHIATRIC PATIENTS.

189 (B) PROVISIONS FOR REGULARLY HELD JOINT PSYCHIATRIC AND MEDICAL  
190 CONFERENCES TO INCLUDE REVIEW OF ALL MEDICAL PSYCHIATRIC CASES.

191 (C) A MECHANISM TO PROVIDE FOR APPROPRIATE TRANSFERS BETWEEN FACILITIES AND  
192 AN AGREED UPON PLAN FOR PROMPT CARE.

193 (D) CONSULTATION ON FACILITIES, EQUIPMENT, STAFFING, ANCILLARY SERVICES, AND  
194 POLICIES AND PROCEDURES FOR THE PROVISION OF MEDICAL PSYCHIATRIC TREATMENT.

195 (b) The applicant shall submit evidence of accreditation as follows:

196 (i) Documentation of its existing medical psychiatric program by CARF or another nationally-  
197 recognized accreditation organization for medical psychiatric care and services; or

198 (ii) within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
199 nationally-recognized accreditation organization for the medical psychiatric beds proposed under this  
200 subsection.

201 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
202 medical psychiatric patients.

203 (d) Staff, INCLUDING CONTRACTED STAFF, will be specially trained in treatment of medical  
204 psychiatric patients.

205 (e) The proposed beds will serve only medical psychiatric patients.  
206

207 (2) All beds approved pursuant to this subsection shall be certified for Medicaid.  
208

209 **Section 78. Acquisition of psychiatric beds approved pursuant to this addendum**  
210

211 Sec. 78. (1) An applicant proposing to acquire psychiatric beds from the statewide pool for special  
212 population groups allocated to developmental disability shall meet the following:

213 (a) The applicant shall submit evidence of accreditation of the existing developmental disability  
214 program by the National Association for the Dually Diagnosed (NADD) or another nationally-recognized  
215 accreditation organization for developmental disability care and services.

216 (b) Within 24-months of accepting its first patient, the applicant shall obtain NADD or another  
217 nationally-recognized accreditation organization for the developmental disability beds proposed under this  
218 subsection.

219 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
220 developmental disability patients.

221 (d) Staff will be specially trained in treatment of developmental disability patients.

222 (e) The proposed beds will serve only developmental disability patients.

223 (f) All beds approved pursuant to this subsection shall be certified for Medicaid.

224

225 (2) An applicant proposing to acquire psychiatric beds from the statewide pool for special population  
226 groups allocated to geriatric psychiatric shall meet the following:

227 (a) The applicant shall submit evidence of accreditation of the existing geriatric psychiatric program  
228 by CARF or another nationally-recognized accreditation organization for geriatric psychiatric care and  
229 services.

230 (b) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
231 nationally-recognized accreditation organization for the geriatric psychiatric beds proposed under this  
232 subsection.

233 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
234 geriatric psychiatric patients.

235 (d) Staff will be specially trained in treatment of geriatric psychiatric patients.

236 (e) The proposed beds will serve only geriatric psychiatric patients.

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

238

239 (3) **AN APPLICANT PROPOSING TO ACQUIRE PSYCHIATRIC BEDS FROM THE STATEWIDE  
240 POOL FOR SPECIAL POPULATIONS ALLOCATED TO HIGH ACUITY PSYCHIATRY SHALL MEET  
241 THE FOLLOWING:**

242 (a) **THE PROPOSED UNIT SHALL CONSIST OF A MAJORITY OF PRIVATE ROOMS AND MUST  
243 INCLUDE ENVIRONMENTAL SAFETY MEASURES THAT MEET STANDARDS FROM THE JOINT  
244 COMMISSION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THROUGHOUT  
245 THE ENTIRE UNIT.**

246 (b) **THE PROPOSED UNIT SHALL HAVE A PHYSICAL ENVIRONMENT DESIGNED TO MINIMIZE  
247 NOISE AND LIGHT REFLECTIONS TO PROMOTE VISUAL AND SPATIAL ORIENTATION.**

248 (c) **THE PROPOSED UNIT'S STAFF SHALL BE SPECIALLY TRAINED IN THE TREATMENT OF  
249 HIGH ACUITY PATIENTS WITH NON-VIOLENT INTERVENTION MODALITIES SUCH AS NON-  
250 ABUSLIVE PSYCHOLOGICAL AND PHYSICAL INTERVENTION, CRISIS INTERVENTION INSTITUTE  
251 TRAINING OR SIMILAR PROGRAMS.**

252 (d) **THE PROPOSED UNITY MUST DEMONSTRATE A PLAN FOR THE SAFE MANAGEMENT OF  
253 AGITATED OR AGGRESSIVE PATIENTS.**

254 (e) **THE PROPOSED BEDS WILL SERVE ONLY HIGH ACUITY PSYCHIATRIC PATIENTS.**

255 (f) **ALL BEDS APPROVED PURSUANT TO THIS SUBSECTION SHALL BE CERTIFIED FOR  
256 MEDICAID.**

257

258

259 (4) An applicant proposing to acquire psychiatric beds from the statewide pool for special population  
260 groups allocated to medical psychiatric shall meet the following:

261 (a) The applicant shall submit evidence of accreditation of the existing medical psychiatric program  
262 by CARF or another nationally-recognized accreditation organization for medical psychiatric care and  
263 services.

264 (b) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
265 nationally-recognized accreditation organization for the medical psychiatric beds proposed under this  
266 subsection.

267 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
268 medical psychiatric patients.

269 (d) Staff will be specially trained in treatment of medical psychiatric patients.

- 270 (e) The proposed beds will serve only medical psychiatric patients.
- 271 (f) All beds approved pursuant to this subsection shall be certified for Medicaid.

272  
273 **Section 89. Project delivery requirements -- terms of approval for all applicants seeking approval**  
274 **under section 3(1) of this addendum**

275  
276 Sec. 89. (1) An applicant shall agree that if approved, the services shall be delivered in compliance  
277 with the terms of approval required by the CON Review Standards for Psychiatric Beds and Services.

278  
279 (2) An applicant for beds from the statewide pool for special population groups allocated to  
280 developmental disability patients shall agree that, if approved, all beds approved pursuant to that  
281 subsection shall be operated in accordance with the following terms of CON approval:

282 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
283 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
284 applicant shall reduce beds to a number of beds necessary to result in an 80 percent average annual  
285 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
286 revert to the total statewide pool established for developmental disability beds.

287 (b) An applicant shall staff the proposed unit for developmental disability patients with employees  
288 that have been trained in the care and treatment of such individuals.

289 (c) An applicant shall maintain NADD certification or another nationally-recognized accreditation  
290 organization for developmental disability care and services.

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

293 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
294 appropriate for admission to the developmental disability unit.

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

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

298 (e) If the specialized program is being added to an existing adult or child/adolescent psychiatric  
299 service, then the existing licensed adult or child/adolescent psychiatric service, as applicable, shall  
300 maintain the volume requirements outlined in Section 14 of the CON Review Standards for Psychiatric  
301 Beds and Services.

302 (f) The developmental disability unit shall have a day/dining area within, or immediately adjacent to,  
303 the unit(s), which is solely for the use of developmental disability patients.

304 (g) The developmental disability unit shall have direct access to a secure outdoor or indoor area at  
305 the facility appropriate for supervised activity.

306 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
307 for developmental disability patients.

308  
309 (3) An applicant for beds from the statewide pool for special population groups allocated to geriatric  
310 psychiatric patients shall agree that if approved, all beds approved pursuant to that subsection shall be  
311 operated in accordance with the following terms of CON approval:

312 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
313 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
314 applicant shall reduce beds to a number of beds necessary to result in an 80 percent average annual  
315 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
316 revert to the total statewide pool established for geriatric psychiatric beds.

317 (b) An applicant shall staff the proposed unit for geriatric psychiatric patients with employees that  
318 have been trained in the care and treatment of such individuals.

319 (c) An applicant shall maintain CARF certification or another nationally-recognized accreditation  
320 organization for geriatric psychiatric care and services.

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

- 323 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
324 appropriate for admission to the geriatric psychiatric unit.
- 325 (ii) The transfer of patients requiring care at other health care facilities.
- 326 (iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment  
327 plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.
- 328 (e) If the specialized program is being added to an existing adult licensed psychiatric service, then  
329 the existing licensed psychiatric service shall maintain the volume requirements outlined in Section 14 of  
330 the CON Review Standards for Psychiatric Beds and Services.
- 331 (f) The geriatric psychiatric unit shall have a day/dining area within, or immediately adjacent to, the  
332 unit(s), which is solely for the use of geriatric psychiatric patients.
- 333 (g) The geriatric psychiatric unit shall have direct access to a secure outdoor or indoor area at the  
334 facility appropriate for supervised activity.
- 335 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
336 for geriatric psychiatric patients.

337  
338 (4) AN APPLICANT FOR BEDS FROM THE STATEWIDE POOL FOR SPECIAL POPULATION  
339 GROUPS ALLOCATED TO HIGH ACUITY PSYCHIATRIC PATIENTS SHALL AGREE THAT, IF  
340 APPROVED, ALL BEDS APPROVED PURSUANT TO THAT SUBSECTION SHALL BE OPERATED IN  
341 ACCORDANCE WITH THE FOLLOWING TERMS OF CON APPROVAL:

342 (a) THE APPLICANT SHALL DOCUMENT, AT THE END OF THE THIRD YEAR FOLLOWING  
343 INITIATION OF BEDS APPROVED, AND THEREAFTER, AN ANNUAL AVERAGE OCCUPANCY RATE  
344 OF 80 PERCENT OR MORE. IF THIS OCCUPANCY RATE HAS NOT BEEN MET, THE APPLICANT  
345 SHALL REDUCE BEDS TO A NUMBER OF BEDS NECESSARY TO RESULT IN AN 80 PERCENT  
346 AVERAGE ANNUAL OCCUPANCY FOR THE THIRD FULL YEAR OF OPERATION AND ANNUALLY  
347 THEREAFTER. THE NUMBER OF BEDS REDUCED SHALL REVERT TO THE TOTAL STATEWIDE  
348 POOL ESTABLISHED FOR HIGH ACUITY PSYCHIATRIC PATIENTS.

349 (b) THE HIGH ACUITY UNIT SHALL CONSIST OF A MAJORITY OF PRIVATE ROOMS AND MUST  
350 INCLUDE ENVIRONMENTAL SAFETY MEASURES THAT MEET STANDARDS FROM THE JOINT  
351 COMMISSION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES THROUGHOUT  
352 THE ENTIRE UNIT.

353 (c) THE HIGH ACUITY UNIT SHALL HAVE A PHYSICAL ENVIRONMENT DESIGNED TO MINIMIZE  
354 NOISE AND LIGHT REFLECTIONS TO PROMOTE VISUAL AND SPATIAL ORIENTATION.

355 (d) THE PROPOSED UNIT'S STAFF SHALL BE SPECIALLY TRAINED IN THE TREATMENT OF  
356 HIGH ACUITY PATIENTS WITH NON-VIOLENT INTERVENTION MODALITIES SUCH AS NON-  
357 ABUSLIVE PSYCHOLOGICAL AND PHYSICAL INTERVENTION, CRISIS INTERVENTION INSTITUTE  
358 TRAINING OR SIMILAR PROGRAMS.

359 (e) THE PROPOSED UNITY MUST DEMONSTRATE A PLAN FOR THE SAFE MANAGEMENT OF  
360 AGITATED OR AGGRESSIVE PATIENTS.

361 (f) THE HIGH ACUITY UNIT SHALL ESTABLISH AND MAINTAIN WRITTEN POLICIES AND  
362 PROCEDURES FOR EACH OF THE FOLLOWING:

363 (i) PATIENT ADMISSION CRITERIA THAT DESCRIBE MINIMUM AND MAXIMUM  
364 CHARACTERISTICS FOR PATIENTS APPROPRIATE FOR ADMISSION TO THE UNIT FOR HIGH  
365 ACUITY PATIENTS.

366 (ii) QUALITY ASSURANCE AND ASSESSMENT PROGRAM TO ASSURE THAT SERVICES  
367 FURNISHED TOHIGH ACUITY PATIENTS MEET PROFESSIONAL RECOGNIZED STANDARDS OF  
368 HEALTH CARE FOR PROVIDERS OF SUCH SERVICES AND THAT SUCH SERVICES WERE  
369 REASONABLE AND MEDICALLY APPROPRIATE TO THE CLINICAL CONDITION OF THE HIGH  
370 ACUITYPATIENT RECEIVING SUCH SERVICES.

371 (iii) ORIENTATION AND ANNUAL EDUCATION/COMPETENCIES FOR ALL STAFF, WHICH SHALL  
372 INCLUDE CARE GUIDELINES, SPECIALIZED COMMUNICATION, AND PATIENT SAFETY.

373 (g) IF THE SPECIALIZED PROGRAM IS BEING ADDED TO AN EXISTING LICENSED ADULT OR  
374 CHILD/ADOLESCENT PSYCHIATRIC SERVICE, THEN THE EXISTING ADULT OR  
375 CHILD/ADOLESCENT PSYCHIATRIC SERVICE, AS APPLICABLE, SHALL MAINTAIN THE VOLUME

376 **REQUIREMENTS OUTLINED IN SECTION 14 OF THE CON REVIEW STANDARDS FOR**  
377 **PSYCHIATRIC BEDS AND SERVICES.**

378  
379

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

383 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
384 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
385 applicant shall reduce beds to a number of beds necessary to result in a 80 percent average annual  
386 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
387 revert to the total statewide pool established for medical psychiatric beds.

388 (b) An applicant shall staff the proposed unit for medical psychiatric patients with employees that  
389 have been trained in the care and treatment of such individuals.

390 (c) An applicant shall maintain CARF certification or another nationally-recognized accreditation  
391 organization for medical psychiatric care and services.

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

394 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
395 appropriate for admission to the medical psychiatric unit.

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

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

399 (e) If the specialized program is being added to an existing licensed adult or child/adolescent  
400 psychiatric service, then the existing adult or child/adolescent psychiatric service, as applicable, shall  
401 maintain the volume requirements outlined in Section 14 of the CON Review Standards for Psychiatric  
402 Beds and Services.

403 (f) The medical psychiatric unit shall have a day/dining area within, or immediately adjacent to, the  
404 unit(s), which is solely for the use of medical psychiatric patients.

405 (g) The medical psychiatric unit shall have direct access to a secure outdoor or indoor area at the  
406 facility appropriate for supervised activity.

407 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
408 for medical psychiatric patients.

409

410 **Section 910. Comparative reviews, effect on prior CON review standards**

411

412 Sec.-910. (1) Projects proposed under Section 4 shall be considered a distinct category and shall be  
413 subject to comparative review on a statewide basis.

414

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

417

418 (3) **PROJECTS PROPOSED UNDER SECTION 6 SHALL BE CONSIDERED A DISTINCT**  
419 **CATEGORY AND SHALL BE SUBJECT TO COMPARATIVE REVIEW ON A STATEWIDE BASIS.**

420

421 (4) Projects proposed under Section 67 shall be considered a distinct category and shall be subject  
422 to comparative review on a statewide basis.

423

424

# **ATTACHMENT 4**

## **Language for Charges #6 and #7**

(As presented at the December  
2018 Psychiatric Bed Workgroup  
meeting)

1 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

2  
3 CERTIFICATE OF NEED (CON) REVIEW STANDARDS  
4 FOR PSYCHIATRIC BEDS AND SERVICES  
5

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

9  
10 **Section 1. Applicability**

11  
12 Sec. 1. These standards are requirements for the approval under Part 222 of the Code that involve  
13 (a) beginning operation of a new psychiatric service, (b) replacing licensed psychiatric beds or physically  
14 relocating licensed psychiatric beds from one licensed site to another geographic location, or (c)  
15 increasing licensed psychiatric beds within a psychiatric hospital or unit licensed under the Mental Health  
16 Code, 1974 PA 258, or (d) acquiring a psychiatric service pursuant to Part 222 of the Code. A psychiatric  
17 hospital or unit is a covered health facility. The Department shall use these standards in applying Section  
18 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section  
19 22225(2)(c) of the code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.  
20

21 (2) An increase in licensed hospital beds is a change in bed capacity for purposes of Part 222 of the  
22 Code.  
23

24 (3) The physical relocation of hospital beds from a licensed site to another geographic location is a  
25 change in bed capacity for purposes of Part 222 of the Code.  
26

27 **Section 2. Definitions**

28  
29 Sec. 2. (1) For purposes of these standards:  
30

31 (a) "Acquisition of a psychiatric hospital or unit" means the issuance of a new license as the result of  
32 the acquisition (including purchase, lease, donation, or other comparable arrangement) of an existing  
33 licensed psychiatric hospital or unit and which does not involve a change in the number of licensed  
34 psychiatric beds at that health facility.

35 (b) "Adult" means any individual aged 18 years or older.

36 (c) "AVERAGE OCCUPANCY RATE" IS CALCULATED AS FOLLOWS:

37 (i) CALCULATE THE NUMBER OF PATIENT DAYS DURING THE MOST RECENT,  
38 CONSECUTIVE 12-MONTH PERIOD, AS OF THE DATE OF THE APPLICATION, FOR WHICH  
39 VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

40 (ii) CALCULATE THE TOTAL LICENSED BED DAYS FOR THE SAME 12-MONTH PERIOD AS IN  
41 (i) ABOVE BY MULTIPLYING THE TOTAL LICENSED BEDS BY THE NUMBER OF DAYS THEY WERE  
42 LICENSED.

43 (iii) DIVIDE THE NUMBER OF PATIENT DAYS CALCULATED IN (i) ABOVE BY THE TOTAL  
44 LICENSED BED DAYS CALCULATED IN (ii) ABOVE, THEN MULTIPLY THE RESULT BY 100.

45 (c) "Base year" means the most recent year for which verifiable data are collected by the Department  
46 and are available separately for the population age cohorts of 0 to 17 and 18 and older.

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

49 (e) "Child/adolescent" means any individual less than 18 years of age.

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

52 (g) "Community mental health board" or "board" or "CMH" means the board of a county(s)  
53 community mental health board as referenced in the provisions of MCL 330.1200 to 330.1246.



- 54 (h) "Comparative group" means the applications which have been grouped for the same type of  
55 project in the same planning area or statewide special population group and are being reviewed  
56 comparatively in accordance with the CON rules.
- 57 (i) "Department" means the Michigan Department of Health and Human Services (MDHHS).
- 58 (j) "Department inventory of beds" means the current list maintained for each planning area on a  
59 continuing basis by the Department which includes:
- 60 (i) licensed adult and child/adolescent psychiatric beds; and  
61 (ii) adult and child/adolescent psychiatric beds approved by a valid CON, which are not yet licensed.  
62 A separate inventory will be maintained for child/adolescent beds and adult beds.
- 63 (k) "Existing adult inpatient psychiatric beds" or "existing adult beds" means:
- 64 (i) all adult beds in psychiatric hospitals or units licensed by the Department pursuant to the Mental  
65 Health Code;  
66 (ii) all adult beds approved by a valid CON, which are not yet licensed;  
67 (iii) proposed adult beds under appeal from a final Department decision, or pending a hearing from a  
68 proposed decision; and  
69 (iv) proposed adult beds that are part of a completed application (other than the application or  
70 applications in the comparative group under review) which are pending final Department decision.
- 71 (l) "Existing child/adolescent inpatient psychiatric beds" or "existing child/adolescent beds" means:
- 72 (i) all child/adolescent beds in psychiatric hospitals or units licensed by the Department pursuant to  
73 the Mental Health Code;  
74 (ii) all child/adolescent beds approved by a valid CON, which are not yet licensed;  
75 (iii) proposed child/adolescent beds under appeal from a final Department decision, or pending a  
76 hearing from a proposed decision; and  
77 (iv) proposed child/adolescent beds that are part of a completed application (other than the  
78 application or applications in the comparative group under review) which are pending final Department  
79 decision.
- 80 (m) "Flex bed" means an existing adult psychiatric bed converted to a child/adolescent psychiatric  
81 bed in an existing child/adolescent psychiatric service to accommodate during peak periods and meet  
82 patient demand.
- 83 (n) "Initiation of service" means the establishment of an inpatient psychiatric unit with a specified  
84 number of beds at a site not currently providing psychiatric services.
- 85 (o) "Involuntary commitment status" means a hospital admission effected pursuant to the provisions  
86 of MCL 330.1423 to 330.1429.
- 87 (p) "Licensed site" means the location of the facility authorized by license and listed on that  
88 licensee's certificate of licensure.
- 89 (q) "Medicaid" means title XIX of the Social Security Act, chapter 531, 49 Stat. 620, 1396 to 1396g  
90 and 1396i to 1396u.
- 91 (r) "Mental Health Code" means Act 258 of the Public Acts of 1974, as amended, being Sections  
92 330.1001 to 330.2106 of the Michigan Compiled Laws.
- 93 (s) "Mental health professional" means an individual who is trained and experienced in the area of  
94 mental illness or developmental disabilities and who is any 1 of the following:
- 95 (i) a physician who is licensed to practice medicine or osteopathic medicine and surgery in Michigan  
96 and who has had substantial experience with mentally ill, mentally retarded, or developmentally disabled  
97 clients for 1 year immediately preceding his or her involvement with a client under administrative rules  
98 promulgated pursuant to the Mental Health Code;  
99 (ii) a psychologist who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to  
100 333.18838;  
101 (iii) a licensed master's social worker licensed in Michigan Pursuant to the provisions of MCL  
102 333.16101 to 333.18838;  
103 (iv) a registered nurse who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to  
104 333.18838;  
105 (v) a licensed professional counsel or licensed in Michigan pursuant to the provisions of MCL  
106 333.16101 to 333.18838;

- 107 (vi) a marriage and family therapist licensed in Michigan pursuant to the provisions of MCL  
108 333.16101 to 333.18838;
- 109 (vii) a professional person, other than those defined in the administrative rules promulgated pursuant  
110 to the Mental Health Code, who is designated by the Director of the Department or a director of a facility  
111 operated by the Department in written policies and procedures. This mental health professional shall  
112 have a degree in his or her profession and shall be recognized by his or her respective professional  
113 association as being trained and experienced in the field of mental health. The term does not include  
114 non-clinical staff, such as clerical, fiscal or administrative personnel.
- 115 (t) "Mental health service" means the provision of mental health care in a protective environment  
116 with mental illness or mental retardation, including, but not limited to, chemotherapy and individual and  
117 group therapies pursuant to MCL 330.2001.
- 118 (u) "Non-renewal or revocation of license" means the Department did not renew or revoked the  
119 psychiatric hospital's or unit's license based on the hospital's or unit's failure to comply with state licensing  
120 standards.
- 121 (v) "Non-renewal or termination of certification" means the psychiatric hospital's or unit's Medicare  
122 and/or Medicaid certification was terminated or not renewed based on the hospital's or unit's failure to  
123 comply with Medicare and/or Medicaid participation requirements.
- 124 (w) "Offer" means to provide inpatient psychiatric services to patients.
- 125 (x) "Physician" means an individual licensed in Michigan to engage in the practice of medicine or  
126 osteopathic medicine and surgery pursuant to MCL 333.16101 to 333.18838.
- 127 (y) "Planning area" means the geographic boundaries of the groups of counties shown in Section 17.
- 128 (z) "Planning year" means a year in the future, at least 3 years but no more than 7 years, for which  
129 inpatient psychiatric bed needs are developed. The planning year shall be a year for which official  
130 population projections from the Department of Technology, Management and Budget or its designee are  
131 available.
- 132 (aa) "Psychiatric hospital" means an inpatient program operated by the Department for the treatment  
133 of individuals with serious mental illness or serious emotional disturbance or a psychiatric hospital or  
134 psychiatric unit licensed under pursuant to MCL 330.1137.
- 135 (bb) "Psychiatrist" means 1 or more of the following, pursuant to MCL 330.1100c:
- 136 (i) a physician who has completed a residency program in psychiatry approved by the Accreditation  
137 Council for Graduate Medical Education or The American Osteopathic Association, or who has completed  
138 12 months of psychiatric rotation and is enrolled in an approved residency program;
- 139 (ii) a psychiatrist employed by or under contract with the Department or a community health services  
140 program on March 28, 1996;
- 141 (iii) a physician who devotes a substantial portion of his or her time to the practice of psychiatry and  
142 is approved by the Director.
- 143 (cc) "Psychiatric unit" means a unit of a general hospital that provides inpatient services for individuals  
144 with serious mental illness or serious emotional disturbances pursuant to MCL 330.1100c.
- 145 (dd) "Psychologist" means an individual licensed to engage in the practice of psychology, who devotes  
146 a substantial portion of his or her time to the diagnosis and treatment of individuals with serious mental  
147 illness, serious emotional disturbance, or developmental disability, pursuant to MCL 333.16101 to  
148 333.18838.
- 149 (ee) "Public patient" means an individual approved for mental health services by a CMH or an  
150 individual who is admitted as a patient under the Mental Health Code, Act No. 258 of the Public Acts of  
151 1974, being Sections 330.1423, 330.1429, and 330.1438 of the Michigan Compiled Laws.
- 152 (ff) "Qualifying project" means each application in a comparative group which has been reviewed  
153 individually and has been determined by the Department to have satisfied all of the requirements of  
154 Section 22225 of the Code, being Section 333.22225 of the Michigan Compiled Laws, and all other  
155 applicable requirements for approval in the Code and these standards.
- 156 (gg) "Registered professional nurse" or "R.N." means an individual licensed in Michigan pursuant to  
157 the provisions of MCL 333.16101 to 333.18838.
- 158 (hh) "Relocate existing licensed inpatient psychiatric beds" means a change in the location of existing  
159 inpatient psychiatric beds from the existing licensed psychiatric hospital site to a different existing

160 licensed psychiatric hospital site within the same planning area. This definition does not apply to projects  
161 involving replacement beds in a psychiatric hospital or unit governed by Section 7 of these standards.

162 (ii) "Replace beds" means a change in the location of the licensed psychiatric hospital or unit, or the  
163 replacement of a portion of the licensed beds at the same licensed site. The beds will be in new physical  
164 plant space being developed in new construction or in newly acquired space (purchase, lease, donation,  
165 etc.) within the replacement zone.

166 (jj) "Replacement zone" means a proposed licensed site that is:

167 (i) in the same planning area as the existing licensed site; and

168 (ii) on the same site, on a contiguous site, or on a site within 15 miles of the existing licensed site.

169 (kk) "Social worker" means an individual registered in Michigan to engage in social work under the  
170 provisions of MCL 333.18501.

171  
172 (2) The terms defined in the Code have the same meanings when used in these standards.  
173

### 174 **Section 3. Determination of needed inpatient psychiatric bed supply**

175  
176 Sec. 3. (1) Until changed by the Commission in accordance with Section 5, the use rate for the base  
177 year for the population age 0-17 is set forth in Appendix B.  
178

179 (2) The number of child/adolescent inpatient psychiatric beds needed in a planning area shall be  
180 determined by the following formula:

181 (a) Determine the population for the planning year for each separate planning area for the population  
182 age 0-17.

183 (b) Multiply the population by the use rate established in Appendix B. The resultant figure is the total  
184 patient days.

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

187 (d) Divide the ADC by 0.75.

188 (e) For each planning area, all psychiatric hospitals or units with an average occupancy of 60% or  
189 less for the previous 24 months will have the ADC, for the previous 24 months, multiplied by 1.7. The net  
190 decrease from the current licensed beds will give the number to be added to the bed need.

191 (f) The adjusted bed need for the planning area is the sum of the results of subsections (d) and (e).  
192 round up to the nearest whole number.  
193

194 (3) The number of needed adult inpatient psychiatric beds shall be determined by multiplying the  
195 population aged 18 years and older for the planning year for each planning area by either:

196 (a) The ratio of adult beds per 10,000 adult population set forth in Appendix A; or

197 (b) The statewide ratio of adult beds per 10,000 adult population set forth in Appendix A, whichever  
198 is lower; and dividing the result by 10,000. If the ratio set forth in Appendix A for a specific planning area  
199 is "0", the statewide ratio of adult beds per 10,000 adult population shall be used to determine the number  
200 of needed adult inpatient psychiatric beds.

201 (c) For each planning area, an addition to the bed need will be made for low occupancy facilities. All  
202 psychiatric hospitals or units with an average occupancy of 60% or less for the previous 24 months will  
203 have the ADC, for the previous 24 months, multiplied by 1.5. The net decrease from the current licensed  
204 beds will give the number to be added to the bed need.

205 (d) The adjusted bed need for the planning area is the sum of the results of subsections (b) and (c).  
206

### 207 **Section 4. Bed need for inpatient psychiatric beds**

208  
209 Sec. 4. (1) The bed need numbers determined pursuant to Section 3 shall apply to projects subject to  
210 review under these standards, except where a specific CON review standard states otherwise.  
211

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

- 213  
214 (3) The effective date of the bed need numbers shall be established by the Commission.  
215  
216 (4) New bed need numbers shall supercede previous bed need numbers and shall be posted on the  
217 State of Michigan CON web site as part of the Psychiatric Bed Inventory.  
218  
219 (5) Modifications made by the Commission pursuant to this Section shall not require Standard  
220 Advisory Committee action, a public hearing, or submittal of the standard to the Legislature and the  
221 Governor in order to become effective.  
222

223 **Section 5. Modification of the child/adolescent use rate by changing the base year**  
224

225 Sec. 5. (1) The Commission may modify the base year based on data obtained from the Department  
226 and presented to the Commission. The Department shall calculate the use rate for the population age 0-  
227 17 and biennially present the revised use rate based on the most recent base year information available  
228 biennially to the CON Commission.  
229

230 (2) The Commission shall establish the effective date of the modifications made pursuant to  
231 subsection (1).  
232

233 (3) Modifications made by the Commission pursuant to subsection (1) shall not require Standard  
234 Advisory Committee action, a public hearing, or submittal of the standard to the Legislature and the  
235 Governor in order to become effective.  
236

237 **Section 6. Requirements for approval to initiate service**  
238

239 Sec. 6. An applicant proposing the initiation of an adult or child/adolescent psychiatric service shall  
240 demonstrate or provide the following:  
241

242 (1) The number of beds proposed in the CON application shall not result in the number of existing  
243 adult or child/adolescent psychiatric beds, as applicable, in the planning area exceeding the bed need.  
244 However, an applicant may request and be approved for up to a maximum of 10 beds if, when the total  
245 number of existing adult beds or existing child/adolescent beds is subtracted from the bed need for the  
246 planning area, the difference is equal to or more than 1 or less than 10.  
247

248 (2) A written recommendation, from the Department or the CMH that serves the county in which the  
249 proposed beds or service will be located, shall include an agreement to enter into a contract to meet the  
250 needs of the public patient. At a minimum, the letter of agreement shall specify the number of beds to be  
251 allocated to the public patient and the applicant's intention to serve patients with an involuntary  
252 commitment status.  
253

254 (3) The number of beds proposed in the CON application to be allocated for use by public patients  
255 shall not be less than 50% of the beds proposed in the CON application. Applications proposed in direct  
256 response to a Department plan pursuant to subsection (5) shall allocate not less than 80% of the beds  
257 proposed in the CON application.  
258

259 (4) The minimum number of beds in a psychiatric unit shall be at least 10 beds. If a psychiatric unit  
260 has or proposes to operate both adult and child/adolescent beds, each unit shall have a minimum of 10  
261 beds. The Department may approve an application for a unit of less than 10 beds, if the applicant  
262 demonstrates to the satisfaction of the Department, that travel time to existing units would significantly  
263 limit access to care.  
264

- 265 (5) An applicant shall not be required to be in compliance with subsection (1) if the applicant  
266 demonstrates that the application meets both of the following:  
267 (a) The Director of the Department determines that an exception to subsection (1) should be made  
268 and certifies in writing that the proposed project is a direct response to a Department plan for reducing the  
269 use of public institutions for acute mental health care through the closure of a state-owned psychiatric  
270 hospital; and  
271 (b) The proposed beds will be located in the area currently served by the public institution that will be  
272 closed, as determined by the Department.

273  
274 **Section 7. Requirements for approval to replace beds**

275  
276 Sec. 7. An applicant proposing to replace beds shall not be required to be in compliance with the  
277 needed bed supply if the applicant demonstrates all of the following:

- 278  
279 (1) The applicant shall specify whether the proposed project is to replace the existing licensed  
280 psychiatric hospital or unit to a new site or to replace a portion of the licensed psychiatric beds at the  
281 existing licensed site.  
282  
283 (2) The proposed licensed site is in the replacement zone.  
284  
285 (3) Not less than 50% of the beds proposed to be replaced shall be allocated for use by public  
286 patients.  
287  
288 (4) Previously made commitments, if any, to the Department or CMH to serve public patients have  
289 been fulfilled.  
290  
291 (5) Proof of current contract or documentation of contract renewal, if current contract is under  
292 negotiation, with the CMH or its designee that serves the planning area in which the proposed beds or  
293 service will be located.

294  
295 **(6) THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS**  
296 **APPLICABLE:**

297 **(a) THE EXISTING PSYCHIATRIC HOSPITAL OR UNIT SHALL HAVE AN AVERAGE**  
298 **OCCUPANCY RATE OF AT LEAST 60% FOR ADULT BEDS AND 40% FOR CHILD/ADOLESCENT**  
299 **BEDS.**

300 **(b) IF THE AVERAGE OCCUPANCY RATE FOR THE EXISTING PSYCHIATRIC HOSPITAL OR**  
301 **UNIT IS BELOW 60% FOR ADULT BEDS OR 40% FOR CHILD/ADOLESCENT BEDS, THEN THE**  
302 **APPLICANT PSYCHIATRIC HOSPITAL OR UNIT SHALL REDUCE THE APPROPRIATE NUMBER OF**  
303 **LICENSED BEDS TO ACHIEVE AN AVERAGE ANNUAL OCCUPANCY RATE OF AT LEAST 60% FOR**  
304 **ADULT BEDS OR 40% FOR CHILD/ADOLESCENT BEDS. THE APPLICANT PSYCHIATRIC**  
305 **HOSPITAL OR UNIT SHALL NOT EXCEED THE NUMBER OF BEDS CALCULATED AS FOLLOWS:**

306 **(i) FOR ADULT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE THE NUMBER**  
307 **OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH PERIOD WHERE**  
308 **VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .60.**

309 **(ii) DIVIDE THE RESULT OF SUBSECTION (i) ABOVE BY 1095 (OR 1096 IF THE 36-MONTH**  
310 **PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10,**  
311 **WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT**  
312 **THE EXISTING LICENSED PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER REPLACEMENT.**

313 **(iii) FOR CHILD/ADOLESCENT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE**  
314 **THE NUMBER OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH**  
315 **PERIOD WHERE VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .40.**

316 **(iv) DIVIDE THE RESULT OF SUBSECTION (iii) ABOVE BY 1095 (OR 1096 IF THE 36-MONTH**  
317 **PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10.**

318 **WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT**  
319 **THE EXISTING LICENSED PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER REPLACEMENT.**

320  
321 **Section 8. Requirements for approval of an applicant proposing to relocate existing licensed**  
322 **inpatient psychiatric beds**  
323

324 Sec. 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed  
325 capacity under Section 1(3) of these standards.  
326

327 (2) Any existing licensed inpatient psychiatric hospital or unit may relocate all or a portion of its beds  
328 to another existing licensed inpatient psychiatric hospital or unit located within the same planning area.  
329

330 (3) The inpatient psychiatric hospital or unit from which the beds are being relocated, and the  
331 inpatient psychiatric hospital or unit receiving the beds, shall not require any ownership relationship.  
332

333 (4) The relocated beds shall be licensed to the receiving inpatient psychiatric hospital or unit and will  
334 be counted in the inventory for the applicable planning area.  
335

336 (5) The relocation of beds under this section shall not be subject to a mileage limitation.  
337

338 (6) The relocation of beds under this section shall not result in initiation of a new adult or  
339 child/adolescent service.  
340

341 **(7) THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS**  
342 **APPLICABLE:**

343 **(a) THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT SHALL HAVE AN AVERAGE OCCUPANCY**  
344 **RATE OF AT LEAST 60% FOR ADULT BEDS AND 40% FOR CHILD/ADOLESCENT BEDS.**

345 **(b) IF THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT DOES NOT HAVE AN AVERAGE**  
346 **OCCUPANCY RATE OF AT LEAST 60% FOR ADULT BEDS AND 40% FOR CHILD/ADOLESCENT**  
347 **BEDS, THEN THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT SHALL REDUCE THE**  
348 **APPROPRIATE NUMBER OF LICENSED BEDS TO ACHIEVE AN AVERAGE OCCUPANCY RATE OF**  
349 **AT LEAST 60% FOR ADULT BEDS AND 40% FOR CHILD/ADOLESCENT BEDS UPON COMPLETION**  
350 **OF THE RELOCATION(S). THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT SHALL NOT EXCEED**  
351 **THE NUMBER OF BEDS CALCULATED AS FOLLOWS:**

352 **(i) FOR ADULT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE THE NUMBER**  
353 **OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH PERIOD WHERE**  
354 **VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .60.**

355 **(ii) DIVIDE THE RESULT OF SUBSECTION (i) ABOVE BY 1095 (OR 1096 IF THE 36-MONTH**  
356 **PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10,**  
357 **WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT**  
358 **THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER THE RELOCATION.**

359 **(iii) FOR CHILD/ADOLESCENT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE**  
360 **THE NUMBER OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 36-MONTH**  
361 **PERIOD WHERE VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .40.**

362 **(iv) DIVIDE THE RESULT OF SUBSECTION (iii) ABOVE BY 1095 (OR 1096 IF THE 36-MONTH**  
363 **PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10,**  
364 **WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT**  
365 **THE SOURCE PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER THE RELOCATION.**  
366

367 **(4) A SOURCE HOSPITAL SHALL APPLY FOR MULTIPLE RELOCATIONS ON THE SAME**  
368 **APPLICATION DATE, AND THE APPLICATIONS CAN BE COMBINED TO MEET THE CRITERIA OF**  
369 **(7)(b) ABOVE. A SEPARATE APPLICATION SHALL BE SUBMITTED FOR EACH PROPOSED**  
370 **RELOCATION.**

371  
372 **Section 9. Requirements for approval to increase beds**  
373

374 Sec. 9. An applicant proposing an increase in the number of adult or child/adolescent beds shall  
375 demonstrate or provide the following:  
376

377 **(1) AN APPLICANT PROPOSING NEW BEDS IN A PSYCHIATRIC HOSPITAL OR UNIT, EXCEPT**  
378 **AN APPLICANT MEETING THE REQUIREMENTS OF SUBSECTION (3), (9), or (10) SHALL**  
379 **DEMONSTRATE THAT** ~~The~~ the number of beds proposed in the CON application will not result in the  
380 number of existing adult or child/adolescent psychiatric beds, as applicable, in the planning area  
381 exceeding the bed need. However, an applicant may request and be approved for up to a maximum of  
382 10 beds if, when the total number of existing adult beds or existing child/adolescent beds is subtracted  
383 from the bed need for the planning area, the difference is equal to or more than 1 or less than 10.  
384

385 **(2) AN APPLICANT PROPOSING NEW BEDS IN A PSYCHIATRIC HOSPITAL OR UNIT, EXCEPT**  
386 **AN APPLICANT MEETING THE REQUIREMENTS OF SUBSECTION (3), (9), or (10) SHALL**  
387 **DEMONSTRATE THAT** ~~The~~ the average occupancy rate for the applicant's facility, where the proposed beds  
388 are to be located, was at least 70% for adult or child/adolescent beds, as applicable, during the most  
389 recent, consecutive 12-month period, as of the date of the submission of the application, for which  
390 verifiable data are available to the Department. **THIS SUBSECTION SHALL NOT APPLY IF ADDING**  
391 **BEDS FROM A SPECIAL POPULATION GROUP CONTAINED IN THE ADDENDUM TO THESE**  
392 **STANDARDS.**  
393

394 **(3) Subsections (1) and (2) shall not apply.** **AN APPLICANT MAY APPLY FOR THE ADDITION OF**  
395 **NEW BEDS** if all of the following **SUBSECTIONS** are met: **FURTHER, AN APPLICANT PROPOSING**  
396 **NEW BEDS AT AN EXISTING LICENSED PSYCHIATRIC HOSPITAL OR UNIT SITE SHALL NOT BE**  
397 **REQUIRED TO BE IN COMPLIANCE WITH THE NEEDED PSYCHIATRIC HOSPITAL BED SUPPLY IF**  
398 **THE APPLICATION MEETS ALL OTHER APPLICABLE CON REVIEW STANDARDS AND AGREES**  
399 **AND ASSURES TO COMPLY WITH ALL APPLICABLE PROJECT DELIVERY REQUIREMENTS.**

400 (a) The number of existing adult or child/adolescent psychiatric beds in the planning area is equal to  
401 or exceeds the bed need.

402 (b) The beds are being added at the existing licensed site.

403 (c) The average occupancy rate for the applicant's facility was at least 75% for facilities with 19 beds  
404 or less and 80% for facilities with 20 beds or more, as applicable, during the most recent, consecutive 12-  
405 month period, as of the date of the submission of the application, for which verifiable data are available to  
406 the Department.

407 (i) For a facility with flex beds,

408 (A) calculate the average occupancy rate as follows:

409 (1) For adult beds:

410 (a) Adult bed days are the number of licensed adult beds multiplied by the number of days they were  
411 licensed during the most recent consecutive 12-month period.

412 (b) Flex bed days are the number of licensed flex beds multiplied by the number of days the beds  
413 were used to serve a child/ adolescent patient.

414 (c) Subtract the flex bed days from the adult bed days and divide the adult patient days of care by  
415 this number, then multiply the result by 100.

416 (2) For child/adolescent beds:

417 (a) Child/adolescent bed days are the number of licensed child/adolescent beds multiplied by the  
418 number of days they were licensed during the most recent 12-month period.

419 (b) Flex bed days are the number of licensed flex beds multiplied by the number of days the beds  
420 were used to serve a child/ adolescent patient.

421 (c) Add the flex bed days to the child/adolescent bed days and divide the child/adolescent patient  
422 days of care by this number, then multiply the result by 100.

423 (d) The number of beds to be added shall not exceed the results of the following formula:

424 (ii) Multiply the facility's average daily census for the most recent, consecutive 12-month period, as  
425 of the date of the submission of the application, for which verifiable data are available to the Department  
426 by 1.5 for adult beds and 1.7 for child/adolescent beds.

427 (iii) Subtract the number of currently licensed beds from the number calculated in (ii) above. This is  
428 the maximum number of beds that may be approved pursuant to this subsection.

429  
430 (4) Proof of current contract or documentation of contract renewal, if current contract is under  
431 negotiation, with at least one CMH or its designee that serves the planning area in which the proposed  
432 beds or service will be located.

433  
434 (5) Previously made commitments, if any, to the Department or CMH to serve public patients have  
435 been fulfilled.

436  
437 (6) The number of beds proposed in the CON application to be allocated for use by public patients  
438 shall not be less than 50% of the beds proposed in the CON application. Applications proposed in direct  
439 response to a Department plan pursuant to subsection (9) shall allocate not less than 80% of the beds  
440 proposed in the CON application.

441  
442 (7) The minimum number of beds in a psychiatric unit shall be at least 10 beds. If a psychiatric unit  
443 has or proposes to operate both adult and child/adolescent beds, then each unit shall have a minimum of  
444 10 beds. The Department may approve an application for a unit of less than 10 beds, if the applicant  
445 demonstrates, to the satisfaction of the Department, that travel time to existing units would significantly  
446 impair access to care. **THIS SUBSECTION SHALL NOT APPLY IF ADDING BEDS FROM A SPECIAL**  
447 **POPULATION GROUP CONTAINED IN THE ADDENDUM TO THESE STANDARDS.**

448  
449 (8) Subsection (2) shall not apply if the Director of the Department has certified in writing that the  
450 proposed project is a direct response to a Department plan for reducing the use of public institutions for  
451 acute mental health care through the closure of a state-owned psychiatric hospital.

452  
453 (9) An applicant shall not be required to be in compliance with subsection (1) if the applicant  
454 demonstrates that the application meets both of the following:

455 (a) The Director of the Department determines that an exception to subsection (1) should be made  
456 and certifies in writing that the proposed project is a direct response to a Department plan for reducing the  
457 use of public institutions for acute mental health care through the closure of a state-owned psychiatric  
458 hospital; and

459 (b) The proposed beds will be located in the area currently served by the public institution that will be  
460 closed as determined by the Department.

461  
462 (10) An applicant proposing to add new adult and/or child/adolescent psychiatric beds, as the  
463 receiving licensed inpatient psychiatric hospital or unit under Section 8, shall demonstrate that it meets all  
464 of the requirements of this subsection and shall not be required to be in compliance with the bed need if  
465 the application meets all other applicable CON review standards and agrees and assures to comply with  
466 all applicable project delivery requirements.

467 (a) The approval of the proposed new inpatient psychiatric beds shall not result in an increase in the  
468 number of licensed inpatient psychiatric beds in the planning area.

469 (b) The applicant meets the requirements of subsections (4), (5), (6), and (7) above.

470 (c) The proposed project to add new adult and/or child adolescent psychiatric beds, under this  
471 subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.

472 (d) Applicants proposing to add new adult and/or child/adolescent psychiatric beds under this  
473 subsection shall not be subject to comparative review.

474

475 **Section 10. Requirements for approval for flex beds**

476



477 Sec. 10. An applicant proposing flex beds shall demonstrate the following as applicable to the  
478 proposed project:

479 (1) The applicant has existing adult psychiatric beds and existing child/adolescent psychiatric beds.  
480

481 (2) The number of flex beds proposed in the CON application shall not result in the existing adult  
482 psychiatric unit to become non-compliant with the minimum size requirements within Section 6(4).  
483

484 (3) The applicant shall meet all applicable sections of the standards.  
485

486 (4) The facility shall be in compliance and meet all design standards of the most recent Minimum  
487 Design Standards for Health Care Facilities in Michigan.  
488

489 (5) The applicant shall convert the beds back to adult inpatient psychiatric beds if the bed has not  
490 been used as a flex bed serving a child/adolescent patient for a continuous 12-month period or if the CON  
491 application is withdrawn.  
492

493  
494 **Section 11. Requirements for approval for acquisition of a psychiatric hospital or unit**  
495

496 Sec. 11. An applicant proposing to acquire a psychiatric hospital or unit shall not be required to be in  
497 compliance with the needed bed supply, for the planning area in which the psychiatric hospital or unit  
498 subject to the proposed acquisition is located, if the applicant demonstrates that all of the following are  
499 met:  
500

501 (1) The acquisition will not result in a change in the number of licensed beds or beds designated for a  
502 child/adolescent specialized psychiatric program.  
503

504 (2) The licensed site does not change as a result of the acquisition.  
505

506 **(3) THE APPLICANT SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS, AS**  
507 **APPLICABLE:**

508 **(a) THE EXISTING PSYCHIATRIC HOSPITAL OR UNIT SHALL HAVE AN AVERAGE**  
509 **OCCUPANCY RATE OF AT LEAST 60% FOR ADULT BEDS AND 40% FOR CHILD/ADOLESCENT**  
510 **BEDS.**

511 **(b) IF THE AVERAGE OCCUPANCY RATE FOR THE EXISTING PSYCHIATRIC HOSPITAL OR**  
512 **UNIT IS BELOW 60% FOR ADULT BEDS OR 40% FOR CHILD/ADOLESCENT BEDS, THE**  
513 **APPLICANT SHALL AGREE TO ALL OF THE FOLLOWING:**

514 **(i) THE PSYCHIATRIC HOSPITAL OR UNIT TO BE ACQUIRED WILL ACHIEVE AN AVERAGE**  
515 **OCCUPANCY RATE OF AT LEAST 60% AVERAGE ANNUAL OCCUPANCY FOR ADULT BEDS OR**  
516 **40% ANNUAL AVERAGE OCCUPANCY FOR CHILD/ADOLESCENT BEDS FOR THE REVISED**  
517 **LICENSED BED COMPLEMENT DURING ANY CONSECUTIVE 12-MONTH PERIOD BY THE END OF**  
518 **THE SECOND YEAR OF OPERATION AFTER COMPLETION OF THE ACQUISITION.**

519 **(A) CALCULATE AVERAGE OCCUPANCY RATE FOR ADULT BEDS AS FOLLOWS:**

520 **(1) ADD THE NUMBER OF ADULT PATIENT DAYS OF CARE TO THE NUMBER OF**  
521 **CHILD/ADOLESCENT PATIENT DAYS OF CARE PROVIDED IN THE FLEX BEDS; DIVIDE THIS**  
522 **NUMBER BY THE ADULT BED DAYS, THEN MULTIPLY THE RESULT BY 100.**

523 **(B) CALCULATE AVERAGE OCCUPANCY RATE FOR CHILD/ADOLESCENT BEDS AS**  
524 **FOLLOWS:**

525 **(1) SUBTRACT THE NUMBER OF CHILD/ADOLESCENT PATIENT DAYS OF CARE PROVIDED**  
526 **IN THE FLEX BEDS FROM THE NUMBER OF CHILD ADOLESCENT PATIENT DAYS OF CARE;**  
527 **DIVIDE THIS NUMBER BY THE CHILD/ADOLESCENT BED DAYS, THEN MULTIPLY THE RESULT BY**  
528 **100.**

529 (C) FLEX BEDS APPROVED UNDER SECTION 10 SHALL BE COUNTED AS EXISTING ADULT  
530 INPATIENT PSYCHIATRIC BEDS.

531 (c) IF THE PSYCHIATRIC HOSPITAL OR UNIT TO BE ACQUIRED DOES NOT ACHIEVE AN  
532 AVERAGE ANNUAL OCCUPANCY RATE OF AT LEAST 60% FOR ADULT BEDS OR 40% FOR  
533 CHILD/ADOLESCENT BEDS, AS CALCULATED ABOVE, DURING ANY CONSECUTIVE 12-MONTH  
534 PERIOD BY THE END OF THE SECOND YEAR OF OPERATION AFTER COMPLETION OF THE  
535 ACQUISITION, THE APPLICANT SHALL RELINQUISH SUFFICIENT BEDS AT THE EXISTING  
536 PSYCHIATRIC HOSPITAL OR UNIT TO RAISE ITS AVERAGE OCCUPANCY TO 60% FOR ADULT  
537 BEDS OR 40% FOR CHILD/ADOLESCENT BEDS. THE REVISED NUMBER OF LICENSED BEDS AT  
538 THE PSYCHIATRIC HOSPITAL OR UNIT SHALL BE CALCULATED AS FOLLOWS. HOWEVER, THE  
539 PSYCHIATRIC HOSPITAL OR UNIT SHALL NOT BE REDUCED TO LESS THAN 10 BEDS.

540 (i) FOR ADULT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE THE NUMBER  
541 OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 12-MONTH PERIOD WHERE  
542 VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .60.

543 (ii) DIVIDE THE RESULT OF SUBSECTION (i) ABOVE BY 365 (OR 366 IF THE 12-MONTH  
544 PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10,  
545 WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT  
546 THE EXISTING LICENSED PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER ACQUISITION.

547 (iii) FOR CHILD/ADOLESCENT BEDS, AS OF THE DATE OF THE APPLICATION, CALCULATE  
548 THE NUMBER OF PATIENT DAYS DURING THE MOST RECENT, CONSECUTIVE 12-MONTH  
549 PERIOD WHERE VERIFIABLE DATA IS AVAILABLE TO THE DEPARTMENT, AND DIVIDE BY .40.

550 (iv) DIVIDE THE RESULT OF SUBSECTION (iii) ABOVE BY 365 (OR 366 IF THE 12-MONTH  
551 PERIOD INCLUDES A LEAP YEAR) AND ROUND UP TO THE NEXT WHOLE NUMBER OR 10,  
552 WHICHEVER IS LARGER. THIS IS THE MAXIMUM NUMBER OF BEDS THAT CAN BE LICENSED AT  
553 THE EXISTING LICENSED PSYCHIATRIC HOSPITAL OR UNIT SITE AFTER ACQUISITION.

## 554 555 **Section 12. Additional requirements for applications included in comparative review**

556  
557 Sec. 12. (1) Any application subject to comparative review under Section 22229 of the Code, being  
558 Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and  
559 reviewed comparatively with other applications in accordance with the CON rules.

560  
561 (2) Each application in a comparative group shall be individually reviewed to determine whether the  
562 application has satisfied all the requirements of Section 22225 of the Code being Section 333.22225 of  
563 the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these  
564 standards. If the Department determines that two or more competing applications satisfy all of the  
565 requirements for approval, these projects shall be considered qualifying projects. The Department shall  
566 approve those qualifying projects which, when taken together, do not exceed the need, as defined in  
567 Section 22225(1) of the Code, and which have the highest number of points when the results of  
568 subsection (3) are totaled. If two or more qualifying projects are determined to have an identical number  
569 of points, then the Department shall approve those qualifying projects which, when taken together, do not  
570 exceed the need, in the order in which the applications were received by the Department, based on the  
571 date and time stamp placed on the applications by the Department in accordance with rule 325.9123.

572  
573 (3)(a) A qualifying project application will be awarded 5 points if, within six months of beginning  
574 operation and annually thereafter, 100% of the licensed psychiatric beds (both existing and proposed) at  
575 the facility will be Medicaid certified.

576 (b) A qualifying project will have 4 points deducted if, on or after November 26, 1995, the records  
577 maintained by the Department document that the applicant was required to enter into a contract with  
578 either the Department or a CMH to serve the public patient and did not do so.

579 (c) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records  
580 maintained by the Department document that the applicant entered into a contract with MDCH or CMH  
581 but never admitted any public patients referred pursuant to that contract.

- 582 (d) A qualifying project will have 5 points deducted if, on or after November 26, 1995, the records  
 583 maintained by the Department document that an applicant agreed to serve patients with an involuntary  
 584 commitment status but has not admitted any patients referred with an involuntary commitment status.  
 585 (e) A qualifying project will be awarded 3 points if the applicant presents, in its application, a plan,  
 586 acceptable to the Department, for the treatment of patients requiring long-term treatment. For purposes  
 587 of this subsection, long-term treatment is defined to mean an inpatient length of stay in excess of 45 days.  
 588 (f) A qualifying project will be awarded 3 points if the applicant currently provides a partial  
 589 hospitalization psychiatric program, outpatient psychiatric services, or psychiatric aftercare services, or  
 590 the applicant includes any of these services as part of their proposed project, as demonstrated by site  
 591 plans and service contracts.  
 592 (g) A qualifying project will have 4 points deducted if the Department has issued, within three years  
 593 prior to the date on which the CON application was deemed submitted, a temporary permit or provisional  
 594 license due to a pattern of licensure deficiencies at any psychiatric hospital or unit owned or operated by  
 595 the applicant in this state.  
 596 (h) A qualifying project will have points awarded based on the percentage of the hospital's indigent  
 597 volume as set forth in the following table.

598	599	600	601
	Hospital Indigent	Points	
	<u>Volume</u>	<u>Awarded</u>	
602	0 - <6%	1	
603	6 - <11%	2	
604	11 - <16%	3	
605	16 - <21%	4	
606	21 - <26%	5	
607	26 - <31%	6	
608	31 - <36%	7	
609	36 - <41%	8	
610	41 - <46%	9	
611	46% +	10	

612  
 613 For purposes of this subsection, indigent volume means the ratio of a hospital's indigent charges to its  
 614 total charges expressed as a percentage as determined by the Department pursuant to Chapter VIII of  
 615 the Medical Assistance Program manual. The indigent volume data being used for rates in effect at the  
 616 time the application is deemed submitted will be used by the Department in determining the number of  
 617 points awarded to each qualifying project.

618 (i) A qualifying project will have points deducted based on the applicant's record of compliance with  
 619 applicable safety and operating standards for any psychiatric hospital or unit owned and/or operated by  
 620 the applicant in this state. Points shall be deducted in accordance with the following schedule if, on or  
 621 after November 26, 1995, the Department records document any non-renewal or revocation of license for  
 622 cause or non-renewal or termination of certification for cause of any psychiatric hospital or unit owned or  
 623 operated by the applicant in this state.

624	625	626	627
	Psychiatric Hospital/Unit		
	<u>Compliance Action</u>	<u>Points Deducted</u>	
628	Non-renewal or revocation of license	4	
629			
630	Non-renewal or termination of:		
631			
632	Certification - Medicare	4	
633	Certification - Medicaid	4	

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

643  
644 **Section 13. Requirements for approval -- all applicants**  
645

646 Sec. 13. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a  
647 new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be  
648 provided to the Department within six (6) months from the offering of services if a CON is approved.

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

651  
652 (3) The applicant certifies that the health facility for the proposed project has not been cited for a  
653 state or federal code deficiency within the 12 months prior to the submission of the application. If a code  
654 deficiency has been issued, then the applicant shall certify that a plan of correction for cited state or  
655 federal code deficiencies at the health facility has been submitted and approved by the Bureau of Health  
656 Systems within the Department or, as applicable, the Centers for Medicare and Medicaid Services. If  
657 code deficiencies include any unresolved deficiencies still outstanding with the Department or the Centers  
658 for Medicare and Medicaid Services that are the basis for the denial, suspension, or revocation of an  
659 applicant's health facility license, poses an immediate jeopardy to the health and safety of patients, or  
660 meets a federal conditional deficiency level, the proposed project cannot be approved without approval  
661 from the Bureau of Health Systems.

662  
663 **Section 14. Project delivery requirements - terms of approval for all applicants**  
664

665 Sec. 14. An applicant shall agree that, if approved, the project shall be delivered in compliance with  
666 the following terms of CON approval:

- 667  
668 (1) Compliance with these standards.  
669  
670 (2) Compliance with the following applicable quality assurance standards:  
671 (a) The proposed licensed psychiatric beds shall be operated in a manner that is appropriate for a  
672 population with the ethnic, socioeconomic, and demographic characteristics including the developmental  
673 stage of the population to be served.  
674 (b) The applicant shall establish procedures to care for patients who are disruptive, combative, or  
675 suicidal and for those awaiting commitment hearings, and the applicant shall establish a procedure for  
676 obtaining physician certification necessary to seek an order for involuntary treatment for those persons  
677 that, in the judgment of the professional staff, meet the Mental Health Code criteria for involuntary  
678 treatment.  
679 (c) The applicant shall develop a standard procedure for determining, at the time the patient first  
680 presents himself or herself for admission or within 24 hours after admission, whether an alternative to  
681 inpatient psychiatric treatment is appropriate.  
682 (d) The inpatient psychiatric hospital or unit shall provide clinical, administrative, and support  
683 services that will be at a level sufficient to accommodate patient needs and volume, and will be provided  
684 seven days a week to assure continuity of services and the capacity to deal with emergency admissions.  
685  
686 (3) Compliance with the following access to care requirements:

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

689 (b) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:  
690 (i) not deny acute inpatient mental health services to any individual based on ability to pay, source of  
691 payment, age, race, handicap, national origin, religion, gender, sexual orientation or commitment status;  
692 (ii) provide acute inpatient mental health services to any individual based on clinical indications of  
693 need for the services; and  
694 (iii) maintain information by payor and non-paying sources to indicate the volume of care from each  
695 source provided annually. Compliance with selective contracting requirements shall not be construed as  
696 a violation of this term.  
697

698 (4) Compliance with the following monitoring and reporting requirements:  
699 (a) The average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at  
700 least 60 percent (%) for adult beds and 40 percent (%) for child/adolescent beds for the second 12  
701 months of operation, and annually thereafter.  
702 (i) Calculate average occupancy rate for adult beds as follows:  
703 (A) Add the number of adult patient days of care to the number of child/adolescent patient days of  
704 care provided in the flex beds; divide this number by the adult bed days, then multiply the result by 100.  
705 (ii) Calculate average occupancy rate for child/adolescent beds as follows:  
706 (A) Subtract the number of child/adolescent patient days of care provided in the flex beds from the  
707 number of child adolescent patient days of care; divide this number by the child/adolescent bed days,  
708 then multiply the result by 100.  
709 (b) Flex beds approved under section 10 shall be counted as existing adult inpatient psychiatric  
710 beds.  
711 (c) After the second 12 months of operation, if the average occupancy rate is below 60% for adult  
712 beds or 40% for child/adolescent beds, the number of beds shall be reduced to achieve a minimum of  
713 60% average annual occupancy for adult beds or 40% annual average occupancy for child/adolescent  
714 beds for the revised licensed bed complement. However, the psychiatric hospital or unit shall not be  
715 reduced to less than 10 beds.  
716 (d) The applicant shall participate in a data collection network established and administered by the  
717 Department or its designee. The data may include, but is not limited to: annual budget and cost  
718 information, operating schedules, and demographic, diagnostic, morbidity and mortality information, as  
719 well as the volume of care provided to patients from all payor sources. The applicant shall provide the  
720 required data on a separate basis for each licensed site; in a format established by the Department; and  
721 in a mutually agreed upon media. The Department may elect to verify the data through on-site review of  
722 appropriate records.  
723 (e) The applicant shall provide the Department with a notice stating the date the beds or services are  
724 placed in operation and such notice shall be submitted to the Department consistent with applicable  
725 statute and promulgated rules.  
726 (f) An applicant required to enter into a contract with a CMH(s) or the Department pursuant to these  
727 standards shall have in place, at the time the approved beds or services become operational, a signed  
728 contract to serve the public patient. The contract must address a single entry and exit system including  
729 discharge planning for each public patient. The contract shall specify that at least 50% or 80% of the  
730 approved beds, as required by the applicable sections of these standards, shall be allocated to the public  
731 patient, and shall specify the hospital's or unit's willingness to admit patients with an involuntary  
732 commitment status. The contract need not be funded.  
733

734 (5) Compliance with this Section shall be determined by the Department based on a report submitted  
735 by the applicant and/or other information available to the Department.  
736

737 (6) Nothing in this section prohibits the Department from taking compliance action under MCL  
738 333.22247.  
739

740 (7) The agreements and assurances required by this Section shall be in the form of a certification  
741 agreed to by the applicant or its authorized agent.  
742

743 **Section 15. Project delivery requirements - additional terms of approval for child/adolescent**  
744 **service**  
745

746 Sec. 15. (1) In addition to the provisions of Section 14, an applicant for a child/adolescent service  
747 shall agree to operate the program in compliance with the following terms of CON approval, as  
748 applicable:

749 (a) There shall be at least the following child and adolescent mental health professionals employed,  
750 either directly or by contract, by the hospital or unit, each of whom must have been involved in the  
751 delivery of child/adolescent mental health services for at least 2 years within the most recent 5 years:

- 752 (i) a child/adolescent psychiatrist;
- 753 (ii) a child psychologist;
- 754 (iii) a psychiatric nurse;
- 755 (iv) a psychiatric social worker;
- 756 (v) an occupational therapist or recreational therapist; and

757 (b) There shall be a recipient rights officer employed by the hospital or the program.

758 (c) The applicant shall identify a staff member(s) whose assigned responsibilities include discharge  
759 planning and liaison activities with the home school district(s).

760 (d) There shall be the following minimum staff employed either on a full time basis or access to on a  
761 consulting basis as needed:

- 762 (i) a pediatrician;
- 763 (ii) a child neurologist;
- 764 (iii) a neuropsychologist;
- 765 (iv) a speech and language therapist;
- 766 (v) an audiologist; and
- 767 (vi) a dietician.

768 (e) A child/adolescent service shall have the capability to determine that each inpatient admission is  
769 the appropriate treatment alternative consistent with Section 498e of the Mental Health Code, being  
770 Section 330.1498e of the Michigan Compiled Laws.

771 (f) The child/adolescent service shall develop and maintain a coordinated relationship with the home  
772 school district of any patient to ensure that all public education requirements are met.

773 (g) The applicant shall demonstrate that the child/adolescent service is integrated within the  
774 continuum of mental health services available in its planning area by establishing a formal agreement with  
775 the CMH(s) serving the planning area in which the child/adolescent specialized psychiatric program is  
776 located. The agreement shall address admission and discharge planning issues which include, at a  
777 minimum, specific procedures for referrals for appropriate community services and for the exchange of  
778 information with the CMH(s), the probate court(s), the home school district, the Michigan Department of  
779 Human Services, the parent(s) or legal guardian(s) and/or the patient's attending physician.  
780

781 (2) Compliance with this Section shall be determined by the Department based on a report submitted  
782 by the program and/or other information available to the Department.  
783

784 (3) The agreements and assurances required by this Section shall be in the form of a certification  
785 agreed to by the applicant or its authorized agent.  
786

787 **Section 16. Department inventory of beds**  
788

789 Sec. 16. The Department shall maintain, and provide on request, a listing of the Department Inventory  
790 of Beds for each adult and child/adolescent planning area.  
791

792 **Section 17. Planning areas**

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Sec. 17. The planning areas for inpatient psychiatric beds are the geographic boundaries of the groups of counties as follows.

<b><u>Planning Areas</u></b>	<b><u>Counties</u></b>
1	Livingston, Macomb, Monroe, 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, Montcalm, Muskegon, Newaygo, Oceana, Ottawa
5	Genesee, Lapeer, Shiawassee
6	Arenac, Bay, Clare, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Mecosta, Ogemaw, Osceola, Oscoda, Saginaw, Sanilac, Tuscola
7	Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Roscommon, Wexford
8	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

**Section 18. Effect on prior CON review standards; comparative reviews**

Sec. 18. (1) These CON review standards supercede and replace the CON Review Standards for Psychiatric Beds and Services, approved by the CON Commission on ~~December 13, 2012~~ **SEPTEMBER 21, 2016** and effective on ~~March 22, 2013~~ **DECEMBER 9, 2016**.

(2) Projects involving replacement beds, relocation of beds, flex beds under Section 10, or an increase in beds, approved pursuant to Section 7(3), are reviewed under these standards and shall not be subject to comparative review.

(3) Projects involving initiation of services or an increase in beds, approved pursuant to Section 6(1), are reviewed under these standards and shall be subject to comparative review.

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**RATIO OF ADULT INPATIENT PSYCHIATRIC  
BEDS PER 10,000 ADULT POPULATION**

The ratio per 10,000 adult population, for purposes of these standards, effective April 1, 2015, and until otherwise changed by the Commission, is as follows:

<b>PLANNING AREA</b>	<b>ADULT BEDS PER 10,000 ADULT POPULATION</b>
1	3.09143
2	2.40602
3	2.44460
4	2.39174
5	3.07912
6	1.75052
7	0.83839
8	2.26654
<b>STATE</b>	2.64279

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**CON REVIEW STANDARDS**  
**FOR CHILD/ADOLESCENT INPATIENT PSYCHIATRIC BEDS**

The use rate per 1000 population age 0-17, for purposes of these standards, effective April 1, 2015, and until otherwise changed by the Commission, is 25.664.

855 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

856  
857 CON REVIEW STANDARDS  
858 FOR PSYCHIATRIC BEDS AND SERVICES  
859 --ADDENDUM FOR SPECIAL POPULATION GROUPS  
860

861 (By authority conferred on the CON commission by Section 22215 of Act No. 368 of the Public Acts of  
862 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being  
863 sections 333.22215, 24.207 and 24.208 of the Michigan Compiled Laws.)  
864

865 **Section 1. Applicability; definitions**  
866

867 Sec. 1. (1) This addendum supplements the CON review standards for psychiatric beds and services  
868 and shall be used for determining the need for projects established to better meet the needs of special  
869 population groups within the mental health populations.  
870

871 (2) Except as provided in sections 2, 3, 4, 5, 6, and 7 of this addendum, these standards supplement,  
872 and do not supersede, the requirements and terms of approval required by the CON Review Standards  
873 for Psychiatric Beds and Services.  
874

875 (3) The definitions which apply to the CON Review Standards for Psychiatric Beds and Services shall  
876 apply to these standards.  
877

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

879 (a) "Developmental disability unit" means a unit designed for psychiatric patients (adult or  
880 child/adolescent as applicable) who have been diagnosed with a severe, chronic disability as outlined in  
881 Section 102, 42 USC 15002, of the Developmental Disabilities Assistance and Bill of Rights Act of 2000  
882 (DD Act) and its update or future guideline changes.

883 (b) "Geriatric psychiatric unit" means a unit designed for psychiatric patients aged 65 and over.

884 (c) "Medical psychiatric unit" means a unit designed for psychiatric patients (adult or child/adolescent  
885 as applicable) who have also been diagnosed with a medical illness requiring hospitalization, e.g.,  
886 patients who may be on dialysis, require wound care or need intravenous or tube feeding.  
887

888 **Section 2. Requirements for approval -- applicants proposing to increase psychiatric beds --**  
889 **special use exceptions**  
890

891 Sec. 2. A project to increase psychiatric beds in a planning area which, if approved, would otherwise  
892 cause the total number of psychiatric beds in that planning area to exceed the needed psychiatric bed  
893 supply or cause an increase in an existing excess as determined under the applicable CON review  
894 standards for psychiatric beds and services, may nevertheless be approved pursuant to this addendum.  
895

896 Section 3. Statewide pool for the needs of special population groups within the mental health populations  
897

898 Sec. 3. (1) A statewide pool of additional psychiatric beds consists of 370 beds needed in the state is  
899 established to better meet the needs of special population groups within the mental health populations.  
900 The number of beds in the pool is based on five percent of the statewide bed need for psychiatric  
901 inpatient beds rounded up to the next ten. Beds in the pool shall be distributed as follows and shall be  
902 reduced in accordance with subsection (2):

903 (a) Developmental disability beds will be allocated 110 adult beds and 20 child/adolescent beds.

904 (b) Geriatric psychiatric beds will be allocated 110 adult beds.

905 (c) Medical psychiatric beds will be allocated 110 adult beds and 20 child/adolescent beds.  
906

907 (2) By setting aside these beds from the total statewide pool, the Commission's action applies only to  
908 applicants seeking approval of psychiatric beds pursuant to sections 4, 5, and 6. It does not preclude the

909 care of these patients in units of hospitals, psychiatric hospitals, or other health care settings in  
910 compliance with applicable statutory or certification requirements.

911  
912 (3) Increases in psychiatric beds approved under this addendum for special population groups shall  
913 not cause planning areas currently showing an unmet bed need to have that need reduced or planning  
914 areas showing a current surplus of beds to have that surplus increased.

915  
916 (4) The Commission may adjust the number of beds available in the statewide pool for the needs of  
917 special population groups within the mental health populations concurrent with the biennial recalculation  
918 of the statewide psychiatric inpatient bed need. Modifying the number of beds available in the statewide  
919 pool for the needs of special population groups within the mental health populations pursuant to this  
920 section shall not require a public hearing or submittal of the standard to the Legislature and the Governor  
921 in order to become effective.

922  
923 **Section 4. Requirements for approval for beds from the statewide pool for special population**  
924 **groups allocated to developmental disability patients**

925  
926 Sec. 4. The CON commission determines there is a need for beds for applications designed to  
927 determine the efficiency and effectiveness of specialized programs for the care and treatment of  
928 developmental disability patients as compared to serving these needs in general psychiatric unit(s).

929  
930 (1) An applicant proposing to begin operation of a new adult or child/adolescent psychiatric service or  
931 add beds to an existing adult or child/adolescent psychiatric service under this section shall demonstrate  
932 with credible documentation to the satisfaction of the Department each of the following:

933 (a) The applicant shall submit evidence of accreditation as follows:  
934 (i) Documentation of its existing developmental disability program by the National Association for the  
935 Dually Diagnosed (NADD) or another nationally-recognized accreditation organization for developmental  
936 disability care and services; or  
937 (ii) within 24-months of accepting its first patient, the applicant shall obtain NADD or another  
938 nationally-recognized accreditation organization for the developmental disability beds proposed under this  
939 subsection.

940 (b) The applicant proposes programs to promote a culture within the facility that is appropriate for  
941 developmental disability patients.

942 (c) Staff will be specially trained in treatment of developmental disability patients.

943 (d) The proposed beds will serve only developmental disability patients.

944  
945 (2) All beds approved pursuant to this subsection shall be certified for Medicaid.

946  
947 **Section 5. Requirements for approval for beds from the statewide pool for special population**  
948 **groups allocated to geriatric psychiatric patients**

949  
950 Sec. 5. The CON commission determines there is a need for beds for applications designed to  
951 determine the efficiency and effectiveness of specialized programs for the care and treatment of geriatric  
952 psychiatric patients as compared to serving these needs in general psychiatric unit(s).

953  
954 (1) An applicant proposing to begin operation of a new adult psychiatric service or add beds to an  
955 existing adult psychiatric service under this section shall demonstrate with credible documentation to the  
956 satisfaction of the Department each of the following:

957 (a) The applicant shall submit evidence of accreditation as follows:

958 (i) Documentation of its existing geriatric psychiatric program by the Commission on Accreditation of  
959 Rehabilitation Facilities (CARF) or another nationally-recognized accreditation organization for geriatric  
960 psychiatric care and services; or

- 961 (ii) within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
962 nationally-recognized accreditation organization for the geriatric psychiatric beds proposed under this  
963 subsection.
- 964 (b) The applicant proposes programs to promote a culture within the facility that is appropriate for  
965 geriatric psychiatric patients.
- 966 (c) Staff will be specially trained in treatment of geriatric psychiatric patients.
- 967 (d) The proposed beds will serve only geriatric psychiatric patients.
- 968
- 969 (2) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.
- 970

971 **Section 6. Requirements for approval for beds from the statewide pool for special population**  
972 **groups allocated to medical psychiatric patients**

973

974 Sec. 6. The CON commission determines there is a need for beds for applications designed to  
975 determine the efficiency and effectiveness of specialized programs for the care and treatment of medical  
976 psychiatric patients as compared to serving these needs in general psychiatric unit(s).

977

978 (1) An applicant proposing to begin operation of a new adult or child/adolescent psychiatric service or  
979 add beds to an existing adult or child/adolescent psychiatric service under this section shall demonstrate  
980 with credible documentation to the satisfaction of the Department each of the following:

981 (a) The beds will be operated as part of a specialized program exclusively for adult or  
982 child/adolescent medical psychiatric patients, as applicable, within a licensed hospital licensed under part  
983 215 of the code.

984 (b) The applicant shall submit evidence of accreditation as follows:

985 (i) Documentation of its existing medical psychiatric program by CARF or another nationally-  
986 recognized accreditation organization for medical psychiatric care and services; or

987 (ii) within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
988 nationally-recognized accreditation organization for the medical psychiatric beds proposed under this  
989 subsection.

990 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
991 medical psychiatric patients.

992 (d) Staff will be specially trained in treatment of medical psychiatric patients.

993 (e) The proposed beds will serve only medical psychiatric patients.

994

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

996

997 **Section 7. Acquisition of psychiatric beds approved pursuant to this addendum**

998

999 Sec. 7. (1) An applicant proposing to acquire psychiatric beds from the statewide pool for special  
1000 population groups allocated to developmental disability shall meet the following:

1001 (a) The applicant shall submit evidence of accreditation of the existing developmental disability  
1002 program by the National Association for the Dually Diagnosed (NADD) or another nationally-recognized  
1003 accreditation organization for developmental disability care and services.

1004 (b) Within 24-months of accepting its first patient, the applicant shall obtain NADD or another  
1005 nationally-recognized accreditation organization for the developmental disability beds proposed under this  
1006 subsection.

1007 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
1008 developmental disability patients.

1009 (d) Staff will be specially trained in treatment of developmental disability patients.

1010 (e) The proposed beds will serve only developmental disability patients.

1011 (f) All beds approved pursuant to this subsection shall be certified for Medicaid.

1012

1013 (2) An applicant proposing to acquire psychiatric beds from the statewide pool for special population  
1014 groups allocated to geriatric psychiatric shall meet the following:

- 1015 (a) The applicant shall submit evidence of accreditation of the existing geriatric psychiatric program  
1016 by CARF or another nationally-recognized accreditation organization for geriatric psychiatric care and  
1017 services.
- 1018 (b) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
1019 nationally-recognized accreditation organization for the geriatric psychiatric beds proposed under this  
1020 subsection.
- 1021 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
1022 geriatric psychiatric patients.
- 1023 (d) Staff will be specially trained in treatment of geriatric psychiatric patients.
- 1024 (e) The proposed beds will serve only geriatric psychiatric patients.
- 1025 (f) All beds approved pursuant to this subsection shall be dually certified for Medicare and Medicaid.  
1026
- 1027 (3) An applicant proposing to acquire psychiatric beds from the statewide pool for special population  
1028 groups allocated to medical psychiatric shall meet the following:
- 1029 (a) The applicant shall submit evidence of accreditation of the existing medical psychiatric program  
1030 by CARF or another nationally-recognized accreditation organization for medical psychiatric care and  
1031 services.
- 1032 (b) Within 24-months of accepting its first patient, the applicant shall obtain CARF or another  
1033 nationally-recognized accreditation organization for the medical psychiatric beds proposed under this  
1034 subsection.
- 1035 (c) The applicant proposes programs to promote a culture within the facility that is appropriate for  
1036 medical psychiatric patients.
- 1037 (d) Staff will be specially trained in treatment of medical psychiatric patients.
- 1038 (e) The proposed beds will serve only medical psychiatric patients.
- 1039 (f) All beds approved pursuant to this subsection shall be certified for Medicaid.  
1040

1041 **Section 8. Project delivery requirements -- terms of approval for all applicants seeking approval**  
1042 **under section 3(1) of this addendum**  
1043

1044 Sec. 8. (1) An applicant shall agree that if approved, the services shall be delivered in compliance  
1045 with the terms of approval required by the CON Review Standards for Psychiatric Beds and Services.  
1046

1047 (2) An applicant for beds from the statewide pool for special population groups allocated to  
1048 developmental disability patients shall agree that, if approved, all beds approved pursuant to that  
1049 subsection shall be operated in accordance with the following terms of CON approval:

1050 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
1051 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
1052 applicant shall reduce beds to a number of beds necessary to result in a 80 percent average annual  
1053 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
1054 revert to the total statewide pool established for developmental disability beds.

1055 (b) An applicant shall staff the proposed unit for developmental disability patients with employees  
1056 that have been trained in the care and treatment of such individuals.

1057 (c) An applicant shall maintain NADD certification or another nationally-recognized accreditation  
1058 organization for developmental disability care and services.

1059 (d) An applicant shall establish and maintain written policies and procedures for each of the  
1060 following:

1061 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
1062 appropriate for admission to the developmental disability unit.

1063 (ii) The transfer of patients requiring care at other health care facilities.

1064 (iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment  
1065 plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.

1066 (e) If the specialized program is being added to an existing adult or child/adolescent psychiatric  
1067 service, then the existing licensed adult or child/adolescent psychiatric service, as applicable, shall

1068 maintain the volume requirements outlined in Section 14 of the CON Review Standards for Psychiatric  
1069 Beds and Services.

1070 (f) The developmental disability unit shall have a day/dining area within, or immediately adjacent to,  
1071 the unit(s), which is solely for the use of developmental disability patients.

1072 (g) The developmental disability unit shall have direct access to a secure outdoor or indoor area at  
1073 the facility appropriate for supervised activity.

1074 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
1075 for developmental disability patients.

1076

1077 (3) An applicant for beds from the statewide pool for special population groups allocated to geriatric  
1078 psychiatric patients shall agree that if approved, all beds approved pursuant to that subsection shall be  
1079 operated in accordance with the following terms of CON approval:

1080 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
1081 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
1082 applicant shall reduce beds to a number of beds necessary to result in a 80 percent average annual  
1083 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
1084 revert to the total statewide pool established for geriatric psychiatric beds.

1085 (b) An applicant shall staff the proposed unit for geriatric psychiatric patients with employees that  
1086 have been trained in the care and treatment of such individuals.

1087 (c) An applicant shall maintain CARF certification or another nationally-recognized accreditation  
1088 organization for geriatric psychiatric care and services.

1089 (d) An applicant shall establish and maintain written policies and procedures for each of the  
1090 following:

1091 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
1092 appropriate for admission to the geriatric psychiatric unit.

1093 (ii) The transfer of patients requiring care at other health care facilities.

1094 (iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment  
1095 plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.

1096 (e) If the specialized program is being added to an existing adult licensed psychiatric service, then  
1097 the existing licensed psychiatric service shall maintain the volume requirements outlined in Section 14 of  
1098 the CON Review Standards for Psychiatric Beds and Services.

1099 (f) The geriatric psychiatric unit shall have a day/dining area within, or immediately adjacent to, the  
1100 unit(s), which is solely for the use of geriatric psychiatric patients.

1101 (g) The geriatric psychiatric unit shall have direct access to a secure outdoor or indoor area at the  
1102 facility appropriate for supervised activity.

1103 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
1104 for geriatric psychiatric patients.

1105

1106 (4) An applicant for beds from the statewide pool for special population groups allocated to medical  
1107 psychiatric patients shall agree that, if approved, all beds approved pursuant to that subsection shall be  
1108 operated in accordance with the following CON terms of approval.

1109 (a) The applicant shall document, at the end of the third year following initiation of beds approved an  
1110 annual average occupancy rate of 80 percent or more. If this occupancy rate has not been met, the  
1111 applicant shall reduce beds to a number of beds necessary to result in a 80 percent average annual  
1112 occupancy for the third full year of operation and annually thereafter. The number of beds reduced shall  
1113 revert to the total statewide pool established for medical psychiatric beds.

1114 (b) An applicant shall staff the proposed unit for medical psychiatric patients with employees that  
1115 have been trained in the care and treatment of such individuals.

1116 (c) An applicant shall maintain CARF certification or another nationally-recognized accreditation  
1117 organization for medical psychiatric care and services.

1118 (d) An applicant shall establish and maintain written policies and procedures for each of the  
1119 following:

- 1120 (i) Patient admission criteria that describe minimum and maximum characteristics for patients  
1121 appropriate for admission to the medical psychiatric unit.
- 1122 (ii) The transfer of patients requiring care at other health care facilities.
- 1123 (iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment  
1124 plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge.
- 1125 (e) If the specialized program is being added to an existing licensed adult or child/adolescent  
1126 psychiatric service, then the existing adult or child/adolescent psychiatric service, as applicable, shall  
1127 maintain the volume requirements outlined in Section 14 of the CON Review Standards for Psychiatric  
1128 Beds and Services.
- 1129 (f) The medical psychiatric unit shall have a day/dining area within, or immediately adjacent to, the  
1130 unit(s), which is solely for the use of medical psychiatric patients.
- 1131 (g) The medical psychiatric unit shall have direct access to a secure outdoor or indoor area at the  
1132 facility appropriate for supervised activity.
- 1133 (h) The applicant shall maintain programs to promote a culture within the facility that is appropriate  
1134 for medical psychiatric patients.

1135

1136 **Section 9. Comparative reviews, effect on prior CON review standards**

1137

1138 Sec. 9. (1) Projects proposed under Section 4 shall be considered a distinct category and shall be  
1139 subject to comparative review on a statewide basis.

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1141 (2) Projects proposed under Section 5 shall be considered a distinct category and shall be subject to  
1142 comparative review on a statewide basis.

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1144 (3) Projects proposed under Section 6 shall be considered a distinct category and shall be subject to  
1145 comparative review on a statewide basis.

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