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

Thursday, June 18, 2020

Zoom Meeting

# APPROVED MINUTES

## I. Call to Order & Introductions

Chairperson Falahee called the meeting to order at 9:32 a.m.

A. Members Present:

James B. Falahee, Jr., JD, Chairperson
Thomas Mittelbrun, Vice-Chairperson
Denise Brooks-Williams
Lindsey Dood
Tressa Gardner, DO
Debra Guido-Allen, RN
Robert Hughes
Melanie LaLonde
Amy McKenzie, MD
Melisa Oca, MD

B. Members Absent:

Stewart Wang, MD

C. Department of Attorney General Staff:

Carl Hammaker

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

Tulika Bhattacharya
Beth Nagel
Tania Rodriguez
Brenda Rogers

## II. Review of Agenda

Motion by Commissioner Mittelbrun, seconded by Commissioner Hughes to approve the agenda as presented. Motion carried.

## III. Declaration of Conflicts of Interests

None.

## IV. Review of Minutes of January 30, 2020

Motion by Commissioner Gardner, seconded by Commissioner McKenzie to approve the minutes as presented. Motion carried.

## V. Psychiatric Beds and Services – Correction

Ms. Rogers gave an overview of the correction and the Department's recommendations (Attachment A).

A. Public Comment

None.

B. Commission Discussion

None.

C. Commission Action

Motion by Commissioner Brookes-Williams seconded by Commissioner Hughes to ask the Department to make the corrections as presented (Attachment A) retroactive to the effective date of November 12, 2019. Motion carried.

## VI. Computed Tomography (CT) Scanner Services – Workgroup Final Report and Draft Language

CT Workgroup Chairperson Geoffrey M. Remes, MD provided the report and presentation (Attachments B and C).

A. Public Comment

Tom Boike, Michigan Healthcare Professionals

B. Commission Discussion

None.

C. Commission Action

Motion by Commissioner Brooks-Williams, seconded by Commissioner Guido-Allen to take proposed action on the language (Attachment D) as presented and move forward to Public Hearing and to the Joint Legislative Committee (JLC). Motion carried.

**VII. Neonatal Intensive Care Services/Beds (NICU) *(Written Interim Report Only)***

NICU Workgroup Chairperson Oca provided an overview of the written report (Attachment E).

**VIII. Nursing Home/Hospital Long-Term Care Unit Beds (NH/HLTCU) – Public Hearing Summary**

Ms. Rogers gave an overview of the public hearing summary and the Department's recommendations (Attachment F).

A. Public Comment

Pat Anderson, Health Care Association of Michigan (HCAM)

B. Commission Discussion

None.

C. Commission Action

Motion by Commissioner Mittlebrun, seconded by Commissioner Brooks-Williams to take final action on the language (Attachment G) as presented and forward to the JLC and Governor for the 45-day review period. Motion carried.

**IX. NH/HLTCU Standard Advisory Committee (SAC) *(Written Interim Report Only)***

Chairperson Falahee mentioned the written report provided by NH/HLTCU SAC Chairperson Donald Haney (Attachment H).

**X. Positron Emission Tomography (PET) Scanner Services – Presentation/Charge**

Anthony Chang, PhD, BAMF Health provided the presentation (Attachment I). Roger Spoelman assisted with questions.

Motion by Commissioner Hughes, seconded by Commissioner Brooks-Williams to add to the PET workgroup language to investigate this area more closely (to review if specific requirements should be added to the PET standards for fixed novel whole-body PET/CT and PET/MR scanners located immediately adjacent to a modern cyclotron-equipped radiopharmacy). Motion carried.

## XI. Legislative Update

Chairperson Falahee provided an update.

## XII. Administrative Update

A. Planning & Access to Care Section Update

Ms. Nagel provided an update.

B. CON Evaluation Section Update

Ms. Bhattacharya provided an update on the following items:

1. Compliance Reports (Attachment J and K)
2. Quarterly Performance Measures (Attachments L and M)
3. Statewide Compliance Review for MRI (Attachment N)
4. Statewide Compliance Review for PET (Attachment O)

## XIII. Legal Activity Report

Mr. Hammaker provided an update on the CON legal activity (Attachment P).

## XIV. Future Meeting Dates: September 17, 2020 and December 10, 2020

## XV. Public Comment

None.

## XVI. Review of Commission Work Plan

Ms. Rogers provided an overview of the changes to the Work Plan including actions taken at today's meeting (Attachment Q).

A. Commission Discussion

None.

B. Commission Action

Motion by Commissioner Brooks-Williams, seconded by Commissioner Guido-Alllen to accept the Work Plan as presented with updates from today's meeting. Motion carried.

## XVII. Election of Officers

Motion by Commissioner Brooks-Williams, seconded by Commissioner Hughes, to nominate and elect Commissioner Falahee as the Chairperson and Commissioner Mittelbrun as Vice-Chairperson of the Commission. Motion Carried.

## XVIII. Adjournment

Motion by Commissioner Brooks-Williams, seconded by Commissioner Lalonde to adjourn the meeting at 11:13 a.m. Motion Carried.

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR PSYCHIATRIC BEDS AND SERVICES**

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

## Section 1. Applicability

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

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

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

## Section 2. Definitions

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

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

(b) “Adult” means any individual aged 18 years or older.

(c) “Average occupancy rate” is calculated as follows:

(i) Calculate the number of patient days during the most recent, consecutive 12-month period, as of the date of the application, for which verifiable data are available to the Department.

(ii) Calculate the total licensed bed days for the same 12-month period as in (i) above by multiplying the total licensed beds by the number of days they were licensed.

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

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

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

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

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

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

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

(j) "Department inventory of beds" means the current list maintained for each planning area on a continuing basis by the Department which includes:

(i) licensed adult and child/adolescent psychiatric beds; and

(ii) adult and child/adolescent psychiatric beds approved by a valid CON, which are not yet licensed. A separate inventory will be maintained for child/adolescent beds and adult beds.

(k) "Existing adult inpatient psychiatric beds" or "existing adult beds" means:

(i) all adult beds in psychiatric hospitals or units licensed by the Department pursuant to the Mental Health Code;

(ii) all adult beds approved by a valid CON, which are not yet licensed;

(iii) proposed adult beds under appeal from a final Department decision, or pending a hearing from a proposed decision; and

(iv) proposed adult beds that are part of a completed application (other than the application or applications in the comparative group under review) which are pending final Department decision.

(l) "Existing child/adolescent inpatient psychiatric beds" or "existing child/adolescent beds" means:

(i) all child/adolescent beds in psychiatric hospitals or units licensed by the Department pursuant to the Mental Health Code;

(ii) all child/adolescent beds approved by a valid CON, which are not yet licensed;

(iii) proposed child/adolescent beds under appeal from a final Department decision, or pending a hearing from a proposed decision; and

(iv) proposed child/adolescent beds that are part of a completed application (other than the application or applications in the comparative group under review) which are pending final Department decision.

(m) "Flex bed" means an existing adult psychiatric bed converted to a child/adolescent psychiatric bed in an existing child/adolescent psychiatric service to accommodate during peak periods and meet patient demand.

(n) "Initiation of service" means the establishment of an inpatient psychiatric unit with a specified number of beds at a site not currently providing psychiatric services.

(o) "Involuntary commitment status" means a hospital admission effected pursuant to the provisions of MCL 330.1423 to 330.1429.

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

(q) "Medicaid" means title XIX of the Social Security Act, chapter 531, 49 Stat. 620, 1396 to 1396g and 1396i to 1396u.

(r) "Mental Health Code" means Act 258 of the Public Acts of 1974, as amended, being Sections 330.1001 to 330.2106 of the Michigan Compiled Laws.

(s) "Mental health professional" means an individual who is trained and experienced in the area of mental illness or developmental disabilities and who is any 1 of the following:

(i) a physician who is licensed to practice medicine or osteopathic medicine and surgery in Michigan and who has had substantial experience with mentally ill, mentally retarded, or developmentally disabled clients for 1 year immediately preceding his or her involvement with a client under administrative rules promulgated pursuant to the Mental Health Code;

(ii) a psychologist who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;

(iii) a licensed master’s social worker licensed in Michigan Pursuant to the provisions of MCL 333.16101 to 333.18838;

(iv) a registered nurse who is licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;

(v) a licensed professional counsel or licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;

(vi) a marriage and family therapist licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838;

(vii) a professional person, other than those defined in the administrative rules promulgated pursuant to the Mental Health Code, who is designated by the Director of the Department or a director of a facility operated by the Department in written policies and procedures. This mental health professional shall have a degree in his or her profession and shall be recognized by his or her respective professional association as being trained and experienced in the field of mental health. The term does not include non-clinical staff, such as clerical, fiscal or administrative personnel.

(t) "Mental health service" means the provision of mental health care in a protective environment with mental illness or mental retardation, including, but not limited to, chemotherapy and individual and group therapies pursuant to MCL 330.2001.

(u) "Non-renewal or revocation of license" means the Department did not renew or revoked the psychiatric hospital's or unit's license based on the hospital's or unit's failure to comply with state licensing standards.

(v) "Non-renewal or termination of certification" means the psychiatric hospital's or unit's Medicare and/or Medicaid certification was terminated or not renewed based on the hospital's or unit's failure to comply with Medicare and/or Medicaid participation requirements.

(w) "Offer" means to provide inpatient psychiatric services to patients.

(x) "Physician" means an individual licensed in Michigan to engage in the practice of medicine or osteopathic medicine and surgery pursuant to MCL 333.16101 to 333.18838.

(y) "Planning area" means the geographic boundaries of the groups of counties shown in Section 16.

(z) "Planning year" means a year in the future, at least 3 years but no more than 7 years, for which inpatient psychiatric bed needs are developed. The planning year shall be a year for which official population projections from the Department of Technology, Management and Budget or its designee are available.

(aa) "Psychiatric hospital" means an inpatient program operated by the Department for the treatment of individuals with serious mental illness or serious emotional disturbance or a psychiatric hospital or psychiatric unit licensed under pursuant to MCL 330.1137.

(bb) "Psychiatrist" means 1 or more of the following, pursuant to MCL 330.1100c:

(i) a physician who has completed a residency program in psychiatry approved by the Accreditation Council for Graduate Medical Education or The American Osteopathic Association, or who has completed 12 months of psychiatric rotation and is enrolled in an approved residency program;

(ii) a psychiatrist employed by or under contract with the Department or a community health services program on March 28, 1996;

(iii) a physician who devotes a substantial portion of his or her time to the practice of psychiatry and is approved by the Director.

(cc) "Psychiatric unit" means a unit of a general hospital that provides inpatient services for individuals with serious mental illness or serious emotional disturbances pursuant to MCL 330.1100c.

(dd) "Psychologist" means an individual licensed to engage in the practice of psychology, who devotes a substantial portion of his or her time to the diagnosis and treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability, pursuant to MCL 333.16101 to 333.18838.

(ee) "Public patient" means an individual approved for mental health services by a CMH or an individual who is admitted as a patient under the Mental Health Code, Act No. 258 of the Public Acts of 1974, being Sections 330.1423, 330.1429, and 330.1438 of the Michigan Compiled Laws.

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

(gg) "Registered professional nurse" or "R.N." means an individual licensed in Michigan pursuant to the provisions of MCL 333.16101 to 333.18838.

(hh) "Relocate existing licensed inpatient psychiatric beds" means a change in the location of existing inpatient psychiatric beds from the existing licensed psychiatric hospital site to a different existing

licensed psychiatric hospital site within the same planning area. This definition does not apply to projects involving replacement beds in a psychiatric hospital or unit governed by Section 6 of these standards.

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

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

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

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

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

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

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

Sec. 3. (1) The number of child/adolescent inpatient psychiatric beds needed in a planning area shall be determined by the following formula:

(a) Tabulate the yearly number of child/adolescent patient days for the most recent five years of data from the CON Annual Survey.

(b) Construct a linear regression model with year as the independent variable and yearly patient days as the dependent variable. If the coefficient of determination ($R^2$) of the linear model is 0.5 or greater, use the regression parameters to predict the statewide patient days in the planning year. If the coefficient of determination of the linear model is less than 0.5, calculate the statewide patient days in the planning year by taking the mean of the most recent three years of data.

(c) Divide the total patient days obtained in subsection (b) by the statewide planning year population age 0-17. The result is the utilization rate for the population age 0-17 in the planning year.

(d) Multiply the utilization rate obtained in subsection (c) by the planning year population age 0-17 in each planning area. The result is the unadjusted number of child/adolescent patient days for each planning area in the planning year.

(e) Using the most recent data from the Department Inventory of Beds, calculate the average number of licensed child/adolescent beds per facility for each planning area.

(f) For planning areas with an average number of beds per facility less than 20, divide the unadjusted planning area patient days by 0.65. For planning areas with an average number of beds per facility of 20 or more, divide the unadjusted planning area patient days by 0.70. The result is the occupancy-adjusted number of child/adolescent patient days for each planning area in the planning year.

(g) For each planning area, divide the occupancy-adjusted number of child/adolescent patient days from (f) by 365 (or 366 for leap years). Round the values up to the nearest whole number. The result is child/adolescent bed need in the planning year.

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

(a) Tabulate the yearly number of adult patient days for the most recent five years of data from the CON Annual Survey.

(b) Construct a linear regression model with year as the independent variable and yearly patient days as the dependent variable. If the coefficient of determination ($R^2$) of the linear model is 0.5 or greater, use the regression parameters to predict the statewide patient days in the planning year. If the coefficient of determination of the linear model is less than 0.5, calculate the statewide patient days in the planning year by taking the mean of the most recent three years of data.

(c) Divide the total patient days obtained in subsection (b) by the statewide planning year population age 18+. The result is the utilization rate for the population age 18+ in the planning year.

(d) Multiply the utilization rate obtained in subsection (c) by the planning year population age 18+ in each planning area. The result is the unadjusted number of adult patient days for each planning area in the planning year.

(e) Using the most recent data from the Department Inventory of Beds, calculate the average number of licensed adult beds per facility for each planning area.

(f) For planning areas with an average number of beds per facility less than 20, divide the unadjusted planning area patient days by 0.65. For planning areas with an average number of beds per facility of 20 or more, divide the unadjusted planning area patient days by 0.70. The result is the occupancy-adjusted number of adult patient days for each planning area in the planning year.

(g) For each planning area, divide the occupancy-adjusted number of adult patient days from (f) by 365 (or 366 for leap years). Round the values up to the nearest whole number. The result is adult bed need in the planning year.

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

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

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

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

(4) New bed need numbers shall supercede previous bed need numbers and shall be posted on the State of Michigan CON web site as part of the Psychiatric Bed Inventory.

(5) Modifications made by the Commission pursuant to this Section shall not require Standard Advisory Committee action, a public hearing, or submittal of the standard to the Legislature and the Governor in order to become effective.

**Section 5. Requirements for approval to initiate service**

Sec. 5. An applicant proposing the initiation of an adult or child/adolescent psychiatric service shall demonstrate or provide the following:

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

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

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

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

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

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

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

**Section 6. Requirements for approval to replace beds**

Sec. 6. An applicant proposing to replace beds shall not be required to be in compliance with the needed bed supply if the applicant demonstrates all of the following:

(1) The applicant shall specify whether the proposed project is to replace the existing licensed psychiatric hospital or unit to a new site or to replace a portion of the licensed psychiatric beds at the existing licensed site.

(2) The proposed licensed site is in the replacement zone.

(3) Not less than 50% of the beds proposed to be replaced shall be allocated for use by public patients.

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

(5) Proof of current contract or documentation of contract renewal, if current contract is under negotiation, with the CMH or its designee that serves the planning area in which the proposed beds or service will be located.

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

(a) The existing psychiatric hospital or unit shall have an average occupancy rate of at least 60% for adult beds and 40% for child/adolescent beds.

(b) If the average occupancy rate for the existing psychiatric hospital or unit is below 60% for adult beds or 40% for child/adolescent beds, then the applicant psychiatric hospital or unit shall reduce the appropriate number of licensed beds to achieve an average annual occupancy rate of at least 60% for adult beds or 40% for child/adolescent beds. The applicant psychiatric hospital or unit shall not exceed the number of beds calculated as follows:

(i) For adult beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed psychiatric hospital or unit site after replacement.

(iii) For child/adolescent beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .40.

(iv) Divide the result of subsection (iii) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed psychiatric hospital or unit site after replacement.

**Section 7. Requirements for approval of an applicant proposing to relocate existing licensed inpatient psychiatric beds**

Sec. 7. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(3) of these standards.

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

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

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

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

(6) The relocation of beds under this section shall not result in initiation of a new adult or child/adolescent service except for an existing adult inpatient psychiatric service requesting to initiate a child/adolescent inpatient psychiatric service in an overbedded child/adolescent planning area pursuant to Section 8(11).

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

(a) The source psychiatric hospital or unit shall have an average occupancy rate of at least 60% for adult beds and 40% for child/adolescent beds.

(b) If the source psychiatric hospital or unit does not have an average occupancy rate of at least 60% for adult beds and 40% for child/adolescent beds, then the source psychiatric hospital or unit shall reduce the appropriate number of licensed beds to achieve an average occupancy rate of at least 60% for adult beds and 40% for child/adolescent beds upon completion of the relocation(s). The source psychiatric hospital or unit shall not exceed the number of beds calculated as follows:

(i) For adult beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the source psychiatric hospital or unit site after the relocation.

(iii) For child/adolescent beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 36-month period where verifiable data is available to the Department, and divide by .40.

(iv) Divide the result of subsection (iii) above by 1095 (or 1096 if the 36-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the source psychiatric hospital or unit site after the relocation.

(8) A source hospital shall apply for multiple relocations on the same application date, and the applications can be combined to meet the criteria of (7)(b) above. A separate application shall be submitted for each proposed relocation.

**Section 8. Requirements for approval to increase beds**

Sec. 8. An applicant proposing an increase in the number of adult or child/adolescent beds shall demonstrate or provide the following:

(1) An applicant proposing new beds in a psychiatric hospital or unit, except an applicant meeting the requirements of subsection (3), (9), or (10) shall demonstrate that the number of beds proposed in the CON application will not result in the number of existing adult or child/adolescent psychiatric beds, as applicable, in the planning area exceeding the bed need. However, an applicant may request and be approved for up to a maximum of 10 beds if, when the total number of existing adult beds or existing child/adolescent beds is subtracted from the bed need for the planning area, the difference is equal to or more than 1 or less than 10.

(2) An applicant proposing new beds in a psychiatric hospital or unit, except an applicant meeting the requirements of subsection (3), (9), or (10) shall demonstrate that the average occupancy rate for the applicant's facility, where the proposed beds are to be located, was at least 70% for adult or child/adolescent beds, as applicable, during the most recent, consecutive 12-month period, as of the date of the submission of the application, for which verifiable data are available to the Department. This subsection shall not apply if adding beds from a special population group contained in the addendum to these standards. For purposes of this section, average occupancy rate shall be calculated as follows:
(a) Divide the number of patient days of care provided by the total number of patient days, then multiply the result by 100.

(3) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed psychiatric hospital or unit site shall not be required to be in compliance with the needed psychiatric hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
(a) The number of existing adult or child/adolescent psychiatric beds in the planning area is equal to or exceeds the bed need.
(b) The beds are being added at the existing licensed site.
(c) The average occupancy rate for the applicant's facility was at least 75% for facilities with 19 beds or less and 80% for facilities with 20 beds or more, as applicable, during the most recent, consecutive 12-month period, as of the date of the submission of the application, for which verifiable data are available to the Department.
(i) For a facility with flex beds,
(A) calculate the average occupancy rate as follows:
(1) For adult beds:
(a) Adult bed days are the number of licensed adult beds multiplied by the number of days they were licensed during the most recent consecutive 12-month period.
(b) Flex bed days are the number of licensed flex beds multiplied by the number of days the beds were used to serve a child/ adolescent patient.
(c) Subtract the flex bed days from the adult bed days and divide the adult patient days of care by this number, then multiply the result by 100.

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

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

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

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

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

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

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

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

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

(7) The minimum number of beds in a psychiatric unit shall be at least 10 beds. If a psychiatric unit has or proposes to operate both adult and child/adolescent beds, then each unit shall have a minimum of 10 beds. The Department may approve an application for a unit of less than 10 beds, if the applicant demonstrates, to the satisfaction of the Department, that travel time to existing units would significantly impair access to care. This subsection shall not apply if adding beds from a special population group contained in the addendum to these standards.

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

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

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

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

(10) An applicant proposing to add new adult and/or child/adolescent psychiatric beds, as the receiving licensed inpatient psychiatric hospital or unit under Section 7, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the bed need if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

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

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

(c) The proposed project to add new adult and/or child adolescent psychiatric beds, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.
(d) Applicants proposing to add new adult and/or child/adolescent psychiatric beds under this subsection shall not be subject to comparative review.

(11) An applicant proposing to initiate a new child/adolescent psychiatric service, as the receiving licensed inpatient psychiatric hospital or unit under Section 7(6), shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the bed need if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
(a) The approval of the proposed new inpatient psychiatric beds shall not result in an increase in the number of licensed inpatient psychiatric beds in the planning area.
(b) The applicant meets the requirements of subsections (4), (5), and (6) above.
(c) The applicant is requesting a minimum of 10 child/adolescent psychiatric beds to a maximum of 20 beds.
(d) The applicant:
(i) is related through common ownership, in whole or in part, or through common control, with an acute-care hospital that has an emergency department that provides 24-hour emergency care services and where child/adolescent patients with a psychiatric and/or developmental disability diagnosis present at an average of at least 100 visits per year for each of the three most recent years in which there is data verifiable by the Department; and
(ii) has an agreement with the acute-care hospital to give primary consideration for admission of child/adolescent patients from the acute-care hospital's emergency department in need of an inpatient psychiatric hospital admission.
(iii) has a collaborative agreement with an existing child/adolescent psychiatric hospital or unit for consultation and supportive services with a proposed term of not less than twelve months after implementation.
(e) The proposed site for the new child/adolescent beds has not previously been approved for beds under this sub-section.
(f) The proposed project to add new child adolescent psychiatric beds, under this subsection, shall constitute a change in bed capacity under Section 1(2) of these standards.
(g) Applicants proposing to add new child/adolescent psychiatric beds under this subsection shall not be subject to comparative review.

**Section 9. Requirements for approval for flex beds**

Sec. 9. An applicant proposing flex beds shall demonstrate the following as applicable to the proposed project:

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

(2) The number of flex beds proposed in the CON application shall not result in the existing adult psychiatric unit to become non-compliant with the minimum size requirements within Section 5(4).

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

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

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

**Section 10. Requirements for approval for acquisition of a psychiatric hospital or unit**

Sec. 10. An applicant proposing to acquire a psychiatric hospital or unit shall not be required to be in compliance with the needed bed supply, for the planning area in which the psychiatric hospital or unit subject to the proposed acquisition is located, if the applicant demonstrates that all of the following are met:

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

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

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

(a) The existing psychiatric hospital or unit shall have an average occupancy rate of at least 60% for adult beds and 40% for child/adolescent beds.

(b) If the average occupancy rate for the existing psychiatric hospital or unit is below 60% for adult beds or 40% for child/adolescent beds, the applicant shall agree to all of the following:

(i) The psychiatric hospital or unit to be acquired will achieve an average occupancy rate of at least 60% average annual occupancy for adult beds or 40% annual average occupancy for child/adolescent beds for the revised licensed bed complement during any consecutive 12-month period by the end of the second year of operation after completion of the acquisition.

(A) Calculate average occupancy rate for adult beds as follows:

(1) Add the number of adult patient days of care to the number of child/adolescent patient days of care provided in the flex beds; divide this number by the adult bed days, then multiply the result by 100.

(B) Calculate average occupancy rate for child/adolescent beds as follows:

(1) Subtract the number of child/adolescent patient days of care provided in the flex beds from the number of child adolescent patient days of care; divide this number by the child/adolescent bed days, then multiply the result by 100.

(C) Flex beds approved under Section 9 shall be counted as existing adult inpatient psychiatric beds.

(c) If the psychiatric hospital or unit to be acquired does not achieve an average annual occupancy rate of at least 60% for adult beds or 40% for child/adolescent beds, as calculated above, during any consecutive 12-month period by the end of the second year of operation after completion of the acquisition, the applicant shall relinquish sufficient beds at the existing psychiatric hospital or unit to raise its average occupancy to 60% for adult beds or 40% for child/adolescent beds. The revised number of licensed beds at the psychiatric hospital or unit shall be calculated as follows. However, the psychiatric hospital or unit shall not be reduced to less than 10 beds.

(i) For adult beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 12-month period where verifiable data is available to the Department, and divide by .60.

(ii) Divide the result of subsection (i) above by 365 (or 366 if the 12-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed psychiatric hospital or unit site after acquisition.

(iii) For child/adolescent beds, as of the date of the application, calculate the number of patient days during the most recent, consecutive 12-month period where verifiable data is available to the Department, and divide by .40.

(iv) Divide the result of subsection (iii) above by 365 (or 366 if the 12-month period includes a leap year) and round up to the next whole number or 10, whichever is larger. This is the maximum number of beds that can be licensed at the existing licensed psychiatric hospital or unit site after acquisition.

**Section 11. Additional requirements for applications included in comparative review**

Sec. 11. (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 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 3 points if it submits site plans or service contracts to demonstrate it will include any of these services as part of its proposed project.

(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 provisional license FOR 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 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.

| 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 BELOW | |
| The highest applicant has 58.3% Medicaid days | 10 points |
| Applicant with 55.3% Medicaid days | (.553 / .583) X 10 = 9 points |
| Applicant with 51.3% Medicaid days | (.513 / .583) X 10 = 9 points |

Percentages of days shall be rounded to the nearest 1/1000 and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(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.

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

(f) 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 the lowest cost per bed | ~~10~~ 7 POINTS |
| All other applicants | LOWEST ~~Applicant's~~ applicant's cost per bed divided by the ~~lowest~~ applicant's cost per bed, then multiplied by 7 |
| Example below | |
| The lowest cost applicant is $698,000 per bed | 7 points |
| Applicant with $710,000 per bed | ($698,000 / $710,000) X 7 = 7 points |
| Applicant with $975,000 per bed | ($698,000 / $975,000) X 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, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(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, with credible documentation acceptable to the Department, 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 the following: 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 TO EXISTING BEDS OF THE SAME TYPE | POINTS AWARDED |
|---|---|
| Less than 30 miles | 0 |
| Between 30 and 60 miles | 1 |
| Between 60 and 90 miles | 2 |
| Greater than 90 miles | 3 |

For purposes of scoring this criteria, the applicant shall submit data using the Michigan State University Geocoder located on the Department's website and the Department's Inventory of Beds at the time the application is deemed submitted.

(k) A qualifying project that proposes beds under the addendum for special population groups, Section 7 for high acuity psychiatric patients, will be awarded 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 HIGH ACUITY BEDS LOCATED IN PRIVATE ROOMS | POINTS AWARDED |
|---|---|
| Applicant with highest percentage of high acuity 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 below | |
| The applicant with the highest percentage of beds in private rooms is 90.0% | 7 points |
| Applicant with 80.0% of beds in private rooms | (.800 / .900) x 7 = 6 points |

| | |
|---|---|
| Applicant with 70.5% beds in private rooms | (.750 / .900) x 7 = 5 points |

Percentages of beds in private rooms shall be rounded to the nearest 1/1000 and points awarded shall be rounded to the nearest whole number, i.e. numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

(4) 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 12. Requirements for approval -- all applicants**

Sec. 12. (1) An applicant shall provide verification of Medicaid participation. An applicant that is a new provider not currently enrolled in Medicaid shall certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.

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

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

**Section 13. Project delivery requirements - terms of approval for all applicants**

Sec. 13. An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

(1) Compliance with these standards.

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

(a) The proposed licensed psychiatric beds shall be operated in a manner that is appropriate for a population with the ethnic, socioeconomic, and demographic characteristics including the developmental stage of the population to be served.

(b) The applicant shall establish procedures to care for patients who are disruptive, combative, or suicidal and for those awaiting commitment hearings, and the applicant shall establish a procedure for obtaining physician certification necessary to seek an order for involuntary treatment for those persons that, in the judgment of the professional staff, meet the Mental Health Code criteria for involuntary treatment.

(c) The applicant shall develop a standard procedure for determining, at the time the patient first presents himself or herself for admission or within 24 hours after admission, whether an alternative to inpatient psychiatric treatment is appropriate.

(d) The inpatient psychiatric hospital or unit shall provide clinical, administrative, and support services that will be at a level sufficient to accommodate patient needs and volume and will be provided seven days a week to assure continuity of services and the capacity to deal with emergency admissions.

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

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

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

(i) not deny acute inpatient mental health services to any individual based on ability to pay, source of payment, age, race, handicap, national origin, religion, gender, sexual orientation or commitment status;

(ii) provide acute inpatient mental health services to any individual based on clinical indications of need for the services; and

(iii) maintain information by payor and non-paying sources to indicate the volume of care from each source provided annually. Compliance with selective contracting requirements shall not be construed as a violation of this term.

(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.

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

(a) The average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at least 60 percent (%) for adult beds and 40 percent (%) for child/adolescent beds for the second 12 months of operation, and annually thereafter.

(i) Calculate average occupancy rate for adult beds as follows:

(A) Add the number of adult patient days of care to the number of child/adolescent patient days of care provided in the flex beds; divide this number by the adult bed days, then multiply the result by 100.

(ii) Calculate average occupancy rate for child/adolescent beds as follows:

(A) Subtract the number of child/adolescent patient days of care provided in the flex beds from the number of child adolescent patient days of care; divide this number by the child/adolescent bed days, then multiply the result by 100.

(b) Flex beds approved under section 9 shall be counted as existing adult inpatient psychiatric beds.

(c) After the second 12 months of operation, if the average occupancy rate is below 60% for adult beds or 40% for child/adolescent beds, the number of beds shall be reduced to achieve a minimum of 60% average annual occupancy for adult beds or 40% annual average occupancy for child/adolescent beds for the revised licensed bed complement. However, the psychiatric hospital or unit shall not be reduced to less than 10 beds.

(d) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to: annual budget and cost information, operating schedules, and demographic, diagnostic, morbidity and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site; in a format established by the Department; and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

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

(f) An applicant required to enter into a contract with a CMH(s) or the Department pursuant to these standards shall have in place, at the time the approved beds or services become operational, a signed contract to serve the public patient. The contract must address a single entry and exit system including discharge planning for each public patient. The contract shall specify that at least 50% or 80% of the approved beds, as required by the applicable sections of these standards, shall be allocated to the public patient, and shall specify the hospital's or unit's willingness to admit patients with an involuntary commitment status. The contract need not be funded.

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

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

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

**Section 14. Project delivery requirements - additional terms of approval for child/adolescent service**

Sec. 14. (1) In addition to the provisions of Section 13, an applicant for a child/adolescent service shall agree to operate the program in compliance with the following terms of CON approval, as applicable:

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

(i) a child/adolescent psychiatrist;

(ii) a child psychologist;

(iii) a psychiatric nurse;

(iv) a psychiatric social worker;

(v) an occupational therapist or recreational therapist; and

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

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

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

(i) a pediatrician;

(ii) a child neurologist;

(iii) a neuropsychologist;

(iv) a speech and language therapist;

(v) an audiologist; and

(vi) a dietician.

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

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

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

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

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

**Section 15. Department inventory of beds**

Sec. 15. The Department shall maintain, and provide on request, a listing of the Department Inventory of Beds for each adult and child/adolescent planning area.

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**Section 16. Planning areas**

Sec. 16. The planning areas for inpatient psychiatric beds are the geographic boundaries of the groups of counties as follows.

| Planning Areas | Counties |
|---|---|
| 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 17. Effect on prior CON review standards; comparative reviews**

Sec. 17. (1) These CON review standards supercede and replace the CON Review Standards for Psychiatric Beds and Services, approved by the CON Commission on March 21, 2019 and effective on May 24, 2019.

(2) Projects involving replacement beds, relocation of beds, flex beds under Section 9, or an increase in beds, approved pursuant to Section 6(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 5(1), are reviewed under these standards and shall be subject to comparative review.

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CON REVIEW STANDARDS**
**FOR PSYCHIATRIC BEDS AND SERVICES**
**--ADDENDUM FOR SPECIAL POPULATION GROUPS**

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

**Section 1. Applicability; definitions**

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

(2) Except as provided in sections 2, 3, 4, 5, 6, 7 and 8 of this addendum, these standards supplement, and do not supersede, the requirements and terms of approval required by the CON Review Standards for Psychiatric Beds and Services.

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

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

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

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

(c) "High acuity psychiatric unit" means a distinct psychiatric unit for individuals who are currently exhibiting three or more to a moderate degree or two or more to a severe degree of the following: confusion, irritability, boisterousness, poor impulse control, uncooperativeness, hostility, verbal threats, physical threats, or attacking objects. This term also includes patients who are unwilling or unable to stop attempts at self-harm or suicide or patients who have a history of violence to self or others on an inpatient psychiatric unit.

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

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

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

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

Sec. 3. (1) A statewide pool of additional psychiatric beds consists of 850 beds needed in the state is established to better meet the needs of special population groups within the mental health populations.

The number of beds in the developmental disability, geriatric and medical psychiatric pools are based on seven and a half percent of the statewide bed need for psychiatric inpatient beds rounded up to the next ten with a minimum of 50 child/adolescent beds in each special pool, as applicable. The number of beds in the high acuity pool is based on ten percent of the statewide bed need for psychiatric inpatient beds rounded up to the next ten with a minimum of 50 child/adolescent beds. Beds in the pool shall be distributed as follows and shall be reduced in accordance with subsection (2):

(a) Developmental disability beds will be allocated 160 adult beds and 50 child/adolescent beds.
(b) Geriatric psychiatric beds will be allocated 160 adult beds.
(c) Medical psychiatric beds will be allocated 160 adult beds and 50 child/adolescent beds.
(d) High acuity psychiatric beds will be allocated 220 adult beds and 50 child/adolescent beds.

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

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

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

(5) Beds approved under subsections 4, 5, 6, and 7 shall not be converted to or utilized as general psychiatric beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The beds will be operated as part of a specialized program exclusively for adult or child/adolescent medical psychiatric patients, as applicable, within one of the following settings:

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

(ii) an adult or child/adolescent psychiatric service or unit with a written collaborative agreement with a licensed hospital licensed under part 215 of the code that is provided as part of the application and includes all of the following:

(A) Procedures for joint credentialing criteria and recommendations for physicians approved to treat medical psychiatric patients.

(B) Provisions for regularly held joint psychiatric and medical conferences to include review of all medical psychiatric cases.

(C) A mechanism to provide for appropriate transfers between facilities and an agreed upon plan for prompt care.

(D) Consultation on facilities, equipment, staffing, ancillary services, and policies and procedures for the provision of medical psychiatric treatment.

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

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

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

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

(d) Staff, including contracted staff, will be specially trained in treatment of medical psychiatric patients.

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

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

**Section 7. Requirements for approval for beds from the statewide pool for special population groups allocated to high acuity psychiatric patients**

Sec 7. The CON commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of high acuity psychiatric patients as compared to serving these needs in a general psychiatric unit(s).

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

(a) The beds shall be operated as part of a specialized program exclusively for adult or child/adolescent patients classified as high acuity.

(b) The applicant shall submit evidence with credible documentation acceptable to the Department of the following:

(i) The proposed unit shall consist of a majority of private rooms and shall include environmental safety measures that meet standards from the Joint Commission and the Centers for Medicare and Medicaid Services throughout the entire unit.

(ii) The proposed unit shall have a physical environment designed to minimize noise and light reflections to promote visual and spatial orientation.

(iii) The proposed unit's staff shall be specially trained in the treatment of high acuity patients with non-violent intervention modalities such as non-abusive psychological and physical intervention, crisis intervention institute training or similar programs.

(iv) The proposed unit shall demonstrate a plan for the safe management of agitated or aggressive patients.

(c) The proposed beds will serve only high acuity psychiatric patients.

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

**Section 8. Acquisition of psychiatric beds approved pursuant to this addendum**

Sec. 8. (1) An applicant proposing to acquire psychiatric beds from the statewide pool for special population groups allocated to developmental disability shall meet the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An applicant proposing to acquire psychiatric beds from the statewide pool for special populations allocated to high acuity psychiatry shall meet the following:

(a) The proposed unit shall consist of a majority of private rooms and shall include environmental safety measures that meet standards from the Joint Commission and the Centers for Medicare and Medicaid Services throughout the entire unit.

(b) The proposed unit shall have a physical environment designed to minimize noise and light reflections to promote spatial orientation.

(c) The proposed unit's staff shall be specially trained in the treatment of high acuity patients with non-violent intervention modalities such as non-abusive psychological and physical intervention, crisis intervention institute training or similar programs.

(d) The proposed unit shall demonstrate a plan for the safe management of agitated or aggressive patients.

(e) The proposed beds will serve only high acuity psychiatric patients.

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

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

Sec. 9. (1) An applicant shall agree that if approved, the services shall be delivered in compliance with the terms of approval required by the CON Review Standards for Psychiatric Beds and Services.

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

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

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

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

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

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

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

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

(e) If the specialized program is being added to an existing adult or child/adolescent psychiatric service, then the existing licensed adult or child/adolescent psychiatric service, as applicable, shall maintain the volume requirements outlined in Section 13 of the CON Review Standards for Psychiatric Beds and Services.

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

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

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

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

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

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

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

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

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

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

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

(e) If the specialized program is being added to an existing adult licensed psychiatric service, then the existing licensed psychiatric service shall maintain the volume requirements outlined in Section 13 of the CON Review Standards for Psychiatric Beds and Services.

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

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

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

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

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

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

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

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

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

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

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

(e) If the specialized program is being added to an existing licensed adult or child/adolescent psychiatric service, then the existing adult or child/adolescent psychiatric service, as applicable, shall maintain the volume requirements outlined in Section 13 of the CON Review Standards for Psychiatric Beds and Services.

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

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

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

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

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

(b) The high acuity unit shall consist of a majority of private rooms and shall include environmental safety measures that meet standards from the Joint commission and the Centers for Medicare and Medicaid Services throughout the entire unit.

(c) The high acuity unit shall have a physical environment designed to minimize noise and light reflections to promote visual and spatial orientation.

(d) The proposed unit’s staff shall be specially trained in the treatment of high acuity patients with non-violent intervention modalities such as non-abusive psychological and physical intervention, crisis intervention institute training or similar programs.

(e) The proposed unit shall demonstrate a plan for the safe management of agitated or aggressive patients.

(f) The high acuity unit shall establish and maintain written policies and procedures for each of the following:

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

(ii) Quality assurance and assessment program to assure that services furnished to high acuity patients meet professionally recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the high acuity patient receiving such services.

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

(g) If the specialized program is being added to an existing licensed adult or child/adolescent psychiatric service, then the existing adult or child/adolescent psychiatric service, as applicable, shall maintain the volume requirements outlined in Section 13 of the CON review standards for psychiatric beds and services.

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

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

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

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

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

# COMPUTED TOMOGRAPHY (CT) SERVICES WORKGROUP FINAL REPORT

The CT services workgroup, as charged by the Certificate of Need Commission, has met five times, concluding its work February 27th, 2020. The charges and conclusions are as follow:

**Charge #1: Determine if freestanding off-campus Emergency Departments (ED) should be Exempt from Meeting Maintenance Volume Requirements for 1st CT Scanner.**

**Charge #1 Recommendation: The Workgroup Recommends Exemption of Freestanding off-campus ED's from Maintenance Volume Requirements for 1st CT Scanner Provided the Facility Meets the Definition of an off-campus ED of a hospital licensed under part 215 of the code, or a Freestanding Surgical Outpatient Facility (FSOF) licensed under part 208 of the code, that treats emergency patients 24 hours a day, 7 days a week, complies with medical control authority protocols and is authorized by the medical control authority to receive ambulance runs.**

**Rationale:** Practice of emergence medicine without the availability of CT is extremely limited, if not impossible. The facility is required to have authorization to receive ambulance runs, by the local medical control authority. This serves to regulate the acuity and type of patient brought to the facility. An off-site ED should be granted the same authority and regulations with regard to CT.

An off-campus ED serves to increase patient care and access. Cost would be expected to be neutral (CT scan would be obtained regardless, just at a different physical facility).

**Charge #2: Review the Definition and Requirements for Dedicated Pediatric CT scanners.**

**Charge #2 Recommendation: The Workgroup is Recommending No Change at this Time. The Commission Could Consider Updating the Definition of a Pediatric Patient as Described by the American Academy of Pediatrics (AAP).**

**Rationale:** Many pediatric diseases, to which patients previously would succumb to before their 18th birthday, are now living well beyond age 18, yet are still treated by pediatric doctors, especially specialists/subspecialists. Examples would include cystic fibrosis, congenital heart disease and numerous metabolic diseases. Ages 18 to 21 are transitional and recognized by AAP as still pediatric.

Currently, with or without this change, there is no impact to patient care, access or costs. Currently, there are no pediatric CT scanners out of compliance, with respect to maintenance volume. A change would be forward looking.

## Charge #3: Review CT Maintenance Volume Requirements.

## Charge #3 Recommendation 1: Reduce Maintenance Volume from 7,500 CT equivalents (CTE's) to 5,000 CTE's for All Services with one (1) fixed CT Scanner.

**Rationale:** Extrapolation of study scan time (2.0 CTE's per scan) with hours of operation (5 days per week, 8 hours per day) yields approximately 6,500 CTE's. Operating at 80% capacity (cancelations, no-shows, down-time, pre-time, etc), 5,000 CTE's would be reasonable required maintenance volume.

Currently, at a maintenance volume of 7,500 CTE's approximately 38 of 108 (35.2%) of all CT scanners are in compliance. Decreasing the maintenance volume to 5,000 CTE's, increases compliant scanners to 47 of 108 (43.5%), bringing an additional 9 scanners into compliance.

This serves to maintain patient care and access. (If maintenance requirements are enforced, this change would improve access, compared to current maintenance requirements.) Does not impact cost. No change to service initiation.

## Charge #3 (Continued)

## Charge #3 Recommendation 2: Reduce Maintenance Volume from 3,500 CTE's to 1,500 CTE's for All Mobile CT Services.

**Rationale:** Extrapolation of study scan time (1.5 CTE's per scan) with hours of operation (5 days per week, 8 hours per day) yields approximately 3,000 CTE's. Operating at 50% capacity (cancelations, no-shows, pre-time, down-time, travel and docking time, etc), 1,500 CTE's would be reasonable required maintenance volume.

This serves to maintain patient care and access. Does not impact cost. No change to service initiation.

**Charge #3 (Continued)**

**Charge #3 Recommendation 3: In computation of CTE's, Add two (2) new categories:**

1. **CT guided Non-Ablation Procedure – with a conversion weighting of 4.0 for adults and 4.25 for pediatric/special needs patients**
2. **CT guided Ablation – with a conversion weighting of 8.0 for adults and 8.25 for pediatric/special needs patients**

**Rationale:** 15 Minutes of CT time equates to a weighting factor of 1.0 CTE's. Interventional procedures without ablation, are scheduled for approximately 1 hour, resulting in 4.0 CTE's. Interventional procedures with ablation, are scheduled for approximately 2 hours, resulting in 8.0 CTE's.

This serves to maintain patient care and access. Does not impact cost. No change to service initiation.

## Charge #3 (Continued)

## Charge #3 Recommendation 4: Reduce Maintenance Volume from 7,500 CTE's to 2,500 CTE's for Services with One (1) Fixed CT Scanner Located Outside the 20 Miles Radius from the Next Closest Fixed CT Scanner.

**Rationale:** Respect and maintain geographic access. In the geographic areas of concern, if a scanner were too close, this would leave a 40 mile or more, gap in coverage. 2,500 CTE's is half of otherwise required maintenance volume, as opposed to the alternative of full exemption for these geographically isolated scanners.

The vast majority of these geographically isolated scanners are north of Claire. There are 33 CT scanners north of Claire, with 23 CT scanners being isolated by 20 or more miles from the next closest scanner. Currently, 12 of these 23 scanners are out of compliance. Decreasing maintenance volume to 2,500 CTE's brings 8 of these 12 scanners into compliance.

This serves to maintain patient care and access. Does not impact cost. No change to service initiation.

Attachment C

# Computed Tomography CON Workgroup 2020

# Thank You !!!

Workgroup Participants and Department of Health and Human Services

# CT CON Workgroup

- Meet five (5) times
- CT Study time survey
- Multiple approaches to data analysis
- Recommendations

Attachment C

# CT CON Workgroup Charge #1

**Determine if freestanding off-campus Emergency Departments (ED) should be Exemption from Meeting Maintenance Volume Requirements for 1st CT Scanner.**

# CT CON Workgroup Charge #1 Recommendation

**The Workgroup Recommends Exemption of Freestanding off-campus ED's from Maintenance Volume Requirements for 1st CT Scanner Provided the Facility Meets the Definition of a Freestanding off-campus ED of a hospital licensed under part 215 of the code, or a Freestanding Surgical Outpatient Facility (FSOF) licensed under part 208 of the code, that treats emergency patients 24 hours a day, 7 days a week, complies with medical control authority protocols and is authorized by the medical control authority to receive ambulance runs.**

Attachment C

# CT CON Workgroup Charge #2

**Review the Definition and Requirements for Dedicated Pediatric CT scanners.**

Attachment C

# CT CON Workgroup Charge #2 Recommendation

**No Recommendation. However, the Commission could consider Updating the Definition of a Pediatric Patient as Described by the American Academy of Pediatrics (AAP).**

Attachment C

# CT CON Workgroup Charge #3

**Review CT Maintenance Volume Requirements**

# CT CON Workgroup Charge #3

Attachment C

## Recommendation I

**Reduce Maintenance Volume from 7,500 CT equivalents (CTE's) to 5,000 CTE's for All Services with one (1) fixed CT Scanner**

# CT CON Workgroup Charge #3

Attachment C

## Recommendation II

**Reduce Maintenance Volume from 3,500 CTE's to 1,500 CTE's for All Mobile CT Services**

# CT CON Workgroup Charge #3 Recommendation III

**In computation of CTE's, Add two (2) new categories:**

**A. CT Guided Non-Ablation Procedures – with a conversion weighting of 4.0 for Adults and 4.25 for Pediatric/Special Needs Patients**

**B. CT Guided Ablation Procedures – with a conversion weighting of 8.0 for Adults and 8.25 for Pediatric/Special Need Patients**

# CT CON Workgroup Charge #3

Attachment C

## Recommendation IV

**Reduce Maintenance Volume from 7,500 CTE's to 2,500 CTE's for Services with One (1) Fixed CT Scanner Located Outside the 20 Mile Radius From the Next Closest Fixed CT Scanner**

# MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR COMPUTED TOMOGRAPHY (CT) SCANNER SERVICES

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

### Section 1. Applicability

Sec. 1. These standards are requirements for the approval of the initiation, expansion, replacement, or acquisition of CT services and the delivery of services under Part 222 of the Code. Pursuant to Part 222 of the Code, CT is a covered clinical service. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

### Section 2. Definitions

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

(a) "Acquisition of an existing CT scanner service" means obtaining possession or control of an existing fixed or mobile CT scanner service or existing CT scanner(s) by contract, ownership, or other comparable arrangement. For proposed projects involving mobile CT scanners, this applies to the central service coordinator and/or host facility.

(b) "Billable procedure" means a CT procedure billed as a single unit and performed in Michigan.

(c) "Body scans" include all spinal CT scans and any CT scan of an anatomical site below and including the neck.

(d) “Bundled body scan” means two or more body scans billed as one CT procedure.

(e) "Central service coordinator" means the organizational unit which has operational responsibility for a mobile CT scanner and which is a legal entity authorized to do business in the state of Michigan.

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

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

(h) "Computed tomography" or "CT" means the use of radiographic and computer techniques to produce cross-sectional images of the head or body.

(i) “CT-angio hybrid unit” means an integrated system comprised of both CT and angiography equipment sited in the same room that is designed specifically for interventional radiology or cardiac procedures. The CT unit is a guidance mechanism and is intended to be used as an adjunct to the procedure. The CT unit shall not be used for diagnostic studies unless the patient is currently undergoing a CT-angio hybrid procedure and is in need of a secondary diagnostic study.

(j) "CT equivalents" means the resulting number of units produced when the number of billable procedures for each category is multiplied by its respective conversion factor tabled in Section 16.

(k) "CT scanner" means x-ray CT scanning systems capable of performing CT scans of the head, other body parts, or full body patient procedures including Positron Emission Tomography (PET)/CT scanner hybrids if used for CT only procedures. The term does not include emission-computed tomographic systems utilizing internally administered single-photon gamma ray emitters, positron annihilation CT systems, magnetic resonance, ultrasound computed tomographic systems, CT simulators used solely for treatment planning purposes in conjunction with an MRT unit, non-diagnostic, intra-operative guidance tomographic units, and dental CT scanners that generate a peak power of 5 kilowatts or less as certified by the manufacturer and are specifically designed to generate CT images to facilitate dental procedures by a licensed dentist under the practice of dentistry.

(l) "CT scanner services" means the CON-approved utilization of a CT scanner(s) at one site in the case of a fixed CT scanner service or at each host site in the case of a mobile CT scanner service.

(m) "CT-GUIDED ABLATION" MEANS ANY INVASIVE PROCEDURE PERFORMED IN A CT SCANNER REQUIRING CT GUIDANCE OF A NEEDLE OR OTHER DEVICE TO TREAT A TUMOR.

(n) "CT-GUIDED NON-ABLATION PROCEDURE" MEANS ANY INVASIVE PROCEDURE, REQUIRING CT GUIDANCE, PERFORMED IN THE CT SCANNER OTHER THAN CT-GUIDED ABLATIONS.

(o) "Dedicated pediatric CT" means a fixed CT scanner on which at least 70% of the CT procedures are performed on patients under 18 years of age.

(~~n~~p) "Department" means the Michigan Department of Health and Human Services (MDHHS).

(~~o~~q) "Emergency room" means a designated area physically part of a licensed hospital and recognized by the Department as having met the staffing and equipment requirements for the treatment of emergency patients.

(~~p~~r) "Excess CT Equivalents" means the number of CT equivalents performed by an existing CT scanner service in excess of 10,000 per fixed CT scanner and 4,500 per mobile CT scanner or either an existing fixed or mobile CT scanner service, the number of CT scanners used to compute excess CT equivalents shall include both existing and approved but not yet operational CT scanners. In the case of a CT scanner service that operates or has a valid CON to operate that has more than one fixed CT scanner at the same site, the term means number of CT equivalents in excess of 10,000 multiplied by the number of fixed CT scanners at the same site. For example, if a CT scanner service operates, or has a valid CON to operate, two fixed CT scanners at the same site, the excess CT equivalents is the number that is in excess of 20,000 (10,000 x 2) CT equivalents. In the case of an existing mobile CT scanner service, the term means the sum of all CT equivalents performed by the same mobile CT scanner service at all of the host sites combined that is in excess of 4,500. For example, if a mobile CT scanner service serves five host sites with 1 mobile CT scanner, the term means the sum of CT equivalents for all five host sites combined that is in excess of 4,500 CT equivalents.

(~~q~~s) "Existing CT scanner service" means the utilization of a CON-approved and operational CT scanner(s) at one site in the case of a fixed CT scanner service or at each host site in the case of a mobile CT scanner service.

(~~r~~t) "Existing CT scanner" means a CON-approved and operational CT scanner used to provide CT scanner services.

(~~s~~u) "Existing mobile CT scanner service" means a CON-approved and operational CT scanner and transporting equipment operated by a central service coordinator serving two or more host sites.

(~~t~~v) "Expand an existing CT scanner service" means the addition of one or more CT scanners at an existing CT scanner service.

(~~u~~w) "Head scans" include head or brain CT scans; including the maxillofacial area; the orbit, sella, or posterior fossa; or the outer, middle, or inner ear; or any other CT scan occurring above the neck.

(~~v~~x) "Health Service Area" or "HSA" means the groups of counties listed in Appendix A.

(~~w~~y) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(~~x~~z) "Hospital-based portable CT scanner or portable CT scanner" means a CT scanner capable of being transported into patient care areas (i.e., ICU rooms, operating rooms, etc.) to provide high-quality imaging of critically ill patients.

(~~y~~aa) "Host site" means the site at which a mobile CT scanner is authorized to provide CT scanner services.

(~~z~~bb) "Initiate a CT scanner service" means to begin operation of a CT scanner, whether fixed or mobile, at a site that does not perform CT scans as of the date an application is submitted to the Department. The term does not include the acquisition or replacement of an existing CT scanner service at the existing site or to a different site or the renewal of a lease.

(~~aa~~cc) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396 to 1396w-5.

(~~bb~~dd) "Mobile CT scanner service" means a CT scanner and transporting equipment operated by a central service coordinator and which must serve two or more host facilities.

(~~cc~~ee) "Mobile CT scanner network" means the route (all host facilities) the mobile CT scanner is authorized to serve.

(~~dd~~ff) "Pediatric patient" means any patient less than 18 years of age.

(~~ee~~gg) "Replace an existing CT scanner" means an equipment change of an existing CT scanner, that requires a change in the radiation safety certificate, proposed by an applicant which results in that applicant operating the same number of CT scanners before and after project completion, at the same geographic location. The term also includes relocating an existing CT scanner or CT scanner service from an existing site to a different site.

(~~ff~~hh) "Sedated patient" means a patient that meets all of the following:

(i) Patient undergoes procedural sedation and whose level of consciousness is either moderate sedation or a higher level of sedation, as defined by the American Association of Anesthesiologists, the American Academy of Pediatrics, the Joint Commission on the Accreditation of Health Care Organizations, or an equivalent definition.

(ii) Who requires observation by personnel, other than technical employees routinely assigned to the CT unit, who are trained in cardiopulmonary resuscitation (CPR) and pediatric advanced life support (PALS).

(ii) "Special needs patient" means a non-sedated patient, either pediatric or adult, with any of the following conditions: down syndrome, autism, attention deficit hyperactivity disorder (ADHD), developmental delay, malformation syndromes, hunter's syndrome, multi-system disorders, psychiatric disorders, and other conditions that make the patient unable to comply with the positional requirements of the exam.

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

**Section 3. Requirements for approval for applicants proposing to initiate a CT scanner service**

Sec. 3. An applicant proposing to initiate a CT scanner service, other than a hospital-based portable CT scanner service, shall demonstrate the following, as applicable:

(1) A hospital proposing to initiate its first fixed CT scanner service shall demonstrate each of the following:

(a) The proposed site is a hospital licensed under Part 215 of the Code.

(b) The hospital operates an emergency room that provides 24-hour emergency care services as authorized by the local medical control authority to receive ambulance runs.

(2) An applicant, other than an applicant meeting all of the applicable requirements of subsection (1), proposing to initiate a fixed CT scanner service shall project an operating level of at least 7,500 CT equivalents per year for the second 12-month period after beginning operation of the CT scanner.

(3) An applicant proposing to initiate a mobile CT scanner service shall project an operating level of at least 3,500 CT equivalents per year for the second 12-month period after beginning operation of the CT scanner.

(4) An applicant proposing to initiate CT scanner services as an existing host site on a different mobile CT scanner service shall demonstrate the following:

(a) The applicant provides a proposed route schedule.

(b) The applicant provides a draft contract for services between the proposed host site and central service coordinator.

**Section 4. Requirements for approval for applicants proposing to expand an existing CT scanner service**

Sec. 4. An applicant proposing to expand an existing CT scanner service, other than a hospital-based portable CT scanner service, shall demonstrate the following, as applicable:

(1) An applicant proposing to expand an existing fixed CT scanner service shall demonstrate that all of the applicant's fixed CT scanners, excluding CT scanners approved pursuant to sections 8, 9, and 12, have performed an average of at least 10,000 CT equivalents per fixed CT scanner for the most recent continuous 12-month period preceding the applicant's request. In computing this average, the Department will divide the total number of CT equivalents performed by the applicant's total number of fixed CT scanners, including both operational and approved but not operational fixed CT scanners.

(2) An applicant proposing to expand an existing fixed CT scanner service approved pursuant to Section 12 shall demonstrate that all of the applicant's dedicated pediatric CT scanners have performed an average of at least 3,000 CT equivalents per dedicated pediatric CT scanner for the most recent continuous 12-month period preceding the applicant's request. In computing this average, the Department will divide the total number of CT equivalents performed by the applicant's total number of dedicated pediatric CT scanners, including both operational and approved but not operational dedicated pediatric CT scanners.

(3) If an applicant proposes to expand an existing mobile CT scanner service, the applicant shall demonstrate that all of the applicant's mobile CT scanners have performed an average of at least 5,500 CT equivalents per mobile CT scanner for the most recent continuous 12-month period preceding the applicant's request. In computing this average, the Department will divide the total number of CT equivalents performed by the applicant's total number of mobile CT scanners, including both operational and approved but not operational mobile CT scanners.

**Section 5. Requirements for approval for applicants proposing to replace an existing CT scanner**

Sec. 5. An applicant proposing to replace an existing CT scanner or service, other than a hospital-based portable CT scanner service, shall demonstrate the following, as applicable:

(1) An applicant proposing to replace an existing fixed, mobile, or dedicated pediatric CT scanner shall demonstrate all of the following:

(a) The replacement CT scanner will be located at the same site as the CT scanner to be replaced.

(b) The existing CT scanner(s) proposed to be replaced is fully depreciated according to generally accepted accounting principles, or, that the existing equipment clearly poses a threat to the safety of the public, or, that the proposed replacement CT scanner offers technological improvements which enhance quality of care, increase efficiency, and/or reduce operating costs and patient charges.

(2) An applicant proposing to replace an existing fixed CT scanner service to a different site shall demonstrate that the proposed project meets all of the following:

(a) The existing fixed CT scanner service to be replaced has been in operation for at least 36 months as of the date an application is submitted to the Department unless the applicant meets the requirement in subsection (c)(ii) or (iii).

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

(c) The CT scanner service to be replaced performed at least an average of 7,500 CT equivalents per fixed scanner in the most recent 12-month period for which the Department has verifiable data unless one of the following requirements are met:

(i) An applicant meets all of the requirements of Section 3(1);

(ii) the owner of the building where the site is located has incurred a filing for bankruptcy under Chapter Seven (7) within the last three years;

(iii) the ownership of the building where the site is located has changed within 24 months of the date of the service being operational; or

(iv) the CT service being replaced is part of the replacement of an entire hospital to a new geographic site and has only one (1) CT unit.

(d) The applicant agrees to operate the CT scanner service in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

(3) An applicant proposing to replace a fixed CT scanner(s) of an existing CT scanner service to a different site shall demonstrate that the proposed project meets all of the following:

(a) The existing CT scanner service from which the CT scanner(s) is to be replaced has been in operation for at least 36 months as of the date an application is submitted to the Department.

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

(c) Each existing CT scanner at the service from which a scanner is to be replaced performed at least an average of 7,500 CT equivalents per fixed scanner in the most recent 12-month period for which the Department has verifiable data.

(d) The applicant agrees to operate the CT scanner(s) at the proposed site in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

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

**Section 6. Requirements for approval for applicants proposing to acquire an existing CT scanner service or an existing CT scanner(s)**

Sec. 6. An applicant proposing to acquire an existing fixed or mobile CT scanner service, other than a hospital-based portable CT scanner service, shall demonstrate the following, as applicable:

(1) The applicant shall not be required to be in compliance with the volume requirement applicable to the seller/lessor on the date the acquisition occurs if the proposed project meets one of the following:

(a) It is the first acquisition of the existing fixed or mobile CT scanner service for which a final decision has not been issued after June 4, 2004.

(b) The existing fixed or mobile CT scanner service is owned by, is under common control of, or has a common parent as the applicant, and the CT scanner service shall remain at the same site.

(2) For any application for proposed acquisition of an existing fixed or mobile CT scanner service, an applicant shall be required to demonstrate the following, as applicable:

(a) The fixed CT scanner service to be acquired performed at least 7,500 CT equivalents per fixed CT scanner in the most recent 12-month period for which the Department has verifiable data, unless an applicant meets all of the requirements of Section 3(1) or meets the requirements of Section 6(1)(b).

(b) The mobile CT scanner service to be acquired performed at least 3,500 CT equivalents per mobile CT scanner in the most recent 12-month period for which the Department has verifiable data, unless an applicant meets the requirements of Section 6(1)(b).

(3) An applicant proposing to acquire an existing fixed or mobile CT scanner(s) of an existing fixed or mobile CT scanner service shall demonstrate that the proposed project meets the following:

(a) For any application for proposed acquisition of an existing fixed or mobile CT scanner(s) of an existing fixed or mobile CT scanner service, an applicant shall be required to demonstrate the following, as applicable:

(i) The fixed CT scanner(s) to be acquired performed at least 7,500 CT equivalents per fixed CT scanner in the most recent 12-month period for which the department has verifiable data.

(ii) The mobile CT scanner(s) to be acquired performed at least 3,500 CT equivalents per mobile CT scanner in the most recent 12-month period for which the Department has verifiable data.

(4) The CT scanner service shall be operating at the applicable volume requirements set forth in Section 14 of these standards in the second 12 months after the date the service is acquired, and annually thereafter.

**Section 7. Requirements for a dedicated research fixed CT scanner**

Sec. 7. An applicant proposing to add a fixed CT scanner to an existing CT scanner service for exclusive research use shall demonstrate the following:

(1) The applicant agrees that the dedicated research CT scanner will be used primarily (70% or more of the scans) for research purposes.

(2) The dedicated research CT scanner shall operate under a protocol approved by the applicant's Institutional Review Board, as defined by Public Law 93-348 and regulated by Title 45 CFR 46.

(3) The proposed site can have no more than three dedicated research fixed CT scanners approved under this section.

(4) The dedicated research scanner approved under this section may not utilize CT procedures performed on the dedicated CT scanner to demonstrate need or to satisfy CT CON review standards requirements.

**Section 8. Requirements for approval of a hospital-based portable CT scanner for initiation, expansion, replacement, and acquisition**

Sec. 8. An applicant proposing to initiate, expand, replace, or acquire a hospital-based portable CT scanner shall demonstrate that it meets all of the following:

(1) An applicant is limited to the initiation, expansion, replacement, or acquisition of no more than two hospital-based portable CT scanners.

(2) The proposed site is a hospital licensed under Part 215 of the Code.

(3) The hospital has been certified as a level I or level II trauma facility by the American College of Surgeons, or has performed >100 craniotomies in the most recent 12- month period verifiable by the Department.

(4) The applicant agrees to operate the hospital-based portable CT scanner in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

(5) The approved hospital-based portable CT scanner will not be subject to CT volume requirements.

(6) The applicant may not utilize CT procedures performed on a hospital-based portable CT scanner to demonstrate need or to satisfy CT CON review standards requirements.

**Section 9. Requirements for approval of a PET/CT hybrid for initiation, expansion, replacement, and acquisition**

Sec. 9. An applicant proposing to initiate, expand, replace, or acquire a PET/CT hybrid shall demonstrate that it meets all of the following:

(1) There is an approved PET CON for the PET/CT hybrid, and the PET/CT hybrid is in compliance with all applicable project delivery requirements as set forth in the CON review standards for PET.

(2) The applicant agrees to operate the PET/CT hybrid in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

(3) The approved PET/CT hybrid will not be subject to CT volume requirements.

(4) A PET/CT scanner hybrid approved under the CON Review Standards for PET Scanner Services and the Review Standards for CT Scanner Services may not utilize CT procedures performed on a hybrid scanner to demonstrate need or to satisfy CT CON review standards requirements.

**Section 10. Requirements for approval of a CT-angio hybrid unit for initiation, replacement, and acquisition**

Sec. 10. An applicant proposing to initiate, replace, or acquire a hospital-based CT-angio hybrid unit shall demonstrate each of the following, as applicable to the proposed project:

(1) The proposed site is a licensed hospital under Part 215 of the Code.

(2) The proposed site has an existing fixed CT scanner service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(3) The proposed site offers the following services:
(a) diagnostic cardiac catheterization; or
(b) interventional radiology; or
(c) surgical services

(4) The proposed CT-angio hybrid unit must be located in one of the following rooms:
(a) cardiac catheterization lab; or
(b) interventional radiology suite; or
(c) licensed operating room

(5) Diagnostic CT studies shall not be performed on a CT-angio hybrid unit approved under this section unless the patient is currently undergoing a CT-angio hybrid interventional procedure and is in need of a secondary diagnostic CT study.

(6) The approved CT-angio hybrid shall not be subject to CT volume requirements.

(7) The applicant shall not utilize the procedures performed on the CT-angio hybrid unit to demonstrate need or to satisfy CT CON review standards requirements.

**Section 11. Additional requirements for approval of a mobile CT scanner service**

Sec. 11. (1) An applicant proposing to initiate a mobile CT scanner service in Michigan shall demonstrate that it meets all of the following additional requirements:
(a) A separate CON application shall be submitted by the central service coordinator and each Michigan host facility.

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

(2) An applicant proposing to become a host facility on an existing mobile CT scanner network shall demonstrate that it meets all of the following additional requirements:

(a) Approval of the application will not result in an increase in the number of operating mobile CT scanners for the mobile CT scanner network unless the requirements of Section 4 have been met.

(b) A separate CON application has been filed for each host facility.

**Section 12. Requirements for approval of an applicant proposing to establish dedicated pediatric CT Scanner**

Sec. 12. (1) An applicant proposing to establish dedicated pediatric CT shall demonstrate all of the following:

(a) The applicant shall have experienced at least 7,000 pediatric (< 18 years old) discharges (excluding normal newborns) in the most recent year of operation.

(b) The applicant shall have performed at least 5,000 pediatric (< 18 years old) surgeries in the most recent year of operation.

(c) The applicant shall have an active medical staff, at the time the application is submitted to the Department that includes, but is not limited to, physicians who are fellowship-trained in the following pediatric specialties:

(i) pediatric radiology (at least two)
(ii) pediatric anesthesiology
(iii) pediatric cardiology
(iv) pediatric critical care
(v) pediatric gastroenterology
(vi) pediatric hematology/oncology
(vii) pediatric neurology
(viii) pediatric neurosurgery
(ix) pediatric orthopedic surgery
(x) pediatric pathology
(xi) pediatric pulmonology
(xii) pediatric surgery
(xiii) neonatology

(d) The applicant shall have in operation the following pediatric specialty programs at the time the application is submitted to the Department:

(i) pediatric bone marrow transplant program
(ii) established pediatric sedation program
(iii) pediatric open heart program

(2) An applicant meeting the requirements of subsection (1) shall be exempt from meeting the requirements of Section 3 of these standards.

**Section 13. Requirements for Medicaid participation**

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

**Section 14. Project delivery requirements and terms of approval for all applicants**

Sec. 14. An applicant shall agree that, if approved, the CT scanner(s) services shall be delivered in compliance with the following terms of approval.

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(a) The applicant shall establish a mechanism to assure that the CT scanner facility is staffed so that:

(i) The screening of requests for CT procedures and interpretation of CT procedures will be performed by physicians with training and experience in the appropriate diagnostic use and interpretation of cross-sectional images of the anatomical region(s) to be examined, and

(ii) The CT scanner is operated by physicians and/or is operated by radiological technologists qualified by training and experience to operate the CT scanner safely and effectively.

For purposes of evaluating (a)(i), the Department shall consider it prima facie evidence of a satisfactory assurance mechanism as to screening and interpretation if the applicant requires the screening of requests for and interpretations of CT procedures to be performed by physicians who are board certified or eligible in radiology or are neurologists or other specialists trained in cross-sectional imaging of a specific organ system. For purposes of evaluating (a)(i) the Department shall consider it prima facie evidence of a satisfactory assurance mechanism as to the operation of a CT scanner if the applicant requires the CT scanner to be operated by a physician or by a technologist registered by the American Registry of Radiological Technologists (ARRT) or the American Registry of Clinical Radiography Technologists (ARCRT). However, the applicant may submit and the Department may accept other evidence that the applicant has established a mechanism to assure that the CT scanner facility is appropriately and adequately staffed as to screening, interpretation, and/or operation of a CT scanner.

(b) The applicant shall employ or contract with a radiation physicist to review the quality and safety of the operation of the CT scanner.

(c) The applicant shall assure that at least one of the physicians responsible for the screening and interpretation as defined in subsection (a)(i) will be in the CT facility or available (either on-site or through telecommunication capabilities) to make the final interpretation.

(d) In the case of an urgent or emergency CT scan, the applicant shall assure that a physician so authorized by the applicant to interpret initial scans will be on-site or available through telecommunication capabilities within 1 hour following completion of the scanning procedure to render an initial interpretation of the scan. A final interpretation shall be rendered by a physician so authorized under subsection (a)(i) within 24 hours.

(e) The applicant shall have, within the CT scanner facility, equipment and supplies to handle clinical emergencies that might occur within the CT unit, with CT facility staff trained in CPR and other appropriate emergency interventions, and a physician on site in or immediately available to the CT scanner at all times when patients are undergoing scans.

(f) Fixed CT scanner services shall be made available 24 hours a day for emergency patients if the facility operates an emergency room that provides 24-hour emergency care services ~~as~~ AND authorized by the local medical control authority to receive ambulance runs.

(g) The applicant shall accept referrals for CT scanner services from all appropriately licensed practitioners.

(h) The applicant shall establish and maintain: (a) a standing medical staff and governing body (or its equivalent) requirement that provides for the medical and administrative control of the ordering and utilization of CT patient procedures, and (b) a formal program of utilization review and quality assurance. These responsibilities may be assigned to an existing body of the applicant, as appropriate.

(i) An applicant approved under Section 12 must be able to prove that all radiologists, technologists and nursing staff working with CT patients have continuing education or in-service training on pediatric low-dose CT. The site must also be able to provide evidence of defined low-dose pediatric CT protocols.

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

(a) The applicant, to assure that the CT scanner will be utilized by all segments of the Michigan population, shall:

(i) not deny any CT scanner services to any individual based on ability to pay or source of payment;

(ii) provide all CT scanning services to any individual based on the clinical indications of need for the service; and

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

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

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

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

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

(a) The approved CT scanners shall be operating AS FOLLOWS FOR THE SECOND 12-MONTH PERIOD AFTER BEGINNING OPERATION OF THE CT SCANNER, AND ANNUALLY THEREAFTER, EXCEPT FOR THOSE SCANNERS EXEMPT UNDER APPLICABLE SECTIONS:

(i) ~~at an~~ An average of 7,500 CT equivalents ~~scanner~~ per fixed scanner PER YEAR UNLESS ONE OF THE FOLLOWING HAS BEEN MET:

(A) 5,000 CT EQUIVALENTS PER FIXED SCANNER PER YEAR FOR CT SERVICES WITH ONE FIXED SCANNER.

(B) 2,500 CT EQUIVALENTS PER FIXED SCANNER PER YEAR FOR CT SERVICES WITH ONE FIXED SCANNER LOCATED OUTSIDE THE 20-MILE RADIUS FROM THE NEXT CLOSEST FIXED CT SERVICE.

(C) A HOSPITAL, WITH ONE FIXED SCANNER, LICENSED UNDER PART 215 OF THE CODE THAT OPERATES AN EMERGENCY ROOM THAT PROVIDES 24-HOUR EMERGENCY CARE SERVICES AND AUTHORIZED BY THE LOCAL MEDICAL CONTROL AUTHORITY TO RECEIVE AMBULANCE RUNS SHALL NOT HAVE A MINIMUM ANNUAL VOLUME REQUIREMENT FOR PURPOSES OF THIS SECTION.

(D) A FREESTANDING SURGICAL OUTPATIENT FACILITY (FSOF), WITH ONE FIXED SCANNER, LICENSED UNDER PART 208 OF THE CODE THAT OPERATES AN EMERGENCY ROOM THAT PROVIDES 24-HOUR EMERGENCY CARE SERVICES AND AUTHORIZED BY THE LOCAL MEDICAL CONTROL AUTHORITY TO RECEIVE AMBULANCE RUNS SHALL NOT HAVE A MINIMUM ANNUAL VOLUME REQUIREMENT FOR PURPOSES OF THIS SECTION.

(E) AN OFF-CAMPUS EMERGENCY DEPARTMENT OF A HOSPITAL, LICENSED UNDER PART 215 OF THE CODE, WITH ONE FIXED SCANNER, THAT HAS OBTAINED PROVIDER-BASED STATUS UNDER 42 CFR 413.65, THAT IS AVAILABLE FOR TREATING EMERGENCY PATIENTS 24 HOURS A DAY, 7 DAYS A WEEK, AND AUTHORIZED BY THE LOCAL MEDICAL CONTROL AUTHORITY TO RECEIVE AMBULANCE RUNS SHALL NOT HAVE A MINIMUM ANNUAL VOLUME REQUIREMENT FOR PURPOSES OF THIS SECTION.

(ii) ~~and 3~~1,500 CT equivalents per mobile scanner per year ~~for the second 12-month period after beginning operation of the CT scanner, and annually thereafter, except for those scanners exempt under applicable sections~~.

(b) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information, operating schedules, through-put schedules, demographic and diagnostic information, the volume of care provided to patients from all payor sources, and other data requested by the Department, and approved by the Commission. The applicant shall provide the required data on a separate basis for each separate and distinct site as required by the Department; in a format established by the Department;

and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(c) Equipment to be replaced shall be removed from service.

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

(5) An applicant approved under Section 8 shall be in compliance with the following:

(a) Portable CT scanner can only be used by a qualifying program for the following purposes:

(i) Brain scanning of patients being treated in an adult or pediatric Intensive Care Unit (ICU).

(ii) Non-diagnostic, intraoperative guidance in an operating room.

(b) The approved applicant must provide annual reports to the Department by January 31st of each year for the preceding calendar year. This requirement applies to all applicants approved under Section 8.

(c) The following data must be reported to the Department:

(i) Number of adult studies (age>=18)

(ii) Number of pediatric studies (age<18)

(iii) Number of studies performed using a portable CT on the same patient while that patient is in an ICU

(6) An applicant approved under Section 10 shall be in compliance with the following:

(a) The proposed site offers the following services:

(i) diagnostic cardiac catheterization; or

(ii) interventional radiology; or

(iii) surgical services

(b) The proposed CT-Angio hybrid unit must be located in one of the following rooms:

(i) cardiac catheterization lab; or

(ii) interventional radiology suite; or

(iii) licensed operating room

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

**Section 15. Project delivery requirements and additional terms of approval for applicants involving mobile CT scanners**

Sec. 15. (1) In addition to the provisions of Section 14, an applicant for a mobile CT scanner shall agree that the services provided by the mobile CT scanner(s) shall be delivered in compliance with the following terms of CON approval:

(a) A host facility shall submit only one CON application for a CT scanner for review at any given time.

(b) A mobile CT scanner with an approved CON shall notify the Department prior to ending service with an existing host facility.

(c) A CON shall be required to add a host facility.

(d) A CON shall be required to change the central service coordinator.

(e) Each host facility must have at least one board certified or board eligible radiologist on its medical staff. The radiologist(s) shall be responsible for: (i) establishing patient examination and infusion protocol, and (ii) providing for the interpretation of scans performed by the mobile CT scanner.

(f) Each mobile CT scanner service must have an Operations Committee with members representing each host facility, the central service coordinator, and the central service medical director. This committee shall oversee the effective and efficient use of the CT scanner, establish the normal route schedule, identify the process by which changes are to be made to the schedule, develop procedures for

handling emergency situations, and review the ongoing operations of the mobile CT scanner on at least a quarterly basis.

(g) The central service coordinator shall arrange for emergency repair services to be available 24 hours each day for the mobile CT scanner as well as the vehicle transporting the equipment. In addition, to preserve image quality and minimize CT scanner downtime, calibration checks shall be performed on the CT scanner at least once each work day and routine maintenance services shall be provided on a regularly scheduled basis, at least once a week during hours not normally used for patient procedures.

(h) Each host facility must provide a properly prepared parking pad for the mobile CT scanner of sufficient load-bearing capacity to support the vehicle, a waiting area for patients, and a means for patients to enter the vehicle without going outside (such as a canopy or enclosed corridor). Each host facility must also provide the capability for processing the film and maintaining the confidentiality of patient records. A communication system must be provided between the mobile vehicle and each host facility to provide for immediate notification of emergency medical situations.

(i) A mobile CT scanner service shall operate under a contractual agreement that includes the provision of CT scanner services at each host facility on a regularly scheduled basis.

(j) The volume of utilization at each host facility shall be reported to the Department by the central service coordinator under the terms of Section 14(2)(i).

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

**Section 16. Determination of CT Equivalents**

Sec. 16. CT equivalents shall be calculated as follows:

(~~a~~1) Each billable procedure for the time period specified in the applicable section(s) of these standards shall be assigned to a category set forth in Table 1.

(~~b~~2) The number of billable procedures for each category in the time period specified in the applicable section(s) of these standards shall be multiplied by the corresponding conversion factor in Table 1 to determine the number of CT equivalents for that category for that time period.

(~~c~~3) The number of CT equivalents for each category shall be summed to determine the total CT equivalents for the time period specified in the applicable section(s) of these standards.

(~~d~~4) THE WEIGHTING IN TABLE 1 IS BASED ON TYPICAL TREATMENT TIMES AND ASSUMES THE CONVERSION FACTOR EQUALS APPROXIMATELY 15 MINUTES OF TIME ON THE CT UNIT.

(5) The conversion factor for pediatric/special needs patients does not apply to procedures performed on a dedicated pediatric CT scanner.

| Table 1<br><br>Category | Number of Billable CT Procedures | | Conversion Factor | | CT Equivalents |
|---|---|---|---|---|---|
| Adult Patient | | | | | |
| Head Scans w/o Contrast | _____ | X | 1.00 | = | _____ |
| Head Scans with Contrast | _____ | X | 1.25 | = | _____ |
| Head Scans w/o & w Contrast | _____ | X | 1.75 | = | _____ |
| Body Scans w/o Contrast | _____ | X | 1.50 | = | _____ |
| Body Scans with Contrast | _____ | X | 1.75 | = | _____ |
| Body Scans w/o & w Contrast | _____ | X | 2.75 | = | _____ |

| | | | | | |
|---|---|---|---|---|---|
| Bundled body Scan | _____ | X | 3.50 | = | _____ |
| CT-GUIDED NON-ABLATION | | | | | |
| PROCEDURE | _____ | X | 4.00 | = | _____ |
| CT-GUIDED ABLATION | _____ | X | 8.00 | = | _____ |
| | | | | | |
| Pediatric/Special Needs Patient | | | | | |
| Head scans w/o Contrast | _____ | x | 1.25 | = | _____ |
| Head Scans with Contrast | _____ | x | 1.50 | = | _____ |
| Head Scans w/o & with Contrast | _____ | x | 2.00 | = | _____ |
| Body Scans w/o Contrast | _____ | x | 1.75 | = | _____ |
| Body Scans with Contrast | _____ | x | 2.00 | = | _____ |
| Body Scans w/o & with Contrast | _____ | x | 3.00 | = | _____ |
| Bundled body Scan | _____ | X | 4.00 | = | _____ |
| CT-GUIDED NON-ABLATION | | | | | |
| PROCEDURE | _____ | X | 4.25 | = | _____ |
| CT-GUIDED ABLATION | _____ | X | 8.25 | = | _____ |
| | | | | | |
| Total CT Equivalents | | | | | _____ |

**Section 17. Documentation of projections**

Sec. 17. An applicant required to project volumes under Section 3 shall demonstrate the following, as applicable:

(1) An applicant required to project under Section 3 shall demonstrate that the projection is based on historical physician referrals that resulted in an actual scan for the most recent 12-month period immediately preceding the date of the application. Historical physician referrals will be verified with the data maintained by the Department through its "Annual Hospital statistical survey" and/or "Annual Freestanding Statistical Survey."

(2) An applicant shall demonstrate that the projected number of referrals to be performed at the proposed site under subsection (1) are from an existing CT scanner service that is in compliance with the volume requirements applicable to that service, and will continue to be in compliance with the volume requirements applicable to that service subsequent to the initiation of the proposed CT scanner service by an applicant. Only excess CT equivalents equal to or greater than what is being committed pursuant to this subsection may be used to document projections under subsection (1). In demonstrating compliance with this subsection, an applicant shall provide each of the following:

(a) A written commitment from each referring physician that he or she will refer at least the volume of CT scans to be transferred to the proposed CT scanner service for no less than 3 years subsequent to the initiation of the CT scanner service proposed by an applicant.

(b) The number of referrals committed must have resulted in an actual CT scan of the patient at the existing CT scanner service from which referral will be transferred. The committing physician must make available HIPAA compliant audit material if needed upon Department request to verify referral sources and outcomes. Commitments must be verified by the most recent data set maintained by the Department through its "Annual Hospital Statistical Survey" and/or "Annual Freestanding Statistical Survey."

(c) The projected referrals are from an existing CT scanner service within a 75-mile radius for rural and micropolitan statistical area counties or 20-mile radius for metropolitan statistical area counties.

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

Sec. 18. (1) These CON review standards supersede and replace the CON Review Standards for Computed Tomography Scanner Services approved by the CON Commission on September ~~25~~21, ~~2014~~ 2016 and effective on December ~~22~~9, ~~2014~~2016.

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

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

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

## APPENDIX B

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

# Neonatal Intensive Care Unit (NICU) and Special Care Nursery (SCN) Services Workgroup Interim Report

The NICU/ SCN services workgroup, as charged by the Certificate of Need Commission, has held the following meetings to date : December 12, 2019, January 9, 2020 and via teleconference (due to Covid 19 meeting restrictions) March 12, 2020, May 14, 2020 and June 4, 2020. All meetings began at 9:30 am and concluded at 11:30 pm..

We have had active participation from all the major health systems across the state listed below:

St. Joseph Mercy Ann Arbor
Henry Ford Health System
Arbor Advisors
RWC Advocacy
Covenant
Mercy Health St. Mary's Grand Rapids
Dexter Area Fire Department
MidMichigan Health
Hurley Medical Center
MEDNAX
Blue Cross Blue Shield of Michigan
Arbor Advisors
RWC Advocacy
Dexter Area Fire Department
Michigan Department of Health and Human Services
Blue Cross Blue Shield of Michigan
Beaumont Health
University of Michigan
Sparrow Health
Munson Health
Spectrum Health
Ascension Michigan
Children's Hospital of Michigan
McLaren Health
Blue Cross Blue Shield of Michigan
Henry Ford Health System
Mercy Health Grand Rapids
Covenant

Discussion regarding each of the charges are summarized below:

Charge 1: Should High Flow Nasal Cannula (HFNC) be included as accepted services for SCNs:

To address this charge the workgroup developed a survey (currently being conducted) to assess the current use of HFNC in SCNs across the state, complications of the use, outcomes of patients, and need for transfer of patients to higher level of care. Covid Challenges have delayed survey reporting from the SCNs; every effort is being made to have these completed before the next meeting in July. The data will assist the workgroup in addressing HFNC as an accepted service for SCN.

Charge 2: Should Neonatal Abstinence Syndrome (NAS) be included as accepted services for SCNs:

With the rise of opioid use and subsequent effects on newborns, the need to treat and monitor infants with NAS has greatly increased around the state. Many infants are born in rural areas and require transfer to higher level of care, separating mom and infant, and incurring higher costs of medical care. The workgroup also recognized that there are well-born Level 1 nurseries in rural areas that currently provide exceptional care for NAS newborns and the impact of adding this accepted service to SCNs would prohibited them from doing so if this language was

added. With concerns raised that this language would ultimately limit access to this service unnecessarily, the workgroup agreed to not include NAS language for the SCN definition so that all nurseries with the appropriate capabilities, equipment, and staff, will continue to be allowed to provide NAS treatment. Clarification of current definitions of all levels of newborn care are being discussed and final recommendation will be discussed at next meeting.

Charge 3: In section 12(2) determine if telemedicine can be used as an acceptable replacement for on-site services:

Telemedicine is already in active use amongst community NICUs across the state and country, providing neonatal/pediatric sub-specialty support. These include but are not limited to cardiology, ophthalmology, surgery and neurosurgery ( on-site services). Draft language has been proposed and accepted to include the use of telemedicine as a replacement for on-site consultative needs of NICU. The group also discussed the importance of neonatal telemedicine that can provide supportive services to both SCNs and well born nurseries to avoid maternal -infant separation and costly transfers. Ongoing discussion will continue in order to draft language that provides modifications/ updates to CON review standards (Charge 7).

Charge 4: Occupancy requirements and high occupancy provisions for NICU:

A subgroup was formed to explore a new high occupancy provision in line with the other high-occupancy standards (i.e hospital, nursing home and psych bed standards). The subgroup presented draft language/bed methodology at the June meeting which was agreed upon by the workgroup. It will be reviewed by the Department and included in the draft revision.

Charge 5: Minimum NICU size exception for rural or micropolitan counties:

The current standards require a minimum size of 15 NICU beds. However, there are 3 facilities in the State currently with fewer than 15 beds. The workgroup discussed the options of creating a smaller size requirement for NICUs in rural and micropolitan counties as well as language that would give the Department discretion to waive the 15-bed requirement if they felt a smaller sized program was appropriate. The Department expressed some hesitation about the latter as it can create conflict and potential dispute if they disagree with an applicant's claim of need for a smaller program. However, they agreed to draft language for the former (reducing to 10 beds) and discuss the latter internally and with the Attorney General's office prior to the next meeting.

Charge 6: Definition of NICU Services found in Section 2:

The workgroup discussed the importance of understanding the definition of NICU services and reviewed the AAP guidelines published in 2012. While the workgroup and Department agree the NICU standards should be in line with AAP guidelines, the interpretation of guidelines leads to continued debate. Draft language has been presented by the Department reflecting the AAP guidelines and this will be further discussed at the July meeting.

Charge 7: Consider any other technical changes from the Department, e.g., updates or modifications consistent with other CON review standards and the Michigan Public Health Code:

Discussion of this charge has been intertwined throughout the workgroups' meetings. The remaining active issues being reviewed include interpretation of the use of CPAP in SCNs as currently defined in the CON standards as well as the use of High Flow Nasal Cannula.

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

Date: February 24, 2020

TO: The Certificate of Need (CON) Commission

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

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

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## Public Hearing Testimony

Pursuant to MCL 333.22215 (3), the Certificate of Need (CON) Commission "...shall conduct a public hearing on its proposed action." The Commission took proposed action on the NH/HLTCU Standards at its January 30, 2020 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed NH/HLTCU Standards on February 11. 2020. Written testimony was accepted for an additional seven days after the hearing. Testimony was received from five organizations and one individual.

### Written Testimony:

*1.) Dalton Herbal – LeadingAge Michigan*
- Supports the proposed language.

*2.) Pat Anderson – Health Care Association of Michigan (HCAM)*
- Supports the proposed language.

*3.) Diana Prichard – Americans for Prosperity of Michigan*
- Opposes the proposed language.

*4.) Renee Beniak – Michigan County Medical Care Facilities Council (MCMCFC)*
- Supports the proposed language.

*5.) Grace Terry – Self*
- Opposes the proposed language.

*6.) Kim Jurincic – Americans for Prosperity of Michigan*
- Opposes the proposed language.

*7.) Peter V. Massey – Trilogy Health Services, LLC*

- Opposes the proposed language.

**Department Recommendation:**

The Department supports the language as presented at the January 30, 2020 CON Commission meeting.

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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

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

## Section 1. Applicability

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

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

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

## Section 2. Definitions

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

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

(b) "ADC adjustment factor" means the factor by which the average daily census (ADC), derived during the bed need methodology calculation set forth in Section 3(2)(d) for each planning area, is divided. The ADC adjustment factor is 0.90 for all planning areas.

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

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

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

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

(g) "Common ownership or control" means a nursing home, regardless of the state in which it is located, that is owned by, is under common control of, or has a common parent as the applicant nursing home pursuant to the definition of common ownership or control utilized by the Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Care Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

(u) "Occupancy rate" means the percentage which expresses the ratio of the actual number of patient days of care provided divided by the total number of patient days. Total patient days is calculated by summing the number of licensed and/or CON approved but not yet licensed beds and multiplying these beds by the number of days that they were licensed and/or CON approved but not yet licensed.

This shall include nursing home beds approved from the statewide pool. Occupancy rates shall be calculated using verifiable data from the actual number of patient days of care for 12 continuous months of data from the CON Annual Survey or other comparable MDHHS survey instrument.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 3. Determination of needed nursing home bed supply**

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

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

(c) Until the base year is changed by the Commission in accord with Section 4(3) and Section 5, the use rates for the base year per 1000 population for each corresponding age cohort, established in accord with subsection (1)(b), are posted on the State of Michigan CON web site.

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

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

(b) Multiply each population age cohort by the corresponding use rate which is posted on the State of Michigan CON web site.

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

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

(e) Divide the ADC determined in subsection (d) by 0.90.

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

**Section 4. Bed need**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) An applicant may request and be approved for up to a maximum of 20 beds if, when the total number of "existing nursing home beds" is subtracted from the bed need for the planning area, the

difference is equal to or more than 1 and equal to or less than 20. This subsection is not applicable to projects seeking approval for beds from the statewide pool of beds.

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

(A) The applicant facility has experienced an average occupancy rate of 92% for the most recent 12 consecutive months and 90% or above for the prior 12 months as verifiable by the Department as of the date an application is submitted to the Department.

(B) The applicant facility has not decreased the number of licensed beds within the 24 months preceding the application date.

(C) The applicant facility shall propose no more than two beds per resident room and shall eliminate all three and/or four bed wards within the existing facility, if applicable, as part of the proposed project.

(D) The applicant facility shall certify the new beds for both Medicare and Medicaid.

(E) The applicant facility shall not relocate any beds from the facility or replace a portion of beds to a new site pursuant to Section 7(3)(d), following CON approval and for at least 24 months from the date of the licensure of the new beds at the facility.

(e) THE APPLICANT SHALL DEMONSTRATE THAT THE PLANNING AREA FOR THE PROPOSED PROJECT HAS AN OCCUPANCY RATE OF 85% OR MORE AS PUBLISHED BY THE DEPARTMENT IN THE MOST RECENT CON ANNUAL SURVEY REPORTS.

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

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

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

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

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

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

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all

licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) THE APPLICANT SHALL DEMONSTRATE THAT THE PLANNING AREA FOR THE PROPOSED PROJECT HAS AN OCCUPANCY RATE OF 85% OR MORE AS PUBLISHED BY THE DEPARTMENT IN THE MOST RECENT CON ANNUAL SURVEY REPORTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) An approved project may involve replacement of a portion of the beds of an existing facility at a geographic location within the replacement zone that is not physically connected to the current licensed site. If a portion of the beds are replaced at a location that is not the current licensed site, a separate license shall be issued to the facility at the new location. If beds have been added pursuant to Section 6(1)(d)(ii), then the applicant facility shall not relocate any beds from the facility or replace a portion of beds to a new site following CON approval and for at least 24 months from the date of the licensure of the new beds at the facility.

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

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

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

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

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

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

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

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

(f) If beds have been added pursuant to Section 6(1)(d)(ii), then the applicant facility shall not relocate any beds from the facility or replace a portion of beds to a new site following con approval and for at least 24 months from the date of the licensure of the new beds at the facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The acquisition will not result in a change in bed capacity.
(c) The licensed site does not change as a result of the acquisition.
(d) The project is limited solely to the acquisition of a nursing home/HLTCU with a valid license.
(e) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Care Services within LARA. Code deficiencies include any unresolved deficiencies still outstanding with the Department, and
(f) The applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health Care Services within LARA, and shall post the annual report in the facility if the facility being acquired has met any of conditions in subsections (a)(i), (ii), (iii), (iv), (v), or (vi).
(g) If the applicant is a new entity with no prior NH-HLTCU history, the applicant shall submit proof that:
(i) The nursing home/HLTCU to be acquired is no longer listed as a special focus nursing home by the Center for Medicare and Medicaid Services, or the applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health Care Services within LARA, and shall post the annual report in the facility; and
(ii) All delinquent debt obligations to the State of Michigan including, but not limited to, QAAP, PASARR or CMPs have been paid.

(2) An applicant proposing to acquire an existing nursing home/HLTCU approved pursuant to the new design model shall demonstrate the following:
(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/HLTCUs:

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

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.
(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.
(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.
(iv) A number of citations at level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/HLTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common

ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

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

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

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

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

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

(e) If the applicant is a new entity with no prior NH-HLTCU history, the applicant shall submit proof that:

(i) The nursing home/HLTCU to be acquired is no longer listed as a special focus nursing home by the Center for Medicare and Medicaid Services, or the applicant shall participate in a quality improvement program, approved by the Department, for five years and provide an annual report to the Michigan State Long-Term-Care Ombudsman, Bureau of Health Care Services within LARA, and shall post the annual report in the facility; and

(ii) All delinquent debt obligations to the State of Michigan including, but not limited to, QAAP, PASARR OR CMPs have been paid.

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

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

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

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

**Section 10. Review standards for comparative review**

Sec. 10. (1) Any application subject to comparative review, under Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, or under these standards, shall be grouped and reviewed comparatively with other applications in accordance with the CON rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Percentage “Applicant’s Cash” | Points Awarded |
|---|---|
| Over 20% | 5 |
| 10 – 20% | 3 |
| 5 – 9% | 2 |

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

(7) A qualifying project will be awarded six (6) or four (4) points based on only one of the following:

(a) Six (6) points if the proposed project has 100% rooms with dedicated toilet room containing a sink, water closet, and bathing facility or

(b) Four (4) points if the proposed project has 80% private rooms with dedicated toilet room containing a sink, water closet and bathing facility.

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

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

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

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

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

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

(13) A qualifying project will be awarded three (3) points if the proposed project includes bariatric rooms as follows: project using 0 – 49 beds will result in at least one (1) bariatric room or project using 50 or more beds will result in at least two (2) bariatric rooms. Bariatric room means the creation of patient room(s) included as part of the CON project, and identified on the architectural schematics, that are designed to accommodate the needs of bariatric patients weighing over 350 pounds. The bariatric patient rooms shall have a larger entrance width for the room and bathroom to accommodate over-sized equipment, and shall include a minimum of a bariatric bed, bariatric toilet, bariatric wheelchair, and a device to assist resident movement (such as a portable or build in lift). If an in-room shower is not included in the bariatric patient room, the main/central shower room that is located on the same floor as the bariatric patient room(s) shall include at least one (1) shower stall that has an opening width and depth that is larger than minimum MI code requirements.

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

(15) The Department shall approve those qualifying projects which, when taken together, do not exceed the need as defined in Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws, and which have the highest number of points when the results of subsections (2) through (12) are totaled. If two or more qualifying projects are determined to have an identical number of points, then the Department shall approve those qualifying projects which, when taken together, do not exceed the need, as defined in Section 22225(1), in the order in which the applications were received by the Department, based on the date and time stamp on the application when the application is filed.

**Section 11. Project delivery requirements and terms of approval**

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

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

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

(a) Compliance with Section 22230 of the Code shall be based on the nursing home's/HLTCU's actual Medicaid participation within the time periods specified in these standards. Compliance with Section 10(2)(a) of these standards shall be determined by comparing the nursing home's/HLTCU's actual patient days reimbursed by Medicaid, as a percentage of the total patient days, with the applicable schedule set forth in Section 10(2)(a) for which the applicant had been awarded points in the comparative review process. If any of the following occurs, an applicant shall be required to be in compliance with the range in the schedule immediately below the range for which points had been awarded in Section 10(2)(a), instead of the range of points for which points had been awarded in the comparative review in order to be found in compliance with Section 22230 of the Code: (i) the average percentage of Medicaid recipients in all nursing homes/HLTCUs in the planning area decreased by at least 10 percent between the second 12 months of operation after project completion and the most recent 12-month period for which data are available, (ii) the actual rate of increase in the Medicaid program per diem reimbursement to the applicant nursing home/HLTCU is less than the annual inflation index for nursing homes/HLTCUs as defined in any current approved Michigan State Plan submitted under Title XIX of the Social Security Act which contains an annual inflation index, or (iii) the actual percentage of the nursing home's/HLTCU's patient days reimbursed by Medicaid (calculated using total patient days for all existing and proposed nursing home beds at the facility) exceeds the statewide average plus 10 percent of the patient days reimbursed by Medicaid for the most recent year for which data are available from the Michigan Department of Health and Human Services [subsection (iii) is applicable only to Section 10(2)(a)]. In evaluating subsection (ii), the Department shall rely on both the annual inflation index and the actual rate increases in per diem reimbursement to the applicant nursing home/HLTCU and/or all nursing homes/HLTCUs in the HSA.

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

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

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

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

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

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

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

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

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

(a) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information; operating schedules; and demographic, diagnostic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on an individual basis for each licensed site, in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

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

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

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

**Section 12. Department inventory of beds**

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

**Section 13. Wayne County planning areas**

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

Planning Area 84/Northwest Wayne

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

Planning area 85/Southwest Wayne

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

Planning area 86/Detroit

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

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

Sec. 14. (1) These CON review standards supersede and replace the CON Standards for Nursing Home and Hospital Long-Term-Care Unit (HLTCU) Beds approved by the CON Commission on ~~December 11, 2014~~JUNE 15, 2017 and effective on ~~March 20, 2015~~SEPTEMBER 21, 2017.

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

(a) replacement of an existing nursing home/HLTCU being replaced in the replacement zone;

(b) replacement of an existing nursing home/HLTCU pursuant to Section 7(3) and within the same planning area as the existing licensed site;

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

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

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

**APPENDIX A**

Counties assigned to each of the HSAs are as follows:

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

**APPENDIX B**

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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

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

**Section 1. Applicability; definitions**

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

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

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

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

(a) “Bariatric patient” means a patient weighting over 350 pounds.

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Behavioral beds will be allocated 400 beds.

(iii) Bariatric beds will be allocated 60 beds.

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

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

(i) Alzheimer's disease has 384 beds.

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

(iii) Religious has 292 beds.

(iv) Hospice beds has 70 beds.

(c) The Commission may adjust/redistribute the number of beds available in the statewide pool for the needs of special population groups in subsection (1)(a) concurrent with the biennial recalculation of the statewide nursing home and hospital long-term care unit bed need. Modifying the number of beds available in the statewide pool for the needs of special population groups in subsection (1)(a) pursuant to this section shall not require a public hearing or submittal of the standard to the Legislature and the Governor in order to become effective.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 6. Requirements for approval for beds from the statewide pool for special population groups allocated to bariatric patients**

Sec. 6. The CON Commission determines there is a need for beds for applications designed to determine the efficiency and effectiveness of specialized programs for the care and treatment of bariatric patients as compared to serving these needs in general nursing home unit(s).

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

(a) The facility shall not be awarded more than 10 beds.

(b) The facility may place beds throughout the facility for a flexible and seamless inclusive resident design.

(c) The proposed beds shall have adequate access to an outdoor or indoor area for activities with appropriate equipment.

(d) The physical environment of any unit containing bariatric beds shall be designed to facilitate visitors.

(e) The unit/beds shall have available specialty equipment to assist staff in providing care.

(f) The beds shall be located on a ground floor and emergency egress will not require stairways or elevators to exit.

(g) The beds shall be established in either single or double occupancy rooms, there shall be no rooms with more than two beds.

(2) Beds approved under this subsection shall not be converted to or utilized for general nursing home use without a CON for nursing home and hospital long-term care unit beds.

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

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

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

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

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

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

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

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

(3) Beds approved under this subsection shall not be converted to or utilized for general nursing home use without a CON for nursing home and hospital long-term care unit beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The facility shall not be awarded more than 10 beds.

(b) The facility may place beds throughout the facility for a flexible and seamless inclusive resident design.

(c) The proposed beds shall have adequate access to an outdoor or indoor area for activities with appropriate equipment.

(d) The physical environment of any unit containing bariatric beds shall be designed to facilitate visitors.

(e) The beds shall have available specialty equipment to assist staff in providing care.

(f) The beds shall be located on a ground floor and emergency egress will not require stairways or elevators to exit.

(g) Beds approved under this subsection shall not be converted to or utilized as general nursing home use without a CON for nursing home and hospital long-term care unit beds under the CON review standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) respiratory therapy.

(ii) occupational and physical therapy.

(iii) psychological services.

(iv) family and patient teaching activities.

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

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

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

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

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

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

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

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

(ii) placement and care of urinary catheters.

(iii) care and use of thermometers.

(iv) care and use of tracheostomy devices.

(v) employee personal hygiene.

(vi) aseptic technique.

(vii) care and use of respiratory therapy and related equipment.
(viii) isolation techniques and procedures.
(e) An applicant shall establish a multi-disciplinary infection control committee that meets on at least a monthly basis and includes the director of nursing, the ventilator-dependent unit program director, and representatives from administration, dietary, housekeeping, maintenance, and respiratory therapy. This subsection does not require a separate committee, if an applicant organization has a standing infection control committee and that committee's charge is amended to include a specific focus on the ventilator-dependent unit.
(f) The proposed ventilator-dependent unit shall have barrier-free access to an outdoor area in the immediate vicinity of the unit.
(g) An applicant shall agree that the beds will not be used to service individuals that are not ventilator-dependent unless a separate CON is requested and approved by the Department pursuant to applicable CON review standards.
(h) An applicant shall provide data to the Department that evaluates the cost efficiencies that result from providing services to ventilator-dependent patients in a hospital.

(6) An applicant for beds from the statewide pool for special population groups allocated to TBI/SCI patients shall agree that if approved:
(a) An applicant shall staff the proposed unit for TBI/SCI patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:
(i) A medical director with specialized knowledge, training, and skills in the care of TBI/SCI patients.
(ii) A program director that is a registered nurse.
(iii) Other professional disciplines required for a multi-disciplinary team approach to care.
(b) An applicant shall establish and maintain written policies and procedures for each of the following:
(i) Patient admission criteria that describe minimum and maximum characteristics for patients appropriate for admission to the unit for TBI/SCI patients. At a minimum, the criteria shall address the required medical stability and the need for ancillary services, including dialysis services.
(ii) The transfer of patients requiring care at other health care facilities, including a transfer agreement with one or more acute-care hospitals in the region to provide emergency medical treatment to any patient who requires such care.
(iii) Upon admission and periodically thereafter, a comprehensive needs assessment, a treatment plan, and a discharge plan that at a minimum addresses the care needs of a patient following discharge, including support services to be provided by transitional living programs or other outpatient programs or services offered as part of a continuum of care to TBI patients by the applicant.
(iv) Utilization review, which shall consider the rehabilitation necessity for the service, quality of patient care, rates of utilization and other considerations generally accepted as appropriate for review.
(v) Quality assurance and assessment program to assure that services furnished to TBI/SCI patients meet professional recognized standards of health care for providers of such services and that such services were reasonable and medically appropriate to the clinical condition of the TBI patient receiving such services.

(7) An applicant for beds from the statewide pool for special population groups allocated to behavioral patients shall agree that if approved:
(a) An applicant shall staff the proposed unit for behavioral patients with employees that have been trained in the care and treatment of such individuals and includes at least the following:
(i) A medical director with specialized knowledge, training, and skills in the care of behavioral patients.
(ii) A program director that is a registered nurse.
(iii) Other professional disciplines required for a multi-disciplinary team approach to care.

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

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

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

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

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

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

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

(a) The facility shall not be awarded more than 10 beds.

(b) The facility may place beds throughout the facility for a flexible and seamless inclusive resident design.

(c) The proposed beds shall have adequate access to an outdoor or indoor area for activities with appropriate equipment.

(d) The physical environment of any unit containing bariatric beds shall be designed to facilitate visitors.

(e) The beds shall have available specialty equipment to assist staff in providing care.

(f) The beds shall be located on a ground floor and emergency egress will not require stairways or elevators to exit.

(g) The beds shall be established in either single or double occupancy rooms. There shall be no rooms with more than two beds.

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

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

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

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

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

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

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

# Standards Advisory Committee Report
# Nursing Homes and Hospital Long-term Care Units
# June 10, 2020 Interim Report

The Nursing Home and Hospital Long-term Care Units (NH/HLTCU) Standards Advisory Committee (SAC) has met on December 19, 2019, January 16, 2020 and February 20, 2020 in person and via Zoom meeting on May 21, 2020. In addition a sub-committee has met often to work through the seven potential models that were considered. The workgroup included staff from the Department and Dr. Paul Delamater. They have been able to find consensus and will be presenting their recommendations to the full SAC committee at our meeting on June 11, 2020 for consideration and final recommendation. The SAC will provide a final report to the full CON Commission after our June 11, 2020 meeting with recommendations on all of the Charges before the SAC.

Thank you,

Donald A Haney SAC Chair

# BAMF Health

BOLD ADVANCED MEDICAL FUTURE

- Serve Unserved and Underserved Patients.

- Achieve Intelligence-Based Precision Medicine through AI-enabled Molecular Imaging and Theranostics (Molecular Targeted Radiation Therapy)

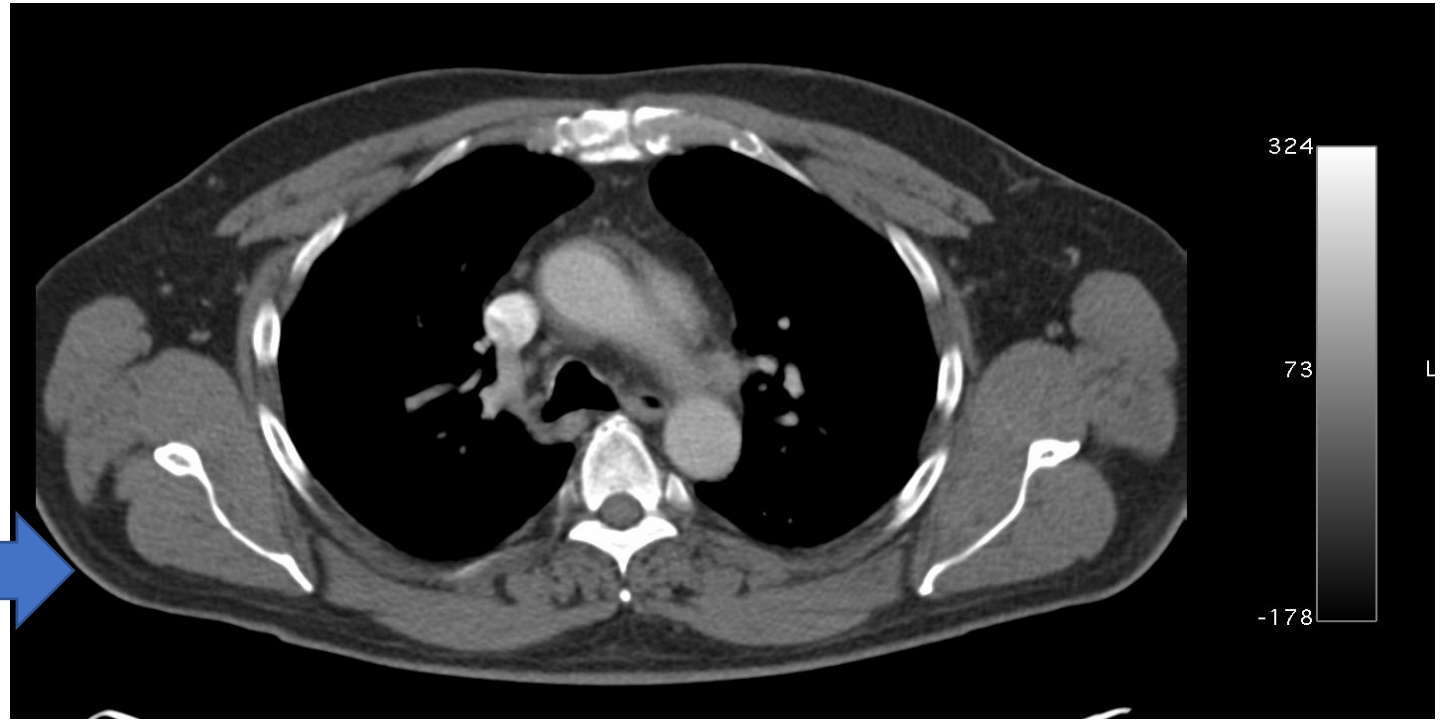
# BAMF Technology:

- Detect/See the diseases which can not be detected/seen.

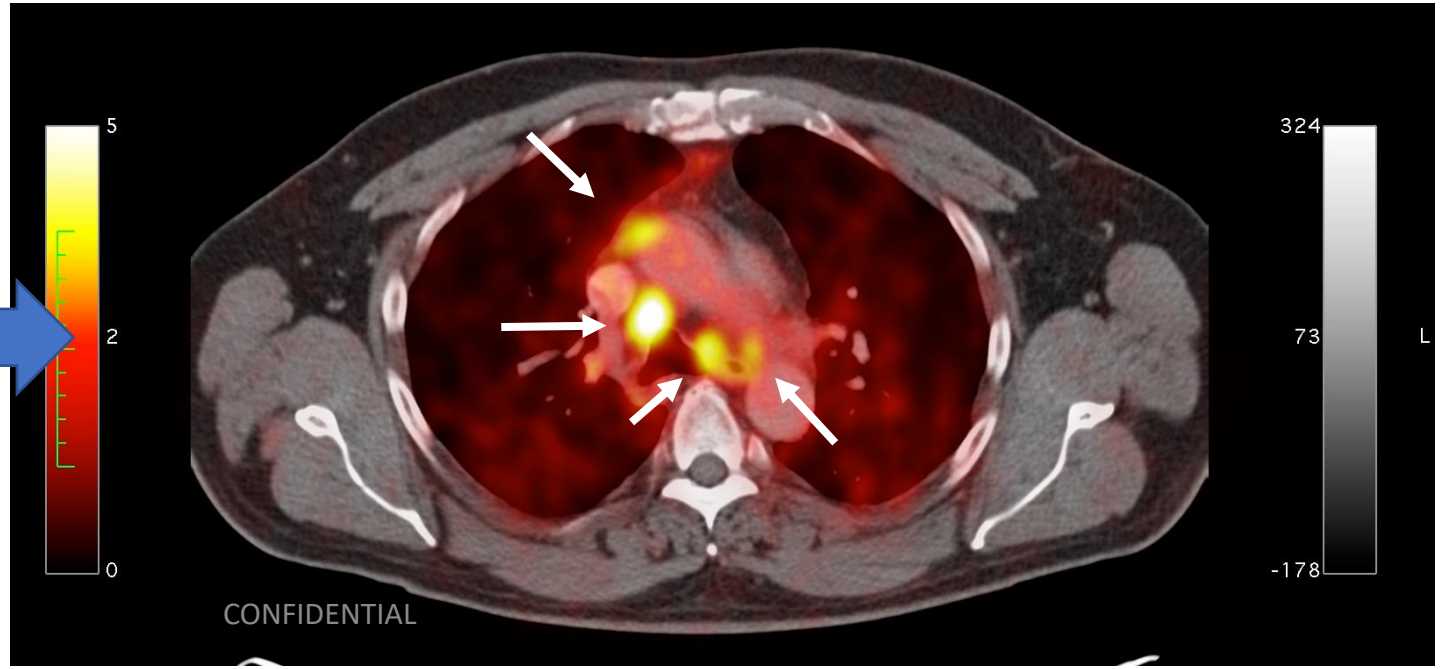
- Treat the diseases which can not be treated.

BAMF's technology can detect diseases that cannot be detected currently.

CT images show no signs of cancer in a 65 y/o patient.




BAMF uses novel PET tracers to identify early stage prostate cancer tumors. (Arrows, ~ 3 mm in size)

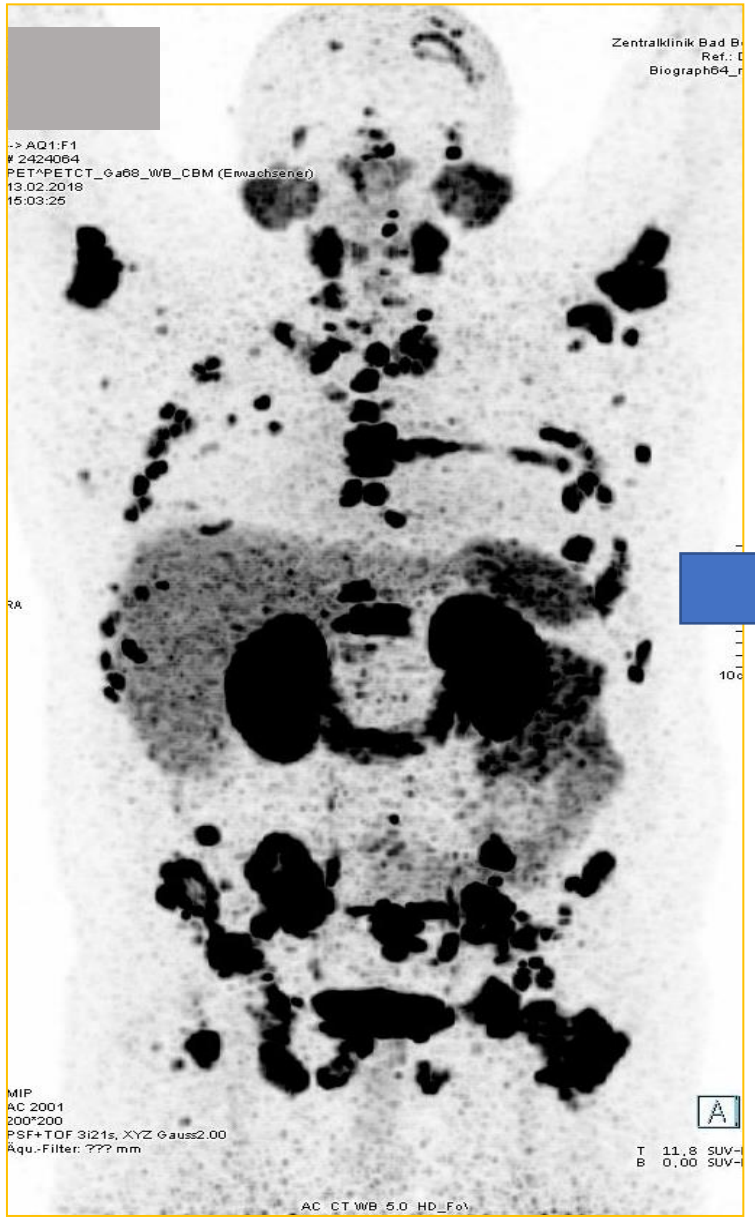





BAMF

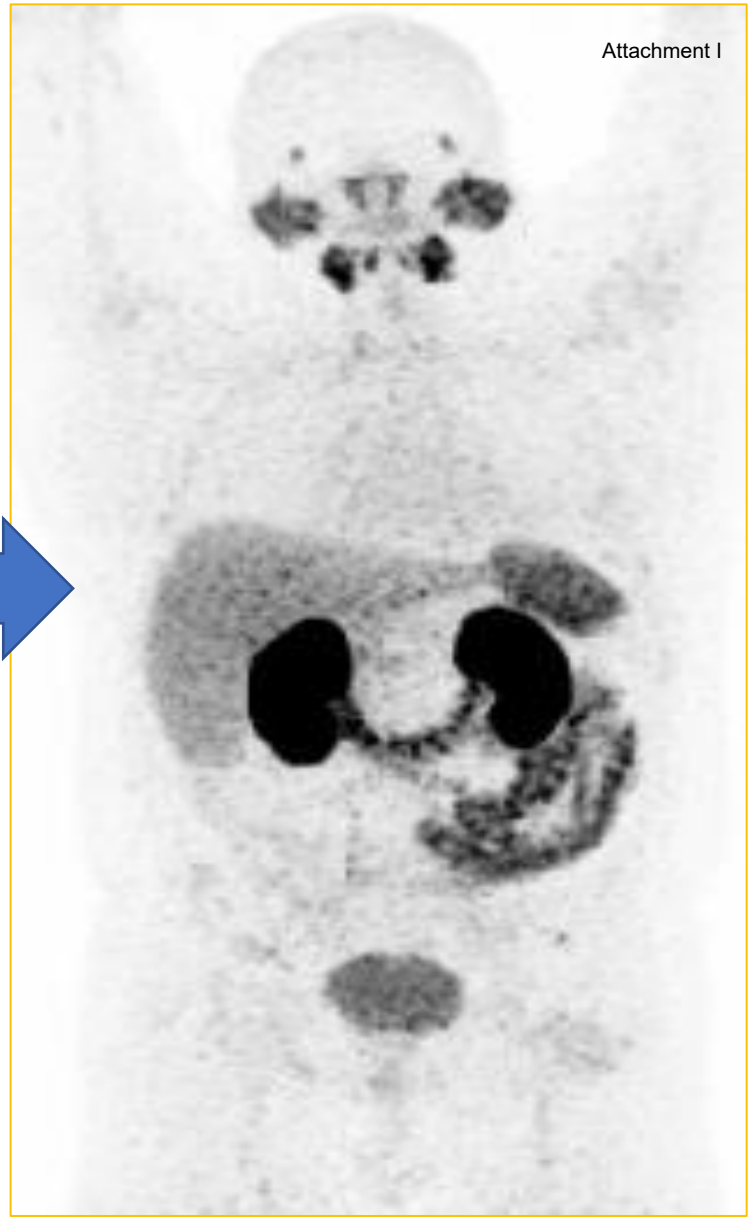
BAMF's technology can treat diseases which cannot be treated currently.

Patient achieved complete remission from end stage prostate cancer with BAMF's molecular targeted radiation therapy. (MTRT)




Before MTRT

(majority of black spots shown are cancers)

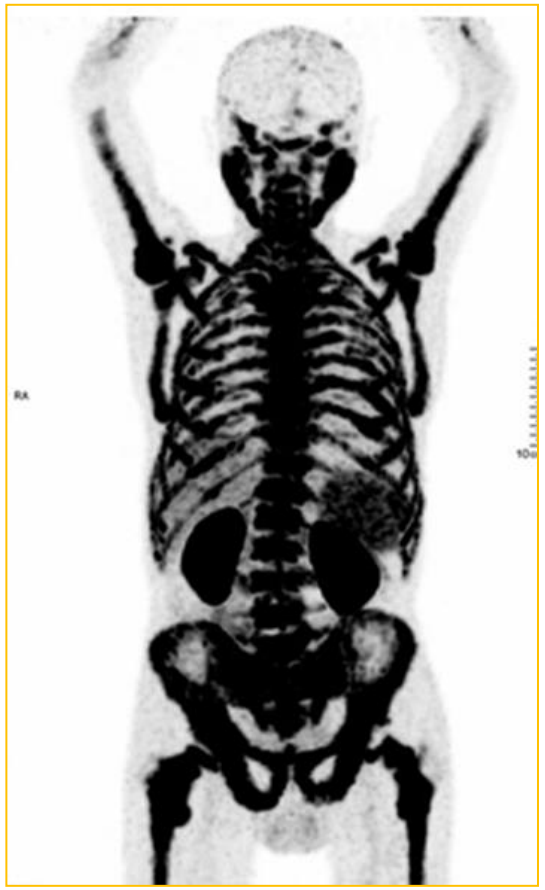



After MTRT

(Complete remission)

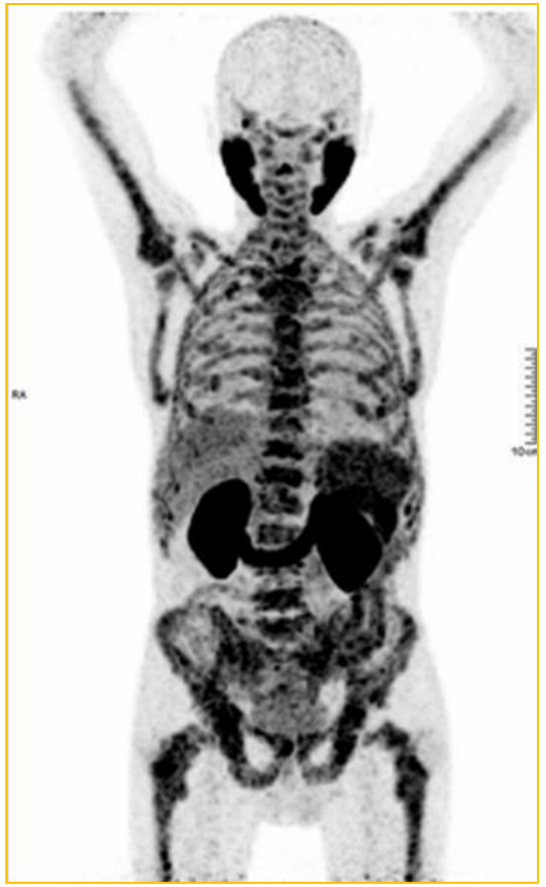
BAMF

## 05.26.2017



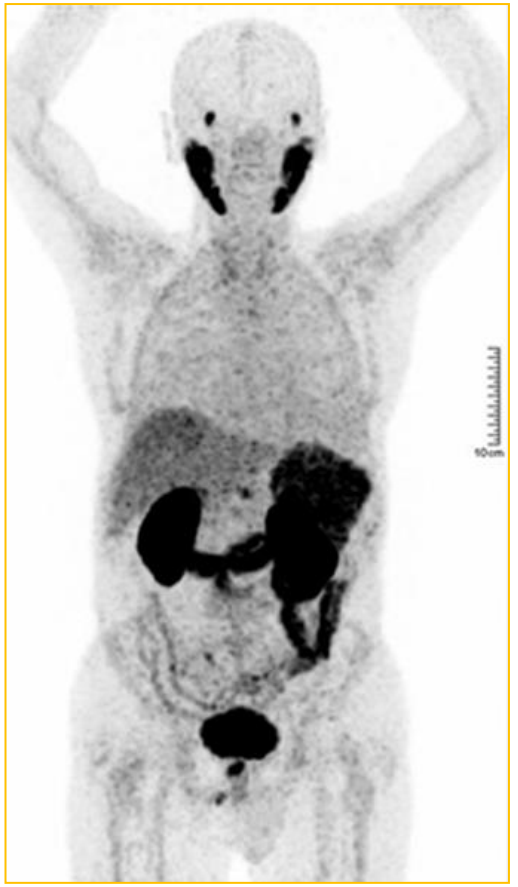
PSA = 1799 ng/ml
(05.05.2017)

## 08.28.2017



PSA = 276 ng/ml
(08.27.2017)

## 04.05.2018



PSA = 9.59 ng/ml
(04.05.2018)

*Courtesy of Dr. Prof. Richard Baum, CMO, BAMF Health/Zentralklinik Bad Berka*

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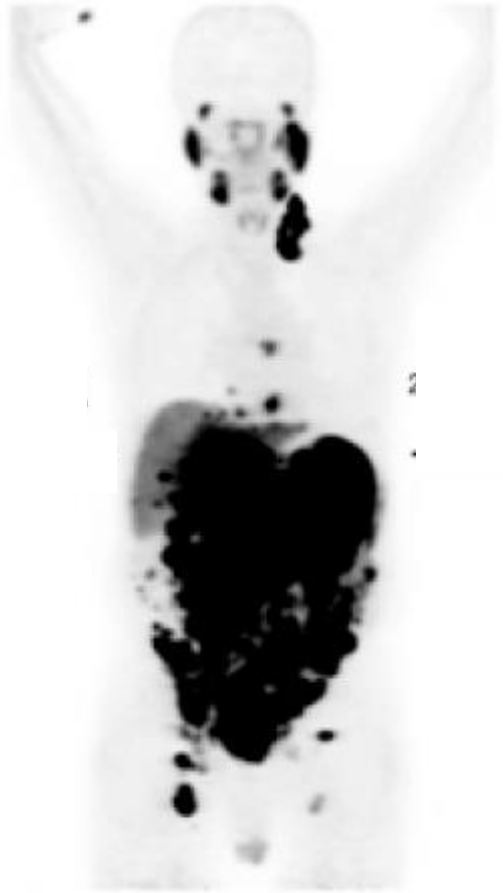
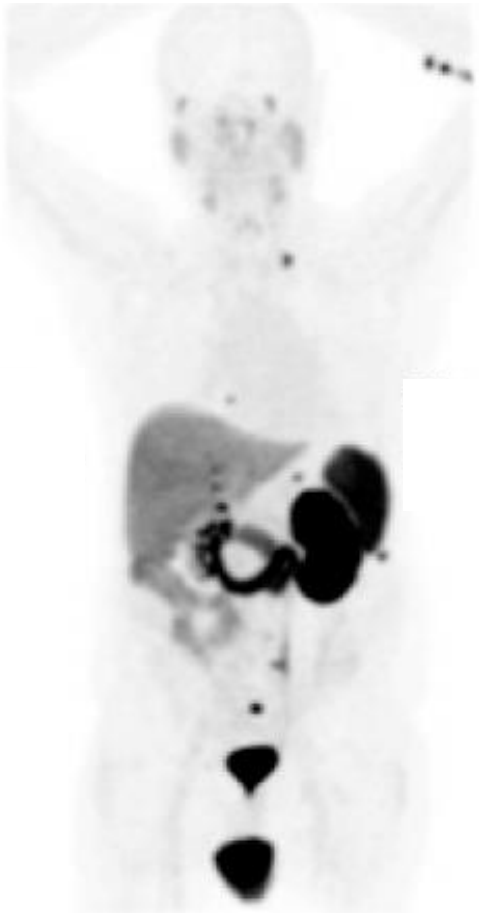
**09.2015**



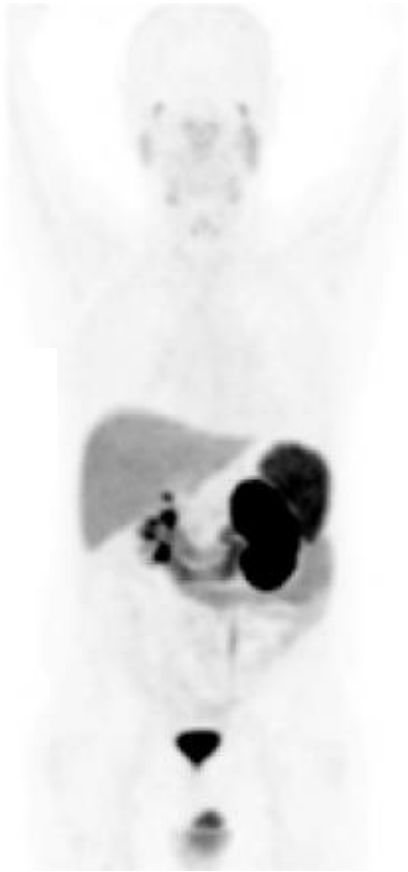
**PSA = 419 ng/ml**

**02.2016**



**PSA = 3.5 ng/ml**

**04.2016**



**PSA = <0.1 ng/ml**

*Courtesy of Dr. Prof. Richard Baum, C* 2/2016 PSA = 3.5 ng/ml *ntralklinik Bad Berk* 4/2016 PSA < 0.1 ng/ml

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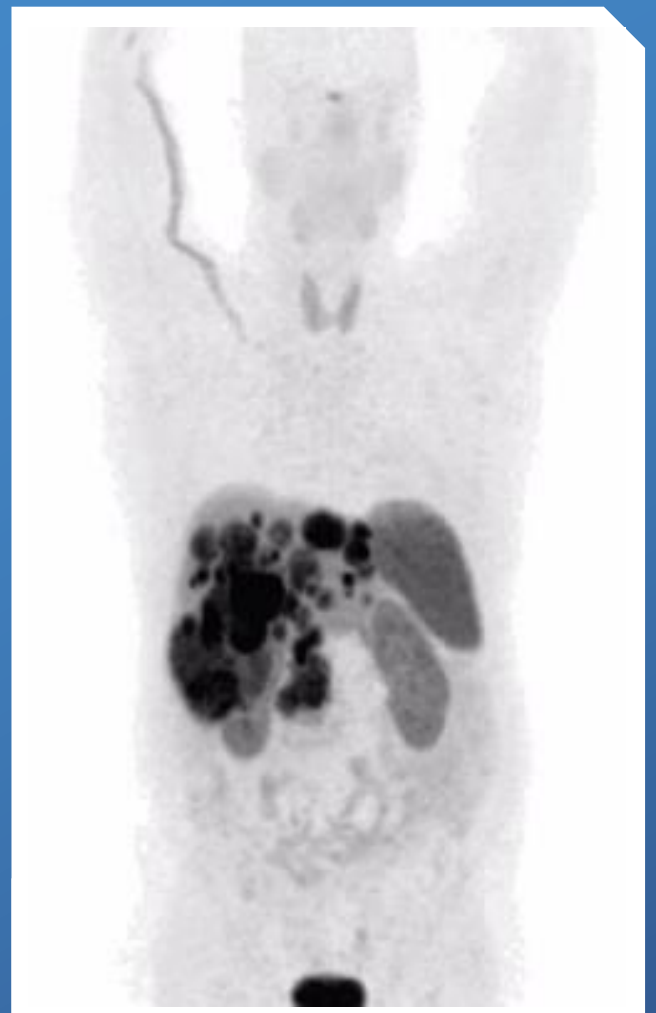
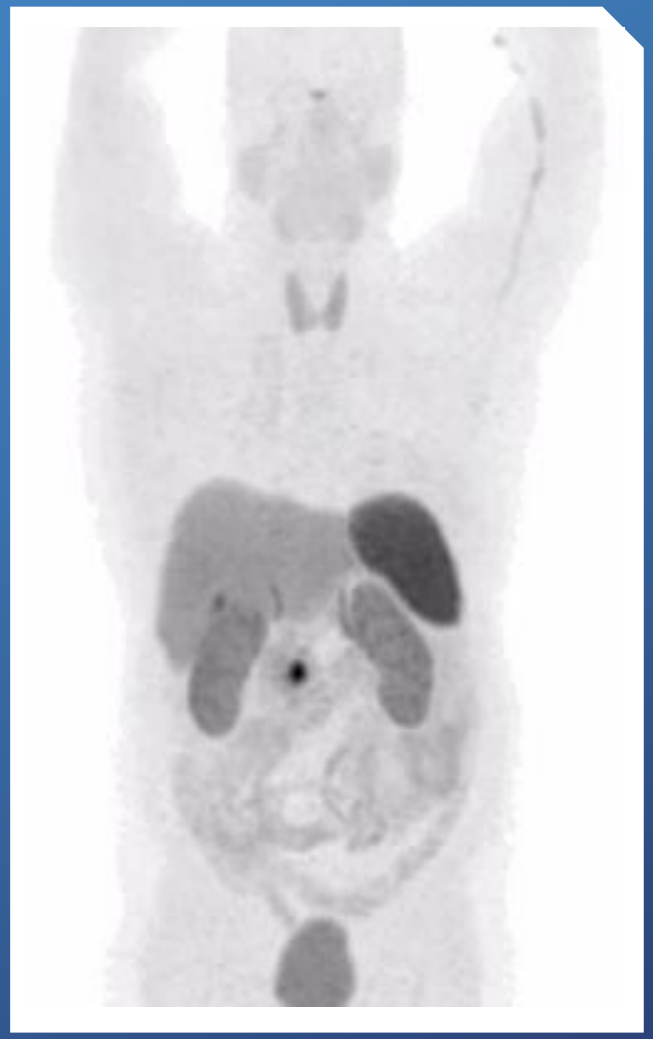
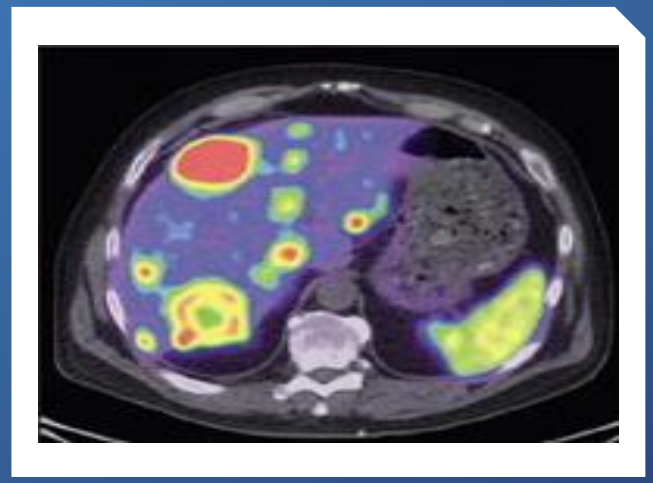
# Theranostics

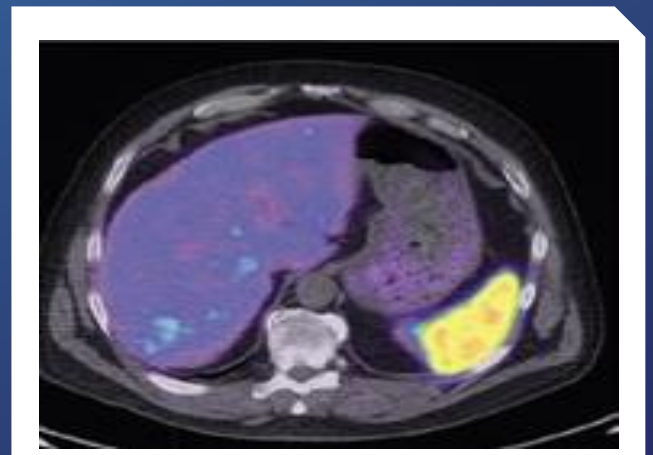
## Molecular Imaging + Molecular Targeted Radiation Therapy

Attachment I









**Neuroendocrine Tumor**
(Steve Job's Cancer)

BAMF

- PET (molecular imaging) has proven to be a very powerful tool in disease detection and as an essential tool for precision medicine.

- It detects the disease earlier, indicates the right treatment strategy, prevents unnecessary medical procedures, improves outcomes, and lowers total medical cost.

- The following 3 major obstacles must be addressed:
  - Extremely outdated radiopharmacy facilities. (Tracer manufacturing)
  - Short Radioactive Half-life of tracers. (Shelf life of 2 minutes to 12 hours)
  - PET scanner install base utilizes principles of physics more than 30 years old (achieving very poor resolution, sensitivity, contrast, and throughput)

## Problems

- Supply of wide variety of novel tracers at commercial scale at affordable price.
- Access to short half-life tracers
- Whole-Body Imaging vs half-body imaging
- High sensitivity
- Less radiation dose (Pediatric patients)
- Faster scan (Pediatric patient, no sedation needed)
- High Throughput
- High soft-tissue contrast

## Solutions

- Modern Cyclotron-Equipped Radiopharmacy
- Whole-Body PET/CT
- PET/MR

# Urgent Need and Request

A CON category for Fixed novel Whole-body PET/CT and PET/MR scanners located immediately adjacent to a modern cyclotron-equipped radiopharmacy.

Un-served/ under-served Patients we can serve with this design:

- Terminal Cancer
- Cardiac Disease
- Mental Disorder (Depression, PTSD,…)
- Dementia (Alzheimer's, Parkinson)
- Epilepsy
- Endometriosis
- Chronic Pain
- Pediatric patients

BAMF

# Whole-Body PET/CT

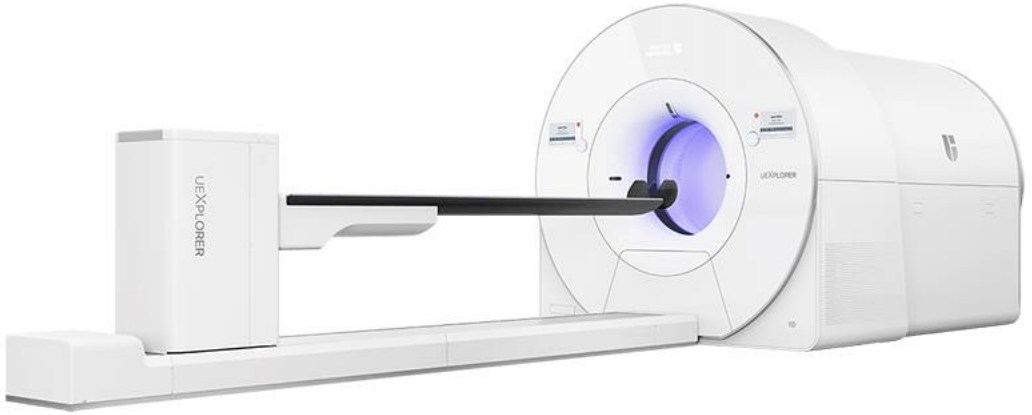
BAMF

# Whole-Body PET/CT (WB-PET/CT)

**FOR THE CLINICAL PRACTICE,**
**THIS MEANS:**

- Scan times can be less than 1 min. (conventional scans are 40 min)
- 40x Less radiation dose to patients
- Ability to see/learn about diseases in new ways, potentially catching them in earlier stages
- May be able to detect sub-millimeter cancer lesions (micro-metastasis)
- Doctors can see more patients (higher throughput)
- Pediatric patients can be scanned due to less radiation and sedation concerns

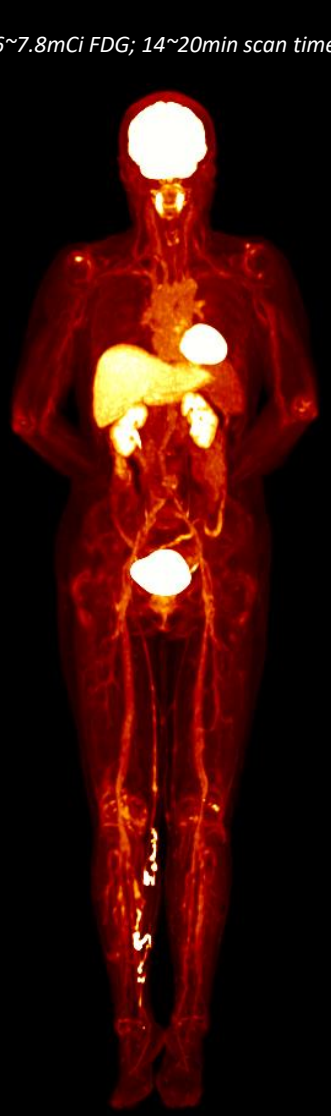
- Higher Resolution & Higher Sensitivity (40X)
- Bigger Field of View (195 cm vs. 30 cm)
- Better Signal-to-Noise Ratio (6X)
- Enables true dynamic imaging



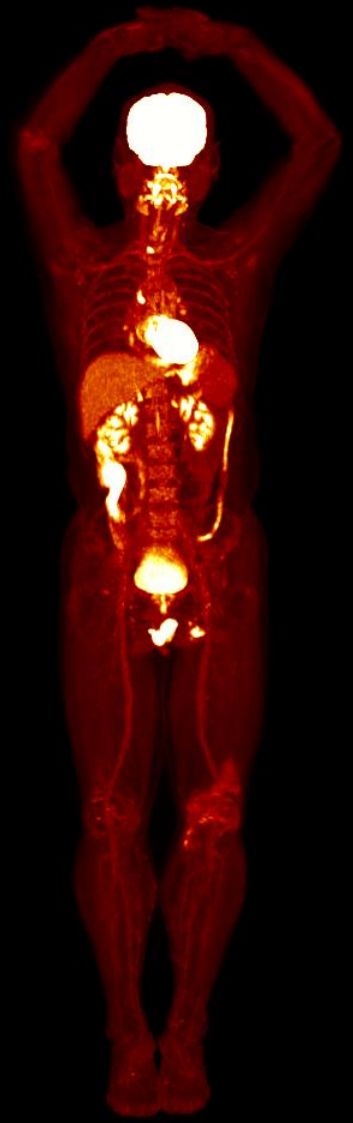

BAMF

# Molecular/Functional Images with Anatomical Details

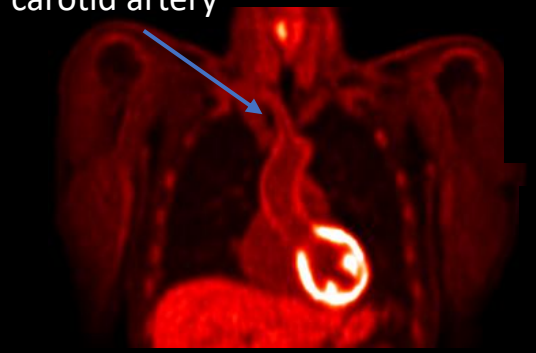
*6~7.8mCi FDG; 14~20min scan time.*

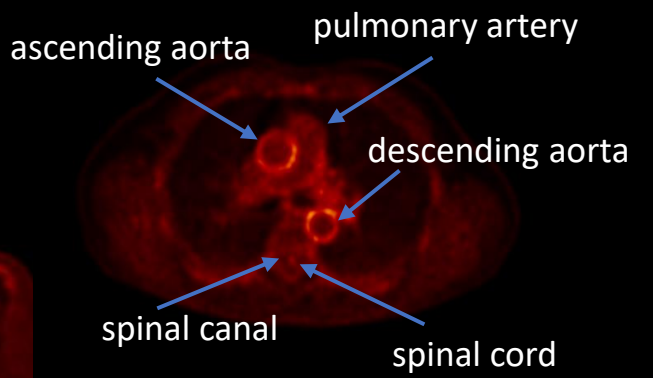


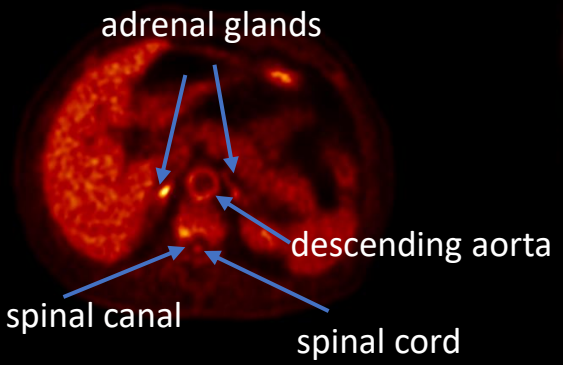
30 min post injection

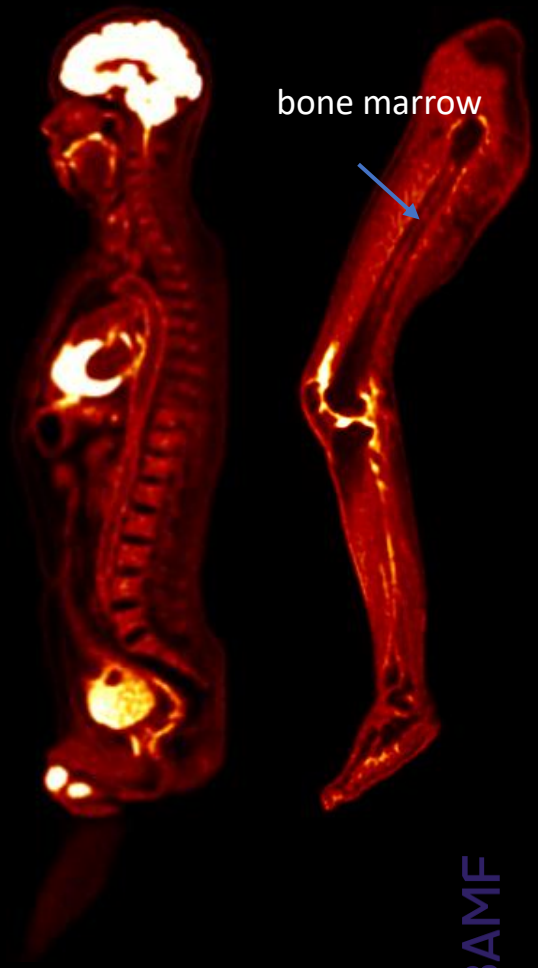


1.7 hr post injection



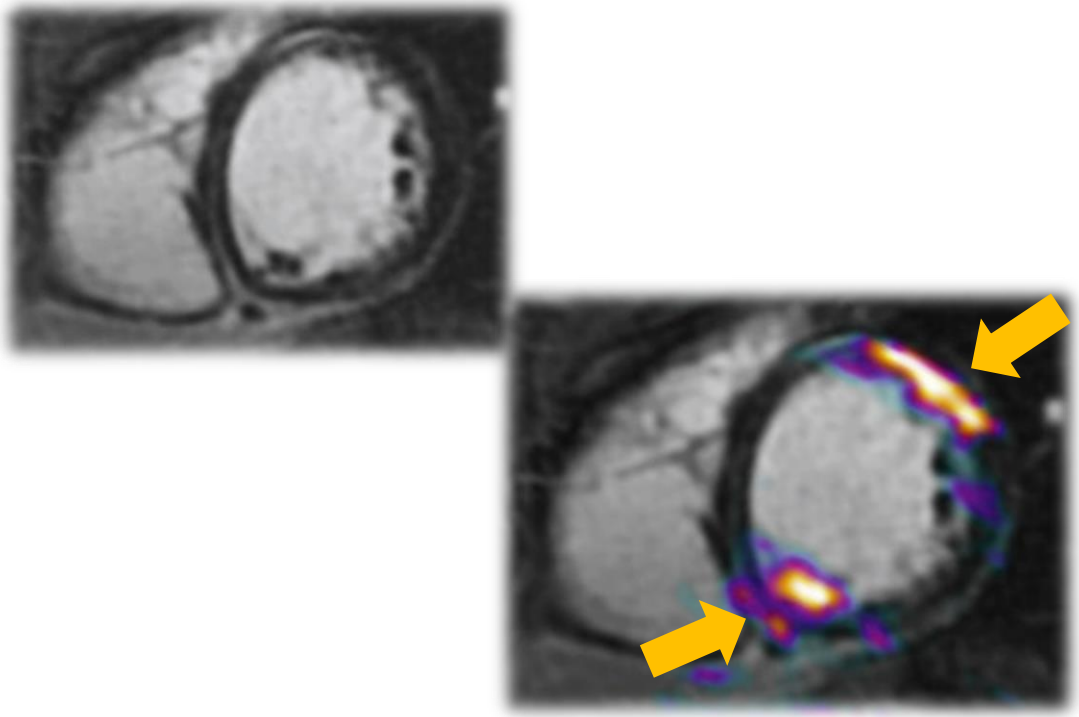

*All human images acquired under IRB-approved protocol.*
*Images courtesy of Dr.* Hongcheng Shi, *Zhongshan Hospital*

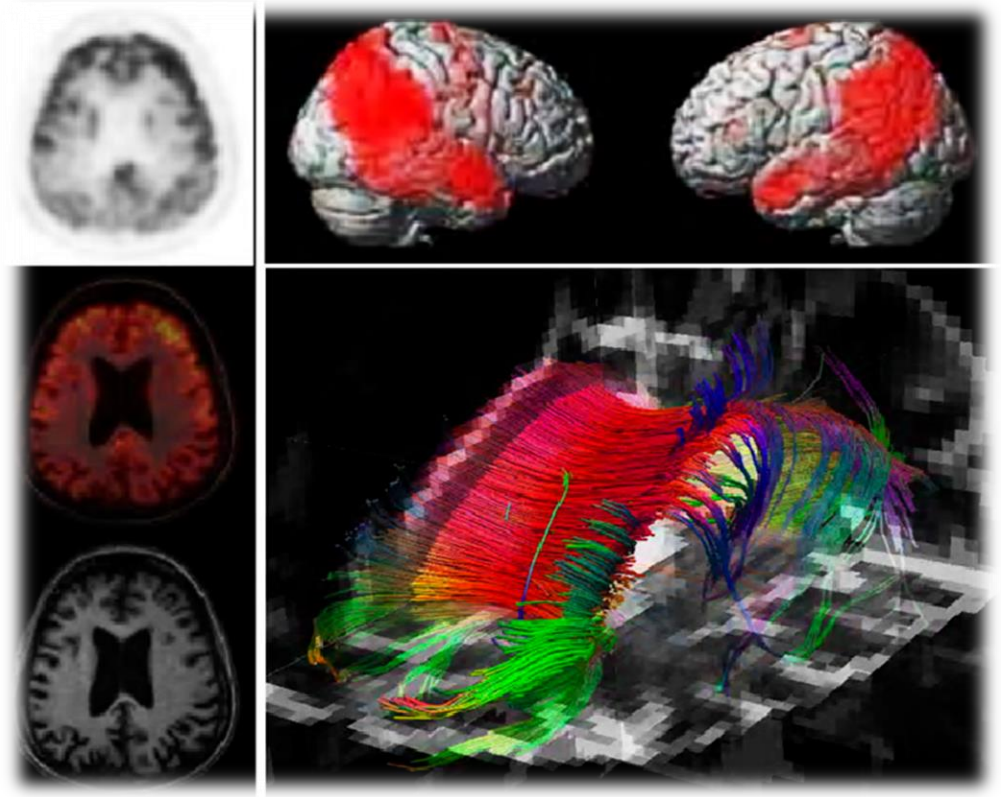
BAMF

# PET/MRI

BAMF

- > 50 PET/MRI scanners installed in US
- 0 in Michigan
- Powerful tool for neurological, cardiological, and oncological diagnosis.





BAMF

BAMF Health is building a modern cyclotron-equipped radiopharmacy, a molecular imaging clinic, and a MTRT clinic located in MSU's Doug Meijer Medical Innovation Building.

Break Ground: November, 2019

Estimated Opening: February, 2022

BAMF

Attachment I


BAMF


BAMF

# Request

A CON category for Fixed novel Whole-body PET/CT and PET/MR scanners located immediately adjacent to a modern cyclotron-equipped radiopharmacy.

Thank you!

BAMF

CERTIFICATE OF NEED

**1st Quarter Compliance Report to the CON Commission**

October 1, 2019 through September 30, 2020 (FY 2020)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients as required by Section 22247 of the Public Health Code.

**MCL 333.22247**

*(1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.*

*(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:*

*(a) Revoke or suspend the certificate of need.*

*(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.*

*(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.*

*(d) Request enforcement action under section 22253.*

*(e) Take any other enforcement action authorized by this code.*

*(f) Publicize or report the violation or enforcement action, or both, to any person.*

*(g) Take any other action as determined appropriate by the department.*

*(3) A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill.*

**Activity Report**

*Follow Up*: In accordance with Administrative Rules 325.9403 and 325.9417, the Department tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

| Activity | 1st Quarter | Year-to-Date |
|---|---|---|
| Approved projects requiring 1-year follow up | 67 | 67 |
| Approved projects contacted on or before anniversary date | 36 | 36 |
| Approved projects completed on or before 1-year follow up | 54% | |
| CON approvals expired | 10 | 10 |
| Total follow up correspondence sent | 219 | 219 |
| Total approved projects still ongoing | 270 | |

*Compliance*: In accordance with Section 22247 and Rule 9419, the Department performs compliance checks on approved and operational Certificates of Need to determine if projects have been implemented, or if other applicable requirements have been met, in accordance with Part 222 of the Code.

- The Department has completed statewide compliance reviews for Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scanner services utilizing the most recent CON Annual Survey and MRI Utilization List data. Please see attached reports detailing findings of the statewide compliance reviews for MRI and PET services.

CERTIFICATE OF NEED

**2nd Quarter Compliance Report to the CON Commission**

October 1, 2019 through September 30, 2020 (FY 2020)

This report is to update the Commission on Department activities to monitor compliance of all Certificates of Need recipients as required by Section 22247 of the Public Health Code.

**MCL 333.22247**

*(1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.*

*(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:*

*(a) Revoke or suspend the certificate of need.*

*(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.*

*(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.*

*(d) Request enforcement action under section 22253.*

*(e) Take any other enforcement action authorized by this code.*

*(f) Publicize or report the violation or enforcement action, or both, to any person.*

*(g) Take any other action as determined appropriate by the department.*

*(3) A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill.*

**Activity Report**

*Follow Up*: In accordance with Administrative Rules 325.9403 and 325.9417, the Department tracks approved Certificates of Need to determine if proposed projects have been implemented in accordance with Part 222. By rule, applicants are required to either implement a project within one year of approval or execute an enforceable contract to purchase the covered equipment or start construction, as applicable. In addition, an applicant must install the equipment or start construction within two years of approval.

| Activity | 2nd Quarter | Year-to-Date |
|---|---|---|
| Approved projects requiring 1-year follow up | 59 | 126 |
| Approved projects contacted on or before anniversary date | 41 | 77 |
| Approved projects completed on or before 1-year follow up | 69% | |
| CON approvals expired | 16 | 26 |
| Total follow up correspondence sent | 243 | 462 |
| Total approved projects still ongoing | 265 | |

*Compliance*: In accordance with Section 22247 and Rule 9419, the Department performs compliance checks on approved and operational Certificates of Need to determine if projects have been implemented, or if other applicable requirements have been met, in accordance with Part 222 of the Code.

- The Department proposes conducting statewide compliance reviews for Surgical Services and Air Ambulance (Helicopter) services, utilizing 2018 CON Annual Survey data. The Department is in the process of evaluating annual survey data, review standard requirements, facilities' responses to compliance questionnaire, and CON approved facilities for these selected services to identify the facilities for compliance investigations. The Department will be setting up conference calls with these identified facilities to discuss compliance issues. The finding of the statewide compliance reviews will be reported to the CON Commission at a later date.

CERTIFICATE OF NEED

**1st Quarter Program Activity Report to the CON Commission**

October 1, 2019 through September 30, 2020 (FY 2020)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

## Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| Letters of Intent Received | 95 | N/A | 95 | N/A |
| Letters of Intent Processed within 15 days | 93 | 98% | 93 | 98% |
| Letters of Intent Processed Online | 95 | 100% | 95 | 100% |

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| Applications Received | 73 | N/A | 73 | N/A |
| Applications Processed within 15 Days | 73 | 100% | 73 | 100% |
| Applications Incomplete/More Information Needed | 48 | 66% | 48 | 66% |
| Applications Filed Online* | 68 | 100% | 68 | 100% |
| Application Fees Received Online* | 17 | 25% | 17 | 25% |

* Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Nonsubstantive Applications | 45 | 100% | 45 | 100% |
| Substantive Applications | 14 | 100% | 14 | 100% |
| Comparative Applications | 2 | 100% | 2 | 100% |

*Note*: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.

**Measures – continued**

Administrative Rule R325.9227 requires the Department to determine if an emergency application will be reviewed pursuant to Section 22235 of the Public Health Code within 10 working days upon receipt of the emergency application request.

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Emergency Applications Received | 0 | N/A | 0 | N/A |
| Decisions Issued within 10 workings Days | 0 | N/A | 0 | N/A |

Administrative Rule R325.9413 requires the Department to process amendment requests within the same review period as the original application.

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Amendments | 19 | 100% | 19 | 100% |

Section 22231(10) of the Public Health Code requires the Department to issue a refund of the application fee, upon written request, if the Director exceeds the time set forth in this section for a final decision for other than good cause as determined by the Commission.

| Activity | 1st Quarter | Year-to-Date |
|---|---|---|
| Refunds Issued Pursuant to Section 22231 | 0 | 0 |

**Other Measures**

| Activity | 1st Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| FOIA Requests Received | 71 | N/A | 71 | N/A |
| FOIA Requests Processed on Time * | 71 | 100% | 71 | 100% |
| Number of Applications Viewed Onsite | 0 | N/A | 0 | N/A |

FOIA – Freedom of Information Act.

*Request processed within 5 days or an extension filed.

*Source*: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

CERTIFICATE OF NEED

**2nd Quarter Program Activity Report to the CON Commission**

October 1, 2019 through September 30, 2020 (FY 2020)

This quarterly report is designed to assist the CON Commission in monitoring and assessing the operations and effectiveness of the CON Program Section in accordance with Section 22215(1)(e) of the Public Health Code, 1978 PA 368.

## Measures

Administrative Rule R325.9201 requires the Department to process a Letter of Intent within 15 days upon receipt of a Letter of Intent.

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| Letters of Intent Received | 139 | N/A | 234 | N/A |
| Letters of Intent Processed within 15 days | 139 | 100% | 232 | 99% |
| Letters of Intent Processed Online | 139 | 100% | 234 | 100% |

Administrative Rule R325.9201 requires the Department to request additional information from an applicant within 15 days upon receipt of an application, if additional information is needed.

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| Applications Received | 129 | N/A | 202 | N/A |
| Applications Processed within 15 Days | 129 | 100% | 202 | 100% |
| Applications Incomplete/More Information Needed | 37 | 29% | 85 | 42% |
| Applications Filed Online* | 87 | 67% | 155 | 77% |
| Application Fees Received Online* | 19 | 15% | 36 | 18% |

** Number/percent is for only those applications eligible to be filed online, potential comparative and comparative applications are not eligible to be filed online, and emergency applications have no fee.*

Administrative rules R325.9206 and R325.9207 require the Department to issue a proposed decision for completed applications within 45 days for nonsubstantive, 120 days for substantive, and 150 days for comparative reviews.

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Nonsubstantive Applications | 35 | 100% | 80 | 100% |
| Substantive Applications | 17 | 100% | 31 | 100% |
| Comparative Applications | 2 | 100% | 4 | 100% |

*Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.*

**Measures – continued**

Administrative Rule R325.9227 requires the Department to determine if an emergency application will be reviewed pursuant to Section 22235 of the Public Health Code within 10 working days upon receipt of the emergency application request.

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Emergency Applications Received | 41 | 100% | 41 | 100% |
| Decisions Issued within 10 workings Days | 41 | 100% | 41 | 100% |

*Note: Data in this table may not total/correlate with application received table because receive and processed dates may carry over into next month/next quarter.*

Administrative Rule R325.9413 requires the Department to process amendment requests within the same review period as the original application.

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | Issued on Time | Percent | Issued on Time | Percent |
| Amendments | 24 | 100% | 43 | 100% |

Section 22231(10) of the Public Health Code requires the Department to issue a refund of the application fee, upon written request, if the Director exceeds the time set forth in this section for a final decision for other than good cause as determined by the Commission.

| Activity | 2nd Quarter | Year-to-Date |
|---|---|---|
| Refunds Issued Pursuant to Section 22231 | 0 | 0 |

**Other Measures**

| Activity | 2nd Quarter | | Year-to-Date | |
|---|---|---|---|---|
| | No. | Percent | No. | Percent |
| FOIA Requests Received | 57 | N/A | 128 | N/A |
| FOIA Requests Processed on Time * | 57 | 100% | 128 | 100% |
| Number of Applications Viewed Onsite | 0 | N/A | 0 | N/A |

FOIA – Freedom of Information Act.

**Request processed within 5 days or an extension filed.*

*Source*: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

## Certificate of Need (CON) Statewide Compliance Review

## Magnetic Resonance Imaging (MRI) Scanner Services

As part of the MRI services Statewide Compliance Review, the Department reviewed 306 facilities: 51 Central Service Coordinators for mobile networks (CSCs), 85 Hospitals, 40 Freestanding Facilities, and 130 Host Sites that offer MRI services based on the reported data in the November 1, 2018 MRI Service Utilization List and the 2017 CON Annual Survey. The MRI services for those facilities were approved under 17 different review standards, the oldest dating back to December 19, 1988.

After reviewing the data in the November 1, 2018 MRI Service Utilization List, the 2017 CON Annual Survey and responses to MRI questionnaire, the Department sent emails to confirm the compliance findings with Host Sites, CSCs, Hospitals and Freestanding Facilities. Compliance findings included CSCs reporting only one host site on the mobile network, service not meeting volume requirements, and CSCs not notifying the Department of any additions, deletions or changes in the host sites after the changes in host sites are made. After discussions among the Department and the Hospitals, CSCs, Host Sites and Freestanding Facilities, the Department completed the compliance investigations by entering into 68 settlement agreements (36 CSCs, 12 Host Sites, 7 Hospitals and 13 Freestanding Facilities).

The table below shows the breakdown of the CSCs under each MRI Review Standards:

| Review Standards Effective Date | No. of Mobile Networks (CSC) |
|---|---|
| December 19, 1988 | 2 |
| July 1, 1997 | 2 |
| May 24, 2002 | 1 |
| July 1, 2002 | 4 |
| July 12, 2004 | 2 |
| October 17, 2005 | 2 |
| March 8, 2007 | 2 |
| November 13, 2007 | 1 |
| November 13, 2008 | 2 |
| November 5, 2009 | 7 |
| March 1, 2011 | 2 |
| November 21, 2011 | 2 |
| September 28, 2012 | 7 |
| September 18, 2013 | 1 |
| December 22, 2014 | 4 |
| May 27, 2016 | 3 |
| October 21, 2016 | 7 |

The table below shows the breakdown of the Hospitals under each MRI Review Standards:

| Review Standards Effective Date | No. of Hospitals |
|---|---|
| October 21, 2016 | 1 |
| May 27, 2016 | 3 |
| December 22, 2014 | 13 |
| September 18, 2013 | 8 |
| September 28, 2012 | 6 |
| November 21, 2011 | 8 |
| March 11, 2011 | 7 |
| November 5, 2009 | 15 |
| November 13, 2008 | 1 |
| November 13, 2007 | 5 |
| March 8, 2007 | 3 |
| October 17, 2005 | 7 |
| July 12, 2004 | 5 |
| July 1, 2002 | 3 |

The table below shows the breakdown of the Freestanding Facilities under each MRI Review Standards:

| Review Standards Effective Date | No. of Freestanding Facilities |
|---|---|
| July 12, 2004 | 4 |
| October 17, 2005 | 2 |
| March 8, 2007 | 4 |
| November 13, 2007 | 3 |
| November 13, 2008 | 2 |
| November 5, 2009 | 6 |
| March 11, 2011 | 1 |
| November 21, 2011 | 1 |
| September 28, 2012 | 1 |
| September 18, 2013 | 5 |
| December 22, 2014 | 4 |
| May 27, 2016 | 5 |
| October 21, 2016 | 2 |

The table below shows the breakdown of the Host Sites under each MRI Review Standards:

| Review Standards Effective Date | No. of Host Sites |
|---|---|
| December 19, 1988 | 1 |
| July 1, 1997 | 3 |
| July 1, 2002 | 2 |
| May 24, 2002 | 1 |
| October 17, 2005 | 4 |
| March 8, 2007 | 1 |
| November 13, 2007 | 4 |
| November 13, 2008 | 2 |
| November 5, 2009 | 7 |
| March 11, 2011 | 6 |
| November 21, 2011 | 6 |
| September 28, 2012 | 10 |
| September 18, 2013 | 19 |
| December 22, 2014 | 37 |
| May 27, 2016 | 7 |
| October 21, 2016 | 18 |
| Closed | 2 |

The table below shows the breakdown of the Hospitals, Host Sites, Freestanding Facilities and CSCs under settlement agreement by Health Service Area (HSA):

| FACILITY NAME | STANDARDS | COUNTY | COUNTY DESIGNATION | COMPLIANCE ISSUE |
|---|---|---|---|---|
| **HSA 1: SOUTHEAST MICHIGAN** | | | | |
| Hospital 1 | Sept. 18, 2013 | Wayne | Metropolitan | Volume |
| Hospital 2 | Nov. 13, 2008 | Wayne | Metropolitan | Volume |
| Host Site 1 Networks: 53, 219 | Dec. 22, 2014 | Wayne | Metropolitan | Volume |
| Host Site 2 Network: 53 | Dec. 22, 2014 | Wayne | Metropolitan | Volume |
| Host Site 3 Networks: 73, 106 | March 11, 2011 | Oakland | Metropolitan | Volume |
| Host Site 4 Network: 73 | Dec. 22, 2014 | Oakland | Metropolitan | Volume |

| FACILITY NAME | STANDARDS | COUNTY | COUNTY DESIGNATION | COMPLIANCE ISSUE |
|---|---|---|---|---|
| Host Site 5 Network: 85 | Sept. 28, 2012 | Wayne | Metropolitan | Volume |
| Host Site 6 Networks: 96, 216 | Sept. 18, 2013 | Washtenaw | Metropolitan | Volume |
| Host Site 7 Network: 96 | Oct. 21, 2016 | Oakland | Metropolitan | Volume |
| Host Site 8 Network: 112 | May 24, 2002 | Macomb | Metropolitan | Volume |
| Host Site 9 Network: 112 | Dec. 22, 2014 | Oakland | Metropolitan | Volume |
| Host Site 10 Network: 112 | Sept. 28, 2012 | Macomb | Metropolitan | Volume |
| Freestanding 1 | May 27, 2016 | Wayne | Metropolitan | Volume |
| Freestanding 2 | Nov. 5, 2009 | Macomb | Metropolitan | Volume |
| Freestanding 3 | May 27, 2016 | Oakland | Metropolitan | Volume |
| Freestanding 4 | Nov. 21, 2011 | Oakland | Metropolitan | Volume |
| Freestanding 5 | Nov. 5, 2009 | Oakland | Metropolitan | Volume |
| Freestanding 6 | Sept. 18, 2013 | St. Clair | Metropolitan | Volume |
| Freestanding 7 | October 21, 2016 | Oakland | Metropolitan | Volume |
| CSC 1 | July 12, 2004 | Wayne | Metropolitan | Volume & not reporting changes in host sites |
| CSC 2 | Nov. 13, 2008 | Oakland | Metropolitan | Volume |
| CSC 3 | Nov. 5, 2009 | Oakland | Metropolitan | Volume |
| CSC 4 | July 1, 2002 | Macomb | Metropolitan | Volume |
| CSC 5 | Dec. 22, 2014 | Oakland | Metropolitan | Volume |
| CSC 6 | Sept. 28, 2012 | Oakland | Metropolitan | Volume |
| CSC 7 | Mar. 11, 2011 | Wayne | Metropolitan | Volume |

| FACILITY NAME | STANDARDS | COUNTY | COUNTY DESIGNATION | COMPLIANCE ISSUE |
|---|---|---|---|---|
| **HSA 2: MID-SOUTH MICHIGAN** | | | | |
| CSC 8 | Nov. 5, 2009 | Ingham | Metropolitan | Volume |
| CSC 9 | May 27, 2016 | Ingham | Metropolitan | Volume |
| CSC 10 | Oct. 21, 2016 | Ingham | Metropolitan | Volume |
| CSC 11 | May 27, 2016 | Ingham | Metropolitan | Volume & only 1 host site |
| CSC 12 | Nov. 13, 2008 | Ingham | Metropolitan | Volume & not reporting changes in host sites |
| CSC 13 | Nov. 5, 2009 | Ingham | Metropolitan | Volume |
| **HSA 3: SOUTHWEST MICHIGAN** | | | | |
| Hospital 3 | Oct. 17, 2005 | Barry | Metropolitan | Volume |
| Host Site 11 Networks: 75, 113, 168 | Dec. 22, 2014 | Kalamazoo | Metropolitan | Volume |
| Freestanding 8 | March 8, 2007 | Calhoun | Metropolitan | Volume |
| Freestanding 9 | July 12, 2004 | Berrien | Metropolitan | Volume |
| CSC 14 | Sept. 28, 2012 | Kalamazoo | Metropolitan | Volume |
| CSC 15 | Sept. 28, 2012 | Kalamazoo | Metropolitan | Volume |
| CSC 16 | Sept. 28, 2012 | Kalamazoo | Metropolitan | Volume |
| CSC 17 | Dec. 19, 1988 | Kalamazoo | Metropolitan | Volume |
| CSC 18 | Dec. 19, 1988 | Kalamazoo | Metropolitan | Volume |
| CSC 19 | July 1, 2002 | Kalamazoo | Metropolitan | Volume |
| CSC 20 | July 1, 1997 | Kalamazoo | Metropolitan | Volume & only reporting 1 Host Site |
| CSC 21 | March 8, 2007 | Kalamazoo | Metropolitan | Volume |
| CSC 22 | Nov. 5, 2009 | Kalamazoo | Metropolitan | Volume |
| CSC 23 | May 27, 2016 | Kalamazoo | Metropolitan | Volume |
| CSC 24 | July 1, 2002 | Kalamazoo | Metropolitan | Volume |
| CSC 25 | Dec. 22, 2014 | Kalamazoo | Metropolitan | Volume |
| **HSA 4: WEST MICHIGAN** | | | | |
| Hospital 4 | July 12, 2004 | Montcalm | Metropolitan | Volume |
| Freestanding 10 | Nov. 13, 2007 | Kent | Metropolitan | Volume |

| FACILITY NAME | STANDARDS | COUNTY | COUNTY DESIGNATION | COMPLIANCE ISSUE |
|---|---|---|---|---|
| Freestanding 11 | Nov. 13, 2008 | Kent | Metropolitan | Volume |
| CSC 26 | Nov. 5, 2009 | Kent | Metropolitan | Volume |
| CSC 27 | Sept. 28, 2012 | Kent | Metropolitan | Reporting 1 Host Site |
| CSC 28 | Dec. 22, 2014 | Muskegon | Metropolitan | Volume |
| **HSA 5: GENESEE-LAPEER-SHIAWASSEE** | | | | |
| Host Site 12 Network: 81 | Oct. 17, 2005 | Genesee | Metropolitan | Volume |
| CSC 29 | Nov. 5, 2009 | Genesee | Metropolitan | Volume |
| **HSA 6: EAST CENTRAL MICHIGAN** | | | | |
| Hospital 5 | Sept. 18, 2013 | Ogemaw | Rural | Volume |
| Freestanding 12 | Nov. 5, 2009 | Isabella | Micropolitan | Volume |
| Freestanding 13 | Nov. 13, 2008 | Wayne | Metropolitan | Volume |
| CSC 30 | Oct. 17, 2005 | Midland | Metropolitan | Volume |
| CSC 31 | July 1, 2002 | Bay | Metropolitan | Volume |
| **HSA 7: NORTHERN LOWER MICHIGAN** | | | | |
| Hospital 6 | Nov. 21, 2011 | Emmet | Rural | Volume |
| **HSA 8: UPPER PENINSULA** | | | | |
| Hospital 7 | Sept. 18, 2013 | Houghton | Micro | Volume |
| **OUT OF STATE** | | | | |
| CSC 32 | Oct. 21, 2016 | | Out of State | Volume |
| CSC 33 | Oct. 21, 2016 | | Out of State | Volume |
| CSC 34 | Oct. 21, 2016 | | Out of State | Volume |
| CSC 35 | Oct. 21, 2016 | | Out of State | Volume |
| CSC 36 | Nov. 21, 2011 | | Out of State | Volume |

**Certificate of Need (CON) Statewide Compliance Review**

**Positron Emission Tomography (PET) Scanner Services**

As part of the PET Services Statewide Compliance Review, the Department reviewed 7 Fixed Services, 10 Central Service Coordinators for mobile networks (CSCs), and 66 Host Sites that offer PET services based on the reported data in the 2017 CON Annual Survey. The PET services for those facilities were approved under 7 different review standards, the oldest dating back to February 25, 2002.

After reviewing the PET data in the 2017 CON Annual Survey and responses to the PET questionnaire, the Department sent emails to confirm the compliance findings with the Fixed Services, CSCs, and Host Sites. Compliance findings included one CSC not meeting volume requirements under the CON standards they were approved. After discussions among the Department and the CSC, the Department completed the compliance investigations by entering into one settlement agreement.

The table below shows the breakdown of the CSCs under each PET Review Standards:

| Review Standards Effective Date | No. of Mobile Networks (CSC) |
|---|---|
| March 8, 2007 | 4 |
| September 28, 2012 | 1 |
| June 2, 2014 | 1 |
| September 14, 2015 | 4 |

The table below shows the breakdown of the Fixed Services under each PET Review Standards:

| Review Standards Effective Date | No. of Host Sites |
|---|---|
| February 25, 2002 | 1 |
| March 8, 2007 | 4 |
| June 2, 2014 | 1 |
| September 14, 2015 | 1 |

The table below shows the breakdown of the Host Sites under each PET Review Standards:

| Review Standards Effective Date | No. of Host Sites |
|---|---|
| February 25, 2002 | 10 |
| June 4, 2004 | 9 |
| March 8, 2007 | 17 |
| November 21, 2011 | 3 |
| September 28, 2012 | 4 |
| June 2, 2014 | 4 |
| September 14, 2015 | 16 |
| Closed | 3 |

The table below shows the CSC under settlement agreement by Health Service Area (HSA).

| FACILITY NAME | STANDARDS | COUNTY | COUNTY DESIGNATION | COMPLIANCE ISSUE |
|---|---|---|---|---|
| **HSA 1: SOUTH EAST MICHIGAN** | | | | |
| CSC 1 | March 8, 2007 | Detroit | Metropolitan | Volume |

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

**DANA NESSEL**
ATTORNEY GENERAL

**M E M O R A N D U M**

June 16, 2020

TO: James Falahee
CON Commission Chair

FROM: Carl J. Hammaker, III
Assistant Attorney General
Corporate Oversight Division

CC: Elizabeth Nagel
Joseph E. Potchen

RE: Legal Report for the September 19, 2019 Commission Meeting

We currently representing DHHS in three pending cases in the Michigan Office of Administrative Hearings and Rules.

1) *Regency at East Ann Arbor, LLC v Michigan Department of Health and Human Services*; MOAHR Docket No.: 18-010742

On October 5, 2018, the Department issued a proposed decision to disapprove CON Application No. 18-0050 to begin operation of a new nursing home, Regency at East Ann Arbor. The Administrative Law Judge issued a Proposal for Decision in the Department's favor.

2) *Beaumont Hospital – Oxford, v Department of Health and Human Services*; MOAHR Docket No.: 19-010768

On September 30, 2019, the Department issued a proposed decision to disapprove CON Application No. 19-0018 to initiate a new hospital in Limited Access Area #6 by William Beaumont Hospital. Beaumont appealed the disapproval. Motions for Summary Disposition are pending.

3) Kalamazoo Psych Operator, LLC v *Department of Health and Human Services*; MOAHR Docket No.: 20-003167.

Kalamazoo Psych Operator appealed the denial of its CON application for psychiatric beds as part of Comparative Review Group 95-058. A telephone pre-hearing conference is scheduled for June 30, 2020.

In addition to the administrative matters, we are representing MDHHS in two additional Court actions relating to Beaumont's CON Application.

1) *William Beaumont Hospital v Certificate of Need Commission and Department of Health and Human Services*; Case No. 19-000183-Mz

In the Court of Claims, Beaumont filed a request for declaratory judgment related to the interpretation of Section 6(5)(g)(i) of the Hospital Bed Review Standards and injunctive relief preventing the Commission from adopting new Standards related to Limited Access Areas while Beaumont's administrative appeal is pending. The Court of Claims granted summary disposition for the Department and the Commission. Beaumont filed a Claim of Appeal with the Court of Appeals.

2) *William Beaumont Hospital v Michigan Department of Health and Human Services*; Case No. 19-000836-AA

In the Ingham Circuit Court, Beaumont filed an appeal of the Department's October 18, 2019 denial of a request for declaratory ruling on the interpretation of Section 6(5)(g)(i) of the Hospital Bed Review Standards and a request for declaratory judgment. This matter is pending a decision on a motion to dismiss.

In addition to these cases, we continue to work with MDHHS staff to assist in developing standards and providing legal advice on various matters.

CJH/

# DRAFT Certificate of Need (CON) Commission Work Plan

Attachment Q

| | 2020 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | January | February | March | April | May | June | July | August | September | October | November | December |
| Commission Meetings | Special Meeting | | Meeting Cancelled | | | Meeting | | | Meeting | | | Meeting |
| Cardiac Catheterization Services | Discussion/ Report | | SAC Nomination & Selection Period | | | | CCSAC Mtg. | CCSAC Mtg. | CCSAC Mtg. | | | |
| Computed Tomography (CT) Scanner Services | CT Workgroup Mtg. | CT Workgroup Mtg. | | | | Report/Draft Language Presented/ Potential Proposed Action | Public Hearing | | Report/ Final Action | | | |
| Hospital Beds | Discussion/ Report | | | | | | Sac Nomination & Selection Period | | HBSAC Mtg. | HBSAC Mtg. | HBSAC Mtg. | HBSAC Mtg. |
| Magnetic Resonance Imaging (MRI) Services | Discussion/ Report | | | | | | | | | | | |
| Neonatal Intensive Care Services/Beds (NICU) | NICU Workgroup Mtg. | | NICU Workgroup Mtg. | | NICU Workgroup Mtg. | NICU Workgroup Mtg. | NICU Workgroup Mtg. | NICU Workgroup Mtg. | Report/Draft Language Presented/ Potential Proposed Action | | | |
| Nursing Home and HLTCU Beds and Addendum (NH-HLTCU) | Interim Report to Commission/ Draft Language Presented/ Proposed Action; NH-HLTCU SAC Mtg. | | Public Hearing; NH-HLTCU SAC Mtg. | | | NH-HLTCU SAC Mtg. | Report/Final Action; NH-HLTCU SAC Mtg. | | Report/Draft Language Presented/ Potential Proposed Action | Public Hearing | | Report/Final Action |
| Positron Emission Tomography (PET) Scanner Services | Discussion/ Report | | | | | Presentation | | | | | | |
| New Medical Technology Standing Committee | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring | Department Monitoring |
| 2-year Report to Joint Legislative Committee (JLC) – 1/1/21 | | | | | | | | | Review Draft Report | | | Approve Report |

For Approval June 18, 2020.

**The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings,**

## SCHEDULE FOR UPDATING CERTIFICATE OF NEED (CON) STANDARDS EVERY THREE YEARS*

| Standards | Effective Date | Next Scheduled Update** |
|---|---|---|
| Air Ambulance Services | June 2, 2014 | 2022 |
| Bone Marrow Transplantation Services | September 29, 2014 | 2021 |
| Cardiac Catheterization Services | December 26, 2018 | 2020 |
| Computed Tomography (CT) Scanner Services | December 9, 2016 | 2022 |
| Heart/Lung and Liver Transplantation Services | September 28, 2012 | 2021 |
| Hospital Beds | November 28, 2018 | 2020 |
| Magnetic Resonance Imaging (MRI) Services | October 21, 2016 | 2021 |
| Megavoltage Radiation Therapy (MRT) Services/Units | September 12, 2019 | 2023 |
| Neonatal Intensive Care Services/Beds (NICU) | December 9, 2016 | 2019 |
| Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups | March 20, 2015 | 2019 |
| Open Heart Surgery Services | December 26, 2018 | 2023 |
| Positron Emission Tomography (PET) Scanner Services | September 14, 2015 | 2020 |
| Psychiatric Beds and Services | November 12, 2019 | 2021 |
| Surgical Services | November 17, 2017 | 2023 |
| Urinary Extracorporeal Shock Wave Lithotripsy Services/Units | November 12, 2019 | 2022 |

*Pursuant to MCL 333.22215 (1)(m): "In addition to subdivision (b), review and, if necessary, revise each set of certificate of need review standards at least every 3 years."

**A Public Comment Period will be held in October prior to the review year to determine what, if any, changes need to be made for each standard scheduled for review. If it is determined that changes are necessary, then the standards can be deferred to a standard advisory committee (SAC), workgroup, or the Department for further review and recommendation to the CON Commission. If no changes are determined, then the standards are scheduled for review in another three years.