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

Thursday, December 10, 2020

Zoom Meeting

APPROVED MINUTES

I. Call to Order & Introductions

Chairperson Falahee called the meeting to order at 9:30 a.m.

A. Members present and participating remotely:
James B. Falahee, Jr., JD, Chairperson – Kalamazoo County
Thomas Mittelbrun, Vice-Chairperson – Orion Township
Lindsey Dood – Traverse City
Amy Engelhardt-Kalbfleisch, DO – Wayne County
Debra Guido-Allen, RN – Oakland County
Ashok Kondur, MD – Oakland County
Melanie K. Lalonde – Wayne County
Amy McKenzie, MD – Washington Township

B. Members Absent:
Justin B. Dimick, MD
Lorissa MacAllister, PhD
Melisa J. Oca, MD

C. Department of Attorney General Staff:

Becky Berels

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

III. Declaration of Conflicts of Interests

Chairperson Falahee stated that for agenda item VII, Bronson has filed an application.

IV. Review of Minutes of September 17, 2020

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

V. Neonatal Intensive Care Services/Beds (NICU) – Public Hearing Summary

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

A. Public Comment

None.

B. Commission Discussion

None.

C. Commission Final Action

Motion by Commissioner Guido-Allen, seconded by Commissioner Mittlebrun to take final action on the language (Attachment B) as presented and forward to the Joint Legislative Committee (JLC) and Governor for the 45-day review period. Motion carried.

VI. 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 C).

A. Public Comment

None.

B. Commission Discussion

None.

C. Commission Final Action

Motion by Commissioner Mittlebrun, seconded by Commissioner Dood to take final action on the language (Attachment D) as presented, forward to the JLC and Governor for the 45-day review period, and to set the effective date of the new bed need numbers concurrent with the effective date of the new standards. Motion carried.

VII. Psychiatric Beds and Services – Special Pool Beds Draft Language

Ms. Rogers and Ms. Nagle provided an overview of the draft language (Attachment E).

A. Public Comment

None.

B. Commission Discussion

Discussion followed.

C. Commission Proposed Action

Motion by Commissioner Kondur, seconded by Commissioner Guido-Allen to take proposed action on the language (Attachment E) as presented and move forward to Public Hearing and to the JLC. Motion carried.

VIII. Magnetic Resonance Imaging (MRI) Services – Draft Language

Ms. Rogers and Ms. Nagle provided an overview of the draft language (Attachment F).

A. Public Comment

1. Melissa Reitz, RWC Advocacy

2. David Walker, Spectrum Health

3. Sean Gehle, Trinity Health

4. Cheryl Martin and Tracy Dietz, Henry Ford Health System (HFHS)

5. Mike VanderPol, Mid-Michigan Health

6. Patrick O'Donovan, Beaumont Health

B. Commission Discussion

Discussion followed.

C. Commission Action

The Commission asked the Department to work with others to provide changes to the language for the January meeting based on today's discussion which includes removal of host site physician commitment language and add it to the upcoming MRI workgroup; possible modification of the percentage reduction for initiation, and possible modification of the annualization language.

IX. Review Draft of CON Commission Biennial Report to JLC

Chairperson Falahee provided an overview of the biennial report (Attachment G).

Motion by Commissioner Kondur, seconded by Commissioner Guido-Allen to approve the report (see Attachment G) and move forward to the JLC. Motion carried.

X. Hospital Beds – Re-calculation of Bed Need Numbers – Setting the Effective Date (Written Report from Paul Delamater, et al.)

Chairperson Falahee mentioned the written report provided by Mr. Delamater, and Ms. Rogers provided an overview. (Attachment H).

Motion by Commissioner Mittlebrun, seconded by Commissioner Kondur to set effective date of January 4, 2021 for the updated bed need. Motion carried.

XI. Cardiac Catheterization Services Standard Advisory Committee (SAC) – Interim Report from Ryan Madder, MD, Chairperson (Written only)

Chairperson Falahee mentioned the written report provided by Cardiac Catheterization Services SAC Chairperson Ryan Madder (Attachment I).

XII. Hospital Beds SAC – Interim Report from Jennifer Groseclose, Chairperson (Written only)

Chairperson Falahee mentioned the written report provided by Hospital Beds SAC Chairperson Jennifer Groseclose (Attachment J).

XIII. Legislative Update

Chairperson Falahee provided an update.

XIV. Administrative Update

A. Planning & Access to Care Section Update

None.

B. CON Evaluation Section Update

Ms. Bhattacharya provided an update on the following items:

1. Compliance Report (Attachment K)
2. Quarterly Performance Measures (Attachment L)

XV. Legal Activity Report

Ms. Berels provided an update on the CON legal activity (Attachment M).

XVI. Future Meeting Dates:

January 28, 2021, March 18, 2021, June 17, 2021, September 16, 2021, and December 9, 2021

XVII. Public Comment

None.

XVIII. 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 N).

A. Commission Discussion

None.

B. Commission Action

Motion by Commissioner Mittlebrun, seconded by Commissioner Lalonde to accept the Work Plan as presented with updates from today's meeting. Motion carried.

XIX. Adjournment

Motion by Commissioner Mittlebrun, seconded by Commissioner Guido-Allen to adjourn the meeting at 11:34 a.m. Motion Carried.

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

Date: November 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 Neonatal Intensive Care Services/Beds (NICU) 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 NICU Standards at its September 17, 2020 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed NICU Standards on October 27, 2020. Written testimony was accepted for an additional seven days after the hearing. Testimony was received from one organization.

Written Testimony:

1.) Charles Barone, MD – Henry Ford Health System (HFHS)

- Supports the proposed language.

Department Recommendation:

The Department supports the language as presented at the September 17, 2020 CON Commission meeting.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF NEED REVIEW (CON) STANDARDS FOR NEONATAL INTENSIVE CARE SERVICES/BEDS (NICU) AND SPECIAL NEWBORN NURSING 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. (1) These standards are requirements for the approval of the initiation, replacement, relocation, expansion, or acquisition of neonatal intensive care services/beds and the delivery of neonatal intensive care services/beds under Part 222 of the Code. Further, these standards are requirements for the approval of the initiation or acquisition of special care nursery (SCN) services. Pursuant to Part 222 of the Code, neonatal intensive care services/beds and special newborn nursing services are covered clinical services. The Department shall use these standards in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws and Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

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

(a) "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.

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

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

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

(e) "Department inventory of beds" means the current list for each planning area maintained on a continuous basis by the Department of licensed hospital beds designated for NICU services and NICU beds with valid CON approval but not yet licensed or designated.

(f) "Existing NICU beds" means the total number of all of the following:

(i) licensed hospital beds designated for NICU services;

(ii) NICU beds with valid CON approval but not yet licensed or designated;

(ii) NICU beds under appeal from a final decision of the Department; and

(iii) proposed NICU beds that are part of an application for which a proposed decision has been ~~issued, but~~issued but is pending final Department decision.

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

(h) "Infant" means an individual up to 1 year of age.

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

(j) "Live birth" means a birth for which a birth certificate for a live birth has been prepared and filed pursuant to Section 333.2821(2) of the Michigan Compiled Laws.

(k) "Maternal referral service" means having a consultative and patient referral service staffed by a physician(s), on the active medical staff, that is board certified, or eligible to be board certified, in maternal/fetal medicine.

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

(m) "Neonatal intensive care services" or "NICU services" means the provision of any of the following services:

(i) constant nursing care and continuous cardiopulmonary and other support services for severely ill infants;

(ii) care for neonates weighing less than 1,500 grams at birth, and/or less than 32 weeks gestation;

(iii) ventilatory support beyond that needed for immediate ventilatory stabilization;

(iv) surgery and post-operative care during the neonatal period;

(v) pharmacologic stabilization of heart rate and blood pressure; or

(vi) total parenteral nutrition.

(n) "Neonatal intensive care unit" or "NICU" means a specially designed, equipped, and staffed unit of a hospital which is both capable of providing neonatal intensive care services and is composed of licensed hospital beds designated as NICU. This term does not include unlicensed SCN beds.

(o) "Neonatal transport system" means a specialized transfer program for neonates by means of an ambulance licensed pursuant to Part 209 of the Code, being Section 333.20901 et seq.

(p) "Neonate" means an individual up to 28 days of age.

(q) "Perinatal care network," means the providers and facilities within a planning area that provide basic, specialty, and sub-specialty obstetric, pediatric and neonatal intensive care services.

(r) "Planning area" means the groups of counties shown in Appendix B.

(s) "Planning year" means the most recent continuous ~~12 month~~12-month period for which birth data is available from the Vital Records and Health Data Development Section.

(t) "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.

(u) "Relocation of the designation of beds for NICU services" means a change within the same planning area in the licensed site at which existing licensed hospital beds are designated for NICU services.

(v) "Special care nursery services" or "SCN services" means provisions of services for infants with problems that are expected to resolve rapidly and who would not be anticipated to need subspecialty services on an urgent basis. These services ~~include~~ARE:

(i) ~~Care~~ care for infants born greater than or equal to 32 weeks gestation and/or weighing greater than or equal to 1,500 grams;

(ii) enteral tube feedings;

(iii) cardio-respiratory monitoring to document maturity of respiratory control or treatment of apnea;

(iv) extended care following an admission to a neonatal intensive care unit for an infant not requiring ventilatory support; ~~or~~

(v) ~~provide mechanical ventilation or~~ continuous positive airway pressure AND HIGH FLOW NASAL CANNULA (HFNC); AND

(vi) mechanical ventilation ~~or both~~ for a brief duration (~~not to exceed~~UP TO 24 hours ~~combined~~). FOR BABIES REQUIRING MECHANICAL VENTILATION EXCEEDING 24 HOURS, SCNS SHALL REQUEST TRANSFER TO A NICU BY THE 24TH HOUR OF MECHANICAL VENTILATION. Referral to a higher level of care should ALSO occur for all infants who need pediatric surgical or medical subspecialty intervention. Infants receiving transitional care or being treated for developmental maturation may have formerly been treated in a neonatal intensive care unit in the same hospital or another hospital. For purposes of these standards, SCN services are special newborn nursing services.

(w) "TELEMEDICINE" MEANS THE USE OF AN ELECTRONIC MEDIA TO LINK PATIENTS WITH HEALTH CARE PROFESSIONALS IN DIFFERENT LOCATIONS. TO BE CONSIDERED TELEMEDICINE UNDER THIS SECTION, THE HEALTH CARE PROFESSIONAL MUST BE ABLE TO

EXAMINE THE PATIENT VIA A HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, PUBLIC LAW 104-191 COMPLIANT, SECURE INTERACTIVE AUDIO, VIDEO, OR BOTH, TELECOMMUNICATIONS SYSTEM, OR THROUGH THE USE OF STORE AND FORWARD ONLINE MESSAGING.

(x) "Well newborn nursery services" means providing the following services and does not require a certificate of need:

(i) the capability to perform neonatal resuscitation at every delivery;

(ii) evaluate and provide postnatal care for stable term newborn infants;

(iii) stabilize and provide care for infants born at 35 to 37 weeks' gestation who remain physiologically stable; and

(iv) stabilize newborn infants who are ill and those born less than 35 weeks of gestation until they can be transferred to a higher level of care facility.

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

Section 3. Bed need methodology

Sec. 3. (1) The number of NICU beds needed in a planning area shall be determined by the following formula:

(a) Determine, using data obtained from the Vital Records and Health Data Development Section, the total number of live births which occurred in the planning year at all hospitals geographically located within the planning area.

(b) Determine, using data obtained from the Vital Records and Health Data Development Section, the percent of live births in each planning area and the state that were less than 1,500 grams. The result is the very low birth weight rate for each planning area and the state, respectively.

(c) Divide the very low birth weight rate for each planning area by the statewide very low birth weight rate. The result is the very low birth weight rate adjustment factor for each planning area.

(d) Multiply the very low birth weight rate adjustment factor for each planning area by 0.0045. The result is the bed need formula for each planning area adjusted for the very low birth weight rate.

(e) Multiply the total number of live births determined in subsection (1)(a) by the bed need formula for the applicable planning area adjusted for the very low birth weight adjustment factor as determined in subsection (1)(d).

(2) The result of subsection (1) is the number of NICU beds needed in the planning area for the planning year.

Section 4. Requirements to initiate NICU services

Sec. 4. Initiation of NICU services means the establishment of a NICU at a licensed site that has not had in the previous 12 months a licensed and designated NICU or does not have a valid CON to initiate a NICU. The relocation of the designation of beds for NICU services meeting the applicable requirements of Section 6 shall not be considered as the initiation of NICU services/beds.

(1) An applicant proposing to initiate NICU services by designating hospital beds as NICU beds shall demonstrate each of the following:

(a) There is an unmet bed need of at least 15 NICU beds based on the difference between the number of existing NICU beds in the planning area and the number of beds needed for the planning year as a result of application of the methodology set forth in Section 3.

(b) Approval of the proposed NICU will not result in a surplus of NICU beds in the planning area based on the difference between the number of existing NICU beds in the planning area and the number of beds needed for the planning year resulting from application of the methodology set forth in Section 3.

(c) A unit of at least 15 beds will be developed and operated.

(d) For each of the 3 most recent years for which birth data are available from the Vital Records and Health Data Development Section, the licensed site at which the NICU is proposed had either: (i) 2,000 or more live births, if the licensed site is located in a metropolitan statistical area county; or (ii) 600 or more live births, if the licensed site is located in a rural or micropolitan statistical area county and is located more than 100 miles (surface travel) from the nearest licensed site that operates or has valid CON approval to operate NICU services.

Section 5. Requirements to replace NICU services

Sec. 5. Replacement of NICU beds means new physical plant space being developed through new construction or newly acquired space (purchase, lease or donation), to house existing licensed and designated NICU beds.

(1) An applicant proposing replacement beds shall not be required to be in compliance with the needed NICU bed supply determined pursuant to Section 3 if an applicant demonstrates all of the following:

(a) the project proposes to replace an equal or lesser number of beds designated by an applicant for NICU services at the licensed site operated by the same applicant at which the proposed replacement beds are currently located; and

(b) the proposed licensed site is in the same planning area as the existing licensed site and in the area set forth in Section 22229 of the Code, being Section 333.22229 of the Michigan Compiled Laws, in which replacement beds in a hospital are not subject to comparative review.

Section 6. Requirements for approval to relocate NICU beds

Sec. 6. An applicant proposing to relocate the designation for NICU services shall demonstrate compliance with all of the following:

(1) The applicant is the licensed site to which the relocation of the designation of beds for NICU services is proposed.

(2) The applicant shall provide a signed written agreement that provides for the proposed increase, and concomitant decrease, in the number of beds designated for NICU services at the 2 licensed sites involved in the proposed relocation. A copy of the agreement shall be provided in the application.

(3) The existing licensed site from which the designation of beds for NICU services proposed to be relocated is currently licensed and designated for NICU services.

(4) The proposed project does not result in an increase in the number of beds designated for NICU services in the planning area unless the applicable requirements of Section 4 or 5 have also been met.

(5) The proposed project does not result in an increase in the number of licensed hospital beds at the applicant licensed site unless the applicable requirements of the CON Review Standards for Hospital Beds have also been met.

(6) The proposed project does not result in the operation of a NICU of less than 15 beds at the existing licensed site from which the designation of beds for NICU services are proposed to be relocated.

(7) If the applicant licensed site does not currently provide NICU services, an applicant shall demonstrate both of the following:

(a) the proposed project involves the establishment of a NICU of at least 15 beds; and

(b) for each of the 3 most recent years for which birth data are available from the Vital Records and Health Data Development Section, the applicant licensed site had either: (i) 2,000 or more live births, if the licensed site is located in a metropolitan statistical area county; or (ii) 600 or more live births, if the licensed site is located in a rural or micropolitan statistical area county and is located more than 100 miles from the nearest licensed site that operates or has valid CON approval to operate NICU services/beds. If the applicant licensed site has not been in operation for at least 3 years and the obstetrical unit at the applicant licensed site was established as the result of the consolidation and closure of 2 or more obstetrical units, the combined number of live births from the obstetrical units that were closed and relocated to the applicant licensed site may be used to evaluate compliance with this requirement for those years when the applicant licensed site was not in operation.

(8) If the applicant licensed site does not currently provide NICU services or obstetrical services, an applicant shall demonstrate both of the following:

(a) the proposed project involves the establishment of a NICU of at least 15 beds; and

(b) the applicant has a valid CON to establish an obstetrical unit at the licensed site at which the NICU is proposed. The obstetrical unit to be established shall be the result of the relocation of an existing obstetrical unit that for each of the 3 most recent years for which birth data are available from the Vital Records and Health Data Development Section, the obstetrical unit to be relocated had either: (i) 2,000 or more live births, if the obstetrical unit to be relocated is located in a metropolitan statistical area county; or (ii) 600 or more live births, if the obstetrical unit to be relocated is located in a rural or micropolitan statistical area county and is located more than 100 miles from the nearest licensed site that operates or has valid CON approval to operate NICU services.

(9) The project results in a decrease in the number of licensed hospital beds that are designated for NICU services at the licensed site at which beds are currently designated for NICU services. The decrease in the number of beds designated for NICU services shall be equal to or greater than the number of beds designated for NICU services proposed to be increased at the applicant's licensed site pursuant to the agreement required by this subsection. This subsection requires a decrease in the number of licensed hospital beds that are designated for NICU ~~services, but~~services but does not require a decrease in the number of licensed hospital beds.

(10) Beds approved pursuant to Section 7(2) shall not be relocated pursuant to this section, unless the proposed project involves the relocation of all beds designated for NICU services at the applicant's licensed site.

Section 7. Requirements for approval to expand NICU services

Sec. 7. (1) An applicant proposing to expand NICU services at a licensed site by designating additional hospital beds as NICU beds in a planning area, EXCEPT AN APPLICANT MEETING THE REQUIREMENTS OF SUBSECTION (2), shall demonstrate that the proposed increase will not result in a surplus of NICU beds based on the difference between the number of existing NICU beds in the planning area and the number of beds needed for the planning year resulting from application of the methodology set forth in Section 3.

(2) An applicant may apply and be approved TO EXPAND NICU SERVICES AT A LICENSED SITE BY DESIGNATING ADDITIONAL HOSPITAL BEDS ~~for~~ AS NICU beds in excess of the number determined as needed for the planning year in accordance with Section 3 if an applicant can demonstrate ALL OF THE FOLLOWING SUBSECTIONS ARE METthat it provides NICU services to patients transferred from another licensed and designated NICU.; The maximum number of NICU beds that may be approved pursuant to this subsection shall be determined in accordance with the following:

(a) An applicant shall document the average annual number of patient days provided to neonates or infants transferred from another licensed and designated NICU, for the 2 most recent years for which

~~verifiable data are available to the Department~~THE PROPOSED NICU BEDS ARE BEING ADDED AT THE EXISTING LICENSED SITE.

(b) The EXISTING NICU BEDS HAVE OPERATED AT AN OCCUPANCY RATE OF 80 PERCENT OR ABOVE FOR THE PREVIOUS, CONSECUTIVE 24 MONTHS BASED ON THE EXISTING SITE'S LICENSED AND APPROVED NICU BED CAPACITY. THE OCCUPANCY RATE SHALL BE CALCULATED AS FOLLOWS:

(i) ~~average annual~~CALCULATE THE number of patient days ~~determined in accordance with subsection (a) shall be divided by 365 (or 366 for a leap year). The result is the average daily census (ADC) for NICU services provided to patients transferred from another licensed and designated NICU~~ PROVIDED TO NEONATES IN THE APPLICANT'S EXISTING NICU BEDS FOR THE MOST RECENT, CONSECUTIVE 24 MONTHS FOR WHICH VERIFIABLE DATA ARE AVAILABLE TO THE DEPARTMENT.

(ii) CALCULATE THE TOTAL POSSIBLE PATIENT DAYS BY MULTIPLYING THE EXISTING LICENSED AND APPROVED NICU BEDS BY 730 (OR 731 IF INCLUDING A LEAP YEAR).

(iii) CALCULATE THE OCCUPANCY RATE BY DIVIDING THE NUMBER CALCULATED IN (i) BY THE NUMBER CALCULATED IN (ii).

(c) ~~Apply the ADC determined in accordance with subsection (b) in the following formula: ADC + 2.06 √ADC. The result is the maximum number of beds that may be approved pursuant to this subsection.~~THE NUMBER OF NICU BEDS THAT MAY BE APPROVED PURSUANT TO THIS SUBSECTION SHALL BE THE NUMBER OF NICU BEDS NECESSARY TO REDUCE THE OCCUPANCY RATE FOR THE NICU TO 70 PERCENT. THE NUMBER OF NICU BEDS TO BE ADDED SHALL BE CALCULATED AS FOLLOWS:

(i) DIVIDE THE NUMBER OF PATIENT DAYS CALCULATED IN SUBSECTION (b)(i) BY .70 TO DETERMINE LICENSED NICU BED DAYS AT 70 PERCENT OCCUPANCY.

(ii) DIVIDE THE RESULT OF STEP (c)(i) BY 730 (OR 731 IF INCLUDING A LEAP YEAR) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER.

(iii) SUBTRACT THE NUMBER OF EXISTING NICU BED DESIGNATIONS AS DOCUMENTED ON THE "DEPARTMENT INVENTORY OF NICU BEDS" FROM THE RESULT OF STEP (c)(ii) AND ROUND THE RESULT UP TO THE NEXT WHOLE NUMBER TO DETERMINE THE MAXIMUM NUMBER OF BEDS THAT MAY BE APPROVED PURSUANT TO THIS SUBSECTION. IF THE RESULT IS LESS THAN 5 BEDS, THE APPLICANT MAY BE APPROVED FOR UP TO 5 BEDS.

(d) A NICU THAT HAS RELOCATED NICU BEDS~~,~~ AFTER THE EFFECTIVE DATE OF THESE STANDARDS~~,~~ SHALL NOT BE APPROVED FOR NICU BEDS UNDER THIS SUBSECTION FOR FIVE YEARS FROM THE EFFECTIVE DATE OF THE RELOCATION OF BEDS.

(e) APPLICANTS PROPOSING TO ADD NICU BEDS UNDER THIS SUBSECTION SHALL NOT BE SUBJECT TO COMPARATIVE REVIEW.

(f) AN APPLICANT PROPOSING TO ADD NICU BEDS SHALL NOT BE REQUIRED TO BE IN COMPLIANCE WITH THE BED NEED METHODOLOGY IF THE APPLICATION MEETS ALL OTHER APPLICABLE CON REVIEW STANDARDS, AND THE APPLICANT AGREES AND ASSURES TO COMPLY WITH ALL APPLICABLE PROJECT DELIVERY REQUIREMENTS.

Section 8. Requirements for approval to acquire a NICU service

Sec. 8. Acquisition of a NICU means obtaining possession and control of existing licensed hospital beds designated for NICU services by contract, ownership, lease or other comparable arrangement.

(1) An applicant proposing to acquire a NICU shall not be required to be in compliance with the needed NICU bed supply determined pursuant to Section 3 for the planning area in which the NICU subject to the proposed acquisition is located, if the applicant demonstrates that all of the following are met:

(a) the acquisition will not result in an increase in the number of hospital beds, or hospital beds designated for NICU services, at the licensed site to be acquired;

(b) the licensed site does not change as a result of the acquisition, unless the applicant meets Section 6; and,

(c) the project does not involve the initiation, expansion or replacement of a covered clinical service, a covered capital expenditure for other than the proposed acquisition or a change in bed capacity at the applicant facility, unless the applicant meets other applicable sections.

Section 9. Requirements to initiate, acquire, or replace SCN services

Sec. 9. An applicant proposing SCN services shall demonstrate each of the following, as applicable, by verifiable documentation:

(1) All applicants shall demonstrate the following:

(a) A ~~board-certified~~board-certified neonatologist serving as the program director.

(b) The hospital has the following capabilities and personnel continuously available and on-site:

(i) ~~the ability to provide~~ mechanical ventilation FOR A BRIEF DURATION (UP TO 24 HOURS). FOR BABIES REQUIRING MECHANICAL VENTILATION EXCEEDING 24 HOURS, SCNS SHALL REQUEST TRANSFER TO A NICU BY THE 24TH HOUR OF MECHANICAL VENTILATION.~~;~~

(ii) ~~and/or~~ continuous positive airway pressure AND HFNC ~~for up to 24 hours~~;

(iii) portable x-ray equipment and blood gas analyzer;

(~~iii~~iv) pediatric physicians and/or neonatal nurse practitioners; and

(iv) respiratory therapists, radiology technicians, laboratory technicians and specialized nurses with experience caring for premature infants.

(2) Initiation of SCN services means the establishment of an SCN at a licensed site that has not had in the previous 12 months a designated SCN or does not have a valid CON to initiate an SCN.

(a) In addition to the requirements of Section 9(1), an applicant proposing to initiate an SCN service shall have a written consulting agreement with a hospital which has an existing, operational NICU. The agreement must specify that the existing service shall, for the first two years of operation of the new service, provide the following services to the applicant hospital:

(i) receive and make recommendations on the proposed design of SCN and support areas that may be required;

(ii) provide staff training recommendations for all personnel associated with the new proposed service;

(iii) assist in developing appropriate protocols for the care and transfer, if necessary, of premature infants;

(iv) provide recommendations on staffing needs for the proposed service; and

(v) work with the medical staff and governing body to design and implement a process that will annually measure, evaluate, and report to the medical staff and governing body the clinical outcomes of the new service, including:

(A) mortality rates;

(B) morbidity rates including intraventricular hemorrhage (grade 3 and 4), retinopathy of prematurity (stage 3 and 4), chronic lung disease (oxygen dependency at 36 weeks gestation), necrotizing enterocolitis, pneumothorax, neonatal depression (~~apgar~~Apgar score of less than 5 at five minutes); and

(C) infection rates.

(b) SCN services shall be provided in unlicensed SCN beds located within the hospital obstetrical department or NICU service. Unlicensed SCN beds are not included in the NICU bed need.

(3) Replacement of SCN services means new physical plant space being developed through new construction or newly acquired space (purchase, lease or donation), to house an existing SCN service.

(a) In addition to the requirements of Section 9(1), an applicant proposing a replacement SCN service shall demonstrate all of the following:

(i) The proposed project is part of an application to replace the entire hospital.

(ii) The applicant currently operates the SCN service at the current licensed site.
(iii) The proposed licensed site is in the same planning area as the existing licensed site.

(4) Acquisition of an SCN service means obtaining possession and control of an existing SCN service by contract, ownership, lease or other comparable arrangement.
(a) In addition to the requirements of Section 9(1), an applicant proposing to acquire an SCN service shall demonstrate all of the following:
(i) The proposed project is part of an application to acquire the entire hospital.
(ii) The licensed site does not change as a result of the acquisition, unless the applicant meets subsection 3.

Section 10. Additional requirements for applications included in comparative reviews.

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) Each application in a comparative review group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code, being Section 333.22225(1) of the Michigan Compiled Laws, and all other applicable requirements for approval in the Code and these standards. If the Department determines that one or more of the competing applications satisfies all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, taken together, do not exceed the need, as defined in Section 22225(1), and which have the highest number of points when the results of subsection (2) are totaled. If 2 or more qualifying projects are determined to have an identical number of points, the Department shall approve those qualifying projects which, taken together, do not exceed the need, as defined in Section 22225(1), which are proposed by an applicant that operates a NICU at the time an application is submitted to the Department. If 2 or more qualifying projects are determined to have an identical number of points and each operates a NICU at the time an application is submitted to the Department, the Department shall approve those qualifying projects which, 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 submission date and time, as determined by the Department when submitted.
(a) A qualifying project will have points awarded based on the geographic proximity to NICU services, both operating and CON approved but not yet operational, in accordance with the following schedule:

Proximity	Points Awarded
Less than 50 Miles to NICU service	0
Between 50-99 miles to NICU service	1
100+ Miles to NICU service	2

(b) A qualifying project will have points awarded based on the number of very low birth weight infants delivered at the applicant hospital or the number of very low birth weight infants admitted or refused admission due to the lack of an available bed to an applicant's NICU, and the number of very low birth weight infants delivered at another hospital subsequent to the transfer of an expectant mother from an applicant hospital to a hospital with a NICU. The total number of points to be awarded shall be the

number of qualifying projects. The number of points to be awarded to each qualifying project shall be calculated as follows:

(i) Each qualifying project shall document, for the 2 most recent years for which verifiable data are available, the number of very low birth weight infants delivered at an applicant hospital, or admitted to an applicant's NICU, if an applicant operates a NICU, the number of very low birth weight infants delivered to expectant mothers transferred from an applicant's hospital to a hospital with a NICU, and the number of very low birth weight infants referred to an applicant's NICU who were refused admission due to the lack of an available NICU bed and were subsequently admitted to another NICU.

(ii) Total the number of very low birth weight births and admissions documented in subdivision (i) for all qualifying projects.

(iii) Calculate the fraction (rounded to 3 decimal points) of very low birth weight births and admissions that each qualifying project's volume represents of the total calculated in subdivision (ii).

(iv) For each qualifying project, multiply the applicable fraction determined in subdivision (iii) by the total possible number of points.

(v) Each qualifying project shall be awarded the applicable number of points calculated in subdivision (iv).

(c) An applicant shall have 1 point awarded if it can be demonstrated that on the date an application is submitted to the Department, the licensed site at which NICU services/beds are proposed has on its active medical staff a physician(s) board certified, or eligible to be certified, in maternal/fetal medicine.

(d) A qualifying project will have points awarded based on the percentage of the hospital's indigent volume as set forth in the following table.

Hospital Indigent Volume	Points Awarded
0 - <6%	0.2
6 - <11%	0.4
11 - <16%	0.6
16 - <21%	0.8
21 - <26%	1.0
26 - <31%	1.2
31 - <36%	1.4
36 - <41%	1.6
41 - <46%	1.8
46% +	2.0

For purposes of this subsection, indigent volume means the ratio of a hospital's indigent charges to its total charges expressed as a percentage as determined by the Hospital and Health Plan Reimbursement Division pursuant to Section 7 of the Medical Provider manual. The indigent volume data being used for rates in effect at the time the application is deemed submitted will be used by the Department in determining the number of points awarded to each qualifying project.

(3) Submission of conflicting information in this section may result in a lower point reward. 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 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 11. Requirements for Medicaid participation

Sec. 11. An applicant for NICU services and SCN services 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 12. Project delivery requirements and terms of approval

Sec. 12. An applicant shall agree that, if approved, the NICU and SCN services shall be delivered in compliance with the following terms of approval:

(1) Compliance with these standards.

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

(a) An applicant shall coordinate its services with other providers of obstetrical, perinatal, neonatal and pediatric care in its planning area, and other planning areas in the case of highly specialized services.

(b) An applicant shall develop and maintain a follow-up program for NICU graduates and other infants with complex problems. An applicant shall also develop linkages to a range of pediatric care for high-risk infants to ensure comprehensive and early intervention services.

(c) If an applicant operates a NICU that admits infants that are born at a hospital other than the applicant hospital, an applicant shall develop and maintain an outreach program that includes both case-finding and social support which is integrated into perinatal care networks, as appropriate.

(d) If an applicant operates a NICU that admits infants that are born at a hospital other than the applicant hospital, an applicant shall develop and maintain a neonatal transport system.

(e) An applicant shall coordinate and participate in professional education for perinatal and pediatric providers in the planning area.

(f) An applicant shall develop and implement a system for discharge planning.

(g) A ~~board-certified~~board-certified neonatologist shall serve as the director of neonatal services.

(h) An applicant shall make provisions for ~~on-site~~ physician consultation services EITHER ON-SITE OR BY PREARRANGED CONSULTATIVE AGREEMENTS in at least the following neonatal/pediatric specialties: cardiology, ophthalmology, surgery and neurosurgery. PREARRANGED CONSULTATIVE AGREEMENTS CAN BE PERFORMED BY USING TELEMEDICINE TECHNOLOGY.

(i) An applicant shall develop and maintain plans for the provision of highly specialized neonatal/pediatric services, such as cardiac surgery, cardiovascular surgery, neurology, hematology, orthopedics, urology, otolaryngology and genetics.

(j) An applicant shall develop and maintain plans for the provision of transferring infants discharged from its NICU to another hospital, as necessary for the care of an infant no longer requiring NICU services but unable to be discharged home.

(3) Compliance with the following applicable quality assurance standards for SCN services:

(a) An applicant shall coordinate its services with other providers of obstetrical, perinatal, neonatal and pediatric care in its planning area, and other planning areas in the case of highly specialized services.

(b) An applicant shall develop and implement a system for discharge planning.

(c) A ~~board-certified~~board-certified neonatologist shall serve as the SCN program director.

(d) The hospital continues to have the following capabilities and personnel continuously available and on-site:

(i) ~~The ability to provide~~ mechanical ventilation FOR A BRIEF DURATION (UP TO 24 HOURS). FOR BABIES REQUIRING MECHANICAL VENTILATION EXEEDING 24 HOURS, SCNS SHALL REQUEST TRANSFER TO A NICU BY THE 24TH HOUR OF MECHANICAL VENTILATION.~~;~~

(ii) ~~and/or~~ continuous positive airway pressure AND HFNC ~~for up to 24 hours~~;

(iii) portable x-ray equipment and blood gas analyzer;
(iiiiv) pediatric physicians and/or neonatal nurse practitioners; and
(iv) respiratory therapists, radiology technicians, laboratory technicians and specialized nurses with experience caring for premature infants.

(4) Compliance with the following access to care requirements:
(a) The NICU and SCN services shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.
(b) The NICU and SCN services shall not deny NICU and SCN services to any individual based on ability to pay or source of payment.
(c) The NICU and SCN services shall provide NICU and SCN services to any individual based on clinical indications of need for the services.
(d) The NICU and SCN services shall maintain information by payor and non-paying sources to indicate the volume of care from each source provided annually.
(e) Compliance with selective contracting requirements shall not be construed as a violation of this term.

(5) Compliance with the following monitoring and reporting requirements:
(a) The NICU and SCN services 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, 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.
(i) The SCN services shall provide data for the percentage of transfers to a higher level of care, hours of life at the time of transfer to a higher level of care, admissions to the SCN at less than 32 weeks gestation, number of admissions requiring respiratory support greater than 24 hours in duration, number of admissions to SCN, and rates of morbidity including: intraventricular hemorrhage (grade 3 and 4), retinopathy of prematurity (stage 3 and 4), chronic lung disease (oxygen dependency at 36 weeks gestation), necrotizing enterocolitis, and pneumothorax.
(b) The NICU and SCN services shall provide the Department with timely notice of the proposed project implementation consistent with applicable statute and promulgated rules.

(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 13. Department inventory of beds

Sec. 13. The Department shall maintain a listing of the Department inventory of beds for each planning area.

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

Sec. 14. (1) These CON review standards supercede and replace the CON Review Standards for Neonatal Intensive Care Services/Beds approved by the Commission on September 2521, 2014 2016 and effective on December 229, 20142016.

(2) Projects reviewed under these standards shall be subject to comparative review except for:
(a) Replacement beds meeting the requirements of Section 22229(3) of the Code, being Section 333.22229(3) of the Michigan Compiled Laws;

(b) The designation of beds for NICU services being relocated pursuant to Section 6 of these standards; or

(c) Beds requested under Section 7(2).

(d) SCN services requested under Section 9.

APPENDIX A

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

APPENDIX B

The planning areas for neonatal intensive care services/beds are the geographic boundaries of the group 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

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

Date: November 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 September 17, 2020 meeting. Accordingly, the Department held a Public Hearing to receive testimony on the proposed NH/HLTCU Standards on October 27, 2020. Written testimony was accepted for an additional seven days after the hearing. Testimony was received from one organization.

Written Testimony:

1.) Pat Anderson – Health Care Association of Michigan (HCAM)

- Supports the proposed language.

Department Recommendation:

The Department supports the language as presented at the September 17, 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) "AVERAGE OCCUPANCY RATE" IS CALCULATED AS FOLLOWS:

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

(ii) CALCULATE THE TOTAL LICENSED BED DAYS FOR THE SAME 12-MONTH PERIOD AS IN (i) ABOVE BY MULTIPLYING THE TOTAL LICENSED BEDS AND CON APPROVED BUT NOT YET LICENSED BEDS BY THE TOTAL NUMBER OF DAYS THEY WERE LICENSED OR CON APPROVED BUT NOT YET 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.

(de) "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.

(ef) "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.

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

(gh) "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.

(hi) "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.

(ij) "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.

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

(kl) "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.

(lm) "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.

(mn) "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.

(no) "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.

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

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

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

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

(st) "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.

(tu) "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.~~ FOR EACH HSA AND FOR EACH AGE COHORT ESTABLISHED IN SUBSECTION (1)(b), PERFORM THE FOLLOWING CALCULATIONS:

(i) DETERMINE THE PATIENT DAYS AND POPULATION FOR THE BASE YEAR AND THREE YEARS PRIOR TO THE BASE YEAR.

(ii) DETERMINE THE PATIENT DAY UTILIZATION RATE PER 1000 PEOPLE FOR THE BASE YEAR AND THREE YEARS PRIOR TO THE BASE YEAR BY DIVIDING THE PATIENT DAYS BY THE POPULATION AND MULTIPLYING BY 1000.

(iii) DETERMINE THE AVERAGE YEARLY CHANGE IN THE PATIENT DAY UTILIZATION RATE FOR THE THREE-YEAR PERIOD BY SUBTRACTING THE UTILIZATION RATE IN THE BASE YEAR FROM THE UTILIZATION RATE FROM THREE YEARS PRIOR AND DIVIDING BY THREE.

(iv) MULTIPLY THE AVERAGE YEARLY CHANGE IN THE PATIENT DAY UTILIZATION RATE BY THE NUMBER OF YEARS BETWEEN THE BASE YEAR AND THE PLANNING YEAR TO CALCULATE TOTAL EXPECTED CHANGE IN THE PATIENT DAY UTILIZATION RATE.

(v) ADD THE TOTAL EXPECTED CHANGE IN THE PATIENT DAY UTILIZATION RATE TO THE PATIENT DAY UTILIZATION RATE TO CALCULATE THE PATIENT DAY UTILIZATION RATE IN THE PLANNING YEAR.

(vi) DETERMINE THE “HIGH” AND “LOW” PATIENT DAY UTILIZATION RATE THRESHOLDS BY MULTIPLYING THE PATIENT DAY UTILIZATION RATE IN THE PLANNING YEAR BY 1.2 AND 0.8.

(b) FOR EACH PLANNING AREA, PERFORM THE FOLLOWING CALCULATIONS:

(i) DETERMINE THE PATIENT DAYS AND POPULATION FOR THE BASE YEAR.

(ii) DETERMINE THE PATIENT DAY UTILIZATION RATE PER 1000 PEOPLE FOR THE BASE YEAR DIVIDING THE PATIENT DAYS BY THE POPULATION AND MULTIPLYING BY 1000.

(iii) FOR EACH AGE COHORT, COMPARE THE PATIENT DAY UTILIZATION RATE TO THE PATIENT DAY UTILIZATION RATE THRESHOLDS OF THE HSA IN WHICH THE PLANNING AREA IS LOCATED.

(A) IF THE PLANNING AREA UTILIZATION RATE IS GREATER THAN THE HSA HIGH THRESHOLD, REPLACE THE PLANNING AREA UTILIZATION RATE WITH THE HSA HIGH THRESHOLD VALUE.

(B) IF THE PLANNING AREA UTILIZATION RATE IS LESS THAN THE HSA HIGH THRESHOLD, REPLACE THE PLANNING AREA UTILIZATION RATE WITH THE HSA LOW THRESHOLD VALUE.

(C) IF THE PLANNING AREA UTILIZATION RATE FALLS BETWEEN THE HSA LOW AND HIGH THRESHOLDS, IT IS UNCHANGED.

(iv) FOR EACH AGE COHORT, MULTIPLY THE PREDICTED POPULATION IN THE PLANNING YEAR BY THE PLANNING AREA UTILIZATION RATE DETERMINED IN SUBSECTION (2)(b)(iii) TO CALCULATE THE PREDICTED NUMBER OF PATIENT DAYS IN THE PLANNING YEAR.

(v) SUM THE PREDICTED NUMBER OF PATIENT DAYS IN THE PLANNING YEAR FOR EACH AGE COHORT TO CALCULATE THE TOTAL PREDICTED PATIENT DAYS.

(vi) DIVIDE THE TOTAL PREDICTED PATIENT DAYS BY 365 (OR 366 FOR LEAP YEARS) TO OBTAIN THE PREDICTED AVERAGE DAILY CENSUS (ADC).

(vii) DIVIDE THE ADC BY 0.90 TO OBTAIN THE NUMBER OF BEDS NEEDED FOR THE PLANNING AREA IN 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.

(f) 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. THE REPLACEMENT FACILITY SHALL CERTIFY A SUFFICIENT NUMBER OF

MEDICAID BEDS TO SATISFY THE NEEDS OF THOSE CURRENT MEDICAID PATIENTS WHO DESIRE TO TRANSFER TO THE REPLACEMENT FACILITY/BEDS.

(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.

(f) 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. THE REPLACEMENT FACILITY SHALL CERTIFY A SUFFICIENT NUMBER OF MEDICAID BEDS TO SATISFY THE NEEDS OF THOSE CURRENT MEDICAID PATIENTS WHO DESIRE TO TRANSFER TO THE REPLACEMENT FACILITY/BEDS.

(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~~ 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 18, 2020 and effective on ~~March 20, 2015~~SEPTEMBER 3, 2020.

(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.

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	7 POINTS
All other applicants	Lowest applicant's cost per bed divided by the 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.

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~~ SEPTEMBER ~~21~~19, 2019 and effective on ~~May~~ NOVEMBER ~~24~~12, 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~~ 1,210 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~~ TEN 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~~ THIRTEEN 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~~4):

(a) Developmental disability beds will be allocated ~~160~~ ~~180~~250 adult beds and 50 child/adolescent beds.

(b) Geriatric psychiatric beds will be allocated ~~160~~ ~~180~~250 adult beds.

(c) Medical psychiatric beds will be allocated ~~160~~ ~~180~~250 adult beds and 50 child/adolescent beds.

(d) High acuity psychiatric beds will be allocated ~~220~~ ~~240~~310 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.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF NEED (CON) REVIEW STANDARDS
FOR MAGNETIC RESONANCE IMAGING (MRI) 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 MRI services and the delivery of services under Part 222 of the Code. Pursuant to Part 222 of the Code, MRI 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 MRI service or existing MRI unit(s)" means obtaining control or possession of an existing fixed or mobile MRI service or existing MRI unit(s) by contract, ownership, lease, or other comparable arrangement.

(b) "Actual MRI adjusted procedures" or "MRI adjusted procedures," means the number of MRI procedures, adjusted in accordance with the applicable provisions of Section 15, performed on an existing MRI unit, or if an MRI service has two or more MRI units at the same site, the average number of MRI adjusted procedures performed on each unit, for the 12-month period reported on the most recently published "MRI Service Utilization List," as of the date an application is deemed submitted by the Department.

(c) "Available MRI adjusted procedures" means the number of MRI adjusted procedures performed by an existing MRI service in excess of 8,000 per fixed MRI unit and 7,000 per mobile MRI unit. For either a fixed or mobile MRI service, the number of MRI units used to compute available MRI adjusted procedures shall include both existing and approved but not yet operational MRI units. In determining the number of available MRI adjusted procedures, the Department shall use data for the 12-month period reported on the most recently published list of available MRI adjusted procedures as of the date an application is deemed submitted by the Department.

In the case of a mobile MRI unit, the term means the sum of all MRI adjusted procedures performed by the same mobile MRI unit at all of the host sites combined that is in excess of 7,000. For example, if a mobile MRI unit serves five host sites, the term means the sum of MRI adjusted procedures for all five host sites combined that is in excess of 7,000 MRI adjusted procedures.

(d) "Central service coordinator" means the organizational unit that has operational responsibility for a mobile MRI unit(s).

(e) "Certificate of Need Commission" or "CON 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) "Contrast MRI procedure" means an MRI procedure involving either of the following: (i) a procedure following use of a contrast agent or (ii) procedures performed both before and after the use of a contrast agent.

(h) "Dedicated pediatric MRI" means an MRI unit on which at least 80% of the MRI procedures are performed on patients under 18 years of age.

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

(j) "Doctor" means an individual licensed under Article 15 of the Code to engage in the practice of medicine, osteopathic medicine and surgery, chiropractic, dentistry, or podiatry.

(k) "Existing MRI service" means either the utilization of a CON-approved and operational MRI unit(s) at one site in the case of a fixed MRI service, and in the case of a mobile MRI service, the utilization of a CON-approved and operational mobile MRI unit(s) at each host site, on the date an application is submitted to the Department.

(l) "Existing MRI unit" means a CON-approved and operational MRI unit used to provide MRI services.

(m) "Expand an existing fixed MRI service" means an increase in the number of fixed MRI units to be operated by the applicant.

(n) "Expand an existing mobile MRI service" means the addition of a mobile MRI unit that will be operated by a central service coordinator that is approved to operate one or more mobile MRI units as of the date an application is submitted to the Department.

(o) "Group practice" means a group practice as defined pursuant to the provisions of 42 U.S.C. 1395nn (h)(4), commonly known as Stark II, and the Code of Federal Regulations, 42 CFR, Part 411, published in the Federal Register on August 14, 1995, or its replacement.

(p) "Health service area" or "HSA" means the geographic areas set forth in Section 21.

(q) "Host site" means the site at which a mobile MRI unit is authorized by CON to provide MRI services.

(r) "Initiate a fixed MRI service" means begin operation of a fixed MRI service at a site that does not provide or is not CON approved to provide fixed MRI services as of the date an application is submitted to the Department. The term does not include the acquisition or replacement of an existing fixed MRI service to a new site or the renewal of a lease.

(s) "Initiate a mobile MRI host site" means the provision of MRI services at a host site that has not received any MRI services within 12 months from the date an application is submitted to the Department. The term does not include the renewal of a lease.

(t) "Initiate a mobile MRI service" means begin operation of a mobile MRI unit that serves two or more host sites.

The term does not include the acquisition of an existing mobile MRI service or the renewal of a lease.

(u) "Inpatient" means an MRI visit involving an individual who has been admitted to the licensed hospital at the site of the MRI service/unit or in the case of an MRI unit that is not located at that licensed hospital site, an admitted patient transported from a licensed hospital site by ambulance to the MRI service.

(v) "Institutional review board" or "IRB" means an institutional review board as defined by Public Law 93-348 that is regulated by Title 45 CFR 46.

(w) "Intra-operative magnetic resonance imaging" or "IMRI" means the integrated use of MRI technology during surgical and interventional procedures within a licensed operative environment.

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

(y) "Magnetic resonance imaging" or "MRI" means the analysis of the interaction that occurs between radio frequency energy, atomic nuclei, and strong magnetic fields to produce cross sectional images similar to those displayed by computed tomography (CT) but without the use of ionizing radiation.

(z) "MRI adjusted procedure" means an MRI visit, at an existing MRI service, that has been adjusted in accordance with the applicable provisions of Section 15.

(aa) "MRI database" means the database, maintained by the Department pursuant to Section 14 of these standards, that collects information about each MRI visit at MRI services located in Michigan.

(bb) "MRI-guided electrophysiology intervention" or "MRI-guided EPI" means equipment specifically designed for the integrated use of MRI technology for the purposes of electrophysiology interventional procedures within a cardiac catheterization lab.

(cc) "MRI procedure" means a procedure conducted by an MRI unit approved pursuant to sections 3, 4, 5, 6, 7, or 9 of these standards which is either a single, billable diagnostic magnetic resonance procedure or a procedure conducted by an MRI unit at a site participating with an approved diagnostic

radiology residency program, under a research protocol approved by an IRB. The capital and operating costs related to the research use are charged to a specific research account and not charged to or collected from third-party payors or patients. The term does not include a procedure conducted by an MRI unit approved pursuant to Section 7.

(dd) "MRI services" means either the utilization of an authorized MRI unit(s) at one site in the case of a fixed MRI service or in the case of a mobile MRI service, the utilization of an authorized mobile MRI unit at each host site.

(ee) "MRI unit" means the magnetic resonance system consisting of an integrated set of machines and related equipment necessary to produce the images and/or spectroscopic quantitative data from scans including FDA-approved positron emission tomography (PET)/MRI scanner hybrids if used for MRI only procedures. The term does not include MRI simulators used solely for treatment planning purposes in conjunction with a Megavoltage Radiation Therapy (MRT) unit.

(ff) "MRI visit" means a single patient visit to an MRI service/unit that may involve one or more MRI procedures.

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

(hh) "Mobile MRI unit" means an MRI unit operating at two or more host sites and that has a central service coordinator. The mobile MRI unit shall operate under a contractual agreement for the provision of MRI services at each host site on a regularly scheduled basis.

(ii) "Ownership interest, direct or indirect" means a direct ownership relationship between a doctor and an applicant entity or an ownership relationship between a doctor and an entity that has an ownership relationship with an applicant entity.

(jj) "Pediatric patient" means a patient who is 12 years of age or less, except for Section 8.

(kk) "Planning area" means

(i) in the case of a proposed fixed MRI service or unit, the geographic area within a 20-mile radius from the proposed site if the proposed site is not in a rural or micropolitan statistical area county and a 75-mile radius from the proposed site if the proposed site is in a rural or micropolitan statistical area county.

(ii) in the case of a proposed mobile MRI service or unit, except as provided in subsection (iii), the geographic area within a 20-mile radius from each proposed host site if the proposed site is not in a rural or micropolitan statistical area county and within a 75-mile radius from each proposed host site if the proposed site is in a rural or micropolitan statistical area county.

(iii) in the case of a proposed mobile MRI service or unit meeting the requirement of Section 15(2)(d), the health service area in which all the proposed mobile host sites will be located.

(ll) "PUBLIC HEALTH EPIDEMIC" MEANS AN EPIDEMIC IDENTIFIED AND CONTROLLED PURSUANT TO MCL 333.2253(1) OR MCL 333.2453(1), OR AN EPIDEMIC OR PANDEMIC AS DECLARED BY THE CENTERS FOR DISEASE CONTROL (CDC) OR THE WORLD HEALTH ORGANIZATION (WHO).

(mm) "Referring doctor" means the doctor of record who ordered the MRI procedure(s) and either to whom the primary report of the results of an MRI procedure(s) is sent or in the case of a teaching facility, the attending doctor who is responsible for the house officer or resident that requested the MRI procedure.

(~~mm~~nn) "Renewal of a lease" means extending the effective period of a lease for an existing MRI unit that does not involve either replacement of the MRI unit, as defined in Section 4, or (ii) a change in the parties to the lease.

(~~nn~~oo) "Research scan" means an MRI scan administered under a research protocol approved by the applicant's IRB.

(~~oo~~pp) "Re-sedated patient" means a patient, either pediatric or adult, who fails the initial sedation during the scan time and must be extracted from the unit to rescue the patient with additional sedation.

(~~pp~~qq) "Sedated patient" means a patient that meets all of the following:

(i) whose level of consciousness is either conscious-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 is monitored by mechanical devices while in the magnet.
(iii) who requires observation while in the magnet by personnel, other than employees routinely assigned to the MRI unit, who are trained in cardiopulmonary resuscitation (CPR).
(~~qq~~rr) "Site" means
(i) in the case of a licensed hospital site, a location that is part of the licensed hospital site or a location that is contiguous to the licensed hospital site or
(ii) in the case of a location that is not a licensed hospital site, a location at the same address or a location that is contiguous to that address.
(~~rr~~ss) "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, implantable cardiac devices (ICDS), and other conditions that make the patient unable to comply with the positional requirements of the exam or is unable to comply with the motionless requirements and whose resulting movements result in non-diagnostic quality images therefore requiring the technologist to repeat the same sequence in an attempt to obtain a diagnostic quality image.
(~~ss~~tt) "Teaching facility" means a licensed hospital site, or other location, that provides either fixed or mobile MRI services and at which residents or fellows of a training program in diagnostic radiology, that is approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association, are assigned.
(~~tt~~uu) "Unadjusted MRI scan" means an MRI procedure performed on a single anatomical site as defined by the MRI database and that is not adjusted pursuant to the applicable provisions of Section 15.

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

Section 3. Requirements to initiate an MRI service

Sec. 3. An applicant proposing to initiate an MRI service or a host site shall demonstrate the following requirements, as applicable:

(1) An applicant proposing to initiate a fixed MRI service shall demonstrate 6,000 available MRI adjusted procedures per proposed fixed MRI unit OR 5,400 AVAILABLE MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARTMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC from within the same planning area as the proposed service/unit.

(2) An applicant proposing to initiate a fixed MRI service that meets the following requirements shall not be required to be in compliance with subsection (1):
(a) The applicant is currently an existing host site.
(b) The applicant has received in aggregate, one of the following:
(i) At least 6,000 MRI adjusted procedures OR 5,400 MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARTMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC.
(ii) At least 4,000 MRI adjusted procedures OR 3,600 MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARTMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC, and the applicant meets all of the following:
(A) Is located in a county that has no fixed MRI machines that are pending, approved by the Department, or operational at the time the application is deemed submitted.
(B) The nearest fixed MRI machine is located more than 15 radius miles from the application site.
(iii) At least 3,000 MRI adjusted procedures and the applicant meets all of the following:
(A) The proposed site is a hospital licensed under Part 215 of the Code.

(B) The applicant hospital operates an emergency room that provides 24-hour emergency care services and at least 20,000 visits within the most recent 12-month period for which data, verifiable by the Department, is available.

(c) All of the MRI adjusted procedures from the mobile MRI service referenced in Section 3(2)(b) shall be utilized even if the aggregated data exceeds the minimum requirements.

(d) The applicant shall install the fixed MRI unit at the same site as the existing host site or within the relocation zone. If applying pursuant to Section 3(2)(b)(iii), the applicant shall install the fixed MRI unit at the same site as the existing host site.

(e) The applicant shall cease operation as a host site and not become a host site for at least 12 months from the date the fixed service and its unit becomes operational.

(3) An applicant proposing to initiate a mobile MRI service shall demonstrate 5,500 available MRI adjusted procedures, OR 4,950 AVAILABLE MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARTMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC, from within the same planning area as the proposed service/unit, and the applicant shall meet the following:

(a) Identify the proposed route schedule and procedures for handling emergency situations.

(b) Submit copies of all proposed contracts for the proposed host site related to the mobile MRI service.

(c) Identify a minimum of two (2) host sites for the proposed service.

(4) An applicant, whether the central service coordinator or the host site, proposing to initiate a host site on a new ~~or existing~~ mobile MRI service shall demonstrate the following, as applicable:

(a) 600 available MRI adjusted procedures, OR 540 AVAILABLE MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC, from within the same planning area as the proposed service/unit, for a proposed host site that is not located in a rural or micropolitan statistical area county, or

(b) 400 available MRI adjusted procedures, OR 360 AVAILABLE MRI ADJUSTED PROCEDURES IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC, from within the same planning area for a proposed host site that is located in a rural or micropolitan statistical area county, and

(c) The proposed host site has not received any mobile MRI service within the most recent 12-month period as of the date an application is submitted to the Department.

(5) AN APPLICANT, WHETHER THE CENTRAL SERVICE COORDINATOR OR THE HOST SITE, PROPOSING TO INITIATE A HOST SITE ON AN EXISTING MOBILE MRI SERVICE SHALL, AS APPLICABLE:

(a) DEMONSTRATE THAT THE PROPOSED HOST SITE HAS NOT RECEIVED ANY MOBILE MRI SERVICE WITHIN THE MOST RECENT 12-MONTH PERIOD AS OF THE DATE THE APPLICATION IS SUBMITTED TO THE DEPARTMENT.

(b) SUBMIT COPIES OF ALL PROPOSED CONTRACTS FOR THE PROPOSED HOST SITE RELATED TO THE MOBILE MRI SERVICE.

(c) DEMONSTRATE THAT THE HOST SITE SHALL PERFORM THE APPLICABLE MINIMUM NUMBER OF MRI ADJUSTED PROCEDURES SET FORTH IN SECTION 14 DURING ITS SECOND 12 MONTHS OF OPERATION, AND ANNUALLY THEREAFTER.

(~~5~~6) An applicant proposing to add or change service on an existing mobile MRI service ~~that meets the following requirements shall not be required to be in compliance with subsection (4)~~SHALL:

(a) DEMONSTRATE THAT ~~The~~ the host site has received mobile MRI services from an existing mobile MRI unit within the most recent 12-month period as of the date ~~an~~ THE application is submitted to the Department.

(b) Submit copies of all proposed contracts for the proposed host site related to the mobile MRI service.

(~~6~~7) The applicant shall demonstrate that the available MRI adjusted procedures from the "Available MRI Adjusted Procedures List" or the adjusted procedures from the "MRI Service Utilization List," as applicable, are from the most recently published MRI lists as of the date an application is deemed submitted by the Department.

Section 4. Requirements to replace an existing MRI unit

Sec. 4. Replace an existing MRI unit means (i) any equipment change involving a change in, or replacement of, the entire MRI unit resulting in an applicant operating the same number and type (fixed or mobile) of MRI units before and after project completion or (ii) an equipment change that involves a capital expenditure of $750,000 or more in any consecutive 24-month period or (iii) the renewal of a lease. Replacement also means the relocation of an MRI service or unit to a new site. The term does not include the replacement of components of the MRI system, including the magnet, under an existing service contract or required maintenance to maintain the system to operate within manufacturer specifications. The term does not include an upgrade to an existing MRI unit or repair of an existing MRI service or unit, and it does not include a host site that proposes to receive mobile MRI services from a different central service coordinator if the requirements of Section 3(5) have been met.

(1) "Upgrade an existing MRI unit" means any equipment change that
(i) does not involve a change in, or replacement of, the entire MRI unit, does not result in an increase in the number of MRI units; or does not result in a change in the type of MRI unit (e.g., changing a mobile MRI unit to a fixed MRI unit); and
(ii) involves a capital expenditure related to the MRI equipment of less than $750,000 in any consecutive 24-month period.

(2) “Repair an existing MRI unit” means restoring the ability of the system to operate within the manufacturer’s specifications by replacing or repairing the existing components or parts of the system, including the magnet, pursuant to the terms of an existing maintenance agreement with the manufacturer of the MRI unit that does not result in a change in the strength of the MRI unit.

(3) An applicant proposing to replace an existing MRI unit shall demonstrate the following requirements:
(a) Equipment that is replaced shall be removed from service and disposed of or rendered considerably inoperable on or before the date that the replacement equipment becomes operational.
(b) The replacement unit shall be located at the same site.
(c) An applicant proposing to replace an existing MRI unit that does not involve a renewal of a lease shall demonstrate that the MRI unit to be replaced is fully depreciated according to generally accepted accounting principles; the existing equipment clearly poses a threat to the safety of the public; or the proposed replacement equipment offers a significant technological improvement which enhances quality of care, increases efficiency, and reduces operating costs.

(4) An applicant proposing to replace an existing mobile MRI host site to a new location shall demonstrate the following:
(a) The applicant currently operates the MRI mobile host site to be relocated.
(b) The MRI mobile host site to be relocated has been in operation as of the date an application is submitted to the Department.
(c) The proposed new site is within a 5-mile radius of the existing site for a metropolitan statistical area county or within a 10-mile radius for a rural or micropolitan statistical area county.
(d) The relocation will not involve a change in the current central service coordinator unless the requirements of Section 3(5) are met.

(5) An applicant proposing to replace an existing fixed MRI service and its unit(s) to a new site shall demonstrate the following:

(a) The existing MRI service and its unit(s) 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)(i) or (ii).

(b) The proposed new site is within a 10-mile radius of the existing site.

(c) Each existing MRI unit to be relocated performed at least the applicable minimum number of MRI adjusted procedures set forth in Section 14 based on the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department unless one of the ~~following~~ requirements OF SUBSECTION (i), (ii), OR (iii) are met~~.~~. IF THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC AND THE FACILITY WAS PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC, THE APPLICANT MAY ANNUALIZE THEIR MRI ADJUSTED PROCEDURES AND SHALL INCLUDE ONLY THOSE MONTHS AND PROCEDURES PERFORMED WHEN THE FACILITY WAS NOT PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC. IF USING ANNUALIZED DATA, THE APPLICANT SHALL SUBMIT AN AFFIDAVIT CONFIRMING THE MONTHS THAT THE FACILITY WAS PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC.

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

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

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

(6) An applicant proposing to replace a fixed MRI unit of an existing MRI service to a new site shall demonstrate the following:

(a) The applicant currently operates the MRI service from which the unit will be relocated.

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

(c) The proposed new site is within a 10-mile radius of the existing site.

(d) Each existing MRI unit at the service from which a unit is to be relocated performed at least the applicable minimum number of MRI adjusted procedures set forth in Section 14 based on the most recently published MRI Service Utilization List as of the date an application is deemed submitted by the Department.

(e) For volume purposes, the new site shall remain associated to the original site for a minimum of three years.

Section 5. Requirements to expand an existing MRI service

Sec. 5. An applicant proposing to expand an existing MRI service shall demonstrate the following:

(1) An applicant shall demonstrate that the applicable MRI adjustable procedures are from the most recently published MRI Service Utilization List as of the date of an application is deemed submitted by the Department:

(a) Each existing MRI unit on the network has performed at least an average of 9,000 MRI adjusted procedures per MRI unit.

(b) Each existing fixed MRI unit at the current site has performed at least an average of 11,000 MRI adjusted procedures per MRI unit.

(c) Each existing dedicated pediatric MRI unit at the current site has performed at least an average of 3,500 MRI adjusted procedures per MRI unit.

(2) IF THE APPLICANT IS APPLYING FOR EXPANSION, AND THE APPLICATION IS UTILIZING AN MRI LIST WHERE THE DEPARMENT DETERMINES THAT THE REPORTING PERIOD IS IMPACTED BY A PUBLIC HEALTH EPIDEMIC, AND THE FACILITY WAS PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC, THE APPLICANT MAY ANNUALIZE THEIR MRI ADJUSTED PROCEDURES AND SHALL INCLUDE ONLY THOSE MONTHS AND PROCEDURES PERFORMED WHEN THE FACILITY WAS NOT PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC. IF USING ANNUALIZED DATA, THE APPLICANT SHALL SUBMIT AN AFFIDAVIT CONFIRMING THE MONTHS THAT THE FACILITY WAS PREVENTED BY LAW FROM OPERATING AT FULL CAPACITY DUE TO THE PUBLIC HEALTH EPIDEMIC.

(3) The additional fixed unit shall be located at the same site unless the requirements of the replacement section have been met.

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

Sec. 6. An applicant proposing to acquire an existing fixed or mobile MRI service and its unit(s) shall demonstrate the following:

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

(a) It is the first application proposing to acquire the existing fixed or mobile MRI service and its unit(s) on or after July 1, 1997.

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

(2) For any application proposing to acquire an existing fixed or mobile MRI service and its unit(s), except an application approved pursuant to subsection (1), an applicant shall be required to document that the MRI service and its unit(s) to be acquired is operating in compliance with the volume requirements set forth in Section 14 of these standards applicable to an existing MRI service on the date the application is submitted to the Department.

(3) An applicant proposing to acquire an existing fixed or mobile MRI unit of an existing MRI service shall demonstrate that the proposed project meets all of the following, as applicable:

(a) An applicant shall demonstrate that the applicable MRI adjustable procedures are from the most recently published MRI service utilization list as of the date of an application is deemed submitted by the Department:

(i) The fixed MRI unit(s) to be acquired performed at least 6,000 MRI adjusted procedures per fixed MRI unit.

(ii) The mobile MRI unit(s) to be acquired performed at least 5,500 MRI adjusted procedures per mobile MRI unit.

(b) The project will not change the number of MRI units at the site from which the number of units are being acquired, subject to the applicable requirements under Section 4(6), unless the applicant demonstrates that the project is in compliance with the requirements of the initiation or expansion Section, as applicable.

(c) The project will not result in the replacement of an MRI unit at the MRI service to be acquired unless the applicant demonstrates that the requirements of the replacement section have been met.

(4) The MRI service and its unit(s) shall be operating at the applicable volume requirements set forth in Section 14 of these standards in the second 12 months after the effective date of the acquisition, and annually thereafter.

Section 7. Requirements to establish a dedicated research MRI unit

Sec. 7. An applicant proposing an MRI unit to be used exclusively for research shall demonstrate the following:

(1) The applicant agrees that the dedicated research MRI unit will be used primarily (70% or more of the procedures) for research purposes only.

(2) Submit copies of documentation demonstrating that the applicant operates a diagnostic radiology residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or an equivalent organization.

(3) Submit copies of documentation demonstrating that the MRI unit shall operate under a protocol approved by the applicant's IRB.

(4) An applicant meeting the requirements of this section shall be exempt from meeting the requirements of sections to initiate and replace.

(5) The dedicated research MRI unit approved under this section may not utilize MRI adjusted procedures performed on the dedicated MRI unit to demonstrate need or to satisfy MRI CON review standards requirements.

Section 8. Requirements to establish a dedicated pediatric MRI unit

Sec. 8. An applicant proposing to establish dedicated pediatric MRI shall demonstrate all of the following:

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

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

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

(a) pediatric radiology (at least two)
(b) pediatric anesthesiology
(c) pediatric cardiology
(d) pediatric critical care
(e) pediatric gastroenterology
(f) pediatric hematology/oncology
(g) pediatric neurology
(h) pediatric neurosurgery
(i) pediatric orthopedic surgery
(j) pediatric pathology
(k) pediatric pulmonology
(l) pediatric surgery
(m) neonatology

(4) The applicant shall have in operation the following pediatric specialty programs:

(a) pediatric bone marrow transplant program
(b) established pediatric sedation program

(c) pediatric open heart program

(5) An applicant meeting the requirements of this section shall be exempt from meeting the requirements of Section 5 of these standards.

Section 9. Requirements for all applicants proposing to initiate, replace, or acquire a hospital based IMRI

Sec. 9. An applicant proposing to initiate, replace, or acquire a hospital based IMRI service 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 MRI service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(3) The proposed site has an existing and operational surgical service and is meeting its minimum volume requirements pursuant to the CON Review Standards for Surgical Services.

(4) The applicant has achieved one of the following:
(a) at least 1,500 oncology discharges in the most recent year of operation; or
(b) at least 1,000 neurological surgeries in the most recent year of operation; or
(c) at least 7,000 pediatric (<18 years old) discharges (excluding normal newborns) and at least 5,000 pediatric (<18 years old) surgeries in the most recent year of operation.

(5) The proposed IMRI unit must be located in an operating room or a room adjoining an operating room allowing for transfer of the patient between the operating room and this adjoining room.

(6) Non-surgical diagnostic studies shall not be performed on an IMRI unit approved under this section unless the patient meets one of the following criteria:
(a) the patient has been admitted to an inpatient unit; or
(b) the patient is having the study performed on an outpatient basis, but is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists.

(7) The approved IMRI unit will not be subject to MRI volume requirements.

(8) The applicant shall not utilize the procedures performed on the IMRI unit to demonstrate need or to satisfy MRI CON review standards requirements.

Section 10. Requirements for all applicants proposing to initiate, replace, or acquire a hospital based MRI-guided EPI service

Sec. 10. An applicant proposing to initiate, replace, or acquire a hospital based MRI-guided EPI service 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 MRI service that has been operational for the previous 36 consecutive months and is meeting its minimum volume requirements.

(3) The proposed site has an existing and operational therapeutic cardiac catheterization service and is meeting its minimum volume requirements pursuant to the CON review standards for cardiac catheterization services and open heart surgery services.

(4) The proposed MRI-guided EPI unit must be located in a cardiac catheterization lab containing a flouroscopy unit with an adjoining room containing an MRI scanner. The rooms shall contain a patient transfer system allowing for transfer of the patient between the cardiac catheterization lab and the MRI unit, utilizing one of the following:

(a) moving the patient to the MRI scanner, or

(b) installing the MRI scanner on a sliding gantry to allow the patient to remain stationary.

(5) Non-cardiac MRI diagnostic studies shall not be performed in an MRI-guided EPI unit approved under this section unless the patient meets one of the following criteria:

(a) The patient has been admitted to an inpatient unit; or

(b) The patient is having the study performed on an outpatient basis as follows:

(i) is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists, or

(ii) has an implantable cardiac device.

(6) The approved MRI-guided EPI unit shall not be subject to MRI volume requirements.

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

Section 11. Requirements for all applicants proposing to initiate, replace, or acquire an MRI simulator that will not be used solely for MRT treatment planning purposes

Sec. 11. MRI simulation is the use of MRI to help simulate (or plan) a patient's MRT treatment and to incorporate superior delineation of soft tissues for MRT treatment plans. An applicant proposing to initiate, replace, or acquire an MRI simulator shall demonstrate each of the following, as applicable to the proposed project.

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

(2) The proposed site has an existing and operational MRT service and is meeting its minimum volume requirements pursuant to the CON review standards for MRT services/units.

(3) MRI diagnostic studies shall not be performed using an MRI simulator approved under this section unless the patient meets one of the following criteria:

(a) The patient has been admitted to an inpatient unit; or

(b) The patient is having the study performed on an outpatient basis, but is in need of general anesthesia or deep sedation as defined by the American Society of Anesthesiologists.

(4) The approved MRI simulator will not be subject to MRI volume requirements.

(5) The applicant shall not utilize the procedures performed on the MRI simulator to demonstrate need or to satisfy MRI CON review standards requirements.

Section 12. Requirements for approval of an FDA-approved PET/MRI scanner hybrid for initiation, expansion, replacement, and acquisition

Sec. 12. An applicant proposing to initiate, expand, replace, or acquire an FDA-approved PET/MRI scanner hybrid shall demonstrate that it meets all of the following:

(1) There is an approved PET CON for the FDA-approved PET/MRI hybrid, and the FDA-approved

PET/MRI scanner 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 FDA-approved PET/MRI scanner hybrid in accordance with all applicable project delivery requirements set forth in Section 14 of these standards.

(3) The approved FDA-approved PET/MRI scanner hybrid shall not be subject to MRI volume requirements.

(4) An FDA-approved PET/MRI scanner hybrid approved under the CON review standards for PET scanner services and the review standards for MRI scanner services may not utilize MRI procedures performed on an FDA-approved PET/MRI scanner hybrid to demonstrate need or to satisfy MRI CON review standards requirements.

Section 13. Requirements for all applicants

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 – terms of approval

Sec. 14. An applicant shall agree that, if approved, MRI services, whether fixed or mobile, shall be delivered and maintained in compliance with the following:

(1) Compliance with these standards.

(2) Compliance with the following quality assurance standards:

(a) An applicant shall develop and maintain policies and procedures that establish protocols for assuring the effectiveness of operation and the safety of the general public, patients, and staff in the MRI service.

(b) An applicant shall establish a schedule for preventive maintenance for the MRI unit.

(c) An applicant shall provide documentation identifying the specific individuals that form the MRI team. At a minimum, the MRI team shall consist of the following professionals:

(i) Physicians who shall be responsible for screening of patients to assure appropriate utilization of the MRI service and taking and interpretation of scans. At least one of these physicians shall be a board-certified radiologist.

(ii) An appropriately trained MRI technician who shall be responsible for taking an MRI scan.

(iii) An MRI physicist/engineer available as a team member on a full-time, part-time, or contractual basis.

(d) An applicant shall document that the MRI team members have the following qualifications:

(i) Each physician credentialed to interpret MRI scans meets the requirements of each of the following:

(A) The physician is licensed to practice medicine in the State of Michigan.

(B) The physician has had at least 60 hours of training in MRI physics, MRI safety, and MRI instrumentation in a program that is part of an imaging program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and the physician meets the requirements of subdivision (1), (2), or (3):

(1) Board certification by the American Board of Radiology, the American Osteopathic Board of Radiology, or the Royal College of Physicians and Surgeons of Canada. If the diagnostic radiology program completed by a physician in order to become board certified did not include at least two months of MRI training, that physician shall document that he or she has had the equivalent of two months of

postgraduate training in clinical MRI imaging at an institution which has a radiology program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

(2) Formal training by an imaging program(s), accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association that included two years of training in cross-sectional imaging and six months training in organ-specific imaging areas.

(3) A practice in which at least one-third of total professional time, based on a full-time clinical practice during the most recent 5-year period, has been the primary interpretation of MR imaging.

(C) The physician has completed and will complete a minimum of 40 hours every two years of Category in Continuing Medical Education credits in topics directly involving MR imaging.

(D) The physician complies with the "American College of Radiology (ACR) Practice Parameter for Performing and Interpreting Magnetic Resonance Imaging (MRI)."

(ii) An MRI technologist who is registered by the American Registry of Radiologic Technicians or by the American Registry of Magnetic Resonance Imaging Technologists (ARMRIT) and has, or will have within 36 months of the effective date of these standards or the date a technologist is employed by an MRI service, whichever is later, special certification in MRI. If a technologist does not have special certification in MRI within either of the 3-year periods of time, all continuing education requirements shall be in the area of MRI services.

(iii) An applicant shall document that an MRI physicist/engineer is appropriately qualified. For purposes of evaluating this subdivision, the Department shall consider it prima facie evidence as to the qualifications of the physicist/engineer if the physicist/engineer is certified as a medical physicist by the American Board of Radiology, the American Board of Medical Physics, or the American Board of Science in Nuclear Medicine. However, the applicant may submit and the Department may accept other evidence that an MRI physicist/engineer is qualified appropriately.

(e) The applicant shall have, within the MRI unit/service, equipment and supplies to handle clinical emergencies that might occur in the unit. MRI service staff will be trained in CPR and other appropriate emergency interventions. A physician shall be on-site, in, or immediately available to the MRI unit at all times when patients are undergoing scans.

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

The applicant, to assure that the MRI unit will be utilized by all segments of the Michigan population, shall

(a) provide MRI services to all individuals based on the clinical indications of need for the service and not on ability to pay or source of payment.

(b) maintain information by source of payment to indicate the volume of care from each source provided annually.

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

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

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

(a) MRI units shall be operating at a minimum average annual utilization during the second 12 months of operation, and annually thereafter, as applicable:

(i) 6,000 MRI adjusted procedures per unit for fixed MRI services unless compliant with (A) or (B),

(A) 4,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(ii) and is the only fixed MRI unit at the current site,

(B) 3,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(iii) and is the only fixed MRI unit at the hospital site licensed under part 215 of the code,

(ii) 5,500 MRI adjusted procedures per unit for mobile MRI services.

(iii) 3,500 MRI adjusted procedures per unit for dedicated pediatric MRI units.

(iv) Each mobile host site in a rural or micropolitan statistical area county shall have provided at least a total of 400 adjusted procedures during its second 12 months of operation, and annually thereafter, from all mobile units providing services to the site. Each mobile host site not in a rural or micropolitan statistical area county shall have provided at least a total of 600 adjusted procedures during

its second 12 months of operation and annually thereafter, from all mobile units providing services to the site.

(v) In meeting these requirements, an applicant shall not include any MRI adjusted procedures performed on an MRI unit used exclusively for research and approved pursuant to Section 7 or for an IMRI unit approved pursuant to Section 9.

(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, operating schedules, demographic and diagnostic information, and the volume of care provided to patients from all payor sources, as well as other data requested by the Department or its designee and approved by the Commission. The applicant shall provide the required data in a format established by the Department and in a mutually agreed upon media no later than 30 days following the last day of the quarter for which data are being reported to the Department. An applicant shall be considered in violation of this term of approval if the required data are not submitted to the Department within 30 days following the last day of the quarter for which data are being reported. The Department may elect to verify the data through on-site review of appropriate records. Data for an MRI unit approved pursuant to Section 7, Section 8, Section 9, Section 10, or Section 11 shall be reported separately.
For purposes of Section 9, the data reported shall include, at a minimum, how often the IMRI unit is used and for what type of services, i.e., intra-operative or diagnostic. For purposes of Section 10, the data reported shall include, at a minimum, how often the MRI-guided EPI unit is used and for what type of services, i.e., electrophysiology or diagnostic. For purposes of Section 11, the data reported shall include, at a minimum, how often the MRI simulator is used and for what type of services, i.e., treatment plans or diagnostic services.

(c) The applicant shall provide the Department with a notice stating the first date on which the MRI unit became operational, and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(d) An applicant who is a central service coordinator shall notify the Department of any additions, deletions, or changes in the host sites of each approved mobile MRI unit after the change(s) in host sites is made.

(5) An applicant for an MRI unit approved under Section 7 shall agree that the services provided by the MRI unit are delivered in compliance with the following terms.

(a) The capital and operating costs relating to the research use of the MRI unit shall be charged only to a specific research account(s) and not to any patient or third-party payor.

(b) The MRI unit shall not be used for any purposes other than as approved by the IRB unless the applicant has obtained CON approval for the MRI unit pursuant to Part 222 and these standards, other than Section 7.

(c) The dedicated research MRI unit will be used primarily (70% or more of the procedures) for research purposes only.

(6) The dedicated pediatric MRI unit approved under Section 8 shall include at least 80% of the MRI procedures that are performed on patients under 18 years of age.

(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. MRI procedure adjustments

Sec. 15. (1) The Department shall apply the following formula, as applicable, to determine the number of MRI adjusted procedures that are performed by an existing MRI service or unit:

(a) The base value for each MRI procedure is 1.0. For functional MRI (fMRI) procedures, MRI-guided interventions, and cardiac MRI procedures, the base value is 2.0.

(i) fMRI means brain activation studies.

(ii) MRI-guided interventions means any invasive procedure performed requiring MRI guidance performed in the MRI scanner.

(iii) Cardiac MRI Procedure means dedicated MRI performed of the heart done for the sole purpose of evaluation of cardiac function, physiology, or viability.

(b) For each MRI visit involving a pediatric patient, 0.25 shall be added to the base value.

(c) For each MRI visit involving an inpatient, 0.50 shall be added to the base value.

(d) For each MRI procedure performed on a sedated patient, 0.75 shall be added to the base value.

(e) For each MRI procedure performed on a re-sedated patient, 0.25 shall be added to the base value.

(f) For each MRI procedure performed on a special needs patient, 0.25 shall be added to the base value.

(g) For each MRI visit that involves both a clinical and research scan on a single patient in a single visit, 0.25 shall be added to the base value.

(h) For each contrast MRI procedure performed after use of a contrast agent, and not involving a procedure before use of a contrast agent, 0.35 shall be added to the base value.

(i) For each contrast MRI procedure involving a procedure before and after use of a contrast agent, 1.0 shall be added to the base value.

(j) For each MRI procedure performed at a teaching facility, 0.15 shall be added to the base value.

(k) The results of subsections (a) through (j) shall be summed, and that sum shall represent an MRI adjusted procedure.

(2) The Department shall apply not more than one of the adjustment factors set forth in this subsection, as applicable, to the number of MRI procedures adjusted in accordance with the applicable provisions of subsection (1) that are performed by an existing MRI service or unit.

(a) For a site located in a rural or micropolitan statistical area county, the number of MRI adjusted procedures shall be multiplied by a factor of 1.4.

(b) For a mobile MRI unit that serves hospitals and other host sites located in rural, micropolitan statistical area, and metropolitan statistical area counties, the number of MRI adjusted procedures for a site located in a rural or micropolitan statistical area county, shall be multiplied by a factor of 1.4 and for a site located in a metropolitan statistical area county, the number of MRI adjusted procedures shall be multiplied by a factor of 1.0.

(c) For a mobile MRI unit that serves only sites located in rural or micropolitan statistical area counties, the number of MRI adjusted procedures shall be multiplied by a factor of 2.0.

(d) For a mobile MRI unit that serves only sites located in a health service area with one or fewer fixed MRI units and one or fewer mobile MRI units, the number of MRI adjusted procedures shall be multiplied by a factor of 3.5.

(e) Subsection (2) shall not apply to an application proposing a subsequent fixed MRI unit (second, third, etc.) at the same site.

(3) The number of MRI adjusted procedures performed by an existing MRI service is the sum of the results of subsections (1) and (2).

Section 16. Documentation of actual utilization

Sec. 16. Documentation of the number of MRI procedures performed by an MRI unit shall be substantiated by the Department utilizing data submitted by the applicant in a format and media specified by the Department and as verified for the 12-month period reported on the most recently published "MRI Service Utilization List" as of the date an application is deemed submitted by the Department. The number of MRI procedures actually performed shall be documented by procedure records and not by application of the methodology required in Section 17. The Department may elect to verify the data through on-site review of appropriate records.

Section 17. Methodology for computing the number of available MRI adjusted procedures

Sec. 17. (1) The number of available MRI adjusted procedures required pursuant to Section 3 shall be computed in accordance with the methodology set forth in this section. In applying the methodology, the following steps shall be taken in sequence, and data for the 12-month period reported on the most recently published "Available MRI Adjusted Procedures List," as of the date an application is deemed submitted by the Department, shall be used:

(a) Identify the number of actual MRI adjusted procedures performed by each existing MRI service as determined pursuant to Section 15.

(i) For purposes of computing actual MRI adjusted procedures, MRI adjusted procedures performed on MRI units used exclusively for research and approved pursuant to Section 7 and dedicated pediatric MRI approved pursuant to Section 8 shall be excluded.

(ii) For purposes of computing actual MRI adjusted procedures, the MRI adjusted procedures, from the host site routes utilized to meet the requirements of Section 3(2)(c), shall be excluded beginning at the time the application is submitted and for three years from the date the fixed MRI unit becomes operational.

(iii) For purposes of computing actual MRI adjusted procedures, the MRI adjusted procedures utilized to meet the requirements of Section 5(1) shall be reduced by 8,000 and shall be excluded beginning at the time the application is submitted and for three years from the date the fixed MRI unit becomes operational.

(b) Identify the number of available MRI adjusted procedures, if any, for each existing MRI service as determined pursuant to Section 2(1)(c).

(c) Determine the number of available MRI adjusted procedures that each referring doctor may commit from each service to an application in accordance with the following:

(i) Divide the number of available MRI adjusted procedures identified in subsection (b) for each service by the number of actual MRI adjusted procedures identified in subsection (a) for that existing MRI service.

(ii) For each doctor referring to that existing service, multiply the number of actual MRI adjusted procedures that the referring doctor made to the existing MRI service by the applicable proportion obtained by the calculation in subdivision (c)(i).

(A) For each doctor, subtract any available adjusted procedures previously committed. The total for each doctor cannot be less than zero.

(B) The total number of available adjusted procedures for that service shall be the sum of the results of (A) above.

(iii) For each MRI service, the available MRI adjusted procedures resulting from the calculation in (c)(ii) above shall be sorted in descending order by the available MRI adjusted procedures for each doctor. Then any duplicate values shall be sorted in descending order by the doctors' license numbers (last 6 digits only).

(iv) Using the data produced in (c)(iii) above, sum the number of available adjusted procedures in descending order until the summation equals at least 75 percent of the total available adjusted procedures. This summation shall include the minimum number of doctors necessary to reach the 75 percent level.

(v) For the doctors representing 75 percent of the total available adjusted procedures in (c)(iv) above, sum the available adjusted procedures.

(vi) For the doctors used in subsection (c)(v) above, divide the total number of available adjusted procedures identified in (c)(ii)(B) above by the sum of those available adjusted procedures produced in (c)(v) above.

(vii) For only those doctors identified in (c)(v) above, multiply the result of (c)(vi) above by the available adjusted procedures calculated in (c)(ii)(A) above.

(viii) The result shall be the "Available MRI Adjusted Procedures List."

(2) After publication of the "Available MRI Adjusted Procedures List" resulting from (1) above, the data shall be updated to account for a) doctor commitments of available MRI adjusted procedures in

subsequent MRI CON applications and b) MRI adjusted procedures used in subsequent MRI CON applications received in which applicants apply for fixed MRI services pursuant to Section 3(2).

Section 18. Procedures and requirements for commitments of available MRI adjusted procedures

Sec. 18. (1) If one or more host sites on a mobile MRI service are located within the planning area of the proposed site, the applicant may access available MRI adjusted procedures from the entire mobile MRI service.

(2)(a) At the time the application is submitted to the Department, the applicant shall submit a signed data commitment on a form provided by the Department in response to the applicant's letter of intent for each doctor committing available MRI adjusted procedures to that application for a new MRI unit that requires doctor commitments.

(b) An applicant also shall submit, at the time the application is submitted to the Department, a computer file that lists, for each MRI service from which data are being committed to the same application, the name and license number of each doctor for whom a signed and dated data commitment form is submitted.

(i) The computer file shall be provided to the Department on mutually agreed upon media and in a format prescribed by the Department.

(ii) If the doctor commitments submitted on the Departmental forms do not agree with the data on the computer file, the applicant shall be allowed to correct only the computer file data which includes adding physician commitments that were submitted at the time of application.

(c) If the required documentation for the doctor commitments submitted under this subsection is not submitted with the application on the designated application date, the application will be deemed submitted on the first applicable designated application date after all required documentation is received by the Department.

(3) The Department shall consider a signed and dated data commitment on a form provided by the Department in response to the applicant's letter of intent that meets the requirements of each of the following, as applicable:

(a) A committing doctor certifies that 100% of his or her available MRI adjusted procedures for each specified MRI service, calculated pursuant to Section 17, is being committed and specifies the CON application number for the MRI unit to which the data commitment is made. A doctor shall not be required to commit available MRI adjusted procedures from all MRI services to which his or her patients are referred for MRI services but only from those MRI services specified by the doctor in the data commitment form provided by the Department and submitted by the applicant in support of its application.

(b) A committing doctor certifies ownership interest, either direct or indirect, in the applicant entity. Indirect ownership includes ownership in an entity that has ownership interest in the applicant entity. This requirement shall not apply if the applicant entity is a group practice of which the committing doctor is a member. Group practice means a group practice as defined pursuant to the provisions of 42 U.S.C. 1395nn (h)(4), commonly known as Stark II, and the Code of Federal Regulations, 42 CFR, Part 411, published in the Federal Register on August 14, 1995, or its replacement.

(c) A committing doctor certifies that he or she has not been provided, or received a promise of being provided, a financial incentive to commit any of his or her available MRI adjusted procedures to the application.

(4)(a) The Department shall not consider a data commitment from a doctor for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support approval of an application for a new MRI unit, pursuant to Section 3, for which a final decision to approve has been issued by the Director of the Department until either of the following occurs:

(i) The approved CON is withdrawn or expires.

(ii) The MRI service or unit to which the data were committed has been in operation for at least 36 continuous months.

(b) The Department shall not consider a data commitment from a doctor for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support an application for a new fixed or mobile MRI unit pursuant to Section 3, for which a final decision to disapprove was issued by the Director of the Department until either of the following occurs:

(i) A final decision to disapprove an application is issued by the Director and the applicant does not appeal that disapproval or

(ii) If an appeal was made, the appeal is withdrawn by the applicant.

(5) The Department shall not consider a data commitment from a committing doctor for available MRI adjusted procedures from the same MRI service if that doctor has submitted a signed data commitment, on a form provided by Department, for more than one (1) application for which a final decision has not been issued by the Department. If the Department determines that a doctor has submitted a signed data commitment for the same available MRI adjusted procedures from the same MRI service to more than one CON application pending a final decision for a new fixed or mobile MRI unit or additional mobile MRI unit pursuant to Section 3, the Department shall,

(a) if the applications were submitted on the same designated application date, notify all applicants, simultaneously and in writing, that one or more doctors have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the doctors' data from the same MRI service shall not be considered in the review of any of the pending applications submitted on the same designated application date until the doctor notifies the Department, in writing, of the one (1) application for which the data commitment shall be considered.

(b) if the applications were submitted on different designated application dates, consider the data commitment in the application submitted on the earliest designated application date and shall notify, simultaneously in writing, all applicants of applications submitted on designated application dates subsequent to the earliest date that one or more committing doctors have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the doctors' data shall not be considered in the review of the application(s) submitted on the subsequent designated application date(s).

(6) The Department shall not consider any data commitment submitted by an applicant after the date an application is deemed submitted unless an applicant is notified by the Department, pursuant to subsection (5), that one or more committing doctors submitted data commitments for available MRI adjusted procedures from the same MRI service. If an applicant is notified that one or more doctors' data commitments will not be considered by the Department, the Department shall consider data commitments submitted after the date an application is deemed submitted only to the extent necessary to replace the data commitments not being considered pursuant to subsection (5).

(a) The applicant shall have 30 days to submit replacement of doctor commitments as identified by the Department in this Section.

(7) The Department shall not consider a withdrawal of a signed data commitment on or after the date an application is deemed submitted by the Department.

(8) The Department shall consider a withdrawal of a signed data commitment if a committing doctor submits a written notice to the Department before the application is deemed submitted, that specifies the CON application number and the specific MRI services for which a data commitment is being withdrawn.

Section 19. Lists published by the Department

Sec. 19. (1) On or before May 1 and November 1 of each year, the Department shall publish the following lists:

(a) A list, known as the "MRI Service Utilization List," of all MRI services in Michigan that includes at least the following for each MRI service:

(i) The number of actual MRI adjusted procedures;

(ii) The number of available MRI adjusted procedures, if any; and

(iii) The number of MRI units, including whether each unit is a clinical, research, or dedicated pediatric.

(b) A list, known as the "Available MRI Adjusted Procedures List," that identifies each MRI service that has available MRI adjusted procedures and includes at least the following:

(i) The number of available MRI adjusted procedures;

(ii) The name, address, and license number of each referring doctor, identified in Section 17(1)(c)(v), whose patients received MRI services at that MRI service; and

(iii) The number of available MRI adjusted procedures performed on patients referred by each referring doctor, identified in Section 17(1)(c)(v), and if any are committed to an MRI service. This number shall be calculated in accordance with the requirements of Section 17(1). A referring doctor may have fractional portions of available MRI adjusted procedures.

(c) For the lists published pursuant to subsections (a) or (b), the May 1 list will report 12 months of data from the previous January 1 through December 31 reporting period, and the November 1 list will report 12 months of data from the previous July 1 through June 30 reporting period. Copies of both lists shall be available upon request.

(d) The Department shall not be required to publish a list that sorts MRI database information by referring doctor, only by MRI service.

(2) When an MRI service begins to operate at a site at which MRI services previously were not provided, the Department shall include in the MRI database, data beginning with the second full quarter of operation of the new MRI service. Data from the start-up date to the start of the first full quarter will not be collected to allow a new MRI service sufficient time to develop its data reporting capability. Data from the first full quarter of operation will be submitted as test data but will not be reported in the lists published pursuant to this section.

(3) In publishing the lists pursuant to subsections (a) and (b), if an MRI service has not reported data in compliance with the requirements of Section 14, the Department shall indicate on both lists that the MRI service is in violation of the requirements set forth in Section 14, and no data will be shown for that service on either list.

Section 20. Effect on prior CON Review Standards; Comparative reviews

Sec. 20. (1) These CON review standards supersede and replace the CON Review Standards for MRI Services approved by the CON Commission on ~~March~~ JUNE ~~16~~15, 2016 and effective ~~May~~ OCTOBER ~~27~~21, 2016.

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

Section 21. Health Service Areas

Sec. 21. Counties assigned to each of the health service areas 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 A

Rural Michigan counties are as follows:

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

Micropolitan statistical area Michigan counties are as follows:

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

Metropolitan statistical area Michigan counties are as follows:

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

Source:

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

STATE OF MICHIGAN

GRETCHEN WHITMER,
Governor

Michigan Certificate of Need Commission
SOUTH GRAND BUILDING, 5TH FLOOR
333 S. GRAND AVE
LANSING, MI 48933
Phone: (517) 335-6708

MEMORANDUM

Date: December 10, 2020

To: Joint Legislative Committee (JLC)

From: Certificate of Need (CON) Commission

RE: Recommendations Pertaining to the CON Program

MCL 333.22215(1)(f) requires the CON Commission, by January 1, 2005, and every 2 years after January 1, 2005, to "*make recommendations to the joint committee regarding statutory changes to improve or eliminate the certificate of need program*." In addition to the responsibility of submitting the 2-year report to the JLC, MCL 333.22215(1)(e) of the CON law requires the Commission to "*Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission*." This report is intended to fulfill these requirements.

To start, we would like to remind the JLC that the CON Commission is composed of 11 volunteers and oversees 15 covered services. The CON Commissioners receive no compensation for their services, other than reimbursement for travel expenses. The CON Commission meets five times per year and all meetings are held in Lansing. Every CON Commission meeting is open to the public and subject to the Open Meetings Act. Each CON Commission meeting starts with a declaration of conflicts of interests. The Michigan Department of Health and Human Services ("Department") supports the CON Commission and administers the CON program.

The CON Commission respectfully submits the following bi-annual report:

Based on our continuous review of the program, the CON Commission believes and recommends that the program should be fully supported as it is serving a valuable need. In our bi-partisan judgment, we strongly believe the current CON process meets the statutory requirements for the program.

Our review of the program is based on reports provided to the Commission by the Department which is done at the close of every fiscal year. The FY2019 CON Program Annual Activity Report can be found here https://www.michigan.gov/documents/mdhhs/FY_2019_CON_Annual_Report_Final_699883_7.pdf. The FY2020 CON Program Annual Activity Report should be available in January 2021 and will be available here: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5106-126234--,00.html.

In addition to these annual reports, the Department provides quarterly program section performance reports to the Commission. These reports demonstrate the effectiveness of the CON program in processing letters of intent, applications, emergency applications, and amendments, as well as issuing decisions within the specified time frames set forth in the Administrative Rules.

We would like to provide the JLC a summary of our activities and accomplishments since the January 2019 report. In the last two years, the Commission has updated 8 of the 15 Review Standards for covered services, including:

- Hospital Beds
- Cardiac Catheterization Services
- Open Heart Surgery Services
- Megavoltage Radiation Therapy (MRT)
- Psychiatric Beds and Services
- Immune Effector Cell Therapy (IECT) Services
- Nursing Home and Hospital Long-Term-Care Unit (NH-HLTCU) Beds
- Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services

In some instances, technical changes were made to modernize standards and/or remove unnecessary regulation. In other instances, major changes were made to benefit the cost, quality and/or access of healthcare for Michigan citizens. Standards were developed for a new service to be covered under CON.

A summary of the changes that have been put into effect or are being proposed to the CON Review Standards during FY2019 and FY2020 is included in Attachment A in an overview chart and in greater detail in Attachment B.

All changes to CON standards, both technical and policy, have been made with the multiple opportunities for public input and with the recommendations of subject matter experts. The statutory process for modifying CON standards includes holding a public hearing before the CON Commission takes final action on any standard. The Commission actively seeks input from the public during the CON Commission meetings and always includes opportunities for public comment/hearings prior to any Commission action.

The CON Commission is currently in process seeking recommendations for modifications to four CON review standards. At the time of this report, there is a Standard Advisory Committee (SAC) reviewing Cardiac Catheterization Services, a SAC is reviewing Hospital Beds, a workgroup will be seated to review MRI Services, and a workgroup will be seated to review PET Scanner Services.

The following review standards will be reviewed in 2021: Bone Marrow Transplantation (BMT) Services, Heart/Lung and Liver Transplantation Services, Magnetic Resonance Imaging (MRI) Services, and Psychiatric Beds and Services.

Per our statutory obligation, the CON Commission submits that there are no statutory changes needed to improve the Certificate of Need program at this time.

The CON Commission appreciates the continuing support of the Governor and the Legislature for the CON program.

Respectfully yours,

James B. Falahee, Jr, JD, Chairperson

Tom Mittelbrun III, Vice-Chairperson

c: CON Commission
Robert Gordon, Director, MDHHS
Elizabeth Hertel, Chief Deputy Director for Administration, MDHHS
Sarah Esty, Senior Deputy Director of Policy and Planning, MDHHS
Emily Schwarzkopf, Director of Legislative, Appropriations, and Constituent Affairs, MDHHS
Becky Berels, Assistant Attorney General, Corporate Oversight Division
Beth Nagel, Planning Office Director, MDHHS
Tulika Bhattacharya, Manager, CON Evaluation Section, MDHHS
Brenda Rogers, Special Assistant to the CON Commission, MDHH

SUMMARY OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT A

Fiscal Year	Standard	Commission Plan for Review	Review Process	Summary of Major Changes Made/Proposed
2019	Hospital Beds	Formed a Standard Advisory Committee (SAC)	• SAC held July - December 2017 • CON Commission took Proposed Action at March 27, 2018 meeting • Public Hearing Held April 26, 2018 • CON Commission took Final Action at June 14, 2018 meeting • Standards became effective November 28, 2018	• Added inpatient rehabilitation facility beds initiation & replacement requirements • Removed unnecessary regulatory requirements regarding relocating beds • Modernized comparative review requirements • Added renewal of lease requirements
2019	Cardiac Catheterization	Formed a SAC	• SAC held July - December 2017 • CON Commission took Proposed Action at March 27, 2018 meeting • Public Hearing Held April 26, 2018 • CON Commission took Proposed Action at June 14, 2018 meeting • Public Hearing Held July 19, 2018 • CON Commission took Final Action at September 20, 2018 meeting • Standards became effective December 26, 2018	• Modified and updated definitions • Pacemakers and implantable cardioconverter defibrillators can only be performed in licensed hospitals with diagnostic CC CON approval • Added requirements for replacement of a cardiac catheterization service simultaneously with an open heart surgery service • Updated project delivery requirements • Updated procedure equivalents
2019	Open Heart Surgery (OHS) Services	Language dependent upon Cardiac Catheterization SAC and language drafted by the Department	• CON Commission took Proposed Action at March 27, 2018 meeting • Public Hearing Held April 26, 2018 • CON Commission took Proposed Action at June 14, 2018 meeting • Public Hearing Held July 19, 2018 • CON Commission took Final Action at September 20, 2018 meeting • Standards became effective December 26, 2018	• Added requirements for replacement of an open heart surgery service
2019	Megavoltage Radiation Therapy (MRT) Services/Units	Formed a SAC	• SAC held June - December 2018 • CON Commission took Proposed Action at March 21, 2019 meeting • Public Hearing Held April 25, 2019 • CON Commission took Final Action at June 13, 2019 meeting • Standards became effective September 12, 2019	• Revised procedure weights and added additional factors and definitions • Reduced the maintenance volume

SUMMARY OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT A

Fiscal Year	Standard	Commission Plan for Review	Review Process	Summary of Major Changes Made/Proposed
2019 & 2020	Psychiatric Beds and Services	Form a Workgroup	• Workgroup held August 2018 - March 2019 • CON Commission took Proposed Action at December 26, 2018 meeting • Public Hearing Held February 6, 2019 • CON Commission took Final Action at March 21, 2019 meeting • Standards became effective May 24, 2019 • CON Commission took Proposed Action at June 13, 2019 meeting • Public Hearing Held July 25, 2019 • CON Commission took Final Action at September 19, 2019 meeting • Standards became effective November 12, 2019	• Added relocation requirements for child/adolescent psychiatric services • Developed a new bed need methodology for child/adolescent and adult beds • Added minimum occupancy requirements • Updated comparative review requirements • Added high acuity psychiatric units • Increased the percentage for determining the number of special pool beds • Revised the standard for med-psych units
2020	Immune Effector Cell Therapy (IECT) Services	Formed a SAC	• SAC held February - April 2019 • CON Commission took Proposed Action at June 13, 2019 meeting • Public Hearing Held July 25, 2019 • CON Commission took Final Action at September 19, 2019 meeting • Legislature took negative action – standards did not go into effect	
2020	Urinary Extracorporeal Shock Wave Lithotripsy Services/Units	Department to draft language based on public testimony	• CON Commission took Proposed Action at the June 13, 2019 meeting • Public Hearing held July 25, 2019 • CON Commission took Final Action at September 19, 2019 meeting • Standards became effective November 12, 2019	• Reduced the volume requirements
2020	Nursing Home and Hospital Long-Term-Care Unit Beds (NH-HLTCU)	Formed a Standard SAC	• SAC held December, 2019 – January, 2020 • CON Commission took Proposed Action at the January 30, 2020 meeting • Public Hearing held February 11, 2020 • CON Commission took Final Action at June 18, 2020 meeting • Standards became effective September 3, 2020	• Added language that requires a planning area to have an occupancy rate of 85% or more to be able to begin operation of a new NH-HLTCU or to increase the number of beds at an existing licensed NH-HLTCU.

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Fiscal Year	Standard	Commission Plan for Review	Review Process	Summary of Major Changes Made/Proposed
2020/ 2021	Computed Tomography (CT) Scanner Services	Formed a Workgroup		• This Workgroup is charged to determine if 24-hour freestanding emergency departments should be exempt from meeting the maintenance volume for its first CT scanner; review the definition and requirements for dedicated pediatric CT scanners; and review the maintenance volume requirements.
2020/ 2021	Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services	Formed a Workgroup		• This Workgroup is charged to determine if high flow nasal cannula treatment and neonatal abstinence syndrome should be included as accepted services for special care nurseries; determine if telemedicine can be used as an acceptable replacement for on-site services; review the high occupancy provisions and occupancy requirements; review a possible minimum NICU size exception for rural or micropolitan counties; and review the definition of NICU services.
2020/ 2021	NH-HLTCU	Formed a Standard SAC		• This SAC is charged to review the bed need methodology; review whether adequate access exists for Medicaid patients; review specialty population beds; review language for minimum occupancy requirements; review changes for replacement.
2020/ 2021	Cardiac Catheterization Services	Formed a SAC		• This SAC is charged to review all minimum volume requirements; review increased exceptions for more rural programs; review allowing patent foramen ovale (PFO) closures in facilities without open heart surgery (OHS); review if diagnostic cardiac catheterization services, elective PCI procedures, and pacemakers and implantable cardioverter defibrillator (ICD) implants should be allowed to be performed in ambulatory surgical centers (ASCs); review the ability of elective PCI programs and hospitals that provide primary PCI without on-site OHS to perform left-sided cardiac ablation procedures.
2020/ 2021	Hospital Beds	Formed a SAC		• This SAC is charged to review limited access areas; review observation status; add definition for "verifiable data;" review replacement zone definition; and review how the emergency CONs were handled during the pandemic.

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Fiscal Year	Standard	Commission Plan for Review	Review Process	Summary of Major Changes Made/Proposed
2020/ 2021	Positron Emission Tomography (PET) Scanner Services	Form a Workgroup		• The Workgroup is charged to review the oversight requirements to initiate mobile and fixed services; review minimum volume requirement to convert to a fixed service; and 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.
2020/ 2021	Magnetic Resonance Imaging (MRI) Services	Form a Workgroup		• The Workgroup is charged to Review minimum volume requirements for fixed and mobile MRI.

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During FY2019, the CON Commission revised the review standards for Hospital Beds, Cardiac Catheterization Services, Open Heart Surgery Services, Megavoltage Radiation Therapy (MRT), and Psychiatric Beds and Services.

The following list of changes shows new language inserted into the standards in all upper case.

Hospital Beds: The revisions to the CON Review Standards for Hospital Beds include the following and became effective on November 28, 2018.

- Updated the Department name throughout the document.
- Section 2(1) - Added and modified definitions as follows:
  - (v) "INPATIENT REHABILITATION FACILITY BED" OR "IRF BED" MEANS A LICENSED HOSPITAL BED WITHIN AN IRF HOSPITAL OR UNIT THAT HAS BEEN APPROVED TO PARTICIPATE IN THE TITLE XVIII (MEDICARE) PROGRAM AS A PROSPECTIVE PAYMENT SYSTEM (PPS) EXEMPT INPATIENT REHABILITATION HOSPITAL IN ACCORDANCE WITH 42 CFR PART 412 SUBPART P.
  - (mm) "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.
  - (oo) "REPLACE IRF BEDS" MEANS A CHANGE IN THE LOCATION OF ALL IRF BEDS FROM AN EXISTING SITE TO A NEW SITE WITHIN THE REPLACEMENT ZONE FOR IRF BEDS.
  - (pp) "Replacement zone" means a proposed licensed site that is (i) in the same hospital group as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles (5 MILES FOR IRF BEDS) of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles (10 MILES FOR IRF BEDS) of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.
- Section 6(4)(a) - Added language to allow for beds received under high occupancy to be replaced to a new IRF hospital site under Section 7(6).
  - The beds are being added at the existing licensed hospital site OR ARE BEING REPLACED TO A NEW IRF HOSPITAL SITE BEING CREATED UNDER SECTION 7(7) AS PART OF THE SAME CON APPLICATION.
- Section 6(4)(f) - Removed language that required applicants adding new hospital beds under high occupancy to pursue a good faith effort to relocate acute care beds from other licensed acute care hospitals within the HSA as it's not deemed necessary.
- Section 7 – Added language to replace IRF beds to a new site as follows:
  - (2) The applicant shall specify whether the proposed project is to replace the licensed hospital to a new site, TO REPLACE ALL LICENSED IRF BEDS TO A NEW SITE, to replace a portion of the licensed beds at the existing licensed site, or the one-time replacement of less than 50% of the licensed beds to a new site within 250 yards of the building on the licensed site containing more than 50% of the licensed beds, which may include a new site across a highway(s) or street(s) as defined in MCL 257.20 and excludes a new site across a limited access highway as defined in MCL 257.26.
  - (6) IF THE APPLICATION INVOLVES THE DEVELOPMENT OF A NEW

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LICENSED IRF HOSPITAL SITE, AN APPLICANT PROPOSING TO REPLACE IRF BEDS WITHIN THE REPLACEMENT ZONE SHALL DEMONSTRATE THAT IT MEETS ALL OF THE REQUIREMENTS OF THIS SUBSECTION:

- (a) THE NEW LICENSE CREATED BY THE PROPOSED PROJECT SHALL ONLY BE UTILIZED FOR INPATIENT REHABILITATION BEDS.
- (b) THE APPLICANT HOSPITAL HAS DEMONSTRATED, AT THE TIME OF THE CON FILING, IT IS OPERATING UNDER HIGH OCCUPANCY AS GOVERNED BY SECTION 6(4) OF THESE STANDARDS.
- (c) THE APPLICANT HAS DEMONSTRATED, AT THE TIME OF CON FILING, THAT THE BEDS TO BE REPLACED ARE EITHER IRF BEDS THAT MEET THE TITLE XVIII REQUIREMENTS OF THE SOCIAL SECURITY ACT FOR EXEMPTION FROM PPS AS AN IRF HOSPITAL, OR HIGH OCCUPANCY BEDS BEING REQUESTED UNDER SECTION 6(4) AS PART OF THE SAME CON APPLICATION.
- (d) THE NEW IRF HOSPITAL WILL HAVE AT LEAST 40 IRF BEDS IF LOCATED IN A COUNTY WITH A POPULATION OF 200,000 OR MORE; OR AT LEAST 25 IRF BEDS IF LOCATED IN A COUNTY WITH A POPULATION OF LESS THAN 200,000.
- (e) AS PART OF THE PHASING OF THE REPLACEMENT OF IRF BEDS TO THE NEW SITE, THE APPLICANT MAY RETAIN, FOR 36-MONTHS FROM THE TIME OF ACTIVATION OF THE NEW SITE, UP TO EIGHT IRF BEDS AT THE EXISTING HOSPITAL SITE. ANY IRF BEDS AT THE EXISTING SITE THAT HAVE NOT BEEN TRANSITIONED TO THE NEW SITE WITHIN THE 36-MONTH TIME PERIOD SHALL NOT BE UTILIZED FOR INPATIENT REHABILITATION AND SHALL REVERT BACK TO ACUTE MEDICAL-SURGICAL HOSPITAL BEDS.
- (f) THE PROPOSED PROJECT TO BEGIN OPERATION OF A NEW SITE, UNDER THIS SUBSECTION, SHALL CONSTITUTE A CHANGE IN BED CAPACITY UNDER SECTION 1(2) OF THESE STANDARDS.
- (g) THE EXISTING HOSPITAL SITE SHALL DELICENSE THE SAME NUMBER OF IRF BEDS PROPOSED BY THE APPLICANT FOR LICENSURE IN THE NEW IRF HOSPITAL.
- (h) APPLICANTS PROPOSING A NEW IRF HOSPITAL UNDER THIS SUBSECTION SHALL NOT BE SUBJECT TO COMPARATIVE REVIEW.
- (i) THE NEW IRF HOSPITAL SHALL BE ASSIGNED TO THE SAME HOSPITAL GROUP AS THE HOSPITAL WHERE THE IRF BEDS ORIGINATED.
- (j) IF THE IRF HOSPITAL APPROVED UNDER THIS SUBSECTION CEASES OPERATION AS AN IRF HOSPITAL, THE BEDS LICENSED AS PART OF THE NEW IRF HOSPITAL MUST BE DISPOSED OF BY ONE OF THE FOLLOWING MEANS:
- (i) RELOCATE THE REPLACED IRF BEDS BACK TO THE SITE OF ORIGIN;
- (ii) RELOCATE ALL IRF BEDS APPROVED UNDER HIGH OCCUPANCY TO THE SITE OF ORIGIN IN SUBSECTION (i) IF THEY ARE TO BE UTILIZED AS AN IRF BED; OR
- (iii) DELICENSE ANY IRF BEDS APPROVED UNDER HIGH OCCUPANCY IF THEY ARE NOT TO BE UTILIZED AS AN IRF BED.

- Section 12 – Updated comparative review criteria.
- Old Section 13 – Removed and combined with Section 12.
- New Section 13 – Added language for the renewal of a lease similar to other CON Review Standards.

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- New Section 14(4) – Added new language for the applicant to certify that the requirements for hospitals found in the Minimum Design Standards for Health Care Facilities of Michigan will be met when the architectural blueprints are submitted for review and approval by Licensing and Regulatory Affairs (LARA). This is similar to other CON Review Standards.
- Removal of Appendix D Limited Access Areas as it's located on the State of Michigan CON web site. All references have been updated to reflect the State of Michigan CON web site. Appendix E is now Appendix D ICD-9-CM TO ICD-10-CM Code Translation.
- Other technical edits.

Cardiac Catheterization Services: The revisions to the CON Review Standards for Cardiac Catheterization Services include the following and became effective on December 26, 2018:

- Updated the Department name throughout the document.
- Added "hospital" after "applicant" throughout the document, as applicable, for clarity.
- Added "/congenital" after "pediatric" throughout the document, as applicable, for clarity.
- Section 2(1) - Added and modified definitions as follows:
    - (a) "ADULT CARDIAC CATHETERIZATION SERVICE" MEANS PROVIDING CARDIAC CATHETERIZATION SERVICES ON AN ORGANIZED, REGULAR BASIS TO PATIENTS AGE 18 AND ABOVE, AND FOR ELECTROPHYSIOLOGY PROCEDURES TO PATIENTS AGE 15 AND OLDER.
    - (b) "Cardiac catheterization laboratory" or "laboratory" means an individual radiological room equipped with a variety of x-ray machines and devices such as electronic image intensifiers, high speed film changers and digital subtraction units to assist in performing diagnostic or therapeutic cardiac catheterizations or electrophysiology studies.
    - (c) "Cardiac catheterization procedure" means any cardiac procedure, including diagnostic, therapeutic, and electrophysiology studies, performed on a patient during a single session in a laboratory. Cardiac catheterization is a medical diagnostic or therapeutic procedure during which a catheter is inserted into a vein or artery in a patient; subsequently the free end of the catheter is manipulated by a physician to travel along the course of the blood vessel into the chambers or vessels of the heart. X rays and an electronic image intensifier are used as aides in placing the catheter tip in the desired position. When the catheter is in place, the physician is able to perform various diagnostic studies and/or therapeutic procedures in the heart. This term does not include "float catheters" that are performed at the bedside or in settings outside the laboratory or the implantation of cardiac permanent pacemakers and implantable cardioverter defibrillators (ICD) devices that are performed in an interventional radiology laboratory or operating room IN A LICENSED HOSPITAL AND HAS DIAGNOSTIC CARDIAC CATHETERIZATION CON APPROVAL.
    - (d) "Cardiac catheterization service" means the provision of one or more of the following types of procedures: adult diagnostic cardiac catheterizations; adult therapeutic cardiac catheterizations; and pediatric/CONGENITAL cardiac catheterizations.
    - (e) "CARDIAC CATHETERIZATION SESSION" MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT MAY UNDERGO ONE OR MORE DIAGNOSTIC OR THERAPEUTIC CARDIAC OR PERIPHERAL PROCEDURES IN A CARDIAC CATHETERIZATION LABORATORY. THE TERM SESSION APPLIES TO BOTH ADULT AND PEDIATRIC/CONGENITAL CATHETERIZATIONS.
    - (h) "COMPLEX THERAPEUTIC SESSION" MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT UNDERGOES ONE OR MORE OF THE

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FOLLOWING PROCEDURES:

- (i) PCI FOR CHRONIC TOTAL OCCLUSION
- (ii) TAVR, MITRAL/PULMONARY/TRICUSPID VALVE REPAIR OR REPLACEMENT, PARAVALVULAR LEAK CLOSURE
- (iii) ABLATION FOR ATRIAL FIBRILLATION (AF) OR VENTRICULAR TACHYCARDIA (VT), PACEMAKER OR ICD LEAD EXTRACTION
- (j) “DIAGNOSTIC CARDIAC CATHETERIZATION PROCEDURE” INCLUDES RIGHT HEART CATHETERIZATION, LEFT HEART CATHETERIZATION, CORONARY ANGIOGRAPHY, CORONARY ARTERY BYPASS GRAFT ANGIOGRAPHY, INTRACORONARY ADMINISTRATION OF DRUGS, FRACTIONAL FLOW RESERVE (FFR), INTRA-CORONARY IMAGING SUCH AS INTRAVASCULAR ULTRASOUND (IVUS), OPTICAL COHERENCE TOMOGRAPHY (OCT), OR NEAR-INFRARED SPECTROSCOPY (NIRS) WHEN PERFORMED WITHOUT A THERAPEUTIC PROCEDURE, CARDIAC BIOPSY, INTRA-CARDIAC ECHOCARDIOGRAPHY, AND ELECTROPHYSIOLOGY STUDY.
- (k) "Diagnostic cardiac catheterization service" means providing diagnostic cardiac catheterization procedures on an organized, regular basis in a laboratory to diagnose anatomical and/or physiological problems in the heart. Procedures include the intra coronary administration of drugs; left heart catheterization; right heart catheterization; coronary angiography; diagnostic electrophysiology studies; and cardiac biopsies (echo-guided or fluoroscopic). A hospital that provides diagnostic cardiac catheterization services may also perform implantations of cardiac permanent pacemakers and ICD devices IMPLANTATION (THERAPEUTIC PROCEDURES).
- (l) “DIAGNOSTIC CARDIAC CATHETERIZATION SESSION” MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT MAY UNDERGO ONE OR MORE DIAGNOSTIC CARDIAC CATHETERIZATION PROCEDURES.
- (m) “DIAGNOSTIC PERIPHERAL PROCEDURE” INCLUDES ANGIOGRAPHY OR HEMODYNAMIC MEASUREMENTS IN THE ARTERIAL OR VENOUS CIRCULATION (EXCLUDING THE HEART).
- (n) “DIAGNOSTIC PERIPHERAL SESSION” MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT MAY UNDERGO ONE OR MORE DIAGNOSTIC PERIPHERAL ROCEDURES IN A CARDIAC CATHETERIZATION LABORATORY.
- (p) “Elective PCI services without on-site open heart surgery (OHS)” means performing PCI, percutaneous transluminal coronary angioplasty (PTCA), and coronary stent implantation on an organized, regular basis in a hospital having a diagnostic cardiac catheterization service and a primary PCI service but not having OHS on-site and adhering to patient selection as outlined in the SCAI/ACC/AHA Expert Consensus Document: 2014 Update on PCI Without On-Site Surgical Backup and published in Circulation 2014, 129:2610-2626 and its update or further guideline changes. A HOSPITAL THAT PROVIDES ELECTIVE PCI WITHOUT ON-SITE OHS MAY ALSO PERFORM RIGHT-SIDED CARDIAC ABLATION PROCEDURES INCLUDING RIGHT ATRIAL FLUTTER, AV REENTRY, AV NODE REENTRY, RIGHT ATRIAL TACHYCARDIA, AND AV NODE ABLATION.
- (t) "Pediatric/CONGENITAL cardiac catheterization service" means providing cardiac AND ELECTROPHYSIOLOGY catheterization services on an organized, regular basis to infants and children ages 18 and below, except for electrophysiology studies that are offered and provided to infants and children ages 14 and below, and PATIENTS BORN with congenital heart disease.

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- (u) “PERCUTANEOUS CORONARY INTERVENTION” (PCI) MEANS A THERAPEUTIC CARDIAC CATHETERIZATION PROCEDURE TO RESOLVE ANATOMIC AND/OR PHYSIOLOGIC PROBLEMS IN THE CORONARY ARTERIES OF THE HEART. A PCI SESSION MAY INCLUDE SEVERAL PROCEDURES INCLUDING BALLOON ANGIOPLASTY, ATHERECTOMY, LASER, STENT IMPLANTATION AND THROMBECTOMY. THE TERM DOES NOT INCLUDE THE INTRACORONARY ADMINISTRATION OF DRUGS, FFR OR IVUS WHERE THESE ARE THE ONLY PROCEDURES PERFORMED.
- (v) “PERIPHERAL CATHETERIZATION SESSION” MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT MAY UNDERGO ONE OR MORE DIAGNOSTIC OR THERAPEUTIC PROCEDURES IN THE ARTERIAL OR VENOUS CIRCULATION (EXCLUDING THE HEART) WHEN PERFORMED IN A CARDIAC CATHETERIZATION LABORATORY.
- (w) “Primary percutaneous coronary intervention (PCI)” means a PCI performed on an EMERGENT BASIS ON A acute myocardial infarction (AMI) patient with confirmed ST-SEGMENT elevation, or new left bundle branch block on an emergent basis, ECG EVIDENCE OF TRUE POSTERIOR MI, OR CARDIOGENIC SHOCK.
- (x) “Primary PCI service without on-site OHS” means performing primary PCI on an emergent basis in a hospital having a diagnostic cardiac catheterization service. A HOSPITAL THAT PROVIDES PRIMARY PCI WITHOUT ON-SITE OHS MAY ALSO PERFORM RIGHT-SIDED CARDIAC ABLATION PROCEDURES INCLUDING RIGHT ATRIAL FLUTTER, AV REENTRY, AV NODE REENTRY, RIGHT ATRIAL TACHYCARDIA, AND AV NODE ABLATION.
- (y) "Procedure equivalent" means a unit of measure that reflects the relative average length of time one patient spends in one session in a CARDIAC CATHETERIZATION laboratory based on the type of procedures being performed. IF A DIAGNOSTIC AND THERAPEUTIC PROCEDURE IS PERFORMED IN THE SAME SESSION, THE HIGHER PROCEDURE EQUIVALENT WEIGHTING WILL BE USED TO EVALUATE UTILIZATION.
- (z) “STRUCTURAL HEART PROCEDURE” MEANS A THERAPEUTIC CARDIAC CATHETERIZATION PROCEDURE TO RESOLVE ANATOMIC AND/OR PHYSIOLOGIC PROBLEMS OF THE HEART VALVES OR CHAMBERS. PROCEDURES INCLUDE: BALLOON VALVULOPLASTY, BALLOON ATRIAL SEPTOSTOMY, TRANSCATHETER VALVE REPAIR, TRANSCATHETER VALVE IMPLANTATION, PARAVALULAR LEAK CLOSURE, LEFT ATRIAL APPENDAGE OCCLUSION, PFO/ASD/VSD/PDA CLOSURE, ALCOHOL ABLATION OF CARDIAC TISSUE, EMBOLIZATION OF CORONARY FISTULAE AND ABNORMAL VASCULAR CONNECTIONS IN THE HEART.
- (aa) "Therapeutic cardiac catheterization service" means providing therapeutic cardiac catheterizations on an organized, regular basis in a laboratory to treat and resolve anatomical and/or physiological problems in the heart.
- (bb) “THERAPEUTIC CARDIAC CATHETERIZATION SESSION” MAY INCLUDE: PCI (ELECTIVE, EMERGENT), PERICARDIOCENTESIS, PERMANENT PACEMAKER IMPLANTATION, ICD IMPLANTATION (ENDOVASCULAR OR SUBCUTANEOUS), PACEMAKER OR ICD GENERATOR CHANGE, PACEMAKER OR ICD LEAD REVISION, CARDIAC ABLATION, AND/OR STRUCTURAL HEART PROCEDURE. THIS ALSO INCLUDES IMPLANTATION OF A CIRCULATORY SUPPORT DEVICE SUCH AS IABP, IMPELLA, ECMO OR TANDEMHEART WHERE THIS IS THE ONLY THERAPEUTIC PROCEDURE. WHEN PCI IS PERFORMED IN MORE THAN

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ONE CORONARY ARTERY DURING THE SAME SETTING, THIS IS COUNTED AS ONE SESSION.

- (cc) "THERAPEUTIC PERIPHERAL PROCEDURE" MEANS A THERAPEUTIC CATHETERIZATION PROCEDURE TO RESOLVE ANATOMIC AND/OR PHYSIOLOGIC PROBLEMS IN THE ARTERIAL OR VENOUS CIRCULATION (EXCLUDING THE HEART). PROCEDURES MAY INCLUDE PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA), ATHERECTOMY, DRUG ELUTING BALLOON, LASER, STENT IMPLANTATION, IVC FILTER IMPLANTATION OR RETRIEVAL, CATHETER-DIRECTED ULTRASOUND/THROMBOLYSIS, AND THROMBECTOMY.
- (dd) "THERAPEUTIC PERIPHERAL SESSION" MEANS A CONTINUOUS TIME PERIOD DURING WHICH A PATIENT MAY UNDERGO ONE OR MORE THERAPEUTIC PERIPHERAL PROCEDURES IN A CARDIAC CATHETERIZATION LABORATORY.
- (ee) "THERAPEUTIC PEDIATRIC/CONGENITAL CARDIAC CATHETERIZATION SESSION" MAY INCLUDE: STRUCTURAL HEART PROCEDURE (AS LISTED ABOVE), PULMONARY ARTERY ANGIOPLASTY/STENT IMPLANTATION, PULMONARY VALVE PERFORATION, ANGIOPLASTY/STENT IMPLANTATION FOR AORTIC COARCTATION, CARDIAC ABLATION, PACEMAKER/ICD IMPLANTATION, AND PCI.

- Section 5(3) - Added language to replace a cardiac catheterization service to a new site simultaneously with an open heart surgery service. (This language will only apply to those cardiac catheterization services that are being replaced simultaneously with an open heart surgery service. An open heart surgery service must have a diagnostic and therapeutic cardiac catheterization service.)
- Section 10(2) – Project delivery requirements have been updated.
  - (d) EACH PHYSICIAN CREDENTIALED BY A HOSPITAL TO PERFORM DIAGNOSTIC LEFT-HEART CATHETERIZATION AND/OR CORONARY ANGIOGRAPHY MUST PERFORM, AS THE PRIMARY OPERATOR, AN AVERAGE OF AT LEAST 50 DIAGNOSTIC CARDIAC CATHETERIZATION SESSIONS INVOLVING A LEFT-HEART CATHETERIZATION OR CORONARY ANGIOGRAPHY PER YEAR AVERAGED OVER THE MOST RECENT 2 YEARS STARTING IN THE SECOND 12 MONTHS AFTER BEING CREDENTIALED. THIS TWO YEAR AVERAGE WILL BE EVALUATED ON A ROLLING BASIS ANNUALLY THEREAFTER. THE ANNUAL CASE LOAD FOR A PHYSICIAN MEANS A CARDIAC CATHETERIZATION SESSION IN WHICH THAT PHYSICIAN PERFORMED, AS THE PRIMARY OPERATOR, AT LEAST ONE LEFT-HEART CATHETERIZATION OR CORONARY ANGIOGRAPHY, IN ANY COMBINATION OF HOSPITALS. PHYSICIANS FALLING BELOW THIS VOLUME REQUIREMENT MUST BE PLACED ON A FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN, WHICH MUST INCLUDE AN INDEPENDENT REVIEW OF ALL DIAGNOSTIC CARDIAC CATHETERIZATION SESSIONS BY AN APPROPRIATE DESIGNEE, TO ENSURE QUALITY OUTCOMES ARE MAINTAINED. IN THE EVENT A PHYSICIAN DOES NOT PERFORM CARDIAC CATHETERIZATION PROCEDURES ON A TEMPORARY OR PERMANENT BASIS FOR A PERIOD OF 3 MONTHS OR MORE, THE PHYSICIAN DIAGNOSTIC PROCEDURE VOLUME WILL BE ANNUALIZED ON THE 24 MONTH PERIOD PRECEDING THE ABSENCE. WHEN A DIAGNOSTIC CARDIAC CATHETERIZATION SESSION AND AD HOC THERAPEUTIC CARDIAC CATHETERIZATION SESSION ARE PERFORMED TOGETHER, DIAGNOSTIC AND THERAPEUTIC SESSIONS ARE COUNTED SEPARATELY FOR THE PURPOSES OF THIS SUBSECTION. IF A PHYSICIAN IS DOING RIGHT HEART ONLY PROCEDURES, THEN THEY ARE NOT REQUIRED TO MEET THIS VOLUME

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REQUIREMENT. PHYSICIANS WHO ARE CREDENTIALED BY A HOSPITAL TO PERFORM ADULT THERAPEUTIC CARDIAC CATHETERIZATION PROCEDURES ARE NOT REQUIRED TO MEET THE VOLUME REQUIREMENT FOR DIAGNOSTIC CARDIAC CATHETERIZATION SESSIONS.

- (e) Each physician credentialed by a hospital to perform adult therapeutic cardiac catheterization procedures shall perform, as the primary operator, aN AVERAGE of AT LEAST 50 adult therapeutic cardiac catheterization SESSIONS per year AVERAGED OVER THE MOST RECENT TWO YEARS STARTING in the second 12 months after being credentialed. THIS TWO-YEAR AVERAGE WILL BE EVALUATED ON A ROLLING BASIS annually thereafter. The annual case load for a physician means adult therapeutic cardiac catheterization SESSIONS performed by that physician in any combination of hospitals. PHYSICIANS FALLING BELOW THIS VOLUME REQUIREMENT MUST BE PLACED ON A FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN, WHICH MUST INCLUDE AN INDEPENDENT REVIEW OF ALL THERAPEUTIC CARDIAC CATHETERIZATION SESSIONS BY AN APPROPRIATE DESIGNEE, TO ENSURE QUALITY OUTCOMES ARE MAINTAINED. IN THE EVENT A PHYSICIAN DOES NOT PERFORM CARDIAC CATHETERIZATION PROCEDURES ON A TEMPORARY OR PERMANENT BASIS FOR A PERIOD OF 3 MONTHS OR MORE, THE PHYSICIAN THERAPEUTIC PROCEDURE VOLUME WILL BE ANNUALIZED ON THE 24-MONTH PERIOD PRECEDING THE ABSENCE. WHEN A DIAGNOSTIC CARDIAC CATHETERIZATION SESSION AND AD HOC THERAPEUTIC CARDIAC CATHETERIZATION SESSION ARE PERFORMED TOGETHER, DIAGNOSTIC AND THERAPEUTIC SESSIONS ARE COUNTED SEPARATELY FOR THE PURPOSES OF THIS SUBSECTION (THIS INCLUDES INTERVENTIONAL CARDIOLOGISTS AND ELECTROPHYSIOLOGISTS). FOR INTERVENTIONAL CARDIOLOGISTS, THE THERAPEUTIC SESSION VOLUME EXCLUDES PACEMAKER AND ICD IMPLANTATION. FOR ELECTROPHYSIOLOGISTS, PACEMAKER AND ICD IMPLANTS PERFORMED IN AN OPERATING ROOM MAY ALSO BE COUNTED TOWARD THE PHYSICIAN THERAPEUTIC VOLUME.
- (f) Each physician credentialed by a hospital to perform pediatric/CONGENITAL cardiac catheterizations shall perform, as the primary operator, aN AVERAGE of AT LEAST 50 pediatric/CONGENITAL cardiac catheterization SESSIONS per year AVERAGED OVER THE MOST RECENT 2 YEARS STARTING in the second 12 months after being credentialed. THIS TWO-YEAR AVERAGE WILL BE EVALUATED ON A ROLLING BASIS and annually thereafter. The annual case load for a physician means pediatric/CONGENITAL cardiac catheterization SESSIONS performed by that physician in any combination of hospitals. PHYSICIANS FALLING BELOW THIS VOLUME REQUIREMENT MUST BE PLACED ON A FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN, WHICH MUST INCLUDE AN INDEPENDENT REVIEW OF ALL CARDIAC CATHETERIZATION SESSIONS BY AN APPROPRIATE DESIGNEE, TO ENSURE QUALITY OUTCOMES ARE MAINTAINED. IN THE EVENT A PHYSICIAN DOES NOT PERFORM CARDIAC CATHETERIZATION PROCEDURES ON A TEMPORARY OR PERMANENT BASIS FOR A PERIOD OF 3 MONTHS OR MORE, THE PHYSICIAN THERAPEUTIC PROCEDURE VOLUME WILL BE ANNUALIZED ON THE 24 MONTH PERIOD PRECEDING THE ABSENCE.
- (g) An adult diagnostic cardiac catheterization service shall have a minimum of two appropriately trained physicians on its active hospital staff MEETING THE FOLLOWING CRITERIA:
- (i) are trained consistent with the recommendations of the American College of Cardiology;
- (ii) are credentialed by the hospital to perform adult diagnostic cardiac

DETAILS OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT B

catheterizations; and
- (iii) have performed a minimum of 100 adult diagnostic cardiac catheterization SESSIONS in the preceding 12 months. THE ANNUAL CASE LOAD FOR A PHYSICIAN MEANS A CARDIAC CATHETERIZATION SESSION IN WHICH THAT PHYSICIAN PERFORMED, AS THE PRIMARY OPERATOR, AT LEAST ONE DIAGNOSTIC CARDIAC CATHETERIZATION, IN ANY COMBINATION OF HOSPITALS.
- (h) An adult therapeutic cardiac catheterization service shall have a minimum of two appropriately trained physicians on its active hospital staff MEETING THE FOLLOWING CRITERIA:
- (i) are trained consistent with the recommendations of the American College of Cardiology;
- (ii) are credentialed by the hospital to perform adult therapeutic cardiac catheterizations; and
- (iii) have performed a minimum of 50 adult therapeutic cardiac catheterization procedures SESSIONS in the preceding 12 months. THE ANNUAL CASE LOAD FOR A PHYSICIAN MEANS A CARDIAC CATHETERIZATION SESSION IN WHICH THAT PHYSICIAN PERFORMED, AS THE PRIMARY OPERATOR, AT LEAST ONE THERAPEUTIC CARDIAC CATHETERIZATION, IN ANY COMBINATION OF HOSPITALS.
- (i) A pediatric/CONGENITAL cardiac catheterization service shall have AT LEAST ONE physician on its active hospital staff MEETING THE FOLLOWING CRITERIA:

- Section 10(5) – Language has been updated to exclude patients with cardiogenic shock.
- Section 10(5)(f) – Modified language to make it applicable to only those catheterization labs providing primary PCI services without on-site OHS service and for catheterization labs providing elective PCI services without on-site OHS service.
- Section 10(5)(i) – Modified language for clarity.
- Section 11 – Updated procedure type, procedure equivalent, and added a description for the procedure type.
- Removed Appendix B as it's no longer needed given the revised definition for "pediatric/congenital cardiac catheterization service."
- Other technical edits.

Open HeartSurgery (OHS) Services: The revisions to the CON Review Standards for OHS Services include the following and became effective December 26, 2018:

- Updated the Department name throughout the document.
- Added language under new Section 4 – Requirements to replace an existing OHS Service. This language will not increase the number of OHS services in the state, instead it will allow current OHS providers to replace their service to a new location and discontinue service at the previous location. This language is consistent with language in other CON review standards.
  - (i) A pediatric/CONGENITAL cardiac catheterization service shall have AT LEAST ONE physician on its active hospital staff MEETING THE FOLLOWING CRITERIA:
  - SEC. 4. REPLACE AN EXISTING ADULT OR PEDIATRIC OHS SERVICE MEANS RELOCATING AN EXISTING ADULT OR PEDIATRIC OHS SERVICE TO A NEW GEOGRAPHIC LOCATION OF AN EXISTING LICENSED HOSPITAL. THE TERM DOES NOT INCLUDE THE REPLACEMENT OF AN EXISTING OHS SERVICE AT THE SAME SITE. AN APPLICANT REQUESTING TO REPLACE AN EXISTING OHS SERVICE SHALL DEMONSTRATE EACH OF THE FOLLOWING, AS APPLICABLE TO THE PROPOSED PROJECT.

DETAILS OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT B

- (1) AN APPLICANT PROPOSING TO REPLACE AN EXISTING OHS SERVICE SHALL DEMONSTRATE THE FOLLOWING:
- (a) THE EXISTING OHS SERVICE 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 A HOSPITAL THAT IS OWNED BY, IS UNDER COMMON CONTROL OF, OR HAS A COMMON PARENT AS THE APPLICANT HOSPITAL.
- (c) THE APPLICANT IS REPLACING THE OHS SERVICE SIMULTANEOUSLY WITH REPLACEMENT OF ITS CARDIAC CATHETERIZATION SERVICE(S) AT THE SAME LOCATION.
- (d) THE PROPOSED NEW SITE IS WITHIN THE SAME PLANNING AREA OF THE SITE AT WHICH THE EXISTING OHS SERVICE IS LOCATED AND WITHIN 5 MILES OF THE EXISTING OHS SERVICE LOCATION IF LOCATED IN A METROPOLITAN STATISTICAL AREA COUNTY, OR WITHIN 10 MILES OF THE EXISTING OHS SERVICE LOCATION IF LOCATED IN A RURAL OR MICROPOLITAN STATISTICAL AREA COUNTY.
- (e) THE EXISTING OHS SERVICE TO BE RELOCATED PERFORMED AT LEAST THE APPLICABLE MINIMUM NUMBER OF OPEN HEART SURGICAL CASES SET FORTH IN SECTION 8 AS OF THE DATE AN APPLICATION IS DEEMED SUBMITTED BY THE DEPARTMENT UNLESS THE OHS SERVICE BEING REPLACED IS PART OF THE REPLACEMENT OF THE ENTIRE HOSPITAL TO A NEW GEOGRAPHIC SITE.
- (f) THE CARDIAC CATHETERIZATION AND OHS SERVICES SHALL CEASE OPERATION AT THE ORIGINAL SITE PRIOR TO BEGINNING OPERATION AT THE NEW SITE.

- Other technical edits.

Megavoltage Radiation Therapy (MRT) Services/Units: The revisions to the CON Review Standards for MRT Services/Units include the following and became effective on September 12, 2019:

- Updated the Department name throughout the document.
- Changed “dedicated stereotactic radiosurgery unit” to “dedicated stereotactic radiosurgery/stereotactic body radiation therapy (SRS/SBRT)” throughout the document.
- Section 10: Revised the weights and added additional factors and definitions for MR-guided real time tracking radiation w/o adaptive, MR-guided real time tracking radiation with adaptive, patient specific QA for IMRT, and patient specific QA for SRS/SBRT.
- Section 11(4): Reduced the maintenance volume for non-special MRT units from 8,000 ETVs annually to 4,000 ETVs annually.

Psychiatric Beds and Services: The revisions to the CON Review Standards for Psychiatric Beds and Services include the following and became effective on May 24, 2019:

- Revised the requirements of Section 8 “Requirements for approval of an applicant proposing to relocate existing licensed inpatient psychiatric beds” to include an exception where a child/adolescent service can be created, as follows in subsection (6):
  - (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 9(11).

DETAILS OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT B

- Added new language in Section 9 "Requirements for approval to increase beds" with a new subsection 11 as follows:
    - (11) AN APPLICANT PROPOSING TO INITIATE A NEW CHILD/ADOLESCENT PSYCHIATRIC SERVICE, AS THE RECEIVING LICENSED INPATIENT PSYCHIATRIC HOSPITAL OR UNIT UNDER SECTION 8(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/ADOLSCENT 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.

During FY2020, the CON Commission revised the review standards for Immune Effector Cell Therapy (IECT) Services, Nursing Home and Hospital Long-Term-Care Unit (NH-HLTCU) Beds, Psychiatric Beds and Services, Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services.

Immune Effector Cell Therapy (IECT) Services: The Commission took final action on CON Review Standards for IECT Services at its September 19, 2019 Commission meeting and were submitted to the JLC and Governor for the required 45-day review period. The legislature took negative action and the standards did not go into effect.

DETAILS OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT B

Psychiatric Beds and Services: The revisions to the CON Review Standards for Psychiatric Beds and Services include the following and became effective on November 12, 2019:

- Section 2: The definition of "base year" was removed as it's no longer used in the standard.
- Section 3: A new bed need methodology. There is now one methodology for both adult and child/adolescent beds. The methodology incorporates a time series approach to predict future patient days and normative approach to distribute those patient days to the Health Service Areas (HSA).
- Old Section 5 was removed as it's no longer needed.
- Added minimum occupancy requirements in last 12-months prior to application submission, as in hospital beds standards, for the existing psych hospital/unit before a new entity can acquire the facility, replace the facility, or relocate beds. Appropriate sections updated accordingly.
- New Section 8 was revised for clarity.
- New Section 11 includes revised comparative review requirements to include more emphasis on access for indigent and high acuity populations. Formulas for comparative review have been simplified.
- Appendices A and B were removed as they're no longer needed.
- The Addendum was revised as follows:
    - Added high acuity psychiatric units.
    - Increased the percentage of the state bed need formula to increase the number of special pool beds.
    - Revised the standard for med-psych units to allow freestanding psychiatric units with collaborative agreements with medical service hospitals.
- Other technical edits.

Urinary Extracorporeal Shock Wave Lithotripsy: The revisions to the CON Review Standards for UESWL Services include the following and became effective on November 12, 2019:

- Revised the requirements for fixed lithotripsy units from 1,000 to 500 procedures per unit annually for the minimum required volume in the project delivery requirements, as well as replacement and acquisition, to be consistent with the newly approved language for initiation.
- Section 7(1)(c): For clarity, added the following language "A SEPARATE CON APPLICATION HAS BEEN SUBMITTED BY THE CSC AND EACH PROPOSED HOST SITE."
- Section 7(3): For clarity, added the following language "THE NORMAL ROUTE SCHEDULE, THE PROCEDURES FOR HANDLING EMERGENCY SITUATIONS, AND COPIES OF ALL POTENTIAL CONTRACTS RELATED TO THE MOBILE UESWL SERVICE AND ITS UNIT(S) SHALL BE INCLUDED IN THE CON APPLICATION SUBMITTED BY THE CENTRAL SERVICE COORDINATOR OR THE APPLICANT HOST SITE."
- Other technical edits.

NH-HLTCU: The revisions to the CON Review Standards for NH-HLTCU include the following and became effective on September 3, 2020:

- Section 6(1)(e): Added language that requires a planning area to have an occupancy rate of 85% or more to be able to begin operation of a new NH-HLTCU or to increase the number of beds at an existing licensed NH-HLTCU. This will help to ensure that beds go to the areas where needed as the standard advisory committee (SAC) continues to work on an improved bed need methodology.

DETAILS OF CON REVIEW STANDARDS REVISIONS FOR FISCAL YEARS 2019 AND 2020 - ATTACHMENT B

- Section 6(2)(f): Added language that requires a planning area to have an occupancy rate of 85% or more to be able to begin operation of a new NH-HLTCU or to increase the number of beds at an existing licensed NH-HLTCU pursuant to the new design model. This will help to ensure that beds go to the areas where needed as the SAC continues to work on an improved bed need methodology.
- Section 14(1): Updated dates.

The following review standards were reviewed with an anticipated completion in FY2021:

Computed Tomography (CT) Scanner Services: Proposed action was taken by the Commission at its June 18, 2020 meeting. The standards were submitted to the joint legislative committee (JLC) and a Public Hearing was held. The Commission took final action at its September 17, 2020 Commission meeting and were submitted to the JLC and Governor for the required 45-day review period. Standards will become effective in FY2021.

Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services: Proposed action was taken by the Commission at its September 17, 2020 meeting. The standards were submitted to the JLC and a Public Hearing was held. The Commission took final action at its December 10, 2020 Commission meeting and were submitted to the JLC and Governor for the required 45-day review period. Standards will become effective in FY2021.[RB(1]

NH-HLTCU Services: Proposed action was taken by the Commission at its September 17, 2020 meeting. The standards were submitted to the JLC and a Public Hearing was held. The Commission took final action at its December 10, 2020 Commission meeting and were submitted to the JLC and Governor for the required 45-day review period. Standards will become effective in FY2021.[RB(2]

Cardiac Catheterization Services: The standards are being reviewed by a SAC.

Hospital Beds: The standards are being reviewed by a SAC.

Positron Emission Tomography (PET) Scanner Services: The standards are scheduled to be reviewed by a workgroup.

Magnetic Resonance Imaging (MRI) Services: The standards are scheduled to be reviewed by a workgroup.

Acute Care Hospital Bed Need and Limited Access Areas
2020 Update

Paul L. Delamater
November 23, 2020
Department of Geography, University of North Carolina at Chapel Hill
E-mail: pld@email.unc.edu

Summary

This report provides updated results for the Acute Care Hospital Bed Need and Limited Access Areas (LAAs).

Determination of Needed Hospital Bed Supply

In the most recent update of the hospital bed need, the base year was determined from the most recently available MIDB data, which is 2018. The planning year is 2023, five years from the base year. The predicted statewide bed need for 2023 is 20,271 beds, which is roughly 1,500 beds more than the previous estimate (bed need for 2021, calculated in 2019). The underlying cause for the overall increase in Michigan's future bed need can be traced to the statewide increase in acute care hospitalization (since falling to a low point in 2013 and 2014). Figure 1 shows statewide patient days since 2000; although patient days decreased slightly from 2017 to 2018, both were higher than those reported in 2015 and 2016.

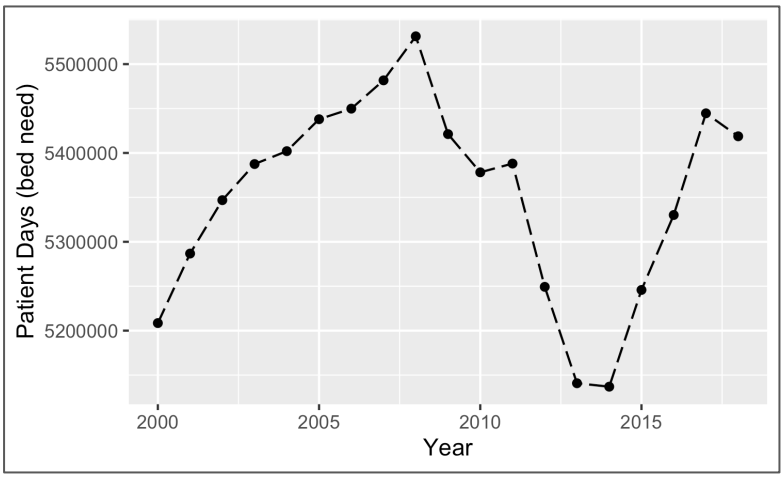


Figure 1. Statewide Patient Days, 2000 to 2018

The detailed bed need output is found in Table 1. The statewide trend in patient days over the prior two years was captured in the county-level patient day prediction phase of the Bed Need Methodology. Of the 84 county units (83 counties plus one "out of state" unit), a significant positive linear trend was detected in 45, resulting in predictions that were greater than current utilization. A significant negative linear trend in patient days was detected in only 5 county units and no discernible trend was detected in 34 county units.

Overall, of the 31 Hospital Groups, 30 showed an excess of beds in this update, while one had the same need and inventory and no Hospital Groups showed a need for additional beds. Statewide, there is a 4,608 bed overage in the state per this most recent update.

HG	Bed Need 2023	Beds 2020	Dept Inv 2020	Difference
1	4,925	5,632	5,621	696
2	2,917	3,620	3,560	643
4	1,644	1,969	1,969	325
5	1,558	1,729	1,735	177
6	278	375	375	97
7	944	1,086	1,058	114
8	389	389	389	0
9	56	113	113	57
10	804	1,034	1,034	230
11	322	427	427	105
12	272	409	409	137
14	1,635	2,045	2,046	411
15	364	543	543	179
17	67	170	170	103
18	75	123	123	48
19	1,339	1,441	1,441	102
20	994	1,355	1,352	358
21	35	188	188	153
22	391	542	542	151
23	64	185	185	121
24	462	550	550	88
25	172	242	242	70
26	79	124	124	45
27	55	98	98	43
28	256	253	279	23
29	15	40	40	25
30	37	86	86	49
31	79	119	119	40
32	24	36	36	12
33	19	25	25	6
STATE	*20,271*	*24,948*	*24,879*	*4,608*

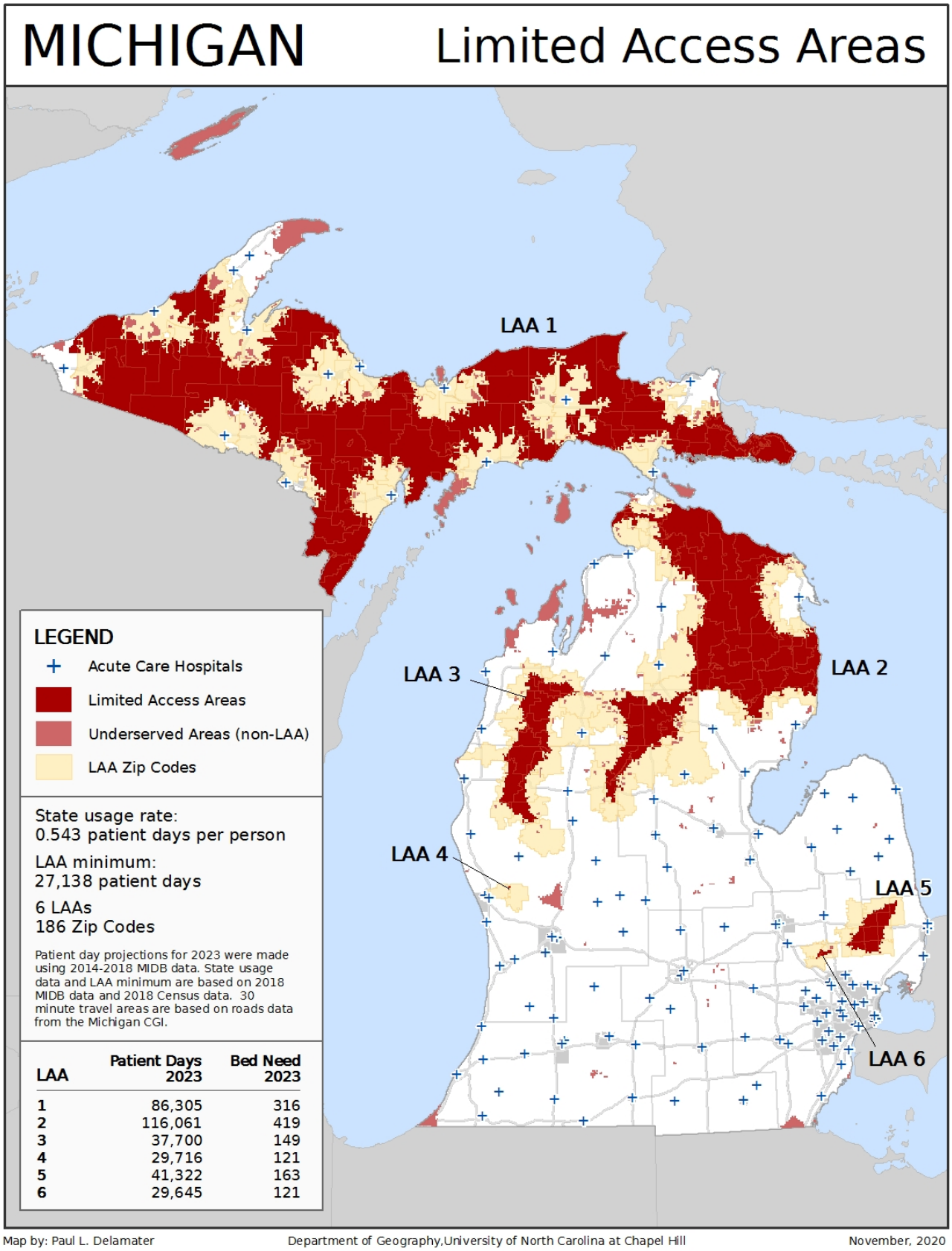
Table 1. 2020 Bed Need Results. Base year: 2014, Planning year: 2018, Dept Inv 2020 data from September 2020, Difference column calculated as difference between Dept Inv 2020 and Bed Need 2023: positive values in the Difference column reflect an excess of hospital beds.

Limited Access Areas

Figure 2 provides the map of the Limited Access Areas. The bed need for each LAA can be found in Table 2, while the Zip Codes associated with each LAA are listed in Table 3. Based on 2018 hospitalization data, the minimum number of predicted patient days for an undeserved area to be considered an LAA was 27,138. This value was calculated using the overall state rate of 0.543 patient days per person and a minimum population of 50,000, per the Review Standards. Six LAAs were identified in the 2020 update, which are the same as those from the 2018 update.

LAA	Predicted Patient Days 2023	Bed Need 2023
1	86,305	316
2	116,061	419
3	37,700	149
4	29,716	121
5	41,322	163
6	29,645	121

Table 2. Bed Need for Limited Access Areas



LAA	Patient Days 2023	Bed Need 2023
1	86,305	316
2	116,061	419
3	37,700	149
4	29,716	121
5	41,322	163
6	29,645	121

Figure 2. Limited Access Areas

LAA 1			LAA 2		LAA 3	LAA 4	LAA 5	LAA 6
49710	49829	49885	48619	49651	49304	49442	48002	48348
49715	49831	49886	48621	49665	49309	49451	48003	48371
49719	49833	49887	48624	49667	49349		48005	48462
49725	49834	49891	48625	49679	49402		48006	
49726	49835	49892	48629	49705	49411		48014	
49728	49836	49893	48630	49706	49459		48022	
49736	49837	49895	48632	49709	49601		48041	
49745	49838	49896	48635	49716	49619		48062	
49752	49839	49905	48636	49721	49620		48065	
49760	49840	49910	48647	49738	49625		48097	
49762	49841	49912	48651	49740	49637		48367	
49768	49847	49916	48653	49743	49638		48428	
49774	49848	49919	48654	49744	49643		48444	
49780	49849	49920	48656	49746	49644			
49781	49853	49925	48705	49747	49645			
49801	49854	49935	48721	49749	49649			
49806	49855	49946	48728	49751	49656			
49807	49858	49947	48737	49753	49663			
49812	49861	49948	48738	49755	49668			
49814	49862	49952	48739	49756	49683			
49815	49866	49953	48740	49759	49689			
49816	49868	49958	48742	49765				
49817	49873	49962	48743	49766				
49818	49874	49965	48745	49769				
49820	49878	49967	48750	49776				
49821	49879	49968	48761	49777				
49822	49880	49969	48762	49779				
49825	49881	49970	49305	49792				
49826	49883		49631	49799				
49827	49884		49632					

Table 3. Zip Codes in Limited Access Areas

December 2, 2020

Dear CON Commission,

This letter is to provide you with an update on the status of the Standard Advisory Committee (SAC) for cardiac catheterization services in the state of Michigan. To date, the SAC has conducted 4 meetings. A brief overview of each of these meetings is as follows:

- August 27, 2020: The SAC members were introduced, a basic overview of the CON program was provided, and the charge was reviewed. The remainder of the meeting was spent developing an agenda and timeline for discussing the specific items listed in the charge.
- September 24, 2020: Charge items 1 through 3 were discussed. Item 1 was discussed and the SAC voted to recommend no changes based on this item. Item 2 was reviewed and the SAC voted to support changes to the initiation and maintenance requirements for rural primary PCI programs. The spirit of these changes, the details of which will be outlined in the final report to the CON, will be to increase access to primary PCI for patients living in rural areas in Michigan. Item 3 was discussed and the SAC voted against allowing PFO closures to be performed at sites without on-site surgical backup.
- October 22, 2020: Charge items 6 – 8 were discussed. Three invited cardiac electrophysiologists from across the state provided their expert opinions on these items. The SAC voted against allowing items 6 and 8 to proceed. The SAC voted in favor of creating a subcommittee of electrophysiologists to discuss item 7. This subcommittee met once in November and has a second meeting scheduled in December. The SAC will await recommendations from this subcommittee prior to voting on item 7.
- November 19, 2020: Initial discussions were held on items 4 and 5. The SAC voted in favor of allowing diagnostic cardiac catheterizations and PCI procedures to be performed in ASCs contingent upon creating safeguards to ensure quality and safety for patients. Creating such safeguards will be the focus of future meetings.

In addition to the above meetings, the SAC convened a subcommittee of members to discuss issues related to the performance of catheterization and PCI procedures in ASCs. This subcommittee has convened three times thus far. A fourth meeting of this subcommittee is scheduled for next week.

In summary, the SAC is currently on track to provide a recommendation to the CON commission within the allotted 6 month time frame. Should you have any questions or concerns, please do not hesitate to contact me directly.

Sincerely,

Ryan D. Madder, MD, FACC

December 4, 2020

Dear CON Commission,

This letter provides an update on the status of the Hospital Bed Standard Advisory Committee (SAC). The SAC convened for their first meeting on November 12, 2020. At that meeting, the SAC members shared introductions along with an educational overview of CON. The remainder of the meeting reviewed the six charges. Subgroups were created for Charge two, observation stay inclusion and Charge four, replacement zone modification. To note, the SAC members shared positive feedback on the Emergency CON process and appreciation for the support of the CON staff.

At the second SAC meeting on December 3, 2020, Paul Delamater shared the history and modification considerations for Charge one, review of the Limited Access Area criteria. A third subgroup will start to support the Limited Access Area review. Charge two and Charge four subgroups provided an update on the subgroup review and next steps. The CON department shared a review of the emergency CONs during the pandemic. SAC members again shared their appreciation for the departments' responsiveness and support with continued COVID related emergency CON applications.

We are currently on scheduled to provide a recommendation to the CON commission within the allotted 6-month time frame. Should you have any questions or concerns, please do not hesitate to contact Jennifer Groseclose or Chad Grant directly.

Sincerely,

Jennifer Groseclose
Munson Healthcare

Chad Grant
McLaren Flint

CERTIFICATE OF NEED

4th 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	4th Quarter	Year-to-Date
Approved projects requiring 1-year follow up	44	229
Approved projects contacted on or before anniversary date	31	149
Approved projects completed on or before 1-year follow up	70%	
CON approvals expired	42	84
Total follow up correspondence sent	260	965
Total approved projects still ongoing	301	

Compliance: In accordance with Section 22247 and Rule 9419, the Department performs compliance checks on approved and operational Certificates of Need to determine if projects have been implemented, or if other applicable requirements have been met, in accordance with Part 222 of the Code.

- The Department is conducting the statewide compliance review for Surgical services, utilizing the 2018 CON Annual Survey data. The Department completed the process of evaluating annual survey data, review standard requirements, and responses to the compliance questionnaire. The Department has identified the CON approved facilities for compliance investigations and is in the process of finalizing compliance action plans with each of these identified facilities. The detailed findings of the statewide compliance review will be reported to the CON Commission in a separate report at a later date.

- The Department is conducting statewide compliance reviews for Cardiac Catheterization Services and Megavoltage Radiation Therapy Services/Units utilizing 2019 CON Annual Survey data. After evaluating the annual survey data, review standards' requirements, and responses to additional questionnaire, the Department has identified the CON approved facilities for compliance investigations. The Department is in the process of completing compliance conference calls with each of these identified facilities. The finding of the statewide compliance reviews will be reported to the CON Commission at a later date.

- MidMichigan Medical Center-Midland, CSC-MRI Mobile Network No. 65 – After a compliance follow-up review, the department became aware that MidMichigan did not meet the minimum volume requirement as the CSC for MRI Mobile Network No. 65. MidMichigan signed onto the October 21, 2016 CON Review Standards for MRI services and agreed to meet all project delivery requirements and terms of approval by June 30, 2022. The facility was required to pay a civil fine of $7,500.

- Ascension St. Mary's Hospital – After a compliance follow-up review, the department became aware that St. Mary's did not meet the minimum volume requirement while operating as a hospital with two (2) fixed MRI units. St. Mary's signed onto the October 21, 2016 CON Review Standards for MRI services and agreed to meet all project delivery requirements and terms of approval by December 31, 2022. The facility was required to pay a civil fine of $7,500.

- Level One Imaging Services, LLC – After a compliance follow-up review, the department became aware that Level One Imaging did not meet the minimum volume requirement operating as an MRI host site within a metropolitan statistical area county. Level One Imaging agreed to meet all project delivery requirements and terms of approval by December 31, 2022. The facility was required to pay a civil fine of $500.

- Focus Imaging LLC – After a compliance follow-up review, the department became aware that Focus Imaging did not meet the minimum volume requirement operating as an MRI host site within a metropolitan statistical area county. Focus Imaging agreed to meet all project delivery requirements and terms of approval by December 31, 2022. The facility was required to pay a civil fine of $500.

Source: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

CERTIFICATE OF NEED (CON)
4th 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	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Letters of Intent Received	81	N/A	420	N/A
Letters of Intent Processed within 15 days	81	100%	418	99%
Letters of Intent Processed Online	81	100%	420	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	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
Applications Received	48	N/A	340	N/A
Applications Processed within 15 Days	48	100%	340	100%
Applications Incomplete/More Information Needed	27	56%	133	39%
Applications Filed Online*	48	100%	288	85%
Application Fees Received Online*	14	29%	61	21%

** 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	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Nonsubstantive Applications	22	100%	119	100%
Substantive Applications	20	100%	81	100%
Comparative Applications	23	100%	36	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	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Emergency Applications Received	3	100%	105	100%
Decisions Issued within 10 workings Days	3	100%	105	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	4th Quarter		Year-to-Date	
	Issued on Time	Percent	Issued on Time	Percent
Amendments	6	100%	66	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	4th Quarter	Year-to-Date
Refunds Issued Pursuant to Section 22231	0	0

Other Measures

Activity	4th Quarter		Year-to-Date	
	No.	Percent	No.	Percent
FOIA Requests Received	61	N/A	246	N/A
FOIA Requests Processed on Time *	61	100%	246	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.

Special Report to the CON Commission
Emergency CONs (ECONs) during COVID-19
March through November 2020

The Department issued Emergency CONs pursuant to MCL 333.22235 during the COVID-19 pandemic in Michigan.

ECON Applications during COVID-19

- Between March 17 and November 24, 2020, the Department approved 115 ECON applications [1 was withdrawn]
- 86 applications for additional hospital beds; 4,997 total hospital beds approved which is 20% of Statewide licensed total [25,292 beds]
- 12 applications for additional nursing home beds; 326 total nursing home beds approved which is 1% of Statewide licensed total [46,319 beds]
- 5 applications for additional psych beds; 61 total adult psych beds approved which is 3% of Statewide licensed total [2,251 adult beds], and 22 flex beds
- 8 applications for additional swing beds at hospitals; 117 total swing beds approved which is 38% of Statewide licensed total [306 beds]
- 6 applications approved for other services [Lithotripsy and MRI]

ECONs Status

	No. of ECONs	Total Beds Approved	ECONs Completed	ECONs Expired	ECONs Pending
Hospital Beds	86	4997	72	6 Exp. w/o Lic. 4 Lic. Issued-Exp. later	8 Recent
NH Beds	12	326	11	2 [Lic. Issued, Exp. Later]	1 older
Psych Beds	5	Adult – 61 Flex - 22	2	2 Exp. w/o Lic.	1 recent
Swing Beds	8	117	6	None	2 recent

- For hospital beds: 4,644 additional beds are in active status which is 93% of approved ECON beds
- For NH beds: 170 additional beds are in active status which is 52% of approved ECON beds
- For psych beds: 47 additional beds are in active status which is 77% of approved ECON beds
- For swing beds at hospitals all 117 additional beds are in active status

Source: Certificate of Need Evaluation Section, Michigan Department of Health and Human Services.

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

DANA NESSEL
ATTORNEY GENERAL

M E M O R A N D U M

December 3, 2020

TO: James Falahee
CON Commission Chair

FROM: Rebecca Berels
Assistant Attorney General
Corporate Oversight Division

CC: Elizabeth Nagel
James Long

RE: Legal Activity Report for the December 10, 2020 Commission Meeting

We are currently representing DHHS in one pending case in the Michigan Office of Administrative Hearings and Rules ("MOAHR").

1) *Beaumont Hospital – Oxford, v DHHS* (MOAHR Docket No.: 19-010768)

   On September 30, 2019, DHHS issued a proposed decision to disapprove William Beaumont Hospital's CON Application to initiate a new hospital in Limited Access Area #6. On July 14, 2020, the Administrative Law Judge issued a Proposal for Decision in the Department's favor. We are still awaiting the Director's Final Order on the proposed decision.

The following fourteen cases, which were pending in MOAHR as of the last Commission meeting, have now been dismissed.

1) Fourteen Nursing Home Comparative Review Appeals: *Trilogy Healthcare of Portage LLC & Medilodge of Kalamazoo v DHHS* (MOAHR Docket Nos. 20-004321 and 20-004921 CON (consolidated)); *Regency at Grand Rapids LLC, Regency at Celebration LLC, Northern Kent Nursing Center & Kent Nursing Center v DHHS* (MOAHR Docket Nos. 20-004906, 20-004908, 20-004909, 20-004911 CON (consolidated)); *Livingston Nursing Center & Pinckney Nursing Center v DHHS* (MOAHR Docket Nos. 20-004950 and 20-004951 CON (consolidated)); *Fountain View of Monroe v DHHS* (MOAHR Docket No. 20-004952 CON (consolidated)); *Novi Nursing Center, Clarkston Nursing Center,*

Oxford Nursing Center, Regency on the Lake-Novi LLC, Bloomfield Orchard Villa v DHHS (MOAHR Docket Nos. 20-004913, 20-004914, 20-004916, 20-004917, 20-004919 CON (consolidated))

Fourteen CON Applicants within five Comparative Review Groups (Kalamazoo County, 95-0263; Kent County, 95-0261; Livingston County, 95-0264; Monroe County, 95-0265; Oakland County, 95-0262) appealed the denial of their CON applications to begin operation of new nursing homes. On September 3, 2020, a revised NH/HLTCU Review Standard took effect, necessitating a remand to DHHS for issuance of a new proposed decision under the revised Standard. All cases have been remanded and dismissed.

Outside of these administrative matters, we are also representing DHHS in two other Court actions related to Beaumont – Oxford's CON Application (see first entry above).

1) *William Beaumont Hospital v Certificate of Need Commission & DHHS*; Court of Claims Case No. 19-000183-MZ; Court of Appeals Case No. 352568

   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 for 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 DHHS and the Commission. Beaumont filed a Claim of Appeal with the Court of Appeals.

   In the Court of Appeals, Beaumont filed its brief, requesting oral argument, on July 6, 2020. We filed our response, declining to request oral argument, on August 10, 2020, and Beaumont filed a reply on August 31, 2020. The matter remains pending in the Court of Appeals for either scheduling of oral argument or issuance of a decision.

2) *William Beaumont Hospital v DHHS*; 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 our motion to dismiss.

In addition to these cases, we continue to work with DHHS staff to assist in developing standards and providing legal advice on various matters.

RAB/

DRAFT Certificate of Need (CON) Commission Work Plan

Attachment N

	2020						2021					
	July	August	September	October	November	December	January	February	March	April	May	June
Commission Meetings			Meeting			Meeting	Special Meeting		Meeting			Meeting
Bone Marrow Transplantation (BMT) Services				Public Comment Period			Discussion/ Report					
Cardiac Catheterization Services		CCSAC Mtg.	CCSAC Mtg.	CCSAC Mtg.	CCSAC Mtg.	CCSAC Mtg.	CCSAC Mtg.	CCSAC Mtg.	Report/Draft Language Presented/ Potential Proposed Action	Public Hearing		Report/Final Action
Heart/Lung and Liver (HLL) Transplantation Services				Public Comment Period			Discussion/ Report					
Hospital Beds		Sac Nomination & Selection Period			HBSAC Mtg.	HBSAC Mtg.	HBSAC Mtg.	HBSAC Mtg.	HBSAC Mtg.	HBSAC Mtg.	HBSAC Mtg.	Report/Draft Language Presented/ Potential Proposed Action
Magnetic Resonance Imaging (MRI) Services				Public Comment Period		Report/Draft Language Presented/ Potential Proposed Action	Public Hearing; Discussion/ Report		Report/Final Action			
Neonatal Intensive Care Services/Beds (NICU)	NICU Workgroup Mtg.	NICU Workgroup Mtg.	Report/Draft Language Presented/ Potential Proposed Action	Public Hearing		Report/Final Action						
Nursing Home and HLTCU Beds and Addendum (NH-HLTCU)			Report/Draft Language Presented/ Potential Proposed Action	Public Hearing		Report/Final Action						
Positron Emission Tomography (PET) Scanner Services									PET Workgroup Mtg.	PET Workgroup Mtg.	PET Workgroup Mtg.	PET Workgroup Mtg.

Psychiatric Beds and Services				Public Comment Period		Report/Draft Language Presented/ Potential Proposed Action	Public Hearing; Discussion/Report		Report/Final Action		Attachment N	
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						

The CON Commission may revise this work plan at each meeting. For information about the CON Commission work plan or how to be notified of CON Commission meetings, contact the Michigan Department of Health and Human Services (MDHHS) at, 517-335-6708 or www.michigan.gov/con**.**

SCHEDULE FOR UPDATING CERTIFICATE OF NEED (CON) STANDARDS EVERY THREE YEARS*

Standards	Effective Date	Next Scheduled Update**
Air Ambulance Services	June 2, 2014	2022
Bone Marrow Transplantation Services	September 29, 2014	2021
Cardiac Catheterization Services	December 26, 2018	2020
Computed Tomography (CT) Scanner Services	November 9, 2020	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	2022
Nursing Home and Hospital Long-Term Care Unit Beds and Addendum for Special Population Groups	September 3, 2020	2022
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.