Healthcare Planning and Certificate of Need

Long-Term and Behavioral Health Committee Minutes - DRAFT

April 8, 2016
10:00 – 12:00 p.m.
Brown Bldg. Room 104

MEMBERS PRESENT: Dr. T.J. Pulliam, Chair, Mr. Peter Brunnick, Mr. Stephen DeBiasi, Mr. Kurt Jakusz, Ms. Denise Michaud, Dr. Jaylan Parikh
MEMBERS ABSENT: James Burgin
HEALTHCARE PLANNING AND CERTIFICATE OF NEED STAFF PRESENT: Elizabeth Brown, Paige Bennett, Amy Craddock, Tom Dickson, Kelli Fisk, Shelley Carraway, Martha Frisone, Lisa Pittman, Fatimah Wilson, Celia Inman, Gloria Hale
DHSR STAFF PRESENT: Mark Payne
AG'S OFFICE: Derrick Hunter

Agenda Items	Discussion/Action	Motion/ Second	Recommendations/ Actions
Welcome & Announcements	Dr. Pulliam welcomed members, staff and guests to the first Long-Term and Behavioral Health (LTBH) Committee meeting of 2016. He stated the purpose of this meeting was to review the policies, methodologies and petitions requesting changes in basic policies and methodologies for the Proposed 2017 Plan (SMFP). Dr. Pulliam stated the meeting was open to the public, but deliberations and recommendations were limited to the members of the LTBH Committee and staff, in order to respect the process of the State Health Coordinating Council (SHCC). Dr. Pulliam asked the committee members and staff seated at the table to introduce themselves.		
Review of Executive Order No. 46: Reauthorizing the State Health Coordinating Council	Dr. Pulliam gave an overview of the procedures to observe before taking action at the meeting. Dr. Pulliam inquired if anyone had conflicts or if there items or matters on the agenda, they wished to declare that they would derive a benefit from or intended to recuse themselves from voting on the matter. Dr. Pulliam asked members to review the agenda and declare any conflicts.		

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<tr><th>Agenda Items</th><th>Discussion/Action</th><th>Motion/
Second</th><th>Recommendations/
Actions</th></tr>
<tr><td>(Continued)</td><td>There were no recusals.

Dr. Pulliam stated that if a conflict of interest, not on the agenda, came up during the meeting that the member with the conflict would make a declaration of the conflict.</td><td></td><td></td></tr>
<tr><td>Approval of the September 4, 2015 Committee Meeting Minutes</td><td>A motion made and second to accept the September 4, 2015 LTBH Committee meeting minutes.</td><td>Mr. Jakusz
Mr. Brunnick</td><td>Approved</td></tr>
<tr><td>Nursing Care Facilities - Chapter 10</td><td>Ms. Bennett provided the following report on policies for Chapter 10.
o There are eight policies in Chapter 4 related to Nursing Homes.
• NH1: Provision of Hospital-Based Nursing Care
o This policy allows a hospital to convert up to 10 beds from its license acute care bed capacity for use as hospital-based nursing care beds without regard to need determinations in Chapter 10 of the SMFP.
o Conversion is contingent on two criteria:
▪ The hospital is in a rural area
▪ It is a small (<150 bed) facility
• NH2: Plan Exemption for Continuing Care Retirement Communities
o This policy allows qualified continuing care retirement communities to include, from the outset, or add or convert bed capacity for nursing care without regard to the nursing care bed need shown in Chapter 10.
o The purpose of this exemption is to meet the needs of residents who have signed continuing care contracts.
• NH-3: Determination of Need for Additional Nursing Care Beds in Single Provider Counties
o This policy allows a nursing care facility with fewer than 80 nursing care beds to apply for a CON for additional beds in order to bring the minimum number of beds in the county to no more than 80 without regard to need determinations in Chapter 10 when that facility is the on nursing care facility in the county.</td><td></td><td></td></tr>
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	• **NH-4: Relocation of Certain Nursing Facility Beds** ○ This policy sets criteria for relocating existing licensed nursing facility beds to another county when the facility is supported by and directly affiliated with a particular religion. • **NH-5: Transfer of Nursing Facility Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities** ○ This policy sets criteria for the transfer of state psychiatric hospital nursing beds to community nursing facilities, provided that services are available in the communities receiving the beds. • **NH-6: Relocation of Nursing Facility Beds** ○ This policy sets conditions for relocating nursing facility beds to contiguous counties served by the facility in order to avoid or create a deficit in the county losing beds and avoid or create a surplus in the county gaining beds. • **NH-7: Transfer of Continuing Care Retirement Community Beds** ○ This policy sets criteria for the transfer of CCRC beds without regard to nursing bed need determinations in Chapter 10. • **NH-8: Innovation in Nursing Facility Design** ○ This policy mandates that new nursing facilities applying for a CON, along with those facilities requesting expansion or renovation, pursue approaches, practices and designs that address quality of care and quality of life needs of the residents.		

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	<u>**Nursing Care Facilities Methodology- Chapter 10**</u>
	• The proximate determinant of nursing home utilization is the age of the population.
	• Steps:
	  o Currently, each of North Carolina's 100 counties is considered a separate service area when determining NH utilization.
	  o Need is determined by calculating the statewide five-year average use rate per 1,000 population for each of four age groups based on data from annual license renewal applications.
	  o These use rates, or "beds per 1,000 population," are applied to the projected population going forward three years for each service area.
	  o The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds.
	  o Page 199 details how deficit size is used to determine the county's bed need.
	
	Committee Recommendation
	A motion made and second to recommend acceptance of nursing care facilities policies, assumptions and methodology and advancing years by one for inclusion in the Proposed 2017 SMFP.
	
	Next, Ms. Bennett provided an update on the Nursing Home Methodology Workgroup.
	
	The Long Term Behavioral Health Committee unanimously voted for all final changes to the nursing home methodology go through the entire planning cycle for the 2017 SMFP. The State Health Coordinating Council received a summary report and draft copies of the proposed changes from Chapter 4 and Chapter 10 at the last meeting on March 2, 2016.
	
	The following is an overview of the Workgroup's recommendations for the nursing home policies and methodology, Chapters 4 and 10, for the *2017 State Medical Facilities Plan (SMFP)*.
		Mr. Brunnick
		Ms. Michaud
			Approved

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<tr><td></td><td>The proposed changes include:
• One use rate (no age groups) calculated by county with annual change rate projection of 36 months.
• Smoothing of average change rate applied to each county with substitution of the state rate at ½ standard deviation (SD) above and below the mean.
• Vacancy factor applied to bed utilization summary (95%).
• For need determinations, use of the higher between the median occupancy rate among all facilities in a county or the county-wide occupancy.
• Alignment of all exclusions for beds and occupancy
• One hundred percent exclusion for Continuing Care Retirement Communities (NH-2) beds.
• Maximum bed need for each service area of 150 beds.
• Policies (Chapter 4)
    • Elimination of NH-1, NH-3, NH-4, and NH-7
    • Wording changes to NH-2, NH-6, and NH-8

Provided to the Committee in the documents posted are the draft proposed changes to both Chapter 4 and Chapter 10.

The agency received only one comment since posting the documents.

If the committee approves the methodology changes, tables using the new methodology will be presented at the next LTBH meeting.

Committee Recommendation
A motion made and second to approve changes to the methodology and policies from the Nursing Home Workgroup.</td><td>Mr. Jakusz
Mr. Brunnick</td><td>Approved</td></tr>
<tr><td>Adult Care Homes - Chapter 11</td><td>Ms. Bennett provided the review of the policies and need methodology for Chapter 11.
There are two policies in Chapter 4 related to Adult Care Homes.</td><td></td><td></td></tr>
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	• **LTC-1: Plan Exemption for Continuing Care Retirement Communities- Adult Care Home Beds**
	  o This policy sets criteria for adding or converting adult care beds in CCRCs without regard for need determinations in Chapter 11.
	  o The policy also provides an exclusion from the SMFP inventory for 50% of the adult care beds in CCRCs developed under this policy.
	• **LTC-2: Relocation of Adult Care Home Beds**
	  o This policy sets conditions for relocating adult care home beds to contiguous counties served by the facility in order to avoid or create a deficit in the county losing beds and avoid or create a surplus in the county gaining beds.
	
	<u>Adult Care Homes Methodology- Chapter 11</u>
	The proximate determinant of adult care home utilization is the age of the population.
	
	<u>Steps</u>:
	• Currently, each of North Carolina's 100 counties is considered a separate service area when determining ACH utilization.
	• Need is determined by calculating the statewide five-year average use rate per 1,000 population for each of five age groups based on data from annual license renewal applications.
	• These use rates, or "beds per 1,000 population," are applied to the projected population going forward three years for each service area.
	• The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds.
	
	Page 217 details how deficit size is used to determine the county's bed need.		

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	No petitions were received for Chapter 11. **Committee Recommendations** A motion made and second to recommend acceptance of adult care homes policies, assumptions and methodology and to advance years by one for inclusion in the Proposed 2017 SMFP.	Ms. Michaud Mr. Jakusz	Approved
Medicare Certified Home Health Services - Chapter 12	Ms. Brown provided the following report: There was one policy related to Chapter 12, located in Chapter 4 of the 2016 SMFP. **Policy HH-3: Need Determination for Medicare-Certified Home Health Agency in a County** *Establishes a need for a new home health office when there is no existing office located in a county with a population of 20,000 people or more; or if the county population is less than 20,000 people and there is no home health office located in a North Carolina county within 20 miles.* *[Except Granville County that has been served by Granville Vance District Health Department and recognized by DHSR as a single geographic entity for purposes of location of a home health agency office.]* **Standard Methodology [Steps 1-14]** A quick review of the standard methodology used to project need for new home health offices… • Through the use of four different age groups, the utilization patterns of young and old patients are assessed. The standard methodology looks at growth in the number of patients and at growth in the existing agencies' ability to serve future patients. Historically, this is done county by county and averaged at the Council of Government region's level annual rate of change. The threshold continues to be an issue because of changing circumstances in Washington regarding reimbursement patterns. Ms. Brown noted no petitions or comments were received for this chapter.		

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	Committee Recommendations A motion made and second to recommend acceptance of home health services policy, assumptions and methodology and to advance years by one for inclusion in the Proposed 2017 SMFP.	Mr. Brunnick Ms. Michaud	Approved
Hospice Services - Chapter 13	Next, Ms. Brown reviewed the methodologies in Chapter 13, Hospice Services. Ms. Brown noted no petitions or comments were received for this chapter. There are no applicable policies to hospice services. **Standard Methodology** **Hospice Home Care [Steps 1-14] (p. 323-324)** A brief summary of the standard methodology used to project need for new hospice home care offices… • The hospice home care standard methodology uses county mortality rates for the most recent five years as the basis for hospice patient need projection. A two-year trailing average growth rate in statewide number of deaths served is used over the previous three years. This projects changes in the capacity of existing agencies to serve deaths from each county by the target year. Median projected hospice deaths is done by applying the projected statewide median percent of deaths served by hospice to projected deaths in each county. An additional home care office is needed if the county's deficit is 90 or more and the number of licensed offices in the county per 100,000 is 3 or less. **Hospice Inpatient Beds [Steps 1-12] (p. 325-326)** To briefly summarize the standard methodology used to project need for new hospices inpatient beds… • The methodology uses total projected admissions, statewide median average length of stay per admission and each county's average length of stay per admission and each county's average length of stay per admission for projecting estimated inpatient days for each county. Similar to the hospice home care methodology, previous years' data is used, so a two-year trailing average growth rate in statewide hospice admissions is done over the previous three years. Total projected admissions and the lower of the statewide median average length of stay per admission and each		

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	county's average length of stay per admission are used as the basis for projecting estimated inpatient days for each county. A two-year trailing average statewide inpatient utilization rate of the total estimated days of care in each county is used as a basis for estimating days of care in licensed inpatient hospice facility beds. **Hospice Residential Beds (p. 316)** There is no need methodology for hospice residential beds. **Committee Recommendation** A motion made and second to recommend acceptance of hospice services assumptions and methodologies and to advance years by one for inclusion in the Proposed 2017 SMFP.	Mr. Jakusz Ms. Michaud	Approved
End-Stage Renal Disease Dialysis Facilities - Chapter 14	Ms. Brown provided the following report: Ms. Brown noted there were no petitions or comments were received regarding this chapter. **2016 SMFP** **Chapter 4: Statement of Policies** **Polices Applicable to End-Stage Renal Disease Dialysis Services (p. 33)** **Policy ESRD-2: Relocation of Dialysis Stations** *This policy notes that stations can be relocated only within the host county and to contiguous counties. Certificate of need applicants proposing to relocate stations to a contiguous county shall demonstrate that the facility currently serving patients of that contiguous county. Even then, the relocation must not create a "surplus" in the receiving county or a "deficit" in the donor county.* **Standard Methodology (p. 371-374)** Provide a short summary of the standard methodology used to project need for new dialysis stations… The need for new dialysis stations is determined two times each calendar year. Determinations are made available in the North Carolina Semiannual Dialysis Report (SDR).		

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	• **County Need:** Is based on all residents of North Carolina, regardless of where they are currently receiving services. Future patient counts are projected for 6 to 12 months into the future based on a five-year trend line. Need is based on 80 percent utilization of existing stations, at 3.2 patients per station. The threshold for need is a projected deficit of 10 stations. • **Facility Need:** Is a permissive methodology, which allows an existing provider located in a county where the projected County Need is zero, to apply for additional stations if that facility is operating at or above 80 percent utilization and feels it needs additional capacity. (Because patients can chose to cross county lines, this allows a facility in "high demand" to apply for expansion even if the host county has sufficient stations based on local county residents.) Ms. Brown provides a brief overview of the 2016 Spring ESRD Provider meeting that DHSR hosted on February 2 here in Raleigh on the Dix Campus. Items covered included changes in the Certificate of Need administrative rules for dialysis; future review of the dialysis methodologies; and the possibility of transitioning from semiannual reporting to annual report of data and need determinations. It was a very productive meeting. **Committee Recommendations** A motion made and second to recommend acceptance of End-Stage Renal Disease dialysis policies, assumptions and methodology and the suggested language to advance years by one for inclusion in the Proposed 2017 SMFP.	Mr. Brunnick Dr. Parikh	Approved

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Psychiatric Inpatient Services - Chapter 15	**<u>LME-MCO Mergers</u>** Before discussing the chapters individually, Dr. Craddock mentioned that DHHS has announced that it is continuing with its plan to merge the eight LME-MCOs into four. The CenterPoint and Cardinal merger may occur within the next month or so, but there is no timeframe for the other mergers. Dr. Craddock provided the following report. **<u>Policies</u>** **MH-1. Linkages between treatment Settings -- Applies to Chapters 15, 16, and 17** CON applicant shall document that the affected LME-MCO has been contacted and invited to comment on proposed services described in the CON application. One Policy applies specifically to Chapter 15. **PSY-1. Transfer of Beds from State Psychiatric Hospitals to Community Facilities** Beds may be relocated from state facilities through the CON process, provided services and programs shall be available in the community. Beds transferred from state facilities shall be closed within 90 days after the date that the community beds become operational. CON applicants must commit to serve the type of short-term patients normally placed in the state facility beds. To help ensure that this occurs, there must be a written Memorandum of Agreement between LME-MCO, Secretary of DHHS, and the CON applicant. No petitions or comments were received for Chapter 15. **<u>Methodology</u>** Basic assumptions of the methodology include identification of the bed service area as the LME-MCO in which the beds are located, that treatment settings for adults should be separate from those for children and adolescents, and that the optimum occupancy to be 75%. Days of care are projected two years beyond the SMFP publication year (2019).		

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	Part 1: Determining Projected Patient Days of Care and Bed Need for Children and Adolescents Step 1: The estimated Year 2019 days of care for children/adolescents are determined by taking the current (2015) days of care for patients up through 17 years of age, multiplying that number by the projected Year 2019 child/adolescent population and then dividing by the Year 2015 child/adolescent population. Step 2: The projected Year 2019 days of care is then adjusted downward by 20 percent to take into account the projected continued decrease in utilization by this age group. Step 3: The adjusted Year 2019 days of care is divided by 365 and then by 75 percent to arrive at the child/adolescent bed need for 75 percent occupancy. Step 4: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. The number of existing child/adolescent beds in the planning inventory is then subtracted from the bed need (from Step 3) to arrive at the Year 2019 unmet bed need for children and adolescents. **Part 2: Determining Projected Patient Days of Care and Bed Need for Adults** The methodology is identical to the child/adolescent methodology, except that the projected bed need is not reduced by 20%. Step 1: The estimated Year 2019 days of care for adults is determined by taking the actual Year 2015 days of care for the age group 18 and over, multiplying that number by the projected Year 2019 adult population and then dividing by the Year 2015 adult population. Step 2: The projected Year 2019 days of care is divided by 365 and then divided by 75 percent to arrive at the adult bed need in Year 2019 for 75 percent occupancy. Step 3: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. The number of existing adult beds in the planning inventory		

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	is then subtracted from the bed need (from Step 2) in order to arrive at the Year 2019 unmet bed need for adults.		
	Committee Recommendation A motion made and second to recommend acceptance of psychiatric inpatient services policies, assumptions and methodology, and to advance years by one for inclusion in the Proposed 2017 SMFP.	Dr. Parikh Mr. Brunnick	Motion approved
	<u>Inclusion of 150 Behavioral Health Inpatient Beds</u> Dr. Craddock presented the agency's recommendation regarding the inclusion of the 150 behavioral health inpatient beds authorized under Session Law 2015-241. The document was posted on the website. This applies to both Chapter 15 and Chapter 16. The General Assembly authorized $25 million for the creation of <u>up to</u> 150 new behavioral health inpatient treatment beds. This funding represents a portion of the proceeds of the sale of the Dorothea Dix Hospital property, and beds will be named in honor of Dorothea Dix. The Session Law included a charge the Department of Health and Human Services (DHHS) to submit a plan, by April 1, 2016, for the development of these beds. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) prepared this plan in consultation with other DHHS divisions, including the Division of Health Service Regulation (DHSR). No timeframe is available for the development of these beds, but they can be developed in acute care hospitals, mental health hospitals, or any other facility licensed to provide inpatient/residential treatment for mental and/or substance use disorders. Development of these beds will not require a Certificate of Need (CON), but they will be required to adhere to all licensure rules and procedures during and after development. Beds will be licensed according to the type of facility in which they are to be located and the type of services they will provide. Some beds will fall under licensure categories covered by the CON law, but some may fall under different categories. Once licensed, these beds will be indistinguishable from any other bed in the designated licensure category – except that they will not have been developed by means of the CON process.		

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	The Session Law is silent regarding whether, and if so how, the SHCC should incorporate these beds into the SMFP. A decision needs to be made on this issue.		
	Committee Recommendation A motion made and second that all beds created under S.L. 2015-241 that become licensed under categories currently covered by the CON Law (10A NCAC 27G .5200, .6000, and .3400) be included in the inventory and in the need determination methodology will be done in the same manner as other beds in the behavioral health chapters of the SMFP.	Mr. Brunnick Mr. Jakusz	Motion approved
	<u>Proposed Methodology Change for Child/Adolescent Beds</u> The Agency proposes eliminating Step 2 of the need determination methodology for inpatient psychiatric beds for children and adolescents. A major redesign of the psychiatric bed need methodology became effective in the 1993 SMFP. The 1993 SMFP Chapter 15 narrative noted that national trend data showed that the average length of stay for adolescents was decreasing. The new methodology instituted the 20% reduction in projected DOC in the child/adolescent section of the methodology. Recent data from the SMFP, however, shows that the utilization of child/adolescent psychiatric inpatient beds has increased consistently. The black line in the figure shows the projected in DOC based on the current methodology. This is the projected DOC, reduced by 20%. The green line shows reported DOC for the same years. Changes to data collection methods between 2011 and 2012 resulted in a significant increase in the reported DOC. The time of the change is indicated on the chart by dashed line. Before 2012, acute care hospitals were the only data source for DOC, but the inventory in the need determination calculations included beds in both acute care hospitals and mental health hospitals. To improve the accuracy of the methodology, beginning in 2012, the SMFP began including DOC data from both acute care hospitals and mental health hospitals. Beginning at this point, the trend continues to show increasing utilization, especially after inclusion of DOC in mental health hospitals. It is also clear that the methodology as currently written projects utilization that is substantially		

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	lower than actual utilization. **Committee Recommendation** A motion made and second to remove of Step 2 of the child/adolescent bed need methodology, which would eliminate the 20% reduction in projected days of care. **<u>Proposed Wording Change to Chapter 15</u>** The proposed changes reflect usage of "people first" terminology. This terminology has been preferred for roughly the past 15 years by The Americans with Disabilities Act Network (funded by the U.S. Department of Health and Human Services), the American Psychological Association, and the American Psychiatric Association, among others. For example, language referring to "the mentally ill," would instead refer to "people with a mental disorder." The "people first" terminology is used in some places in Chapter 15, but not in all places. The agency is recommending changes to make the usage consistent throughout Chapter 15 and the remainder of the SMFP. There are exceptions. Where the language refers to the DHHS Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), its programs, policies, or facilities, however, the text will use the term used by that division. Another exception would be where material is quoted from, or reflects required language in, another source or for some other reason cannot be changed (e.g., the CON law). Before making any changes, staff will confer with the cognizant authority to verify the appropriateness of the language change. **Committee Recommendations** A motion was made and seconded to make the language changes wherever the terms may appear in the SMFP - where it is appropriate to do so.	Ms. Michaud Mr. Jakusz Mr. Jakusz Dr. Parikh	Motion approved Motion approved
Substance Abuse/Chemical Dependency - Chapter 16	**Policies and Need Methodology Review** Dr. Craddock provided the following report:		

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	<u>Policies</u> MH-1 covers Chapter 16. No policies specific to Chapter 16. No petitions or comments were received for Chapter 16. **<u>Methodology</u>** Basic assumptions of the methodology note that treatment units for the adult and the child/adolescent population should be physically and programmatically separate. Eighty-five percent has been determined to be the target occupancy rate for chemical dependency treatment beds in hospitals and residential treatment facilities. Days of care and bed need are projected two years beyond the current SMFP publication year (2019). **Part 1: Determining Projected Patient Days of Care and Total Bed Need** Step 1: The estimated Year 2019 days of care for all age groups is determined by taking the current reporting year (2015) days of care, multiplying that number by the projected Year 2019 population and then dividing by the Year 2015 population. Step 2: The Year 2019 days of care figure is divided by 365 and then by 85 percent to arrive at the total bed need in Year 2019, assuming an 85 percent occupancy. Eighty-five percent has been determined to be the target occupancy rate for chemical dependency (substance abuse) treatment beds in hospitals and residential treatment facilities. **Part 2: Determining Projected Unmet Bed Need for Children and Adolescents and for Adults** Step 1: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. The number of existing beds in the planning inventory is then subtracted from the total bed need (from Part 1, Step 2) to arrive at the Year 2019 *unmet* bed need for all age groups ("total bed surplus/deficit"). Step 2: Nine percent of the total bed need is subtracted as the		

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	estimated Year 2019 bed need for children and adolescents, based on utilization patterns reflected in past data (nine percent of the days of stay were for children and adolescents). Step 3: The child/adolescent planning inventory is subtracted from the child/adolescent bed need (from Part 2, Step 2) to arrive at the Year 2019 child/adolescent unmet bed need. Step 4: The adult bed need is then calculated by subtracting the child/adolescent bed "surplus/deficit" from the total bed "surplus/deficit." **Committee Recommendation** A motion made and second to recommend acceptance of substance abuse/ chemical dependency policy, assumptions and methodology and to advance years by one for inclusion in the Proposed 2017 SMFP. **<u>Proposed Wording Change to Chapter 16</u>** The agency recommends wording changes to the Chapter 16 narrative to assure consistent usage of "people first" terminology. In addition, the agency recommends incorporation of the term "substance use disorder" rather than "substance abuse" to align with usage in the DSM-5. The exceptions discussed for Chapter 15 would also apply. Before making changes, staff will confer with the cognizant authority to verify the appropriateness of the language change. **Committee Recommendations** A motion made and second for the term "substance use disorder" replaced other terms such as "substance abuse, and recommended that this term be changed to "substance use disorder." The exceptions noted for Chapter 15 would also apply. Before making changes, staff will confer with the cognizant authority to verify the appropriateness of the language change.	Mr. Brunnick Dr. Parikh Mr. Jakusz Ms. Michaud	Approved Approved
Intermediate Care Facilities Chapter 17	**Policies and Need Methodology Review** Dr. Craddock provided the following report. Three polices address Chapter 17.		

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	ICF/IID-1: Transfer of Beds from State Operated Developmental Centers to Community Facilities for Medically Fragile Children Beds in state operated development centers may be relocated to community facilities via the CON process to serve children age birth through six years who have severe to profound developmental/intellectual disabilities and are medically fragile. Pertains to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. **ICF/IID-2: Transfer of Beds from State Operated Developmental Centers to Community Facilities for Individuals Who Currently Occupy the Beds** Existing beds in state facilities may be transferred via the CON process to establish group homes in the community to serve people with complex behavioral challenges and/or medical conditions for whom such a community placement is appropriate. Once licensed in the community, the state operated beds shall be closed. **ICF/IID-3: Transfer of Beds of State Operated Developmental Centers to Community Facilities for Adults with Severe to Profound Developmental Disabilities** Existing ICF/IID beds in state facilities may be transferred to the community via the CON process to replace Community Alternatives Program for Individuals with Intellectual and Developmental Disabilities (CAP I/DD) waiver slots lost as a result of the Centers for Medicaid and Medicare Services (CMS) policy designed to prohibit CAP I/DD waiver and ICF/IID beds from being located on the same campus. This policy applies to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. Applies only to facilities that have lost waiver slots as a result of this CMS policy. No petitions or comments were received for Chapter 17. **Methodology** Beds are created in ICF/IID facilities by issuance of a CON to transfer beds from State Operated developmental centers. There is no calculation of bed need for ICF/IID facilities.		

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	Committee Recommendation A motion made and second to recommend acceptance of intermediate care facilities policies, assumptions and methodology to advance years by one for inclusion in the Proposed 2017 SMFP.	Ms. Michaud Dr. Parikh	Approved
	Terminology Changes to Chapter 17 The agency recommends wording changes to the Chapter 17 narrative to assure consistent usage of "people first" terminology and consistent usage of "intellectual disabilities." The exceptions discussed for Chapter 15 would also apply. Before making changes, staff will confer with the cognizant authority to verify the appropriateness of the language change.		
	Committee Recommendations A motion made and second to make the language changes wherever the terms may appear in the SMFP - where it is appropriate to do so.	Mr. Jakusz Ms. Michaud	Approved
	Committee Recommendations A motion made and second to allow staff to update narratives, tables and need determinations for the Proposed 2017 Plan as new and corrected data is received.	Mr. Brunnick Mr. Jakusz	Approved
Other Business	Mr. Jakusz made the suggestion that he would like to see a member on the SHCC who has expertise in dialysis. Dr. Pulliam noted the next Committee meeting is May 6th and a Special Called SHCC meeting held today immediately following the LTBH meeting. Dr. Pulliam encouraged each member to stay for this meeting. Dr. Pulliam also stated the next SHCC meeting is May 25th. He then thanked the members and staff.		
Adjournment	Dr. Pulliam asked for a motion to adjourned the meeting. A motion made and second to adjourn the meeting.	Mr. Brunnick Mr. Jakusz	Approved