

STATE HEALTH SERVICES PLAN TASK FORCE

Friday, June 12, 2026, 9:00 AM to 12:00 PM
Virginia Department of Health Office of Licensure and Certification
Virtual Meeting

Meeting Agenda

1. Call to Order

- *Karen Cameron, Chair*

2. Approval of February 27, 2026 Minutes

3. Public Comment Period

4. Subcommittee Reports

- i. *Open Heart Surgery, Transplant Surgery, and Cardiac Catheterization Committee*
- ii. *General Hospital Committee*

5. Progress Report on Committees:

- *Neonatal Committee (NEONATCom)*
- *Medical Desert (DESERTCom)*

6. Expedited Review Process & Subcommittee Recommendation Summary

- *Proposed Recommendation on Expedited Review Process*
 - *Committee Recommendations*
 - *Diagnostic Imaging Facilities and Services Committee (DIFSCOM)*
 - *General Hospital Committee (GENHOSPCOM)*
 - *Nursing Home Bed Committee (NHCOM)*
 - *Open Heart Surgery, Transplant Surgery Committee, & Cardiac Catheterization Committee (OHTCCOM)*
 - *Outpatient Surgical Hospitals and Operating Room Additions Committee (OSHORACOM)*
 - *Radiation Therapy Committee (RADCOM)*
 - *Substance Abuse Treatment, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Medical Rehabilitation Beds Committee (SIMCOM)*

7. Adjourn and Next Steps

- *August 28, 2026, 9:00 AM to 12:00 PM, Perimeter Center*



Meeting Minutes

State Health Services Plan Task Force

February 27, 2026, 9:00 a.m.

Perimeter Center, Board Room 3

9960 Mayland Drive

Henrico, Virginia 23233

Task Force Members in Attendance (alphabetical by last name):

Ms. Jeannie Adams; Dr. Kathy Baker; Mr. Jim Beckner; Mr. Erik Bodin; Ms. Karen Cameron (Chair); Ms. Carrie Davis; Mr. Michael Desjadon; Ms. Tracy Douglas; Mr. Paul Dreyer; Ms. Amanda Dulin; Mr. Paul Hedrick; Mr. Deepak Madala; Mr. Rufus Phillips; Mr. Neil Rolfes; Mr. Marcus Stone

Absent Committee Members: Dr. Keith Berger; Mr. Dean Montgomery; Mr. Tom Orsini; Dr. Marilyn West

Staff in Attendance (alphabetical by last name): Ms. April Dovel, Director; Mr. Antwon Jacobs, Supervisor of COPN; Mr. Geoff Garner, Senior Policy Analyst; Mr. Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs; James Jenkins, Jr., RN, Deputy Director; Ms. Casey Miller, Policy Analyst; Dr. Cameron Webb, State Health Commissioner, VDH.

Ms. Cameron called the meeting to order at 09:04 a.m.

Dr. Cameron Webb welcomed the committee with opening remarks.

Each member in attendance gave a brief introduction, which served as roll call. Quorum was established.

The meeting minutes from October 10, 2025, were approved.

No one offered public comment.

Mr. Garner walked through the SHSP TF work plan, status of regulatory processes, and previous expedited review recommendations. He shared requirements from the Assembly, including HB1337 and SB239 in the 2026 General Session.

Ms. Cameron thanked the subcommittee members and their chairs and turned the conversation to Dr. Baker.

Subcommittee Reports

Open-Heart Surgery, Transplant Surgery Committee, & Cardiac Catheterization Committee (OHTCCOM)

Dr. Baker, the chair of OHTCCOM, led the conversation through the Criteria and Standards for Organ transplant.

A new definition for maturity was introduced. The committee agreed upon the new definition, “maturity” means the minimum number of transplants would be performed in the third full year of operation.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote:

Ms. Adams, Dr. Baker, Mr. Beckner, Mr. Bodin, Ms. Cameron, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone accepted the definition recommended by Ms. Dulin.

The taskforce amended the language and removed the table under 12VAC5-230-720. The revised language to read as:

A. Proposals to establish organ transplantation services should demonstrate maturity.

B. Applicants shall demonstrate that they will achieve and maintain at least the minimum transplant patient survival rates. Minimum one-year survival rates listed by organ system are: applicants shall demonstrate that they will achieve and maintain one-year survival rates equal to or higher to the most recent Tier III performance of the Scientific Registry of Transplant Recipients.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote:

Ms. Adams, Dr. Baker, Mr. Beckner, Mr. Bodin, Ms. Cameron, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone accepted replacing the word “latest” to “most recent” and removing the link and chart, while Ms. Dulin abstained.

The committee discussed 12VAC5-230-390 the need for new service of cardiac catheterization services, subsection B:

“Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district below 1,200 DEPs.”

The committee discussed removal of the first sentence and the word, “additionally” under Subsection B.

The taskforce participated in a discussion about mobile vs fixed site.

Mr. Garner clarified under the need for new service, to keep it inclusive of fixed site and mobile, the following should be removed:

- “fixed site” from subsection A and A1

- “at a location” from subsection C

Ms. Dulin suggested mobile could be moved to non-emergent, leaving the preference.

Mr. Bodin advised typically, a non-working piece of equipment, that has been replaced temporarily, is treated as an exception and is allowable.

Mr. Stone expressed concern with removing the word “mobile”.

Ms. Cameron suggested tabling this conversation for the OHTC committee to discuss in the next OHTC meeting, including Ms. Douglas in the conversation.

Dr. Baker advised that cardiac catheterization will not be closed out today. It will be reported at the next full task force committee, with the open-heart standards recommendation.

The taskforce took a ten-minute break.

Ms. Cameron called the meeting to order.

Outpatient Surgical Hospitals and Operating Room Additions Committee

Committee (OSHORACOM)

Mr. Rolfes, chair of OSHORACOM, thanked the committee members and the staff. He advised that the committee reached a consensus in maintaining the current standard. As VHI begins to collect more market data with a broader span of CPT codes, there will be enough information to reevaluate in the future. He explained the new definitions, “inpatient” and “outpatient”, are less time based and more dependent on a physician order:

"Inpatient" means a patient who is hospitalized longer than 24 hours for health or health related services pursuant to an order issued by or under direction of a physician.

"Outpatient" means a patient who visits a hospital, clinic, or associated medical care facility for diagnosis or treatment, but is not admitted as an inpatient.

He walked through the remainder of the standard.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote for approval:

Ms. Adams, Dr. Baker, Mr. Beckner, Mr. Bodin, Ms. Cameron, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone accepted the recommendations of the OSHORA Committee.

Ms. Cameron suggested the staff create a cheat sheet for the next committee assigned to this set of standards.

Radiation Therapy Committee (RADCOM)

Mr. Dreyer, presenting on Dr. West’s (chair of RADCOM) behalf, thanked the committee and the staff. He explained the approach to the recommendation is to move toward more of a time-based

assessment of capacity for linear accelerators based on the type of treatment performed. He walked through the recommended standardization Equivalent Simple Treatment Visit (ESTV) weighing definition with chart.

“Equivalent Simple Treatment Visit” or “ESTV” means a standardized unit used to measure radiation therapy workload across different treatment types and different treatment complexities. One ESTV equals a simple treatment visit, which is 15 minutes. ESTVs are used for weighing the relative value of various radiation therapy procedures as follows:

Simple Radiation Treatment	One ESTV
Verification Simulation	One ESTV
Intensity Modulated Radiation Therapy (IMRT)	One ESTV
Inpatient simple radiation treatment	Two ESTVs
SRS or SRT on a non-dedicated linear accelerator	Two ESTVs
SRS or SRT on a dedicated machine, such as Cyberknife or Gamma Knife®	Three ESTVs
Proton Therapy	Two ESTVs
Complex Radiation Treatment (includes but is not limited to, treatment involving anesthesia, Total Body Irradiation (TBI), Hemibody Irradiation (HBI), Total skin radiation, Online adaptive radiation therapy (ART)	Four ESTVs

He walked through the entire standard, calling out the change from number of procedures to ESTVs throughout. Article two, Criteria and Standards for Stereotactic Radiosurgery, was removed as this section is now covered in the recommended chart.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote for approval:

Ms. Adams, Dr. Baker, Mr. Beckner, Mr. Bodin, Ms. Cameron, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone accepted the recommendations of the Radiation Committee.

Ms. Cameron advised there are three new committees kicking off, General Hospital Committee (GENHOSPCOM), Neonatal Committee (NEONATCom), Medical Desert Committee (DESERTCom).

Ms. Cameron called for volunteers for General Hospital Committee (GENHOSPCOM).

Amanda Dulin (chair), Mike Desjadon, Paul Dreyer, Paul Hedrick, and Neil Rolfes volunteered.

Ms. Cameron called for volunteers for Neonatal Committee (NEONATCom).

Dr. Kathy Baker (Chair), Erik Bodin, Tracy Douglas, and Paul Dreyer volunteered. Dean Montgomery was assigned.

Ms. Cameron called for volunteers for Medical Desert Committee (DESERTCom).

Karen Cameron (Chair), Jim Beckner, Carrie Davis, Amanda Dulin, Deepak Madala, Rufus Phillips, and Marcus Stone volunteered.

Mr. Garner encouraged that DESERT COM should have draft regulation to submit to Office of the Commissioner OCOM so that OCOM can submit to The Board of Health with a target date of July 1, 2026.

Ms. Cameron suggested selecting dates for the next full taskforce meeting.

The committee agreed the next SHSP TF will be scheduled June 12, 2026, 9:00 am virtually and August 28, 2026, at 9:00 am in person at The Perimeter Center.

Ms. Cameron opened the floor for nominations for chair and vice chair.

Ms. Cameron was nominated as chair.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote:

Ms. Adams, Dr. Baker, Mr. Beckner, Mr. Bodin, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone voted

Dr. Baker was nominated as vice chair.

Ms. Miller called the taskforce members in alphabetical order for a roll call vote:

Ms. Adams, Mr. Beckner, Mr. Bodin, Ms. Cameron, Ms. Davis, Mr. Desjadon, Ms. Douglas, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Madala, Mr. Phillips, Mr. Rolfes, and Mr. Stone

Mr. Garner explained the bylaws of in person and virtual meeting.

Ms. Cameron advised the subcommittees to set up their first meetings before leaving today.

The meeting adjourned at 11:52 am.

Subcommittee Reports

Redlined Version

Open Heart Surgery, Transplant Surgery Committee, & Cardiac Catheterization Committee (OHTC)

Updating Definitions in the VAC regarding Open Heart Surgery, Transplant Surgery Committee, & Cardiac Catheterization

<https://law.lis.virginia.gov/admincode/title12/agency5/chapter230/section10/>

Redlined Document

Goal: Determine which definitions in the Open Heart Surgery, Transplant Surgery Committee, & Cardiac Catheterization in the Virginia Code need the following:

- Added
- Brought up-to-date
- Deleted

Recommended Revisions

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Criteria and Standards for Open Heart Surgery

12VAC5-230-10. Definitions.

"Open heart surgery" means a surgical procedure requiring the use or immediate availability of a heart-lung bypass machine or "pump." The use of the pump during the procedure distinguishes "open heart" from "closed heart" surgery. Open heart surgery is defined by the following APR-DRGs:

- 160 Major Cardiothoracic Repair of Heart Anomaly
- 161 Implantable Heart Assist Systems
- 162 Cardiac Valve Procedures with AMI or Complex Procedure

- 163 Cardiac Valve Procedures without AMI or Complex Procedure
 - 165 Coronary Bypass with AMI or Complex Procedure
 - 166 Coronary Bypass without AMI or Complex Procedure
 - 167 Other Cardiothoracic & Thoracic Vascular Procedures
- *when writing regulatory language, note that the APR-DRG codes will remain the same; however, the description language may vary*

12VAC5-230-440. Travel time.

A. Open heart surgery services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

B. Such services shall be available 24 hours a day, seven days a week.

12VAC5-230-450. Need for new service.

A. No new open-heart services should be approved unless:

1. The service will be available in an inpatient hospital with an established cardiac catheterization service that has performed an average of 1,200 DEPs for the relevant reporting period and has been in operation for at least 30 months;
2. Open heart surgery services located in the health planning district performed an average of 400 open heart and closed heart surgical **procedures cases** for the relevant reporting period; and
3. The proposed new service will perform at least 150 **procedures cases** per room in the first year of operation and 250 **procedures cases** per room in the second year of operation without significantly reducing the utilization of existing open heart surgery services in the health planning district.

B. Preference may be given to a project that locates new open heart surgery services at an inpatient hospital more than 60 minutes driving time one way under normal condition from any site in which open heart surgery services are currently available and:

1. The proposed new service will perform an average of 150 open heart **procedures cases** in the first year of operation and 200 **procedures cases** in the second year of operation without significantly reducing the utilization of existing open heart surgery rooms within two

hours driving time one way under normal conditions from the proposed new service location below 400 ~~procedures cases~~ per room; and

2. The hospital provided an average of 1,200 cardiac catheterization DEPs during the relevant reporting period in a service that has been in operation for at least 30 months.

12VAC5-230-460. Expansion of service.

~~Proposals to expand open heart surgery services shall demonstrate that existing open heart surgery rooms operated by the applicant have performed an average of:~~

~~1. 400 adult equivalent open heart surgery procedures in the relevant reporting period if the proposed increase is within one hour driving time one way under normal conditions of an existing open heart surgery service; or~~

~~2. 300 adult equivalent open heart surgery procedures in the relevant reporting period if the proposed service is in excess of one hour driving time one way under normal conditions of an existing open heart surgery service in the health planning district.~~

~~Proposals to expand open heart surgery shall demonstrate that existing cardiac surgery operating rooms have performed 1,600 hours of service hours per cardiac operating room per year for the most recent year cardiac surgery operating rooms have been reported by VHI.~~

~~Available service hours per operating room per year includes operating hours and prep and cleanup hours and is based on 80% utilization of an operating room available 40 hours per week, 50 weeks per year.~~

12VAC5-230-470. Pediatric open heart surgery services.

No new pediatric open heart surgery service should be approved unless the proposed new service is provided at an inpatient hospital that:

1. Has pediatric cardiac catheterization services that have been in operation for 30 months and have performed an average of 200 pediatric cardiac catheterization procedures for the relevant reporting period; and

2. Has pediatric intensive care services and provides specialty or subspecialty neonatal special care.

12VAC5-230-480. Staffing.

A. Open heart surgery services should have a medical director who is board certified in cardiovascular or cardiothoracic surgery by the appropriate board of the American Board of Medical Specialists.

In the case of pediatric cardiac surgery, the medical director should be board certified in cardiovascular or cardiothoracic surgery, with special qualifications and experience in pediatric cardiac surgery and congenital heart disease, by the appropriate board of the American Board of Medical Specialists.

B. Cardiac surgery should be under the direct supervision of one or more qualified physicians.

Pediatric cardiac surgery services should be under the direct supervision of one or more qualified physicians.

Part IX. Organ Transplant

12VAC5-230-10. Definitions.

“Maturity” means the minimum number of transplants would be performed in the third full year of operation. - transplant

12VAC5-230-700. Travel time.

A. Organ transplantation services should be accessible within two hours driving time one way under normal conditions of 95% of Virginia's population using mapping software as determined by the commissioner.

B. Providers of organ transplantation services should facilitate access to pre and post transplantation services needed by patients residing in rural locations by establishing part-time satellite clinics.

12VAC5-230-710. Need for new service.

A. There should be no more than one program for each transplantable organ in a health planning region.

B. Performance of minimum transplantation volumes as cited in [12VAC5-230-720](#) does not indicate a need for additional transplantation capacity or programs.

Statutory Authority

12VAC5-230-720. Transplant volumes; survival rates; service proficiency; systems operations.

A. Proposals to establish organ transplantation services should demonstrate ~~that the minimum number of transplants would be performed annually when the program reaches maturity. The minimum number transplants of required by organ system is:~~

Kidney	30
Pancreas or kidney/pancreas	12 6
Heart	17
Heart/Lung	12 6
Lung	12
Liver	21
Intestine	2

Note: Any proposed pancreas transplant program must be a part of a kidney transplant program that has achieved a minimum volume standard of 30 cases per year for kidney transplants as well as the minimum transplant survival rates stated in subsection B of this section.

B. ~~Applicants shall demonstrate that they will achieve and maintain at least the minimum transplant patient survival rates. Minimum one-year survival rates listed by organ system are:~~ Applicants shall demonstrate that they will achieve and maintain one-year survival rates equal to or higher to the ~~latest~~ most recent Tier III performance of the Scientific Registry of Transplant Recipients <inbed link www.srtr.org>

Kidney	95%
Pancreas or kidney/pancreas	90%
Heart	85%

Heart/Lung	70%
Lung	77%
Liver	86%
Intestine	77%

12VAC5-230-730. Expansion of transplant services.

- A. Proposals to expand organ transplantation services shall demonstrate at least two years successful experience with all existing organ transplantation systems at the hospital.
- B. Preference may be given to a project expanding the number of organ systems being transplanted at a successful existing service rather than developing new programs that could reduce existing program volumes.

12VAC5-230-740. Staffing.

Organ transplant services should be under the direct supervision of one or more qualified physicians.

Statutory Authority

§ [32.1-102.2](#) of the Code of Virginia.

Historical Notes

Derived from Virginia Register [Volume 25, Issue 9](#), eff. February 15, 2009.

Website addresses provided in the Virginia Administrative Code to documents incorporated by reference are for the reader's convenience only, may not necessarily be active or current, and should not be relied upon. To ensure the information incorporated by reference is accurate, the reader is encouraged to use the source document described in the regulation.

As a service to the public, the Virginia Administrative Code is provided online by the Virginia General Assembly. We are unable to answer legal questions or respond to requests for legal advice, including application of law to specific fact. To understand and protect your legal rights, you should consult an attorney.

Article 1. Criteria and Standards for Cardiac Catheterization Services

12VAC5-230-380. Travel time.

Article 1

Criteria and Standards for Cardiac Catheterization Services

Cardiac catheterization services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

Historical Notes

Derived from Virginia Register [Volume 25, Issue 9](#), eff. February 15, 2009.

12VAC5-230-390. Need for new service.

A. No new fixed site cardiac catheterization service should be approved for a health planning district unless:

1. Existing fixed-site cardiac catheterization services located in the health planning district performed an average of 1,200 cardiac catheterization DEPs per existing and approved laboratory for the relevant reporting period;
2. The proposed new service will perform an average of 200 DEPs in the first year of operation and 500 DEPs in the second year of operation; and
3. The utilization of existing services in the health planning district will not be significantly reduced.

B. Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district below 1,200 **procedures DEPs**.

C. Preference may be given to a project that locates new cardiac catheterization services at an inpatient hospital that is 60 minutes or more driving time one way under normal conditions from existing services if the applicant can demonstrate that the proposed new

laboratory will perform an average of 200 DEPs in the first year of operation and 400 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district.

12VAC5-230-400. Expansion of services.

Proposals to increase cardiac catheterization services should be approved only when:

1. All existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 DEPs per existing and approved laboratory for the relevant reporting period; and
2. The applicant can demonstrate that the expanded service will achieve an average of 200 DEPs per laboratory in the first 12 months of operation and 400 DEPs in the second 12 months of operation without significantly reducing the utilization of existing cardiac catheterization laboratories in the health planning district.

12VAC5-230-410. Pediatric cardiac catheterization.

No new or expanded pediatric cardiac catheterization services should be approved unless:

1. The proposed service will be provided at an inpatient hospital with open heart surgery services, pediatric tertiary care services or specialty or subspecialty level neonatal special care;
2. The applicant can demonstrate that the proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation; and
3. The utilization of existing pediatric cardiac catheterization laboratories in the health planning district will not be reduced below 100 pediatric **cardiac catheterization procedures** per year.

12VAC5-230-420. Nonemergent cardiac catheterization.

A. Simple therapeutic cardiac catheterization. Proposals to provide simple therapeutic cardiac catheterization are not required to offer open heart surgery service available on-site in the same hospital in which the proposed simple therapeutic service will be located. However, these programs shall adhere to the requirements described in subdivisions 1 through 9 of this subsection.

The programs shall:

1. Participate in the Virginia Heart Attack Coalition, the Virginia Cardiac Services Quality Initiative, and the Action Registry-Get with the Guidelines or National Cardiovascular Data Registry to monitor quality and outcomes;
 2. Adhere to **strict written** patient-selection criteria;
 3. Perform annual institutional volumes of 300 cardiac catheterization procedures, of which at least 75 should be percutaneous coronary intervention (PCI) or as dictated by American College of Cardiology (ACC)/American Heart Association (AHA) Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories effective 1991;
 4. Use only AHA/ACC-qualified operators who meet the standards for training and competency;
 5. Demonstrate appropriate planning for program development and complete both a primary PCI development program and an elective PCI development program that includes routine care process and case selection review;
 6. Develop and maintain a quality and error management program;
 - ~~7. Provide PCI 24 hours a day, seven days a week;~~
 - ~~8. 7. Develop and maintain necessary agreements with a tertiary facility that must agree to accept emergent and nonemergent transfers for additional medical care, cardiac surgery, or intervention; and~~
 - ~~9. 8. Develop and maintain agreements with an ambulance service capable of advanced life support and intra-aortic balloon pump transfer that **guarantees is capable of** a 30-minute or less response time.~~
- B. Preference shall be given to programs which provide PCI 24 hours a day, seven days a week;**
- B: C. Complex therapeutic cardiac catheterization.** Proposals to provide complex therapeutic cardiac catheterization should be approved only when open heart surgery services are available on-site in the same hospital in which the proposed complex therapeutic service will be located. Additionally, these complex therapeutic cardiac catheterization programs will be required to participate in the Virginia Cardiac Services Quality Initiative and the Virginia Heart Attack Coalition.

Derived from Virginia Register [Volume 25, Issue 9](#), eff. February 15, 2009; amended, Virginia Register [Volume 37, Issue 14](#), eff. March 31, 2021.

12VAC5-230-430. Staffing.

A. Cardiac catheterization services should have a medical director who is board certified in cardiology and has clinical experience in performing physiologic and angiographic procedures.

In the case of pediatric cardiac catheterization services, the medical director should be board-certified in pediatric cardiology and have clinical experience in performing physiologic and angiographic procedures.

B. Cardiac catheterization services should be under the direct supervision or one or more qualified physicians. Such physicians should have clinical experience in performing physiologic and angiographic procedures.

Pediatric catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians should have clinical experience in performing pediatric physiologic and angiographic procedures.

General Hospital Committee (GENHOSP)

Recommended Revisions

Part VI. Inpatient Bed Requirements

12VAC5-230-520. Travel time.

Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using a mapping software as determined by the commissioner.

12VAC5-230-530. Need for new service.

A. No new inpatient beds should be approved in any health planning district unless:

1. The resulting number of beds for each bed category contained in this article does not exceed the number of beds projected to be needed for that health planning district for the fifth planning horizon year; and

2. The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:

a. 80% at midnight census for medical/surgical beds ~~or pediatric beds~~;

b. 65% at midnight census for intensive care beds ~~or pediatric beds~~.

c. 70% at midnight census for obstetric care beds.

~~B. For proposals to convert under-utilized beds that require a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection C of this section, consideration may be given to such proposal if:~~

~~1. There is a projected need in the applicable category of inpatient beds; and~~

~~2. The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.~~

For the purposes of this part, "underutilized" means less than 80% average annual occupancy for medical/surgical ~~or pediatric beds~~, when the relocation involves such beds and less than 65% average annual occupancy for intensive care beds ~~and pediatric beds~~, and 70% for obstetric beds when relocation involves such beds.

~~C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:~~

$$A \times (1 + B)$$

~~where:~~

~~A = the capital expenditure threshold amount for the previous year~~

~~and~~

~~B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.~~

~~Statutory Authority~~

~~§ 32.1-102.2 of the Code of Virginia.~~

12VAC5-230-540. Need for medical/surgical beds.

The number of medical/surgical beds projected to be needed in a health planning district shall be computed as follows:

1. Determine the use rate for the medical/surgical beds for the health planning district using the formula:

$$BUR = (IPD/PoP)$$

Where:

BUR = the bed use rate for the health planning district.

IPD = the sum of total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

PoP = the sum of total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of medical/surgical beds needed for the health planning district in five years from the current year using the formula:

$$\text{ProBed} = ((\text{BUR} \times \text{ProPop})/365)/-0.80$$

Where:

ProBed = The projected number of medical/surgical beds needed in the health planning district for five years from the current year.

BUR = the bed use rate for the health planning district determined in subdivision 1 of this section.

ProPop = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of medical/surgical beds that are needed in the health planning district for the five planning horizon years as follows:

$$\text{NewBed} = \text{ProBed} - \text{CurrentBed}$$

Where:

NewBed = the number of new medical/surgical beds that can be established in a health planning district, if the number is positive. If NewBed is a negative number, no additional medical/surgical beds should be authorized for the health planning district.

ProBed = the projected number of medical/surgical beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentBed = the current inventory of licensed and authorized medical/surgical beds in the health planning district.

12VAC5-230-550. Need for pediatric beds.

The number of pediatric beds projected to be needed in a health planning district shall be computed as follows:

1. Determine the use rate for pediatric beds for the health planning district using the formula:

$$PBUR = (PIPD/PedPop)$$

Where:

PBUR = The pediatric bed use rate for the health planning district.

PIPD = The sum of total pediatric inpatient days in the health planning district for the most recent five years for which inpatient days data has been reported by VHI; and

PedPop = The sum of population under 18 years of age in the health planning district for the same five years used to determine PIPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of pediatric beds needed to the health planning district in five years from the current year using the formula:

$$ProPedBed = ((PBUR \times ProPedPop)/365)/\del{0.80} 0.65$$

ric beds needed in the health planning district for five years from the current year.

PBUR = The pediatric bed use rate for the health planning district determined in subdivision 1 of this section.

ProPedPop = The projected population under 18 years of age of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of pediatric beds needed within the health planning district for the fifth planning horizon year as follows:

$$NewPedBed = ProPedBed - CurrentPedBed$$

Where:

NewPedBed = the number of new pediatric beds that can be established in a health planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the health planning district.

ProPedBed = the projected number of pediatric beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the health planning district.

12VAC5-230-560. Need for intensive care beds.

The projected need for intensive care beds in a health planning district shall be computed as follows:

1. Determine the use rate for ICU beds for the health planning district using the formula:

$$\text{ICUBUR} = (\text{ICUPD}/\text{Pop})$$

Where:

ICUBUR = The ICU bed use rate for the health planning district.

ICUPD = The sum of total ICU inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

Pop = The sum of population 18 years of age or older for adults or under 18 for pediatric patients in the health planning district for the same five years used to determine ICUPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of ICU beds needed for the health planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:

$$\text{ProICUBed} = ((\text{ICUBUR} \times \text{ProPop})/365)/0.65$$

Where:

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year;

ICUBUR = The ICU bed use rate for the health planning district as determined in subdivision 1 of this section;

ProPop = The projected population 18 years of age or older for adults or under 18 for pediatric patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of ICU beds that may be established or relocated within the health planning district for the fifth planning horizon planning year as follows:

$\text{NewICUBed} = \text{ProICUBed} - \text{CurrentICUBed}$

Where:

NewICUBed = The number of new ICU beds that can be established in a health planning district, if the number is positive. If NewICUBed is a negative number, no additional ICU beds should be authorized for the health planning district.

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentICUBed = The current inventory of licensed and authorized ICU beds in the health planning district.

12VAC5-230-### Need for obstetric beds.

The projected need for obstetric beds in a health planning district shall be computed as follows:

1. Determine the use rate for OB beds for the health planning district using the formula:

$$\text{OBBUR} = (\text{OBD}/\text{Pop})$$

Where:

OBBUR = The OB bed use rate for the health planning district.

OBPD = The sum of total OB inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

Pop = The sum of population 15 - 44 female age reproductive year patients in the health planning district for the same five years used to determine OBPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of OB beds needed for the health planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:

$$\text{ProOBBed} = ((\text{OBBUR} \times \text{ProPop})/365)/0.80 \text{ } 0.70$$

Where:

ProOBBed = The projected number of OB beds needed in the health planning district for five years from the current year;

OBBUR = The OB bed use rate for the health planning district as determined in subdivision 1 of this section;

ProPop = The projected population 15 - 44 female age reproductive year patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of OB beds that may be established or relocated within the health planning district for the fifth planning horizon planning year as follows:

$$\text{NewOBB} = \text{ProOBBed} - \text{CurrentOBBed}$$

Where:

NewOBBed = The number of new OB beds that can be established in a health planning district, if the number is positive. If NewOBBed is a negative number, no additional OB beds should be authorized for the health planning district.

ProOBBed = The projected number of OB beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentOBBed = The current inventory of licensed and authorized OB beds in the health planning district.

12VAC5-230-570. Expansion or relocation of services.

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:

1. Off-site replacement is necessary to correct life safety or building code deficiencies;
2. The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;
3. The number of beds to be moved off-site is taken out of service at the existing facility;
4. The off-site replacement of beds results in:
 - a. A decrease in the licensed bed capacity;
 - b. A substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or

- c. Generally improved operating efficiency in the applicant's facility or facilities; and
 - 5. The relocation results in improved distribution of existing resources to meet community needs.
- B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the site of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

12VAC5-230-580. Long-term acute care hospitals (LTACHs).

A. LTACHs will not be considered as a separate category for planning or licensing purposes. All LTACH beds remain part of the inventory of inpatient hospital beds.

B. A LTACH shall only be approved if an existing hospital converts existing medical/surgical beds to LTACH beds or if there is an identified need for LTACH beds [occupancy averaging at least 80% for LTACHs within the planning district for the most recently reported year by VHI] within a health planning district. New LTACH beds that would result in an increase in total licensed beds above 165% of the average daily census for the health planning district will not be approved. Excess Underutilized inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds.

C. If an existing or host hospital converts existing beds for use as LTACH beds, those beds must be delicensed from the bed inventory of the existing hospital. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of 12 months within its first year of operation, the beds delicensed by the host hospital to establish the LTACH shall revert back to that host hospital.

If the LTACH ceases operation in subsequent years of operation, the host hospital may reacquire the LTACH beds by obtaining a COPN, provided the beds are to be used exclusively for their original intended purpose and the application meets all other applicable project delivery requirements. Such an application shall not be subject to the standard batch review cycle and shall be processed as allowed under Part VI ([12VAC5-220-280](#) et seq.) of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

~~D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.~~

~~E. A LTACH shall be established for 10 or more beds.~~

F. A LTACH shall become certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital and shall not convert to ~~an acute care hospital for patients needing a length of stay of less than 25 days~~ without obtaining a certificate of public need.

~~1. If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after beginning operation, it may apply for a six-month extension of its COPN.~~

~~2. If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.~~

12VAC5-230-590. Staffing.

Inpatient services should be under the direction or supervision of one or more qualified physicians.

Progress Reports on Committees

- Neonatal Committee – Dr. Kathy Baker
- Medical Desert Committee – Ms. Karen Cameron

Expedited Review Process & Subcommittee Recommendation Summary

- *Proposed Recommendation on Expedited Review Process*

*****PLEASE NOTE this is proposed regulation currently under review*****

Project 8366 - Fast-Track

Fast Track Project - COPN Expedited Review Process

12VAC5-220-280. Applicability.

A. Capital expenditures as contained in subdivision 8 of "project" as defined in § 32.1-102.1 of the Code of Virginia or projects that involve relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another, when the cost of such relocation is less than \$5 million, shall be subject to an expedited review process.

B. The following projects shall also be subject to an expedited review process:

1. The establishment of a new medical care facility described in subdivision A 2 of § 32.1-102.1:3 by an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 6 of § 32.1-102.1:3, provided such new medical care facility is located in the same planning district as the existing medical care facility;

2. The addition of psychiatric beds at an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 5 of § 32.1-102.1:3, not to exceed 10 beds or 10 percent of all beds at the medical care facility, whichever is greater, and provided that the applicant has not been awarded a certificate for the addition of psychiatric beds pursuant to this provision in the previous two-year period;

3. The relocation of psychiatric beds to an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has had an existing certificate to introduce a psychiatric service for at least the previous 12 months pursuant to subdivision B 5 of § 32.1-102.1:3 and that is within the same planning district; and

4. Any capital expenditure of \$15 million or more, not defined as reviewable in subdivisions 1 through 7 of § 32.1-102.1:3, by or on behalf of a medical care facility described in subsection A other than a general hospital.

12VAC5-220-285. Ninety-Day Review Cycle.

A. The department shall review completed applications which qualify for expedited review pursuant to 12VAC5-220-280 in accordance with the following 90-day scheduled expedited review cycles.

Batch Group	Due Date for Complete Applications	Review Cycle	
		Begins	Ends
A	February 5	Feb. 10	May 10
B	May 7	May 12	Aug. 9
C	August 6	Aug. 11	Nov. 8
D	November 5	Nov. 10	Feb. 7

12VAC5-220-290. Application forms.

A. Obtaining application forms. Application forms for an expedited review shall be available from the department upon the request of the applicant. The department shall transmit application forms to the applicant within seven days of receipt of such request.

B. Application fees. The department shall collect application fees for applications that request a certificate of public need under the expedited review process. No application will be reviewed until the required application fee is paid as provided in 12VAC5-220-180 B.

C. Filing application forms. Complete applications for review under the expedited review process must be received by the Department and the appropriate regional health planning agency by the close of business at least five days before the start of the batch review cycle. All requests for a certificate of public need in accordance with the expedited review process shall be reviewed by the department and the regional health planning agency which shall each forward a recommendation to the commissioner within 40 60 days from the start date of the relevant batch cycle, after the submitted application has been deemed complete. No application for expedited review shall be reviewed until the application form has been received by the department and the appropriate regional health planning agency, has been deemed complete, and the application fee has been paid to the department. The

expedited review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12VAC5-220-285. If the application is not determined to be complete for the applicable batch cycle within five calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

12VAC5-220-300. Participation by other persons.

Any person directly affected by the review of a project under the expedited review process may submit written opinions, data and other information to the appropriate regional health planning agency and to the commissioner prior to their final action. Any member of the public may request a public hearing for an expedited application.

12VAC5-220-310. Action on application.

A. Decisions to approve any project under the expedited review process shall be rendered by the commissioner within 45 90 days of the start of the relevant batch review cycle. The commissioner may approve and issue a certificate for any project which is determined to meet the criteria for expedited review set forth in 12VAC5-220-280.

B. If the commissioner determines that a project does not meet the criteria for an expedited review set forth in 12VAC5-220-280, the applicant will be notified in writing of such determination within 45 90 days of the receipt of such request. In such cases, the department will forward the appropriate forms to the project applicant for use in filing an application for review of a project in the appropriate review cycle in accordance with Part V of this chapter.

C. Any project which does not qualify for an expedited review in accordance with 12VAC5-220-280, as determined by the commissioner, shall be exempted from the requirements of 12VAC5-220-180 A and B when such project is filed for consideration in accordance with Part V of this chapter.

Committee Recommendations

DIFSCOM Recommendations

PET Recommendations

- Maintain the following standards:

- 60-minute drive-time standard;
- Requirement that hospitals that have radiation therapy services have 850 PET-appropriate cases;
- 230 PET- or PET/CT-appropriate patients seen by mobile PET unit standard; and
- 1,400 procedures for conversion of mobile to fixed-site PET scanner standard.
- New fixed-site PET scanner and expansion of fixed-site PET services:
 - lower utilization from 6,000 procedures to 3,000 procedures
- Staffing standard: include individuals trained in the use of a PET scanner, which may include any of the professions listed in 18VAC85-101.

MRI Recommendations

- Maintain the following standards:
 - 30-minute drive-time standard
 - 2,400 procedure mobile MRI scanner standard
 - 3,000 procedures for conversion of a mobile MRI to a fixed-site scanner standard
- New fixed-site MRI scanners: lower from 5,000 procedures to 4,500.
- Expansion of fixed-site MRI scanner: lower from 5,000 procedures to 4,500.
- Staffing standard: include individuals trained in the use of a MRI scanner.

CT Recommendations

- Maintain the following standards:
 - 30-minute drive-time standard.
 - 7,400 average scan standards for new or expanded fixed site service.
 - Volume exemption for simulation of radiation therapy treatment.

- 4,800 average scan standards for mobile CT scanner standards for addition of services.
- 6,000 average scan standards for conversion of mobile to fixed site CT scanner.
- Expand volume exemption to operating room-based CT scanners and image guided procedures.
- Change staffing standard to include individuals trained in the use of a CT scanner, which may include any of the professions listed in 18VAC85-101.
- Specify definitions of scan, visit, institutional need, and site of service in the SHSP.

GENHOSP Recommendations

- Maintain the following standards:
 - 30-minute drive-time standard
 - Need for medical/surgical bed standard
 - Need for ICU beds
 - Expansion or relocation of services
 - Staffing
- Change occupancy for pediatric (ped) beds to 65%; added obstetric beds (OB) at 70%
- Removed the capital expenditure section
- Changed the calculation $\text{ProPedBed} = ((\text{PBUR} \times \text{ProPedPop})/365)$ /from 0.80 to 0.65
- Added a new standard for the projected need for OB beds
- Added an occupancy averaging at least 80% for long-term acute care hospitals (LTACHs) within the planning district for the most recently reported year by VHI
 - Changed “excess” to “underutilized” inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds

- Removed Subsection D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.
- Removed Subsection E. A LTACH shall be established for 10 or more beds.
- Removed 1 from subsection F, If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after beginning operation, it may apply for a six-month extension of its COPN.
- Removed 2 from subsection F, If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.

NHCOM Recommendations

Nursing Home Beds

- Maintain the following standards set in the State Medical Facilities Plan:
 - 30-minute drive-time one way under normal conditions to 95% of the population in a health planning district using mapping software as determined by the commissioner
 - Nursing facilities should be accessible by public transportation when such systems exist in an area;
 - Preference may be given to proposals that improve geographic access and reduce travel time to nursing facilities within a health planning district.
- Change standard for need for new service under the planning district bed need from “most recent” to “annual” nursing home patient origin study, which will no longer be authorized by VHI.
- Special recommendations to include:
 - 610: The Office of Licensure and Certification should develop a set of data elements to be provided by licensees contemporaneously with license renewal applications, in order to operationalize 12VAC5-230-610.

- 630: The Task Force should recommend to the Board of Health that it direct the Virginia Department of Health to consider a legislative proposal for General Assembly 2027 to amend the Code of Virginia to limit to three years from initial licensure date the allowance of open admissions.

- "Outpatient" means a patient who visits a hospital, clinic, or associated medical care facility for diagnosis or treatment, but is not admitted as an inpatient.

OHTC Recommendations

Criteria and Standards for Open Heart Surgery

New definitions

- **"Open heart surgery"** means a surgical procedure requiring the use or immediate availability of a heart-lung bypass machine or "pump." The use of the pump during the procedure distinguishes "open heart" from "closed heart" surgery. Open heart surgery is defined by the following APR-DRGs:
 - 160 Major Cardiothoracic Repair of Heart Anomaly
 - 161 Implantable Heart Assist Systems
 - 162 Cardiac Valve Procedures with AMI or Complex Procedure
 - 163 Cardiac Valve Procedures without AMI or Complex Procedure
 - 165 Coronary Bypass with AMI or Complex Procedure
 - 166 Coronary Bypass without AMI or Complex Procedure
 - 167 Other Cardiothoracic & Thoracic Vascular Procedures

when writing regulatory language, note that the APR-DRG codes will remain the same; however, the description language may vary

- Maintain the following standards set in the State Medical Facilities Plan:
 - Maintain travel time
 - Staffing

- Need for new service

- Replaced “procedure” with “cases” as weighted measurement
- Expansion of service
 - Proposals to expand open heart surgery shall demonstrate that existing cardiac surgery operating rooms have performed 1,600 hours of service hours per cardiac operating room per year for the most recent year cardiac surgery operating rooms have been reported by VHI.
 - Available service hours per operating room per year includes operating hours and prep and cleanup hours and is based on 80% utilization of an operating room available 40 hours per week, 50 weeks per year.

Criteria and Standards for Organ Transplant

New definitions

- **“Maturity”** means the minimum number of transplants would be performed in the third full year of operation.

Transplant volumes; survival rates; service proficiency; systems operations

- Proposals to demonstrate (updated totals # vs %)

Kidney	30
Pancreas or kidney/pancreas	6
Heart	17
Heart/Lung	6
Lung	12
Liver	21
Intestine	2

- Proposed new language, “Applicants shall demonstrate that they will achieve and maintain one-year survival rates equal to or higher to the most recent Tier III performance of the Scientific Registry of Transplant Recipients”

- **Criteria and Standards for Cardiac Catheterization**
 - Replaced procedures with “DEP”
- **Nonemergent cardiac catheterization**
 - Remove current number 7 Provide PCI 24 hours a day, seven days a week;
 - Add Subsection B. Preference shall be given to programs which provide PCI 24 hours a day, seven days a week;

OSHORA Recommendations

- Maintain the following standards set in the State Medical Facilities Plan:
 - Surgical services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the health planning district using mapping software as determined by the commissioner.

New definitions

- "Inpatient" means a patient who is hospitalized longer than 24 hours for health or health related services pursuant to an order issued by or under direction of a physician.

RADCOM Recommendations

Radiation Therapy

- Maintain the following standards set in the State Medical Facilities Plan:
- Radiation therapy services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the planning district using a mapping software as determined by the commissioner.
- A. No new radiation therapy service should be approved unless:
 - Existing radiation therapy machines located in the planning district exceed an average of 7,200 ESTVs per existing and approved radiation therapy machine in the relevant reporting period; and

- The new service will perform at least 4,500 ESTVs by the second year of operation without significantly reducing the utilization of existing providers in the planning district.

Standardized unit of measurement

Equivalent Simple Treatment Visit or “ESTV” means a standardized unit used to measure radiation therapy workload across different treatment types and different treatment complexities. One ESTV equals a simple treatment visit, which is 15 minutes. ESTVs are used for weighing the relative value of various radiation therapy procedures as follows:

Simple Radiation Treatment	One ESTV
Verification Simulation	One ESTV
Intensity Modulated Radiation Therapy (IMRT)	One ESTV
Inpatient simple radiation treatment	Two ESTVs
SRS or SRT on a non-dedicated linear accelerator	Two ESTVs
SRS or SRT on a dedicated machine, such as <u>Cyberknife</u> or Gamma Knife®	Three ESTVs
Proton Therapy	Two ESTVs
Complex Radiation Treatment (includes but is not limited to, treatment involving anesthesia, Total Body Irradiation (TBI), <u>Hemibody Irradiation (HBI)</u> , Total skin	Four ESTVs

SIMCOM Recommendations

ICF/IIDs

- Maintain the following standards set in the State Medical Facilities Plan:
 - Alternatives to proposed service are not available in the service area;
 - Documented source of referrals for the proposed new facility;
 - Continuum of care standard;

- Distinct factors affecting access to care that require development of a new ICF/IID;
 - Alternatives to creating a new ICF/IID consistent with the Medicaid waiver program considered;
 - Ancillary and supportive services needed for the new facility are available;
 - Service alternatives for residents of the proposed new facility are available;
 - Transfer agreement for emergencies; and
 - ICF/IIDs meet licensure standards from DBHDS.
- Change standard that new facility will have a maximum of 12 beds as consistent with DBHDS regulations.

Medical Rehabilitation Services

- Maintain the following standards set in the State Medical Facilities Plan:
 - 60-minute drive-time standard;
 - Formula and standard for determination of need for medical rehabilitation beds;
 - 80% utilization standard for expansion of services for medical rehabilitation beds;
 - Standard of demonstrating need and that service does not exist in planning district;
 - Preference for expansion by conversion of underutilized medical/surgical beds; and
 - Physician staffing standard.

