MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF NEED (CON) PROGRAM

ANNUAL ACTIVITY REPORT

October 2022 through September 2023
(FY2023)

Michigan Department of Health & Human Services

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EXECUTIVE SUMMARY

One of the Michigan Department of Health and Human Services (MDHHS or Department) duties under Part 222 of the Public Health Code, MCL 333.22221(b), is to report to the Certificate of Need (CON) Commission annually on the Department's performance under this Part. This is the Department's 35th report to the Commission and covers the period beginning October 1, 2022, through September 30, 2023 (FY 2023). Data contained in this report may differ from prior reports due to updates subsequent to each report's publishing date.

Administration

The Department through its Policy, Planning and Operational Support Administration provides support for the CON Commission (Commission) and its Standard Advisory Committees (SACs). The Commission is responsible for setting review standards and designating the list of covered services. The Commission may utilize a SAC to assist in the development of proposed CON review standards, which consists of a 2/3 majority of experts in the subject area. Further, the Commission, if determined necessary, may submit a request to the Department to engage the services of consultants or request the Department to contract with an organization for professional and technical assistance and advice or other services to assist the Commission in carrying out its duties and functions.

The Department, through its CON Evaluation Section, manages and reviews all incoming Letters of Intent, applications and amendments. These functions include determining if a CON is required for a proposed project as well as providing the necessary application materials, when applicable. In addition, the Section is responsible for monitoring implementation of approved projects, as well as the compliance with the terms and conditions of approvals.

During FY 2023, the Department has continued to make process improvements in both the Policy and Evaluation Sections.

The Evaluation Section worked with other Governmental agencies and health care organizations to appropriately review and expire previously approved Emergency CONs to assist health care providers statewide in planning and implementing the bed surge plans to adequately treat patients impacted by COVID-19 pandemic in Michigan. The Department also launched the recorded instructional aids for the Annual Survey online system to assist healthcare providers in understanding the survey reporting requirements and completing the health facility surveys. The Department completed statewide compliance review of all facilities providing CT scanner services. The Section also facilitated webinars to provide up-to-date information on revised CON standards, application processes and CON annual survey reporting requirements.

The Policy Section assisted the Commission to make the necessary modifications to the CON Review standards to better reflect practice, improve quality, and add clarity to the standards; modified and added definitions, updated requirements to easily initiate a mobile Magnetic Resonance Imaging (MRI) host site and expand fixed MRI services, and added provisions for hospital-based portable MRI in MRI Review Standards; during 2022 modified requirements to replace a Megavoltage Radiation Therapy (MRT) service to a new site in Rural/Micropolitan Counties, added language to provide equal additive factors for CT-guided MRT in MRT Review Standards that were in effect during FY2023; during 2022 modified requirements for movement of psychiatric beds being added under high occupancy provisions for Planning Areas meeting or exceeding the bed need, added an exception to initiate child/adolescent psychiatric beds for Planning Areas meeting or exceeding the bed need, and added comparative review criteria for bariatric rooms in Psychiatric Beds and Services Review Standards that were in effect during FY2023; revised methodology for computing Positron Emission Tomography (PET) data units and revised the initiation volume requirements for mobile and fixed sites in PET Review Standards; added language to clarify staffing requirements in Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services Review Standards.

The following CON Standards were reviewed during 2023 with an anticipated completion in FY2024: Open Heart Surgery (OHS), Megavoltage Radiation Therapy (MRT), Hospital Beds and Hospital Beds Rural Emergency Hospital (REH) Addendum, Psychiatric Beds and Services, Nursing Home and Hospital Long-Term-Care Unit Beds (NH-HLTCU), Computed Tomography (CT) Scanner Services, Air Ambulance Services deregulation; Surgical Services is being reviewed by a SAC, and Cardiac Catheterization Services will be reviewed by a SAC starting in FY2024.

CON Required

In accordance with MCL 333.22209, a person or entity is required to obtain a Certificate of Need, unless elsewhere specified in Part 222, for any of the following activities:

- Acquire an existing health facility or begin operation of a health facility.
- Make a change in the bed capacity of a health facility.
- Initiate, replace, or expand a covered clinical service.
- Make a covered capital expenditure.

CON Application Process

To apply for a CON, the following steps must be completed:

- Letter of Intent filed and processed prior to submission of an application.
- CON application filed on appropriate date as defined in the CON Administrative Rules
- Application reviewed by the Evaluation Section.
- Issuance of Proposed Decision by the Policy, Planning and Legislative Services Administration
    - Appeal if applicant disagrees with the Proposed Decision issued.
- Issuance of the Final Decision by the MDHHS Director.

There are three types of CON review: nonsubstantive, substantive individual, and comparative. The Administrative Rules for the CON program establish timelines by which the Department must issue a proposed decision on each CON application. The proposed decision for a nonsubstantive review must be issued within 45 days of the date the review cycle begins, 120 days for substantive individual, and 150 days for comparative reviews.

FY 2023 in Review

In FY 2023, there were 301 Letters of Intent received resulting in 195 applications filed for CON review and approval. In addition, the Department received 66 amendments to previously approved applications. In total, the Department approved 195 proposed projects resulting in approximately $953,233,474 of new capital expenditures into Michigan's healthcare system. The Department also surveyed 1,087 facilities and collected statistical data.

As required by Administrative Rules, the Department was timely in processing Letters of Intent, pending CON applications and issuing its decisions on pending applications. These measures, along with the other information contained in this report, aid the Commission in its duties as set forth in Part 222 of the Public Health Code.

During FY2023, the CON Commission revised the review standards for Magnetic Resonance Imaging (MRI), Megavoltage Radiation Therapy (MRT), Psychiatric Beds and Services, Positron Emission Tomography (PET), and Neonatal Intensive Care Services/Beds (NICU).

This report is filed by the Department in accordance with MCL 333.22221(f). The report presents information about the nature of these CON applications and decisions, as well as the Commission's actions during the reporting period. Several tables include benchmarks for timely processing of applications and issuing decisions as set forth in the CON Administrative Rules. Note that the data in the report represents some applications that were carried over from last fiscal year while others may be carried over into next fiscal year.

HISTORICAL OVERVIEW OF MICHIGAN'S CERTIFICATE OF NEED PROGRAM

1972 Legislation was introduced in the Michigan legislature to enact the Certificate of Need (CON) program. The Michigan CON program became effective on April 1, 1973.

1974 Congress passed the National Health Planning and Resources Development Act (PL 93-641) including funding incentives that encouraged states to establish a CON program. The purpose of the act was to facilitate recommendations for a national health planning policy. It encouraged state planning for health services, manpower, and facilities. And, it authorized financial assistance for the development of resources to implement that policy. Congress repealed PL 93-641 and certificate of need in 1986. At that time, federal funding of the program ceased and states became totally responsible for the cost of maintaining CON.

1988 Michigan's CON Reform Act of 1988 was passed to develop a clear, systematic standards development process and reduce the number of services requiring a CON.

Prior to the 1988 CON Reform Act, the Department found that the program was not serving the needs of the state optimally. It became clear that many found the process to be excessively unclear and unpredictable. To strengthen CON, the 1988 Act established a specific process for developing and approving standards used in making CON decisions. The review standards establish how the need for a proposed project must be demonstrated. Applicants know before filing an application what specific requirements must be met.

The Act also created the CON Commission. The CON Commission, whose membership is appointed by the Governor, is responsible for approving CON review standards. The Commission also has the authority to revise the list of covered clinical services subject to CON review. However, the CON sections inside the Department are responsible for day-to-day operations of the program, including supporting the Commission and making decisions on CON applications consistent with the review standards.

1993 Amendments to the 1988 Act required ad hoc committees to be appointed by the Commission to provide expert assistance in the formation of the review standards.

2002 Amendments to the 1988 Act expanded the CON Commission to 11 members, eliminated the previous ad hoc committees, and established the use of Standard Advisory Committees or other private consultants/organizations for professional and technical assistance.

Present The CON standards now allow applicants to reasonably assess requirements for approval, before filing an application. As a result, there are far fewer appeals of Department decisions. Moreover, the 1988 amendments appear to have reduced the number of unnecessary applications, i.e., those involving projects for which a need cannot be demonstrated.

The standards development process now provides a public forum and involves organizations representing purchasers, payers, providers, consumers, and experts in the subject matter. The process has resulted in CON review standards that are legally enforceable, while assuring that standards can be revised promptly in response to the changing healthcare environment.

ADMINISTRATION OF THE CERTIFICATE OF NEED PROGRAM

Commission The Commission is an 11-member body. The Commission, appointed by the Governor and confirmed by the Senate, is responsible for approving CON review standards used by the Department to make decisions on individual CON applications. The Commission also has the authority to revise the list of covered clinical services subject to CON review. Appendix I is a list of the CON Commissioners for FY2020.

NEWTAC The New Technology Advisory Committee is a standing committee responsible for advising the Commission on the new technologies, including medical equipment and services that have not yet been approved by the federal Food and Drug Administration for commercial use.

SAC A Standards Advisory Committee (SAC) may be appointed by and report to the CON Commission. The SACs advise the Commission regarding creation of, or revisions to the standards. The Committees are composed of a 2/3 majority of experts in the subject matter and include representatives of organizations of healthcare providers or professionals, purchasers, consumers, and payers.

MDHHS The Michigan Department of Health and Human Services is responsible for administering the CON program and providing staffing support for the Commission. This includes promulgating applicable rules, processing and rendering decisions on applications, and monitoring and enforcing the terms and conditions of approval. These functions are within the Policy and Legislative Administration.

Policy Section The Policy Section within the Administration provides professional and support staff assistance to the Commission and its committees in the development of new and revised standards. Staff support includes researching issues related to specific standards, preparing draft standards, and performing functions related to both Commission and Committee meetings.

Evaluation Section The Evaluation Section, also within the Administration, has operational responsibility for the program, including providing assistance to applicants prior to and throughout the CON process. The Section is responsible for reviewing all Letters of Intent and applications as prescribed by the Administrative Rules. Staff determines if a proposed project requires a CON. If a CON is required, staff identifies the appropriate application forms for completion by the applicant and submission to the Department. The application review process includes the assessment of each application for compliance with all applicable statutory requirements and CON review standards, and preparation of a Program Report and Finance Report documenting the analysis and findings. These findings are used by the Director to make a final decision to approve or deny a project.

In addition to the application reviews, the Section reviews requests for amendments to approved CONs as allowed by the Rules. Amendment requests involve a variety of circumstances, including changes in how an approved project is financed and authorization for cost overruns. The Section is also responsible for monitoring the implementation of approved projects, as well as the long-term compliance with the terms and conditions of approvals.

The Section also provides the Michigan Finance Authority (MFA) with information when healthcare entities request financing through MFA bond issues and Hospital Equipment Loan Program (HELP) loans. This involves advising on whether a CON is required for the item(s) that will be bond financed.

CERTIFICATE OF NEED PROCESS

The following discussion briefly describes the steps an applicant follows in order to apply for a Certificate of Need.

Letter of Intent — An applicant must file an LOI with the Department and, if applicable, the regional CON review agency. The CON Evaluation Section identifies for an applicant all the necessary application forms required based on the information contained in the LOI.

Application — On or before the designated application date, an applicant files an application with the Department and the regional review agency, if applicable. The Evaluation Section reviews an application to determine if it is complete. If not complete, additional information is requested. The review cycle starts after an application is deemed complete or received in accordance with the Administrative Rules.

Review Types and Time Frames — There are three review types: nonsubstantive, substantive individual and comparative. Nonsubstantive reviews involve projects such as replacement of covered equipment or changes in ownership that do not require a full review. Substantive individual reviews involve projects that require a full review but are not subject to comparative review as specified in the applicable CON review standards. Comparative reviews involve situations where two or more applicants are competing for a resource limited by a CON review standard, such as hospital and nursing home beds. The maximum review time frames for each review type, from the date an application is deemed complete or received until a proposed decision is issued, are: 45 days for nonsubstantive, 120 for substantive individual and 150 days for comparative reviews. The comparative review time frame includes an additional 30-day period for determining if a comparative review is necessary. Whenever this determination is made, the review cycle begins for comparative reviews.

Review Process — The Evaluation Section reviews the application. Each application is reviewed separately unless part of a comparative review. Each application review includes a program and finance report documenting the Department's analysis and findings of compliance with the statutory review criteria, as set forth in Section 22225 of the Public Health Code and the applicable CON review standards.

Proposed Decision — The Policy and Legislative Administration in which the Evaluation Section resides issues a proposed decision to the applicant within the required time frame. This decision is binding unless reversed by the Department Director or appealed by the applicant. The applicant must file an appeal within 15 days of receipt of the proposed decision if the applicant disagrees with the proposed decision or its terms and conditions. In the case of a comparative review, a single decision is issued for all applications in the same comparative group.

Final Decision — If the proposed decision is not appealed, a final decision is made by the Director of the Department in accordance with MCL 333.22231. If a hearing on the proposed decision is requested, the final decision by the Director is not issued until completion of the hearing and any filing of exceptions to the proposed decision by the Michigan Administrative Hearing System. A final decision by the Director may be appealed to the applicable circuit court.

LETTERS OF INTENT

The CON Administrative Rules, specifically Rule 9201, provides that Letters of Intent (LOI) must be processed within 15 days of receipt. Processing an LOI includes entering data in the management information system, verifying historical facility information, and obtaining proof of authorization to do business in Michigan. This information determines the type of review for the proposed project, and the Department then notifies the applicant of applicable application forms to be completed.

Table 1 provides an overview of the number of LOIs received and processed in accordance with the above-referenced Rule.

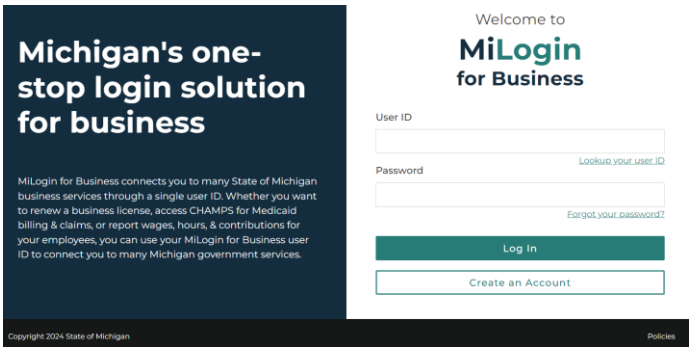
TABLE 1
LETTERS OF INTENT RECEIVED AND PROCESSED WITHIN 15 DAYS
FY2019 - FY2023

	LOIs Received	Processed within 15 Days	Percent Processed within 15 Days	Waivers Processed*
FY2019	365	363	99%	79
FY2020	420	418	99%	42
FY2021	396	394	99%	37
FY2022	292	288	99%	53
FY2023	301	301	100%	65

** Waivers are proposed projects that do not require CON review, but an LOI was submitted for Department's guidance/confirmation.*

In FY 2023, LOIs were processed in a timely manner as required by Administrative Rule and available for public viewing on the online application system. The online system allows for faster processing of LOIs and subsequent applications by the Evaluation Section, as well as modifying these applications by applicants when needed.

In 2006, Michigan became the first state to have an online application and information system. Today 100% of all LOIs and applicable applications are submitted online.



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TYPES OF CERTIFICATE OF NEED APPLICATION REVIEWS

The Administrative Rules also establish three types of project reviews: nonsubstantive, substantive individual, and comparative. The Rules specify the time frames by which the Bureau (Evaluation Section) must issue its proposed decision related to a CON application. The time allowed varies based on the type of review.

Nonsubstantive

Nonsubstantive reviews involve projects that are subject to CON review but do not warrant a full review. The following describes types of projects that are potentially eligible for nonsubstantive review:

- Acquire an existing health facility
- Replace a health facility within the replacement zone and below the covered capital expenditure
- Add a host site to an existing mobile network/route that does not require data commitments
- Replace or upgrade a covered clinical equipment
- Acquire or relocate an existing freestanding covered clinical service

The Rules allow the Bureau (Evaluation Section) up to 45 days from the date an application is deemed complete to issue a proposed decision. Reviewing these types of proposed projects on a nonsubstantive basis allows an applicant to receive a decision in a timely fashion while still being required to meet current CON requirements, including quality assurance standards.

Substantive Individual

Substantive individual review projects require a full review but are not subject to comparative review and not eligible for nonsubstantive review. An example of a project reviewed on a substantive individual basis is the initiation of a covered clinical service such as Computed Tomography (CT) scanner services. The Bureau (Evaluation Section) must issue its proposed decision within 120 days of the date a substantive individual application is deemed complete or received.

Comparative

Comparative reviews involve situations where two or more applications are competing for a limited resource such as hospital or nursing home beds. A proposed decision for a comparative review project must be issued by the Bureau (Evaluation Section) no later than 120 days after the review cycle begins. The cycle begins when the determination is made that the project requires comparative review. According to the Rules, the Department has the additional 30 days to determine if, in aggregate, all of the applications submitted on a window date exceed the current need. A comparative window date is one of the three dates during the year on which projects subject to comparative review must be filed. Those dates are the first working day of February, June, and October.

Section 22229 established the covered services and beds that were subject to comparative review. Pursuant to Part 222, the CON Commission may change the list subject to comparative review.

Figure 1 delineates services/beds subject to comparative review.

FIGURE 1 *Services/Beds Subject to Comparative Review in FY2023*	
Neonatal Intensive Care Unit	Nursing Home/HLTCU Beds
Hospital Beds	Nursing Home Beds for Special Population Groups
Psychiatric Beds	Psychiatric Beds for Special Population Groups
Transplantations	

Note: See individual CON review standards for more information.

Table 2 shows the number of applications received by the Department by review type.

TABLE 2
APPLICATIONS RECEIVED BY REVIEW TYPE
FY2019 - FY2023

	FY2019	FY2020	FY2021	FY2022	FY2023
Nonsubstantive*	132	118	191	146	113
Substantive Individual	72	80	84	78	79
Comparative	6	36	8	4	3
TOTALS	210	234	283	228	195

∗ Includes 1 swing bed application; does not include Emergency CONs.

Table 3 provides a summary of applications received and processed in accordance with Rule 9201. The Rule requires the Evaluation Section to determine if additional information is needed within 15 days of receipt of an application. Processing of applications includes: updating the management information system, verifying submission of required forms, and determining if other information is needed in response to applicable Statutes and Standards.

TABLE 3 *APPLICATIONS RECEIVED AND PROCESSED WITHIN 15 DAYS FY2019 - FY2023*					
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Applications Received	210	234	283	228	195
Processed within 15 Days	210	234	282	227	195
Percent Processed within 15 Days	100%	100%	99%	99%	100%

Note: Includes swing bed applications; does not include Emergency CONs.

Table 4 provides an overview of the average number of days taken by the Evaluation Section to complete reviews by type.

TABLE 4 *AVERAGE NUMBER OF DAYS IN REVIEW CYCLE BY REVIEW TYPE FY2019- FY2023*					
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Nonsubstantive	37	42	37	40	36
Substantive Individual	114	98	105	118	110
Comparative	94	112	227	113	148

Note: Average review cycle accounts for extensions requested by applicants.

EMERGENCY CERTIFICATES OF NEED

Table 5 shows the number of emergency CONs issued. The Department is authorized by Section 22235 of the Public Health Code to issue emergency CONs when applicable. Rule 9227 permits up to 10 working days to determine if an emergency application is eligible for review under Section 22235. Although it is not required by Statute, the Bureau (Evaluation Section) attempts to issue emergency CON decisions to the Director for final review and approval within 10 days from receipt of request. In FY2023 the Bureau issued the six (6) emergency CON decisions within an average of two (2) days.

TABLE 5 *EMERGENCY CON DECISIONS ISSUED FY2019 - FY2023*					
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Emergency CONs Issued	0	105	26	14	6*
Percent Issued within 10 Working Days	N/A	100%	100%	100%	100%

**Emergency CON - 1 application was submitted but withdrawn before a decision was to be issued.*

PROPOSED DECISIONS

Part 222 establishes a 2-step decision making process for CON applications that includes both a proposed decision and final decision. After an application is deemed complete and reviewed by the Evaluation Section, a proposed decision is issued by the Bureau (Evaluation Section) to the applicant and the Department Director according to the timeframes established in the Rules.

Table 6 shows the number of proposed decisions by type, issued within the applicable timeframes set forth in the Administrative Rules 325.9206 and 325.9207: 45 days for nonsubstantive, 120 days for substantive individual, and 150 days for comparative reviews, or any requested extension(s) to the review cycle.

TABLE 6 PROPOSED DECISIONS ISSUED FY2019- FY2023						
	Nonsubstantive		**Substantive Individual**		**Comparative**	
	Issued	Issued on Time	Issued	Issued on Time	Issued	Issued on Time
FY2019	123	100%	98	100%	4	100%
FY2020	119	100%	83	100%	34	100%
FY2021	173	100%	58	100%	34	100%
FY2022	149	100%	93	100%	4	100%
FY2023	116	100%	76	100%	3	100%

Table 7 compares the number of proposed decisions by decision type made.

TABLE 7 COMPARISON OF PROPOSED DECISIONS BY DECISION TYPE FY2019- FY2023					
	Approved	**Approved w/ Conditions**	**Disapproved**	**Percent Disapproved**	**TOTAL**
FY2019	162	62	2	0.8%	226
FY2020	156	64	16	7%	236
FY2021	150	92	29	9%	271
FY2022	150	92	3	1.22%	245
FY2023	159	35	1	0.5%	195

Note: Not all proposed decisions issued in a given year will have a final decision in the same year.

If a proposed decision is disapproved, an applicant may request an administrative hearing that suspends the time frame for issuing a final decision. After a proposed disapproval is issued, an applicant may also request that the Department consider new information. The Administrative Rules allow an applicant to submit new information in response to the areas of noncompliance identified by the Department's analysis of an application and the applicable Statutory requirements to satisfy the requirements for approval.

FINAL DECISIONS

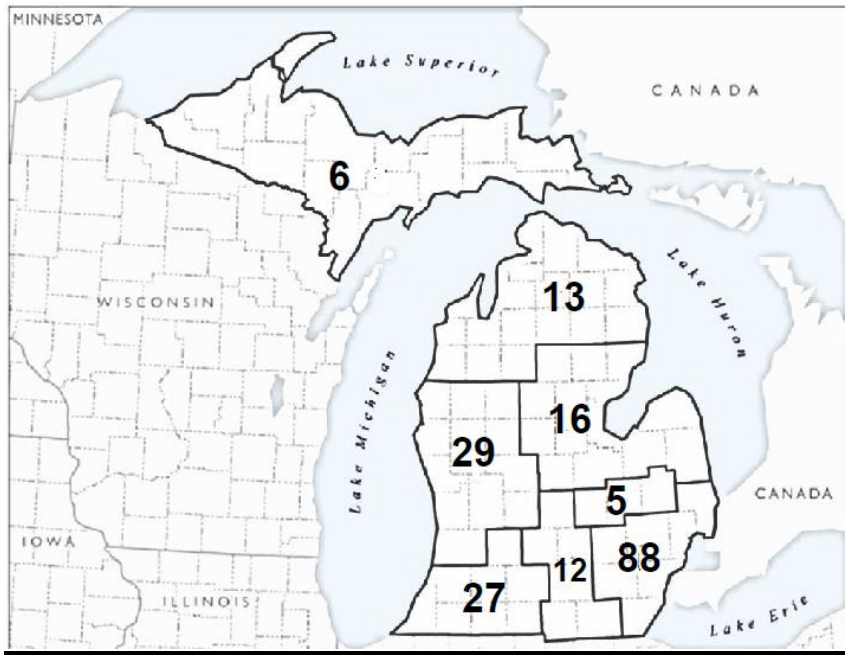
The Director issues a final decision on a CON application following either a proposed decision or the completion of a hearing, if requested, on a proposed decision. Pursuant to Section 22231(1) of the Public Health Code, the Director may issue a decision to approve an application, disapprove an application, or approve an application with conditions or stipulations. If an application is approved with conditions, the conditions must be explicit and relate to the proposed project. In addition, the conditions must specify a time period within which the conditions shall be met, and that time period cannot exceed one year after the date the decision is rendered. If approved with stipulations, the requirements must be germane to the proposed project and agreed to by the applicant.

This section of the report provides a series of tables summarizing final decisions for each of the review thresholds for which a CON is required. It should be noted that some tables will not equal other tables, as many applications fall into more than one category.

Table 8 and **Figure 2** display the number of final decisions issued.

TABLE 8 *FINAL DECISIONS ISSUED FY2019- FY2023*	
FY2019	224
FY2020	314
FY2021	287
FY2022	261
FY2023	198

FIGURE 2
FY 2023 FINAL DECISIONS ISSUED BY HEALTH SERVICE AREAS



Note: Figure 2 does not include 2 out-state decisions.

Table 9 summarizes final decisions by review categories defined in MCL 333.22209(1) and as summarized below:

Acquire, Begin Operation of, or Replace a Health Facility
Under Part 222, a health facility is defined as a general hospital, hospital long-term care unit, psychiatric hospital or unit, nursing home, freestanding surgical outpatient facility (FSOF), and health maintenance organization under limited circumstances. This category includes projects to construct or replace a health facility, as well as projects involving the acquisition of an existing health facility through purchase or lease.

Change in Bed Capacity
This category includes projects to increase in the number of licensed hospital, nursing home, or psychiatric beds; change the licensed use; and relocate existing licensed beds from one geographic location to another without an increase in the total number of beds.

Covered Clinical Services
This category includes projects to initiate, replace, or expand a covered clinical service: neonatal intensive care services, open heart surgery, extrarenal organ transplantation, extracorporeal shock wave lithotripsy, megavoltage radiation therapy, positron emission tomography, surgical services, cardiac catheterization, magnetic resonance imaging services, computed tomography scanner services, and air ambulance services.

Covered Capital Expenditures
This category includes capital expenditure projects in the clinical area of a licensed health facility that is equal to or above the threshold set forth in Part 222. Typical examples of covered capital expenditure projects include construction, renovation, or the addition of space to accommodate increases in patient treatment or care areas not already covered. In 2022, the covered capital expenditure threshold was $3,492,500 and as of January 1, 2023, the covered capital expenditure threshold was increased to $3,735,000. The threshold is updated in January of every year.

TABLE 9 *FINAL DECISIONS ACTIVITY CATEGORY FY2019 - FY2023*					
Approved	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Acquire, Begin, or Replace a Health Facility	27	36	43	50	29
Change in Bed Capacity	40	136	54	48	25
Covered Clinical Services	164	160	163	237	145
Covered Capital Expenditures	36	58	53	66	43
Disapproved					
Acquire, Begin, or Replace a Health Facility	2	2	23	1	0
Change in Bed Capacity	0	2	28	2	1
Covered Clinical Services	0	0	1	0	0
Covered Capital Expenditures	0	1	25	2	1

Note: Totals above may not match Final Decision totals because one application may include multiple categories.

Table 10 provides a comparison of the total number of final decisions and total project costs by decision type.

TABLE 10 *COMPARISON OF FINAL DECISIONS BY DECISION TYPE FY2019 - FY2023*				
	Approved	**Approved with Conditions**	**Disapproved**	**Totals**
Number of Final Decisions				
FY2019	162	62	2	226
FY2020	147	167	2	316
FY2021	168	90	29	287
FY2022	186	68	2	256
FY2023	162	35	1	198
Total Project Costs				
FY2019	$828,424,031	$494,288,355	$174,010,658	$1,496,723,044
FY2020	$2,023,996,054	$292,720,764	$22,323,062	$2,339,039,880
FY2021	$1,092,194,095	$288,134,537	$562,706,545	$1,943,035,177
FY2022	$1,220,532,622	$421,855,410	$43,388,140	$1,685,776,172
FY2023	$776,646,425	$176,587,049	$6,346,626	$959,580,100

Note: Final decisions include emergency CON applications.

In FY2023, one (1) CON application received final decision of disapproval from the Department. The project was to add 16 adult psychiatric beds to an approved-only new inpatient psychiatric hospital in Health Service Area - 4.

CERTIFICATE OF NEED ACTIVITY SUMMARY COMPARISON

Table 11 provides a comparison for various stages of the CON process.

TABLE 11 *CON ACTIVITY COMPARISON FY2019 - FY2023*				
	Number of Applications	**Difference from Previous Year**	**Total Project Costs**	**Difference from Previous Year**
Letters of Intent Processed				
FY2019	365	(8%)	$2,876,054,374	(8%)
FY2020	420	15%	$1,861,451,187	(35%)
FY2021	396	(6%)	$2,443,097,718	31%
FY2022	300	(24%)	$1,845,302,652	(24%)
FY2023	301	0.3%	$3,531,890,321	91%
Applications Submitted				
FY2019	212	(28%)	$1,237,316,450	(52%)
FY2020	339	61%	$2,507,922,695	3%
FY2021	309	(9%)	$1,703,931,501	(32%)
FY2022	255	(17%)	$2,321,037,942	36%
FY2023	201	(21%)	$1,159,033,442	(50%)
Final Decisions Issued				
FY2019	225	(18%)	$1,333,240,369	(43%)
FY2020	316	40%	$2,339,039,880	75%
FY2021	288	(9%)	$1,944,965,809	(17%)
FY2022	287	(.03%)	$2,517,447,509	29%
FY2023	198	(31%)	$960,425,600	(62%)

Note: Applications submitted, and final decisions Issued include Emergency CONs and swing bed applications.

AMENDMENTS

The Rules allow an applicant to request to amend an approved CON for projects that are not complete. The Department has the authority to decide when an amendment is appropriate or when the proposed change is significant enough to require a separate application. Typical reasons for requesting amendments include:

- **Cost overruns -** The Rules allow the actual cost of a project to exceed the approved amount by 15 percent of the first $1 million and 10 percent of all costs over $1 million. Fluctuations in construction costs can cause projects to exceed approved amounts.

- **Changes in the scope of a project -** An example is the addition of construction or renovation required by regulatory agencies to correct existing code violations that an applicant did not anticipate in planning the project or a change in covered clinical equipment.

- **Changes in financing -** Applicants may decide to pursue a financing alternative better than the financing that was approved in the CON.

- **Change in construction start date** – The Rules allow an Applicant to request an extension to start construction/renovation for an approved project.

Table 12 provides a summary of amendment requests received by the Department and the time required to process and issue a decision. Rule 9413 permits that the review period for a request to amend a CON-approved project be no longer than the original review period.

TABLE 12 *AMENDMENTS RECEIVED AND DECISIONS ISSUED FY2019 - FY2023*					
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Amendments Received	92	57	57	74	66
Amendment Decisions Issued	90	66	57	61	80
Percent Issued within Required Time Frame	100%	100%	100%	100%	100%

NEW CERTIFICATE OF NEED CAPACITY

Table 13 provides a comparison of existing covered services, equipment and facilities already operational to new capacity approved in FY 2023. Seventy-one (71) of the 198 CON approvals in FY 2023 were for new or additional capacity. The remaining approvals were for replacement equipment, relocation of existing services, acquisitions, renovations and other capital expenditures.

TABLE 13 *COVERED CLINICAL SERVICES AND BEDS FY2023*				
Covered Clinical Services/Beds	**Existing Sites**	**Existing Units/Beds**	**New Sites**	**New Units/Beds**
Air Ambulances	11	26	0	0
Cardiac Catheterization Services	56	232	1	3
Primary PCI	1	N/A	2	N/A
Elective PCI	15	N/A	1	N/A
Open Heart Surgical Services	*34	N/A	0	0
Surgical Services	273	1538	6	14
CT Scanners Services	247	389	12	10
MRI Services	343	257	8	8
PET Services	98	32	4	1
Lithotripsy Services	90	11	0	0
MRT Services	70	128	0	0
Transplant Services	6	N/A	0	N/A
Hospitals	160	24,869	1	0
NICU Services	21	653	0	1
SCN Services	14	111	0	0
Extended Care Services Program (Swing Beds)	43	403	1	10
Nursing Homes/HLTCU	440	45,285	3	153
Psychiatric Hospitals/Units	58	3,598	0	129
Psychiatric Flex Beds	4	62	0	10

Note: The source for the existing site and unit/bed information for Table 13 was the 2022 CON Annual Survey, and CON applications approved but not yet operational. Table 13 does not account for projects expired, facilities closed, and beds delicensed and returned to the various bed pools since the last survey period for CY 2023. New sites include LTAC Hospitals; mobile host sites for CT, Lithotripsy, MRI and PET services; & Psychiatric data includes special pool beds.

**One OHS hospital received approval to become a primary & elective PCI service provider without on-site OHS.*

COMPLIANCE ACTIONS

Table 14 shows there were 264 projects requiring follow-up for FY 2023 based on the Department's Monthly Follow-up/Monitoring Report as shown below.

TABLE 14 *FOLLOW UP AND COMPLIANCE ACTIONS FY2019 - FY2023*					
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Projects Requiring 1-yr Follow-up	226	225	314	261	264
Approved CONs Expired	83	87	95	62	204
Compliance Orders Issued	30	65	95	26	47

Note: CONs are expired due to non-compliance with terms and conditions of approval or when the recipient has notified the Department that either the approved-project was not implemented or the site is no longer providing the covered service/beds. Compliance Orders include orders issued by the Department under MCL 333.22247, settlement agreements offered or remedies for non-compliance. The Department completed statewide compliance review of all facilities providing Computed Tomography Scanner Services. In addition to the Compliance Orders Issued in the table above, the Department also issued eight (8) Compliance Letters in FY 2023. The Section also facilitated webinars to provide up-to-date information on revised CON standards, application processes and CON annual survey reporting requirements.

ANALYSIS OF CERTIFICATE OF NEED PROGRAM FEES AND COSTS

Section 20161(3) sets forth the fees to be collected for CON applications. Figure 3 shows the application fees based on total projects costs and additional fees per the new fee structure, effective October 15, 2013, approved under House Bill No. 4787.

FIGURE 3 *CURRENT CON APPLICATION FEES*	
Total Project Costs	**CON Application Fee**
$0 to $500,000	$3,000
$500,001 to $3,999,999	$8,000
$4,000,000 to $9,999,999	$11,000
$10,000,000 and above	$15,000
Additional Fee Category	**Additional Fee**
Complex Projects (i.e. Comparative Review, Acquisition or replacement of a licensed health facility with two or more covered clinical services.)	$3,000
Expedited Review - Applicant Request	$1,000
Letter of Intent (LOI) Resulting in a Waiver	$500
Amendment Request to Approved CON	$500
CON Annual Survey	$100 per Covered Clinical Service

Table 15A analyzes the number of applications by fee assessed.

TABLE 15A *NUMBER OF CON APPLICATIONS BY FEE FY2019 – FY2023*					
CON Fee	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**
*$ 0**	0	106	32	21	6
$3,000	76	78	84	77	81
$8,000	87	79	101	64	63
$11,000	23	25	58	36	21
$15,000	25	53	34	57	30
TOTAL	211	341	309	255	201

Note: Table 15A may not match fee totals in Table 16, as Table 16 accounts for refunds, overpayments, MFA funding, etc.

** No fees are required for emergency CON and swing beds applications.*

Table 15B analyzes the fees collected for the additional fee categories. More than one fee category may be assessed for one application.

TABLE 15B *NUMBER OF ADDITIONAL CON APPLICATION FEES FY2019 – FY2023*					
CON Fee Category	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**
Complex Project	5	36	7	5	5
Expedited Review	29	41	26	12	39
*LOI Waiver**	79	45	37	53	63
*Amendment**	92	57	57	74	66
Annual Survey (Facilities)	1066	1067	1094	1091	1087

**Note: Some waivers and amendments do not require a fee based on the type of change requested.*

Table 16 provides information on CON program costs and source of funds.

TABLE 16 *CON PROGRAM COST AND REVENUE SOURCES FOR FY2019– FY2023*					
	FY2019	**FY2020***	**FY2021**	**FY2022**	**FY2023**
Program Cost	$2,114,316	$2,109,705	$2,463,147	$2,348,344	$2,220,542
Fees/Funding	$1,990,861	$2,447,531	$2,520,217	$2,204,660	$1,953,109
Fees % of Costs	94%	100%+	100%+	94%	88%

Source: MDHHS Budget and Finance Administration.

**Under Public Act 169 of 2020, for the fiscal year ending September 30, 2020 only, $3,000,000 of the money in the Certificate of Need program was transferred to and deposited into the general fund.*

CERTIFICATE OF NEED COMMISSION ACTIVITY

During FY2023, the CON Commission revised and/or reviewed the CON Review Standards for Magnetic Resonance Imaging (MRI), Megavoltage Radiation Therapy (MRT), Psychiatric Beds and Services, Positron Emission Tomography (PET), Neonatal Intensive Care Services/Beds (NICU), Open Heart Surgery Services, Hospital Beds, Nursing Home and Hospital Long-Term-Care Unit Beds (NH-HLTCU), Computed Tomography (CT) Scanner Services, Air Ambulance Services, Surgical Services, and Cardiac Catheterization Services.

MRI

The revisions to the CON Review Standards for Magnetic Resonance Imaging (MRI) received final approval by the CON Commission on September 15, 2022 and were forwarded to the Governor and legislature. Neither Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective January 26, 2023. The final language changes include the following:

- 1. Section 2(1): Modified/added definitions as follows:
  - (h) “CRITICAL ACCESS HOSPITAL” OR “CAH” MEANS, A HOSPITAL DESIGNATED BY CMSPURSUANT TO 42 CFR 485.606.
  - (q) “HOSPITAL-BASED PORTABLE MRI” MEANS AN MRI UNIT THAT CAN BE TRANSPORTED INTO PATIENT CARE AREAS (E.G., DEDICATED NEUROSCIENCE UNIT,ICU, OPERATING ROOM) TO PROVIDE IMAGING OF THE BRAIN.
  - (mm) "Planning area" means
  - (i) in the case of a proposed fixed MRI service or unit, the geographic area within a 20-mile radius from the proposed site if the proposed site is not in a rural or micropolitan statistical area county and a 75-mile radius from the proposed site if the proposed site is in a rural or micropolitan statistical area county, OR IS DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH).
  - (ii) in the case of a proposed mobile MRI service or unit, except as provided in subsection (iii), the geographic area within a 20-mile radius from each proposed host site if the proposed site is not in a rural or micropolitan statistical area county and within a 75-mile radius from each proposed host site if the proposed site is in a rural or micropolitan statistical area county, OR IS DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH).
  - (oo) “REFERRING LICENSED HEALTHCARE PROFESSIONAL” MEANS:
  - (i) THE DOCTOR OF RECORD WHO ORDERED THE MRI PROCEDURE(S) AND EITHER TO WHOM THE PRIMARY REPORT OF THE RESULTS OF AN MRI PROCEDURE(S) IS SENT, OR IN THE CASE OF A TEACHING FACILITY, THE ATTENDING DOCTOR WHO IS RESPONSIBLE FOR THE HOUSE OFFICER OR RESIDENT THAT REQUESTED THE MRI PROCEDURE; OR
  - (ii) A NON-PHYSICIAN LICENSED HEALTHCARE PROFESSIONAL ACTING WITHIN THESCOPE OF THEIR PRACTICE.

- 2. Section 3(2): Updated requirements to initiate a fixed MRI service to include reduced emergency department visits required for an applicant hospital in a rural or micropolitan statistical area county or an applicant designated by CMS as a Critical Access Hospital:
  - (b) The applicant has received in aggregate, one of the following:
  - (i) At least 6,000 MRI adjusted procedures.

- (ii) At least 4,000 MRI adjusted procedures and the applicant meets all of the following:
- (A) Is located in a county that has no fixed MRI machines that are pending, approved by the Department, or operational at the time the application is deemed submitted.
- (B) The nearest fixed MRI machine is located more than 15 radius miles from the application site.
- (iii) At least 3,000 MRI adjusted procedures and the applicant meets all of the following:
- (A) The proposed site is a hospital licensed under Part 215 of the Code.
- (B) The applicant hospital operates an emergency room that provides 24-hour emergency care services and at least 20,000 visits IF LOCATED IN A METROPOLITAN STATISTICAL AREA COUNTY, OR 10,000 VISITS IF LOCATED IN A RURAL OR MICROPOLITAN STATISTICAL AREA OR IS DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH), within the most recent 12-month period for which data, verifiable by the Department, is available.

- 3. Section 3(4): Added requirement for applicants proposing to initiate host site on a new or existing mobile MRI service who currently operate an existing fixed MRI service. Also created exception for Critical Access Hospitals to allow same reduced adjusted procedures as applicants in rural/micropolitan statistical area counties:
  - (4) An applicant, whether the central service coordinator or the host site, proposing to initiate a host site on a new or existing mobile MRI service shall demonstrate the following, as applicable:
  - (a) 600 available MRI adjusted procedures, from within the same planning area as the proposed service/unit, for a proposed host site that is not located in a rural or micropolitan statistical area county, or
  - (b) 400 available MRI adjusted procedures from within the same planning area for a proposed host site that is located in a rural or micropolitan statistical area county, and
  - (c) The proposed host site has not received any mobile MRI service within the most recent 12-month period as of the date an application is submitted to the Department.
  - (d) AN APPLICANT THAT OPERATES AN EXISTING FIXED MRI SERVICE AND IS PROPOSING TO INITIATE A MOBILE MRI HOST SITE AT THE SAME SITE SHALL NOT BE REQUIRED TO PROJECT AVAILABLE ADJUSTED PROCEDURES IF IT MEETS THE FOLLOWING REQUIREMENTS:
  - (i) EACH MOBILE MRI SERVICE(S) THAT PROPOSES TO PROVIDE MOBILE MRI SERVICES TO THE APPLICANT'S SITE CURRENTLY SERVES AND WILL CONTINUE TO SERVE AT LEAST TWO MOBILE HOST SITES.

- 4. Section 4: Modified the replacement criteria for an existing MRI unit:
  - Sec. 4. Replace an existing MRI unit means (i) any equipment change involving a change in, or replacement of, the entire MRI unit resulting in an applicant operating the same number and type (fixed or mobile) of MRI units before and after project completion or (ii) the renewal of a lease. Replacement also means the relocation of an MRI service or unit to a new site. The term does not include the replacement of the MRI system magnet THAT IS under an existing service contract. The term does not include an upgrade to an existing MRI unit or repair of an existing MRI service or unit, and it does not include a host site that

proposes to receive mobile MRI services from a different central service coordinator if the requirements of Section 3(5) have been met.

- 5. Section 4(1): Modified the definition for “Upgrade an existing MRI unit”:
  - (1) "Upgrade an existing MRI unit" means any equipment change that does not involve a change in, or replacement of, the MRI SYSTEM MAGNET, does not result in an increase in the number of MRI units; or does not result in a change in the type of MRI unit (e.g., changing a mobile MRI unit to a fixed MRI unit).

- 6. Section 4(4): Added requirement for applicants proposing to replace an existing MRI host site to a new location to exclude those initiated under Section 3(4)(d), as these applicants are not required to project available adjusted procedures. Also created exception for Critical Access Hospitals to allow same radial distance requirements as applicants in rural/micropolitan statistical area counties:
  - (4) An applicant proposing to replace an existing mobile MRI host site to a new location shall demonstrate the following:
  - (a) The applicant currently operates the MRI mobile host site to be relocated.
  - (b) The MRI mobile host site to be relocated has been in operation as of the date an application is submitted to the Department.
  - (c) The proposed new site is within a 5-mile radius of the existing site for a metropolitan statistical area county or within a 10-mile radius for a rural or micropolitan statistical area county OR IS DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH).
  - (d) The relocation will not involve a change in the current central service coordinator unless the requirements of Section 3(5) are met.
  - (e) THE APPLICANT CONFIRMS THAT THE HOST SITE WAS NOT INITIATED UNDER SECTION 3(4)(d).

- 7. Section 5(1): Modified requirements for applicants proposing to expand an existing MRI service:
  - (1) An applicant shall demonstrate that the applicable MRI adjustable procedures are from the most recently published MRI Service Utilization List as of the date of an application is deemed submitted by the Department:
  - (a) Each existing MRI unit on the network has performed at least an average of 7,000 MRI adjusted procedures per MRI unit.
  - (b) Each existing fixed MRI unit at the current site has performed at least an average of 9,000 MRI adjusted procedures per MRI unit.
  - (c) Each existing dedicated pediatric MRI unit at the current site has performed at least an average of 3,500 MRI adjusted procedures per MRI unit.
  - (d) THE APPLICANT OPERATES BOTH A FIXED MRI AND MOBILE MRI HOST SITE AT THE SAME SITE; AND
  - (i) THE SITE COLLECTIVELY PERFORMED AT LEAST AN AVERAGE OF 9,000 MRI ADJUSTED PROCEDURES PER EXISTING FIXED MRI UNIT WHEN ITS FIXED AND MOBILE HOST SITE MRI ADJUSTED PROCEDURES ARE COMBINED.
  - (ii) IT IS PROPOSING TO CEASE OPERATION AS A HOST SITE AND NOT BECOME A HOST SITE FOR AT LEAST 12 MONTHS FROM THE DATE THE PROPOSED FIXED MRI UNIT BECOMES OPERATIONAL.

- 8. New Section 13: Added requirements for all applicants proposing to initiate, replace,

or acquire an FDA-approved hospital-based portable MRI unit:

- (1) AN APPLICANT IS LIMITED TO THE INITIATION, EXPANSION, REPLACEMENT, OR ACQUISITION OF NO MORE THAN TWO HOSPITAL-BASED PORTABLE MRI UNITS.
- (2) THE PROPOSED SITE IS A HOSPITAL LICENSED UNDER PART 215 OF THE CODE.
- (3) THE PROPOSED SITE HAS AN EXISTING FIXED MRI SERVICE THAT HAS BEEN OPERATIONAL FOR THE PREVIOUS 36 CONSECUTIVE MONTHS AND IS MEETING ITS MINIMUM VOLUME REQUIREMENTS.
- (4) THE APPLICANT HOSPITAL IS DESIGNATED AS A LEVEL I OR II TRAUMA FACILITY BY THE AMERICAN COLLEGE OF SURGEONS AND HAS BEEN CERTIFIED AS A COMPREHENSIVE STROKE CENTER BY THE JOINT COMMMISSION, THE ACCREDITATION COMMISSION FOR HEALTH CARE, INC., OR DET NORSKE VERITAS OR HAS CARED FOR MORE THAN 500 ACUTE STROKE PATIENTS IN THE MOST RECENT 12-MONTH PERIOD IF LOCATED IN A METROPOLITAN COUNTY OR 300 ACUTE STROKE PATIENTS IN THE MOST RECENT 12-MONTH PERIOD IF LOCATED IN A RURAL OR MICROPOLITAN COUNTY.
- (5) THE APPLICANT AGREES TO OPERATE THE FDA-APPROVED HOSPITAL-BASED PORTABLE MRI UNIT IN ACCORDANCE WITH ALL APPLICABLE PROJECT DELIVERY REQUIREMENTS SET FORTH IN SECTION 15 OF THESE STANDARDS.
- (6) THE AUTHORIZED FDA-APPROVED HOSPITAL-BASED PORTABLE MRI UNIT WILL NOT BE SUBJECT TO MRI VOLUME REQUIREMENTS.
- (7) THE APPLICANT MAY NOT UTILIZE MRI PROCEDURES PERFORMED ON AN FDA-APPROVED HOSPITAL-BASED PORTABLE MRI UNIT TO DEMONSTRATE NEED OR TO SATISFY MRI CON REVIEW STANDARDS REQUIREMENTS.

- 9. Section 15(4): Modified/added monitoring and reporting requirements. Also created exception for Critical Access Hospitals to allow same reduced annual utilization as applicants in rural/micropolitan statistical area counties:
  - (a) MRI units shall be operating at a minimum average annual utilization during the second 12 months of operation, and annually thereafter, as applicable:
  - (i) 5,000 MRI adjusted procedures per unit for fixed MRI services unless compliant with (A), (B) OR (C),
  - (A) 4,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(ii) and is the only fixed MRI unit at the current site,
  - (B) 3,000 MRI adjusted procedures for the fixed MRI unit initiated pursuant to Section 3(2)(b)(iii) and is the only fixed MRI unit at the hospital site licensed under part 215 of the code,
  - (C) 2,000 MRI ADJUSTED PROCEDURES PER UNIT PER YEAR FOR MRI SERVICES WITH ONE FIXED UNIT LOCATED OUTSIDE THE 20-MILE RADIUS FROM THE NEXT CLOSEST FIXED MRI SERVICE.
  - (ii) 3,500 MRI adjusted procedures per unit for mobile MRI services.
  - (iii) 3,500 MRI adjusted procedures per unit for dedicated pediatric MRI units.
  - (iv) Each mobile host site in a rural or micropolitan statistical area county OR DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH), shall have provided at least a total of 400 adjusted procedures during its second 12 months of operation, and annually thereafter, from all mobile units providing services to

the site. Each mobile host site not in a rural or micropolitan statistical area county shall have provided at least a total of 600 adjusted procedures during its second 12 months of operation and annually thereafter, from all mobile units providing services to the site.
    - (v) In meeting these requirements, an applicant shall not include any MRI adjusted procedures performed on an MRI unit used exclusively for research and approved pursuant to Section 7 or for an IMRI unit approved pursuant to Section 9.

- 10. New Section 15(7): Added monitoring and reporting requirements for applicants approved under Section 3(4)(d):
    - (7) AN APPLICANT APPROVED UNDER SECTION 3(4)(d) SHALL AGREE THAT THE SERVICES PROVIDED BY THE MOBILE MRI SERVICE(S) ARE DELIVERED IN COMPLIANCE WITH THE FOLLOWING TERMS:
    - (a) EACH MOBILE MRI SERVICE(S) THAT PROVIDES MOBILE MRI SERVICES TO THE APPLICANT'S SITE ALSO SERVES AND WILL CONTINUE TO SERVE AT LEAST TWO MOBILE HOST SITES.

- 11. New Section 15(8): Added monitoring and reporting requirements for applicants approved under Section 13:
    - (8) AN APPLICANT APPROVED UNDER SECTION 13 SHALL BE IN COMPLIANCE WITH THE FOLLOWING:
    - (a) THE FDA-APPROVED HOSPITAL-BASED PORTABLE MRI UNIT CAN ONLY BE USED BY A QUALIFYING PROGRAM FOR BRAIN SCANNING OF PATIENTS BEING TREATED IN A DEDICATED NEUROSCIENCE UNIT, AN ADULT OR PEDIATRIC INTENSIVE CARE UNIT (ICU) AND/OR AN OPERATING ROOM.
    - (b) THE APPROVED APPLICANT MUST HAVE AN INSTITUTIONAL MRI SAFETY COMMITTEE.
    - (c) THE APPROVED APPLICANT MUST PROVIDE ANNUAL REPORTS TO THE DEPARTMENT BY APRIL 30TH OF EACH YEAR FOR THE PRECEDING CALENDAR YEAR, WHICH INCLUDE AT LEAST ALL OF THE FOLLOWING VISITS PERFORMED ON THE FDA-APPROVED HOSPITAL-BASED PORTABLE MRI UNIT:
    - (i) NUMBER OF ADULT VISITS (AGE >= 18).
    - (ii) NUMBER OF PEDIATRIC VISITS (AGE < 18).
    - (iii) NUMBER OF VISITS PERFORMED IN AN ICU.
    - (iv) NUMBER OF VISITS PERFORMED IN A DEDICATED NEUROSCIENCE UNIT.
    - (v) NUMBER OF VISITS PERFORMED IN AN OPERATING ROOM.

- 12. Section 16(1): Modified added values for MRI procedures on a sedated patient:
    - (d) For each MRI procedure performed on a sedated patient:
    - (i) 0.75 SHALL BE ADDED TO THE BASE VALUE FOR CONSCIOUS SEDATION; OR,
    - (ii) 1.50 SHALL BE ADDED TO THE BASE VALUE FOR GENERAL ANESTHESIA OR DEEP SEDATION AS DEFINED BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS.

- 13. Section 16(2): Modified to include exception for Critical Access Hospitals:
    - (a) For a site located in a rural or micropolitan statistical area county, OR A SITE

DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH), the number of MRI adjusted procedures shall be multiplied by a factor of 1.4.

- (b) For a mobile MRI unit that serves hospitals and other host sites located in rural, micropolitan statistical area, and metropolitan statistical area counties, the number of MRI adjusted procedures for a site located in a rural or micropolitan statistical area county, OR A SITE DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH), shall be multiplied by a factor of 1.4 and for a site located in a metropolitan statistical area county, the number of MRI adjusted procedures shall be multiplied by a factor of 1.0.
- (c) For a mobile MRI unit that serves only sites located in rural or micropolitan statistical area counties, OR A SITE(S) DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AS A CRITICAL ACCESS HOSPITAL (CAH), the number of MRI adjusted procedures shall be multiplied by a factor of 2.0.

- 14. Section 18: Revise appearance of “doctor” to “LICENSED HEALTHCARE PROFESSIONAL”:
  - (1)(c) Determine the number of available MRI adjusted procedures that each referring LICENSED HEALTHCARE PROFESSIONAL may commit from each service to an application in accordance with the following:
  - (ii) For each LICENSED HEALTHCARE PROFESSIONAL referring to that existing service, multiply the number of actual MRI adjusted procedures that the referring LICENSED HEALTHCARE PROFESSIONAL made to the existing MRI service by the applicable proportion obtained by the calculation in subdivision (c)(i).
  - (A) For each LICENSED HEALTHCARE PROFESSIONAL, subtract any available adjusted procedures previously committed. The total for each LICENSED HEALTHCARE PROFESSIONAL cannot be less than zero.
  - (B) …
  - (iii) For each MRI service, the available MRI adjusted procedures resulting from the calculation in (c)(ii) above shall be sorted in descending order by the available MRI adjusted procedures for each LICENSED HEALTHCARE PROFESSIONAL. Then any duplicate values shall be sorted in descending order by the LICENSED HEALTHCARE PROFESSIONAL’S license numbers (last 6 digits only).
  - (iv) Using the data produced in (c)(iii) above, sum the number of available adjusted procedures in descending order until the summation equals at least 75 percent of the total available adjusted procedures. This summation shall include the minimum number of LICENSED HEALTHCARE PROFESSIONALS necessary to reach the 75 percent level.
  - (v) For the LICENSED HEALTHCARE PROFESSIONALS representing 75 percent of the total available adjusted procedures in (c)(iv) above, sum the available adjusted procedures.
  - (vi) For the LICENSED HEALTHCARE PROFESSIONALS used in subsection (c)(v) above, divide the total number of available adjusted procedures identified in (c)(ii)(B) above by the sum of those available adjusted procedures produced in (c)(v) above.
  - (vii) For only those LICENSED HEALTHCARE PROFESSIONALS identified in (c)(v) above, multiply the result of (c)(vi) above by the available adjusted

procedures calculated in (c)(ii)(A) above.
    - (viii) …
    - (2) After publication of the "Available MRI Adjusted Procedures List" resulting from (1) above, the data shall be updated to account for a) LICENSED HEALTHCARE PROFESSIONAL commitments of available MRI adjusted procedures in subsequent MRI CON applications and b) MRI adjusted procedures used in subsequent MRI CON applications received in which applicants apply for fixed MRI services pursuant to Section 3(2).
- 15. Section 19: Revise appearance of “doctor” to “LICENSED HEALTHCARE PROFESSIONAL”:
    - (2)(a) At the time the application is submitted to the Department, the applicant shall submit a signed data commitment on a form provided by the Department in response to the applicant’s letter of intent for each LICENSED HEALTHCARE PROFESSIONAL committing available MRI adjusted procedures to that application for a new MRI unit that requires LICENSED HEALTHCARE PROFESSIONAL commitments.
    - (b) An applicant also shall submit, at the time the application is submitted to the Department, a computer file that lists, for each MRI service from which data are being committed to the same application, the name and license number of each LICENSED HEALTHCARE PROFESSIONAL for whom a signed and dated data commitment form is submitted.
    - (i) …
    - (ii) If the LICENSED HEALTHCARE PROFESSIONAL commitments submitted on the Departmental forms do not agree with the data on the computer file, the applicant shall be allowed to correct only the computer file data which includes adding LICENSED HEALTHCARE PROFESSIONAL commitments that were submitted at the time of application. (c) If the required documentation for the LICENSED HEALTHCARE PROFESSIONAL commitments submitted under this subsection is not submitted with the application on the designated application date, the application will be deemed submitted on the first applicable designated application date after all required documentation is received by the Department.
    - (4) …
    - (a) A committing LICENSED HEALTHCARE PROFESSIONAL certifies that 100% of his or her available MRI adjusted procedures for each specified MRI service, calculated pursuant to Section 18, is being committed and specifies the CON application number for the MRI unit to which the data commitment is made. A LICENSED HEALTHCARE PROFESSIONAL shall not be required to commit available MRI adjusted procedures from all MRI services to which his or her patients are referred for MRI services but only from those MRI services specified by the LICENSED HEALTHCARE PROFESSIONAL in the data commitment form provided by the Department and submitted by the applicant in support of its application.
    - (b) A committing LICENSED HEALTHCARE PROFESSIONAL certifies ownership interest, either direct or indirect, in the applicant entity. Indirect ownership includes ownership in an entity that has ownership interest in the applicant entity. This requirement shall not apply if the applicant entity is a group practice of which the committing LICENSED HEALTHCARE PROFESSIONAL is a member. Group practice means a group practice as defined pursuant to the provisions of 42 U.S.C. 1395nn (h)(4), commonly known as Stark ii, and the Code of Federal Regulations, 42 cfr, Part 411, published in the Federal Register on August 14, 1995, or its replacement.

- (c) A committing LICENSED HEALTHCARE PROFESSIONAL certifies that he or she has not been provided, or received a promise of being provided, a financial incentive to commit any of his or her available MRI adjusted procedures to the application.
- (5)(a) The Department shall not consider a data commitment from a LICENSED HEALTHCARE PROFESSIONAL for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support approval of an application for a new MRI unit, pursuant to Section 3, for which a final decision to approve has been issued by the Director of the Department until either of the following occurs:
- (i) …
- (ii) …
- (b) The Department shall not consider a data commitment from a LICENSED HEALTHCARE PROFESSIONAL for available MRI adjusted procedures from a specific MRI service if the available MRI adjusted procedures from that specific MRI service were used to support an application for a new fixed or mobile MRI unit pursuant to Section 3, for which a final decision to disapprove was issued by the Director of the Department until either of the following occurs:
- (i) …
- (ii) …
- (6) The Department shall not consider a data commitment from a committing LICENSED HEALTHCARE PROFESSIONAL for available MRI adjusted procedures from the same MRI service if that LICENSED HEALTHCARE PROFESSIONAL has submitted a signed data commitment, on a form provided by Department, for more than one (1) application for which a final decision has not been issued by the Department. If the Department determines that a LICENSED HEALTHCARE PROFESSIONAL has submitted a signed data commitment for the same available MRI adjusted procedures from the same MRI service to more than one CON application pending a final decision for a new fixed or mobile MRI unit or additional mobile MRI unit pursuant to Section 3, the Department shall,
- (a) if the applications were submitted on the same designated application date, notify all applicants, simultaneously and in writing, that one or more LICENSED HEALTHCARE PROFESSIONAL(S) have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the LICENSED HEALTHCARE PROFESSIONALS' data from the same MRI service shall not be considered in the review of any of the pending applications submitted on the same designated application date until the LICENSED HEALTHCARE PROFESSIONAL notifies the Department, in writing, of the one (1) application for which the data commitment shall be considered.
- (b) if the applications were submitted on different designated application dates, consider the data commitment in the application submitted on the earliest designated application date and shall notify, simultaneously in writing, all applicants of applications submitted on designated application dates subsequent to the earliest date that one or more committing LICENSED HEALTHCARE PROFESSIONAL(S) have submitted data commitments for available MRI adjusted procedures from the same MRI service and that the LICENSED HEALTHCARE PROFESSIONALS' data shall not be considered in the review of the application(s) submitted on the subsequent designated application date(s).
- (7) The Department shall not consider any data commitment submitted by an applicant after the date an application is deemed submitted unless an applicant is

notified by the Department, pursuant to subsection (6), that one or more committing LICENSED HEALTHCARE PROFESSIONAL(S) submitted data commitments for available MRI adjusted procedures from the same MRI service. If an applicant is notified that one or more LICENSED HEALTHCARE PROFESSIONALS' data commitments will not be considered by the Department, the Department shall consider data commitments submitted after the date an application is deemed submitted only to the extent necessary to replace the data commitments not being considered pursuant to subsection (6).
    - (a) The applicant shall have 30 days to submit replacement of LICENSED HEALTHCARE PROFESSIONAL commitments as identified by the Department in this Section.
    - (9) The Department shall consider a withdrawal of a signed data commitment if a committing LICENSED HEALTHCARE PROFESSIONAL submits a written notice to the Department before the application is deemed submitted, that specifies the CON application number and the specific MRI services for which a data commitment is being withdrawn.

- 16. New Section 19(3): Added exception criteria for Section 19(2) for projects involving mobile MRI host sites approved under Section 3(4)(d):
    - (3) SUBSECTION 19(2) SHALL NOT APPLY IF THE PROPOSED PROJECT INVOLVES THE INITIATION OF A MOBILE MRI HOST SITE UNDER SECTION 3(4)(d) IF THE MOBILE MRI HOST SITE WILL BE AT THE SAME SITE AS A FIXED MRI SERVICE AND THE HOST SITE WILL BE OWNED BY THE SAME APPLICANT ENTITY AS THE FIXED MRI SERVICE.

- 17. Section 20: Revise appearance of "doctor" to "LICENSED HEALTHCARE PROFESSIONAL":
    - (1) …
    - (a) …
    - (b) …
    - (ii) The name, address, and license number of each referring LICENSED HEALTHCARE PROFESSIONAL, identified in Section 18(1)(c)(v), whose patients received MRI services at that MRI service; and
    - (iii) The number of available MRI adjusted procedures performed on patients referred by each referring LICENSED HEALTHCARE PROFESSIONAL, identified in Section 18(1)(c)(v), and if any are committed to an MRI service. This number shall be calculated in accordance with the requirements of Section 18(1). A referring LICENSED HEALTHCARE PROFESSIONAL may have fractional portions of available MRI adjusted procedures.
    - (c) …
    - (d) The Department shall not be required to publish a list that sorts MRI database information by referring LICENSED HEALTHCARE PROFESSIONAL, only by MRI service.

- 18. Other technical edits.

MRT

The revisions to the CON Review Standards for Megavoltage Radiation Therapy (MRT) received final approval by the CON Commission on December 8, 2022 and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective January 26, 2023. The final language

changes include the following:

- 1. Section 4(2): Modify requirements to replace an MRT service to a new site to allow applicants in rural or micropolitan statistical area counties the same reduced equivalent treatment visits as those approved under Section 3(3):
    - (2) An applicant proposing to replace an existing MRT service to a new site shall demonstrate the following:
    - (a) The proposed site is within the same planning area as the existing MRT service site.
    - (b) The existing MRT unit(s) shall be operating at the following volumes, as applicable to the proposed project:
    - (i) Non-special MRT unit(s) at 8,000 equivalent treatment visits per unit or 5,500 for a unit EITHER approved under Section 3(2) or 3(3) OR LOCATED IN A RURAL OR MICROPOLITAN STATISTICAL AREA COUNTY.
    - (ii) HMRT unit(s) AT 8,000 equivalent treatment visits per unit.
    - (iii) Special purpose unit(s) at 1,000 equivalent treatment visits per unit.

- 2. Section 10(4): Add language to provide additive factor to visit weight for CT-guided real time tracking radiation without adaptive and CT-guided real time tracking with adaptive:
    - CT-GUIDED REAL TIME TRACKING RADIATION W/O ADAPTIVE RECEIVES A 1.00 ADDITIVE FACTOR. CT-GUIDED REAL TIME TRACKING RADIATION W/O ADAPTIVE MEANS A VISIT INVOLVING AN INTEGRATED CT/MRT UNIT PROVIDING CT IMAGES IN THE TREATMENT ROOM BEFORE AND DURING AN MRT TREATMENT OF ANY COMPLEXITY.
    - CT-GUIDED REAL TIME TRACKING RADIATION WITH ADAPTIVE RECEIVES 3.00 ADDITIVE FACTOR. CT-GUIDED REAL TIME TRACKING RADIATION WITH ADAPTIVE MEANS A VISIT INVOLVING AN INTEGRATED CT/MRT UNIT PROVIDING CT IMAGES IN THE TREATMENT ROOM BEFORE AND DURING AN MRT TREATMENT OF ANY COMPLEXITY; ALONG WITH CREATION, EVALUATION AND DELIVERY OF A NEW RADIATION THERAPY PLAN WHILE THE PATIENT REMAINS IN THE TREATMENT ROOM.

- 3. Other technical edits.

Psychiatric Beds and Services

The revisions to the CON Review Standards for Psychiatric Beds and Services received final approval by the CON Commission on December 8, 2022 and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective March 6, 2023. The final language changes include the following:

- 1. Section 2(1): Modified/added definitions as follows:
    - (g) “COMMON OWNERSHIP AND CONTROL,” AS DEFINED BY THE DEPARTMENT, MEANS ANY LICENSED PSYCHIATRIC HOSPITAL OR UNIT DETERMINED TO BE OWNED BY THE SAME LEGAL ENTITY AS EVIDENCED BY THE SAME CORPORATE IDENTIFICATION NUMBER (CID) ISSUED BY THE MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS, CORPORATE DIVISION, AND/OR THE SAME FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN). THE PARENT CORPORATION IN A PARENT-SUBSIDIARY RELATIONSHIP DOES NOT

OWN OR CONTROL THE LICENSED PSYCHIATRIC HOSPITALS OR UNITS OF THE SUBSIDIARY IF THEY HAVE SEPARATE CID AND/OR EIN FROM THE SUBSIDIARY.

- 2. New Section 5(6): Added exception for hospitals in areas currently meeting or exceeding bed need that can demonstrate an unmet need through inability to place child/adolescent patients requiring inpatient psychiatric treatment:
    - (6) AN APPLICANT SHALL NOT BE REQUIRED TO BE IN COMPLIANCE WITH SUBSECTION (1) IF THE APPLICANT DEMONSTRATES IN ITS CON APPLICATION COMPLIANCE WITH ALL OF THE FOLLOWING:
    - (a) THE NUMBER OF EXISTING CHILD/ADOLESCENT PSYCHIATRIC BEDS IN THE PLANNING AREA IS EQUAL TO OR EXCEEDS THE BED NEED;
    - (b) THE APPLICANT IS AN EXISTING HOSPITAL LICENSED UNDER PART 215 OF THE CODE PROPOSING TO INITIATE CHILD/ADOLESCENT INPATIENT PSYCHIATRIC SERVICES WITH 10 CHILD/ADOLESCENT BEDS;
    - (c) THERE IS AN UNMET NEED FOR CHILD/ADOLESCENT PSYCHIATRIC BEDS AS DEMONSTRATED BY SUBMISSION OF DOCUMENTATION BY THE APPLICANT SATISFACTORY TO THE DEPARTMENT SHOWING ALL OF THE FOLLOWING:
    - (i) WITHIN THE PREVIOUS 12 MONTHS, A SUFFICIENT NUMBER OF CHILD/ADOLESCENT PATIENTS, AS DEFINED IN APPENDIX A, WERE EVALUATED IN THE EMERGENCY DEPARTMENT OF THE APPLICANT HOSPITAL AND/OR ANY OTHER HOSPITAL LOCATED WITHIN 30 RADIAL MILES OF THE PROPOSED SITE OF THE CHILD/ADOLESCENT PSYCHIATRIC BEDS IF THE PROPOSED SITE IS LOCATED IN A METROPOLITAN STATISTICAL AREA COUNTY, OR WITHIN 90 RADIAL MILES IF THE PROPOSED SITE IS LOCATED IN A RURAL OR MICROPOLITAN STATISTICAL AREA COUNTY; AND
    - (ii) EACH CHILD/ADOLESCENT PATIENT UNDER SUBSECTION 6(c)(i) REQUIRED AN INPATIENT PSYCHIATRIC HOSPITAL ADMISSION BUT WAS NOT ADMITTED TO AN INPATIENT PSYCHIATRIC BED LOCATED WITHIN 30 MINUTES DRIVE TIME OF THE PROPOSED SITE WITHIN 36 HOURS AFTER COMING TO THE EMERGENCY ROOM OF THE HOSPITAL(S) UNDER SUBSECTION 6(c)(i); AND
    - (iii) FOR THOSE PATIENTS NOT ADMITTED TO AN INPATIENT PSYCHIATRIC BED, THE APPLICANT MUST DEMONSTRATE THEY ATTEMPTED PLACEMENT AT A MINIMUM OF 6 FACILITIES OVER AT LEAST A 36-HOUR PERIOD TO SECURE ADMISSION OF THE PATIENT TO A CHILD/ADOLESCENT PSYCHIATRIC BED OR THE CHILD/ADOLESCENT PATIENT LEFT THE HOSPITAL AGAINST MEDICAL ADVICE BEFORE EXPIRATION OF THE 36-HOUR PERIOD. (d) ALL HOSPITALS WHOSE CHILD/ADOLESCENT EMERGENCY DEPARTMENT DATA ARE USED UNDER SUBSECTION 6(c) HAVE COMPLETED THE REQUIRED DEPARTMENTAL FORM(S), INCLUDING SIGNATURE BY AN AUTHORIZED REPRESENTATIVE, VERIFYING ALL OF THE FOLLOWING:
    - (i) THE LICENSED HOSPITAL SITE IS ADMITTING PATIENTS REGULARLY AS OF THE DATE THE APPLICATION IS SUBMITTED TO THE DEPARTMENT; AND
    - (ii) THE LICENSED HOSPITAL SITE IS LOCATED WITHIN 30 RADIAL MILES OF THE PROPOSED CHILD/ADOLESCENT INPATIENT PSYCHIATRIC UNIT IF THE PROPOSED SITE IS LOCATED IN A METROPOLITAN STATISTICAL

AREA COUNTY, OR WITHIN 90 RADIAL MILES IF THE PROPOSED SITE IS LOCATED IN A RURAL OR MICROPOLITAN STATISTICAL AREA COUNTY; AND
    - (iii) THE LICENSED HOSPITAL SITE HAS NOT COMMITTED DATA TO AN APPLICATION FOR BEDS UNDER THIS SUBSECTION WITHIN 5 YEARS OF THE FILING DATE OF THE CON APPLICATION UNLESS THE CHILD/ADOLESCENT PSYCHIATRIC SERVICE APPROVED UNDER THAT APPLICATION IS NO LONGER IN SERVICE; AND
    - (e) THE APPLICANT HOSPITAL DOES NOT HAVE LICENSED CHILD/ADOLESCENT BEDS APPROVED UNDER THIS SUBSECTION.

- 3. New Section 7(4) and Section 7(5): Restricts ability to relocate beds approved under Section 5(6) until they have been licensed and operationalized for at least 5 years:
    - (4) THE INPATIENT PSYCHIATRIC HOSPITAL OR UNIT FROM WHICH THE BEDS ARE BEING RELOCATED, SHALL NOT HAVE ANY PSYCHIATRIC BEDS OF THE SAME TYPE THAT WERE APPROVED UNDER SECTION 8(3) AND ARE NOT YET LICENSED AND OPERATIONAL.
    - (5) IF THE BEDS BEING RELOCATED WERE APPROVED UNDER SECTION 5(6), THEN THE BEDS MUST HAVE BEEN LICENSED AND OPERATIONAL FOR AT LEAST 5 YEARS AS OF THE DATE THE APPLICATION IS SUBMITTED TO THE DEPARTMENT, AND THE BEDS MUST BE RELOCATED TO A HOSPITAL LICENSED UNDER PART 215.

- 4. Section 8(3): Added restriction to relocation of beds approved under Section 8(3) until the high occupancy beds have been licensed and operationalized:
    - (3) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed psychiatric hospital or unit site shall not be required to be in compliance with the needed psychiatric hospital bed supply if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
    - (a) The number of existing adult or child/adolescent psychiatric beds in the planning area is equal to or exceeds the bed need.
    - (b) The beds are being added at the existing licensed site.
    - (c) The average occupancy rate for the applicant's facility was at least 75% for facilities with 19 beds or less and 80% for facilities with 20 beds or more, as applicable, during the most recent, consecutive 12-month period, as of the date of the submission of the application, for which verifiable data are available to the Department.
    - (i) For a facility with flex beds,
    - (A) calculate the average occupancy rate as follows:
    - (1) For adult beds:
    - (a) Adult bed days are the number of licensed adult beds multiplied by the number of days they were licensed during the most recent consecutive 12-month period.
    - (b) Flex bed days are the number of licensed flex beds multiplied by the number of days the beds were used to serve a child/ adolescent patient.
    - (c) Subtract the flex bed days from the adult bed days and divide the adult patient days of care by this number, then multiply the result by 100.
    - (d) THE HIGH OCCUPANCY BEDS APPROVED PURSUANT TO SUBSECTION (3) MUST BE LICENSED AND OPERATIONAL AT THE SAME

LICENSED SITE AS THE PROPOSED PROJECT. THE APPLICANT SHALL NOT RELOCATE ANY EXISTING PSYCHIATRIC BEDS OF THE SAME TYPE FROM THIS LICENSED INPATIENT PSYCHIATRIC HOSPITAL OR UNIT, PRIOR TO THE HIGH OCCUPANCY BEDS BEING LICENSED AND OPERATIONAL.

- 5. Section 8(11): Modified requirements to initiate a new child/adolescent psychiatric service for the receiving licensed inpatient psychiatric hospital or unit for consistency with regard to updated Section 2(1) and the added definition of "common ownership and control":
  - (11) An applicant proposing to initiate a new child/adolescent psychiatric service, as the receiving licensed inpatient psychiatric hospital or unit under Section 7(68), shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the bed need if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.
  - (a) The approval of the proposed new inpatient psychiatric beds shall not result in an increase in the number of licensed inpatient psychiatric beds in the planning area.
  - (b) The applicant meets the requirements of subsections (4), (5), and (6) above.
  - (c) The applicant is requesting a minimum of 10 child/adolescent psychiatric beds to a maximum of 20 beds.
  - (d) The applicant:
  - is related through common ownership, in whole or in part, or through common control, HAS AN AGREEMENT with an acute-care hospital that has an emergency department that provides 24-hour emergency care services and where child/adolescent patients with a psychiatric and/or developmental disability diagnosis present at an average of at least 100 visits per year for each of the three most recent years in which there is data verifiable by the Department; and

- 6. Section 11(3): Added subsection to award 3 points for certain number of bariatric rooms based on size of proposed project:
  - (l) A QUALIFYING PROJECT WILL BE AWARDED THREE (3) POINTS IF THE PROPOSED PROJECT INCLUDES BARIATRIC ROOMS AS FOLLOWS: A PROJECT PROPOSING 0-49 BEDS WILL RESULT INCLUDE IN AT LEAST ONE (1) BARIATRIC ROOM OR A PROJECT PROPOSING 50 OR MORE BEDS WILL RESULT INCLUDE IN AT LEAST TWO (2) BARIATRIC ROOMS. "BARIATRIC ROOM" MEANS THE CREATION OF PATIENT ROOM(S) INCLUDED AS PART OF THE CON PROJECT, AND IDENTIFIED ON THE FLOOR PLANS, THAT ARE DESIGNED TO ACCOMMODATE THE NEEDS OF BARIATRIC PATIENTS WEIGHING OVER 350 POUNDS. THE BARIATRIC PATIENT ROOMS SHALL HAVE A LARGER ENTRANCE WIDTH FOR THE ROOM AND BATHROOM TO ACCOMMODATE OVER-SIZED EQUIPMENT, AND SHALL INCLUDE A MINIMUM OF A BARIATRIC BED, BARIATRIC TOILET, BARIATRIC WHEELCHAIR, AND A DEVICE TO ASSIST PATIENT MOVEMENT (SUCH AS A PORTABLE OR BUILT IN LIFT). IF AN IN-ROOM SHOWER IS NOT INCLUDED IN THE BARIATRIC PATIENT ROOM, THE MAIN/CENTRAL SHOWER ROOM THAT IS LOCATED ON THE SAME FLOOR AS THE BARIATRIC PATIENT ROOM(S) SHALL INCLUDE AT LEAST ONE (1) SHOWER STALL THAT HAS AN OPENING WIDTH AND DEPTH THAT IS LARGER THAN MINIMUM MI CODE REQUIREMENTS.

- 7. New Appendix A: Required number of patients to document for those applying under Section 5(6) and criteria for updating the required number of patients to be documented every 2 years:
    - APPENDIX A
    - (1) UNTIL CHANGED BY THE DEPARTMENT, THE NUMBER OF PATIENTS REQUIRED TO BE DOCUMENTED UNDER SECTION 5(6)(c) SHALL BE 170.
    - (2) THE DEPARTMENT SHALL AMEND APPENDIX A EVERY TWO YEARS BY REVISING THE NUMBER OF PATIENTS IN SUBSECTION (1) IN ACCORDANCE WITH THE FOLLOWING STEPS:
    - (a) STEPS FOR DETERMINING THE NUMBER OF PATIENTS REQUIRED TO BE DOCUMENTED UNDER SECTION 5(6)(c):
    - (i) MULTIPLY 10 BEDS BY MINIMUM OCCUPANCY FOR CHILD/ADOLESCENT BEDS TO DETERMINE THE AVERAGE DAILY CENSUS.
    - (ii) MULTIPLY THE AVERAGE DAILY CENSUS CALCULATED IN (2)(a)(i) BY 365 TO CALCULATE THE PATIENT DAYS.
    - (iii) CALCULATE THE AVERAGE LENGTH OF STAY FOR THE PREVIOUS THREE (3) YEARS USING THE THREE (3) MOST RECENTLY AVAILABLE CON ANNUAL SURVEYS BY DIVIDING THE TOTAL PATIENT DAYS FOR THE THREE (3) YEARS BY TOTAL DISCHARGES FOR THE SAME THREE (3) YEARS.
    - (iv) DIVIDE THE PATIENT DAYS CALCULATED IN (2)(a)(ii) BY THE AVERAGE LENGTH OF STAY CALCULATED IN (2)(a)(iii) TO DETERMINE THE NUMBER OF PATIENTS REQUIRED TO BE COMMITTED UNDER SECTION 5(6)(c)(i).

- 8. Updated definition for “Medical psychiatric unit” in Addendum for Special Population Groups, Section 1(4):
    - (d) “Medical psychiatric unit” means a unit PRIMARILY designed for psychiatric patients (adult or child/adolescent as applicable) who have A MEDICAL CONDITION REQUIRING TREATMENTS SUCH AS also been diagnosed with a medical illness requiring hospitalization, e.g., patients who may be on dialysis, require wound care or need intravenous or tube feeding. IF THE UNIT IS LOCATED IN A FREESTANDING PSYCHIATRIC HOSPITAL LICENSED ONLY UNDER 1974 PA 258, CHAPTER 1, THE PATIENT MUST NOT REQUIRE ACUTE CARE HOSPITALIZATION. IF THE UNIT IS LOCATED WITHIN A HOSPITAL THAT IS ALSO LICENSED UNDER 1978 PA 368, ARTICLE 17, THE PATIENT MAY REQUIRE ACUTE CARE HOSPITALIZATION.

- 9. Other technical edits.

PET

The revisions to the CON Review Standards for Positron Emission Tomography (PET) Scanner Services received final approval by the CON Commission on December 8, 2022 and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective March 6, 2023. The final language changes include the following:

- Section 13(1)(a): Modified as follows:

    - Combine the number of cancer cases for lung (site codes C340-C349),

esophagus (site codes C150-C159), colorectal (site codes C180-C209), lymphoma (morphology codes 9590-9729), melanoma (morphology codes 8720-8790), PROSTATE (SITE CODE C619), NEUROENDOCRINE TUMORS (SMALL INTESTINE: SITE CODES C170-C179; PANCREAS: SITE CODES C250-C259; AND INTESTINAL TRACT, NOS: SITE CODE C260; WHICH HAVE ANY OF THE FOLLOWING MORPHOLOGY CODES: 8240/3, 8574/3, 8249/3, 8246/3, 8013/3, 8041/3, 8151/3, 8152/3, AND 8150/3), and head & neck [site codes C000-C148, C300-C329, C410, C411, C470 or C490 excluding C440-C444 (skin of head and neck), and additional codes approved by national coverage determination]. Use the name "combined" for this grouping.

- 2. Other technical edits.

NICU Beds

The revisions to the CON Review Standards for Neonatal Intensive Care Services/Beds (NICU) received final approval by the CON Commission on December 8, 2022 and were forwarded to the Governor and legislature. Neither the Governor nor the legislature took a negative action within 45 days; therefore, the revisions became effective March 6, 2023. The final language changes include the following:

- Section 9(b): Modified to clarify "continuously available" personnel as follows:
  - (b) The hospital has the following capabilities and personnel continuously available and on-site, 24 HOURS PER DAY/7 DAYS PER WEEK:
  - (i) mechanical ventilation for a brief duration (up to 24 hours). For babies requiring mechanical ventilation exceeding 24 hours, SCNs shall request transfer to a NICU by the 24th hour of mechanical ventilation;
  - (ii) continuous positive airway pressure AND HFNC;
  - (iii) portable x-ray equipment and blood gas analyzer;
  - (iv) pediatric physicians and/or neonatal nurse practitioners; and
  - (v) respiratory therapists, radiology technicians, laboratory technicians and specialized nurses with experience caring for premature infants.

- 2. Section 12(3)(d): Modified as follows:
  - (d) The hospital continues to have the following capabilities and personnel continuously available and on-site, 24 HOURS PER DAY/7 DAYS PER WEEK:
  - (i) mechanical ventilation for a brief duration (up to 24 hours). For babies requiring mechanical ventilation eceeding EXCEEDING 24 hours, SCNs shall request transfer to a NICU by the 24th hour of mechanical ventilation;
  - (ii) continuous positive airway pressure and HFNC;
  - (iii) portable x-ray equipment and blood gas analyzer;
  - (iv) pediatric physicians and/or neonatal nurse practitioners; and
  - (v) respiratory therapists, radiology technicians, laboratory technicians and specialized nurses with experience caring for premature infants.

- 3. Other technical edits.

The following CON Standards were reviewed with an anticipated completion in FY2024:

Open Heart Surgery (OHS): Proposed action was taken by the Commission at its December 7, 2023 meeting. The standards will be sent to the JLC, and a Public Hearing will be held in FY2024.

Megavoltage Radiation Therapy (MRT): Proposed action was taken by the Commission at its December 7, 2023 meeting. The standards will be sent to the JLC, and a Public Hearing will be held in FY2024.

Hospital Beds: Proposed action was taken by the Commission at its December 7, 2023 meeting. The standards will be sent to the JLC, and a Public Hearing will be held in FY2024.

Hospital Beds Rural Emergency Hospital (REH) Addendum: Proposed action was taken by the Commission at its December 7, 2023 meeting. The standards will be sent to the JLC, and a Public Hearing will be held in FY2024.

Psychiatric Beds and Services: Final action was taken by the Commission at its December 7, 2023 meeting. The standards will be submitted to the JLC and Governor for the required 45-day review period and will become effective in FY2024.

Nursing Home and Hospital Long-Term-Care Unit Beds (NH-HLTCU): Final action was taken by the Commission at its December 7, 2023 meeting. The standards will be submitted to the JLC and the Governor for the required 45-day review period and will become effective in the FY2024.

Computed Tomography (CT) Scanner Services: Final action was taken by the Commission at its December 7, 2023 meeting. The standards will be submitted to the JLC and the Governor for the required 45-day review period and will become effective in the FY2024.

Air Ambulance Services: Final action was taken by the Commission at its December 7, 2023 meeting. The standards will be submitted to the JLC and the Governor for the required 45-day review period and will become effective in the FY2024.

Surgical Services: This CON Standard is being reviewed by a SAC.

Cardiac Catheterization Services: This CON Standard will be reviewed by a SAC starting in FY2024.

APPENDIX I - CERTIFICATE OF NEED COMMISSION

James B. Falahee, Jr., JD, CON Commission Chairperson
Amy McKenzie, MD, CON Commission Vice Chairperson
Amy Engelhardt-Kalbfleisch, DO
Eric Ferguson, MD
Debra Guido-Allen, RN
Donald Haney
Ashok Kondur, MD
Renee Turner-Bailey
Archie Drake
Greg Salwin

For a list and contact information of the current CON Commissioners, please visit our web site at **https://www.michigan.gov/con**.