STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF NEED COMMISSION

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, September 19, 2019, 9:30 a.m.

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Lansing, Michigan

Thursday, September 19, 2019 - 9:29:15 a.m.

MR. FALAHEE: Good morning, everybody. If this is working. Hang on. Let's call the September meeting of the CON Commission together. It's a little bit before 9:30, but we've got a lot on the agenda so let's get started. For those of you who are new to the Commission meeting, my name is James "Chip" Falahee. I'm the chairman. And we won't bother to introduce all the other people because of the packed agenda. So get right to it, to that agenda. To the members of the Commission, in front of you Brenda has placed the final agenda. I would ask for a motion to approve that final agenda as presented to us.

MR. MITTELBRUN: Motion to approve final agenda, Mittelbrun.

MR. HUGHES: Second.

MR. FALAHEE: Second by Hughes. Any discussion? All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That motion carries.

(Whereupon motion passes at 9:30 a.m.)

MR. FALAHEE: Next item is declaration of conflicts of interest. Does any member of the Commission have any conflicts of interest they wish to declare based on the agenda we just approved? Okay. Hearing none, we'll

proceed. Next item is a review of the minutes of our last meeting on June 13. I would entertain a motion to accept the minutes as presented or if anyone has any changes, I'd like to hear about those as well.

DR. WANG: Wang moves to accept the minutes as previously accepted.

MR. FALAHEE: Do we have support for that?

MS. GUIDO-ALLEN: Guido-Allen, second.

MR. MITTELBRUN: Mittelbrun, second.

MR. FALAHEE: Okay. Mittelbrun, second. Thank you everybody for identifying yourself. Appreciate it. Motion to approve, all in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? Okay. That carries.

(Whereupon motion passes at 9:30 a.m.)

MR. FALAHEE: Okay. The next item on the agenda is immune effector cell therapy. It's hard for me to say. But I will turn it over to Brenda for our usual introduction of the topic and then our first witness will be Senator Curt VanderWall and I'll introduce him as soon as Brenda finishes her remarks.

MS. ROGERS: Thank you. This is Brenda. And for easier pronunciation, I'm going to use the acronym IECT. The Commission took proposed action at your June 13th meeting. A public hearing was scheduled and comment was

received. The public hearing was held on July 25th, the language also was submitted to the Joint Legislative Committee as well. The testimony can be found in your binder. And as you can see, you received testimony from several different organizations both in support and not in support of the standards.

Today the language is in front of you for potential final action. The Department encourages the Commission to consider all testimony as you review it. And if you decide to take final action today, the language will be forwarded again to the Joint Legislative Committee and the Governor for the required 45-day review period. If you accept the language today with any potential amendments and those amendments are deemed substantive in nature, then a second public hearing would be scheduled and then brought back to you in December for potential final action. Another option for the Commission today is to not take final actua- -- not to take final action or to postpone indefinitely. And if you do either one of those, then IECT would not become regulated under CON at this time. So several different options for the Commission today. Thank you.

MR. FALAHEE: Okay. This is Falahee. Any questions of Brenda from anyone? Okay. For those who may want to testify on this issue, in order that so I know who

wants to testify, you need to fill out one of these blue-ish cards that you see where you sign in and turn it over to Tania Rodriguez, right here, so I have an idea who wants to testify. Right now, in addition to Senator VanderWall whom I know wants to testify -- you don't need to submit a blue card -- I have three people that would like to testify. So if there are any others, please submit your blue card. With that, I'll introduce my friend and good discussion mate on CON issues, Senator Curt VanderWall. Senator Vanderwall is -- chairs the Senate -- I always get the name wrong because it's new -- the Senate Committee, the Health Services and Human Services Committee or something like that. Senator VanderWall is here with his chief of staff Patrick. Patrick and I stopped texting each other last night about 10:00 o'clock, I think. So issues going back and forth. So, Senator VanderWall, Curt, you have three minutes like every other witness. Senator VanderWall is on a tight time line. He's got to get back to the Capitol by 10:00, so we'll be respectful of that. You have the floor.

SENATOR CURT VANDERWALL

SENATOR CURT VANDERWALL: Well, thank you very much, Mr. Chairman, and Commission. And I -- I truly do take this as a great opportunity to come in and introduce myself as chair of Health Policy, but most of all to discuss today on the proposed commission standards on immune

effector cell therapy. I wish I could stay and listen to the entire testimony today and -- and see where the Commission goes; however, as stated by -- I must get back. We have a very hectic day as most of you know at the Capitol today so I -- I must leave right away.

I would like to say I appreciate the dialogue that we've had. Some of it's been on -- you know, back and forth, but that's -- that's where good legislation and -- and good progress is made. And I appreciate what the chairman has done and he -- I will tell you he has given me an abundance of time on the subject of -- of this and several other things under CON.

Having open communication on such a topic is extremely important. The Commission has the letter that I submitted along with Health Policy vice chair Bizon, Senate Majority Leader Shirkey on the subject and our belief that the Commission should reject the proposed new standard on IETC (sic). I certainly understand the concern for patient safety and share those concerns. However, I am not convinced that Michigan should be an outlier requiring FACT accreditation which will not be the national standard. I don't believe I have seen compelling evidence that the residents of Michigan would see noticeable difference in treatment and success of treatment because of this proposed standard as compared to the citizens in the other 49 states.

Because I represent so many rural counties, I am especially sensitive to anything that restricts service or access in these areas. And I say knowingly that it is unlikely that this current treatments on this market or this service would take place in my -- my communities. I know there is others that are planning to speak on this, but I do ask that you listen to testimony, you take careful considerations, and I would request that you do not take action on this new treatment. And with that, I could stay for a couple questions if anybody has that, but I do truly appreciate the time, appreciate everybody in this room that is giving up the day to listen and learn, and, again, I appreciate the Commission and everything that you do.

MR. FALAHEE: Okay. Thank you, Senator VanderWall and I -- I saw you struggling because you probably didn't know my first name was "James" because everybody knows me as Chip.

SENATOR CURT VANDERWALL: No, I -- I never -- I have -- I'm going, oh, man. What have I done here? I called him Chip.

MR. FALAHEE: So does everybody else other than salesmen. Okay. Any Commission questions? I told Senator VanderWall the standard procedure is once a witness is finished, I ask the Commissioners if they have any questions and given your time limits, I ask if anybody has any

questions? Commissioner Hughes?

MR. HUGHES: Thanks for joining us today, Senator. I think in my years of doing this, this is the first time somebody has actually come down to join us. And you represent one of the most beautiful areas in our state and if you want to win over Chip, you should just ask him to Art's for a burger and pick up the tab, cash of course.

MR. FALAHEE: Right. No checks. Never a check.

MR. HUGHES: You could never do anything there.

SENATOR CURT VANDERWALL: I'll remember that.

MR. HUGHES: Just a little bit of background here. There's a lot of great expertise on the Commission from various walks of life with -- with different backgrounds. I'm here not because of a medical background, but because I represent payers, and in my day job I work with employers and employees that in a very competitive labor market are trying to provide great health care benefits and as you know, costs go through the roof. That's a -- an old topic. But one of the big things that's been driving health care costs has been prescription drugs and specifically specialty drugs, and specialty drugs have been rolling out at an unprecedented pace because they come out at very exorbitant prices. Are you aware of the price tag of one of the drugs here, the drugs in this particular category and one of the ones that Celgene has not yet approved yet but would hit the

street at?

SENATOR CURT VANDERWALL: I would say I do not know what the total price of any of the prescription drugs are for this treatment. I will say that we are very aware of the cost of many of the prescription drugs as they enter markets right now and the -- the cost of what that is to health plans and, of course, to the patient.

MR. HUGHES: Yeah. This one is projected to come in around $800,000. And so appreciate to the rural access standpoint, but as you know, many years ago, not too many years ago, if you needed a transplant in this state you had to go over to U of M for that. Now we have one on the west side of the state. This is such an expensive drug and a lot of people forget when the FDA approves a drug they don't talk about its effectiveness. They talk about whether it's safe or not. So a lot of these drugs are unproven yet in terms of their clinical trials and they get rolled out. We're dealing with children here that would be getting these issued. I think it's a mistake and -- and just -- I -- I am from your side of the fence. I am a free market person. The word "regulation" makes the hair on my back, if I had some, stand up. So the problem is that health care is not a free market. Half the people are covered by the government and the other half it's not a consumer transaction. People don't know what it costs, they don't pay for it out of

pocket, and so that's what causes this mess with expensive prescription drugs. By doing what you're doing, you're saying it's going to limit access and that anybody could administer this. I think if you allow anybody to administer, that's playing to the drug companies that want massive distribution. If Nike can only sell shoes through Nike stores verse all the other stores, they're going to sell a lot less. If these drug companies can disperse these drugs to anybody including rural centers that don't have the expertise and the people and the specialty to deliver this drug properly because it's so expensive, and you're talking about children that could take it over the rest of their lifetime, and you're going to get this drug prescribed for people that probably it's not going to work for, you'd be shocked at how many of these drugs end -- end of the day don't get the clinical result that you want. I'm just curious as to why you feel -- I'm looking at your comments in your letter about you think this is going to limit access and the FACT accreditation is a bad thing when it's a voluntary thing driven by the experts in this industry. I've never been a fan of matching the state's policies with the feds. I think that does more harm than good. I think we're better than that. So I'm just trying to understand why you think this would be a better outcome both financially and medically for the citizens of Michigan?

SENATOR CURT VANDERWALL: Well, I -- I appreciate the question and the comments. As Chip and I have had many discussions on this and I'm sure he's relayed to some on the Commission that, you know, as we continue to limit where some of this can be performed or where the access is, and of course when we start getting into my area -- and I'm going to say from M-20 to -- through the UP -- you know, the access to care becomes critical and when we start forcing folks to drive many miles to get service or potential service. Do I feel that we're going to have clinics open up all over the state? I don't believe that. I think that, you know, the federal government has put on some pretty serious standards. There's many states that have CON. There's nobody that's looking at, that we know of in other states, to add CAR-T cell therapy into CON. And I urge the Commission to, you know, carefully consider what we do because I -- I really truly believe that we struggle as we continue to move forward with population in our area dropping, young -- young folks moving to the south of the state and more elderly in the north. And I know that most of this therapy is usually done on younger folks, but I -- I'm just very concerned right now that we're going to limit access to care. And I -- I appreciate the cost of the drug. I understand that. As you know I work very hard to make sure and we have things that are going to address some of

these drug costs. But in this situation I really feel that we need to make sure that we follow the federal standard and allow the free market to play and we -- we set the standards to make sure that that -- that procedure is done fairly and ethically and make sure that those treatments are done with the most care.

MR. HUGHES: Unfortunately this is anything but a free market and that's kind of my point. And I just think --

SENATOR CURT VANDERWALL: I understand what you're saying.

MR. HUGHES: -- if it's that expensive of a drug, then it should be delivered properly by the right people. I don't think driving a couple hours to get such an expensive, life-saving drug is asking too much, and a FACT accreditation to me seems to make sense from a payer's perspective and an outcomes perspective. So I was just curious on your thoughts.

SENATOR CURT VANDERWALL: I appreciate that.

MR. FALAHEE: Other questions for Senator VanderWall?

MR. MITTELBRUN: I guess I'll -- I'll ask. Commissioner Mittelbrun. Senator, when you mentioned that you -- you had a phrase "carefully consider" and we've been talking about this for some time and we've been listening to

the experts, some of which are going to speak again today after yourself, I have to agree with Commission Hughes and virtually all his comments. You know, this is, you know, just like many of us in this room, I've been dealing with state and federal regulations for the last 30 years, many of which I don't want to deal with. This is a very complicated -- this -- this is very complicated and dangerous procedure. And so when I'm listening to some folks that are against the FACT accreditation and then I went and I read some of the materials both for and against, I had to go look at the definition because I figured, well, I must be missing something. And the last sentence said,

> "FACT accreditation -- FACT accredit organizations voluntarily seek and maintain FACT accreditation through a rigorous process demonstrating their belief that the patient's needs are paramount."

And that was the sentence of that -- of that definition that struck me the most when I was reading, re-reading all this information. And I think it would be a disservice to the residents of the state of Michigan not to pay attention and do what we need to do here, you know, in terms of this Commission. If it turns out in the end -- and I remember, I'm old enough to remember when bone marrow transplants started, you know, and I don't think it's any different than that. And I don't think we can just stand,

stand aside and let things just, well, possibly turn out very badly if we don't pay attention. So that's not really a question, but --

SENATOR CURT VANDERWALL: You know what, I appreciate your comments. And I will say that Chip is a -- projected that. We've had great dialogue and he knows -- he knows where I come from and my concerns and, you know, I really am -- I'm not looking that I want to destroy health care in the state of Michigan and allow things to pop up on corners. I understand that. I just feel very strongly that the federal government has -- has put some really strict standards in, especially on this therapy, and I feel that we're -- we are taking the option away from some facilities, potentially up north. I don't think that would probably happen; however, I don't want to be that barrier and I would -- I would, again, thank you for considering not doing this CON on this.

MR. FALAHEE: Other questions? Well, to Senator Vanderwall, Curt, thank you again for being here. It's a pleasure. And as I'll update later, I won't see him again until next week when I'm meeting with about 15 other legislators about CON issues. So see you then. Enjoy the weekend. Thank -- thank you for --

SENATOR CURT VANDERWALL: Thank you very much. I appreciate the opportunity. Again, thank you, Commission,

for being here. Appreciate your time.

MR. FALAHEE: Thank you. Tania, do you have any other cards on this?

MS. RODRIGUEZ: (Shaking head negatively)

MR. FALAHEE: Okay. So, just, if anybody arrived late, if you want to testify on this topic, you need to submit a blue card. Currently I have three. So if anybody else wants to say anything, now is the time to get your card over to Tania. All right. Seeing none, the next one I have is Bret Jackson from the Economic Alliance. Bret's here, so -- there he is. Hi, Bret. And I'll remind Bret, even though he doesn't need to be reminded, there's a three minute limit and then unlimited questions from the Commission thereafter.

BRET JACKSON

MR. BRET JACKSON: Good morning. I am Bret Jackson, president of the Economic Alliance for Michigan. We represent about 900,000 covered lives, people who are -- have employer-sponsored health insurance around the state of Michigan. And at first we were not in favor of putting a standard in for immune effector cell therapy, but we -- we were pushed to take a really deep dive and as we did, we -- we had a multi-month process, many meetings with experts around the state to learn about not just CAR-T cell therapy, but a lot of the cell therapies that are either in process

or have been approved and are into the medical marketplace today. And the more that we learned, the more frightened we became about the future. These are wonderful miracles of science that we're seeing come before our health care system. But the toxicity, the cost, the risks of doing these are tremendous and we have to take steps, we believe the state should take steps to ensure that every patient that gets this procedure or these procedures going in the future should have the best possible outcome, or the chance of a best possible outcome.

We think FACT accreditation may not even go far enough, but I think it's a good first step in trying to achieve giving every patient the best possible outcome. Because when you work -- if -- if -- if the new drug comes out at $800,000, that's only a fraction of the total cost of the service. There is considerable testing, hospitalizations, doctor visits, there's additional chemotherapy that is separate from this particular drug that will be administered. You know, I'm assuming these -- the infusions for -- for the CAR-T cell therapy could probably be done in someone's house. That's not where the cost is driven from. It's all of the other things that are going to have to happen pre or post-infusion that will make up a large cost and will require dozens of providers and services. And we -- we just think that FACT accreditation

is a minimal step to assure quality so that when we, the payers, are making that investment in one patient, call it a million dollars in one patient that could have been used for thousands, tens of thousands of immunizations or tens of thousands of insulin doses, that we provide the absolute best opportunity for that patient to survive.

So I very much appreciate your time and we support the actions that the Commission has taken thus far and hope you continue on that path.

MR. FALAHEE: Thank you, Bret. Questions for Mr. Jackson from the Commission members? Thank you. Next is Dr. Greg Yanik. Where's -- hi, Greg. Those of you who've been here before will recognize Dr. Yanik as being here at least once or twice on this topic already and I believe you served on the SAC as well. And I'll just explain for a second. The SAC, Standard Advisory Committee, presented at our June meeting and under the rules or the bylaws or whatever of the Commission once a SAC presents its report, the SAC disappears, all right, as a formal body, formal committee. So what I have done in the ensuing months is reach out to Doctors Stella and Uberti as the co-chairs of the SAC. Dr. Stella is here, he'll be talking next just to say here's what's happened with Medicare, with CMS, what do you think, and Dr. Yanik will probably talk about it as well. They all talked amongst themselves, the physicians on

the SAC, and you'll hear what they decided. So, but I wanted you to know sort of where we were at. The SAC was there, then it went away, but still those experts, those physicians are still available to us and they've been very engaged since about July on this topic. So I'll shut up, turn it over to Dr. Yanik. Thank you for being here.

GREG YANIK, M.D.

DR. GREG YANIK: By the way, I just want to start by saying that I actually support everything that Commissioner Hughes and Commissioner Mittelbrun said when they were questioning Senator VanderWall. You know, I have several thoughts. One, will the SAC recommendations restrict access to care? The SAC recommendations did not limit access to care to any health care system or any hospital. The SAC recommendations simply mandated that those centers that provide that care provide quality care. You know, reviewing the state's cancer registry, I'd estimate that approximately 300 patients per year will require such IECT therapy. That's not a large number of patients. We're not talking 3,000, we're not talking 30,000. Unless do we want unregulated access where let's say 100 hospitals can each treat three patients? No. I really firmly believe that the SAC recommendations will probably end up with 10 to 20 hospitals and those with fairly large oncology group practices each treating 15 to 20

patients.

In my estimation, in case you're curious because I've thought through this, just looking at the oncology practices around the state, my guess is -- although I can't say I've talked to them in particular -- Traverse City, Midland, Saginaw, Flint, Lansing, Grand Rapids, Kalamazoo, Jackson along with St. Joe's, Beaumont, Providence, St. Johns in Southeast Michigan along with the existing centers all will at least consider doing this.

The next thing is why regulate something that the FDA is already regulating? The FDA only regulates the manufacturer of these products. It doesn't regulate the quality of the blood bank that's handling them or the quality of the care delivering them. FACT is the only -- FACT is not a barrier to this care. In fact, FACT is the only body I know, it's the only platform that will ensure quality of care. Every opponent who comes up here to talk about this will state that the FDA requires a "comprehensive risk evaluation and mitigation strategies training site or a training program for sites."

Well, I brought it with me, guys. For the most common CAR-T product -- just pass it around -- this is the certification test to become REMS certified. It's eight questions. Give me ten minutes, I will have everybody in this room REMS certified. If that's the most -- if that's

the comprehensive FDA oversight is this eight question test, good heavens. REMS is a start. It's not the platform we need that ensures comprehensive kind of care.

The other thing I want to say is that everybody who's focusing on this is focusing on CAR-T. The SAC did not focus on -- solely on CAR-T cells. We had to build a platform for the citizens of our state not for CAR-T, but for the future of all these genetically programmed blood cell products; NK cell cars, tumor pulse dendritic cells, any of these myriad of stem cells that are being reprogrammed genetically. Don't focus on CAR-T. Focus on the fact that we have to build a platform for care for all of these patients, not just commercial products, but investigator initiator products.

And I just want to end just by saying this. In my 30 years as an oncologist, I've never run into anything quite like this group of agents. This is the most complex technology that I've ever seen in my career. Period. The potential benefits are high, the risks are potentially even higher. We owe it to the citizens of our state to give them the optimal care with the optimal quality. Thank you.

MR. FALAHEE: Thank you, Dr. Yanik. Any questions for Dr. Yanik?

DR. GREG YANIK: You can ask me questions on the test, too, if you want.

MR. FALAHEE: Commissioner Hughes?

DR. GREG YANIK: Yes.

MR. HUGHES: I was just going to say you could get the other Commissioners to pass this, but probably not me. But there is a multiple choice and I see -- but I just wanted to -- your comments are really great and I think a lot of people don't realize that there's a ton of substantial information out there that shows you're in a much better chance of having a good outcome by somebody that does the procedure 50 times as opposed to five. If I was going to go get a hair transplant, do I want the guy that does two of them a year or do I want the guy that does 500? And this is certainly applicable in this case and watering down and diluting this type of application can't be good.

DR. GREG YANIK: I agree 100 percent.

MR. FALAHEE: Dr. Yanik, just as the layperson, help me understand. You talked about, okay, there's the administration of the IECT -- I say "CAR-T" because it's easier for me to say, but I mean "IECT." There's the simple administration of it but there's a lot that goes before that and after that.

DR. GREG YANIK: Certainly.

MR. FALAHEE: Can you help explain that at least to me?

DR. GREG YANIK: You know, just think of it this

way. With -- with many of these products, it means genetically reprogramming your immune system to target your cancer. And there's three basic tenets for all these products and every one of these is scary in its own way. The first basic tenet for this therapy is that the cancer you're targeting ubiquitously expresses that target protein on its surface. If you're treating leukemia and you've got 1,000 leukemia cells and only 999 have that target, you'll relapse. That one cell remaining that doesn't have that target will turn into two, four, eight, 16 down the road.

So the first tenet of all this IECT therapy is that whatever you're targeting ubiquitously expresses that target. The second basic premise is even scarier. That target better not be on normal tissue. Ugh. If those cell surface proteins you're targeting are found on myocardial tissue, neuronal tissue, lungs, liver, good heavens. These cells don't care what they're targeting. They just target that protein. Then the third basic tenet is just as scary, too. This is gene therapy. These genes have to get inserted in the right place. We can't bat .300 here like baseball. These genes have to get in the right place every single time.

When IECT therapy first started in Europe in 2007, they were treating a group of patients, children, with a condition called SCIDs, where their immune -- they were

immune deficient at birth so they're putting in a new immune system. Oh, those genes weren't inserted in the right place at all. They're being inserted into a place that promoted lymphomas.

You know, think about this. This therapy has to target the tumor antigens 100 percent of the time, can't be on normal tissue, and those genes have to be in the right place. I'm fine with -- you know, pharma companies are fine if they want to come up and speak, write letters about how their company is fine by doing this. But what about the investigator in a hospital health care system who's trying to do this in his own lab? What about the guy on the street who's trying to do this? We can't have cell therapy programs off the street. These have to be the most highly regulated products because in my mind they're the scariest products I've ever seen.

I hope this isn't being videotaped because I actually do what I'm about to show you. I'm Roman Catholic. Every patient I give CAR-T or these IECT therapies to, right before I treat I go like this (indicating). That tells you how serious I feel about this therapy.

MR. FALAHEE: Thank you. Other questions?

MR. HUGHES: I actually have one more.

MR. FALAHEE: Commissioner Hughes?

MR. HUGHES: I am sorry. The -- the FACT

accreditation is kind of a big discussion of this whole thing and in reviewing the thing it's put together by people in the industry self-policing, it's voluntary, a very thorough program and it looks at outcomes and monitoring and so forth. The con against it is that it takes time, it's a barrier co- -- can you put in perspective at all how big of a deal or hard of a deal it is to get FACT and what it means and why --

DR. GREG YANIK: Sure.

MR. HUGHES: -- why something other than a drug company wants to have everybody be able to distribute it, they'd be against having the FACT accreditation for people that are dispersing this drug?

DR. GREG YANIK: That's a very good question. So we're going through our -- our re-upping of our FACT accreditation this winter. It'll cost us just -- just for the application for it, it'll be around $15,000 just for all the -- just to apply for FACT re-accreditation. But really what it means is that we hired -- we -- we got one person as one of our lead research coordinators dedicated to basically 24/7 ensuring that we're meeting the FACT guidelines and getting all of our paperwork ready. So literally it's a 1.0 FTE if you think of it that way of a full-time job for somebody just to ensure that our FACT accreditation is met. We actually have weekly meetings every Wednesday at our

center with our blood bank, with our clinical research coordinators, our data managers, nursing, physicians that are involved in the care just to go over all of the patients, to go over all of our standards, to go over what we need to do to meet FACT accreditation. It literally becomes a team process to get FACT accreditation. And as I said, we have one lead person, 1.0 FTE, to ensure that we're meeting all of those guidelines. It is a fairly rigorous process. And -- but I wouldn't say that it's onerous. I actually smile at it because when I look at it, it gets things right. It doesn't allow us to cut corners. It doesn't allow us to have people doing this care that aren't properly educated. It doesn't allow us to go on to keep doing therapy without having good outcomes. We have to report our outcomes to FACT. So the FACT system, though it does require an effort on our part, a team effort with one lead person, as I look at it from top to bottom, it's a very good system.

MR. HUGHES: Thank you.

MS. ROGERS: Other questions? Dr. Yanik, thank you again. We appreciate all your work, effort, and testimony. Thank you.

DR. GREG YANIK: Thank you, Chip. Thanks.

MR. FALAHEE: Last call for cards. I have none other so I will call the last witness up and that's Dr.

Stella. While Dr. Stella is coming up, just to remind to the Commission members, Dr. Stella was one of the co-chairs of the SAC. The other co-chair, Dr. Joe Uberti, was supposed to be here. He e-mailed Dr. Stella and myself late yesterday afternoon saying that he could not be here. Leave it to Dr. Stella and I to get even with Dr. Uberti for failing to show up. We'll figure out something to do. And in the interest of full disclosure, Dr. Stella and our family know each other. We go way back. And the other I've already disclosed. I have a nephew that is involved in Boston in IECT therapy development and he's given me chapter and verse, and with his Ph.D. it goes right over my head so never mind. But Dr. Stella, I wanted him to be here to explain what went on within the former SAC members and any other comments he would like to make and then we'll open it up for questions.

PHIL STELLA, M.D.

DR. PHILLIP STELLA: So, yeah, Joe Uberti and I won the lottery to co-chair this SAC and -- and first of all I wanted to say that I agree with everything that Greg Yanik has testified to. Okay. He was a member on the SAC. The SAC was well constituted actually. It has -- had the haves and have not, okay, and those are that had bone marrow transplant programs because, remember, we were thinking should this be regulated under the bone marrow transplant

SAC or CON or not, and -- and so it was equally divided in terms of the providers there and we had representatives from payers as well as others. And -- and it was a very interesting thing.

We were in about three meetings. We quickly came to a consensus that this is a very high tech process. It is fraught with risks and all, and that, that really quality standards should be part of it. Even on those facilities, representatives from those facilities that did not have a transplant program, we felt that this should be -- that we needed to have something to look at the -- to assess quality, have some kind of a bar to -- that the programs wanted to do this high tech procedure on, and that we could then look at the quality of the procedures and the treatments given at each of the facilities. We quickly came to a consensus that this should not be a limiting the number of sites. So that was that issue of access issue. As you heard the senator talk about, there's nothing in -- we -- we felt that the sites should not be limited as in the bone marrow transplant world, but that if the -- a site wanted to get into the immune effector cell treatments, that there should be a bar that is -- that they have to pass because it's a complicated procedure. And so we quickly said that -- and looked at FACT accreditation, we looked thoroughly at that. We talked to the people that are going

through it on a regular basis and have to get recertified, and we all felt comfortable with the FACT accreditation as a means, as a really -- a basic level or hurdle that these sites would have to meet those qualifications. So that was a basic.

In fact, in our report back, in our recommendations back to this Committee, that was the only, the only requirement is they meet FACT accreditation. Again, it is not limiting the sites, but if some site has the interest, the dollars because it's expensive to do these treatments, and the patient population and they meet FACT accreditation, it gave all of us as providers a reassurance that if there -- these are people that know what they're doing, know what they're getting into, and they'll be able to provide this safely. So it's not an issue in my mind, in any of our minds of -- of a access issue or not. It really is safety and quality issue.

So when we went into this initially was the --

MR. FALAHEE: Dr. Stella, let me -- I think I heard the beeper go off.

DR. PHILLIP STELLA: Oh.

MR. FALAHEE: But if you want to make a concluding comment, but then rest assured there will be some questions asked of you.

DR. PHILLIP STELLA: Okay. I didn't hear the

beeper sound.

MR. FALAHEE: That's all right.

DR. PHILLIP STELLA: So basically we -- we had a recommendation, some things came out from Medicare in terms of changing their initial policy on FACT accreditation. We've heard from other people that had contrary views of things. And so Joe and I we -- we discussed not at a SAC committee meeting, but individually, the members on the SAC, does anything that has happened since we reported back to this Committee change what we thought and the answer was "no" and that was unanimous across all those, including the haves and haves not, and for the basic reasons of safety and quality.

MR. FALAHEE: Questions of Dr. Stella? I'll go first -- oh, Tom, go ahead.

MR. MITTELBRUN: Commissioner Mittelbrun. The Senator commented on the federal government, CMS. Could you explain what -- what they've done and what -- what he was referring to?

DR. PHILLIP STELLA: Yes. CMS came up with a policy or they proposed a policy initially that made our job a little bit easier because they suggested that they would pay for immune effector cell therapy if they -- the institution that was going to do that had to have FACT accreditation. That was part of their initial policy. That

did not come out in the final policy as it turned out and -- for whatever reason. Now, let me just comment that this is an evolving area, just like bone marrow transplants has evolved. This is a new technology. It is going to involve -- we all thought that this should be revisited in three years according to the -- the CON guidelines because there may be things that are different. But anybody that is going to get -- my view is somebody who is a have not, does not have FACT accreditation, anybody that wants to get into this you want to have the reassurance as a provider that you're meeting certain standards and that I personally would go for FACT accreditation whether it was mandated or not. But I would definitely do that.

The problem is if there was no way, even in the REMS and all the data that you had to supply to the FDA for how these patients do for a long time, there's no one that is really looking at that data and no assurances that -- that somebody will act. If you have to put in all this data to the FDA and it's bad, your patients are doing poorly, who the heck is looking at it, you know? We thought that the CON by virtue of having to renew it and review it, at least someone is going to be looking at that data. So that was an important part of our deliberations as well.

MR. FALAHEE: Other questions? I'll just add, and then I'll end with a question. I communicated both to Dr.

Stella and Dr. Uberti the CMS final coverage memo or whatever it was called, decision memo, and sent it to them and I highlighted the two instances where they said, "Some commentators wanted us to preserve FACT. We choose not to." That's about all they said. There wasn't a lot of rationale for it. So I sent -- I copied and pasted that and sent it to both Dr. Uberti and Dr. Stella and said, "Gentlemen, you're the experts. We -- at least this person on the Commission is not. Please help us. Please recommend what to do." And so I've -- I've been impressed again with their work to pull this together. They could not meet as a group because of the rules, but they -- they were able to get together one by one by one. I'm glad to hear it's a unanimous recommendation.

And I'm -- Dr. Stella hit up on one issue. This isn't -- in my opinion, we're at the early, early stages of IECT. We, as a Commission, on any standard can say we want to bring this back. Even if it's off the three-year cycle, we can bring it back. If -- if we see things are moving forward two years, three years, five years from now, we could change it as the Commission. But I strongly agree with those comments about right now for the safety of the residents of Michigan to get this treatment, this is the way to go.

In terms of Senator VanderWall's comments about

places where it could happen, where you could do this, as you said, FACT -- anybody that thinks they can apply, they can apply. It might cost $15,000 and an FTE, but the SAC recommendation doesn't per se limit where this will happen.

DR. PHILLIP STELLA: No, it does not. That's why I say it was not a -- we quickly dispensed of the -- the issue of access because we said let's take it out of the Bone Marrow CON and do a specific immune effector cell treatment CON and that anybody that met that criteria -- but we all felt very -- we all felt the same about having at least some measure of quality of a program, that is by an independent body to be -- before going forward on a very complex and potentially very toxic program.

MR. FALAHEE: Other questions? There's a certain reason that there were ten physicians on the SAC and there were five from each side. Some of you will recall that the first time Dr. Stella was here was March of 2018, and he and Dr. Uberti and others were going back and forth on the witness stand and I called them the dueling physicians. I ran into them after the meeting and I said to Phil and Joe, "You've just made yourselves the co-chair of the new SAC and rest assured the chairman of the Commission will make sure that there's going to be an equal number of the haves and have nots" because that's how you get things resolved. And to their credit and a result of a lot of hard work, thank

you very much. Thank you to Dr. Yanik, Uberti, and everybody else.

DR. PHILLIP STELLA: Thank you.

MR. FALAHEE: Thank you very much. So I have no other witness cards on this topic and now we move into Commission discussion. Sorry, I've got to wait for -- we'll move into Commission discussion. I'll just -- I'll just add a couple additional comments. I appreciate the comments from the two Commissioners to my left and for everyone else that did their homework on this. This is a complicated issue and I know from dealing with many of you in between the June meeting and this meeting, many of you were diving into this and looking at it yourself. So thank you for that. Thank you for the physician expertise on this Commission. It comes in handy. Thank you.

And I think what's in front of us, as Brenda laid out, is a few options. One is -- and, Brenda, please tell me when I screw it up. One is we can approve the recommendation as it was presented to us in June. That's option one. Let's go 180 degrees the other way. We could reject it. No, we're not going to do it at all. And then there's two sort of middle grounds. One would be to table it indefinitely, meaning then you could bring it back whenever you wanted, or table it for a certain period of time: six weeks, six months, two years, whatever. So those

are the four options in front of us. I'll say that based on the evidence I've heard and the homework I've done, that I think for the safety of the residents of Michigan we need to proceed with that recommendation as it came to us from the experts on the SAC. Everyone I've talked to has that same opinion. I understand there are many comments that were in our packet that came in from the public comment, but I think our job is to look as a Commission at the quality, safety and cost. When you look at all of that and you hear the quote from Commissioner Mittelbrun about FACT, we're here to make sure that those residents that get care get the best care and the safest care they can. In my opinion, that preserves the FACT requirement and that says we proceed with the SAC recommendation as it was presented to us in June. Discussion? Commissioner Dood?

MR. DOOD: Commissioner Dood. One part of the CON standard that was proposed that I really appreciated that impacted access was that it was required that not only impacted accreditation, but it be done without regard to whether the patient could pay or not, and we haven't talked about that at all today, but to me that's an access issue; that if we don't move forward on that, that's not a requirement so that's gone.

MR. FALAHEE: And as one of the two hospital members on the SAC, I will tell you that there are many

treatments out there where the treatment is in the best interest of the patient. You treat the patient, you worry about the payment later and sometimes your payment is zero. That's part of being in the health care industry these days. But it is something that I think every hospital is sensitive to, every provider, every physician is sensitive to, especially when as Commissioner Hughes noted, we have pharmaceuticals that are very, very expensive. Other discussion? Other questions? Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yeah. Commissioner Brooks-Williams. So -- so just -- just so I make sure I'm clear. So we're saying that IECT if we move forward with the recommendation that is before us, it really is essentially saying FACT accreditation is the threshold that's required for anyone to enter. Is it retrospective for anyone who's doing it now? Because I'm always confused with the standard if it goes back or if it -- yeah.

MS. ROGERS: This is Brenda. So as it was discussed during the SAC and in discussions since then at the Department level, so it's not retroactive, but because this is a brand new Certificate of Need review standard of a new covered service, we are going to require anybody currently providing this service to apply once these standards go into effect. It's the same as if you'll recall a few years ago with the special newborn nursery. It's the

same type of situation.

MS. BROOKS-WILLIAMS: Okay. Thank you.

MR. MITTELBRUN: Mittelbrun. Brenda, what's the time frame for compliance when you go through that process?

MS. ROGERS: I'm going to let Tulika address that. Thank you.

MS. BHATTACHARYA: So -- this is Tulika. Once the standards go into effect, I believe we discussed at the SAC that the existing providers who are currently offering IECT services will have up to six months to submit an application to secure approval under the standards and we have up to 12 months to get the approval. Is that right?

MS. NAGEL: I think so.

MS. BHATTACHARYA: Because these are going to be substandard review applications. So once you submit an application, there is a four-month -- four- to five-month review process. So those are the timelines. And if a center is truly initiating service, so there is no restriction on them when they can apply. They can apply whenever, you know, they want because it is a new service they will start to offer. If that makes sense?

MR. FALAHEE: This is Falahee. I'll add I believe there are two entities now that are FACT accredited: University of Michigan and Henry Ford; is that right? Okay. That's what I thought.

UNIDENTIFIED SPEAKER: Spectrum is.

MR. FALAHEE: Spectrum as well? So three.

UNIDENTIFIED SPEAKER: Karmanos.

MR. FALAHEE: Karmanos? Great. I'm doubling my number. That's good. So we have -- the audience corrects me, thankfully, there are four entities in Michigan that are already FACT accredited: University of Michigan, Karmanos, Henry Ford, and Spectrum. Other discussion?

DR. MCKENZIE: I was just going to add, if I understand correctly, that the way this is written in the standard, that upon CON approval, the entity would have three years to obtain their FACT accreditation; correct?

MS. BHATTACHARYA: Yes. That will be correct. So Henry Ford, U of M, Karmanos, and Spectrum, they are currently offering IECT services, so they'll have six months to submit an application and up to 12 months to secure approval. And then after approval, let's say they did not have FACT accreditation, they'll have three years after approval to obtain that FACT. Now, let's say a new provider, for example, Beaumont wants to apply to initiate service, there is no restriction that they'll have to file within six months. They can file whenever they want. But after they secure approval, they'll have three years to get their FACT accreditation for this service.

DR. MCKENZIE: Thank you.

MR. FALAHEE: I see the look in Commissioner Brooks-Williams eyes, so I know there's a question coming.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. So if we approve it and it goes to JLC -- and Chip and I had an opportunity to talk a little bit about this before this meeting -- given the testimony against the standard that we've seen in writing and here today, just remind us what that JLC review looks like in a circumstance where we've had one person come forward to speak to their dissension on the topic.

MR. FALAHEE: This is Falahee. I just happen to have the language in front of me in case that question came up because I wanted -- and I was going to talk about it anyway. Thank you. When we go and we approve these, we always say, "Well, we'll send it to the JLC and the Governor." Well, what's that mean? All right. I know that over the course of the summer some members of the legislature were approached and said -- and told, "You remember the JLC?" And they went, "What's the JLC? Never knew I was on it." Okay. The way it works, it says once we -- let's say we approve a standard or this standard -- okay? -- it goes to the Joint Legislative Committee and the Governor. The Governor or the legislature may disapprove the proposed final action within 45 days after the date of submission. There's some language about how many

legislative days you have to have within that 45-day period. Then the legislative disapproval, I'm going to read the language. I'll quote it.

"Legislative disapproval shall be expressed by concurrent resolution which shall be adopted by each house of the legislature. The concurrent resolution shall state specific objections to the proposed final action."

That's the language. That's how it works internally at the capitol. And Senator VanderWall's chief of staff is still here, so if I get it wrong, I'm sure Patrick will say something about it. So there. So that's right out of the statute. So Commissioner Brooks-Williams, that's how it works, let's say, behind the scenes.

MS. BROOKS-WILLIAMS: Thank you.

MR. FALAHEE: Any other discussion? If not, I'd entertain a motion.

MR. MITTELBRUN: Mittelbrun. Based on the description and the answer to the questions in terms of the process of going through the FACT accreditation, it looks pretty liberal and I don't want to say lenient, but certainly plenty of time to get that. I'll make a motion we approve the standards as presented in June in accordance with the recommendation of the SAC and that the standards proceed through its normal course with being reviewed by the

JLC and then the Governor.

MR. FALAHEE: Is there support for that motion?

MR. HUGHES: Commissioner Hughes, second.

MR. FALAHEE: Any discussion? All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Any opposed? Carries.

(Whereupon motion passes at 10:25 a.m.)

MR. FALAHEE: Thank you very much for all your work. Thank you to Dr. Stella, Uberti in absentia and Dr. Yanik. Express our concern or thanks to the other physicians and the other members of the SAC. Thank you very, very much. Next item on the agenda is psychiatric beds and services and I'll turn it over to Brenda Rogers for her usual summary for us. Please, Brenda.

MS. ROGERS: Again, this is Brenda. You do have the material in your packet. You took proposed action at your June meeting. A public hearing was scheduled in July. Testimony was received from five different organizations and can be found in your material. There was testimony both in support of the language and -- yeah, I'm looking -- I'm making sure I'm looking at the right one here so, sorry. We have a lot of standards this time. In there -- so, therefore, the Department supports the language as you passed it in June and if you take final action today, again,

it will move forward to the Joint Legislative Committee and the Governor for the 45-day review period along with the language. As you'll recall a -- an updated bed need methodology is part of this draft language. Those numbers had already been run as a part of the review. The Commission does need to set the effective date of those bed need numbers and since the Commission typically asks the Department if we have a recommendation or suggestion, we would suggest making the effective date of the new bed need numbers the same as the effective date of the new standards once they become effective assuming you take final action today. Thank you.

MR. FALAHEE: Any questions of Brenda? All right. I have no cards for anything else on the agenda. So if anybody wants to say anything about any of the future agenda items, please submit a blue card. Having no blue cards on this agenda item, no public comment, we move right into the Commission discussion. I think Brenda laid it out exactly what the options are in front of us. Is there any discussion amongst the Commission? Any questions of the Commissioners to the members of the Department here? If not, I'll -- sorry. Beth Nagel has a comment.

MS. NAGEL: Thank you for allowing me to comment. I wanted to make a comment. There was a bit of testimony that was received about high acuity beds in your packet and

I just wanted to say that we've done some due diligence, worked back with the chair of the work group, Dr. Laura Hirshbein, and just wanted to make it clear that testimony was essentially saying if the new high acuity pool, if a patient goes into the high acuity pool, the goal should be to raise their acuity, and so then what happens to them there? Are they still eligible to be in that bed? And the work group is very clear that that's a clinical decision; that the physician should be able to decide whether they should go to a general psych bed or whether that patient should stay in the high acuity bed. And the language and our interpretation of the language supports that. So we didn't see a conflict based on that testimony and I just wanted to make that clear.

MR. FALAHEE: Thank you, Beth. That's an important clarification. Thank you. Questions? Discussion? If not, I'd entertain a motion, please.

MS. BROOKS-WILLIAMS: I'm laughing because I'm, like, I should have this right by now; right? I move that we accept the psych standards as presented and move them onto the JLC and the Governor for the 45-day review.

MR. FALAHEE: And I'm sure you also want to set the effective date at the same date that the standards are effective?

MS. BROOKS-WILLIAMS: Absolutely. I want to do

that as well.

MR. FALAHEE: I knew that.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams.

MR. FALAHEE: Thank you. Support for that motion?

DR. GARDNER: Commissioner Gardner, support.

MR. FALAHEE: Thank you. Discussion? All in favor of the motion say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That motion carries.

(Whereupon motion passes at 10:30 a.m.)

MR. FALAHEE: Thank you, everyone. Next, the always on the agenda topic lithotripsy. I'll turn it over to Brenda Rogers.

MS. ROGERS: This is Brenda. Again, you took Commission -- the Commission took action at your June meeting. Public hearing was scheduled. We received one piece of testimony which you have in your packet. And so the recommendation today is to move the language forward for final action to the JLC and the Governor for the 45-day review period. Thank you.

MR. FALAHEE: Any questions of Brenda? Again, I have no public comment cards for this agenda item so we move right into the Commission discussion. Any Commission discussion? If none, I'll entertain a motion.

DR. WANG: Commissioner Wang moves that we accept the proposal as previously stated and that we move it for JLC consideration and the 45-review standard period or something to that effect.

MR. FALAHEE: And we'll include the Governor in that as well?

DR. WANG: And we will include the Governor in that as well.

MR. FALAHEE: Support for that motion?

MS. BROOKS-WILLIAMS: Support, Brooks-Williams.

MR. FALAHEE: Thank you. Any questions or discussion? All in favor of the motion say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? Motion carries.

(Whereupon motion passes at 10:32 a.m.)

MR. FALAHEE: Next topic, hospital beds limited access areas, and I'll let Beth Nagel explain this confusing to me topic. Should we put you on a two-minute limit?

MS. NAGEL: Please. I'd love that. If you don't mind, I'll come up here because I'm going to want to point. I'm sorry that it's confusing to you. It's also a little bit confusing to us as well.

In the hospital bed standards there is a section called limited access areas and it was created about 15 years ago for the purpose of making sure that the hospital

bed need methodology didn't miss any areas of the state that might have extra circumstances for need. Now it has been in the standard for 15 years. Every time we renew the hospital bed, bed need numbers, we give you a new map of the limited access areas that have been identified, but we, as the Department, has never received an application for a limited access area facility ever until this year. And so the language was challenged for the first time. We went through as a Department the language with the bed need and we found an issue that we need to bring to the Commission and ask for your help in resolving it.

Just for some background, this is directly from the hospital bed standards. These are the definitions in the definition section. The first one is an "underserved area" and that's an area that -- that with -- in that area you have to drive 30 minutes to reach, 30 minutes or more to reach the next critical or acute care hospital with 24/7 emergency room services. The "limited access area" is a subset of the underserved area and it means within that underserved area, it's an area where the patient day demand meets or exceeds the statewide average for 50,000 residents.

So if it'll help if I show on the map? This is your map that we show every time we redo the hospital bed need. And the red areas are the limited access areas and the yellow areas around it are the zip codes that touch a

limited access area -- okay? -- and so we assign a bed need to each of those as well. I keep walking away from the microphone. You probably don't like that. So like the limited access area 1 is in the UP and that has a bed need of 306 beds. So in this area, all the red areas in the UP are more than 30 minutes from the next hospital that has 24/7 emergency room service and has a patient day demand for 50,000 people that meets or exceeds the statewide average. And as you can see, the little plus hash marks are hospitals and so around those hospitals you can see the 30-minute drive time is kind of in the yellow. And then, you know, there's a part of the upper part of the mitten that's a limited access area, and then there are some that have been added more recently which are down here (indicating) below, limited access area 4, 5, and then 6 as well. And we projected based on the methodology in the hospital bed standards the bed need based on those -- on those specific areas.

So there is the definition of the limited access area which I -- I just told you about and the map. And then within the standard itself there are specific requirements that you have to meet in order to build a hospital in these limited access areas. And one of them, the one that's most salient to today's discussion, is that the hospital, if it's in a metropolitan area, has to be within the limited access

area; that limited access at a point where it can hit 50,000 people within a 30-minute drive time of that hospital -- okay? -- and if it's in a rural or micropolitan, they get 60-minute drive time. So if you look back at -- the UP is kind of the best example. So if you were to place your hospital here (indicating) at this very tip limited access area, at the very tip of the western UP, you would have to in a 30-minute or 60-minute drive time has to hit 50,000 people within that area. And so you -- you -- that wouldn't be eligible; right? But maybe if you had it somewhere else, like in limited access area 2, you might be able to do that.

So when we looked more specifically at limited access area 4, which as you remember was just east of Muskegon, you can see the zip codes here (indicating), these two zip codes. Together those two zip codes have a population of 50,600 people, but the limited access area that was identified, that small area there actually has zero residents in it. And so that's slightly perplexing. When we looked at -- when we looked at access area 6, there are three zip codes as well that have about 60,000 people in it, but the actual block itself has 7,600 people in it.

So essentially in those two limited access areas -- and we hadn't done -- we haven't done this analysis on all of them, but at least in these two there would be no place to put a hospital where you would get 50,000 people

inside the limited access area and within a 30- or 60-minute drive time. So essentially the problem that I'm bringing to you is that there's an issue with how the limited access areas are being identified in the methodology. We're finding these areas, but they don't meet the standards and so we're putting out a bed need that can't actually be taken advantage of. Does that -- should I stop here for questions?

MR. FALAHEE: Any questions of Beth at this point? You'll get your other chances later.

MR. MITTELBRUN: I'll wait for the solution.

MR. FALAHEE: Okay. Yeah; yeah.

MS. NAGEL: Okay. Yes. Because the solu- -- thank you.

MR. FALAHEE: Now what is what we're waiting, yes. Now what?

MS. NAGEL: Thank you. I appreciate your confidence. The solution is next. So what we'd like to ask you for, your permission to work with Dr. Paul Delamater from the University of North Carolina who does most -- does all of our analysis for updating the bed needs and was integral in bringing this issue to our attention. He believes that there are potentially just some tweaks that can be made to identify these areas better so that we're actually looking for the 50,000 people first and then the

drive time as opposed to the kind of -- it's kind of the other way around now. And that may involve some changes to the language in the methodology and the standard. It may not. We need to explore that further. But I also wanted to bring to your attention as well that the hospital bed standards are part of the -- their annual review cycle or three-year review cycle is next year and so we will be taking public comment on hospital beds this fall like we normally do. It'll come back to you at your special Commission meeting. You know, from our perspective you could do one, both, or the other. We're concerned with having this bed need out there and knowing this conflict. And so from our perspective, this Department's perspective, we want to be able to fix it and find a solution as soon as possible, but also at the same time know that it's going through it's going through its regular process as well.

MR. FALAHEE: So this is Falahee. Beth, question. Do you need a formal motion from the Commission to say yes, proceed with the proposed solution?

MS. ROGERS: I'm going to turn to Carl on that.

MR. HAMMAKER: I think that would be the best, yes.

MR. FALAHEE: I don't want to shortcut any questions we might -- I just want to figure out what -- what the end game is here. Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yes. So, Beth, just to clarify, I followed you 'til the end, but you said -- so the proposed solution is to allow the Department to work on the fix, which I totally understand, but it would be folded into the regular bed need process or would you -- would -- if we said fix it and you identified the fix, it would come back sooner or --

MS. ROGERS: Yeah. So, yes. So potentially if you said, yes, fix it, we would come back to you with a fix as soon as we have that information, and at the same time, if you want to take a whole comprehensive review of the limited access area concept in full, you could also do that at -- in next year.

MS. BROOKS-WILLIAMS: Okay. So when the fix would come back, the fix would come back and then it still would go through the normal comment period? I'm just trying to make sure how it gets reviewed. Right?

MS. ROGERS: Yes. Absolutely. Yup.

MS. BROOKS-WILLIAMS: Okay.

MR. FALAHEE: Commissioner Dood?

MR. DOOD: I wasn't here 15 years ago, but presumably our predecessors or maybe some people left over knew what they were doing. So what -- what exact -- I mean, if more people moved into these areas it wouldn't be a problem. Was that the intent all along or is it -- is it

really a problem or I'm missing a part?

MS. NAGEL: The problem is that we're identifying need, but the standards -- a need that can't be accomplished given the criteria in the standards. Neither was I here 15 years ago and our researcher wasn't here 15 years ago either. But what he believes happened is that when it was these large areas, like the UP and part of the mitten, it made sense. But now that we're identifying these smaller areas it might -- it doesn't make as much sense and needs to be fixed.

MR. FALAHEE: This is Commissioner Falahee. I wasn't on the Commission 15 years ago, but I've been attending Commission meetings for at least 25 years, so I am a leftover. Okay. I will say that Beth is exactly right. When we started to look at this -- and I see Mr. Wheeler over here so he may add to it -- but when we started to look at this, we were identifying large area. I recall looking at the Alpena area going, oh, my gosh, that's an area where you don't get easy access to care, and the same with certain areas of the UP. But we were looking at much larger blocks, if you will. We didn't have the finiteness that we can do now and I can say we didn't have Professor Delamater to help us either, so I can see how this could happen. But that's why we did the best we -- or the Commission then did the best it could given the data it had. Any other questions

for Beth? If not, I'll entertain a motion.

MS. ROGERS: Excuse me. This is Brenda. Do you have public comment?

MR. FALAHEE: No.

MS. ROGERS: Okay.

MR. FALAHEE: No public comment on this issue.

MR. MITTELBRUN: Mittelbrun. Oh, don't take my slide away. Motion to proceed with the proposed solution as identified in items one and two in the slide presented by Beth.

MR. FALAHEE: Support for that motion?

MR. HUGHES: Second.

MR. FALAHEE: Commissioner Hughes supports. Discussion? All in -- sorry.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. Because I'm not going to say I can't fully read that slide, but I just want to make sure that before we take action that the question that I asked before about what that means in terms of time line, does the -- does the proposal say how it comes back to us and how it ultimately -- whatever the fix is; right? So I'm supporting the fix. I'm not sure that I'm understanding the process after you have resolution.

MS. NAGEL: Yeah. That's a good -- so if -- let's just say hospital bed is not part of the next review cycle

at all. I would say we'll go back, we'll look at this fix, and then we'll bring it back to you at, you know, the next meeting or the meeting after that. That was going to be our proposal, but then we noticed that the hospital bed standard is up for review. And so essentially what we're saying is that we can bring you back a solution and we'd like to do that, and also you can have that solution checked, double checked, re-tuned whatever needs to be by the hospital, as the hospital bed standard gets reviewed next year, too. So we're not taking away any option for this to be reviewed. I just wanted to highlight another way that it can be reviewed, too.

MS. BROOKS-WILLIAMS: Okay. So at this point it's just the fix and then we figure out what to do with the fix once you bring it to us?

MS. BHATTACHARYA: Standards need to be updated with the fix.

MS. NAGEL: Yeah; yes. And that's a good point. So what may happen -- what potentially could happen is that we come back to you in December with a fix and you take proposed action and it moves to final action, and then the hospital bed, let's say you have a SAC next year, would look at the new version of those standards. Or we could bring you a fix and you don't like it and you say have the SAC do this next year.

MS. BROOKS-WILLIAMS: Okay. Thank you.

MR. FALAHEE: Commissioner Gardner?

DR. GARDNER: Commissioner Gardner. So you said that this is the first time you've ever had an application for it. What happens to that application during this process?

MS. NAGEL: I'm looking at my legal counsel because I do not believe that I can comment on an application that's pending right now.

MR. HAMMAKER: Yeah. That application is currently pending and it'll be -- you know, a decision will be made when the Department issues the decision, which is due at the end of the month, so --

MR. FALAHEE: So we have a motion on the floor, it's been made and seconded. All in favor of the motion say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That motion carries.

(Whereupon motion passes at 10:47 a.m.)

MR. FALAHEE: Let me take this time to publicly acknowledge the people sitting around the table that Commissioner Mittelbrun and I work with extensively in between these meetings, whether it's Tania, Tulika, Beth, Brenda, or Carl. We are in constant communication with them and they with us, and I want to thank them publicly for all

the excellent work they do. Keeping Commissioner Mittelbrun and I on our toes and up to speed is not an easy task. But thank you very, very much for all you do for us. Thank you.

Next we'll move on to the nursing home/hospital long-term care unit beds Standard Advisory Committee update and that's got my name next to it. So I'll go back a little bit in time. In March of '18 -- = '18, we first talked about nursing home and beds and a bed need methodology was presented and attached to the minutes of the March of '18 meeting. I think it was Exhibit F, I think, or H. I forget. I looked at it last night as I was communicating with Patrick from Senator VanderWall's office. And then that was March of '18. And we did not set a date on the bed need methodology at that point. We held off on it and the people to my right will tell me if I get any of this wrong.

In March of '19, so this year, we said that we would like to appoint a SAC to look at a number of issues in the nursing home area. One of those issues, the first charge, was the new bed need methodology, March of '19. And so we as the Commission approved that SAC, that a SAC be established. And then what happens behind the scenes is we work -- the chairman and the co-chair work with Brenda and Beth to send out nominations for any SAC including this one to get the people on it, to nominate themselves, to get people to nominate themselves to be on the SAC. And as I do

with every attempt to put together a SAC, Brenda or Beth will send me a note. "We've sent out the first round of nominations, only three people applied, or five people, not enough numbers." I'll send -- I'll say, "Okay. Send it out again a second time." That happened here first time it went out, not enough people, second time it went out, not enough people, and I believe at this June meeting I said at the Commission meeting we're not getting people in the Nursing Home SAC to submit names to be on the SAC. And as I do with every other SAC, I give it three times. We sent it out the third time, didn't get sufficient nominations. Three strikes and you're out. So there was no SAC created in spite of the Commission and the Department's best efforts to put one together.

So the update is that there isn't a SAC and if anybody has any questions about that or Brenda or Beth, if I've misstated anything, please correct me, because the attempt was there, three attempts, nothing happened. That's the discussion on the SAC. I think that's the end of that agenda item. I do have three cards, but one has the same person twice, that's because Pat Anderson is so good she can be here twice.

MS. ROGERS: Can I comment on that?

MR. FALAHEE: Oh, sure. You can, yeah.

MS. ROGERS: Okay. So, yes, this is Brenda and

Chip is accurate in his analysis. So now what we are going to be looking for from the Commission is how do you want to proceed and maybe you were going to get to that. But I just want -- so the Commissioners aren't left hanging, okay, what's the next step? We are going to be asking you what is that next step. Do you still want to proceed moving and looking at the charge that was originally set up for the SAC and that could be via a work group, via the Department, via yourselves as the Commission, or do you see no need to do that at this point in time and wait 'til the next review period in three years? So just -- just as FYI as you continue the discussion. Thank you.

MR. FALAHEE: Thank you, Brenda. This one Commissioner -- this is Falahee. We tried three times to get the SAC for the substantive issues, I mean, bed need methodology and the other issues. I don't think a work group is the best thing to do. But failing to get a SAC after multiple attempts to do it, we can't be stymied. We need to move forward. To me the most important thing to move forward on is to see the next agenda item which is the -- set the effective date of the new bed need numbers which were first I think published or discussed in late 2017, then they were attached to the March 2018 CON Commission minutes, so it's not as if people didn't know about them. So that's just one person's opinion.

MS. ROGERS: Okay. So, again, sorry, Chip.

MR. FALAHEE: No, that's --

MS. ROGERS: This is Brenda. So having said that, the numbers for the next agenda item that you have today is a result of its -- it was time to run the new need numbers again this year, 2019. So the numbers are slightly different than what you had two years ago so I just want to make that clear for the Commission members.

MR. FALAHEE: So the --

MS. ROGERS: So these have been rerun based on the standard that it's required that the Department run the numbers every two years. Having said that, had a SAC been seated, we still would have been doing that and we still would have been bringing these numbers to the Commission because according to the standard it's your responsibility to set the effective date of the bed need numbers. But the SAC could have still continued its work, okay. So I just want to make -- make clear in what we're doing here as far as the process goes.

MR. FALAHEE: Got it.

MS. ROGERS: Thank you.

MR. FALAHEE: So this is Falahee again. So Brenda, to confirm, the numbers we have, or the bed need numbers we have in front of us are the most current available?

MS. ROGERS: This is Brenda. That is correct. And so, and also in case you didn't -- we had both of Paul's reports in there, the one for this time plus we provided the one from two years ago. And the reason we did that is because when you look at the bed need numbers that came out in this run, they are higher than what's currently in place. Two years ago they were higher than what was currently in place. So when you looked at it, it does, it looks like a significant increase in the number of beds. Having said that, had the last run been put into effect and then comparing it to what the run is now in 2019, you would have seen a decrease of 400 plus beds. So I just want to make sure that you're -- when you're looking at these, that you're comparing and that type of thing.

MR. FALAHEE: Thank you.

MR. MITTELBRUN: Mittelbrun. Brenda, what was the recommended effective date by the Department?

MS. ROGERS: The Department is suggesting an effective date of November 1st as that is when the next scheduled publication of the bed need inventory is provided. And then also what that does, will give any applicant seeking to apply for new beds time because the next window date to apply is February 1st.

MR. MITTELBRUN: Thank you.

MS. ROGERS: So it will just make it even for all

players.

MR. FALAHEE: Thank you. So, and like I said before, at least I rely on all these people to my right and across, so thank you, Brenda, for those clarifications. I think that I'll move to the next -- well, I guess, is there -- is there any Commission action that we would like to take having not been able to seat a SAC? Commissioner Dood?

MR. DOOD: You made a comment that you didn't think a work group would be best, that a SAC would have been best and that's what we were looking for. But is a work group a possibility or you're saying hey, since that's -- would be far inferior to having a SAC. We couldn't get a SAC, so we should just give up on the issues that we had wanted addressed?

MR. FALAHEE: That's up to the entire Commission to decide.

MR. DOOD: Yup. I was just looking for your opinion on that.

MR. FALAHEE: I have the charge for what the SAC would have looked at had it been able to come together. Number one, bed need methodology. There are six total. I think one was the most important. Two, whether adequate access exists for Medicaid patients; three, specialty population beds; four, language changes as presented by the

Department regarding minimum occupancy requirements to section 6 and 8; five, language changes regarding technical edits; six, any other technical edits or changes. So those are the six charges. And the language about -- the four, five and six about language changes, you often see that when SACs are put together. To me, of those six, the most important was the bed need methodology. To be able to have a SAC, look at it, much like with the IECT SAC, you put people from both sides of the issue on it so there can be a robust debate one way or the other. My issue with work groups, other may disagree, is you don't know who's going to be there that morning or that afternoon when you hold the work group. You don't know if you're going to get 10 people or 20. You don't know if those 10 or 20 are all evenly split on the issue or happen to be on one side of the issue. So you could get a skewed result. That's why when it comes to issues like a bed need methodology, this -- this one Commissioner says no, you need the formal SAC and that's why the legislature in 2002 set up the SAC process, so there can be a robust discussion amongst experts that then those experts can report to us Commission members so that we can help understand what's going on. And sometimes work groups do work when there aren't substantive issues, things that need to be worked through. We've just went through one. But on this one at least, this one Commissioner doesn't

think a work group is the best way to look at the issue.

MR. DOOD: Commissioner Dood. So the options are to -- since a SAC could not be established would be either to do a work group that has some disadvantages to the SAC or to do nothing -- right? -- and just let it go, or you mentioned something about the Commission itself could have its own work group and -- was that something you said two minutes ago or no? Okay.

MR. FALAHEE: No; no. The Commission couldn't do its own work group. The Commission always has the ability to take a standard off cycle, if you will. We look at every standard every three years and as we discussed with IECT, we could always say, hey, we need to look at any standard out of -- out of cycle, out of sync. Am I correct on that?

MR. HAMMAKER: Yeah.

MR. FALAHEE: Okay.

MR. DOOD: And if we don't do anything, there's no work group established? That's not a default to when a SAC is not established? It would just -- is that correct?

MR. FALAHEE: You mean if you can't get one then you're stuck with the other?

MR. DOOD: I'm wondering or is the default nothing happens if we don't fill a work group?

MR. FALAHEE: The Commission decides what the "default" is.

MR. DOOD: You were going to move onto the next agenda item. I was trying to decide what that would mean.

MR. FALAHEE: Right. Well, they're kind of tied together.

MR. DOOD: I -- yeah, I agree.

MS. ROGERS: This is Brenda. Just in my side conversation and partly in answer to your question there, I think if the Commission decides that no work group is going to be required at this point in time, I think it would be just for making it clear and clean for the Commission to take -- make a motion to -- I don't even know if it has to say "not seat a work group," but just to in lieu of not seating a SAC or a work group, the standards will be put out for the next review period in three years or something to that effect just to make sure that it's clear and on the record.

MR. FALAHEE: Okay.

MS. ROGERS: Thank you.

MR. FALAHEE: Commissioner Dood, anything else?

MR. DOOD: Not at this time.

MR. FALAHEE: Thank you. Other questions? I don't have public comment specifically on this. I've got public comment from two individuals on the bed need. Pat, did you want to speak about this specific issue as well, Pat, on the SAC?

MS. PAT ANDERSON: Well, HCAM is in support of the SAC if it can be called and we'd be willing to help approve members.

MR. FALAHEE: Yeah. Okay. Pat Anderson from HCAM is in the audience and for the sake of the record, she said that HCAM is in support of a SAC. I knew that. They've always been in support of a SAC, we still didn't get a SAC. Okay. So with that, I have two cards, but that's on the next issue, the bed need numbers. So I think what we're left with is if there's no further Commission discussion, as Brenda just said, I'd entertain a motion if someone wants to make it along the lines of what she was just discussing or something else if you want to do that.

MR. DOOD: Could we -- Commissioner Dood. Could we wait on that until we have the next discussion since they are tied together or --

MR. HAMMAKER: Yeah, you can move on the agenda, suspend, you'll make a motion to suspend debate on this until after the bed need.

MR. DOOD: Make a motion to suspend this until we have the discussion on the bed need.

MR. FALAHEE: Support for that motion?

MR. MITTELBRUN: Second, Mittelbrun.

MR. FALAHEE: Motion made and supported. All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That carries.

(Whereupon motion passes at 11:03 a.m.)

MR. FALAHEE: So now let's move to agenda item ten. Set the effective date for the new bed need numbers. And as I said earlier, there are two cards I have for that and I will mess up his name, but Henry Boutros from Illuminate. Are you here? Good timing. I don't think you were here earlier. With any witness, you're limited to three minutes time and then the Commission members can ask you one or 100 questions after that.

MR. HENRY BOUTROS: Within the three minutes?

MR. FALAHEE: No. You have three minutes and we can make you --

MR. HENRY BOUTROS: You have all day?

MR. FALAHEE: -- yeah, we can make you stay here all day, so, yes.

MR. HENRY BOUTROS: Terrific. I might need a bathroom break after a few questions, but we'll go on.

HENRY BOUTROS

MR. HENRY BOUTROS: Chair Falahee and Commissioners, thank you for the opportunity to speak today regarding the new bed need numbers for nursing homes and hospital long-term care units. My name is Henry Boutros. I'm the vice president of Illuminate HC, which operates 16

skilled nursing facilities in the state of Michigan. For the last three years I've served as the chairman of the board of directors for the Health Care Association of Michigan and have recently been appointed by Governor Whitmer to the Veterans Facility Authority Board.

I'm here today to respectfully request that the commission not adopt the bed need projection and instead continue to work to form a Standard Advisory Committee, SAC, to review the basic methodologies used to determine the bed need going forward. HCAM and it's 348 skilled nursing facility members have been willing to serve on a SAC to review the bed need methodology. In fact, HCAM's vice president of reimbursement as well as HCAM's members applied to participate in the SAC in the early spring of this year following the first call for participation. Applicants did not receive any information in return about the status of the SAC. Convening a SAC for nursing facilities has proven to be difficult over the past few years, but we certainly understand and we support the need of a SAC to review the important issues. In recent years HCAM has provided chairs to the work group when a SAC was not able to be formed. HCAM is willing to continue to identify individuals to serve on the SAC or on a work group.

The August 2019 updates of the nursing home and hospital long-term care unit bed need reports a 6,797 bed

increase over the current bed need. That's a 17 percent increase moving from 39,391 to 46,188. The current methodology for determining nursing facility bed need projected this dramatic increase which does not appear to be reasonable as it's inconsistent with occupancy trends, contradicts real life experience of providers and does not reflect the rapid changes incurring in how people are interacting with the segment of the health care system which is integrated on the continuum of care -- long-term care supports and services. The continuum of long-term care supports and services provide alternate settings and programs for individuals to receive long-term care services that at one time were provided within the skilled nursing environment. The primary goal of the CON is to help control costs by preventing excess capacity in health services. The cost implications of having thousands of nursing home beds in Michigan are significant. Following the assumptions provided by the current CON methodology, Medicaid program would be over $45 million of state's general fund dollars year over year if we were to go forward with this program. The work force providing care --

MR. FALAHEE: Sum up your remarks, please.

MR. HENRY BOUTROS: Pardon?

MR. FALAHEE: Your three-minute timer is going off, so if you could sum up your remarks, please?

MR. HENRY BOUTROS: Great. Yup. So summing up. I'm here today to respectfully request that the Commission not adopt the bed need projection and instead continue to work to form a Standard Advisory Committee to review the basic methodologies used to determine the bed needs going forward.

MR. FALAHEE: Thank you very much. Questions from the Commission members of Mr. Boutros?

MR. MITTELBRUN: Mittelbrun. I'm a little -- your comments about the SAC, what would be different than what just happened where we tried to seat the SAC three times and failed because organizations like yourself didn't participate? And two, I'd like Brenda maybe to give that explanation on the bed need numbers or the calculation that you just gave the Commission before the gentleman walked in. He didn't get the chance to hear that.

MR. HENRY BOUTROS: So, as far as HCAM and our facility membership within the Health Care Association of Michigan, we are very interested in participating on any level by providing names to participate on the SAC itself, and -- and I think once the application is made, I believe it's out of our hands so we can't force the CON, you know, this Commission here to appoint somebody. All we've done is applied and have waited for a response and we've not had that response come back. And so it's a disappointment on

our end not to have this go forward.

MR. FALAHEE: This is Falahee. I'm going to respectfully disagree. As the one -- as the chairman, I work with Brenda and Beth very closely on these, on any SAC, and there was notice that we weren't getting adequate nominees.

MR. HENRY BOUTROS: Well, I believe that this spring --

MR. FALAHEE: And there was -- there were -- there were one, two, three attempts to get adequate nominations. And in fact, I'm pretty certain if you look at the minutes of the June meeting of this Commission, I said something right there at that June meeting about we're having trouble getting nominations. If you want to do that, get your name in. So I think there was more than adequate notice and three attempts to put the SAC together. Brenda, if I'm wrong, please correct me.

MS. ROGERS: Brenda. That is correct.

MR. HUGHES: I get the e-mails, too; right?

MR. HENRY BOUTROS: So, and I don't know where the disconnect may have happened. I do know that the vice president of reimbursement for HCAM applied as did other members within HCAM, as -- as members have, and they applied during the first round, the invitation in early spring, and we did not hear anything back. So obviously there's a

disconnect and it's -- I'm -- I'm hoping standing here before you today we can hopefully try to clear that up, that our intention -- we believe that there is a good value in putting the SAC together and to have our representation there to provide input to this Commission. Truly, it sounded that we didn't -- that we somehow we -- we disconnected on this issue which is important to all of us here.

MR. HUGHES: Wasn't done in secret.

MR. HENRY BOUTROS: Oh, no, and I apologize.

MR. MITTELBRUN: Brenda, would you go through those numbers again, please? Mittelbrun. The explanation of -- that you gave the Commission?

MS. ROGERS: This is Brenda. Maybe, yeah. Get this thing turned around. Okay. Yeah. So as far as the bed need numbers that are in front of you today, as I stated earlier, so this is part of the requirement of the standard for the Department to run the bed needs every two years. So it was ran in 2017, it was due again here in 2019. When we ran it in 2017, the Commission decided -- and it's the Commission's responsibility to set the effective date of those bed need numbers. And at that time there was discussion and the Commission decided to not put an effective date on the bed need numbers and to postpone them indefinitely knowing that the standards were going to be

coming up for review in 2019 and to seat a SAC and take a look at that bed need methodology. So, therefore, those numbers didn't go into effect. Now, doing due diligence, the Department, because of they're due again in 2019 and we would have done this as I stated earlier even if a SAC or a work group would have been seated, the Department asked Paul Delamater, because that's who does the calculations for us, to run the bed need numbers. And so you have them in front of you today for -- again, for you as the Commission to determine the effective date of those bed need numbers or you can do as you did two years ago, decide to postpone or, you know, whatever you want to do with the effective date. And, again, as I stated earlier, I don't know if you -- did you want me to cover this, too, Tom, as far as the comparison of the numbers?

MR. MITTELBRUN: Yes, please.

MS. ROGERS: Okay.

MR. MITTELBRUN: That was important.

MS. ROGERS: So -- so when we ran the numbers in 2017, it showed a significant increase in beds compared to what was in effect at that time. A lot of that had to do with the one prior. There were questions because the numbers were so low, so we've done some cleanup. We found -- we did some digging, founded that -- found out that there was a lot of reporting issues on the numbers. So the

last two runs now we are working with -- on my term -- good data from what we had over years past. Okay. So as a result of that, though, it is showing an increase in bed need numbers.

So when you're looking at the numbers today and comparing it to what's in place, keep in mind you did not set an effective date on the last run, so it is looking like it's a large increase. Had you set the effective date two years ago, it would have been a large increase at that time again because of all the -- you know, the cleanup of the reporting, et cetera. But comparing that to today's run, you would be see -- you actually see a decrease of 400 plus beds. So it depends on how you want to look at it. And I'm in agreement, because of the numbers that are in effect right now which were last run in 2015, you're going to see that discrepancy or change. I hope that helped.

MR. MITTELBRUN: Now, go on. That's a good job, but that's why I wanted him to hear that.

MR. HENRY BOUTROS: May I -- may I respond? Thank you, sir. So in 2015 we believe that the report, as you said, Ms. Rogers, was bed need was far too low and HCAM brought that information forward recognizing as you said and identified that not all of the providers are actually providing data as an input for the basic methodology that Paul has put together. And then in 2017 and 2019, the

report projected that the numbers were too high. So while I believe there has been some sort of cleanup that's been done by having providers report, we still don't know and we're still not assured ourselves that providers are reporting the exact data that is needed for the methodology. In addition, what we've noticed since 2015, occupancy rates in the state of Michigan have actually been on a decline and so it seems alarming that by 2017 and 2019 the bed numbers have gone up. Irrespective of where you have your cutoff, we know from 2015 to 2019 occupancy rates have declined throughout the state. And so it just does -- and so -- and part of that may due to having outside supports and services that normally would have been fulfilled by the long-ter- -- by skilled nursing are now being fulfilled through programs like PACE, the waiver programs, other type of home health programs where individuals who are actively moving individuals who no longer meet the requirements for long-term care for skilled nursing are now being moved back into their home. And that's an active -- a active program that all the providers here in the state of Michigan are participating in to put individuals in the right place.

So, you know, we don't know if the formula that we are using today actually takes into account how supports and services are actually being utilized. So the real data of from a provider level have seen our rates drop. The

occupancy rates drop. Seems inconsistent with the notion that we have more beds that are available. Especially like in Oakland County or some of the other very specific counties that we've identified in our report that we submitted to the Commission here earlier, it was suggesting that Oakland County is going to need another 1100 beds. Well, Oakland County's occupancy rates have dropped below 80 percent. And as all of you are well aware, that the 85 percent occupancy rule is this structure for providers where you start being penalized anything less than 85 percent occupancy. So adding more beds to the system, it's not going to meet any more needs, it's just going to add more costs to the state. As you projected, it's about a $45 million increase -- potentially an increase of $45 million year over year.

So all we're asking is can we step it back and take a look at what are the new inputs? Is it comprehensive enough? Should we be looking at data of individuals being now actively being placed outside of the system? And can we be really assured that the information that providers are providing today as part of an accepted formula, is that accurate information? Just because we have greater participation of data being put in, is it accurate information that's being put in?

MR. FALAHEE: This is Falahee. One would hope

that when that data is submitted it is accurate. And I also -- you said the numbers were too high. Well, the numbers are the numbers based on the data that's submitted. Maybe individual people or individual entities think the numbers are too high, but I think when Professor Delamater runs the numbers, he bases it on the data that's submitted to him.

MR. HENRY BOUTROS: Correct. And so we're -- we're -- yes, sir.

MR. FALAHEE: And -- and the point -- and the point is here you are asking again give us another chance to put a SAC together. We tried. It didn't happen.

MR. HENRY BOUTROS: I can commit that this will happen rather quickly --

MR. MITTELBRUN: Mittelbrun -- oh.

MR. HENRY BOUTROS: -- absolutely within a short period of time. So, but, I mean, have we taken into consideration the decreased occupancy? That's also a hard fact. That's easy numbers that regardless of whether we argue it or not, it's a fact that occupancy levels have dropped significantly throughout the state.

MR. MITTELBRUN: Okay. Mittelbrun. Henry, just as a followup, I think that might be a little -- well, I don't know if I'm confused or not. We're talking about the data that's submitted?

MR. HENRY BOUTROS: Yes; yes.

MR. MITTELBRUN: Isn't it the members of your association that are submitting the data?

MR. HENRY BOUTROS: That is correct.

MR. MITTELBRUN: And I'm -- and I'm assuming you're helping them to make sure it's -- it's correct and accurate?

MR. HENRY BOUTROS: Well, to the extent that they reach out and to the extent that they listen to the advice that we've provided that is correct and, as we found out in 2015, that was not happening. And so we, too, are saying let's take a look at this. Let's step back. Is this really the right kind of data that should be collected?

MR. MITTELBRUN: Well, you've got to correct the rep, Henry, that's all I can tell you because I --

MR. HENRY BOUTROS: Point taken. Please give us the chance to put this SAC together. I mean, this can be taken care of extremely fast.

MR. MITTELBRUN: Thank you.

MR. HENRY BOUTROS: Thank you, sir.

MR. FALAHEE: Any other questions? I have one more comment card. Thank you. Last card, Pat Anderson -- oh, Pat, you moved. Thank you. Okay.

PAT ANDERSON

MS. PAT ANDERSON: I'm Pat Anderson with the

Health Care Association of Michigan and I did apply for the SAC. I understand that you're looking for payers. In the nursing facility arena, 63 to 65 percent of the payers --

MS. NAGEL: Purchaser.

MS. PAT ANDERSON: Purchasers. Okay. Purchasers? How do you define a purchaser?

MS. NAGEL: Typically it's been an employer, someone who purchases --

MS. PAT ANDERSON: An employer base? Okay. Most of the nursing facility services are paid by Medicaid. They would be the purchaser. The other big chunk is Medicare and that represents probably 80 percent of our business. I guess one of those would have to be at the table? I don't know. Medicaid doesn't usually participate.

MS. ROGERS: This is Brenda. Typically for purchasers, it's a purchaser of health care services. That's if you look at the statute. So typically what we've had in the past is your union -- your union organizations have been the biggest, but a purchaser of health care services. I mean, that's repre- -- that type of representation. And not only did we not have purchaser organizations, we were also short on the expert side of nominations as well.

MS. PAT ANDERSON: We have access to many experts. Purchasers is a little more difficult. A lot of health

benefits don't include long-term care. That's not a benefit there, so that's not -- they're not a purchaser of it so that is a little more difficult. But Henry has made the commitment we would be willing to help with that.

The only other comment is I wanted to support what Henry said about the bed need and the methodology. And, yes, we've worked with the CON staff over the last probably five years to correct the filing report to get that information more correct and it has done a better job. Some of the terminology about five years ago was more on what a hospital would be used to as versus a nursing facility. So miss -- data was missed. It is much better data today. It can always get better. But the big point is our occupancies are still going down. Like Henry pointed out there are alternatives to going to the nursing facility and somehow they need to be measured in the methodology. The numbers will come out and it'll look like that the population is getting older, it grows and grows, but there's alternatives and I think that's what's being missed in the methodology. Thank you.

MR. FALAHEE: Any questions from the Commission members? Okay. I don't have any other comment cards on this topic. So let me see if I can figure out where we're at. In front of us now is whether we as the Commission want to set the effective date for the new bed numbers. Whatever

action we take on that, then we need to go back to the prior agenda item where we -- agenda item nine to figure out what if any Commission action we want to take on that. Am I stating that correctly, people to my right?

MR. HAMMAKER: That's correct.

MR. FALAHEE: Okay. So on the agenda item ten, setting the effective date. There is a recommendation from the Department to set the effective date as of November 1 of this year, 2019. And what, Brenda, what other -- or anybody else -- what other options are there? We could just not set an effective date and just keep it as is? What are our options there?

MS. ROGERS: Yeah, this is Brenda. As I stated previously, or you can do like you did two years ago, you can postpone setting indefinitely the effective date of the number so then the bed needs remains the same so there would be no change in the bed need numbers.

MR. FALAHEE: So then if we took that action, the bed need is based on 2015 data?

MS. ROGERS: And actually when it was run in 2015, I think it was based on -- I don't have that information in front of me -- I want to say probably 2013 or '14 because it's always like a year off, behind.

MR. FALAHEE: Okay. All right.

MR. MITTELBRUN: Mittelbrun, a question. So based

on your comments, Brenda, and actually the comments of the test- -- both who provided testimony, that the data is better than it was in 2014 or '13, whenever it was run before. So it makes sense to me that this is more accurate than it was in the past. So I don't know -- I guess my -- my thought process is why would we keep pushing it off when we know we're working off of inferior data or not, or less accurate data than we have today?

MS. ROGERS: This is Brenda. That is correct. I think we at the Department -- and Beth or Tulika can correct me if I'm wrong -- that we have done due diligent and the data that we have today as far as what the facilities are reporting is much significantly better data than what we had in the past. And I will just say that even if you decide to set an effective date for this current run, that does not preclude you as the Commission to still form a work group or something to still take a look at the methodology. So it does not preclude you from doing that. So I just want to make sure that you're aware of that as well.

MR. FALAHEE: This is Falahee. Thank you, Brenda, for that explanation. Questions about setting effective date? If not, I think we need to proceed to see if we can have a motion on that issue one way or the other. Any questions? Commissioner Dood?

MR. DOOD: Commissioner Dood. Yeah, kind of a

question, kind of a comment. But we've got the data and then we have a methodology and the two together presented this result that we're talking about setting effective date. In my mind the, from what I've heard from the testimony, what I know of the industry, it creates kind of an illogical result. You have very low occupancy and we'd be increasing the supply rather dramatically. And the data is good, everybody's saying that, so it seems like it's the methodology is the issue. Jumping ahead on the agenda item, you know, that's the problem. We didn't get anybody in time to opine on the methodology to look at that to figure this out. But setting an effective date, because that didn't happen, to create an illogical result is -- doesn't make any sense to me.

MR. FALAHEE: This is Falahee. In some people's minds it may be illogic, in some they would say the data is the data and derived, the numbers are driven by it and the data is what it is and it was the data that was submitted by the nursing home community.

MR. DOOD: But it's the data times the methodology -- right? -- that -- it's the two together that produces the results, not just the data. It's the methodology and the methodology we all agreed in March needed to be looked at and it -- it -- it hasn't been. I understand the frustration with that.

MR. FALAHEE: Other questions or comments? If not, I think we need to proceed to a motion if possible.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. So when we -- I just want to make sure what's on the table -- right? -- because we had two considerations that we kind of said we were going to wait and combine them and so as we look to take a motion, it's on what?

MR. FALAHEE: Setting the effective date for these -- the nursing home bed methodol- -- the numbers.

MS. BROOKS-WILLIAMS: So setting a -- setting a -- a -- a date for the numbers. What about the methodology? We're just saying because we couldn't seat the SAC we're not dealing with that one now? Because we --

MR. FALAHEE: Not --

MS. BROOKS-WILLIAMS: -- we set it aside to address them together, so I'm just trying to make sure I understand what we're -- do we have two items we need to act on or one?

MR. FALAHEE: I would say the answer is two. Okay. Because we need to set the effective date as Brenda explained a few minutes ago.

MS. BROOKS-WILLIAMS: Yes; uh-huh.

MR. FALAHEE: Then we need to go back to the prior agenda item --

MS. BROOKS-WILLIAMS: We go back. Okay.

MR. FALAHEE: -- and say, okay, given what we did or did not do on the effective date, do we as a Commission want to try again to do a SAC, do we want to do a work group, do we want to do nothing?

MS. BROOKS-WILLIAMS: Okay.

MR. FALAHEE: So I look at it they're connected, but they're two separate issues.

MS. BROOKS-WILLIAMS: Okay. Thank you.

MR. FALAHEE: Fair enough? Okay. So I think what's before us now is setting the effective date of the new bed need numbers.

MR. DOOD: Commissioner Dood. I make a motion that we postpone indefinitely the setting an effective date for the new bed -- the need methodology.

MR. FALAHEE: Is there support for that motion? Hearing none, that motion fails.

MR. MITTELBRUN: Mittelbrun. Taking into account Commissioner Dood's comments, which I completely understand, by the way, but on the other -- on the other -- other side I don't think it's right to continue to kick the can down the road. So I'm happy to make both motions, but the first one, we've got to take care of that first. Make the motion to set the effective date as November 1st, 2019. I'll stop there, but there will be a part two. I don't know if it'll

satisfy --

MR. FALAHEE: Is there, is there support for that motion?

MS. LALONDE: Lalonde. Support.

MR. FALAHEE: Okay. Thank you. So there's a motion on the floor and supported to set the effective date for the bed need numbers as of November 1 of 2019. Any discussion? Questions? All in favor of that motion say "aye."

ALL: Aye.

MR. FALAHEE: Opposed?

MR. DOOD: Aye.

MR. FALAHEE: One opposed, all others in favor, the motion carries.

(Whereupon motion passes at 11:31 a.m.)

MR. FALAHEE: Now we will go back to the prior agenda item. Do we need a motion to go back to the prior agenda item?

MR. HAMMAKER: Why not?

MR. FALAHEE: Okay. Always follow what the attorney general tells you to do. Okay. We need a motion to go back to the one we motioned to go ahead from.

MS. BROOKS-WILLIAMS: Brooks-Williams. I move that we go back to the agenda item that we moved --

MR. FALAHEE: Nine.

MS. BROOKS-WILLIAMS: -- yeah, agenda item nine.

MR. FALAHEE: Support?

MR. HUGHES: Support.

MR. FALAHEE: All in favor?

ALL: Aye.

MR. FALAHEE: Opposed? Okay.

(Whereupon motion passes at 11:32 a.m.)

MS. ROGERS: Excuse me. This is Brenda. Who was the support?

MS. NAGEL: Hughes.

MR. FALAHEE: Oh, Mr. Hughes.

MR. HUGHES: Commissioner Hughes. Sorry. Sorry about that.

MR. FALAHEE: Okay. So now we're back at nine. Any discussion? Otherwise, I think Commissioner Mittelbrun has something to say.

MR. MITTELBRUN: Well, I will do -- I -- I will do part two of my thoughts. Is that I make a motion that we attempt once again for the last time hopefully to seat another SAC in this matter to address all of Commissioner Dood's comments and the comments of our presenters today.

DR. GARDNER: Support.

MR. HUGHES: Second. But jeez, oh Pete's.

MR. FALAHEE: Well, hang on. One second.

MR. HUGHES: All right.

MR. FALAHEE: So we have a motion -- we have a motion and support by Commissioner Gardner.

DR. GARDNER: Gardner. Support.

MR. FALAHEE: And then I think Commissioner Hughes has something to say.

MR. HUGHES: Strike me from the record.

MR. FALAHEE: Anything?

MR. HUGHES: It's already been said. Let's just get it done.

MR. FALAHEE: And let me suggest that a friendly amendment to your motions would be that if the Commission decides to approve that motion, that the chair and the vice chair are authorized to develop the charge for that SAC and to do whatever we can do to encourage, strongly encourage, coerce membership on the SAC. "Coerce" was said in jest. All right? So I would assume you meant -- you included that in your motion?

MR. MITTELBRUN: I amend my motion to include all of the above.

DR. GARDNER: And I support.

MR. FALAHEE: Thank you. All right.

MR. DOOD: Quick question. So you're not bound by the earlier charge that we work through in -- in March then? With your friendly amendment you're -- you're starting from scratch on that?

MS. ROGERS: Yeah, this is Brenda. That's how I read Chip's amendment.

MR. DOOD: Would you anticipate the bed need methodology still being on the charge or not?

MR. FALAHEE: That would be my anticipated charge number one, two, three, and four, yes. And then whatever other charges are appropriate given anything that's transpired between March of this year and now, when we set the first charge on March 21 of this year. Other questions? Okay. We have a motion on the floor. All in favor of the motion say "aye."

ALL: Aye.

MR. FALAHEE: All opposed? The motion carries.

(Whereupon motion passes at 11:34 a.m.)

MR. FALAHEE: Let me say in the strongest possible terms. We've been through this before, we have not been able to form a SAC. Let's put a SAC together. Because I, too, do not like kicking the can down the road. Thank you.

MS. LALONDE: Can I propose a five-minute break?

MR. FALAHEE: That -- you've read my mind. Okay. We'll take a five-, ten-minute break and we'll come back for the last few minutes of our meeting. We're on, next agenda item is CT.

(Off the record)

MR. FALAHEE: This is Commissioner Falahee. We're

going to go ahead and get started again. I notice far fewer people in the room, so that's okay. We've had a discussion in -- in the break with some real fine tuning we may need to go through to make it easier to put this SAC together and I'm going to let Mr. Hammaker explain the details and then get ready, Commission members, I think we may need to do another motion to fine tune what we just did. Carl?

MR. HAMMAKER: Okay. So what we were just discussing, the administrative process of forming the SAC and typically when someone applies to be a member of the SAC, their application stays in the pipeline. So when the Commission moved to form a SAC back in the March meeting, there are applications that are already received. If the Commission -- when the Commission voted to form a SAC now, that would restart the process and the Department would lose those applications that were already in the pipeline. So rather than doing that, I would recommend to the Commission that someone bring a motion to reconsider the previous vote to form a new SAC and, instead, direct the Department to continue to work off the charge that was previously developed as a result of the vote from the March Commission meeting, and then we'll go -- the Department will proceed to try to put the SAC together, you know, for a -- put a fourth callout on the same previous charge.

MR. FALAHEE: Which -- this is Falahee -- would

then keep those that are in the pipeline still in the pipeline; right?

MR. HAMMAKER: Correct.

MS. BHATTACHARYA: Yes.

MR. FALAHEE: Okay.

MR. DOOD: Make a motion that we reconsider our earlier vote. Do a -- do we need to vote on that first or can we --

MR. HAMMAKER: Yeah.

MR. FALAHEE: Yeah; right. Yeah, we do -- right; right.

MR. HAMMAKER: We need a second, too.

MR. MITTELBRUN: Second. Mittelbrun.

MR. FALAHEE: So we have a motion on the floor. At this point all the motion is, is just to reconsider the prior vote. Any questions? All in favor say "aye."

ALL: Aye.

MR. FALAHEE: All opposed? That motion carries.

(Whereupon motion passes at 11:46 a.m.)

MR. DOOD: I make a motion that we continue the process of filling the SAC with the charge from the March meeting.

MS. GUIDO-ALLEN: Guido-Allen. Second.

MR. FALAHEE: Motion made and seconded. And by the "March meeting," you mean the March 2019 meeting?

MR. DOOD: Correct.

MR. FALAHEE: Any questions?

DR. MCKENZIE: Yeah, I have a question. Would -- would those that have applications in the system be notified that there's going to be a new call for a SAC so that they're aware and ready if they applied months and months and months ago? Or if they're already part of the community and might be able to solicit additional support -- because I did hear that -- you know, I heard from the testimony that there was a lack of awareness and I'm not sure if you're not part of the Listserv maybe they're not receiving that -- that information that there's yet another round. So is that an option or what's the expectation around that?

MS. NAGEL: So the people that have already applied wouldn't have to reapply again. Is that what -- did I miss --

DR. MCKENZIE: Yeah. Would they be notified, though, that we're now going to seek -- we need additional applications, we still have your application, we're going to move it forward, you know, but we'd still need additional participants?

MS. NAGEL: We certainly can do that. Brenda, reminds me, yes, that is something that we do.

DR. MCKENZIE: Okay. Thank you.

MR. FALAHEE: Other questions? So we have a

motion on the floor. All in favor of the motion say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? That motion carries.

(Whereupon motion passes at 11:48 a.m.)

MR. FALAHEE: Okay. Next agenda item is a written report, it is in our packet, on the CT scanner services, the work group and there's a written report there. There's really no formal action required, just to notice that the -- be aware of the written report. Brenda, anything else on that?

MS. ROGERS: This is Brenda. I don't believe so. Although I believe the chair had a comment in the report about seeking the Commission's opinion, but I don't know that that was something he necessarily was asking for at this meeting. But I just -- I do draw you to that attention as to his comment, and I'm sorry I don't have it right here in front of me. And then just to let the Commission know, they've actually only held one meeting at this point, so they've really just gotten into the discussions. And I -- and the comment that's in there about the question to the Commission, I do know at the end of that very first meeting they were throwing out a lot of different things and so I think, I believe -- and Beth can correct me if I'm -- might be not remembering this correctly -- but I think that's where that came from.

MR. FALAHEE: This is Falahee. I guess we just wait to see as they have additional meetings and maybe fine tune what they're working on and if they want to ask question of the Commission even after they fine tune it, that's fine. So Brenda, are we all set on that then?

MS. ROGERS: Yes. Thank you.

MR. FALAHEE: Okay. Let's move on then to agenda item 12, the legislative update. That has my name, Falahee, next to it. As you can tell from listening to Senator VanderWall today, he and I have met four times since February and about IECT, CON in general, and most recently potential CON reforms that he has talked with me about and others. No legislation has yet been introduced on those reforms and I don't know whether any or all of those will be introduced as legislation. So I think it's premature to talk about what might happen. But we've had robust discussions, he and I. And going forward over the next two weeks I'll be meeting with I think 15 legislators in my role as chair of the CON Commission and another hat I wear is on the board of the Michigan Hospital Association, to talk with them about CON. Because with the term limits, many of our legislators, through no fault of their own, we talk Certificate of Need to them and they don't know exactly what that is, how it works, and what our job is and what their job is. And so it's -- and I've done this before, prior

chairmen have done this, Ed Goldman did it, Mark Keshishian and I did it, to go educate the members of the legislature. So I'll be meeting with all the members of the JLC and other members of the legislature and leadership to -- just to tell them, you know, let's talk about CON, what it is, what it does and answer any questions they may have. And then if they want to talk about potential reforms, happy to do that and whatever happens, I'll report back at our next meeting in -- in December. And if there's anything that comes up urgently, I always can get out by e-mail information or phone call. So that's where we're at on that. Any questions? Okay.

Administrative update, a couple reports here. Beth, for the planning and access to care section update?

MS. NAGEL: Yes. I wanted to update you that the open heart surgery standards has in it the need to -- I think it's every -- I'm looking at Brenda -- five years?

MS. ROGERS: Open heart is three.

MS. NAGEL: Open -- every three years we update utilization weights for adult and pediatric numbers. Those are not in the statute that we need the Commission to set an effective date. The Department sets the effective date and we are -- I'm just notifying you that those will be updated on our web site. I believe the effective date is October 1.

MS. ROGERS: Correct.

MS. NAGEL: I also just wanted to note -- to note that our notice of public comment period will be going out soon for the standards to be updated in 2020 to the Commission and that will be held from October 4th to October 18th. It's how we generate all of the information that you look at at your special Commission meeting in January. Those standards that we're specifically asking for feedback on are: cardiac catheterization, hospital beds, MRT, open heart surgery, PET scanners, and surgical services. That's it.

MR. FALAHEE: Any questions of Beth? We'll move on then. Tulika?

MS. BHATTACHARYA: Hi. There are two reports in your packet: the performance measures for the program and the compliance report. We are doing the MRI and PET services compliance. We have made progress. We have sent out letters of appropriate actions or a proposal for settlement agreement to the providers based on our investigation and our conference calls with the providers. There are just a few providers that we are still working on to figure out appropriate actions.

The third one is an application process update. So under the statute, the Department frequently monitors the processes and develops forms in order to promote administrative efficiency of the application review process.

So the Department has developed this new form called Certification of Planning Area Bed Need, a form 200C. So all applications for new beds for which the Department maintains the bed inventory, so hospital beds, nursing home beds, psych beds, NICU beds, for those applications the applicant will need to submit this form. So when providers file their letters of intent, we will assign this form to their application so that they know they're required to fill out this form. So basically what this form says is based on the Department inventory, if the planning area shows no bed need or a negative bed need which means there is a surplus of beds, the Department is not going to accept applications for new beds in those planning areas. Any questions?

MS. GUIDO-ALLEN: Can you repeat that one more time?

MS. BHATTACHARYA: So this form will be applicable to proposed projects that are requesting new beds from the Department inventory. We maintain the Department inventory for hospital beds, nursing home beds, psych beds, and NICU beds, and we publish a new report every two months, January, March, May, the odd months, July. So what we are saying is -- and the applications for new beds can only be submitted three times a year: February, June, and October under the statute and the rules. So what this form is saying, if a planning area does not show that there are

available new beds, then an applicant cannot submit an application for those beds in that planning area.

MS. GUIDO-ALLEN: Got it.

MR. FALAHEE: Commissioner Dood?

MR. DOOD: Commissioner -- so if there's another basis for needing a Certificate of Need, let's say replacing a facility which would be allowed even if there was excess inventory, this form would prohibit that now and it didn't in the past? I'm confused on the language.

MS. BHATTACHARYA: No. So when you are replacing beds or acquiring existing facilities or relocating beds from one existing to another existing facility, you are not requesting new beds from the Department inventory.

MR. DOOD: So this is just for new?

MS. BHATTACHARYA: This is just for new beds.

MR. DOOD: Thank you. So this is a process you do internally now. You're asking people, hey, make sure you looked at it, fill out the form beforehand?

MS. BHATTACHARYA: We are making it public. It was kind of informal because if there are no new beds, why would you apply for it? But now we are making sure that the applicant certifies they have reviewed the bed inventories and they have made sure that there are available beds before they apply for those.

MS. NAGEL: If I could just add? Even though it

does seem strange that someone would apply for new beds when there are no beds, it does happen and so we are trying to fix the problem.

MR. FALAHEE: Other questions? Okay. We'll turn next to the legal activity report.

MR. HAMMAKER: So there's not much of an update from our last meeting. I put a -- there's a written report in the packet. There is still one administrative case ongoing. That's through discovery and it's been adjourned until next month.

MR. FALAHEE: Any questions? All right. For those in the audience, future meeting dates for next year if you don't have them, this year our last meeting will be December 5. Then for next year January 30, that'll be our usual special Commission meeting, then March 19, June 18, September 17, and December 10th. So those are the meetings for next year. I'll do it quickly again: January 30, March 19, June 18, September 17, and December 10th. Okay.

The next agenda item is public comment. I do not have any cards in front of me and I don't see anyone approaching the podium, so I'm going to assume no public comment. Brenda, turn it over to you for Commission work plan review.

MS. ROGERS: This is Brenda. You do have the draft work plan in your packet. I'm not going to go -- read

through everything, but if you have a question on it, please let me know. We will just need to have a motion to accept the work plan as presented. And the only modification made today is that we are going to continue to work on the nursing home SAC, so we will update it accordingly. Thank you.

MR. MITTELBRUN: Motion to accept work plan as presented.

DR. MCKENZIE: Second.

MR. FALAHEE: Second by McKenzie. Discussion? All in favor say "aye."

ALL: Aye.

MR. FALAHEE: Opposed? All right.

(Whereupon motion passes at 12:01 p.m.)

MR. FALAHEE: That brings us to adjournment. I would entertain a motion to adjourn.

MS. BROOKS-WILLIAMS: Brooks-Williams. I move that we adjourn the meeting.

MR. fALAHEE: Okay. Support?

MR. HUGHES: Second.

MR. FALAHEE: All in favor?

ALL: Aye.

(Whereupon motion passes at 12:01 p.m.)

MR. FALAHEE: Thank you, everyone. Thanks for all your diligence on getting through the agenda and our packet.

Thank you very much.

(Proceedings concluded at 12:01 p.m.)

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