1 STATE OF MICHIGAN
2 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
3 CERTIFICATE OF NEED COMMISSION
4
COMMISSION MEETING
5
BEFORE MARC D. KESHISHIAN, M.D., CHAIRPERSON
6
333 South Grand Townsend Street, Lansing, Michigan
7
Wednesday, September 21, 2016, 9:30 a.m.
8
9 COMMISSION MEMBERS: SURESH MUKHERJI, M.D., VICE CHAIRPERSON
DENISE BROOKS-WILLIAMS
10 GAIL CLARKSON
CATHLEEN COWLING, D.O.
11 JAMES FALAHEE
DEBRA GUIDO-ALLEN, R.N.
12 ROBERT HUGHES
THOMAS MITTELBRUN III
13 JOSEPH POTCHEN
LUIS A. TOMATIS, M.D.
14
15 MICHIGAN DEPARTMENT OF
HEALTH AND HUMAN
16 SERVICES STAFF: TULIKA BHATTACHARYA
BETH NAGEL
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1 Lansing, Michigan
2 Wednesday, September 21, 2016 - 9:31 a.m.
3 DR. KESHISHIAN: Good morning. I'm calling the
4 meeting to order. I want to thank everyone for finding this
5 location and this room. Thank you very much. This is our
6 final location. We've been moving around for the last nine
7 months, and this is the place we'll be permanently.
8 First item is review of the agenda. Are there any
9 changes on the agenda at this time that anyone wants to
10 recommend? Do I hear a motion for approval of the agenda?
11 DR. COWLING: Move to approve, Commissioner
12 Cowling.
13 DR. KESHISHIAN: Second?
14 MR. MITTELBRUN: Mittelbrun, second.
15 DR. KESHISHIAN: Thank you. All in favor?
16 (All in favor)
17 DR. KESHISHIAN: In your package is a Declaration
18 of Conflict of Interest. If anybody conflicts, they can
19 declare them now or at any time during the meeting. Are
20 there any conflicts that anyone wants to declare now? Okay.
21 Next item is Review of Minutes of June 15th, 2016. Do I
22 hear a motion for approval?
23 MR. FALAHEE: This is Falahee. I'll move for
24 approval of minutes.
25 DR. KESHISHIAN: Do I hear a second?

1 DR. TOMATIS: Tomatis, second.
2 DR. KESHISHIAN: Thank you. Any discussion? All
3 in favor say "aye."
4 (All in favor)
5 DR. KESHISHIAN: Opposed?
6 (None opposed)
7 DR. KESHISHIAN: Thank you. Next is CT scanner
8 services. And I'll turn it over to Brenda. Brenda?
9 MS. NAGEL: Good morning, this is Brenda. And
10 before I get started, just a friendly reminder to please
11 identify yourselves before you speak today. Thank you.
12 All right. CT Scanners, we held the public
13 hearing back in July, I believe it was. And after hearing
14 that public hearing, no further changes are being
15 recommended to the Commission. We received two pieces of
16 testimony during that public hearing, both in support of the
17 language changes as the Commission passed it at your June
18 meeting. So the Department is moving this forward to the
19 Commission for final approval and to the JLC and the
20 Governor for the final 45-day review period. Thank you.
21 DR. KESHISHIAN: Do we have any questions? As a
22 comment, if anybody in the audience has any comments, we do
23 need cards. The limitation to speak is three minutes. I do
24 not have any cards on CAT scans. Are there any -- does
25 anyone want to speak? Please give a blue card, if not,

1 we'll go to the Commission discussion. Okay. Any
2 discussion on this issue from the Commissioners?
3 MR. FALAHEE: This is Falahee. Just one technical
4 question, I guess. If you look at the first page down on
5 line 51, Brenda or Joe, where it says "certified by the
6 manufacturer, and specifically," you may want to delete the
7 comma and say "and are specifically designed." Because you
8 refer "dental CT scanners that generate a peak of five and
9 are specifically designed to generate CT images to
10 facilitate dental procedures." It's a minor point, but I
11 think it ties it together that really it's -- there's two
12 qualifications. "Peak power of 5 and are specifically
13 designed to generate CT images." That's it.
14 MS. ROGERS: This is Brenda. Yeah. And I'll
15 defer to Joe but, yeah, I would agree that's a technical
16 change. So after "manufacturer" review the comma and then
17 after "and" insert the word "are."
18 MR. FALAHEE: Falahee again. Apologize I didn't
19 get a chance to catch it beforehand. But, yup, just that
20 knit, and that's it.
21 DR. KESHISHIAN: Any other discussion? Okay. I
22 do want to reference there's a letter from the University of
23 Michigan. There was some comments made at the last CON
24 meeting regarding the use of CT scanners. I believe it's
25 page 124. People can look at it at their convenience

1 related to the CT scan issue that we discussed at the last
2 meeting. Having said that, do I hear a motion for approval
3 of the standard as written with the changes that
4 Commissioner Falahee brought up in and the Department states
5 is a technical change?
6 MR. FALAHEE: This is Falahee. I'll move to
7 approve the standard as presented to us and that they move
8 forward to the JLC and the Governor for the 45-day review
9 period subject to revision by Brenda, if I got anything
10 wrong just now.
11 MS. CLARKSON: This is Commissioner Clarkson. I
12 second.
13 DR. KESHISHIAN: Thank you. Any discussion? All
14 in favor say "aye."
15 (All in favor)
16 DR. KESHISHIAN: Opposed?
17 (None opposed)
18 DR. KESHISHIAN: Thank you. Next item is Neonatal
19 Intensive Services/Beds and Special Newborn Services.
20 Brenda?
21 MS. ROGERS: Good morning. Again this is Brenda.
22 NICU services was sent out to public hearing after your
23 proposed action in June again. That public hearing was held
24 in July, and we received one piece of testimony from that
25 public hearing and that testimony is included in your binder

1 of materials. The piece of testimony that was provided was
2 more than just a technical change, and it was actually kind
3 of a deviation from the definition that we have inserted for
4 well newborn nursery services. That definition was
5 specifically pulled from the national guidelines and the --
6 so the Department is not recommending any new changes on
7 this language. So today the language is being presented to
8 you as you took proposed action on it at the June meeting
9 for final action and movement to the JLC and the Governor
10 for the 45-day review period. Thank you.
11 DR. KESHISHIAN: Thank you, Brenda. I do not have
12 any cards for this topic, so we will move on to Commission
13 discussion. Any discussion? Okay. Final action, do I hear
14 a motion?
15 DR. TOMATIS: Commissioner Tomatis, so move.
16 DR. KESHISHIAN: Thank you.
17 MR. MITTELBRUN: Mittelbrun, second.
18 MS. BROOKS-WILLIAMS: Commissioner Brooks --
19 DR. KESHISHIAN: Thank you. We have a motion and
20 a second. Any more discussion? All in favor say "aye."
21 (All in favor)
22 DR. KESHISHIAN: Opposed?
23 (None opposed)
24 DR. KESHISHIAN: Okay. Next one is Psychiatric
25 Beds and Services, July 21st, 2016 Public Hearing Summary

1 and Report. Brenda?
2 MS. ROGERS: Again this is Brenda. As you'll
3 recall at your June meeting you did move language forward
4 for a second public hearing due to a substantive amendment,
5 and that public hearing was held in July. We received no
6 testimony during that public hearing. However, there are a
7 couple of pieces I want to bring to your attention, and
8 hopefully you saw those in your material. One, the first
9 thing is an additional proposed amendment, and we did
10 include this language in the language that went out for
11 public hearing in July, and that was to Sections 82E, 3E and
12 4E of the Addendum. That language was removing the
13 geographic boundary language. And because it's no longer
14 needed since we're not restricting this to existing services
15 and that was the amendment that you approved in June, that
16 we would open this up to both existing and new services but
17 still maintaining the volume requirement. Okay. So that
18 language, after discussion with Tom and Joe because that was
19 brought to our attention subsequent to that June Commission
20 meeting and in talking with Joe and Tom, we got the okay.
21 And we talked to Marc about this, too, before we put it out
22 for public hearing, because that would have been deemed a
23 substantive change making that change to these three
24 subsections. And so they have been through public hearing,
25 and again no additional testimony was received. So that

1 part was included.
2 Today we are bringing a potential technical
3 amendment to your attention and for your consideration.
4 Given the interest that has sparked with the special
5 population beds and to provide better access, as you'll
6 recall, we created a methodology in there to come up with a
7 set number of beds to get started in these special pools,
8 and it was two percent of the current statewide bed need.
9 And that would be updated every two years as the bed need is
10 updated, and then the Commission could choose to make
11 changes to the special pops as necessary. What we're
12 finding out though, due to the interest that's out there,
13 the two percent is going to be severely under supply for
14 these beds. So we are asking for the Commission's
15 consideration to increase that percentage. As long as the
16 Commission only changes the percentage and nothing else in
17 the methodology, in talking again with Joe and Tom because
18 we would be adding beds, not decreasing beds, this would be
19 deemed a technical amendment. So we would be asking that
20 you consider something at a minimum of at least four percent
21 or higher. And in your memo that we provided to you, we did
22 give you some different breakdowns so you could kind of get
23 a feel for what some of the numbers would be with some
24 various percentages. And having said that, if you have any
25 further questions, if you take action on the language today

1 with the amendments that are already included in the
2 language and then potentially this technical amendment, then
3 it would be moved forward to the Governor and JLC for the
4 45-day review period. If you make any substantive changes
5 today, then obviously then we would schedule a third public
6 hearing. Thank you.
7 DR. KESHISHIAN: Any questions for Brenda?
8 MS. BROOKS-WILLIAMS: This is Commissioner Brooks-
9 Williams. Brenda, can you clarify -- so when we created the
10 pool, was it nonspecific; i.e., it was any psychiatric beds
11 or was it adult?
12 MS. ROGERS: No. There are very specific
13 populations in that addendum. And some are adult-related
14 and some are child-related.
15 MS. BROOKS-WILLIAMS: So it does cover all of --
16 okay.
17 MS. ROGERS: Yes.
18 MS. BROOKS-WILLIAMS: Okay. I'm on page 80.
19 Okay. Thank you.
20 MS. ROGERS: Thank you.
21 DR. KESHISHIAN: Any other questions? This is
22 Commissioner Keshishian. I had the opportunity to discuss
23 this with you last week. My follow-up question is last week
24 there was some -- there was a lot of interest expressed by
25 the hospital community. What kind of -- in the last week

1 what kind of interest has there been? I mean, the question
2 that I think many of us -- at least I have -- is that I
3 don't want to limit that there's this problem and, if we go
4 4 percent, if we go 6 percent, what has been the interest
5 that's been expressed out there?
6 MS. BHATTACHARYA: This is Tulika. So, Dr.
7 Keshishian, since we spoke last week, we received two more
8 letters of intent from two separate hospitals requesting
9 adult med/psych beds from the special pool. So the total
10 requested beds through the Letters of Intent as of today
11 stands like this: For geriatric, 83 beds requested so far;
12 for developmental disability for 20 adult and 20 child beds;
13 and from the med/psych pool, 45 adult and 10 child beds. So
14 if you look at the current pool for geriatric and med/psych
15 and even the developmental disability pool, the requests
16 have already exceeded the current pool, and we still don't
17 know how many providers are planning to submit Letters of
18 Intent in the future. For example, I talked to one more
19 hospital yesterday, and they are planning to submit for
20 geriatric pool. And I think that also have talked to other
21 hospitals that are not in this list and they have expressed
22 interest, and their applications are coming.
23 DR. KESHISHIAN: Brenda, from my -- if we stayed
24 at the 2 percent, which I'm not recommending, how many beds
25 have we added for each one of these categories if we --

1 MS. ROGERS: 50 beds.
2 DR. KESHISHIAN: 50 beds for each category?
3 MS. ROGERS: Correct.
4 DR. KESHISHIAN: Okay.
5 MS. ROGERS: Yes, adult.
6 MS. BROOKS-WILLIAMS: Commissioner
7 Brooks-Williams. That's the adult; right? So that's 10 per
8 child in each --
9 MS. ROGERS: Yes, adult. Yup; correct. Yes. I'm
10 sorry. That is correct, 50 for adult, 10 for child.
11 DR. KESHISHIAN: In total?
12 MS. ROGERS: Yes, except for geriatric.
13 DR. MUKHERJI: Question. So, you know, I've been
14 on the CON Commission for about eight, nine years, and I'm
15 surprised, I guess, with all the interest all of a sudden in
16 this pool of beds to address the psychiatric issue. Is it
17 pretty crystal clear in these guidelines that these beds are
18 going to be used just for psychiatric disorders and are not
19 going to be used for other intent?
20 MS. ROGERS: This is Brenda. Yeah. Within each
21 subsection, it specifically states that these beds will be
22 used for that specific purpose. So under each subsection,
23 it does state that.
24 DR. MUKHERJI: And we're comfortable with the
25 guardrails?

1 MS. ROGERS: (Nodding head in affirmative)
2 DR. KESHISHIAN: This is Commissioner Keshishian.
3 Interesting comment. What is psychiatric? Is it somebody
4 with depression? Many geriatric people, to answer your
5 question. Commissioner Falahee?
6 MR. FALAHEE: This is Falahee. To Suresh's
7 question, you can't play the game as one who has tried to
8 play the game of moving psych beds to general acute care.
9 Now, to Commissioner Keshishian's comment, yeah, you could,
10 I guess, game it that way if you wanted. But I, too, am not
11 in favor -- if we've already maxed out on the 2 percent,
12 some of us were talking before the meeting began. The issue
13 isn't the number of beds. Make it, you know, 20 percent of
14 the bed need. The issue is finding the psychiatrists to
15 take care of the patients. That's the issue. It's not the
16 beds themselves. Yeah. I'm not in favor of the 2 percent.
17 We've already blown through it.
18 DR. KESHISHIAN: Any more comments or questions
19 for Brenda before we go to the public comments? I do have
20 two cards. Commissioner Tomatis?
21 DR. TOMATIS: Commissioner Tomatis. How did we
22 reach the number 4 percent?
23 MS. ROGERS: The number 4 percent?
24 DR. TOMATIS: You recommend 4 percent. How did we
25 reach that number?

1 MS. ROGERS: Oh, that was again basically -- the
2 original 2 percent, if you'll recall way back when we first
3 described this to the Commission, was taken from the
4 original calculations of nursing home special population
5 beds. So we kind of based the methodology on that at the
6 time. The reason we're -- we're recommending an increase.
7 We're not necessarily set on 4 percent, but we aren't
8 recommending an unlimited number either. So we do want to
9 kind of keep some type of cap for quality on that. But that
10 -- the 2 percent originally came -- was the starting point
11 when we first set this up, and 4 percent we just kind of
12 thought, well, that seems to be reasonable to at least at a
13 minimum to double it. And I also want to clarify the
14 examples that I gave you in your cover memo. Those are only
15 the calculations from the adult beds, but we would do that
16 same calculation on the child/adolescent as well.
17 DR. KESHISHIAN: Any other questions? Karen Amon,
18 Bay Arenac Behavioral Health?
19 KAREN AMON
20 MS. AMON: Good morning. Thank you very much for
21 letting me speak today. I'll be very brief. I serve -- or
22 our agency, Bay Arenac Behavioral Health, serves people in
23 Bay and Arenac Counties with severe and persistent mental
24 illness, intellectual and developmental disabilities,
25 substance use disorders and co-occurring disorders. And I'm

1 here today to tell you that our agency supports the addendum
2 to the Michigan Certificate of Need Commission review
3 standards. We, in particular, are concerned or we want to
4 encourage those beds to be identified for the individuals
5 with severe and persistent mental illness as well as the
6 intellectual and developmental disabilities, the geriatric
7 population and those with medical and psychiatric needs. We
8 would also like to strongly encourage the Commission to
9 consider, you know, assuring that the increased occupancy
10 threshold for all inpatient psychiatric units be at least 70
11 percent for adult beds and 50 percent for child/adolescent
12 beds. And we would also like to encourage the Commission to
13 increase the compliance sanctions for hospitals who do not
14 meet the public patient obligations. We continue to
15 experience barriers in getting people into hospitals with
16 very high needs for psychiatric issues. Thank you.
17 DR. KESHISHIAN: Thank you. Are there any
18 questions? I have a couple questions. Where would you put
19 the percentage? You heard 2 percent, you heard 4 percent.
20 Where would you put the percentage as somebody out in the
21 field seeking --
22 MS. AMON: I don't think that I'm qualified to
23 give you a percentage. I just know that we experience long
24 periods of time trying and attempting to get people into
25 hospitals especially when they have very serious issues,

1 behavioral as well as very chronic, serious mental
2 illnesses. And so I don't have a percentage, and I
3 apologize.
4 DR. KESHISHIAN: Following question, do you
5 perceive the problem is there are no beds for people because
6 lack of psychiatrists, level of care that's needed that
7 hospitals are reluctant to take patients? I'm struggling a
8 little bit, because, you know, when I read some of the
9 letters I've received from behavioral, between mental health
10 agencies, it seems like it's, if you gave us more beds, we
11 would solve the problem. But yet I believe that the
12 testimony and the letters I've received previously is that
13 it's not a bed issue; it's the other issues associated with
14 it. What's your opinion?
15 MS. AMON: Well, I can tell you that the denials
16 give reasons like the person is too -- the acuity is too
17 high for their milieu, and so we hear that a lot. We hear
18 that there -- they are not -- there's no vacancies. But
19 they explain that by saying that the person may have a bed
20 open -- they may have a bed open, but it may be a shared bed
21 and the person that is being referred may not fit with that
22 individual. So there's still -- there's capacity, but the
23 person may not fit in with the occupancy that's open.
24 DR. KESHISHIAN: Okay. And you mentioned 70/50
25 percent; 70 for adult and 50 for pediatric. Do you think

1 some hospitals might just close their beds if they're not
2 meeting them and therefore they would just close to --
3 rather than be penalized by the state government if they're
4 not meeting them? I mean, when -- we had this issue
5 previously. We previously discussed this issue. What do
6 you think?
7 MS. AMON: I can't speak to that.
8 DR. KESHISHIAN: Okay. Thank you. Any other
9 questions?
10 MR. FALAHEE: I've got a question. Falahee again.
11 When you say the acuity is too high, help me understand
12 that, please.
13 MS. AMON: Well, the person may be experiencing
14 behavioral issues like aggression --
15 MS. CLARKSON: They're too violent.
16 DR. COWLING: Yeah, too violent.
17 MS. CLARKSON: They don't want them.
18 MS. AMON: Exactly. That seems to be the problem.
19 Or the length of stay may be perceived to be too long. We
20 never really hear that it's a rate issue. We always hear
21 the acuity is too high or that they don't have the staff
22 available to treat that person. It may require more one-on-
23 one staff. People who really need to be in the hospital,
24 that they either pose a problem in the community -- as a
25 matter of fact, what's ending up happening is those people

1 are either housed in emergency rooms or they're housed in
2 jail so that they can be safe until we can get a bed. And
3 some days, sometimes that takes three days, two days,
4 multiple days trying to get these people into hospitals
5 MR. FALAHEE: That's what I thought, but thank you
6 for confirming.
7 DR. KESHISHIAN: Any other questions? Thank you
8 very much.
9 MS. AMON: Thank you.
10 DR. KESHISHIAN: Joe Sedlock, Midstate Health
11 Network.
12 JOE SEDLOCK
13 MR. SEDLOCK: Good morning. MidState Health
14 Network is a prepaid inpatient health plan covering the
15 middle part of our state, 21 counties and 12 Community
16 Mental Health Services programs. On behalf of those
17 programs, I'd like to encourage the Commission to adopt the
18 proposed standards including the technical increase that has
19 been discussed here this morning.
20 We applaud the identification of these beds for
21 special populations but want to point out that we have a
22 statewide problem with access to psychiatric care for the
23 general population. You may be aware -- and it's beyond the
24 scope of my -- of the time available today. You may be
25 aware that Midstate Health Network has partnered with the

1 Certificate of Need Commission and other state departments
2 to measure the frequency of denial of inpatient care in our
3 state, at least in our region. And I can tell you with
4 absolute certainty that, in a six-month period of time, that
5 12 Community Mental Health Services programs in the Midstate
6 Health Network region experienced over 11,000 denials;
7 11,000. Most of those denials, 75 percent of them, in fact,
8 were based on capacity reasons. That's 8,280 denials based
9 on capacity. There were an additional 540 denials on the
10 issue that Karen Amon just spoke to, and that is the issue
11 of acuity and the individual having behavioral
12 manifestations of their psychiatric illness that for
13 whatever reason the hospital did not feel was appropriate
14 for the setting. If not appropriate for a psychiatric
15 hospital, then where? These folks are the most
16 psychiatrically vulnerable people in our communities.
17 So I would encourage as a future agenda item for
18 the Commission that you take actions to strengthen
19 enforcement and compliance of the standards that you've
20 already promulgated. We'd also encourage continued review
21 of the standards including the efficacy issue that was
22 raised by the previous speaker. I'd be happy to respond to
23 any questions.
24 DR. KESHISHIAN: Thank you very much. Any
25 questions?

1 MR. MITTELBRUN: Commissioner Mittelbrun. I
2 guess, when I listen to your -- the volume of denials and so
3 your thought is, you know, our change in the percentage will
4 help that, will alleviate that. But when I listen to
5 everybody at this table and some of the people giving
6 testimony over the last couple meetings, what is the
7 solution to the staffing problem, the people to provide
8 these services to these patients?
9 MR. SEDLOCK: I don't network at the hospital, so
10 I don't think I can address the myriad of staffing issues
11 that I'm sure the hospitals face. There is -- to
12 acknowledge the Chair's earlier comment, there is an issue
13 with psychiatric capacity across the state.
14 MR. MITTELBRUN: Well, I guess on the capacity
15 side, I'm just kind of curious if that's, let's just say, a
16 generic excuse instead of a legitimate excuse when you were
17 trying to track this and to identify that. I'm just curious
18 if they just didn't want the patient and just said "We don't
19 have the capacity" or if it was really another reason?
20 MR. SEDLOCK: Well, we've tracked some -- we track
21 reasons at a pretty granular level, so some of the reasons
22 for denial -- and I can look up the number for you if you
23 want from our pilot study. But some of the reasons for
24 denial are inadequate staffing on the unit itself. That has
25 little to do with psychiatric supervision and more with

1 direct care staff. So that is an issue that has been
2 identified. I can tell you from experience and from reports
3 from many of our Community Mental Health Services, Emergency
4 Services programs, that it is often understood to be just an
5 excuse that they don't want to deal with the person.
6 MR. MITTELBRUN: Thank you.
7 DR. KESHISHIAN: Any other questions? I have a
8 couple of follow-up questions. When you say 75 percent
9 capacity and 11,000 denials, I just want -- that is 11,000
10 not patients, but that's, you know, one patient per
11 (inaudible).
12 MR. SEDLOCK: That is correct. And the number of
13 people involved over this period of time, so it was 11,108
14 instances of denial involving 682 adults and 127 children.
15 And again it wasn't my point to report on the pilot at this
16 particular point but to illustrate that we have ongoing
17 need.
18 DR. COWLING: This is Commissioner Cowling. I
19 would like to make a potential clarification with respect to
20 those numbers only knowing how these social workers are
21 actually going after beds and then being denied when they
22 know from already calling a facility on a Friday, for
23 instance, that they're being told that there will be no beds
24 until Monday. They are not even calling again over the
25 weekend. So those numbers are going to be underestimated,

1 because it's not -- they're not going to waste their time.
2 MR. SEDLOCK: Right. That is correct. Thank you,
3 Doctor.
4 DR. KESHISHIAN: Thank you.
5 MR. HUGHES: When you're saying the number is
6 underestimated, you're talking about the admission request,
7 not the number of patients?
8 DR. COWLING: Correct. So basically if a patient
9 is sitting in the Emergency Department being boarded on a
10 psych hold and they know from calling on Friday that they
11 are being denied and they're not -- there is no hope of beds
12 until Monday when, in fact, what they should be doing for
13 the study is still calling on Saturday, calling on Sunday,
14 which would increase the total number of denials per the
15 patient but still the total numbers. They aren't even doing
16 that. So I just wanted everybody to be aware that the total
17 numbers of denials, I think, are still under represented.
18 It's huge, it's catastrophic, but it's still under what
19 we --
20 MR. SEDLOCK: And keep in mind it's only 21
21 counties and 12 Community Mental Health boards. If you
22 extrapolated that to all 46 Community Mental Health
23 Agencies, conservatively annually there would be 85,000
24 denials.
25 DR. KESHISHIAN: Thank you. A couple other

1 follow-up questions. Where would you set the percentage if
2 you have a idea on, you know, additional beds?
3 MR. SEDLOCK: I'm not sure I'm qualified to give
4 you a recommendation on that. However, the number of beds
5 that was being talked about earlier around the public
6 hearing time -- and I apologize. I wasn't able to make that
7 public hearing -- was around 400 beds, and I think that's
8 closer to the need.
9 DR. KESHISHIAN: Okay. Thank you. That's
10 helpful. And I think this is important. And since you're
11 up here now, I'm going to ask the question. Later on the
12 agenda we're going to write a report to the Joint Commission
13 regarding the works of Certificate of Need, one of the first
14 times we're going to actually make recommendations to change
15 other policies that are not under the purview of Certificate
16 of Need if the Commission decides to do so. One of the
17 issues is the registry. Since you're up here and you're
18 actually doing the voluntary registry now, how is it
19 working? Should we actually -- because we're going to have
20 to make a decision whether we put this in the letter. So my
21 question, so the other Commissioners can hear, is how is it
22 working and would you support a mandated state registry and,
23 if not or if so, why?
24 MR. SEDLOCK: Well, first of all, the registry is
25 not being done currently. That is a finding that we have

1 come up with as a result of our involvement in the pilot and
2 our experience otherwise. So if you're talking about a
3 statewide central bed availability registry, to clarify? Is
4 that what you're --
5 DR. KESHISHIAN: Yeah. My understanding -- and
6 people can correct me if I'm wrong -- is that, in one area
7 of the state, we're doing a registry. It's a voluntary
8 registry. And people are saying whether the things are
9 working or not, and you had mentioned -- maybe Beth can help
10 me.
11 MS. NAGEL: This is Beth. What we're doing with
12 Midstate PIHP is to keep track of all of the denials. So
13 every time they get a denial, it comes to the state. We
14 are -- and we presented this data preliminarily at the June
15 meeting. It's not a registry like what's been talked about
16 where we see bed availability. This is just tracking the
17 reasons for denial. It was primarily to help us understand
18 the scope of the problem and to really see in data form what
19 was happening. Because what we were hearing in the work
20 group and other places was more anecdotal. And so this is
21 not comparable to a statewide registry of bed need.
22 DR. KESHISHIAN: Thank you. I was -- I confused
23 concepts.
24 MR. SEDLOCK: However, I would add my voice to
25 encourage you to recommend that we establish a statewide

1 registry. Look at all of the phone calling and back and
2 forth that's going on while people are being boarded in
3 Emergency Rooms or in other settings that are inappropriate
4 to their current functioning. It certainly would improve
5 the efficiency of our system, it certainly would improve, I
6 think, the way to access an appropriate care setting by
7 having a central place where entities that are responsible
8 for the placement of individuals with psychiatric needs in
9 hospital settings can call and say where are the beds
10 instead of calling -- what is it? -- 87 different hospitals
11 across the state, waiting for a response, calling the next
12 one, waiting for a response, calling the next one and on and
13 on and on. This is a very, very, I think, life threatening
14 issue for some our consumers across the state and for the
15 staff that support them while they're being boarded in
16 Emergency Rooms, Community Mental Health Emergency Centers
17 and so forth. So I would strongly encourage you to make
18 that recommendation.
19 DR. KESHISHIAN: Thank you. Any other questions?
20 MS. BROOKS-WILLIAMS: Commissioner
21 Brooks-Williams. I wonder if you know this for your
22 population that you cover. Are these special populations
23 reimbursed at a higher rate than the adult population?
24 MR. SEDLOCK: No; typically, no. The contracts
25 that our organization and our sister Community Mental Health

1 Agencies have typically don't differentiate in terms of
2 rates paid for care for the individuals in the special pool.
3 Personally I am aware that, from time to time because of the
4 presentation of a particular individual, one of the
5 Community Mental Health Agencies may negotiate for
6 additional staffing or an enhanced rate but because of some
7 special need presented by a particular individual. But that
8 is the exception rather than the rule.
9 MS. BROOKS-WILLIAMS: Okay. Thank you.
10 DR. KESHISHIAN: Any other questions? Thank you
11 very much.
12 MR. SEDLOCK: Thank you very much.
13 DR. KESHISHIAN: Commission discussion? Any
14 comments?
15 DR. MUKHERJI: Two questions. Cathy --
16 Commissioner Cowling -- sorry -- are you comfortable that
17 the definitions of these special need beds are going to
18 solve the issue that we -- or the problem that we
19 specifically sought to address? I'm still presently
20 surprised about the need to increase this pool, but I just
21 want to make sure you feel the definition is such that it is
22 going to address this problem.
23 DR. COWLING: This is Commissioner Cowling. I'll
24 do my best to answer your question pointedly, which is, no,
25 it's not going to fix it, but it's one thing that we have

1 under our purview under CON that we can do that will help.
2 But in terms of actually answering the multi-faceted problem
3 of there's not enough providers, there's funding issues, I
4 mean, the ripple effect can go on and on. And so I think
5 this is one step of helping those psych hospitals that are
6 willing to designate, for instance -- because there's
7 nothing worse than having for me as a provider in the
8 Emergency Department having an elderly patient that is
9 suicidal that needs in-patient psych treatment for major
10 depression not be able to go somewhere because they are at
11 risk for being hurt by one of the other patients in the
12 psych hospital because they're too violent. So we have to
13 protect them for their frailty and get them treatment. And
14 so it's very difficult to have that be an issue. And I
15 think this particular carve-out for special populations will
16 address those gero-psych needs and the developmentally
17 disabled and especially the dual diagnosis medical ones
18 where we have a COPD patient that needs breathing treatments
19 and oxygen and cannot go to a regular psych hospital because
20 of their extra medical needs. So I think this is a step in
21 the right direction but, no, it is not, by any means, going
22 to fix this.
23 DR. MUKHERJI: So, yeah. I totally understand.
24 Certainly from your perspective in the Emergency Room,
25 getting out of the Emergency Room, this is going to help

1 that. And as Commissioner Keshishian said, there is this
2 subtle difference between psychiatric disorders, behavioral
3 disorders and mental illness. And what falls within those
4 categories and whether or not these are in scope for this
5 expansion of the special needs beds is -- I guess, is yet to
6 be seen.
7 So that poses my next question, is that, if we do
8 expand these special needs beds, is there a way to determine
9 whether or not the problem that we were trying to solve has
10 been addressed? Are there any outcome measures? So
11 specifically are there specific ways to look for overall
12 denials, individual patient denials, anything else that we
13 could see whether or not the strategy that we're likely
14 going to undertake was successful?
15 MS. NAGEL: This is Beth. And that's a excellent
16 question and one that we've been asking ourselves at the
17 Department as well so much so that we have talked with
18 Midstate about garnering other resources from other places
19 in the Department to track denials on a statewide basis, not
20 just for CON compliance issues but for compliance with other
21 areas of the Department, Medicaid and our mental health folk
22 as well. So we are looking for -- and you may be able to
23 imagine with just the barely six months of data and 11,000
24 on a statewide level, this will be a massive undertaking.
25 And so we want to make sure that we're doing it right and

1 protecting patient safety -- or protecting patient data
2 confidentially. So I don't have an estimate for when we
3 will do that, but we are looking at the resources right now
4 to make sure that that's the case. More near term, though,
5 the occupancy requirements for these beds in this pool is
6 set at 80 percent currently. So we'll be able to look at
7 that -- the Commission will be able to look at that as it's
8 collected every year on the annual survey.
9 DR. MUKHERJI: One last question. So, Cathy, the
10 patients that qualify for these special need beds, are these
11 based on certainly a clinical evaluation that you'll be able
12 to determine whether or not they qualify? But again if this
13 pool of beds increases, I'm still surprised by the -- the --
14 exceeding the threshold already before the policy has even
15 been agreed upon. Is this based on specific ICD-10
16 diagnosis codes? Because obviously different patients can
17 have different ICD-10 codes. And if -- and you have through
18 EHR the ability to put five
19 ICD-10 codes. If one of them has to be -- could be one of
20 the codes that falls under psychiatric disorders, behavior
21 health or mental health, would then these then qualify these
22 patients to have access to those beds? Even though it may
23 not be a primary -- the primary reason?
24 DR. COWLING: The coding, I would say, is going to
25 be a separate issue because, to meet the qualifications for

1 those beds, they obviously would have to have -- be
2 developmentally disabled or have other -- they'll have that
3 tag along with it. But I think, if you were going to ask
4 the question are we -- would we better off just ballooning
5 and opening up the psych bed registry -- or the number of
6 beds and not limit it to special patient populations, I
7 don't think that's going to fix the problem either. So by
8 doing what we've done, we have enabled those psychiatric
9 hospitals to have special carve-outs more for those
10 particular patients, but it's still based on the volume. I
11 don't think we're going to get close to fixing the problem
12 with this measure. It's just one -- and I think it's
13 drawing attention to that we need to monitor and follow the
14 denials, the denials need to be consistent, providers that
15 are denied placing a patient where they think that it was
16 based on other reasons besides lack of actual bed space, you
17 know, measure a way to be able to report infractions on a
18 regular basis. I mean, I think there needs to be a 800
19 number to call and say, "We were denied this patient
20 access," and so that it needs to be followed up by the
21 Commission -- by the Department.
22 Unfortunately I don't know if what I'm answering
23 is your question which is, if I'm going to see a patient,
24 for instance, that's 80 years old that's suicidal and needs
25 to be in-patient because they took an overdose but now

1 they're medically cleared by us in the Emergency Department
2 and they -- the social worker is trying to find them a bed
3 and they can't find them a bed anywhere, I don't know how
4 besides a regular psychiatric adult bed may not be able to
5 take that patient due to their frailty. So this is going to
6 allow a particular carve-out to help get that patient placed
7 better as long as the, you know, opportunity is given.
8 DR. MUKHERJI: You know, I totally agree. My
9 issue is that -- and it's just a question for discussion
10 before we pass it -- is, if the patients that you're seeing
11 in the Emergency Room clearly need to be admitted, the goal
12 is to try to make sure that those beds are available for
13 these patients. But if under the rubric of mental health,
14 behavioral disorders, so on and so forth, who qualifies?
15 You know, if someone comes in they have a variety of medical
16 problems, that's the primary reason they are coming to the
17 Emergency Room or being seen by their primary care physician
18 and then one of those is a behavioral disorder that is coded
19 under an ICD-10 code, are these the ones that are going to
20 be triaged into these beds such that they inadvertently lock
21 out the other patients?
22 DR. COWLING: No. Actually I think --
23 DR. MUKHERJI: That's what I'm -- want to make
24 sure we clarify.
25 DR. COWLING: Okay. So I see what you're saying.

1 The patients still are going to need to be medically
2 admitted to an inpatient general hospital, are still going
3 to be -- even if they have a concurrent psychiatric illness,
4 they're still going to be admitted for medical reasons. The
5 only reason that they would be going to a psychiatric
6 hospital with a dual diagnosis for medical would be if their
7 medical condition was stable but they still needed oxygen
8 therapy. I mean, I can tell you having personally done
9 this, I sent a COPDer to another institution that needed to
10 wear a nasal canula to sleep with at night. And they
11 basically ping-ponged right back to me because, once they
12 got to that institution, they said, "Well, we don't have the
13 capabilities providing them oxygen at night." And it was my
14 bad and was because it just got failed to be communicated to
15 that receiving institution that they needed to wear oxygen.
16 So that's the kind of stuff that this is going to help deal
17 with. Because they're not medically needy at the time; they
18 just have concurrent medical needs that cannot be addressed
19 in a regular psych hospital. Okay? So I get -- I get what
20 you're saying, yes.
21 DR. KESHISHIAN: Are there other questions?
22 MS. BROOKS-WILLIAMS: Commission Brooks-Williams.
23 This is for the Department. So if a organization is
24 requesting beds from the special pool but they already have
25 an adult unit and that adult unit is not meeting the

1 occupancy requirements, does that factor into this at all?
2 MS. NAGEL: So the answer --
3 MS. BROOKS-WILLIAMS: Because could they take
4 those beds to convert to one of these special populations?
5 MS. NAGEL: That was something that we talked
6 about and we discussed quite a bit internally. And
7 where -- how it ends up reading in the standards is that
8 they have to come up -- their entire unit will have to come
9 up to the correct occupancy rate after they've implemented
10 this specific special pool. And that's a little different
11 from how we do it in other areas of Certificate of Need.
12 But the reasoning is we have found that some programs aren't
13 meeting their occupancy rate because they need to implement
14 a geriatric unit.
15 MS. BROOKS-WILLIAMS: Correct. Understood.
16 MS. NAGEL: And so once they implement a geriatric
17 unit, we would expect them, not only the geriatric unit, but
18 their general unit, to be meeting the standards.
19 MS. BROOKS-WILLIAMS: Well, that would make sense
20 if the bed count stayed the same. I think that's why I'm
21 asking the question, if I'm making sense. So if I already
22 have 25 beds, I'm coming to the pool for 20 beds, am I going
23 to be able to fill up 45 beds because the 20 beds are going
24 to cover the special population that maybe I needed when I
25 had the 25 beds? I'm not sure I understand how getting the

1 incremental beds will help them be at capacity overall.
2 MS. NAGEL: Oh. I'm not sure this will answer the
3 question. But specific to geriatric anyway, today in
4 Michigan, the CON standards actually prevent you from
5 opening a geriatric only unit, because you have to take a
6 certain percentage of Medicaid, and most of the geriatric
7 patients are not Medicaid. And so the thought there is that
8 they would now be able to open a geriatric unit and address
9 those needs, but they still need a -- the institutions that
10 are going to make this decision still need to meet their
11 volume requirements after they've implemented.
12 MS. BROOKS-WILLIAMS: Okay.
13 MS. CLARKSON: This is Commissioner Clarkson. Did
14 you say the majority of residents aren't on Medicaid?
15 Because 75 percent of nursing home residents are on
16 Medicaid. So when you're talking about general population,
17 75 percent of our clients in long term care are on Medicaid.
18 MS. NAGEL: When we --
19 MS. CLARKSON: They are duals, but --
20 MS. NAGEL: When we ran a compliance most
21 recently -- I can let Tulika speak to this -- that was one
22 of the biggest problems that came up in compliance with
23 taking what's considered in our standards a public patient
24 is that they were implementing -- or they were addressing
25 more geriatric needs than general needs. And so they

1 weren't meeting the threshold for admitting a public
2 patient.
3 MS. BHATTACHARYA: This is Tulika. So for that
4 geriatric population, those are mostly Medicare patients.
5 MS. CLARKSON: Dual; they're dual eligible.
6 MS. BHATTACHARYA: They are dual eligible. But
7 from what we gathered -- the information that we gathered
8 from the psychiatric hospitals for psychiatric patients, we
9 were told that geriatric population specifically are mostly
10 Medicare patients. Now, is it -- is the data specific to a
11 particular hospital or region? That needs to be
12 investigated.
13 MS. CLARKSON: See, I don't know necessarily,
14 because it -- normally it's after 20 days you have a
15 co-pay. So that's when the dual kicks in. So if they were
16 in for over 20 days, they would be a dual, not a just
17 Medicare patient.
18 MS. BROOKS-WILLIAMS: Commissioner
19 Brooks-Williams. Part of it -- and I don't know the -- I
20 haven't had a gero-psych unit in awhile. I left that a few
21 years ago.
22 MR. FALAHEE: I've got it.
23 MS. BROOKS-WILLIAMS: Jim has it. But what I
24 think some of it could be is that in a lot of counties --
25 right? -- the mental health benefit is coming through that

1 county program, so that is the indigent component, what we
2 would traditionally say is Medicaid on the medical side. So
3 it probably is there. But when you answer the survey, you
4 probably are attesting to the Medicare and you're not
5 talking about the Medicaid eligibility, because a lot of
6 times that's running through the Community Mental Health
7 Agency. So that might be why.
8 MS. CLARKSON: Thank you. All right. Yeah.
9 Thanks.
10 MR. MITTELBRUN: This is Commissioner Mittelbrun.
11 Can I ask, whatever percentage is chosen, when will it be
12 reviewed next?
13 DR. KESHISHIAN: This is Commissioner Keshishian.
14 We can review standards at any time that we want. The
15 Community Mental Health providers, Emergency Room providers
16 could come to any public comment. We have those annually in
17 October, and request that we review the standards. In the
18 past 10 years that I've been on the CON, a provider will
19 come and say, "This is a problem. Can you move it up?" By
20 law we have to review standards every three years, but
21 there's nothing that precludes us from reviewing it at any
22 time we feel necessary. And there's many avenues to request
23 a review earlier than the three years.
24 MR. MITTELBRUN: Well, the reason I ask that
25 question is because I very much, you know, appreciate all

1 the complexities being discussed. But from the point of
2 view of organizations that provide health care to their
3 participants and want to see their participants and their
4 dependents receive this care and, as was mentioned, this is
5 one step, one tool that we have, why wouldn't we choose a
6 percentage to give ourselves a cushion? Because I realize
7 that there's a lot of work to be done in tracking all this,
8 that the Department is trying to, you know, gather this data
9 for us to make informed decisions. But since we can review
10 it at any time and that maybe at the maximum in three years,
11 why not provide some sort of cushion because, as was
12 mentioned, it seems like we've already blown through the --
13 you know, the previous percentage. So that was my only
14 thought. Thank you.
15 DR. KESHISHIAN: Thank you. On that, any other
16 questions? I was going to ask Dr. Cowling -- Commissioner
17 Cowling a question. Where would you set the percentage?
18 Right now it's -- you're my expert, it's -- you chaired the
19 work group -- it's 170 beds. Where would you set it? I
20 mean, personally I have gone from, you know, 170 is fine,
21 let's see what happens to just open it up completely. Why
22 would I want to restrict any beds psychiatric because we
23 have this problem? So I'm all over the place. I would be
24 very interested in your opinion since you've chaired the
25 work group, you live this every day. Since none of the

1 people who spoke at the podium would give me an answer,
2 maybe you will.
3 DR. COWLING: Well, I think it's -- you're asking
4 for an intangible. Because at this point if you were going
5 to ask me as an individual, a practicing emergency
6 physician, I'd say open it up because, if the need is there
7 and hospitals can fill it, then they're going to go for it.
8 But at the same time, we do have facilities that aren't
9 meeting capacity. So as a Commissioner with charge of
10 responsible, you know, investment in terms of the residents
11 in the state of Michigan, I would say that we should at
12 least choose something and use it and then measure it and
13 then review it when we have metrics that we can actually
14 have, you know, data to support that. So I guess, if you're
15 asking for me to actually choose a hard number, I would say
16 I would go with 5 percent now.
17 DR. KESHISHIAN: 5 percent. Okay. And right now,
18 if my math is correct, we're at 170 beds and that's 2
19 percent, so this would be two-and-a-half times.
20 MS. ROGERS: This is Brenda. Marc, when you're
21 saying 170 beds, are you looking at the total number of beds
22 of the 2 percent?
23 DR. KESHISHIAN: I'm looking at Section 3 of --
24 MS. ROGERS: Okay. Okay. Yeah. So that would be
25 the 2 percent that's currently written in there.

1 DR. KESHISHIAN: 420.
2 MR. FALAHEE: This is Falahee. Brenda, I'm
3 looking at the Commission brief you gave us, page 5 of our
4 agendas where you broke it out 4, 8 and 10 percent. Help me
5 understand that. If we went -- I'm not disagreeing with
6 Commissioner Cowling's number, but I'm trying to understand.
7 If we went with a 4 percent, that would be an additional 90
8 beds over what we have already?
9 MS. ROGERS: No. If you went with 4 percent, it
10 would be 90 beds in each of the adult special pools. I did
11 not do the breakdown for child/adolescent. So right now
12 each adult has 50, the child/adolescent, each of the two
13 have 10. And so instead of 50, it would be 90 in each of
14 those pools, and then the child/adolescent we'd have to do
15 the calculation but it would be higher than 10.
16 MR. FALAHEE: Okay. Thank you.
17 DR. KESHISHIAN: Any other --
18 MR. FALAHEE: This is Falahee. I can combine what
19 Commissioner Mittelbrun and Commissioner Cowling both said
20 because I agree we can always adjust this. The difficult
21 part would be if we start too high and have to adjust it
22 down. But that can be taken care of through a compliance
23 function as well if they're not meeting occupancy. So I
24 understand that. We can always tweak it higher if need be.
25 I like the number that Commissioner Cowling said. And

1 anybody can conjecture what the number should be. I think
2 it's a good start to address already we're over booked with
3 the numbers, and I don't want a race to the courthouse for
4 Mr. Potchen to figure out which beds do I get, am I the
5 first one there or the second, because we all -- the beds
6 are out there and needed. Let's make sure hospitals can get
7 them.
8 DR. KESHISHIAN: This is Commissioner Keshishian.
9 So you said 5 percent. And are you comfortable with
10 comparative review standards in these standards that they
11 will meet from a legal perspective? I'm just asking --
12 MR. POTCHEN: Comfortable with what?
13 DR. KESHISHIAN: The comparative review standards,
14 you know, we have request?
15 MR. POTCHEN: I'm fine with these, yeah.
16 DR. KESHISHIAN: Okay. Any other questions?
17 Okay. Do I hear a motion?
18 DR. MUKHERJI: Motion to approve with 5 percent,
19 Mukherji.
20 MR. MITTELBRUN: Mittelbrun, second.
21 DR. KESHISHIAN: Okay. And the motion includes to
22 send to the Joint Legislative Committee and for a public
23 hearing in -- nope. Go ahead, Beth.
24 MS. NAGEL: It is the -- this is -- you're taking
25 final action, because this is not -- this is a technical

1 amendment, so it's the 45-day review period by the JLC and
2 the Governor.
3 DR. KESHISHIAN: Okay. Is that part of your
4 motion?
5 DR. MUKHERJI: Yes, it is.
6 DR. KESHISHIAN: Is that your second?
7 MR. MITTELBRUN: Mittelbrun, second.
8 DR. KESHISHIAN: Thank you. Any more discussion?
9 All in favor say "aye."
10 (All in favor)
11 DR. KESHISHIAN: Opposed?
12 (None opposed)
13 DR. KESHISHIAN: Okay. Thank you. Nursing Home
14 and Hospital Long-Term-Care Unit Beds workgroup report. You
15 have a report from Ms. Conner, who is chair of the work
16 group for Nursing Home and Hospital Long-Term-Care. Do you
17 have any questions? Okay. Thank you. Hospital Beds,
18 Recalculation of Bed Need Numbers Setting the Effective
19 Date. Brenda?
20 MS. ROGERS: Again this is Brenda. And you should
21 have in your binder received the report from Mr. Delamater.
22 It is that time of year to re-run the hospital bed need,
23 which he has done. And accordingly to the hospital bed
24 standards, this Commission needs to set the effective date
25 of those bed need numbers. If you have any questions, we'll

1 do our best to answer them. I think his report was pretty
2 straightforward on the calculations. I think most every
3 area is still over bedded in this state. There are a couple
4 of additional limited access areas and, as he explained in
5 his report, those are areas that were kind of on the
6 threshold under previous runs and this kind of actually met
7 the criteria to be a limited access area.
8 So having said that, the Commission does need to
9 set the effective date. If you ask the Department what we
10 recommend, we're suggesting October 1st, but it's truly up
11 to the Commission to set that date. These standards do not
12 need to go to the JLC, public hearing or Governor for
13 approval. Just the effective date and, if you set the
14 effective date, then everything will be updated on our web
15 site. If you have any questions, feel free to ask. Thank
16 you.
17 DR. KESHISHIAN: Any questions?
18 MR. FALAHEE: You want a motion then?
19 MS. ROGERS: This is Brenda. Yeah, it would be
20 helpful to have a motion. Thank you.
21 MR. FALAHEE: Falahee. I'll move that the
22 effective date be October 1 of 2016.
23 DR. KESHISHIAN: Do I hear a second?
24 MS. BROOKS-WILLIAMS: Commissioner
25 Brooks-Williams, second.

1 DR. KESHISHIAN: Any discussion? All in favor say
2 "aye."
3 (All in favor)
4 DR. KESHISHIAN: Opposed?
5 (None opposed)
6 DR. KESHISHIAN: Thank you. Review Draft of the
7 CON Commission Biennial Report to the Joint Legislative
8 Committee. Each year we -- every other year we provide a
9 report to the Joint Legislative Committee about our
10 activities. Usually it is just a summary of what we've done
11 in the previous year. And you have the summary which is the
12 first part of the presentation that you received from the
13 Department. The second part that is different this year is
14 we have talked multiple times about recommending other
15 issues to the Joint Legislative Committee to solve the
16 problem of the psychiatric beds. We've had -- in my ten
17 years on the CON Commission, I've never had an outpouring
18 from such a wide geographical area as on this issue. From
19 the UP down to Monroe, everybody has sent -- many, many
20 organizations have sent letters. And I think that our input
21 into this issue is important. Having said that, there have
22 been many suggestions. And rather than just move to ask the
23 Department to do a laundry of taking all the suggestions,
24 what I thought was that we would discuss what we want to
25 recommend to the Joint Legislature Committee and say -- and

1 ask the Department and maybe some of the Commissioners --
2 Commissioner Cowling at least on one of the issues -- to
3 help us write the letter. We will have to make a decision
4 as a Commission whether we want to make it very expansive,
5 and that has its downfalls, or very narrow on the few things
6 that we think are most important.
7 And so with that, I will -- I will enter into the
8 issue of the letter. And the Department has listed some of
9 the things that they have listed. And I would want to --
10 what I want to do is take a vote of each one of these or,
11 when we get around just take a vote, which ones we want to
12 put into the letter and develop language and which ones we
13 say, "Well, you know, it's a good idea, but we want to stay
14 focused." Of course, if the Commission decides that they
15 want to add everything in and that's our right to say
16 whatever -- you know, to write a letter to the Joint
17 Legislative Committee.
18 Beth and Brenda, do you have anything to add
19 before we move on to this?
20 MS. ROGERS: No. This is Brenda. And just for
21 clarification, in case some of you don't recognize it, the
22 items that we've inserted in there right now for psychiatric
23 beds literally came from the final report from Dr. Cowling
24 as those items that were recommended by the work group.
25 DR. KESHISHIAN: Okay. And with that, I'm going

1 to just go through these not in the order on the list. What
2 I think is most important and, I think, the plea of the work
3 group was the state health registry. Dr. Cowling had
4 mentioned that they have one in Virginia, I believe it was,
5 and that works very well. The ER's can actually go and see
6 where beds are available, and they're not calling all over
7 the state because they know where there's availability. The
8 other part of it is, is that, when people have beds and they
9 refuse it, they can actually look to see what's going on and
10 see who's refusing beds. It's computerized, it's automated.
11 So I believe that is probably the one thing that we can do
12 that would help this situation the most on this issue.
13 Any discussion on the state health registry? I
14 think what I'll do, if it's okay -- and somebody can
15 object -- is we'll just go through these, and then somebody
16 can make a motion what they want -- what they think is most
17 important that we include. And as I said, we can include
18 everything.
19 Commissioner Cowling, on this one, I will ask you
20 to help me and the Department write this part, because
21 you're the expert, you know what's going on in Virginia in
22 this arena.
23 Any questions on the state health registry? What
24 it does, what it is, anything like that?
25 I thought there was another one, and it's not

1 listed here and I just -- it is -- it would be
2 controversial. And I just don't know if we as a Commission
3 want to get into this. And I want to bring it up and to
4 have this discussion. And I thought there was some
5 discussion about student loan forgiveness for psychiatric
6 residents and -- either in the work group or someplace. I
7 don't know if that's our role. Obviously somebody has to
8 pay if we do loan forgiveness for psychiatrists, and that
9 would be the state. On the other hand, we have a shortage
10 of psychiatrists. They are the lowest paid medical
11 professionals out there and especially psychiatrists who
12 deal with the public sector. And so we have to make a
13 decision whether we want to include it in the letter or
14 whether we should be quiet, silent on that issue. So I'm
15 looking for comments on this. Commissioner Falahee?
16 MR. FALAHEE: This is Falahee. As one who does
17 physician contracts every day, some of which include student
18 loan forgiveness as part of a way to attract that position
19 to Michigan, so I'm wondering if we could do a combination
20 public and private forgiveness program where the hospitals,
21 if they want -- if they have the community need for a
22 psychiatrist and that need is there, they offer a certain
23 percentage of the student loan forgiveness, and then there's
24 a state program -- I don't know how it gets funded -- but
25 there is a state program as well that also provides a loan

1 forgiveness package for that recruit. I think that might be
2 a good public/private partnership to show how we're all in
3 it together trying to meet this need.
4 DR. KESHISHIAN: Do you have a recommendation as
5 percentages? Because I think -- 50/50?
6 MR. FALAHEE: Oh, 1/99. But I think 50/50 would
7 be better. and it's all going to be tied to fair market
8 value. I mean, what compensation is fair market value. The
9 value of the loans are forgiven year by year by year can't
10 exceed the fair market value. So some of these are
11 structured over a four- or five-year period of time. If you
12 stay in the community for five years, let's say, every year
13 20 percent of your loan is forgiven. As it's forgiven, it
14 does become income to the recruit, but then they just pay
15 taxes on it. It's better doing that than paying the whole
16 thing off. So, yeah, I think, Commissioner Keshishian, that
17 50/50 would be fine. I would include it in here -- I mean,
18 if our goal is to help meet the need as we've discussed,
19 this is one way, though it's outside of our purview, to
20 suggest a way to meet the need.
21 DR. KESHISHIAN: Commissioner --
22 DR. MUKHERJI: I think it's a good idea. I think
23 we just have to be aware of unintended consequences from
24 perceived externalities. I think we have to be -- someone
25 may look -- I mean, in this room, we understand the

1 rationale of suggesting that loan forgiveness be for a
2 certain medical subspecialty. But when people look into
3 this, we could be cast as trying to identify winners and
4 losers. I think there's a lot of people that contribute to
5 society that are not paid as well as some of the
6 subspecialists. I think we need to be cautious about that.
7 So the other thing is that there are a lot of other health
8 care professionals besides psychiatrists that provide health
9 care to individuals with psychiatric disorders and other
10 mental health providers. And if we're specifically going to
11 say individuals with a M.D. or D.O., then we also have to be
12 cognizant about social workers, physician assistants, nurses
13 who oftentimes share the largest burden, if you will. So I
14 think it's a good idea, but we have to look at the whole
15 continuum and spectrum of individuals taking care of
16 patients with these treatable disorders.
17 DR. KESHISHIAN: Any questions? Comments?
18 MS. GUIDO-ALLEN: That's where I was going. I
19 mean, we can't exclude the nurse practitioners that are --
20 that specialize in psychiatry or the, you know, physicians
21 assistant, social work. It's just a little shortsighted.
22 DR. KESHISHIAN: But then -- I don't need to
23 follow up. One of the things I've heard during this
24 discussion over the last year or so is that there's a
25 shortage of nurses who want to actually work on psychiatric

1 units. So how far -- you know, where do we draw the line?
2 MS. GUIDO-ALLEN: Good question.
3 DR. KESHISHIAN: Because when I -- when we write
4 this letter, we have to -- I think we have to draw the line
5 someplace.
6 DR. COWLING: And this is Commissioner Cowling. I
7 guess, if I would weigh in and since I actually am actually
8 involved in graduate medical education on a daily basis, I
9 would say that I can totally empathize with the whole going
10 with the scope and including the AAP's and everybody
11 involved in providing mental health care. The problem was -
12 - is, when you look at the debt burden that psychiatry
13 residents are coming out and they are expected to do a four-
14 year graduate medical education training program after the
15 four years of medical school and usually on average owe a
16 quarter of a million dollars or more towards their loans for
17 schooling to expect them to be at the lowest paid tier of
18 specialists, in general, it is disenfranchising to try and
19 recruit people to go into psychiatry for that reason. So I
20 think if you're looking at, for instance, how primary care
21 providers that are in family medicine or internal medicine
22 can work at any of the federal qualified centers and get
23 their loan forgiveness done like that (indicating) and you
24 can't do that with psychiatry, I think we've got inequities
25 in how we do loan forgiveness. So I guess, if we were going

1 to target this right now, I would say focus on getting the
2 physicians' loan forgiveness done and then put it on the
3 agenda to deal with other organizations to encourage
4 stipends, loan forgiveness or grants to other people that
5 want to specialize in access to mental health. But it's
6 very difficult.
7 And I can tell you right now from looking at the
8 first graduating class going through the psychiatric program
9 at Central Michigan University, there are four that are in
10 the program, and they're already looking at taking their out
11 clause of leaving during their third year rather than
12 completing the program, because they can go and do a
13 fellowship on the east coast and leave Michigan and not
14 suffer that extra burden of that fourth year of training.
15 So you have to look at retainment of trainees, and so that's
16 why I would also include that we talk about -- since CMS
17 capped GME programs in 1997 and all of these psychiatric
18 residencies basically have to go in over the cap, that I
19 would also include that we encourage the state to help fund
20 GME programs.
21 MR. POTCHEN: This is Joe. I just have -- hearing
22 all this, there are so many factors and so many variables
23 here. I'm somewhat concerned about the Commission
24 recommending something when there are just so many factors
25 in there. If you do this, I propose that you just ask the

1 Legislature to consider a variety of areas versus
2 recommending, because even that's not going to be solid when
3 you write this letter. So I would be much broader. And
4 this is beyond your purview, and I don't want to be stepping
5 on areas that are beyond the CON Commission.
6 DR. KESHISHIAN: Commissioner --
7 MR. HUGHES: Commissioner Hughes, strongly agree.
8 DR. KESHISHIAN: This is Commissioner Keshishian.
9 I thought, you know, we've identified a problem, and we want
10 to help solve the problem. And we believe -- whatever we
11 vote, this will be our collective belief -- that this
12 problem has been identified. I -- you know, I've received
13 letters from people, "Thank you for opening this up." At
14 some point, does the Legislature know what's going on? And
15 the iss- -- because we would have tried to solve this
16 problem very differently if we had a broader scope of -- if
17 you're saying that we shouldn't even write anything --
18 MR. POTCHEN: I'm not suggesting. I mean, there's
19 been a lot of work into it, and we've heard a lot of
20 testimony of these issues. The concern is -- is that
21 recommending specific ideas, it looks like or it sounds like
22 there's a lot more research and a lot more things need to be
23 looked into. So I would just raise these issues and have
24 the Legislature deal with it, because it'd be more
25 appropriate.

1 DR. KESHISHIAN: And you're talking about
2 specifically loan forgiveness. Just leave it --
3 MR. POTCHEN: Yeah.
4 DR. KESHISHIAN: -- just loan forgiveness for
5 professionals and let them decide what we -- what we --
6 MR. POTCHEN: We've got a lot of ideas here that
7 look like they could be addressed, but there's a lot of
8 factors and a lot of other areas that need to be looked at.
9 DR. TOMATIS: I understand what you say, but we
10 have to recognize here that increasing the number of beds
11 doesn't solve the problem, because there isn't -- and we
12 don't recommend, but we can suggest. We don't need to
13 recommend. We can suggest that the solution is increase the
14 providers in many ways. We can suggest that. We can
15 suggest it, but we increase the beds, and we solve the
16 problem, no. We are not solving the problem. We need to
17 increase to increase the providers. A suggestion is not a
18 recommendation.
19 MR. POTCHEN: Which is what I think we're saying.
20 DR. MUKHERJI: Yeah. I think also -- I think the
21 letter is a good idea. I just -- if we're going to write
22 the letter, we have to really define what the scope of the
23 problem is. So, for instance, as you said, you know, our
24 role in increasing the bed is trying to find the right
25 triage for individuals that could be a menace to society

1 that are either housed in Emergency Rooms or in jails, et
2 cetera, because they can't get the right medical care. And
3 that really was the solution and that was the goal of the
4 deliberations that we have now. And if that letter is going
5 to address that what we tried to do within our purview but
6 we also see these other factors to try to help this specific
7 problem, that's one thing. But we also, I think, have to
8 stay our lanes and separate that from trying to solve all of
9 the mental health and behavioral disorders as they pertain
10 to society. So I think, if we draft a letter, I think it's
11 important to know which one of those specific problems that
12 we're trying to address and also convey to the Legislature
13 that, you know, from a quality and access point of view, we
14 did consider all these areas, but this was within our scope
15 that we think could help, and that's all we really had
16 oversight on. So I think it's just important to say what's
17 the problem that we were trying to address to stick to our
18 lanes.
19 DR. KESHISHIAN: Any other comments? Okay.
20 Cathleen, there's a list here that came from the workgroup.
21 Is there anything that you feel that we should put in the
22 letter as you look through these?
23 DR. COWLING: If I had a wish list? I don't --
24 and I not mean to make this at all any joking matter,
25 because it's definitely not. It's truly a life-and-death

1 matter. And I am grateful that the Commission has taken the
2 amount of time to deliberate on the subject that it has,
3 because I think we have enabled us to focus more on what we
4 can do, what we can't do. But calling attention to it is
5 something that we can do as a Commission. So I am very
6 grateful that you guys have taken this very seriously.
7 I would say we've hit the highlights. I think our
8 letter going forward, I think, should strongly encourage
9 them to do what other states have done, which is open a
10 live, online registry database that social workers can go to
11 for a repository of open beds that will help facilitate
12 placement of patients that need placement. Beyond that, we
13 can suggest that there are other things that they could look
14 into helping to deal with like GME and other things, but I
15 think we've hit the bold -- the bullet points right now as
16 far as what I would be asking for.
17 DR. KESHISHIAN: Just so when we give direction to
18 the Department, it's the state health registry and loan
19 forgiveness, and we'd just say study it, evaluate it. And
20 these other issues, telepsychiatry and psych observation
21 units are things we should include in the letter or just --
22 DR. COWLING: Well, we can talk about telemedicine
23 and how that has enabled some states like South Carolina to
24 be much more effective, because they put a psychiatrist in
25 one central location and then have, you know, facilities be

1 able to call in. There are places that are changing scope
2 of practice so that you can have nurse practitioners
3 actually be able to be the ones do the intake, assessments
4 on patients on the weekends, which is part of the problem,
5 because usually there's little influx/outflux on the
6 weekends. So there's other things that, yes, we could
7 include in the letter. But I guess given what has been
8 discussed, you know, do we want to shoot for the moon and
9 aim for the stars or vice versa? I think the registry is
10 the one thing that we should focus on trying to get put
11 through. I'm happy to write a ten-page letter if you want
12 me to, but I just -- I think we need to focus on what --
13 what really is keen here.
14 DR. KESHISHIAN: Okay.
15 MR. HUGHES: Commissioner Hughes. And very few
16 times does technology when it helps health care reduce costs
17 and, in this instance, that's exactly what telemedicine does
18 and our state wants to be a leader in things -- I -- we
19 should be pushing this as a huge potential to provide
20 access, which is the big issue here for people through
21 telemedicine. And that's something our state should be
22 leading on, not following. We should be pushing that. If
23 we're going to be talking about loan forgiveness, that's
24 something that can be done now and can be really effective
25 without strings attached.

1 DR. KESHISHIAN: Uh-huh (affirmative). Any other
2 comments?
3 MR. FALAHEE: Falahee. I agree with that,
4 because, if anything, it's in the purview of the Legislature
5 in terms of scope of practice and all that. It would be
6 telemedicine -- and Dr. Cowling is correct -- it's going on
7 everywhere around the country.
8 MR. HUGHES: And Michigan has a problem, because
9 you can't practice telemedicine if you're not in the state,
10 and they could change that.
11 DR. KESHISHIAN: Okay. Any other comments? We
12 can do this. You know, we've had a discussion, and we could
13 end up discussing this for two hours, but I don't think that
14 would be a good use of any of our time. We can either just
15 make a motion just what to include and what not to include
16 and debate the motion and then finalize it, or we can
17 delegate it and I would work with Dr. Cowling if she's
18 willing to do it as part of the final work effort on the
19 psych beds to develop language given the sense of what we
20 said here of what we should include. My belief is shorter
21 is better in this. If we give them ten recommendations, the
22 one we really want, which is the registry, will be
23 forgotten. And although I think mentioning a few others,
24 telepsychiatry, you know, talk about what's going on in
25 other states so that they're at least aware of it to solve

1 this problem that's come forth would also be worthwhile.
2 But what would the Commission like to do at this point?
3 MR. MITTELBRUN: Commissioner Mittelbrun. I'm not
4 in the Legislature but, if I were, I would appreciate, you
5 know, being informed of the problem. And, of course, not
6 being a, you know, an expert in the field, if I was in the
7 Legislature, most likely I would want the expert's opinions,
8 which there are several of those at this table. So I think
9 you're absolutely right, you have to provide focus. You
10 know, you have to give them something to focus on, and you
11 have to have a good starting point. So I think that
12 registry seems like the right starting point and then -- I
13 mean, something like telemedicine, which is not that
14 complicated, you know, as was referenced, that would be
15 maybe another one you could reference, and then, you know,
16 tell them you've got other ideas if they want to hear them.
17 MR. FALAHEE: This is Falahee. As a former chair,
18 I think it's good to give leeway to the current chair to
19 draft the appropriate letter with the assistance that he
20 needs, whether it's Commissioner Cowling or anybody else
21 around this table or others sitting in the audience. I
22 think we've talked about the three highlights; the
23 telemedicine, the state registry and then some sort of loan
24 forgiveness program. To me, it makes sense to say something
25 about those but most of the detail going in on the registry,

1 because we know that's being done elsewhere, so is
2 telemedicine and we're lagging on that.
3 I think it would be good, Commissioner Keshishian,
4 if we invest in you the authority to work with the
5 Department and whomever else you think is appropriate --
6 winking to Commissioner Cowling -- to put together the
7 letter.
8 DR. KESHISHIAN: If you'd ask that in the form of
9 a motion, I'll --
10 MR. FALAHEE: I'll make that in the form of a
11 long-winded motion.
12 DR. KESHISHIAN: Thank you.
13 MR. FALAHEE: Sorry.
14 DR. KESHISHIAN: Do I hear a second?
15 MR. MITTELBRUN: Short second, Mittelbrun.
16 DR. KESHISHIAN: Any more discussion? All in
17 favor say "aye."
18 (All in favor)
19 DR. KESHISHIAN: Opposed?
20 (None opposed)
21 DR. KESHISHIAN: Okay. Thank you. Legislative
22 Report. I don't see Elizabeth, so --
23 MS. NAGEL: There is none.
24 DR. KESHISHIAN: Okay. Administrative Update,
25 Planning and Access to Care Section Update, Beth?

1 MS. NAGEL: Yes. This is Beth. I have a couple
2 of updates. First, as you noticed with the written report
3 from the Nursing Home work group chair, that we are
4 currently in a Nursing Home work group. We've had two
5 meetings already. There are three others on the calendar.
6 I'd also like to update you on the Lithotripsy
7 Standard Advisory Committee attempts. We've made four
8 attempts to seat a Standard Advisory Committee for
9 lithotripsy. Each time we did not get -- we did not meet
10 the statutory requirements for a Standard Advisory
11 Committee. You may recall the charge to that committee is
12 to consider and recommend if lithotripsy services should
13 continue to be regulated by Michigan CON. That was the
14 charge. In addition to that charge, the Department has some
15 language that we'd like to put forward that specifically
16 fixes some issues with administering the standards, and
17 those were brought up in your January Commission meeting as
18 well. So at this point, we're asking the Commission for
19 some guidance on how to proceed with to either continue
20 trying to seat a SAC to consider continued regulation or
21 bring language forward at a subsequent meeting that
22 addresses some of the issues. We have some urgency that we
23 want to address those issues as soon as possible. I have
24 two other updates as well.
25 MR. FALAHEE: Can I interrupt and ask just a

1 question about that, Beth, on the -- so you've tried four
2 times and you're 0 for 4.
3 MS. NAGEL: Yeah.
4 MR. FALAHEE: Are you thinking of potentially
5 bringing language to the Commission at a future date from
6 the Department or are you thinking of putting a work group
7 together?
8 MS. NAGEL: The Department is able to addre- -- we
9 believe we're able to address the changes that need to be
10 made given that there will be public comment that the
11 Commission -- a public comment period to fix anything that
12 perhaps doesn't meet with industry standards.
13 MR. FALAHEE: Okay. Thank you.
14 DR. KESHISHIAN: And -- why don't you go ahead,
15 and then we'll --
16 MS. NAGEL: Okay. Included in your packet on page
17 107 was a survey that Dr. Delamater sent to bone marrow
18 transplant providers in Michigan and some national experts
19 as well. You may recall at the last meeting you directed
20 the Department to work with our contractor who is Dr.
21 Delamater to come up with a needs-based methodology for bone
22 marrow transplant services. We anticipate that you will --
23 or he will be able to provide a update at the December
24 meeting. But in the meantime, we wanted to make sure that
25 you had the materials that have been distributed. It was a

1 very thorough survey. Results are coming back currently.
2 And then finally I wanted to draw your attention
3 to something that will be sent out soon. It is the 2017
4 Standards for Review Public Comment Period, which will start
5 on October 7th and go through the 21st. These are the five
6 standards that the Commission will look at at the January
7 meeting next year and plan for in 2007 -- 2017. Excuse me.
8 DR. KESHISHIAN: Are there any questions for Beth?
9 I think the one action item we have to take is we have to
10 decide what -- oh, go ahead.
11 MS. ROGERS: This is Brenda. Just one additional
12 under that. The open heart surgery has -- excuse me.
13 Sorry. Go ahead.
14 MS. NAGEL: Yeah; sure. In the Open Heart Surgery
15 Standards, there is a place for the Department can update
16 certain weights that are used to calculate need. It does
17 not re- -- and the standard does not require Commission
18 action. We have done that and updated the Open Heart
19 Surgery Standards. And the correct weight -- the updated
20 weights are listed on our web site. They are effective
21 September 1st.
22 DR. KESHISHIAN: Anything else?
23 MS. NAGEL: No.
24 DR. KESHISHIAN: I think the one action item we
25 have to take is what are we going to do with lithotripsy.

1 In January we took an official vote to have a SAC. We've
2 tried to seat the SAC four times, and we did not receive the
3 membership that we needed. I tried to beat the bushes to
4 try to get some people and was unsuccessful. So we'll
5 either have a work group, which I'm not sure we need, or
6 just ask the Department to make the changes that they're
7 recommending at this point and bring them back in the
8 December meeting. I think those are our two options. We
9 can discuss it further if we'd like, but I think a work
10 group might not -- I don't think -- I'm not sure it's
11 necessary, but we can have discussion.
12 MR. FALAHEE: This is Falahee. I'll agree with
13 that. We've been around and around on these issues, and I
14 think I'd be comfortable with the Department submitting
15 language. So I'll make a motion just to get it on the
16 table. Move that the Department submit language on the
17 lithotripsy to us at our December meeting if that timing
18 works out and that we'd consider that language at that time.
19 MR. HUGHES: Commissioner Hughes, second.
20 DR. KESHISHIAN: Thank you. Any discussion? All
21 in favor say "aye."
22 (All in favor)
23 DR. KESHISHIAN: Opposed?
24 (None opposed)
25 DR. KESHISHIAN: Thank you. Is there anything

1 else in that area that we have to --
2 MS. NAGEL: No.
3 DR. KESHISHIAN: Okay. Legal Ac- -- no. I'm
4 sorry. Tulika, CON Evaluation Section Update?
5 MS. BHATTACHARYA: This is Tulika. The written
6 reports are in your packet. I have nothing further to
7 report. If you have any questions, I'd be happy to answer.
8 DR. KESHISHIAN: Any questions? Legal Activity
9 Report, Joe?
10 MR. POTCHEN: This is Joe. The legal activity
11 report is in your binder. We currently have one pending
12 case in Oakland Circuit Court. It involves Regency of
13 independent township of filing a lawsuit requesting a ruling
14 to allow Regency to operate a nursing home in a site
15 different from the site stated in its application. In
16 August of this year, the Circuit Court ordered a stay of the
17 proceedings and it set for a status conference in March of
18 2017. So there will be no decision on there for awhile.
19 Additionally continue to assist the Department and the
20 Commission in developing the rules and standards.
21 DR. KESHISHIAN: Thank you. Any questions for
22 Joe? Thank you. 2016-17 meeting dates. They are listed.
23 Please put them on your calendar. Public comment? I do not
24 have any cards. If there are any public comments? If
25 somebody wants to make public comments at this point? Nope.

1 Okay. Review of Commission Work Plan. Brenda?
2 MS. ROGERS: This is Brenda. I'll try this again.
3 All right. Yeah. You have the draft work plan in front of
4 you and, based on the recommendations you made today, we
5 will make sure that it is up-to-date. But I think we've
6 captured pretty much everything on there. But we will
7 double check it before posting. And we just ask the
8 Commission to approve the work plan as presented or if you
9 have additional changes. Thank you.
10 DR. KESHISHIAN: Is there a motion to approve the
11 Commission Work Plan?
12 DR. COWLING: Move to approve.
13 DR. KESHISHIAN: Second?
14 MR. HUGHES: Mr. Hughes, second.
15 DR. KESHISHIAN: Thank you. Any discussion? All
16 in favor say "aye."
17 (All in favor)
18 DR. KESHISHIAN: Opposed?
19 (None opposed)
20 DR. KESHISHIAN: Okay. And with that it is
21 adjournment so we do not have to have a 10 to 15 minute
22 break. A three-month break. We need a motion for
23 adjournment.
24 MR. MUKHERJI: Motion to adjourn.
25 MR. MITTELBRUN: Second.

1 DR. KESHISHIAN: Thank you. Any discussion? All
2 in favor?
3 (All in favor)
4 (Proceeding concluded at 10:59 a.m.)
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