STATE OF MICHIGAN

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF NEED

QUARTERLY COMMISSION MEETING

BEFORE MARC D. KESHISHIAN, M.D., CHAIRPERSON

Grand Tower Building, Dempsey Room
235 South Grand Avenue, Lansing, Michigan
Wednesday, March 16, 2016, 9:30 a.m.

COMMISSION MEMBERS:	SURESH MUKHERJI, M.D., Vice-Chairperson
	DENISE BROOKS-WILLIAMS
	GAIL J. CLARKSON, RN and NHA (Absent)
	KATHLEEN COWLING, D.O.
	JAMES B. FALAHEE, JR.
	DEBRA GUIDO-ALLEN
	ROBERT L. HUGHES
	JESSICA A. KOCHIN
	THOMAS MITTELBRUN (Absent)
	JOSEPH E. POTCHEN
	LUIS A. TOMATIS, M.D.
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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA
	AMBER MYERS
	BETH NAGEL
	TANIA RODRIQUEZ
	BRENDA ROGERS

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Wednesday, March 16, 2016 - 9:32 a.m.

DR. KESHISHIAN: We will call the meeting to order at 9:32. I note that we have more than six commission members present, and therefore we have reached a quorum.

First, I would like to do an introduction. We have a new commissioner. Debra Guido-Allen was appointed to the Commission earlier this year. She takes the position of Gay Landstrom. Welcome, Debbie.

MS. GUIDO-ALLEN: Thank you.

DR. KESHISHIAN: We're glad to have you here.

MS. GUIDO-ALLEN: Thanks.

DR. KESHISHIAN: The Department of Health and Human Services is presenting a Certificate of Appreciation to Gay Landstrom. I'd like to read it and then we'll move on to the agenda. This is from the Department, so we don't need to approve it.

"A Certificate of Appreciation presented to Gay L. Landstrom, RN, for your years of service on the Certificate of Need Commission. This is presented with grateful appreciation for your years of dedication and service to the people of the State of Michigan during your tenure as a member of the Certificate of Need Commission. Your professionalism

and commitment to serving the public and insuring access to quality and cost-effective health care services have made a significant impact on the Commission, the Department, the State of Michigan, and most importantly, our citizens."

Signed by Nick Lyon, director of the Michigan Department of Health and Human Services and myself as the chairperson of the CON Commission.

With that, I'll turn it -- both Gail Clarkson and Tom Mittelbrun will be absent today. There is no new Department staff. In this meeting location there is no recording system, no microphones, and it's a different room layout. There is a court reporter who is also recording the meeting, so be sure to identify yourself when speaking. Speak clearly and loud enough so the audience can hear. And with that I'll turn it over to -- I'll turn -- the next item is Review of Agenda. The tentative agenda was --

(Off the record interruption)

MR. KESHISHIAN: Sure. We're going to go around and introduce everybody. Go ahead.

MR. FALAHEE: James "Chip" Falahee with Bronson Healthcare Group.

MR. HUGHES: Bob Hughes from Advantage Benefits Group.

(Off the record interruption)

MS. KOCHIN: This is Jessica Kochin from Ford Motor Company.

MS. GUIDO-ALLEN: Debbie Guido-Allen, nursing representative.

MS. BROOKS-WILLIAMS: Denise Brooks-Williams, Henry Ford Health System.

DR. COWLING: I'm Kathleen Cowling. I'm with Central Michigan University in Saginaw.

DR. TOMATIS: Luis Tomatis. I don't think I represent anybody.

(Off the record interruption)

DR. MUKHERJI: Suresh Mukherji, M.S.U..

DR. KESHISHiAN: Marc Keshishian, Blue Cross/Blue Shield.

MR. POCHEN: Joe Potchen, Department of Attorney General.

MS. ROGERS: Brenda Rogers, Department of Health and Human Services.

MS. NAGEL: Beth Nagel, Department of Health and Human Services.

MS. BHATTACHARYA: Tulika Bhattacharya, Department of Health and Human Services.

MS. RODRIGUEZ: Connie Rodriquez, Department of Health and Human Services.

MS. MYERS: Amber Myers, Department of Health and

Human Services.

DR. KESHISHIAN: Okay. Thank you. The next item is a review of the agenda. It's the tentative agenda that was sent to you last week and was posted on the CON Commission website. The final agenda has been placed at your seat and included in the final accounting binder. Please review the agenda. I will accept a motion to approve or amend today's agenda.

MS. KOCHIN: I'll make the motion to approve. Commissioner Kochin.

DR. KESHISHIAN: Thank you.

MR. MUKHERJI: Mukherji, second.

DR. KESHISHIAN: Thank you. Any discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, say, "Aye."

ALL: Aye.

MR. KESHISHIAN: Oppose?

ALL: (No verbal response)

MR. KESHISHIAN: The motion carries. The next item is declaration of conflicts of interest. Based on the agenda before us do any commissioners wish to declare a conflict of interest?

ALL: (No verbal response)

MR. KESHISHIAN: No conflicts of interest have been declared. Commissioners may disclose any potential

conflict of interest at any time that the conflict becomes apparent.

The next item is review of minutes of January 28th, 2016, the draft January 28th, 2016, meeting minutes were included in the packet that was sent to you last week. We need a motion to accept or provide revisions to the minutes. Do I hear a motion?

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams, move to approve.

DR. KESHISHIAN: Second?

MS. KOCHIN: Commissioner Kochin, second.

DR. KESHISHIAN: Thank you. Any discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, say, "Aye."

ALL: "Aye."

MR. KESHISHIAN: Oppose?

ALL: (No verbal response)

MR. KESHISHIAN: The motion carries. Next item is MRI services and I'll turn it over to Brenda.

MS. ROGERS: Good morning. This is Brenda Rogers. In your packet you'll find the set of language that you took -- proposed action on back at your December Commission meeting. We did hold a public hearing on that language, and we received one piece of testimony and that was supporting the MRI language so today it's being brought

back to you at the Commission to take final action on it. And if you take final action today then we will send it on to the Joint Legislative Committee and the Governor for the 45-day review period. So it's being presented today with no additional changes from your December meeting. Thank you.

DR. KESHISHIAN: Any questions for Brenda by the Commissioners?

ALL: (No verbal response)

MR. KESHISHIAN: I do not have any cards that there was any public comments. Commission discussion? Any discussion on MRI standards?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Do I hear a motion to approve and to move on for a public hearing?

(Off the record interruption)

MR. TOMATIS: Commissioner Tomatis moves.

MR. KESHISHIAN: Okay. Do I hear a second?

DR. COWLING: I second.

DR. KESHISHIAN: Thank you. Any more discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, say "Aye."

ALL: Aye.

MR. KESHISHIAN: Opposed?

ALL: (No verbal response)

MR. KESHISHIAN: Great. Nursing home and hospital long-term care bed needs effective date.

(Off the record interruption)

MR. KESHISHIAN: Sorry about that. Common ownership. Brenda?

MS. ROGERS: All right. Again, this is Brenda. The common ownership has been an issue that was raised initially during the MRI work group that held -- took place in earlier 2015 and then also public testimony was received by the Commission at your September Commission meeting. At that time the Commission asked the Department to work with the Attorney General's office to see if we could possibly come up with some language allowing for acquisition under common ownership if -- without having to meet the volume requirement.

We have worked with the Attorney General's Office and believe that we do have language to -- that will facilitate that, keeping in mind that they would only be exempt from the going requirement of -- if there's a common parent, common control or the same parent of the applicant. They would still have to meet all other acquisition requirements, so that's the only piece that they would be exempted from.

As you will note and as I have stated in my cover memo to you, Michigan's healthcare system has changed

dramatically over the last seven years, and so we are seeing a lot more hospitals and entities merging together, but in the State of Michigan we do not have a definition for "health systems," so we feel that this is a way to be able to allow that, give a little bit of flexibility toward acquisition under the MRI standards. So that -- the draft of that language is basically under Section 6 of the standards that were included in your packet.

Now, especially for Debra, who is newer to the Commission or for those of you that haven't seen us do this before, we do have two sets of language, though the one piece you took final action on today. If you take proposed action on this language, again, it will move forward to the Joint Legislative Committee and a public hearing will be scheduled.

At the time that this comes back to you for final action in June, if the set of standards that you just took final action on are effective by that date, then you will see this language in that piece. But we couldn't put it there now, because this is the language that's in effect today. So this is a two-step process, instead of combining it. The other option that was tossed around earlier and everybody, I think, was in agreement because there's -- there's changes in the MRI language that you took final action on today that we really think are going to be

beneficial to applicants, and the applicants are waiting for that language to become effective, so we wanted to do a two-step process this time around. And that was the reason for that. So if anybody's got any questions on the language, feel free to ask. Thank you.

DR. KESHISHIAN: Any questions for Brenda?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Do I hear a motion to approve the language regarding --

PUBLIC SPEAKER: Public comments?

MR. KESHISHIAN: Oh, public comments. I don't have any cards. Is that --

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Commission discussion? Any discussion?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Do I hear a motion to approve the language of the MRI Services common ownership to have a public hearing and move it to the Joint Legislative Committee?

MR. FALAHEE: This is Falahee. I'll make that motion.

MR. KESHISHIAN: Thank you.

DR. COWLING: Commissioner Cowling, second.

DR. KESHISHIAN: Thank you. Any more discussion?

DR. MUKHERJI: Just a point of clarification. Is this going to -- is this now going on to public comment? Or is it just going straight to JLC? You mentioned --

MS. ROGERS: This is Brenda. Any time you take proposed action, we schedule a public hearing and at the same time it goes to the joint legislative committee because they also get in point during this public hearing process.

DR. MUKHERJI: Is this going to come back to us, then?

MS. ROGERS: And it will come back to you at your June meeting for final action.

(Off the record interruption)

MR. FALAHEE: I've got another question, Brenda. This would, then -- assuming we get to this in June and we approve it in June, it will then get inserted into the standards we've just approved?

MS. ROGERS: If they are effective. I mean, at some point, they will get merged together, so, yeah.

MR. FALAHEE: And if they're not effective as of June, whenever they become effective, then, they get -- this gets inserted?

MS. ROGERS: Yes; yeah. Yeah, so if for some reason they're not effective and then this set continues to move forward by the time hopefully that September gets

here, I would hope this current set is effective and then we would just merge it all together before we post it out there on the web.

MR. FALAHEE: Okay. Thank you.

DR. KESHISHIAN: Any other questions?

DR. MUKHERJI: Is this retroactive?

MS. ROGERS: No.

DR. MUKHERJI: Because it says only acquisitions that are made after this is initially approved?

MS. ROGERS: Once it becomes effective.

DR. KESHISHIAN: Any other questions?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. We'll take a vote. All in favor of the motion, say "Aye."

ALL: Aye.

MR. KESHISHIAN: Opposed?

ALL: (No verbal response)

MR. KESHISHIAN: Thank you. Next item, nursing home beds. This is -- the Commission delayed action from the December 2015 meeting. Brenda Rogers can provide background and additional information.

MS. ROGERS: So again, this is Brenda. At your September Commission meeting, the bed need -- new bed need numbers had been run and appendices were updated based on that run of the numbers. And then the Commission delayed

action on setting the effective date until the December Commission meeting. So now today we are picking up from what you postponed at the December Commission meeting.

There were recording discrepancies at that time that had been identified and the Department had asked for the additional postponement so we could continue to try and get more complete data before having you set an effective data. So in that time period more data has been collected from hospitals -- or, excuse me -- nursing homes that hadn't initially reported or maybe reported in error. Some of them have corrected their data is my understanding. And, Tulika, just correct me if I'm stating it wrong.

So given that, Paul Delematter has rerun the bed need methodology again. You have new numbers in your packet, so we did -- by doing that and including the additional nursing homes there are additional beds. Most areas, I believe, are still over-bedded, but we do feel that we at least have a better sense of what those numbers are. So today, if by setting the effective date of the bed need numbers, these do not require SAC action. These do not require public hearing or submittal to the legislature or governor.

And, again, going along those lines, by setting the effective date today this will also help in the SAT and/or work group that this commissioner asked to be put

together on nursing homes in January, so they will -- because they will be looking at the methodology. And this methodology will be re-run again in 2017 because it's a two-year cycle. So we started this in 2015, so even given the -- setting the effective date -- I'm just giving an example of April 1st -- those bed need numbers are really only going to be in effect for maybe a year, give or take and then next year either we'll have a new or revised bed need methodology at that point or the group may define that the bed need methodology we have is, you know, sufficient.

But at any rate, the numbers will be rerun with either a new or the same methodology. So numbers will only be in effect for, you know, like I say, a year or so, give or take. So just keeping that in mind. Again, it will allow the SAC or work group to, you know, at least take a look using the most current calculations.

DR. KESHISHIAN: Just if there's follow-up on those issues, if we decide to set an effective date today a motion would need to be made and seconded and we'd need to vote on it. And as Brenda said, it doesn't need to go any further, I believe we do need to set an effective date. The reasons I believe that is that under law we should be setting an effective data, and it was supposed to be done in 2015. It's now already 2016. The numbers that we received were the numbers that people submitted to us.

There was some -- there were a lot of concerns expressed at the December meeting and the Department, to their credit, went out and seeked (sic) advice and asked people to provide numbers. And they rerun the numbers again and they're about as good as they're going to get at this point in time. We've learned from the methodology we instituted back in '14, and we just need to -- I think we need to move forward. There isn't officially amu place for public comments, and Gail had -- unfortunately she's not here today, she had a lot of comments or concerns expressed. So I will -- unless somebody -- and I don't know if I need to have a motion to amend the agenda, but to ask for any public comments from anybody regarding the effective date. Do I need a motion to amend the agenda? I don't think so. Any public comments?

MALE VOICE: Yeah; Marc, you got one over here. You can't see him, I don't think.

MR. KESHISHIAN: Please pass the blue cards beforehand. And I should read a statement. You have three minutes and -- to give your public comments. Thank you.

PUBLIC SPEAKER: Good morning. I'm Pat Anderson. You've seen me before. I'm with the Healthcare Association of Michigan, which is the largest representative of nursing homes across the state. We did send out a letter last week asking the Commission to not implement these bed needs

as they are. The new numbers, yes, they are a little bit better; they still show in every planning area that it's negative. There's still a lot of problems with the data. I commend the Department, they did try to get it. They asked me some of it. Some of them -- of the data that's there, there's problems with it and to get it correct is almost impossible. There's changes of ownership, there's facilities that closed; there is just no way to get -- like I said, I worked with Tulika and Andrea and Beth in trying to get that, so really HCAM would like you to not put that in place, and I understand that. But let the SAC or the work group, whichever gets called, deal with it at that time. We're -- even though you're saying it's (inaudible), we're not sure that's real good public policy because we know the data is incorrect. But thank you for your time.

DR. KESHISHIAN: Any questions? Chip?

MR. FALAHEE: Never let the perfect get in the way of the good. This is the best data the State has right now. It's not perfect, but it's the best, most accurate data. So what's wrong with us approving it now and letting the SAC use those most current numbers versus the numbers that are out there now that we know are way off? What we've got now is better than what we had.

PUBLIC SPEAKER: I don't think the numbers we have now are better because with these we show that the data,

some of them -- like, there was one chain, and unfortunately the chain changed ownership in '15, so we can't go back to them to get the information from '14. They reported all their data -- it appears they reported quarterly data, not a full year. So every one of theirs shows a very low occupancy, and that was the deal from about 12 facilities alone. Like I said, there's still a few missing ones. So we still think the data in the way the numbers are right now are not better than what is sitting there in place; we think they're more representative.

We have worked with the Department in trying to get a better survey for '15. Tulika and Andrea came over to our committee meetings. And the people that are going to be filling them out were at the meeting. We had almost -- we had, like, 35 people there. They understood how it was going to be used, where it was going to be used. Part of the problem was, is the age cohort, which is a big factor in calculating the bed needs. They're asking for numbers like being 60 years younger than that in different categories; five different categories, even though we use only four in the calculation. They're not tracking information like that, because no one ever asks them and I think someone even at the meeting either commented then or commented to me that, "Well, they just added the numbers

together and put it on the page." But they didn't understand that that made a difference to what happens in the age cohort. The big concern is that we know we are now serving a somewhat -- we have kind of two populations that -- post-acute care, which is more short term, and also a younger age and then we have the long-stage patient, who is typically your -- more what you would think in a nursing home, 85-plus. We have a lot of people coming in for transition services and I don't know if that's being reflected appropriately. So that would be my concern.

MR. FALAHEE: Then a follow-up, if I may, --

MR. KESHISHIAN: Yeah.

MR. FALAHEE: -- to Tulika or Andrea, we've heard what Pat has to say. Is there a counter-point? What's your comment?

MS. BHATTACHARYA: This is Tulika. And the annual survey data is self-reported and then a data problem is pointed out to us for any service, in this case we are talking nursing home. We do reach out to our providers and ask them to go back, check your numbers, and report them accurately. And we have done our due diligence to the best of our ability. But at the end of the day, the provider would have to submit the data to us for us to run the methodology. Now, we did reach out to Medicaid for the number of patient days each nursing home reported to

Medicaid, but the problem with Medicaid data is it's one bulk of data. They don't break it up by age cohort. So if we compare the two, we do see the differences in the total number of days, but, I mean, this is the best we have. And right now the numbers that are out there, yes, there are more planning areas that -- bed need, whether it is one or two, but there is a bed need. And in these new numbers, there are nine planning areas that we have a bed need. So in my mind, the data that we have currently on the bed need numbers on our bed side, and the new numbers are really not that big. I mean, there is not much difference. We accept that there -- it's flawed, but we are working towards getting more -- or better data into Carbon 15 so they -- which will be launched tomorrow. But for the time being, if we have these new numbers there -- it's not much difference from what we currently have on our website.

MS. NAGEL: If I could just add, I think full sets of data probably have the exact same problems. I think that the one that is already in effect is problematic and the one that's currently in effect is problematic and it's really a decision on the -- it's -- the statutory responsibility is with the Commission to hash that out.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. So, Pat, if you could again say what is the implication that you're feeling will happen if the data is

approved?

PUBLIC SPEAKER: Well, it gets that some of the planning areas they say they have no beds available, and yet there is. And if you get the beds and you're adding -- you're building a new facility, there's not many planning areas that would have enough for a brand new facility but if you were expanding -- it takes a long time. Once you get the beds and then get the construction going and that, and as the population is aging and what we're seeing is needing more private rooms so we're taking our facilities and extending them and trying to get more private rooms and accommodating the customers' needs that that progress will slow down.

We're pretty proud that in Michigan over the last 10 years, really, nursing facilities have been upgrading and renovating and building new (inaudible) and we think that's a very positive move. A lot of our buildings, four were built in -- the 70's was a big building year. It happened to be in Medicaid at that time, but -- so that means that a lot of them were before 1960. So we have aged buildings that don't accommodate the residents that we serve today. Thank you.

DR. KESHISHIAN: Any other questions?

(Off the record interruption)

MR. FALAHEE: So Commissioner Hughes and I are

looking at the -- I think the new numbers. And are these showing that there's unmet bed needs almost everywhere now with the new numbers?

PUBLIC SPEAKER: No, no.

MS. BHATTACHARYA: There are only nine planning areas with bed need now.

PUBLIC SPEAKER: No; those are over.

MS. BHATTACHARYA: If you put the new numbers in the plan there will be nine planning areas with an unmet bed need. But just one point of clarification, bed need is important to start new nursing homes. But bed need doesn't really play a role in new construction, renovation of existing facilities, or replacement facilities, just to make it clear.

MR. FALAHEE: Got it.

MS. BHATTACHARYA: So right now most of the planning areas are over-bedded. I think there are nineteen that has bed need, but not enough to create a new nursing home. Like, you cannot start a new nursing home with 10 bed or 20 beds. So right now we have the same issue. And if you put the new numbers in effect, it's kind of a similar issue for creating new nursing home, but that doesn't play a role in -- for construction, replacement, renovation projects.

MR. HUGHES: Dumb question -- are we -- with the

new numbers are we more over-bedded or less over-bedded with the new numbers?

MS. BHATTACHARYA: More over-bedded; yes.

MR. HUGHES: That's fine. Okay.

DR. KESHISHIAN: Any other questions?

MS. BHATTACHARYA: But whether you're over-bedded by one or 1,000 it doesn't matter because there are no new beds.

DR. KESHISHIAN: Any other questions?

MS. KOCHIN: Commissioner Kochin. Tulika, what I've heard you say is that you were able to compare the numbers that we have in this updated -- well, this -- better data than we had in December against another report, which was from Medicaid, I believe. And I understand that there's reporting differences in terms of how we put our projection together, it sounds like are in those age bands that you describe versus the Medicaid, which is more of an aggregate number. How did the aggregate numbers compare? Were we under or over the Medicaid predictions? And do we know that from a percentage, like, were we very high or very low?

MS. BHATTACHARYA: We just got through -- there are 470 nursing homes. We just got through the comparison. We need to put it in a database or Excel to do that analysis. We haven't done it yet. I don't know if Pat

has.

MS. NAGEL: Pat, didn't you do that?

PUBLIC SPEAKER: I looked at some of them back at the end of last year in comparing the data and there were differences which didn't quite make sense, either, comparing the total days. Yeah; and on the Medicaid -- through the Medicaid cost report it is -- we'll have all those who are Medicaid-served by -- this is most of the facilities in Michigan. There's probably five to ten that are not, so they don't file that report. They may be Medicare or private pay only but they're still licensed in the CON. And there were some differences which didn't make sense, and I know the new -- the 2015 survey they were going to add a thing where you can't -- if you put your HCOHORTS in, those total days have to equal the total days you reported over here, so there's a check and balance in the system because I think we found that the two numbers weren't matching. They put the HCOHORT in short -- short beds -- or short days compared to the days you said you had in total. So it's (inaudible) which one's right. I don't know. And I don't remember exactly how many were right or wrong. I kind of went through quickly and I could just tell it's -- like you said on the one I can tell based on reporting data, they didn't send in other because if you multiply it by four, you get all of the (inaudible)

everybody else, but that's the big assumption you can't made on (inaudible).

DR. KESHISHIAN: Any other questions? I have a few and some of them is for the Department and some to Pat. My understanding is under the statute we used 2014 data and then we set the standards in 2015 based on 2014 and then we use 2016 bed days to set the statutes in '17. Is there any reason we can't look at '15 bed days and to do it a year early versus having to do it every two years? Because -- do you understand what I'm asking?

MS. ROGERS: I can answer part of it and then I'll let Tulika complete the rest of it. Just for correction, it was 2013 data.

DR. KESHISHIAN: 200- -- what?

MS. ROGERS: '13.

DR. KESHISHIAN: For 2015?

MS. ROGERS: And for -- so then the planning year was '18, so it's five years out. So -- and maybe I'll let Tulika respond as far as using the 2015 because as she said, is's going out tomorrow. So if they -- I don't know how long the time frame is, but if we don't have that data completely -- I'm going to say "cleaned up" at this point until the end of the year -- okay? So it's not going to be something that's going to be done in the next month or two.

DR. KESHISHIAN: Right. But the alternative --

and let me just -- the alternative is to wait for 2016 data to make the decision and I'm saying that is -- would it better to use the most -- no?

MS. ROGERS: You're usually a year or so behind just because of the timing of everything. So let's say next year in 2017, when it's time to run the data again, it more than likely will be the 2015 data because at that point the 2016 may or may not be available. So you're usually -- there's that one year of lag time, which if you -- those of you that have been around CON for a long time know that that's a significant improvement from where we were years ago.

DR. KESHISHIAN: Tulika, do you have any other --

MS. BHATTACHARYA: Yes. So the numbers -- the new numbers that you have in front of you, utilize the 2013 annual survey data calendar year. So in 2017 when we run the numbers again, we will use the 2015 annual survey data, which is being launched tomorrow. It is due in six weeks, so the end of April but does everybody assimilate the data on or before the due date? The answer is "no." We constantly are calling, e-mailing, to get the data in. So if everybody submits the data within the deadline, we will have a data set, then we need some time to audit and verify and then it will be ready for Paul to run it again. But that depends on how the providers are reporting the data

and whether it is timely and whether it is accurate or not.

DR. KESHISHIAN: Pat, any -- what I hear is that we changed the process and we put it on the website. Anyone can go to the CON website and see the process. And yet we have a statutory responsibility to set a date and if we don't set it, then somebody could (inaudible) the committee or Commission that we didn't set our date. And you're saying, please don't set a date because the data's wrong. But it was the nursing homes that didn't provide the data in the correct format initially and everyone can go out to the website and look to see how it's supposed to be presented. So my question is, you're requesting that we don't do our statutory responsibility because the data was submitted incorrectly, because people didn't look at the website and didn't understand how to submit the data. Is that -- and so that puts us in a bad position as far as the State goes that, you know, we have this responsibility, we never were audited, it could be said that we didn't live up to our responsibility. What am I missing on this? Can you help me out?

PUBLIC SPEAKER: You know, I can't apologize or say why they submitted the data wrong. CON touches a lot of the facilities, a lot of it is for rep positions and sales, not as much as in the bed need in that, they're just switching ore replacements that are not into the bed need

in that. So for a lot of facilities it just wasn't a high priority, which is not a good excuse. So, you know, we -- looking at finding and straightening out, I think there was quite a few years -- we started reporting the section data about four years ago, was it?

MS. BHATTACHARYA: 2009.

PUBLIC SPEAKER: 2009; okay. And not -- I don't even know if that got used for anything as we rolled forward. So, yeah, I understand you have a statutory requirement. You know, even the standards -- and maybe it's not in there -- I think you really see that in there but I would default to you; you know it much better than I do. It's just that I think it doesn't seem -- in a way I guess it's using one bad set of data or another bad set of data to set public policy. I would push our members to get the data in immediately, due the end of April. Like I said. we already had a pre-meeting getting people hyped up for it. We represent over 300 of the facilities, and we'll contact the other associations to see if they can try to get the data in for '15. It's probably the best I can offer, is to push that.

DR. KESHISHIAN: Okay. Thank you. And I just want to make sure my facts are right. We have a responsibility to set the due date.

MS. ROGERS: Yeah. In the -- and I apologize, I

don't have the standards with me. But in the standards where you run the bed need methodology -- and Joe is shaking his head --

MR. POTCHEN: I'm just trying to find where we're supposed to be/

MS. ROGERS: Yup -- it's -- I mean, it's under the bed need portion that it's the Department's responsibility to rerun the bed need methodology on a bi-annual basis and then it's the Commission's responsibility to set the effective date of those bed needs. So the Department will build its responsibility in 2015, now it's the Commission's turn to set the actual effective date.

MS. GUIDO-ALLEN: So just one comment. Debbie Guido-Allen. With Medicare spent, the beneficiary really holding for three days prior, the hospitalization -- acute hospitalization stay up to 30-days post, there's a lot of emphasis on decreasing post-acute, high cost strategies. So sub-acute rehabs or going to home care or going to facilities, so it would be interesting from the standpoint of looking at what would be the 2016 data as to what we see as far as bed needs with a huge emphasis on that. Now there isn't.

DR. KESHISHIAN: Any other questions for Pat?

ALL: (No verbal response)

MR. KESHISHIAN: Thank you very much, Pat. We appreciate your comments. I'm going to open it up for discussion now, whether we make a motion -- what do we do? Any comments?

MR. FALAHEE: This is Falahee. I'll make the motion that we set the effective date for today for those standards because I understand the new survey goes out tomorrow. So since the new survey goes out tomorrow, my motion would be we set the effective date for the standards as of today and that will do it.

DR. KESHISHIAN: Do I hear a second?

MR. HUGHES: This is Mr. Hughes. Second.

DR. KESHISHIAN: Okay. Any more discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, raise your right hand. Nine in favor? No -- none opposed?

ALL: (No verbal response)

MR. KESHISHIAN: The motion carries. Thank you. Site beds and services work group final report follow-up. Commissioner Cowling?

DR. COWLING: Okay. So the Commission will remember my impassioned discussion in December that out of all the issues that we are facing with respect to access to mental health care in this state and specifically the psychiatric bed availability for placement of patients,

that my bottom line was is that there was not much under the purview of CON that we can actually impact. But what we can do and what the Department staff eloquently put together and ran past several CON experts to get it to today's draft in front of you, is focusing on the particular populations of developmentally disabled, geriatric and the medical dual diagnosis people, like your COPDers that are oxygen dependent, but also need care. So I am 100-percent in favor of what they have done. I wish that we could do more. I wish I had a magic wand; I do not. But I think that at least what we've got from what the staff did is something that at least under our domain we can control and I would encourage us to move forward. So -- but I'm going to turn it over to the staff because I know Beth and Brenda can run through the specifics better than I can.

MS. ROGERS: Again, this is Brenda and as Kathleen has stated, you do have draft language in front of you today. There are a few technical changes in the first part of the standards, really just to kind of accommodate what we are doing and proposing in this addendum, which is the last part of the standards.

So in this addendum what we are proposing is adding a special population bed pool, similar to what we do in nursing homes, special population groups. The three

groups that are being proposed -- and, again, this was discussed during the work group and then the Department did additional follow-up after the work group concluded its efforts. The three areas that the work group and Department agreed to were the developmentally disabled, geriatrics and medical psychiatric. And basically, this hopefully will provide more access to beds for these specific, hard to place patients.

The language -- I'm not going to read through every section in the addendum, but I'm just going to point out a few highlights that I think kind of summarize what the language actually does. So the addendum is basically a supplement to the Certificate of Need standards. So it doesn't replace what's in the first part of the standards -- the actual standards, so it supplements; except for those in the initiation of these beds, the acquisition of these beds. That's farther out and that is provided under Section 1 where I'm making these comments from. So it's very clear that except as provided in Sections 2, 3, 4, 5, 6 and 7, this does not supercede. Okay?

We've come up with definitions, again, working through research and working with our experts and sharing it with the experts after the work group was over on defining developmental disabilities, geriatric psychiatric

units and medical psychiatric units. The bed pool is -- the way we set it up is similar -- not the same, similar to how the bed pool numbers were first created for the nursing homes special populations. So it's based on 2 percent of the state-wide bed need for psychiatric beds, and then rounded up to the next ten. So if it came out with three, then it's ten beds. If it came out with 25, it was rounded up.

So for each of those groups we allocated 50 adult beds and ten child/adolescent for developmental disabilities. We've allocated 50 beds for geriatric and then 50 adult beds and ten child/adolescent for the medical psychiatric. Subsection 2, under Section 3, where we're talking about defining these bed pools, very specifically states that it does not preclude the care these patients in the units of hospitals, psychiatric hospitals or other healthcare settings in compliance with applicable statutory or certification requirements. Because keep in mind right now even though we're setting up these three pool of beds, there's nothing preventing facilities right now to care for these types of patients. So this is just getting a lit- -- creating a little bit more access if a facility wants to go this route.

And then these bed numbers can be adjusted by the Commission concurrent with the biennial running of the

psychiatric bed need because, again, as a nursing home, psychiatric beds are rerun every two years, so then we can re-adjust those special population numbers so you could either add or subtract to it. And we put it in here, "the Commission may adjust." So if for some reason the numbers come down and you don't want to change that number, you can leave it alone. But if they go up, then you can increase the numbers that would be part of that special population, and then just basically setting up the requirements to be able to initiate.

We tried to keep it simple versus complex, because we really don't want this to be a barrier to anybody that really wants to try and do this. So -- and that was kind of the thought process going into this; we wanted some requirements, but we didn't want it so complex that nobody was even going to be able to utilizes this if they chose to. Again, we realize it may or may not get used but we feel it's at least a step in the right direction; something that the Certificate of Need can at least help with and assist with, given all of the other areas that we can't do anything about.

Having said that, then we just developed project delivery requirements. There's requirements for acquisition; again, more generic, basic, but it's still specific requirements. There's quality components in the

project delivery requirements as well as, you know, being certified with CARF and/or some other national organization for each of those three categories.

And then they are -- could be subject to comparative review. If they're subject to comparative review, it's no different than the comparative review for regular psychiatric beds. And we do the same thing in nursing home beds, standards for special population groups. Now, in talking with our counterpart, Tulika here, over the years there really hasn't been comparative reviews for special pops, even in nursing homes. But the requirements are there if it were to happen. Having said that, if anybody's got any questions, we'd be happy to answer those.

DR. KESHISHIAN: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yes. So just so I make sure I understand it, if a -- so if a planning area shows that it's over-bedded, but a particular institution wants to add in of the three designated groups, they apply to the statewide pool, how does it -- do they, themselves, have to be, then, at capacity with --

MS. ROGERS: No. You -- first of all, you do have to be a -- already have -- offer psychiatric purposes.

MS. BROOKS-WILLIAMS: Yes, okay. Understood.

MS. ROGERS: So you can't just start one of these from the ground up. You do have to be --

MS. BROOKS-WILLIAMS: So it's addition to what they already have, --

MS. ROGERS: Correct; yup.

MS. BROOKS-WILLIAMS: -- I understand that.

MS. ROGERS: So -- and it's completely separate from the regular bed need for psychiatric beds. This is outside of that.

MS. BROOKS-WILLIAMS: But I'm wondering what are the requirements around the existing bed need? Or is there a need?

MS. ROGERS: There is -- this would be separate -- totally outside. So even if there's a bed need in their planning area, they certainly could get that -- apply for beds from that planning area just to add to their -- and do the same thing, or they can apply for special pops -- special population beds. And by applying for the special population beds, they do have to meet these specific criteria to do that. So there's a -- a little bit additional requirements that aren't there under the regular psychiatric beds. But there's still nothing preventing them from getting beds, if there's a bed need from just the generic psychiatric bed pool.

MS. BROOKS-WILLIAMS: Thank you.

MR. FALAHEE: Commission Falahee; a question for anybody. If you go in and you say I want to add beds for

developmental disability, if I read the standards correctly, it says that's the only purpose for which those beds can be used.

MS. ROGERS: Correct.

MR. FALAHEE: Is there any sense that -- of a DD unit could also function as a medical psychiatric unit? Can you get anything like that combined? I just -- are you being too limited by saying you can only function as a developmental disability --

MS. ROGERS: I guess -- I'm not sure if we really have -- if that was really raised. I guess my thought on it would be is these are very specific. Again, keeping in mind, you can set up these beds just from regular psychiatric beds. There's nothing preventing that right now. So I think the thought was if you're going to apply for beds from a special pool, then those beds should really be for those particular types of patients. Because what we're hearing out there is even though there are beds available in facilities and they might have these -- let's say, disability beds already, or a unit, they don't necessarily -- can't always place a patient in there for various reasons. So at least if they have this very specific pool of beds for this specific population, there will always be a -- they can't use that argument, because that's what those beds are for. I don't know if that

answers it, but -- or helps.

DR. MUKHERJI: From a big picture standpoint I think I get what you're saying is that we're essentially trying to improve the access to the ability to house people in hospitals like this, which is reasonable, I would assume. I guess it really is more of a business decision of the hospitals whether -- and the health systems whether to invest in this.

MS. ROGERS: Correct.

DR. MUKHERJI: Again, why the specific three areas? Because there's lots of -- we all know, being physicians with lots of psychiatric, why did we pick these three?

DR. COWLING: Those are the most typical to place in a general bed. And the prob- -- this is Commissioner Cowling. So looking at specifically then tailoring out beds that would have the staff and the facilities that would -- because logically, for instance, you can't put an 80-year-old who's suddenly psychotic and frail in a room next to somebody else who has been agitated and violent because as soon as she gets pushed over, she's going to break her hip. So part of this whole thing is carving out special needs and those were the three populations that we heard from the work group that were the most difficult for facilities to find beds for universally.

There is a fourth one that was not included in this, which is the severely violent, and those are very challenging because of the staffing requirements and the facility needs because those -- they are incredibly challenging to deal with. So that was -- I think at this point left out simply because the finances requiring the institutions to tailor towards that population is very demanding. I think we had an estimate that just for one room alone to remodel in a hospital, it would be a million dollars to get it geared towards the severely violent.

So that's -- I mean, there's just needs no matter where you look; there's needs everywhere. But at least what we've accomplished today is at least encouraging places that if they want to go for these special pools we can make it easier and accessible for them to do that.

The other thing that we haven't pointed out yet so far this morning is loosening restrictions in the pediatric facilities dealing specifically with the specialists that they need to have available when they have a special needs there, like, the pediatricians, child neurologists, neuropsychologists, speech and language therapists, audiologists, dieticians, you, those -- and previously those were required basically all the time where as now the verbiage is "as needed." So at least it loosens that a little bit as well. So like I said earlier, I wish

that we could make bigger changes but under our purview at CON for right now at least this is I think as what we're -- as good as we're going to get. And the staff did an excellent job getting this to this point.

DR. KESHISHIAN: Any other question, comment? I have two public comments. Arlene Elliott from Arbor Advisors.

PUBLIC SPEAKER: Good morning. My name is Arlene Elliott and I'm with Arbor Advisors. I have several clients who have psychiatric bed services. But I am here on my own behalf, speaking my own words and thinking about the proposals here. I would like to thank the Commission for looking at means it has to open up access to psychiatric services, especially for these difficult placement populations.

A couple things I just wanted to comment on and let the Commission wrestle with it if it so chooses, were a couple of things that I thought were here inside or maybe hidden in the way that these are written. One is whether or not the Commission feels the need for limiting the number of beds any single applicant could get for these -- from the pool so that could one applicant have all of the entire pool? Is that something that's desirable or undesirable? And the way it's written, there's no restrictions, no (inaudible).

And the other thing was that the initiation requirements do not speak to whether or not the current program for the general psychiatric beds needs to be hitting the required occupancy for those beds. It does appear in the project delivery requirements that to initiate is not a requirement that you be actually meeting your existing occupancy requirements. So if you look at the project delivery requirements under Section 8, 2E, there is one section that's included that says that that is where -- this is in the project delivery requirements -- that the (inaudible) geriatric service is meeting volume requirements, and it's not until after you've been approved and you've gotten your couple years in that you have to go back and set your program -- your existing program is meeting occupancy requirements. So I didn't know if that was the Commission's intention to actually initiate one of these special pools program but actually not be at occupancy (inaudible).

And then likewise, I would just like to point out that I'm not personally aware of anywhere within any of the CON standards where "geographically adjacent" also in this line E is defined. So I understand what -- I understand what "attack" means but I don't know what "geographically adjacent" means. So does that mean if you have an existing service that's in Grand Rapids, that geographically

adjacent is Wyoming? Or does it mean across the street? I don't think that it's defined. So I would just like to make sure that if it needs to be defined for the Department to administer (inaudible).

DR. KESHISHIAN: Are there questions?

ALL: (No verbal response)

MR. KESHISHIAN: Does the Department have any comments?

MS. ROGERS: Uh-huh (affirmative).

MR. KESHISHIAN: Go ahead.

MS. ROGERS: Well, I'll -- as far as the restriction on the number of beds, no; we did toss that one around and at this point didn't feel that we needed to say "you can only have five" or "x" amount. Okay? Because, again, the reality is we're really not sure how much this is going to be utilized, and we really did not want to limit it in case there is somebody that really wants to do this and provide that access.

As far as having to meet the occupancy rate under existing site beds before they apply for beds from the special pool, again, we talked about that. This partly is one of the reasons we thought this would be a good idea because -- and Tulika can add to this if I'm saying this incorrectly -- but there are facilities when they were going through and auditing that because -- I think it was

geriatric; I think that's the example that jumps into my mind when I go back to the discussions that were had even during the work group, there's a facility that that's what they were focusing was the geriatric psychiatric care and because of the way the standards are written, we were having to cite them because they weren't meeting volume. They can't provide that care. And I don't know all the details, so that's why I'm looking at Tulika; I'm not -- just want to make sure I'm stating this correctly. But that was one of the reasons why we decided, you know, even if you're not currently meeting the volume on your existing beds, if you want to provide this access to this particular set of patients and can do it and can meet the requirements, you can have access to those beds to do that. But at the same time, as it was stated in the project delivery requirements, though, you do have to maintain a set occupancy or you're going to have to reduce beds in the most -- beds that aren't being utilized go back into that special pool for something else to use. Did that make sense?

MS. NAGEL: And so that would defeat the purpose of access?

MS. ROGERS: Correct.

MS. NAGEL: And then geographically means -- adjacent is actually a term that is pulled from our nursing

home standards.

MS. ROGERS: And so I would just look at Tulika to -- if that's an issue because, again, it was our model.

MS. BHATTACHARYA: Yeah, I mean -- this is Tulika. Visiting those special program group, so far whenever a nursing home applies for a special pool of beds for an existing nursing home it goes into the same license site. That's our interpretation. I mean, if it is geographically different, Grand Rapids and Grandville, it's not -- the same license site does not meet the criteria.

DR. KESHISHIAN: Any other questions?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. I have another public comment. Nancy Liss from McLaren, psych beds.

PUBLIC SPEAKER: Hi, I'm Nancy Liss from McLaren Health Care. First of all, we appreciate the time that Dr. Cowling has put in as a Commissioner and chair of the work group. It was a substantial amount of time and we really appreciate those efforts. McLaren is very supportive of a creation of a special pool bed, and we have some comments just for consideration.

The first one is under Section 1, 4c, we want to recommend the addition of individuals who have been diagnosed with a medical illness requiring hospitalization of such severity they cannot be managed under general adult

psychiatric. So it clarifies more the severity of the conditions.

Some clarification under the licensing requirements to have two-day (inaudible). It was real confusing whether these standards were required under the third rule. Licensing right now if there's two rooms per unit, I don't know if the intention was to have a third (inaudible).

The last one is I just wanted to comment about the indigent population of (inaudible) being awarded. It has -- it's a comparative review -- up to 10 points awarded for the indigent population and we're wondering if you knew that with the changes in the Affordable Care Act and the Medicaid expansion if that means we wouldn't be better reflecting recovering patients. Hospitals are working using their staff to help patients get into an insurance program to be rewarded, you know, we -- 10 points where you would want your patients -- if you want to work to get them into an insurance program where they can also receive follow-up care on a continual basis. There was a comment about the changes that we're experiencing in the different insured population that we are starting to see in hospitals. Again, thank you, for the time and effort you've put in.

DR. KESHISHIAN: Any comments? Questions?

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. I apologize. If we can go back, your first comment was related to Section 4c and what I have didn't read the same as what you were offering as an adjustment.

PUBLIC SPEAKER: Under the Special Pool, Section 1, 4c. I meant, Section 1.

MS. BROOKS-WILLIAMS: Okay. Got it; Section 1, 4c.

PUBLIC SPEAKER: Line 768.

MS. BROOKS-WILLIAMS: Okay. Wonderful. Thank you.

DR. KESHISHIAN: Can you repeat how you would change that?

PUBLIC SPEAKER: Well, severity that you cannot manage on a general adult psychiatric unit. Patients are coming in -- I received a list that the types of medical that are really severe -- I mean, I'm not -- but the way it -- suctioning of tracheotomies, weeping wounds requiring continual dressing, the way it was written, dialysis was put in there -- I don't know if those are necessarily requiring inpatient stay if you have dialysis or (inaudible) wound care, but it should be so severe that they deserve to be in a special pool that -- with the type of resources that a hospital -- or facility, but a hospital

can provide.

MS. ROGERS: This is Brenda. Just for clarification, it's -- those are just examples. It's not saying that's what it is; these are just examples to give some idea of the types of things.

MR. FALAHEE: This is Falahee. The key is medical illness requiring hospitalization.

MS. ROGERS: Right.

MR. FALAHEE: Whatever that medical illness may be.

MS. ROGERS: Correct. And we toyed with even putting examples in there but as we did our little -- you know, did some research and stuff, where some of this was coming from, they did -- these were just some examples that were provided so we thought, well, let's put them in there knowing that they could -- it could be misinterpreted but that's why -- the "e.g.," it's -- those are strictly examples.

DR. COWLING: But it also is medical need that can't be provided in a typical adult psychiatric facility, like oxygen. That's been a problem before with patients that require oxygen.

DR. KESHISHIAN: Any other questions?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Thank you very much.

Commission, discussion?

MS. BHATTACHARYA: Can I say one thing? This is Tulika. Going back to Arlene's comment about no restriction on the maximum number of beds that an applicant can request in a single application, just to give you a little bit of process information, so there are a restricted number of beds in each of the pools; for example, 50 beds in the DD pool, and it is going to be state-wide pool. So if there are three hospitals applying for those beds from the entire state and the total requested number of beds go over 50, we are going to get into a comparative review because we cannot approve everybody.

So somebody is going to be approved and somebody is going to be denied. And when there is a denial, the applicant has the right to appeal the denial from the Department. And if it goes into that litigation process -- and Joe, correct me if I'm wrong -- none of the approved applicant can implement a project until the entire litigation for the whole group is resolved. So thanks to Arlene for bringing it up. So if the goal is to promote access for these patients and put them in the right bed at the right time, getting into a long litigation is not going to solve anything. So just to bring that up and -- because somebody can ask for the entire 50 for their hospital and

the standards do not restrict that.

MR. POTCHEN: This is Joe, just a little it of a tweak on that from what I recall; I haven't looked at this in awhile -- they can begin to implement the project after the Department's final decision, but they do so at their own risk that it may be reversed on appeal to the Circuit Court.

MS. BHATTACHARYA: Right. And the Department's final decision cannot be issued until the ALJ appeal is resolved.

MR. POTCHEN: Well, the ALJ issues a proposal for decision which goes to the director for final decision.

MS. BHATTACHARYA: Right; right.

MR. POTCHEN: Once the director issues a final decision, that can be appealed to the Circuit Court.

MS. BHATTACHARYA: Yes.

MR. POTCHEN: The project can be implemented but it's at the peril that it may be reversed on appeal and then you're left with nothing. I just want to be real clear on what that is.

MS. BHATTACHARYA: Yeah.

MR. POTCHEN: It's very risky, too, to do it, but it can be done.

MR. FALAHEE: This is Falahee. But that wouldn't -- in that situation, the -- let's say the

hypothetical is three apply. They could all agree, "Okay, we're going to drop our requested numbers" to stay under the 50; right ?

MS. BHATTACHARYA: They can if they chose to.

MR. POTCHEN: And that would be resolved through some sort of a settlement agreement or something like that.

MR. FALAHEE: Right; right.

MS. BROOKS-WILLIAMS: Commission Brooks-Williams. So maybe another way to look at it is what criteria would be applied? So say I applied for all 50. What criteria would the Department look at to confirm that I need all 50?

MS. BHATTACHARYA: The only criteria we can look at legally are the criteria in the comparative review section, which does not --

MS. BROOKS-WILLIAMS: So multiple -- so multiple facilities could qualify for it, --

MS. BHATTACHARYA: Yes.

MS. BROOKS-WILLIAMS: -- so how will -- just if we had the wonderful problem that everybody wanted them all -- how would we decide if we don't have --

MS. ROGERS: There's specific requirements in the comparative review language here, Section --

MS. BROOKS-WILLIAMS: And I did look at them, but it's not answering the question for me, if everyone could potentially have the need based on the criteria to Chip's

point other than them agreeing amongst themselves, "Well, I'll just take 15, you just take 10," do we have any objective criteria that would help us to decide?

MS. NAGEL: Section 12 of the standards is the -- well, Section 12 --

MS. ROGERS: It's not in the addendum, no; the actual standards.

MS. NAGEL: It's up before that. So it's specific comparative review criteria, and they're awarded points based on, you know, all of this -- these different requirements. And at the end of the day, the bottom line is whoever gets the most points is the one that would be awarded the beds.

MS. BHATTACHARYA: Exactly. But that doesn't give the Department any rights to reduce the number of requested beds.

MS. NAGEL: Correct.

MR. FALAHEE: Or, if you -- this is Falahee. In the happy unlucky event, the Commission could always change the 50 to make it 250, --

MS. BROOKS-WILLIAMS: Yeah; if you had --

MR. POTCHEN: Right.

MR. FALAHEE: -- if that happy occasion was out there.

(Off the record interruption)

DR. KESHISHIAN: I just want to follow-up with what Chip said, in the fact that when I read this, I said, "Why do we have any limits?" Because we want people to apply. You explained why you chose the numbers you did if somebody -- if we ever get into that issue -- I think we would have to go to a work group immediately to look at it. Now, a work group would take six months, but -- ***

MS. BROOKS-WILLIAMS: Not probable; no.

MS. ROGERS: Yes. And, again, this is Brenda. Keeping in mind that these standards are reviewed eery three years. So given if this does get put into place, you know, we can see how it works and then it can be looked at again, or even before if it needs to.

DR. KESHISHIAN: Any other questions, comments?

DR. MUKHERJI: So just when -- this is Mukherji. So do you feel or do others feel there's sufficient guardrails on these? Because this is a major change to the psychiatric -- are there sufficient guardrails to make sure that the intended potential expansion in beds is really going to be limited to this population that we're trying to help?

DR. COWLING: I would say so. I mean, I don't see there being an unyieldy arm of this that we couldn't control with the previous standards. But like I said before, I wish we could do more but this is definitely, I

think, at least a step from what was here when we came back over, a place now to help.

MS. ROGERS: And keep in mind -- this is Brenda again -- if you take action on today, this proposed action, a public hearing will be scheduled so you'll get an -- additional opportunities for comment; it will go to the JLC if they wish to weigh in; and then it will be brought back to you again at your June meeting before you take final action, which, again, people will have that opportunity to comment. So there's -- this is really kind of the first -- if they haven't been involved up to this point, there's still several more opportunities to receive input.

DR. KESHISHIAN: Any other questions or comments?

ALL: (No verbal response)

MR. KESHISHIAN: I'd just like to make a comment that the issue of "indigent" is an interesting issue as we move forward in other standards. We need to just start thinking about "what does 'indigent' mean anymore" when we have ACA and far fewer people uninsured and somebody ends up in the hospital and they get insurance and so, you know, what weight do we put on that for future standards? I don't think we need to change these standards but in three years when we review them again, it would be something that would need to be discussed.

MR. POTCHEN: This is Joe. I want to make one

point and to kind of solidify what Tulika said, and this is specifically that language in Section 8, 2e, "The specialized program shall be attached or geographically adjacent to a licensed psychiatric service." The Department applies that language to mean the same license site, so I want to make sure the Commission is okay with that. That's how it's going to be applied, so that -- the Department would be acting on the Commission's intent of what that language means.

DR. KESHISHIAN: Okay. Any other questions, comments?

ALL: (No verbal response)

MR. KESHISHIAN: Do I hear a motion? Commissioner Falahee?

MR. FALAHEE: I'll make a motion -- first, before I make a motion, I want to thank Commissioner Cowling for her passion and perseverance and pushing this. Thank you very much.

DR. COWLING: You're welcome. Thank you.

MR. FALAHEE: It's been great to have you on the Commission and working on this issues.

DR. COWLING: And I won't be here in three years when it comes back.

(Off the record interruption)

MR. FALAHEE: Thank you very, very much. The

motion would be to approve these -- the standards and the addendum language that we have in front of us to send it to public hearing and to the JLC.

DR. KESHISHIAN: Do I hear a second?

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

DR. KESHISHIAN: Any more discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, say "aye"?

ALL: Aye.

MR. KESHISHIAN: All opposed?

ALL: (No verbal response)

MR. KESHISHIAN: Motion carries. I just want to reiterate what Chip just said. Kathleen, thank you very much. You did --

DR. COWLING: Thank you.

DR. KESHISHIAN: -- a superb job. This brought forth a lot of concerns that have been bubbling under there and it brought it forth to the State government and you did an outstanding job of talking to people and listening to people, from the U.P. to the border between Ohio and Indiana and Michigan. In my tenure on CON, I've never seen such an outpouring of concerns among the providers in the State of Michigan over taking care of our most vulnerable population. So thank you very much. I know everybody on the Commission --

DR. COWLING: Thank you.

DR. KESHISHIAN: -- really appreciates all the work that you did. Thank you.

DR. COWLING: Thank you.

DR. KESHISHIAN: I also have to say the Department did an outstanding job, too.

DR. COWLING: The staff did a great job. they were outstanding.

MR. KESHISHIAN: Thank you very much for doing a great job on this very difficult issue. It brought -- again, a lot of people have been complaining about -- expressing concerns about a real problem and they didn't have any place to go. And CON -- it came forth to CON and you took care of it as a Department, so thank you.

The next item is bone marrow transplant. There is a written report in your binder from Bruce Carl, who is the chair of the BMT SAC. And we also have a public comment, and since we didn't need to change the agenda for public comments earlier, I will ask Susan Grant from Beaumont Health to provide a public comment, and then we'll ask for any questions.

PUBLIC SPEAKER: Good morning. Thank you for the opportunity to address you this morning. I'm Susan Grant and I'm the new executive vice-president and chief nursing officer for Beaumont Health. And I'm excited to come to

the State of Michigan to continue my career as a nurse. Prior to joining Beaumont Health, I held the chief nursing officer roles at Emory Health Care in Atlanta and at Carver Cancer Institute in Boston, and the University of Washington Medical Center in Seattle. Included in Seattle, (inaudible) which was a joint venture with the Fred Hutchinson Cancer Center. All of these health systems are smaller than Beaumont Health, and all of them offer bone marrow transplant services, which is a standard of care for certain cancers, and an integral part of many large cancer programs across the countries.

Quite frankly, I was stunned when I came to Beaumont Health and learned that we did not offer bone marrow transplant. I was further distressed and concerned that Beaumont is prohibited from offering bone marrow transplant due to Certificate of Need regulations. I understand that there is a cap of the number of bone marrow programs in the State of Michigan. But that cap goes back 30 years. Clearly a lot has changed in the last 30 years, including consolidation of stand-alone hospitals and the development of integrated health systems. 30 years ago, in 1986, Beaumont had two hospitals totaling 1100 beds and 48,000 discharges. Today Beaumont Health has eight hospitals, 3300 beds, 174,000 discharges, and they're the largest health system in the State of Michigan.

Early on we developed a vision for Beaumont Health, which is to be the leading high-volume health care network focusing on extraordinary clinical outcomes through education, innovation and compassion. We recognize that the health care world is shifting from volume to value, and we embrace that. We also understand that the goal was to reduce the total cost of care and not just units of care -- of costs, rather, total cost of care. To accomplish this, though, we need to become very patient and family centered, which requires a major focus on coordination of care and more importantly transitions of care and reducing those transitions of care and hand-offs from one provider to the next, making sure that patients have safe, effective and efficient care.

Becoming more patient centered has been identified and it's actually been mandated by regulatory agencies and organizations such as BMF, the Joint Commission, the National Patient Safety Foundation and the Michigan Health and Hospital Association. In fact, MHA as asked Michigan hospitals to identify their two primary goals this year for 2016 in driving patient centeredness. Our mission is to serve the patients that come to us for care, and there's a disconnect right now.

Beaumont patients in need of bone marrow transplant who are frail and vulnerable are required, and

unnecessarily leave their care team who they know and who know them, creating more fragmentation and additional handoff in care; the antithesis of patient centeredness and contrary to national mandates. Beaumont has the resources, the expertise, and the commitment to offer an outstanding bone marrow transplant program. So for the benefit of our patients now and in the future, we ask that the bone marrow transplant standards be eliminated or changed to remove this barrier to access. Thank you again for the opportunity to address you this morning. I'd be happy to answer any questions.

DR. KESHISHIAN: Thank you very much for the presentation. Are there any questions?

ALL: (No verbal response)

MR. KESHISHIAN: Seeing none, thank you.

PUBLIC SPEAKER: Thank you.

DR. KESHISHIAN: Any questions on the bone marrow transplant report or the public comments?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. The next item is a legislative report. It has Elizabeth, but I don't think I see her.

MS. NAGEL: Well, I'll fill in. The legislative report, the only bill that we have to report on is Senate Bill 741, which is currently in the Senate Health Policy

Committee; heard testimony yesterday. And that bill, the only change it makes to the CON regulation and the Public Health Code is to specifically prohibit the -- the CON to cover dental CT. So it creates a specific carve-out that that can't be a regulatory service of CON. As I said, it's in the Health Policy Committee right now and that's the only legislative update I have.

DR. KESHISHIAN: Thank you. Just to let the commissioners know, I was at the hearing yesterday and testified on the -- as chairperson of the CON Commission and it went well. We'll have to see what happens in the future.

DR. MUKHERJI: This is Mukherji. Out of all the things we covered, this is the only carve-out that they're asking for?

MS. NAGEL: This bill.

DR. MUKHERJI: It sounds interesting. Okay.

MR. FALAHEE: This is Falahee. There are more in the pipeline?

DR. KESHISHIAN: Okay. Administrative update. (Inaudible) and access to the care section update.

MS. NAGEL: From the policy side, taking the outcome of the January planning meeting they are starting a CT work group to look at the removal of -- or the deregulation of dental CT. We hope to start that in the

coming weeks. Dr. Mukherji is our chair for that meeting. We will get dates out for that meeting very soon. We are also starting nominations for two SACs; one is for nursing home and the other one is for lithotripsy. Those charges have been approved by the chair and we will start that nomination process in the very near future as well.

Just one other update I wanted to give. It's about administrative rules for the evaluation of the Certificate of Need process. In the statute the Department is called upon to develop administrative rules that are promulgated through our statewide administrative rules process. You will recall an issue sometime in 2015 came up with the nursing home work group; that specifically an amendment to a approved Certificate of Need cannot change the site of that facility. So that was an issue that was discussed quite a bit here at the Commission. What keeps the Commission from putting anything specific to that in the standard is that the administrative rules set is specific that, as it states currently, that an amendment to not change the location of a covered service -- or of a licensed facility. So we have proposed new administrative rules that are just in the very beginning of the administrative rule process to rectify that, that says that an amendment can change the location of a licensed facility under specific requirements: One, that an unforeseen event

took place that makes the previous location unusable; and, two, that the new location meets all of the same requirements of the standards under which that applicant was approved under. So that is going through the process. It is a lengthy process, but I will keep the Commission up to date as that goes forward.

DR. KESHISHIAN: Any questions? Tulika?

MS. BHATTACHARYA: You have three reports about the program activities. The first one is the CON annual report for FY 2015. If you have any questions, I'll be happy to answer.

For the quarterly compliance activity report, we continue to follow up and monitor our approved projects so that they're completed within the time frame or they receive appropriate extension for implementation for unforeseen events: Financing and other issues.

We have concluded the open heart and psychiatric state-wide compliance review and have -- we have taken appropriate actions through settlements agreements with various (inaudible) and things like that.

We have started looking at lit- -- lithotripsy services and opened some compliance investigations. Those are ongoing. I will keep you posted as to what are the outcomes.

For 2016, we have selected cardiac cath services

and MRT services for statewide compliance review. And once again, I'll keep you posted as to what are our findings. There was one other compliance action for a particular facility that was referred to us by the Department of Licensing and Regulatory Affairs, but that matter has been resolved also. Are there any questions about the annual report?

ALL: (No verbal response)

MS. BHATTACHARYA: Also, I just wanted to give you one more update because it is in the area of compliance. At the request of the different sections and bureaus within the department, we have initiated psychiatric denial of service pilot program for one particular PIHP region in the state because it's a pilot right now.

What they are doing is they are monitoring the impatient psychiatric patient placement at their hospitals through the CMH boards so then their representative calls a hospital trying to place an inpatient, whether you admit them or you deny them. If you admit them, that's fine. But if the patient is denied service that is logged into the system, and the PIHP is reporting those denial data to the Department for our appropriate analysis and investigation. We launched it on March 1. It will -- we will try to do it in a two-week cycle to consolidate the

data and look at what type of patients, what specific conditions they have, and what are the reasons for denial. Now, there are certain psychiatric programs in the state that are grandfathered, so they are not regulated under any CON review standards, but most of them are. So depending on the project delivery requirements in the standard that they are required to maintain and abide by, and depending on the reason for denial of inpatient psychiatric patients, there will be investigations and appropriate actions, and we plan to keep you posted on those.

DR. KESHISHIAN: Any questions?

ALL: (No verbal response)

MR. KESHISHIAN: On the psychiatric, are you also looking to see what type of insurance that they're turning down versus accepting?

MS. BHATTACHARYA: There is one broad category for source of payment as defined in -- because that's one of the program delivery requirements in the standards; you have to serve patients regardless of their age and all those other things and source of payment. But are we tracking what specific source of payment?

DR. KESHISHIAN: I was referring --

MS. BHATTACHARYA: Unless they volunteer that information, no; it's not a requirement.

DR. KESHISHIAN: I was referring to Medicaid

versus private pay or versus Medicare.

MS. BHATTACHARYA: No; it's any denial, regardless of the insurance status.

DR. KESHISHIAN: Are you looking at what the insurance is?

MS. BHATTACHARYA: (Shaking head negatively)

DR. KESHISHIAN: Okay. Thank you. Any other questions?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. legal activity report. Joe from the Attorney General's Office will provide the legal activities report.

MR. POTCHEN: This is Joe Potchen. We continue to assist in the development of standards and we have no active litigation at this time.

DR. KESHISHIAN: Thank you. Any questions?

ALL: (No verbal response)

MR. KESHISHIAN: Keep up the streak. Future meeting dates. The future meeting dates for 2016 are listed on the agenda. Please let the Department staff know if you have any conflicts as soon as possible. Public comment. The Commission will now take public comment. I do not have any cards at this point. Are there any cards? Any public comments?

ALL: (No verbal response)

MR. KESHISHIAN: No. Okay. Review of Commission Workplan. Brenda.

MS. ROGERS: This is Brenda. You do have the draft workplan included as part of your packet. As of today's meeting I'm not making any suggested changes, and would just propose that you adopt the draft plan -- workplan as presented unless you have some additional changes. Thank you.

DR. KESHISHIAN: Any discussion?

ALL: (No verbal response)

MR. KESHISHIAN: Do I hear a motion?

MR. FALAHEE: Falahee. So moved as Brenda said.

MR. KESHISHIAN: Second?

MR. HUGHES: Hughes; second.

DR. KESHISHIAN: Thank you. Any discussion?

ALL: (No verbal response)

MR. KESHISHIAN: All in favor, say "Aye."

ALL: Aye.

MR. KESHISHIAN: Opposed?

ALL: (No verbal response)

MR. KESHISHIAN: Okay. Election of officers. Every year we have to elect officers and on an annual basis we must select a chairperson and vice-chairperson for a one-year term, not to exceed three consecutive terms. The chairperson and vice-chairperson cannot be members of the

same major political party. Any Commission member attending the meeting may nominate officers. Nominees do not have to be in attendance. Are there any questions? If none, nomination are open for chairperson.

DR. TOMATIS: Commissioner Tomatis. I will propose to re-elect the present chairman and vice-chairman.

MR. KESHISHIAN: Is there a second?

FEMALE VOICE: Second.

DR. KESHISHIAN: Thank you. Thank you very much. All in favor say "Aye"?

ALL: Aye.

MR. KESHISHIAN: Wait -- any more nomination, I should say? I think we should probably take a hand vote. All in favor raise your right hand.

ALL: (Comply)

MR. KESHISHIAN: Okay. All right. Thank you. I enjoy it and I appreciate all the support that everybody on the Commission provides me. Thank you very much for the honor. Now, vice-chairperson, do I hear a motion for vice-chair?

FEMALE VOICE: I thought we did them both.

FEMALE VOICE: He did -- he did both.

DR. TOMATIS: I made one motion in two.

DR. KESHISHIAN: Very good.

DR. MUKHERJI: That's why --

DR. KESHISHIAN: Okay. It's adjournment, then, unless there's anything else. Thank you very much. Have a nice day. Oh, we need a motion to adjourn.

MS. BROOKS-WILLIAMS: Thank you. So moved.

MR. KESHISHIAN: Second. Anybody opposed?

ALL: (No verbal response)

MR. KESHISHIAN: It passes. Thank you.

(Meeting concluded at 11:06 a.m.)

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