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

COMMISSION MEETING

BEFORE AMY L. MCKENZIE, M.D., CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, September 15, 2022, 9:30 a.m.

COMMITTEE MEMBERS:	JAMES FALAHEE, VICE CHAIRPERSON AMY ENGELHARDT-KALBFLEISCH, D.O. ERIC FERGUSON, M.D. DEBRA GUIDO-ALLEN, R.N. DONALD HANEY ASHOK KONDUR, M.D. LORISSA MACALLISTER, PH.D. RENEE TURNER-BAILEY
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	MR. BRIEN WINFIELD HECKMAN (P76006) Assistant Attorney General PO Box 30736 Lansing, Michigan 48909 (517) 335-7632
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA BETH NAGEL KATE TOSTO KENNETH WIRTH
RECORDED BY:	Marcy A. Klingshirn, CER 6924 Certified Electronic Recorder Network Reporting Corporation Firm Registration Number 8151 1-800-632-2720

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Lansing, Michigan

Thursday, September 15, 2022 - 9:34 a.m.

DR. MCKENZIE: I'm going to call our meeting to order this morning. Thank you for everyone who has joined. Our first topic is the review of the agenda. We have a very robust agenda today, so I'd ask Commissioners to take a look at it. We have five standards coming in front of us, three for initial review, two for final. We have a bylaws update that we're going to be voting on as well as the biennial report. In addition to that, we typically have public comment near the end. We do have some participants here that have some time sensitivity related to public comments and have asked to put one comment near the beginning of the agenda which I would propose that we would position that after Declaration of Conflict of Interest and before Review of Meeting Minutes, before we get into the business part of the agenda. But I will need a motion if we want to make that adjustment as well as any other adjustment today, what would be on the agenda today. So I would entertain that now.

DR. FERGUSON: So moved.

MR. FALAHEE: Support.

DR. MCKENZIE: Okay. Great. We've also been asked -- I know we've been doing votes by either consensus or roll call. We have been asked for transparency purposes

and transcription purposes to do a roll call vote. So I think we're going to do a roll call vote on the agenda change as well. Kenny, can you take that for me?

MR. WIRTH: Yes. McKenzie?

DR. MCKENZIE: Support.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Support.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Support.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Here.

MR. WIRTH: Ferguson?

DR. FERGUSON: Support.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Support.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 9:36 a.m.)

DR. MCKENZIE: Great. Thank you. So if everybody could go on mute? I'm getting a little bit of an echo. So

next up before we move forward with that one public comment, I would ask if any of the Commissioners have a declaration of conflict of interest? The summary of what a conflict of interest is, is within your packet. So I'll pause here now for any declarations.

MR. HANEY: Don Haney. I just want to note that I am a registered lobbyist here in Lansing.

DR. MCKENZIE: Thank you. Any questions associated with that? Okay. So noted. So next up we are going to have -- I think we have the one public comment. And, Kenny, can you -- I think you might have that information on who the speakers are and the topic? For those that are on the phone, the public commenters are here in the room today, so we're getting them set up to be able to provide that public comment. One thing I would like to note while we're getting this moved up and get everyone set up is because we have a very robust agenda today, I'm going to be asking that we have our commenters during public comment limit their comments to three minutes and also just our Commissioners to be cognizant that we have a pretty aggressive agenda to get through today, so -- so thank you.

MR. WIRTH: So first up we have Jack Curtis, supervisor, Oxford Township.

JACK CURTIS

MR. JACK CURTIS: Good morning, members of the

Board. Thank you very much for taking the time and moving your agenda to allow for our schedules. I want to speak today to reiterate the fact surrounding the need for a hospital in Oxford.

What happened was in 2018 a local area of access number six was identified as 117 acute bed hospital care need. In 2018 -- 2019, that need went to 121. With our growing area, it keeps growing. In 2020, the methodology was changed and we had some circumstances that were anomalies to this methodology. One was M-24, the major trunk line through Lapeer and Oxford and Pontiac was under complete construction. They tore it down to the dirt. The traffic pattern went from 32,000 (sic) a day down to 112,000 a day. Major roads on the side were burdened with that traffic. In response to all this in 2020, the local area access need change in methodology showed Oxford needs zero beds. So it went from 117 to 121 and then it went to zero.

And while all this went on, we did have a hospital system that was willing to step up and try and come meet with our planning commission and township board to show their interest in building a 225,000 square foot, 117-bed hospital in Oxford. Oxford spent $2.5 million building a sewer line, sanitary sewer line, to ensure the capacity of the hospital and the surrounding areas were met. When this hospital system met with resistance, it was because the area

said it did not have 50,000 people inside LAA6 and within 30 minutes.

I know Orion Township supervisor Chris Burnett and in your packets I gave to Kenny is a map showing that within a 10 mile area of Oxford Township there are 183,000 people. And what's happening in Oxford, we're isolated. We're 17 miles to the north to Lapeer, 17 miles to the south to Pontiac. So either way the ambulatory time in our area is dramatically increased and it's growing with the billions of dollars in investment in Orion Township for the Orion Assembly Center, the battery centers. The population is growing consistently.

I'm asking today that we consider and move rapidly towards reviewing of our CON process, the methodology, and looking at supporting Oxford's need for a hospital. We have several hospital systems that have purchased 25 acres, 15 acres, and McLaren just announced a $35 million improvement to their current hospital system which can only be a emergency room. Thank you for your time.

DR. MCKENZIE: Thank you, Mr. Curtis.

MR. WIRTH: Next we have Sheriff Mike Bouchard of Oakland County.

MIKE BOUCHARD

MR. MIKE BOUCHARD: Thank you, Madam Chair, members. Thanks for moving the agenda a bit. I thought it

was at 9:00 o'clock and I've got a whole bunch of other things. I've got meetings with members of our legislature back in my office. So thank you for allowing us to speak.

Very supportive, obviously, of a Oxford -- a hospital for Oxford on so many levels. As you know, we had a huge tragedy in Oxford with the Oxford High School shooting. Average time to get to a hospital from that venue? Twenty minutes. And so when you have a mass casualty incident like we had at the Oxford High School shooting, that's a big problem. And with traffic growing and with population growing, those times get extended. So the areas, three of the townships that touch Oxford: Addison, Orion and Brandon, we police all four of those: Brandon, Oxford, Orion and Addison. So I'm the police agency of record. That is equivalent of almost 90,000 people just in those four townships and it's growing exponentially. They're some of the fastest growing communities in the state of Michigan, one being growing over 14 percent. So it projects out that in the future this hospital need will even be more dramatic. But I can tell you after experiencing what I think is the worst day of anybody's life to have a high school shooting and having facilities not nearby and having to stage ambulances and try to predetermine routes to get them to those hospitals, it certainly makes I think important sense if not just on a

daily basis, but for any emergency basis to look at a hospital for Oxford. I am agnostic of what hospital. We just need a facility that can serve the community on so many levels. So, again, thank you for allowing us to get towards the front of your very busy agenda. Thanks for your work and your thoughtful process on this.

DR. MCKENZIE: Thank you very much.

MR. WIRTH: And we have Peter Scholz, chief of Oxford Fire Department.

PETER SCHOLZ

MR. PETER SCHOLZ: Thank you, Board Members, for allowing us to speak today, taking time out from your schedule and I definitely appreciate you guys moving us up in the schedule. It greatly helps.

As a health care professional yourself know that right now in the state of Michigan, basically across the United States, health care professionals, fire professionals, police officials, EMS, right now is at an all time disaster level of trying to get personnel and help to hire. Right? Every single one of us is begging and borrowing, doing everything we can to try to get more people onto our departments, into the hospitals, into police, whatever, for health care. So we're all struggling.

Our issue is with right now running our calls is it takes us on an average of over 20 minutes to get to a

hospital and that's if we're going lights and sirens. Normal traffic because of M-24 runs from Lapeer all the way to Pontiac, that's our only road to go from us being to try to get to Rochester, to get to Pontiac, to get to Royal Oak or Beaumont, to go north to Lapeer or whatever, takes us that much time to get there. Our normal transport by the time we start the call until I've got to call my trucks are clear to back in service into the Oxford Community, I'm averaging close to two hours every single time. So that takes two paramedics, an EMT, and my ambulance out of the township for up to two hours.

Our normal call volume right now is we're running close to ten calls a day, and most of the time we're running two calls at the same time or three calls at the same time so that leaves me with absolutely nobody in town to provide coverage and at the same time we all -- the neighboring departments from Oxford, Orion, Addison, Brandon, all rely on mutual aid. We're all working together, trying to get everybody to back or forth. So we're continually moving, bumping back and forth ambulances on the road which means instead of covering my own township, I'm covering the other three township or they're doing the same to us because, again, we're having to leave our community to go someplace. So having a hospital in my community that we can transport to and roughly have three to five minutes turnaround time

would be phenomenal to help.

The November incident is one of the incidents that we've all trained for and it's one of those incidents that I was hoping that my career would end before we got to that point. Very frustrating to be able to know as I'm trying to get to the hospital with my ambulances, on a good call we're running, you know, 20 minutes, we're still taking half an hour lights and sirens to try to get because at that time of day traffic is bumper to bumper either north or south. It doesn't matter which direction I'm going. And we had ambulances go in all three directions at the same time and it took them that much longer to get to the hospital because we don't have something close by that we can get to.

Our number of calls keep increasing by 43 percent over the last ten years. Call volume went from 1550 in 2011, to 2220 in 2021. Of the 2220 calls last year, 81 percent of them or 1812 were all medical calls. The issue is, again, with traffic we can't get from one place to the other and basically the common saying "I can't get there from here." That's my whole -- our whole problem is we can't get the coverage.

So, again, thank you for your time today and I appreciate listening to us and please consider us because this is not only a need for us individually, it's a need for life safety for my department. That's the biggest thing we

have to worry about. Thank you.

DR. MCKENZIE: Thank you very much for the comments. Any questions by the Commissioners?

DR. FERGUSON: Commissioner Ferguson. So two questions. The bed need assessment that was referenced, is that done annually or every few years and what's the next timeline on that? And then a follow-up to that is the methodology and how often is the methodology reviewed and when is the next review point was the questions. I don't know who can answer that.

MS. NAGEL: This is -- hang on. Sorry. This is Beth Nagel. I can answer that. There are two avenues that the Commission can explore. One is as you said the bed need methodology data run on the current methodology. We expect that to come to the Department in November and come to the Commission in December. It is a biannual -- I believe it says biannual, I would have to double check -- rerun of the methodology every year with the newest data available. The second path that the Commission has at its disposal is to look at the hospital bed standards to form either a workgroup or a Standard Advisory Committee to look at those standards. That was done two years -- finalized two years ago. It is back on your agenda for January of this coming year. And so those are the two paths that we have identified.

DR. FERGUSON: Thank you.

MS. NAGEL: Uh-huh (affirmative).

DR. MCKENZIE: Any other questions or comments by Commissioners?

DR. MACALLISTER: Sorry. Thank you. So I also was wondering in regards to -- it sounds like while the bed need may be an issue, I'm wondering if it's also something that we might want to look at for emergency room access. It sounds like that might be another component of it. So not just the bed need, but understanding as well that emergency need for services. And I don't know, would that be considered as part of that review in November? It wouldn't; right?

MS. NAGEL: The Certificate of Need does not regulate emergency rooms.

DR. MACALLISTER: Right. That's what I figured, yeah.

DR. MCKENZIE: Yeah. It's the hospital bed need. It really falls under the CON criteria for us to be able to review.

DR. MACALLISTER: Got it.

DR. MCKENZIE: Yeah.

DR. FERGUSON: Commissioner Ferguson again, follow-up question on that. So CON doesn't regulate the emergency room. So in theory a hospital system could open a

freestanding emergency room in that community today?

MS. NAGEL: Yes, that is correct. There are several freestanding emergency rooms throughout the state.

DR. MCKENZIE: Commissioner Falahee?

MR. FALAHEE: This is Commissioner Falahee. Related to that, not all emergency rooms are created equal. As we all know, there's level 1 trauma centers, level 2, level 3, level 4. And depending on what the condition of the patient is, the closest emergency room might not be able to handle that patient. So even though there might be an "emergency room" -- and I'm saying that in quotes for people that can't see me -- that emergency room if it's five or ten miles away may not be able to handle a certain trauma or whatever, so they may have to go to a level 1 trauma center to handle that specific patient condition.

DR. FERGUSON: So Ferguson responding. You know, as a physician who cares for trauma patients on a daily basis, I'm keenly aware of that. I'm also keenly aware that the same is true for hospitals. And the resources at our large trauma, level 1 trauma facilities are very different than critical access hospital and how we triage patients through that acutely. And so there's a whole set of layers of complexity there.

DR. MCKENZIE: So as outlined by Beth, currently we will have a refreshed bed need based upon the data from

this year coming to us in November/December which will be applied with the existing standards. In addition, the hospital bed standards are up for review again beginning in January so we will be having that discussion about next steps with that bed need methodology as well in the coming months. Any other comments or discussion?

MR. WIRTH: Dr. McKenzie, I know this was a special agenda item for public comment. We do have the township supervisor for Orion Township who is wishing to comment during this item virtually. I'm not sure how --

DR. MCKENZIE: Yeah, we can take -- go ahead, Chip.

MR. FALAHEE: This is Commissioner Falahee. I understand Mr. Barnett's on the phone, or on the Zoom, but we've got a packed agenda. We've had three witnesses. Mr. Barnett, I'm -- if you're going to say some of the same things that we've already heard in deference to the packed agenda and others, if you can just say those that represented the township already, you agree, that's fine with us and that would be preferable to us if that's possible.

CHRIS BARNETT

MR. CHRIS BARNETT: Yes, sir; yeah. Thank you. And I -- this is going to be my third meeting I've attended virtually. I apologize for not being able to be there. I'm

actually at a meeting with mayors in Florida actually talking about access to health care.

Anyway, I would just echo what was said and actually one of the Commissioners has mentioned one of the things that I was going to bring up, just a little bit different angle. We do have access to emergency rooms. But ironically if you look at the run volume from our fire department, many of the runs we are running are actually picking up patients that have gone to those emergency rooms for care but need additional care beyond what's available in our community or Oxford. So we're actually picking them up from the emergency rooms and taking them to the hospitals that are 15 and 17 miles away. So I would just agree with what was said by Supervisor Curtis, Sheriff Bouchard and others. And I also serve as the chair of SEMCOG. We are all about data -- the Southeast Michigan Council of Governments -- and we can help provide this committee and this Commission all the data that you need to show that this is not an emotional request. This is a real data driven request. And that's my comments for today. We appreciate your consideration.

DR. MCKENZIE: Thank you for your comments. I'll just add -- Commissioner McKenzie -- you know, that we very much appreciate, you know, the passion on this issue. I think I can speak for every Commissioner that this is, you

know, a, you know, it's a very difficult issue that your community has faced and we do understand that and sympathize with that. I think from where the Commissioners sit -- and I know there have been multiple discussions about this -- you know, the decision around a hospital for a particular community is guided by the hospital bed need. And so the prior actions that, you know, the Commission has decided upon has been, "hey, we have refreshed data coming in November/December." We know this bed need is coming up. We frankly have trouble seating some of the workgroups and SACs around this, although hospital bed need is one of the ones that tends to be more well attended. But this is coming up in the next couple of months and, you know, we are committed to having that refreshed. So, any other comments or discussion that other Commissioners have currently? Okay. Thank you.

MR. CHRIS BARNETT: Thank you very much, Commission.

DR. MCKENZIE: Okay. So for those on the call, we will have time for public comment again at the end. We have not taken that off and moved the entire public comment. We just wanted to prioritize that piece. So next on the agenda we have the review of minutes from June 16th, 2022, which are contained within your packet. So if you can take a look at those and then I will take a motion.

MR. FALAHEE: This is Commissioner Falahee. I'll make a motion to approve the minutes as presented.

MS. TURNER-BAILEY: Commissioner Turner-Bailey, support.

DR. MCKENZIE: Thank you. And we'll do a roll call vote on the minutes.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 9:56 a.m.)

DR. MCKENZIE: Thank you. Okay. We have come to

the substantive review of the various different standards that are before us today. First up is our Psychiatric Beds. And as you recall we had an informal workgroup that's been meeting. It's been a lot of work. They had a very extensive set of charges. And so we have Dr. Jain here with us to be able to present that report, so I will invite him to the podium at this time.

SUBODH JAIN, M.D.

DR. SUBODH JAIN: Thank you, Madam Chairperson for having me. It was quite a privilege to lead this workgroup. For those who do not know me, I am Subodh Jain. I'm chief of psychiatry and behavior medicine at Spectrum Health in Grand Rapids and I have been leading this workgroup for -- we met about seven times and concluded this work in April, on April 7, 2022. And we do have the PowerPoint up as well for the ones who are on Zoom call.

So I would say -- I would say that a lot of work was done during this workgroup. Most of the people who worked with us were leaders in their own areas, had pretty good faith effort in improving the health crisis in our state through this work, especially the inpatient needs that have arisen over the period of time. So some of these charges were put forth prior to us starting this workgroup and a couple of things were added on, so I'll highlight as we go. I do have a little entry presentation, so please

bear with me. I'll try to be as quick as possible.

So on charge one, review special provisions for facilities to care for bariatric patients. The workgroup recommends adding a comparative review criterion that will grant three points to a project proposing to include one bariatric room if the project is requesting 49 beds or fewer, and two bariatric rooms if the project is requesting 50 beds or more. So the rationale behind is that bariatric beds has been an issue for placement of bariatric patients needing inpatient care. Some facilities are having to admit patients on the medical floors with psychiatry consultation and they did not find it appropriate. So the workgroup felt that providing incentive to include bariatric rooms in new and existing inpatient psychiatric hospitals will be the best approach to improving access. The workgroup also focused on the nursing home bed standards as a guide where there's a provision in the comparative review criteria which grants extra points to project for incorporating these rules into their project design. This was met with consensus.

Charge second is consider language for a public health epidemic. The recommendation was that workgroup agreed by consensus that there are no changes to the standards that are required. We reviewed the data on emergency CONs including the number of psychiatry beds requested, utilization of those beds, and emergency CON

denied. The workgroup agreed by consensus that no changes to these standards are required as the emergency CON provisions, and the CON statute allow the Department to respond adequately to public health academic. So this charge was also approved with consensus.

Charge three, review allowing telehealth treatment for child and adolescent programs and project delivery requirements. Workgroup agreed by consensus that no changes to the standards are required. The workgroup agreed that telehealth can be an avenue for improving access. And so a subcommittee was formed then to look at mental health code and other related regulations including CON standards to determine the CON standards were -- if the CON standards were creating any barriers to utilizing telehealth in the inpatient psychiatry setting. So the subcommittee determined that the CON standards do not create any restrictions or barriers for telehealth treatment in Michigan and even includes incentives and comparative review criteria to utilize telehealth. So this was met with consensus as well.

Charge four, review adding restrictions for high occupancy beds like hospital beds, not allowing relocation of beds for a period of years. We had a extensive discussion on this charge. So the recommendation is modify section 7, relocation section, and section 8(3) high

occupancy subsection to add language that requires all approved high occupancy beds be licensed and operational before any beds can be relocated from a facility with a high occupancy bed approval. This -- the rationale behind that was the high occupancy provision in the standards is an exception to the bed need methodology allowing facility to add beds in an area where the methodology does not necessarily indicate a need existing. Both the Hospital Beds and Nursing Home Bed standards include restrictions on relocation of beds before and/or after approval for high occupancy beds as the relocation of beds can impact a facility's occupancy rate. In addition, it has historically been viewed that high occupancy beds should be implemented in the facility that qualified for them rather than being allowed to relocate to another site. Although the Hospital Bed and Nursing Home Bed standards include more restrictive provisions, the workgroup recommendation is intended to provide some restrictions while not over eliminating flexibility. So this was met with consensus.

Charge five, review the comparative criteria related to Medicaid participation, section 11(3)(d) to address unintended inequities caused by large variation in Medicaid population in the various health service areas developed within the standards. So workgroup was not able to reach consensus on a recommendation for this charge, but

did take a vote on proposed language which would make following three charges to the comparative -- to current comparative review criterion. You can also look at Appendix 1 for language and supportive documents. The recommendations for changing language would be allow for Medicaid cost report to be submitted electronically with just an excerpt included in the paper CON application to ease the process. Use the most recently submitted Medicaid cost report rather than the most recently reviewed and accepted report. And require inclusion of Medicaid data from all commonly owned facility located within same health service area as the applicant facility rather than anywhere in the state. So all the major participating organizations supported, however, the workgroups are actually designed to bring consensus, so this language is not incorporated in the language presented by the Department. Appendix 1 includes the language considered, details regarding the work summary of the arguments and supporting opposition. The workgroup will defer to CON Commission on whether this language should be incorporated into the CON standards for public hearing.

Charge six, consider creative ideas for improving access to child and adolescent psychiatric beds. The workgroup's recommendation is modify section 5 to allow an acute care hospital to demonstrate need for a 10-bed child and adolescent inpatient psychiatric bed unit outside of the

bed need methodology using documentation of pediatric ED patients requiring an inpatient admission who were unable to be placed within a child/adolescent bed within 30 minutes of drive time of the applicant's hospital. For those patients who are not placed in child/adolescent bed within 36 hours, the applicant must demonstrate at least six attempts placement within the 36-hour period. Multiple hospitals may pool the ED patient data to demonstrate the need if they are located within 30 radial miles of the applicant hospitals if the applicant is located in a metropolitan county, or within 90 miles if it is a rural or micropolitan county. In addition, modify Section 7 (the relocation section) to restrict any beds approved under this provision from relocation for first five years after licensure and operations, and after five years only allow relocation to another acute care hospital in the same planning area.

So this was met with consensus. The rationale behind was access and child and adolescent as we know has been a ever increasing problem. The CON Commission and previous workgroup completed a thorough review of bed need methodology in 2018, including significant improvements to the methodology. However, methodology has inherent limitations in its ability to predict need for specific geographies because of a lack of patient origin data. This results in a prediction of need in areas where beds are

either exist rather than patient -- rather than areas where actual patient needs exist. If a patient has to travel outside of the planning area to find a bed, the patient is included in future calculations for a bed in the planning area where they receive service rather than a planning area where they reside perpetuating access issues in their home planning area and the need -- the need to travel long distances to obtain access.

The Department has explored options for collecting patient origin data but determined that there is not a good or an immediate solution. The options are wrought within patient privacy and data security, complications and considerations. The proposed solution will provide an opportunity for more immediate implementation of beds in these planning areas where beds are not guaranteed available while also helping the bed need methodology to better predict future need in the planning areas where these beds are granted creating both the short-term and a long-term solution. So this charge was met with consensus.

Charge seven, consider any technical changes from the Department, for example, updates or modifications consistent with other CON review standards and the Michigan Public Health Code. So recommendations were modify Section 7(2) (sic) to reference Section 8(3) rather than Section 6(3). The workgroup delegated any additional technical

updates found during the finalizing of these recommendations to the Department. In the last meeting of the workgroup, the Department also brought forth an issue with current definition of med psych unit. The current definition requires that patients using these beds to be diagnosed with a medical condition requiring hospitalization. However, the beds can be granted to the freestanding psychiatric hospital that do not have an acute care hospital license. According to LARA, only hospitals that have an acute care licenses are legally allowed to admit patients meeting this current definition. The Department presented an initial modification that was briefly discussed by the workgroup, but there were some concerns regarding the proposed language. The workgroup acknowledged a need to update the definition to resolve a conflict between the statute -- between the statute and they suggested anyone interested in this work should work directly with the Department with the goal of bringing forward a revised definition along with the workgroup recommendations.

So I cannot speak to all the work that has been done on this definition and any updates since then, but I personally participated in discussions with MDHHS on this issue on behalf of Spectrum Health and we have provided a proposed definition to the Department which is being vetted with LARA. So no modification to that definition are

included in the language presented here today. My understanding is that Department feels that there is more work is still needed. Since there is a modification needed to resolve this conflict between CON standards and the statute, it would seem to be a very time sensitive issue. So perhaps Commission could add the proposed language to the change in public hearing and solicit feedback including LARA's or make any final tweaks at December meeting even if that results in a second public hearing if necessary, final action could still happen before March 2023 whereas sending to a future workgroup may delay given the current crisis we have already with bariatric and med psych beds. Thank you.

DR. MCKENZIE: Thank you very much, Dr. Jain. If you could stay for just a minute, we may have a couple of questions. I will just try to summarize really quickly that this was obviously very complicated work. I wanted to thank Dr. Jain for all of his leadership through this. And as they worked through the various different charges, I think you were able to hear that the workgroup wasn't necessarily able to arrive at consensus, particularly around charge five and there's a description of that in your packet in the workgroup information and around the voting, as well as the secondary issue that came up where the CON standard is sitting in conflict with LARA. And so those two issues we're going to have to kind of discuss. But I want to open

this time up for questions to Dr. Jain first, and then we'll take public comment and then we'll have Commission discussion.

MR. FALAHEE: This is Commissioner Falahee. A question for you, Dr. Jain, -- hear me now? There we go. Okay. Sorry about that. On charge six you make a reference to lack of patient origin data. It may be not so much a question for you as to the Department. I know in hospitals we can easily access patient origin data, where they came from. Even though they may get service in a different county, we know where they came from. Is the Department saying it doesn't have access to that data? I'm trying to understand here.

MS. NAGEL: This is Beth. That is correct. So for hospitals you collect -- that data gets collected and reported to the Department in the Michigan Inpatient Database. Not all of the freestanding psychiatric facilities participate with the Michigan Inpatient Database. So the data we do have is -- does not include those patients, so it doesn't give us the whole picture of where patients are traveling from within Michigan. So several times now the workgroup has -- the last couple of workgroups actually have looked at this issue on how we could collect from the freestanding facilities that patient origin data. And there isn't -- there hasn't been a way identified that

complies with the privacy and security standards that need to be met for the state to have that data. On the Michigan Inpatient Database side, the Michigan Hospital Association does the bulk of that work for us and we would almost need a mediator like that to collect that data from the freestanding facilities in order to have that available to use for Certificate of Need. So that's kind of a, you know, a long way to explain we don't have the data and it's mostly a freestanding issue.

MR. FALAHEE: Okay. Thank you, Beth. That's a very good explanation. I understand it. I see Commissioner Ferguson has a follow-up.

DR. FERGUSON: I have a question on that. So with respect to the data and the inpatient database for the medical facilities, is that a requirement or that's just something that the MHA is doing as a courtesy to come up with data?

MS. NAGEL: That's a great question. I am -- it's not clear to me what the requirements are and how those get promulgated to facilities.

DR. FERGUSON: And the follow-up to that is -- the next logical extension is if it's a requirement for the medical hospitals, maybe it ought to be a requirement for the psychiatric hospitals.

MS. NAGEL: I will say it's not a Certificate of

Need requirement, so understood.

DR. MCKENZIE: Any other questions for Dr. Jain? Commissioner Ferguson?

DR. FERGUSON: Commissioner Ferguson again. A question on charge four, just a limitation in my understanding. When we talk about transferring beds or reallocating beds, are all of these reallocations psychiatric beds to psychiatric beds to psychiatric beds or are we talking about reallocations that are medical bed to psychiatric bed to pediatric bed that crisscross all over the place?

DR. SUBODH JAIN: I believe they are psychiatric to psychiatric beds.

DR. FERGUSON: Thank you. That's all I need.

DR. MCKENZIE: Okay. Not seeing any other questions here in the room, thank you so much, Dr. Jain, for all of your work. We greatly appreciate it.

DR. SUBODH JAIN: Thank you. And I would also like to thank the Department folks, Kenny and Beth, who I have worked very closely with. So -- they made my work very easy. Thank you.

DR. MCKENZIE: Okay. Then next up we have public comment related to Psychiatric Beds. There is comment in your packet as well, but I don't know if we have any public comments right now?

MR. WIRTH: Yeah, we do. We have a handful. So to start with Scott Miles of Universal Health Services.

MR. SCOTT MILES: Good morning, everybody. Can you hear me?

MR. WIRTH: Yes.

MR. SCOTT MILES: All right.

DR. MCKENZIE: Yes, we can.

MR. SCOTT MILES: All right.

SCOTT MILES

MR. SCOTT MILES: Thank you for your time. I'm Scott Miles, CEO of Cedar Creek Hospital and today representing Universal Health Services or UHS, which operates Cedar Creek, Forest View, Havenwyck, and Beaumont Behavioral Health. I was actually able to serve on the workgroup and we greatly appreciated the time and dedication everyone spent evaluating the standards for Psychiatric Beds and Services.

The current standards award comparative review points based on the Medicaid patient days of psychiatric hospitals under common ownership or control with the applicant which MDHHS interprets as being psychiatric hospitals and units licensed to the same legal entity as the applicant and located anywhere in the state. During the workgroup meetings, MDHHS explained that Medicaid's a statewide program and accordingly Medicaid patient days

should be measured on a statewide basis, not based on the geographical confines of the CON planning area.

Awarding comparative review points based on statewide Medicaid days is, one, consistent with Section 22230 of the Public Health Code, under which acceptance of Medicaid patients must be heavily weighted in the CON standards. And two, it's good public policy because it encourages willingness to serve Medicaid patients anywhere in the state not just within the applicant's own planning area which benefits the overall state Medicaid program and its beneficiaries.

In our written comments we outlined UHS facility data highlighting our commitment as an organization to serve Michigan's Medicaid population. In fact, we -- up to 55 percent of those we serve are actually on Medicaid.

The workgroup considered a proposal to change the Medicaid patient day formula to award points based on Medicaid patient days for psychiatric hospitals under common ownership or control from only within the same CON planning area as the applicant which would take away a key incentive for current CON-holders to provide care for Medicaid patients outside their immediate service area which goes against public policy. In justifying their proposed revisions to the Medicaid patient day formula, the proponents of the changes provided data stating that 75

percent of the Medicaid patients are treated at facilities within their immediate service area. The workgroup cited this data, but it's our understanding that the data has not been supplied or verified by the Department, therefore we do not know with certainty where these numbers came from. Additionally, the data does not address the requirements of Section 22230 of the Public Health Code which focus on the provider's Medicaid patterns, not where the beneficiaries receive care. It does not address the Medicaid patient mix of the CON applicant such as taking into consideration the number of Medicaid days each facility treats. It also fails to take into account the number of Medicaid patients those facilities deflected, both from their local service area as well as from those across the state. Therefore, it doesn't tell the complete storey of the Medicaid patients that were served or those that were not.

Furthermore, the new changes would be anti-competitive in that they would create regional monopolies of psychiatric CON beds with new entrants being unable to enter the region since the local facilities would be the only ones to have local Medicaid patient days. So, you know, our stance, statewide policy should take precedence over local competitive considerants (sic). So for these reasons -- oh. For these reasons we --

MR. WIRTH: Sorry. Mr. Miles?

MR. SCOTT MILES: Yeah.

MR. WIRTH: That's three minutes.

MR. SCOTT MILES: Yup. So for these reasons, we support CON review standards as written and would welcome any questions. Thank you.

DR. MCKENZIE: Any questions by the Commissioners? Okay. Thank you very much.

MR. WIRTH: Next up with have Rob Casalou of Trinity Health.

ROB CASALOU

MR. ROB CASALOU: Yes. Good morning, Madam Chair. Morning members of the CON Commission. I'm Rob Casalou. I'm president and CEO of Trinity Health Michigan. We operate eight hospitals in the state of Michigan as part of Trinity Health which is one of the largest, not for profit Catholic health systems in the nation with a presence in 25 states. You received my written comments in your packet regarding the workgroup's recommendation and thank you for allowing me to comment.

Trinity Health Michigan appreciated also the opportunity to participate in the informal workgroup and likewise appreciated the leadership of Dr. Jain in developing the recommendation. We support the recommendations, but I did want to comment as the previous person commented on charge five, that asked the workgroup to

review the comparative review criteria related to applicant's Medicaid participation and the large variation in the Medicaid population in various health service areas. Now, the current standards for Psych Beds and Services includes language in the comparative review that measures Medicaid patient days by including the applicant and any psychiatric units owned by that legal entity anywhere in the state of Michigan. Now, proponents of changing this language argued for measuring the Medicaid patient days based on the applicant's unit and any psychiatric unit under common ownership with the applicant only in the applicant's health service area. Now, Trinity Health Michigan supports the current language in the standards, believes they are consistent with the Michigan Public Health Code in awarding the most comparative review points to those facilities that are accepting Medicaid patients from anywhere in the state. Changing this language to limit measurement of Medicaid days to hospitals and units under common ownership or control in the same HSA would negatively impact access to psychiatric services in the state as it will allow a facility that deflects a higher number of Medicaid patients from outside the health service area to still win a comparative review based on its numbers solely within the HSA. Additionally, changing this language could be anti-competitive and likely denying new entrance into a market as would have the effect

of locking in providers in an HSA. A new entrant to the market would not have any Medicaid patient days in that HSA even if they provide a significant number of Medicaid inpatient days outside that HSA.

So the current language and the standard reflects an institutional organizational commitment to serving the Medicaid population regardless of where the patient's located within the state. And Trinity Health Michigan continues to support the current language as a matter of good public policy. Thank you for the opportunity to comment.

DR. MCKENZIE: Thank you for your comments. Any questions from the Commissioners? Commissioner Ferguson?

DR. FERGUSON: This is Commissioner Ferguson. Question probably for the Department. So I'm hearing from several speakers here the suggestion or the statement or the implication that we may serve a broader, larger number of Medicaid patients, a larger number of disadvantaged patients by keeping the current standard versus a change. Do we have any analysis supportive of that? Do we have data that supports? I mean, at the end of the day I'm going to favor whatever provides the broadest based service to our underserved community. And does the Department have a stance on which of these two sets of language ultimately reaches the biggest chunk of our population?

MS. NAGEL: That's a great question, Dr. Ferguson. The Department does have a stance. We do support the language as presented in your packets today. We do not support a change to the -- the change that's being suggested to the comparative review requirements. We believe that psychiatric beds, inpatient psychiatric beds are something that we would not want to limit in any way expanding statewide or any entrant into the market. We also believe that participating in the Medicaid program is an extremely important tenant not only to us in the Department, but to the state legislature that created the code that created the Commission and the entire Certificate of Need program. There is a statute that says that within comparative review requirements, Medicaid participation must be rated very highly. And so it is our stance from the Department that creating a caveat in comparative review where only Medicaid data from that HSA would severely limit the ability of new entrants to enter that market and therefore would not be advantageous to the entire state. That is our stance on -- on this -- on this particular language. In regards to data, I'm not sure exactly the question. I may have missed the emphasis.

DR. FERGUSON: I think in the end you answered it. Right. So my question is essentially which is going to serve, make it easier to broad service to those in need in

our state, the disadvantaged in our state. And I'm hearing the current language does that. We've heard a couple of speakers articulate that. I would at this point support the current language.

DR. MCKENZIE: Commissioner Falahee?

MR. FALAHEE: Yeah, this is Commissioner Falahee. In response to some of the comments that Mr. Casalou raised and Mr. Miles, I guess, Beth, I've got a question for you. How would the current language -- not changed, the current language -- let's say you've got an out-of-state provider, not out state, but out-of-state, all right, and they wanted to come in. We all know there's a dire need for more psychiatric beds, and they wanted to build a facility in whatever HSA, how would that be interpreted under the current language?

MS. NAGEL: This is Beth and that's a great question, one that we have wrestled with in the Department, one that we have asked. I think almost every single bed standard that we have has some version of this and something that we have asked repeatedly for those workgroups or SACs to look at. How could -- how would we handle out-of-state data, recognizing that it's not the same as in-state data and how would we weigh it? I would actually ask and I wouldn't want to put her on the spot, but, Tulika? If you are able, Tulika? Tulika is joining us via Zoom to answer

if we -- this has come up in the past and how we have handled it?

MS. BHATTACHARYA: Good morning. Thanks, Beth. This is Tulika. So to answer Commissioner Falahee's question. In the context of a comparative review and when the CON standards is specifically stating that the comparative review points will be awarded based on your Medicaid patient days for hospitals under common ownership in Michigan, then we have to follow and honor that language and only, you know, count the Medicaid patient days in Michigan. So if it is an out-of-state provider and they don't have any hospitals in Michigan currently, then they will not be able to score those comparative review points under the psych bed standards. What Beth was referring to, there are some other standards, like, for example, cardiac cath where there is a methodology for projecting unmet need say, for example, initiating primary PCI or elective PCI where the -- there is no comparative review and we believe that the language is not so specific. We have shown differential consideration to hospitals that are right at the border -- bordering counties in Michigan -- and allowed them to project need when they are treating patients that are coming from out of Michigan.

MR. FALAHEE: This is Commissioner Falahee. Thank you. That helps. I've got to go back a little bit.

Patient origin data, the MIDB, it's a voluntary program for hospitals in Michigan. There might be a way for the Department to encourage psychiatric hospitals to also participate voluntarily to submit that data. But that's why the 130, 140 Michigan hospitals that participate in MIDB do that because it's voluntary and it helps all of us figure out where the patients are coming from and perhaps there's a way we can make that available and an opportunity for psych hospitals, too.

MR. WIRTH: We do still have more public comments on this item, so --

DR. MCKENZIE: Really quickly, Commissioner Haney has a comment as well and then we'll -- we do have time for Commission discussion as well, so --

MR. HANEY: Okay. I just want to -- I had a follow-up question, I think, to Dr. Ferguson's question with that. And that is so if we're looking within a point -- number one, I think if there's a comparative review there are two providers looking for the same beds. Right? So access is really going to be covered either way because one of the two of them is going to gain, win the CON; correct? Second to that, if what we're really looking at is a predictor of how much Medicaid services will be provided in that planning area, no two planning areas are the same. Right? So the Medicaid mix in Barry County is going to be a

little different than the Medicaid mix in Wayne County. So if I'm using Wayne County's Medicaid pair mix, that's not really good predictor of Barry County's Medicaid volume or usage within that planning area in my mind. So I'm trying to figure out how that -- how using a Medicaid mixture in another planning area benefits my planning area which may have a higher or lower Medicaid population than where they're referencing.

MS. NAGEL: Yeah. I definitely understand what you're saying. And I think if you -- the -- I would have to pull up and it may take me too long to pull up exactly what the -- how the language is written. But it's a percentage of -- I might -- I might want to actually pull it up before I answer this question so I don't say it wrong. I'm a little nervous that I will. But it is a percentage of the -- actually, could I look it up first and then answer your question? I really don't want to get this wrong and I'm afraid -- I confuse a lot of the bed standards together. So if I could come back, is that okay?

DR. MCKENZIE: Yes.

MS. NAGEL: Okay. Let's --

DR. MCKENZIE: Can we pull that and have some discussion? Okay. We have a couple more public comments, so, Kenny, I'll turn it back over to you.

MR. WIRTH: Yes. Next we have Bob Nykamp of Pine

Rest.

BOB NYKAMP

MR. BOB NYKAMP: Good morning. My name is Bob Nykamp. I'm vice president and chief operating officer at Pine Rest Christian Mental Health Services in Grand Rapids, Michigan. I wanted to thank the Commission for your attention and important job in discerning these key issues for our state and for our citizens. I also want to thank Dr. Jain for his incredible leadership in our workgroup work and thank him for his continued advocacy for the people requiring behavioral health care in our state.

I'd like to speak to the Commission briefly about charge five. It is Pine Rest's position that charge five should be included in the review and sent for public comment. And just some real brief information to help you in your discernment. What is charge five really asking to fix in public policy? Well, first, it's trying to fix the gaming of a system. So I'll give you an example. If there are beds available -- this is hypothetical. If there are beds available in Traverse City and a Traverse City area hospital goes into a comparative review against a hospital in Detroit, based on the weighted factor of Medicaid usage which is highly important and by code needs to be considered very important, there is almost no likelihood that the Traverse City hospital will be able to win a comparative

review simply because of the weight and value of that Medicaid population and the scoring that it produces. So Medicaid is, in the CON comparative review, is a predictive value. And as Commissioner Haney pointed out, it's very hard to predict Medicaid volume from region to region, county to county or health service area to health service area. So we're trying to fix that.

Secondly, we'd like consistency across standards. The fact that Beth has to -- the fact that Beth has to look up these standards is the fact there is no consistency across Psychiatric Bed, Nursing Home Bed, and Med/Surg Hospital standards as it relates to how we score Medicaid volume predictors in the standards. And we were hoping to eliminate that inconsistency with charge five.

And then thirdly, charge five would -- if not changed would basically automatically give HSA1, the southeast Michigan health service area, in essence an automatic win in any comparative review across the state.

What is the recommended language that we are asking for you to support --

MR. WIRTH: Mr. Nykamp?

MR. BOB NYKAMP: -- not do? It doesn't recross competition --

MR. WIRTH: Mr. Nykamp? That's three minutes.

MR. BOB NYKAMP: Okay. Thank you. Our ask is for

the workgroup participants who supported -- who in a super majority supported this charge --

MR. WIRTH: Mr. Nykamp?

MR. BOB NYKAMP: Yes. Thank you, Kenny.

MR. WIRTH: We have to move to the next comment. I'm sorry.

DR. MCKENZIE: Questions from the Commissioners?

MR. FALAHEE: This is Commissioner Falahee. To Mr. Nykamp or anybody else. So, Bob, you're saying that the language as currently written would give HSA1, I think you said, an automatic win. Is the flip also true? If this new language was adopted, would it give that hospital in your hypothetical -- I think you said a Traverse City hospital -- would that hospital get an automatic win in the Traverse City area HSA?

MR. BOB NYKAMP: Great question, Commissioner Falahee. Not necessarily. One, as you know, there are multiple items that are required in scoring including costs, capital costs, quality, data and it also doesn't preclude a organization from using Medicaid data for persons in that HSA. And so this isn't -- this is something that we support because we want there to be good competition and also it certainly does not preclude a comparative review where outside hospitals, either outside the state or outside an HSA, can compete for beds where there is not a local

provider or a local provider is not wishing to compete for those available beds.

DR. MCKENZIE: Commissioner Haney?

MR. HANEY: You had just briefly mentioned there a super majority. What was the vote? Was it five to five? Was it -- you know, I don't know how many people were -- participants were in the workgroup. But was it, you know, ten to four? Ten -- what -- what percentage of the workgroup that supported the change versus supported the current language, I guess?

MR. BOB NYKAMP: Yeah, thank you, Commissioner Haney. To the best of my knowledge, the subgroup that worked specifically in charge five, the vote was eight organizations to two organization, eight of them being in favor of charge five. And in the full workgroup I believe it was eight organizations in favor and four organizations not in favor of charge five.

DR. MCKENZIE: If the Commissioners would direct their attention in your packet to Dr. Jain's report? There's an appendix one which spells out the pros and cons in charge five as well as the way the vote broke out both at the organization level but also at the individual level and what organization they were representing. So that may be helpful as we're deliberating on this. I do have a additional question that may get into, you know -- I'm not

sure who can answer it, in fact, if we need to table it back to the discussion piece. I think getting into Commissioner Haney's question previously is, is the methodology around how Medicaid is counted, is there weighting associated with the case mix adjustment that's available to the entity that is applying? I don't know if that makes sense, but I'm curious. Like is it a numerator/denominator type of thing? Like what's available to (inaudible) versus kind of what percent they're, you know, devoting beds to or is it just, you know, they have got ten patients and you have five and, you know, type of thing. And that may be -- I know you're still looking at the methodology, so if we wanted to move that into discussion I'm totally fine with that.

MS. NAGEL: I can answer that. I appreciate the ability to take a moment to look it up. And just for the record, I look everything up all the time. But it is -- what I wanted to point out is that it is a percentage of patient days and it doesn't weight how many patients are in that HSA that would have either -- that are Medicaid or Medicaid eligible. It does not weight it. It is a straight percentage of patient days. The applicant with the highest percentage of Medicaid patient days gets ten points and then there's an example laid out. I see now that it's actually in Dr. Jain's appendix one as well, that shows that the next applicant would get nine points and so on and so forth. And

so it is a calculation just of the Medicaid patient days that that provider and all of the provider, the facilities of that same legal entity, a calculation of those patient days.

DR. MCKENZIE: Thank you. Any other Commissioner -- oh. I thought I heard another Commissioner question? Oh, sorry. Go ahead. Yeah, we can go back to public comment.

MR. WIRTH: Next up we have Kathy Dollard of My Michigan.

KATHY DOLLARD

MS. KATHY DOLLARD: Hi. I'm Kathy Dollard and I'm the service line director for My Michigan Health for behavioral health and I'm not going to speak on five. I'm speaking on charge six. I want to thank you for this opportunity to provide comments regarding Psychiatric Beds and the workgroup recommendations.

In September of last year we came to the Commission asking to have the workgroup look at a creative solution to the ever increasing access problem for child/adolescent inpatients and we -- you supported our request and we thank you for that. Thank you -- and because of the support, the workgroup recommendation includes a new provision for to allow acute care hospitals that can document sufficient pediatric patient needing inpatient

psychiatric care that either cannot go to -- get into a psychiatric hospital within a reasonable amount of time or must travel great distances to receive care. We would also like to thank Dr. Jain and the members of the workgroup for all their efforts put into this crafting and fine tuning also of the proposal and we ask for your support in moving the workgroup recommendations to public hearing. And I'm happy to answer any questions you might have about the child/adolescent access provision included in this recommendation.

MS. GUIDO-ALLEN: This is Commissioner Guido-Allen. Can you help me understand how acute care hospital would create a ten-bed psychiatric unit for adolescents with all of the requirements and stipulations that are required of psychiatric units? I can tell you that we -- adolescent access is almost impossible from an acute care hospital perspective. I can tell you right now I have been meeting with DHHS and Wayne County for a patient I've had in my hospital since February that we cannot get a place for. I can't open a ten-bed psychiatric unit for adolescents in any way, shape or form. So how does this help our community?

MS. KATHY DOLLARD: Well, right now we're precluded from having a psychiatric child/adolescent unit in the HSA where I'm located, in Midland, Michigan, because of

the current CON standard and it has to do with that flawed methodology that Dr. Jain talked about where we can't count where the patient's coming from. So in our health system, patients who are in the mid-Michigan area have to travel usually more than 50 miles away and at great distances because we're precluded on having more patient beds, psychiatric patient beds for child and adolescents because it looks like we're over bedded because health source Saginaw has 31 beds. And so this is trying to solve that problem. So at this point, My Michigan Health, for instance, has two child/adolescent psychiatrists. They're doing mostly adult work, inpatient, and then child/adolescent work outpatient but we're not able to stand up a hospital, ten-bed hospital in our unit, in our hospital because of the way that the standard is now. So we're trying to say if we have the amount of kids in our region that are traveling elsewhere, we should be able to do that. I hope that makes sense.

DR. MCKENZIE: Commissioner Falahee?

MR. FALAHEE: It's not a question to our witness, but I think what Commissioner Guido-Allen is talking about is even if an acute care hospital would desperately love and want to open a ten-bed, 50-bed acute care adolescent unit, you just can't do that easily given the requirements for those beds. The ligature requirements, the bed

requirements, the door requirements, that's not something that can be easily or even hardly done. It's very, very, very, probably impossible to just flip it like that. So I think if I'm reading your mind, that that's the point you're trying to make.

MS. GUIDO-ALLEN: You are correct.

MS. KATHY DOLLARD: My point is we can't do that under the CON standards even if we wanted to. Even if we had the magic and the ability to do it how it is right now we're not able to in our health service area for My Michigan or any other entity. If McLaren wanted to do that, in the current health service area where we are, we wouldn't be able to do that. So we're saying we need more access. I think everyone can agree to that. And so we're saying could we get your support on changing the CON language.

DR. MCKENZIE: This is Commissioner McKenzie. Commissioner Falahee and Commissioner Guido-Allen, though, if I understand correctly, the change to this language would still require all of those other components of being able to meet. It's not easy. This just would potentially open it halfway, but they would still have to meet all of the kind of other criteria to be able to implement those beds. Okay. Thank you. Any other questions for the current -- okay. Thank you. Any other public comment?

MR. WIRTH: Yeah. I have one written comment and

two more virtual speakers. So the written comment was from Stacy Leick of the Economic Alliance for Michigan. And they support the proposed changes for charge five regarding only counting beds within the service area. And that was the written comment. You can see that in the Zoom chat. And the next speaker we have is Dave Walker of Spectrum.

DAVE WALKER

MR. DAVE WALKER: Hi. Good morning. I hope you all can hear me and maybe see me. I apologize. I am actually on vacation today, so I apologize for my casual appearance. Working from an iPad and a phone, again, on vacation but since I find CON Commission's meetings so recharging and relaxing, I decided I would join today to discuss, speak on the Psych Bed standards.

I specifically want to reiterate a point from Dr. Jain's presentation on the med psych definition. As he mentioned, the Department brought to the last psych workgroup meeting the need to update the definition, specifically given discrepancy between the statute and the standards allowing for med psych beds to be put into non-acute care facilities. However, at the time we were not able to come to a consensus on language, decided to work on it more. Spectrum Health under Dr. Jain's leadership worked proactively to find a solution to this and presented a couple drafts definitions to the Department and I think we

finally found one that may work. I understand that they -- that the Department wants to work on it more and I respect that and I think that -- and I understand that. But my ask today is I respectfully request that the language be added to the proposed standards and move to public -- to the upcoming public hearing now. Thank you. With that, I'd be happy to answer any questions.

DR. MCKENZIE: Thank you. Any Commissioner questions? Commissioner Falahee? You're on mute.

MR. FALAHEE: Sorry. First to Mr. Walker, we always knew you loved CON, but you've proven you're just zany and you love it too much. So thank you for calling in on vacation. A question for you, Dave, or the Department. So we have this, the language about med psych that hasn't been agreed upon. Is that something that we could throw out -- not throw out -- send out to public comment or does the Department want to look at the language first? I'm just trying to figure out the logistics of how to try to get that language resolved and, if necessary, sent out to public comment.

MS. NAGEL: Yeah, thank you for that. Just for a little bit of context. The -- and I think it was covered, but the Department brought this to the workgroup and there was a very robust discussion at the workgroup that brought up some unintended consequences for the draft that we had

proposed. And it was the very last workgroup meeting, you know, and so thankfully Dr. Jain and Dave and others kind of after the meeting got together and thought of a new way to do it that might, you know, minimize some of those unintended consequences that came up during the workgroup discussion.

From the Department side, we have had a chance to look at it. We have not had a chance to make sure that our colleagues at LARA are completely on the same page with it. We're not opposed to it. It could very well work. We just didn't go through the workgroup. It wasn't fully vetted in that capacity. And, again, we have this other kind of outstanding "to do" hanging over us as well. If it went ahead to public comment, the one thing that I would -- I may need Brien's help on this -- would be to put it forward in a way that wouldn't hold up -- let's say it goes to public comment and some of the comments weren't favorable, I wouldn't want it to hold up the other work in the draft. Do you know what I mean? Because then if it came back to the Commission and the Commission says "take out that language," I think it goes back to public comment, again, without that language. So I don't know if there's a way to put forward two drafts, two separate drafts, consider it maybe two separate public hearings in a way and so we could, you know, have those go forward in tandem but not necessarily impact

each other if there is something that isn't favorable. I don't know, Brien, if you --

MR. HECKMAN: This is Assistant Attorney General Brien Heckman. Yes, you can move forward with two separate hearings at the same time. If there's anything else, that's probably what you should do under these circumstances.

MS. NAGEL: Okay. Thank you. And I'll just repeat. Brien said that we could move forward with two separate drafts in this circumstance.

DR. MCKENZIE: Thank you. That was helpful. Any other questions or comments from Commissioners right now? We'll go back over to Kenny for public comment.

MR. WIRTH: All right. Next up we have Melissa Reitz of McCall Hamilton.

MELISSA REITZ

MS. MELISSA REITZ: Thank you. Good morning. I'm Melissa Reitz with McCall Hamilton. I was a participant in the Psych Beds workgroup. And I wasn't planning to speak this morning, but I wanted to just take a real brief moment because I feel like there was a lot of confusion in previous, like, comments and discussion about the Medicaid patient days and, like, what counts and what doesn't under different scenarios. And I just wanted to take a minute to try to clarify that, as Beth said, this is a percentage of your total Medicaid patient days provided at -- I'm going to

say "the facility," and then I'll talk about which facilities under different scenarios -- at the facility that's being counted divided by the total patient days. And so if a patient is -- if a Medicaid patient is cared for at a facil- -- the -- I'm going to say "the facility," it doesn't matter where that patient came from. Their day, their patient days are going to be included in that numerator. And so the question is which facilities should we be counting? And currently we count any facility with common ownership anywhere in the state with the applicant. In the proposed revisions under charge five, it would be limited to only those facilities that were either the applicant facility or commonly owned by an applicant facility located in the same health service area. And for psych -- or, I'm sorry, in the same planning area. For psychiatric beds that planning area is the health service area, so the multiple county regions that we are often familiar with. There's eight of them in the state.

And so I just -- I wanted -- so there was a comment, I think, or two made about, well, it would -- the change, if we were to go to only that facility in the HSA or only facilities in the HSA, that we would be disincentivizing facilities from taking Medicaid patients from anywhere else in the state besides in the HSA, but, in fact, doesn't matter where the patient comes from in either

one of these scenarios. If they were -- if they received service at a facility whose Medicaid is counted, then they would count. And so I just wanted to make sure that that was understood. That that's not -- that's not a issue in either one of these, whether it's current or in the proposed. Any patient, any Medicaid patient cared for in a facility whose Medicaid days are being counted counts. So incentive all over the place to take in as much Medicaid as you can. And I'm happy to answer any questions.

DR. MCKENZIE: Questions for Melissa? Okay.

MR. WIRTH: I believe that's it for public comment on this one. If anyone hasn't spoken yet and wishes to provide comment, please let me know in the Zoom chat. But I think we can move towards Commission discussion.

DR. MCKENZIE: Okay. So I will open it up to Commission discussion. If you see anything, let me know in public comment. So can --

MR. WIRTH: Sorry. We just had Tom Stankewicz submit his name.

DR. MCKENZIE: Okay.

MR. WIRTH: Tom?

TOM STANKEWICZ

MR. TOM STANKEWICZ: Sorry there. Good morning, everyone. Tom Stankewicz, Trinity Health, Grand Rapids, Michigan. Thank you very much for the opportunity to

comment. And I just would like to reiterate and thank Dr. Jain for his leadership on this as well as the Department who weighed in heavily, particularly on the Medicaid days and I just appreciate that at least those of us who support the current language agree with the Department in that the current language in the standards, not that the others have proposed, does in fact serve the greater need in our state of which we know behavior health issues affect the underserved and those most vulnerable, and part of Trinity's commitment to serving our state is that of serving those particular populations.

So you heard a lot of confusing, maybe on different sides and I would just reiterate that we feel that restricting the catchment area to the health service area does, in fact, limit new entries into the market as well as favoring those who are currently in the market. So thank you and just wanted to close with those thoughts. And would be happy to address any questions that the Commissioners may have.

DR. MCKENZIE: Thank you. Questions? We have one more? I thought I saw something else pop up in the chat, but -- okay. Okay. Now I will open it for Commission discussion. What we have before us is proposed language. I just wanted to remind everybody. So this is language, whatever we decide, based upon everything that you've heard

with regards to these charges, will be put out for public comment again and then would come back to us for review. So the way the workgroup, you know, worked through and we heard a lot of testimony I think on charge five, both sides of the issue. The workgroup's recommendation and what the Department is support of is to keep the language the same although the workgroup had kind of this split vote. Right? And so they did draft language. They had discussion. They had a majority vote on that draft language. It is there for you. But what was put forward was basically the Commission should decide whether the draft language goes in or not. And then the second issue that I see is this other kind of technical piece that came up of the current language related to med psych beds is not consistent with other regulations with LARA. What we heard from the Department is that there was some work to draft some language around that, but there probably is still some additional work to go related to that item. We can, you know, ask for that language to be put in and I think what we heard is we can have two separate actions on this particular standard so that we wouldn't hold up the other charges based upon this technical issue. So that would be my recommendation is if we are going to include that this time, that we do it in two separate motions. But I'll open it up for discussion because I know we've had -- we've heard a lot of testimony, so --

Commissioner Ferguson?

DR. FERGUSON: This is Commissioner Ferguson. So I would support your idea of putting these out as a dual path to public comment. A question or idea around charge five and do we count Medicaid at a state level, do we count Medicaid at a local level? I support the existing language of counting it at the state level and do not feel compelled to make a change if this is enormously controversial which it sounds like it might be, and I don't know, maybe this was already considered in the working group, I heard -- I believe I heard that this gives you points on a -- you know, be it ten points or whatever or nine points. One alternative option of compromise is to say we're going to run both methodologies and you get five points out of one bucket, you get five points out of the other bucket and then it's a little bit of a balance measuring act of run it both ways. It's more complicated than I'd like to see. I'm not necessarily suggesting we should do that. But if we're trying to find peace and compromise, that may be a way to get there.

DR. MCKENZIE: Commissioner Falahee?

MR. FALAHEE: I like Commissioner Ferguson's idea. I'm not sure if that's workable or not. But a question, Beth, I guess for you. I think it was Mr. Stankewicz that just said that the current language best serves the greater

need in our state by looking at the overall need for psych beds. Can you help me understand, if you agree with that statement, how the current language helps and best serves getting the beds we need in the places where we need them?

MS. NAGEL: Sure. The way that the Department is reading the proposed language, the proposed language to us would make it almost impossible for any provider outside of that HSA to compete in a meaningful way on quality, on the innovation or anything else in the standard, if they are not able to count their Medicaid days that they already have in other places in the state. And so we believe that that would greatly limit new entrants into a market that we are, the Department, with every policy lever it has is trying to promote. We want to see more innovation. We want to see expansion. We want to see more providers stepping up to care for this population, and particularly, you know, our interest is in the Medicaid population. And so we believe that the language as written allows for those Medicaid days in the state to be counted. Now, that said, this is the language -- the way the language that is in the packet was what came from subgroup for the workgroup to consider. It is very possible that there are other ways to do this that, you know, that may be more perfect or that may make sense. The Department stance is what came to us for consideration is not the way to do it.

DR. MCKENZIE: Thank you, Beth, that's helpful. So I think what Commissioner Ferguson has kind of put on the table is maybe a third option, whether that could be put into this as well or whether it would have to be taken back up by a work group, I guess, would be the question that I would have is if we were to entertain, like, we were not really happy with option A or option B and maybe we wanted to entertain option C, how would that potentially be done? I don't know if you have a perspective on that or if you could help me understand that as we consider all the options?

MS. NAGEL: Absolutely. I think -- and, again, I'm going to speak from the Department's perspective. We would be most comfortable if a group of experts evaluated any language that came to the Commission. And so certainly the Commission -- but that's a preference from the Department. The Commission has the ability to craft language and evaluate it as a working body all your own. So the Commission certainly can do that. But, I do think with a change this large I would recommend to you a working group or a Standard Advisory Committee to look at this exact, specific issue if there are changes that are going to be made to this language.

DR. MCKENZIE: Thank you. And I just want to kind of clarify my understanding here. This was a workgroup.

And I think the reason that the proposed language that ended up being on voted on was left out was because a working group doesn't have quite the same standards around it in terms of attendees, in terms of required attendance. You may have a group show up, you know, that's been -- only attends one meeting and so the structure around it is just a little bit looser. And so typically when we end up with a -- an issue where we have -- I don't know what you called it before, the dueling doctors or the -- you know, where we have these kind of differing opinions on each side, those are oftentimes best handled in a Standard Advisory Committee or a SAC. As you may recall, we've had trouble seating SACs, right, as part because of COVID, in-person attendance, all of those types of things. You know, you can chalk it up to whatever you like. But we have had difficulties seating SACs. So I think what we're hearing is if we were going to take up something different, we probably would need to then form another group on the back end of this group that just completed. So that would probably be the recommendation, I think, if I'm understanding correctly. Chip, I welcome you to weigh in if you have any thoughts there as well with your experience.

MR. FALAHEE: Yeah, this -- would that there had been a SAC on this. We tried and tried and tried, didn't get it. Because I think this is a classic example where you

have, as we've all heard for the last hour and a half in spite of Dr. Jain's hard work and everybody on the workgroup, there were arguments on both sides. And Commissioner McKenzie is exactly right. At that point we would put them on the SAC together and say you experts figure it out. What's the compromise here if there's a compromise that can be reached? Is it as Commissioner Ferguson said let's tweak the numbers. But I think that we as the Commission, we're not the experts on that and we need to rely on experts for that and what we've got here is dueling experts. I mean, to me, one option is -- and by no means there's probably five others -- we send the language out in two different -- or we send it out for comment again about charge five and anything else, we also send it out with that two separate drafts on the proposed language for the med psych and the differential that we found that Mr. Walker talked about, to see what the comments are about that and we can send it out as separate public hearings, if you will, one with the proposed language, one without. So, Beth, to your point, it doesn't hold it up. We may not get a resolution even after public comment about charge five. And at that point what we probably could do as a Commission -- I'm going to look to Brien or Beth -- we could always as a Commission accept all of the elements except charge five, for example, and throw that again out for

another workgroup to look at and hopefully reach a compromise. I think that's within our ability to do. So that's a potential, try to work something out, hear the public comment, see if there's a potential compromise. It's going to take time, but, again, I think it's in the best interest of psychiatric care in the state of Michigan to do whatever we can to equalize it, but also as Beth said, to expand it because we know the need is there.

DR. FERGUSON: I think that's a great idea. I guess my question would be is if it comes back unresolved after it goes out for comment, et cetera, et cetera, which I think is perfect and if we're able to bifurcate it and say, okay, we're going to adopt all of this except charge five which we're still struggling over, I think I heard you say kick it back to another workgroup. Maybe at that point we try to kick it out to a SAC, maybe we make another run at creating a SAC so it's more fully empowered and balanced. And I don't know if that would work or not. I don't quite understand all the moving parts here.

MR. FALAHEE: My goal, we always like SACs when we know there's different sides trying to battle it out. Maybe we can try to form a SAC, or if we get the sense we're really close and maybe a workgroup could come together and resolve this all the better and it'd be faster at that point.

DR. MCKENZIE: So I think what I'm hearing is a proposal, if that's what you're making, on the table to put out the feedback from the workgroup that included the proposed language for charge five that would change it to including the exclusion to the HSA so that we can get more public comment back with the understanding this is proposed language and we're looking for that public comment and the idea that when this comes back we will have that discussion again, and if we don't feel like we're any further along, we have the opportunity to pull back out charge five and re-look at this in a different way.

DR. FERGUSON: Why wouldn't you send the workgroups' recommendations as is out?

DR. MCKENZIE: The workgroup basically, I mean, the recommendation was we drafted language, we'd like the Commission to decide whether that language should go in or not. The Department is not supportive of the language. They're supportive of existing language. So we can go either way. We can leave the language out, we can put it in, either way we can handle charge five when it comes back. I don't know what your recommendation was, whether we put the language in or -- maybe I misinterpreted what you were recommending, so --

MR. FALAHEE: This is Falahee. My recommendation was send it out for public comment with the understanding

that there's a issue with charge five and that there is -- there was lack of full agreement within the workgroup and to seek public comment on that charge five, either side. Either support the current language as the Department does or support changing in the language and what the various constituent organizations have to say one way or the other to help us as a Commission hear what the reaction is about the public -- in the public comment, and then when it comes back to us we have a discussion. So that's -- that's where I was coming from on that issue.

DR. MCKENZIE: So can I ask another clarifying -- this may seem like a really silly question so I apologize for it. But if we want to seek public comment on that charge five specifically and we don't include the proposed language from the working group, would it be part of the public comment, I guess? You know -- does that make sense?

MS. NAGEL: I'm struggling with some of those same questions, actually. That it's a very important process point and I see Brien has his hand up. When I heard the proposal, I had envisioned actually three separate drafts. Right? We're talking about charge five not changed, charge five changed, and then med psych changed. And my concern was, is because if any of those drafts come back to the Commission and the Commission says -- if they're all in one and the Commission takes one out, it goes back out to public

comment again. So I don't want to hold up the changes that there were consensus on. Brien, have I understood this correctly or am I over thinking it?

MR. HECKMAN: Yeah, I think you and I are on the same page. The -- that's -- how many of these you want to move forward with is the question. As far as let's say we had all three drafts -- because currently this third draft we don't have anything specific to. Is that accurate? This third option is still nobody has a draft regarding that?

MS. NAGEL: Do you mean the med psych?

MR. HECKMAN: Yeah.

MS. NAGEL: It's in the report from Dr. Jain, yeah.

MR. HECKMAN: Okay. I apologize. If we have all of the draft language, then we can move forward with all of them. Your point about one kicking the others out is probably what would happen. I suppose it depends on what the issue is. As far as moving forward with public comment, one thing that you might just do is indicate in the notice itself that there are these specific issues so that it kind of highlights it for the public so that people are keyed in to commenting on those issues.

MS. NAGEL: Thank you. That cleared up my --

DR. MCKENZIE: Go ahead Commissioner Falahee.

MR. FALAHEE: So to Beth and Brien -- I do not

like the reverb we get in this room when we're all together like this. So what I'm hearing is what, like, could potentially do is send out, if you will, three matters for public comment. The first is the med psych definition; the second is the workgroup language without changing the current language that's talked about in number five, keep the current language; the third is the workgroup language with the proposed change in that charge five language. So there's the three, if you will, segments of public comment that we would be sending out for public comment if I'm hearing what people are saying and trying to read the tea leaves here. Does that work, to Beth and Brien, does that make sense?

MR. HECKMAN: Yes, and that's fine as far as I'm concerned.

MS. NAGEL: My only concern is that they are three distinct drafts and that's what I believe that they would need to be.

MR. HECKMAN: I would agree.

DR. MCKENZIE: Commissioner Turner-Bailey?

MS. TURNER-BAILEY: Commissioner Turner-Bailey. I am against sending out three drafts. I guess I'm not, you know, we -- this -- obviously these issues are extremely complicated. They are complicated enough. I feel that we're moving down a road to complicating them to a point

where we could never come to a resolution or at least not a timely resolution. So if we're going to vote on that, you'll -- you know what my vote is going to be. I don't -- I don't see how that's going to help anything. Because if we decide as a Commission to send -- you know, let's say the med -- we'll leave the med surg one alone. The charge five language, we can make a decision here as to which language we want to send out for public comment. Right? That doesn't keep -- if we say we're going to send the current language out for public comment, that doesn't keep the public from commenting that they think that language should be changed; correct? So I guess I'm -- this -- I thought I had a question, but I guess I have a statement. And that is I believe that, you know, dealing with the one issue, we have to deal with that. And then -- but the second one I think we can make a decision as a Commission do we want to put the proposed language or the current language out for public comment and keep -- try to keep it a little bit more simple. It's not going to be simple. But I think we're going to get the same responses either way.

DR. MCKENZIE: Thank you. I think that's helpful, you know, helpful feedback. I keep forgetting to see you down there. Thank you.

DR. MACALLISTER: Back in the corner. Commissioner MacAllister. I also support that concern and

the proposed language as it was presented. The Department has weighed in and provided us their guidance as well, so I feel comfortable supporting the proposed language by the Department and not complicate it and allow for the public to make further comments on that language.

DR. FERGUSON: (inaudible). Ferguson asking for a point of clarification. So with respect to charge five, you would suggest that that which we send out is the Department's recommendation of no change in language, not the workgroup's recommendation of change in language? That's fine.

DR. MACALLISTER: Yes, you're -- yes.

DR. FERGUSON: I just want to be really clear with -- because there's a couple of shifting proposals here. One is to send it out with the workgroup's language, one is to send it out with the Department's language. Just want to make sure I know which one we're proposing to --

DR. MCKENZIE: Okay. So -- Commissioner --

DR. MACALLISTER: Commissioner -- I just feel like it's important to recognize as our -- as the Commission's responsibility for access as you duly noted earlier, I think that we have not been proven that the revision that was proposed by the workgroup provides greater access for the -- for the requirement. So that is -- that is really our essential duties here and that's where I feel is that --

strongly that we need to go forward with it as written and recommended.

DR. MCKENZIE: Okay. So I just want to summarize what I'm hearing here which sounds like -- and I want to clarify with Commissioner Turner-Bailey and Commissioner MacAllister, sorry. What I'm hearing is a desire to move forward with one proposed language and Commissioner MacAllister I think is proposing we move forward with the Department language for public comment. Did I also hear in that we have this other complexity issue on the technical update that we don't want to slow down kind of the language that the workgroup has come out with, but also want to deal with the technical update potentially in a timely way is what I've heard other Commissioners. So is there agreement potentially and then also splitting off the update to the language to make sure that we are consistent with LARA and other regulations and have two separate drafts and language dealing with those two separate issues but not have the third draft? Would that be agreeable to you Commissioner Turner-Bailey?

MS. TURNER-BAILEY: This is Commissioner Turner-Bailey. I would agree with that. And I guess I also wonder -- I'm just going to ask a question -- why can't we wait to get a response from LARA or, you know, to get a better idea of what their thoughts are on that before we

move forward? And are we -- is that an extremely extensive process?

MS. NAGEL: It shouldn't be an extremely extensive process. I am comfortable with having enough time between Commission taking proposed action today and being able to talk to LARA. The only thing that I am concerned about is them having changes that would then have us repeat the process again later. That's all that I really don't know at this time.

MS. TURNER-BAILEY: Okay. Thank you. So, yes, what you said is what I would recommend.

DR. MCKENZIE: Commissioner Haney?

MR. HANEY: Okay. Commissioner Haney. Just a question for Brien. Can -- if we send out a draft with the language as written as it relates to charge five for public comment, can the public comment on something that's not there?

MR. HECKMAN: Well, I mean, it's going to be tied to what they're reviewing. So ultimately when it comes back (inaudible). Assistant Attorney General Brien Heckman. Ultimately what comes back to the Commission is what they've reviewed and if there's a substantive difference, making comment on it however they want to comment. So once they -- they're not limited by what we send to them. So if we send them one version, everybody could comment and in essence

comment on another version that's not necessarily before them. That's free for them to do in public comment. So -- does that answer your specific question? Ultimately what comes back to the Commission is only going to be what has been at public hearing.

DR. MCKENZIE: Okay. So is everybody clear with the options on the table? If so -- I'm seeing nodding heads -- I would entertain a motion related to either the added language or the workgroup recommendations and Department recommendations.

MR. FALAHEE: So this is Commissioner Falahee. Let's give this a shot. I don't know -- my brain goes slow, so my talk will go slow given what we've discussed. My motion is as to the technical language, to send that technical language out for public comment. Once that technical language is agreed upon between the Department and LARA and hopefully we can schedule a public hearing not too distant in the future to allow LARA and the Department to come up with that language so it can be reviewed at the public hearing. That's part one of the public hearing. Part two would be to send out for public comment the language or the language proposed by the workgroup but with no change in the language that was discussed as part of charge five. In other words, the Department recommendation to keep the current language as is. And then also with my

motion then would be to send that language out for public hearing and to the Joint Legislative Committee as well. And that would be my slow motion. Thank you.

DR. MCKENZIE: (inaudible).

UNIDENTIFIED SPEAKER: (inaudible).

DR. MACALLISTER: Commissioner MacAllister, support.

DR. MCKENZIE: We have support for that motion. It looks like the Department's trying to weigh in. Beth?

MS. NAGEL: Yeah. Just one point of clarification if you don't mind. I heard in your proposal that the Department can work with LARA and then send it out for public comment. So that gives the Department some leeway to maybe change a couple words if we need to based on that agreement with LARA, is that a correct interpretation?

MR. FALAHEE: (Nodding head in affirmative). I was nodding my head "yes," but people can't see that. So the answer is "yes." Thank you, Beth.

MS. NAGEL: Thank you.

DR. MCKENZIE: Any further Commission discussion? Okay. I'm going to call for a vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Support.

MR. WIRTH: Falahee?

MR. FALAHEE: Support.

MR. WIRTH: Kondur?

DR. KONDUR: (inaudible).

MR. WIRTH: Haney?

MR. HANEY: Support.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Support.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Support.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Support.

MR. WIRTH: Ferguson?

DR. FERGUSON: Support.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Support.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 11:27 a.m.)

DR. MCKENZIE: Thank you, all. I feel like we just ran a marathon together. So we are -- we have a number of items left on our agenda. It is 11:30. We can push through a little bit further. I am not sure that we will get through the entire agenda, so I think we will be taking a break at some point. We have two more items for the initial proposed language change. Our hope had been to get through those before we would take a break. Are folks okay if we continue to go for another 20 to 30 minutes? Nodding

heads -- or do you need a break now? It's okay to say "no."

MR. WIRTH: Just --

DR. MCKENZIE: Okay.

MR. WIRTH: -- yeah, are we going -- moving forward? Is that --

DR. MCKENZIE: That's what I'm trying -- that's what I'm trying to assess, if folks need a break or not. Good? Okay. All right. If we go too long, I will break us for sure. So we'll be breaking in the next 30 minutes. Okay. Next up we have PET SAC final report and draft language and we have Dr. Myers.

DANIEL MYERS, M.D.

DR. DANIEL MYERS: Yes. Good morning. I'm sorry I couldn't join you in person, but I'm here virtually. So thank you for the opportunity to serve on the PET SAC. For those that don't know me, I'm a nuclear medicine physician at Henry Ford Hospital and I'm the vice chair of radiology there. And special thanks to Kenny Wirth for all his help during the process. It was very useful. And offer a brief ray of hope to the Commission members. This was all very non-controversial, at least among the SAC members. If we could go to the next slide, please?

So our charges were to review the oversight requirements to initiate mobile and fixed services in Section 3 with specific attention to review the following:

review the methodology for computing PET data units, initiation volume requirements, and whether to include accreditation requirements. Next slide.

So what the group felt was there has been a substantial change in clinical PET with a lot of tumors that are being imaged that weren't accounted for in the formulas. And we've probably seen the most progress in prostate cancer and neuroendocrine tumors. So we felt that those should both be included with prostate cancer. There's been an explosion of PSMA imaging. We wanted to use the same formula that were being used for the other significant cancers: lung, esophagus, colorectal, lymphoma, et cetera. So we just wanted to include prostate. Neuroendocrine tumors -- and these are all these somatostatin receptor imaging agents that proliferated. Although the tumor isn't so terribly common, imaging of the tumor is quite common. We were having a little trouble coming up with the best methodology because these tumors occur in multiple sites -- not on these slides, but in the formal recommendations I turned in. We kind of came up with our best efforts at identifying specific C co- -- C or site codes and morphology codes to kind of give a comprehensive inclusion of these tumors and also felt the formula that we wanted to use for prostate that's used for all the other major cancers was a reasonable formula. So those were the main things we wanted

to add. We did discuss cardiac sarcoid and non-ischemic cardiac conditions, we discussed dementia and neurodegenerative disorders and fever of unknown origin which are all additional indications for PET but are not accommodated in computing PET data units currently. We did not feel, A, that these volumes were super high and, B, it didn't readily lend itself to easily trackable, verifiable data that we could use to compute PET data units. So we basically recommended that could be reevaluated at a future SAC if these could come more common imaging indications but we decided to have no actions on those particular topics. So mainly just prostate and neuroendocrine. Next slide, please.

For the initiation volume requirements for mobile and fixed sites, the SAC recommended no change to the volume requirements, particularly since we were increasing potential PET data units by adding these other two malignancies. We didn't want to have a double hit by dropping the volume requirements. So we thought that should be left alone. Next slide, please.

Regarding the inclusion of accreditation requirements. The SAC recommends no change. To our knowledge, no other imaging relating to the CON standards required accreditation. We thought it would add a disproportionate financial burden on some low volume sites

that could potentially inhibit access. So we recommended against accreditation requirements. Next slide.

Just want to comment on requirements to initiate a PET scanner service. Within Section 3 there is an area that talks about the services that a PET site must have or contract with a nearby hospital. It was ambiguous to us whether this was included in the scope of our charges. We did ask for clarification and were initially said to not rule on that. We asked again because there was some concern that we were missing something. It was somewhat ambiguous. Our group did briefly discuss this and decided not to make any recommendations on it since it was unclear if that was in the scope of our charges and we thought it was a fairly in-depth topic to tackle as one of our members had been on a workgroup that was unable to resolve this particular issue. Next slide.

And then the blanket statement to consider any other technical changes from the Department. We had no additional changes that we were recommending. Next slide, please.

So basically that's all I have and I'm certainly open for any questions.

DR. MCKENZIE: Thank you so much for your work on this. We greatly appreciate your leadership, Dr. Myers. And also coming here today to present this information to

the work- -- or to the Commission. Any Commissioners with questions for Dr. Myers?

MR. WIRTH: I do have one addition. After, you know, the SAC concluded, we did find one section that was misreferenced. I believe it referenced Section 11, and we're updating that to Section 12 which it should actually be referencing. So that's -- that's the only technical change and, of course, the dates at the bottom. So I just wanted to clarify that there was one technical change found.

DR. DANIEL MYERS: Thank you.

DR. MCKENZIE: Thank you. Commissioner Ferguson?

DR. FERGUSON: Yeah. This is Commissioner Ferguson. Thank you for your work on this. Of what you presented, was any of it controversial? And if so, what were the sticking points?

DR. DANIEL MYERS: No, it wasn't controversial. Every -- everybody wanted to include the prostate and neuroendocrine tumors. Some people felt a little more strongly than others about the inclusion of additional things like cardiac sarcoid and dementia, but that backed down as when we got to the point of saying, well, how do we include it because we could not come up with a verifiable and trackable data on that topic. And so it was a very agreeable group of people to be honest. It was a pleasure to work with them. So, no, there really wasn't any strong,

controversial topic. And even the question of the one charge, whether it was in the scope or not of the scope, we did a vote. It was -- there was a almost split vote on whether to even discuss it further. And once discussion did start, it was rapidly decided to not pursue it. It was a pretty -- there was a lot of consensus in what we discussed.

DR. FERGUSON: Thank you. And then to follow-up, kind of probing at the same general topic is were you able to get fairly broad-based membership on your working group?

DR. DANIEL MYERS: Yes. I think we had a good -- a good representation --

MS. TURNER-BAILEY: This is a SAC.

DR. DANIEL MYERS: I'm sorry?

DR. FERGUSON: Oh, this is a SAC, sorry, yeah.

DR. MCKENZIE: This was a SAC.

DR. DANIEL MYERS: This was a -- yes, it's a SAC.

DR. FERGUSON: (inaudible) about it. Thank you.

DR. DANIEL MYERS: We were fortunate to be able to seat a SAC actually. And I think we had a pretty good, broad representation of physician experts and non-physicians and people with knowledge of specific disorders and former members, members of former workgroups who brought a little historical perspective in. So, no, I thought it was a very good representative group that the Commission was able to get together.

DR. FERGUSON: Sounds like great work. Thank you.

DR. MCKENZIE: Any further questions from the Commission? Otherwise we'll go to public comment. Is there any public comment?

MR. WIRTH: I haven't received any comment cards on PET standards.

DR. MCKENZIE: Great. I will open it up for Commission discussion. If there's no discussion, then we can entertain, again, this is a proposal for draft language submission to public comment and the JLC.

MR. FALAHEE: This is Commissioner Falahee. Make a motion -- first of all, Dr. Myers, thanks so much again. We all say that, but having served on SACs and workgroups, it's a lot of work, a lot of herding of cats even if they are agreeable cats. So thank you for all your work on this. Very much appreciated.

DR. DANIEL MYERS: You're very welcome. I have been conned into doing a workgroup for a CT CON next, so you haven't scared me off yet.

MR. FALAHEE: Well, thank you for that. We'll keep your phone number handy. I would make a motion to send this language out to public hearing and to the Joint Legislative Committee.

DR. FERGUSON: I'll second that. Ferguson.

DR. MCKENZIE: Thank you. Any further discussion?

Okay. We'll take a vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 11:37 a.m.)

DR. MCKENZIE: Thank you, all. We're going to run through one more item. We have the NICU standards and some draft language. And I will turn it over to the Department. I believe Kate is leading us through this discussion.

MS. TOSTO: I just want to make sure that microphone is picking up my voice.

DR. MCKENZIE: Yes. We can hear you.

MS. TOSTO: During the January CON meeting, the Commission requested the Department draft language for consideration that would clarify how the standard is enforced. The proposed language specifies that staff must be available onsite 24 hours a day, seven days a week and this is found in Section 9 and 12.

DR. MCKENZIE: Thank you. The proposed language is in your packet. I'll open it up for any public comment first on the proposed language changes.

MR. WIRTH: I haven't had anyone submit comments on NICU services.

DR. MCKENZIE: Okay. And I will open it up for Commission discussion. Just a reminder, this came out after our last review that we asked the Department to clarify and define something. They've proposed that 24/7 standard and that's what's before the Commission today, is inclusion of that for public comment and JLC. Commissioner Falahee?

MR. FALAHEE: This is Commissioner Falahee. I'll go ahead and make a motion to send this language that they presented out to the public hearing and to the Joint Legislative Committee.

DR. ENGELHARDT-KALBFLEISCH: Commissioner

Engelhardt, support.

DR. MCKENZIE: Thank you. Any further discussion on that? Okay. We can take a roll call vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: (inaudible).

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 11:39 a.m.)

DR. MCKENZIE: Great. Okay. Well, as promised, we will now take a break and then we will be back in ten

minutes. I would ask that everybody be back -- I have 12:40, so please be back by -- or, I'm sorry, 11:40. Please be back by 11:50. Thank you.

(Off the record)

DR. MCKENZIE: Okay. Thank you, everybody. Can you hear me? Perfect. Okay. Thank you for the time for the break and for getting back here timely. Could I ask everybody to mute? Just getting some feedback. Okay. So next on our agenda we have our bylaw update and I'm going to turn it over to Assistant Attorney General Brien Heckman to walk us through that.

MR. HECKMAN: Okay. Assistant Attorney General Brien Heckman. You guys should have received a copy of this resolution amending the bylaws in the Board packet. There were a number of potential issues to the bylaws identified by the CON section of the Michigan Department of Health and Human Services. The principal ones are I think on the screen now. So one of the issues that the CON section identified was bringing back changes to the written charges so that there's -- could be some type of formal approval to those written changes. That is in Article VII B.1. Additionally, the CON section wanted us to address the potential conflict related to a member of a workgroup acting as a lobbyist. And then one of the more substantive changes is in paragraph seven of the resolution amending the bylaws.

It's highlighted,

"No later than five days before each workgroup meeting, the Department must post any materials and relevant background on the appropriate section of the Department's web site."

Does anybody have any questions regarding any of these amendments? Okay. I am not a CON Commissioner, so I cannot move to approve.

MR. FALAHEE: This is Fal- --

DR. FERGUSON: I presume these are viewed as non-controversial from your side and the Department's side?

MR. HECKMAN: None of these changes have -- these changes are all appropriate. That's my opinion.

DR. MCKENZIE: Yeah, just for context -- and I'll move us into Commission discussion. Thank you for the update and summary. Some of the context on this was based on some of the discussion and feedback that we had gotten at our prior workgroup meeting or prior Commission meeting related to, hey, if there are charges, we want to make sure that there are things that come in during the workgroup or the SAC after it's seated. We want those to come back to the Commission to be voted on. So those are my own opinion. I guess there's a bit of a plus/minus. You know, sometimes CON can get -- you know, we can have discussions and hear about lack of flexibility or ability to kind of, you know,

move things forward. So, you know, having some of that flex can be beneficial, but we were getting an increasing number of these and I think that can be difficult to handle as well. So I do think that these are appropriate changes and the other one was just making sure that people are identifying -- just like we identify conflicts of interests that if there's -- if you're representing an interest group or a lobbyist group, that that is being declared at, you know, during some of these discussions. So anything else to add? Okay.

MR. FALAHEE: If you would entertain a motion?

DR. MCKENZIE: I will entertain a motion.

MR. FALAHEE: This is Commissioner Falahee. I move that the Commission approve all the changes as presented by Assistant Attorney General Heckman.

DR. FERGUSON: Second that, Ferguson.

DR. MCKENZIE: Thank you. Any further discussion? Okay. We can go with a roll call vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 11:58 a.m.)

DR. MCKENZIE: Thank you. Okay. Next on our agenda we have the final language and also public hearing summary for MRI Services. So I will turn it over to Kenny to summarize the language changes as well as any public comment.

MR. WIRTH: Thank you. So in your electronic binder you have the draft language that proposed action was taken on at the June 16th Commission meeting. A public hearing was held on July 28th and we received three letters in support. All of this is included in your electronic binder. And the Department supports the language as presented.

DR. MCKENZIE: Thank you. Any questions on that? Do we have any public comment? I don't have any cards here, but do you have any public comments from --

MR. WIRTH: I don't believe we have any public comments on MRI. If anyone does wish to provide comment, please put your name in the chat, but I don't have any at this point.

DR. MCKENZIE: Okay. Any Commission discussion? All right. Then I will entertain a motion to move forward a proposed language which will be forwarded to the Joint Legislative Commission and the Governor for a 45-day review period.

DR. ENGELHARDT-KALBFLEISCH: Commiss- --

UNIDENTIFIED SPEAKER: (inaudible)

DR. MCKENZIE: Are you making the proposal?

UNIDENTIFIED SPEAKER: No.

DR. MCKENZIE: Oh, I -- well, I guess I can make it a proposal. No? Sorry. I'll entertain a proposal. Does somebody want to make that proposal?

MR. HANEY: So moved.

DR. MCKENZIE: Okay. Ferguson? Oh, sorry.

DR. FERGUSON: Yeah, I'm second (inaudible).

DR. MCKENZIE: Okay. Okay. Any further questions or discussion? Otherwise, I will entertain a vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:00 noon)

DR. MCKENZIE: Thank you. Next on our agenda we have the Megavolt Radiation Therapy (MRT) Services which, again, came to us for initial proposal. We're now receiving back with public comment on those language changes. And I'm going to turn it over to Kate to review those with you. They're also included in your binder.

MS. TOSTO: The Commission took proposed action on the MRT standards at the June 16th meeting. A public hearing was held on July 28th, and written testimony was accepted for an additional seven days past that date. Three organizations provided written testimony in support of the proposed language and the Department supports language as presented in the June 16th meeting.

DR. MCKENZIE: Thank you. Do we have any public comment?

MR. WIRTH: I am not seeing any public comment for MRT.

DR. MCKENZIE: Okay. Then I will turn it over for Commission discussion. And if there's no discussion, then I can entertain a motion to move forward the proposed language. Again, this is final action, so the language will be forwarded to the Joint Legislative Committee and the Governor for the 45-day review period.

MR. FALAHEE: This is Commissioner Falahee. I make the motion to approve this language as final action and send it on to the JLC, Joint Legislative Committee, and Governor for their 45-day review.

MR. HANEY: This is Haney, support.

MS. TURNER-BAILEY: Commissioner Turner-Bailey, support.

DR. MCKENZIE: Okay. So we have a motion and a

second. Unless there's any further discussion, we can take a vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:03 p.m.)

DR. MCKENZIE: Thank you very much. Next on our agenda we have a review of the draft CON Commission biennial report which goes to the Joint Legislative Committee. This

summarizes a lot of the information that you get to hear about on a quarterly basis on what the Commission, or what the Department is monitoring, but then also summarizes the standards and what work changes the Commission has made over the last two years. The report is published online. There is also a summary letter to the JLC in your packet. We do need approval on this item. So I will entertain a motion to move forward on submission of the biennial report to the JLC.

MR. WIRTH: Dr. McKenzie? One clarification on that. This will be the approval of the draft. We'll bring a final version of the draft that's updated with anything taken today. We will bring that to the December meeting and then you will take final action to then have us send that to the JLC.

DR. MCKENZIE: Thank you for that clarification.

MR. HANEY: Haney, so moved.

DR. MCKENZIE: Thank you. Do I have a second?

DR. KONDUR: (inaudible).

DR. MCKENZIE: Thank you. Any further discussion? Okay. We can vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: (inaudible).

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:04 p.m.)

DR. MCKENZIE: Thank you. Next we have a legislative update and Kate is going to be providing that.

MS. TOSTO: Of the CON-related legislation that we're tracking there's been little movement, but there's one update on Senate Bill 812 that passed through the Senate in June. It has been sent to the House Health Policy Committee. That bill requires persons who establishes or operates a cardiac related office space/laboratory to register with LARA or pay a fine.

DR. MCKENZIE: Thank you. Okay. Next we have our administrative updates and this is going to be a combination of Kenny talking about Commission and special projects and rural emergency hospital, as well as Tulika who's going to be giving us our CON evaluation section update. Kenny, I'll turn it over to you.

MR. WIRTH: Thank you. So for Commissions and Special Projects, we are working internally to draft language that would address a new hospital designation called a rural emergency hospital at a very high level. It's essentially a hospital without inpatient beds. So there is legislation being introduced that would create this designation for LARA and has some language related to CON. So we are still working internally to figure out how that introduced legislation sort of directs us to do certain things and how we can address that within our review standards. So we're hoping that we'll have something to bring to you to take proposed action on in December.

DR. FERGUSON: Ask a question about that. Commissioner Ferguson. So what's the intent on this new designation and how is it different than -- if it has no beds, no inpatient beds, how is different than a robust emergency room doing 23 hour stays anyway?

MS. NAGEL: That's a good question, Dr. Ferguson, and this is a CMS policy that is being rolled out to the

states and the states are required to implement a framework, particularly the bulk of the work will fall to licensing, but there will be an impact on Certificate of Need. I believe from the federal documents that I've read that the emphasis is to be able to support rural hospitals that may close completely and allow them a path to remain open with a limited amount of services to still continue their caring for their community in some capacity. Others may have a -- you know, a better read on that than I do.

MR. FALAHEE: This is Commissioner Falahee. Beth is exactly right, Commissioner Ferguson. Wearing my other hat, the advocacy hat, what CMS and Congress was hearing was across the country because of COVID, many small hospitals were just hanging by a thread and this would give them an option to give up their inpatient beds, bank them, if you will, and stay open only as an emergency room as a last effort to provide some level of care to the community.

MR. HANEY: Can I ask just a clarification question for me? Because it's always been my impression and maybe I haven't been involved in the financials of a hospital, but that the ED was always a loss leader to the inpatient beds. Is that not the case anymore? That they can operate effectively as just a standalone depending on the market and the situation?

MR. FALAHEE: This is Commissioner Falahee. The

answer is it depends. It depends on where the hospital is located, what's coming in through the door, how quickly they can treat, if they can treat and then they can move them on to another facility. There is one hospital in Michigan that has already publicly expressed its intent when this goes effective to convert to a REH and that's a hospital in southwest Michigan, but I'm not aware of any other that said that they would be converting.

DR. MACALLISTER: Chairman McKenzie?

DR. MCKENZIE: Go ahead.

DR. MACALLISTER: Sorry. I just wanted to also make aware -- I don't know if Americ- -- AHA just published the rural health care closure report that just came out this month and it has some really staggering statistics in regards to the closure rate, 74 percent. And so, yeah, I think that there's some -- it'll be nice to be able to provide some support for that.

DR. MCKENZIE: Yeah. It's definitely a significant issue. Thank you. Okay. So I think that we can turn it to Tulika to provide the other update.

MS. BHATTACHARYA: Good morning (sic). This is Tulika. Commissioners, there are two written reports in your packet. One is on the CON program activities and the second one is a compliance report. As you can see from the compliance report, we continue to follow up CON-approved

projects for a timely completion of those. We are still receiving requests for extensions to either start construction or complete the projects mainly due to the pandemic and other factors affecting financial or construction related activities. So we are working -- we continue to work with our providers appropriately on those CONs and, you know, when appropriate we do expire projects as needed.

Update on the statewide compliance reviews. As you are aware, we are doing the reviews for CT scanner services for both hospital-based and freestanding facilities. We are still in the process of finalizing. We are consulting with our facilities about meeting the project delivery requirements or what requirements they are not needing and finalizing a plan for compliance action and things like that. We will bring a report back to the Commission when it is complete. There was one other MRI-related compliance action in the last quarter.

As far as the program activity report, as you can see from the report we continue to process applications and complete our reviews within the legal and regulatory timelines and happy to report there was only one emergency application in the third quarter. With that said, if there are any questions, I'm happy to answer.

DR. MCKENZIE: Any questions for Tulika? Okay. I

can't recall, do we need approval on these reports? We don't. I didn't think so. Beth, I see your hand?

MS. NAGEL: Yes. I have one more administrative update if you don't mind. A face that you may have gotten to know over the course of the last year is Brad Barron sitting next to me and this is his last Commission meeting with us. He is moving on to a promotion and greener pastures within the Department. So I just wanted to take a moment to say thank you to Brad, and to let you all know why he won't be here at the next meeting. So thank you, Brad.

DR. MCKENZIE: Thank you for the update and thank you, Brad. Congratulations and we wish you all the best and appreciate the support you provided to the -- to the Commission. Okay. Next we have our legal activity report and I'll turn it over to Assistant Attorney General Brien Heckman.

MR. HECKMAN: This is Assistant Attorney General Brien Heckman. The Pine Rest/Havenwyck Hospital litigation is resolved. The period for them to file an appeal by right has passed. At this point I do not expect them to file a delayed application to appeal. If they were going to appeal, they would have done so during the initial period. My understanding is that they may be trying to seek a legislative remedy for their situation. It's the same issue that's been before the Commission in regards to psychiatric

beds and the counting and that methodology so that's I believe the avenue that they're seeking is either having us address it or trying to get a legislative solution. Next month or, I'm sorry, next Commission meeting that will be off the report so you won't have anything on it. Thanks.

DR. MCKENZIE: Thank you. Any questions? We can now open it up for public comment.

MR. WIRTH: First up we have Senator Rosemary Bayer speaking on the Oxford topic. Senator?

SENATOR ROSEMARY BAYER: Thank you. Can you hear me okay? Can you --

DR. MCKENZIE: Yes, we can.

SENATOR ROSEMARY BAYER: Okay. Thanks.

SENATOR ROSEMARY BAYER

SENATOR ROSEMARY BAYER: I appreciate the opportunity. I understand that the group from Oxford spoke earlier today and this was the time that we were given earlier, so sorry I didn't mention to line up with them and I appreciate the opportunity to say just a few words. I've talked to some folks over the last couple years about this. I am the State Senator for the 12th district which includes Oxford, of course, Lake Orion, Addison Township, Oakland Township, other northern, and Clarkston, and independents, northern townships and communities that have expressed a need for a hospital that's closer, that's more within reach.

So you've heard it from us before; you've heard it from them before. I've heard it often from our north Oakland constituents and I lived up there for 26 years until I had an opportunity to experience this issue firsthand. I know exactly what happens and why the complaint happens, why the model doesn't seem to really work as people think it should because of the rural environments. It's a little more complicated than the formula, I think. So all of those communities in the north part of my district and really in all around the edges of Oakland County have been growing pretty dramatically and the medical services haven't really been able to keep up with that from a hospital perspective. There's other circumstances that we need to pay attention to that are particular to rural communities that just add time on to travel. It's that simple. In Oxford and Orion specifically it's a heavy manufacturing and construction hub, a lot of industry, a lot of big trucks. There's big gravel mining there, you know, those two -- two-ganger (phonetic) hauler trucks with gravel in them that, you know, basically stop traffic at any given time and if something goes wrong, can be stopped for a long time. There's really only one main road up and down north and south from Oxford and Orion both to get to a hospital system. So anything that goes wrong, getting stuck behind a truck is frustrating for everyone, but if anything goes wrong, you can easily

add, you know, another -- double the time you're trying to spend to get somewhere. Not a good situation for anybody trying to get to a hospital. Even an ambulance has trouble getting through those -- those circumstances.

There's really -- the other thing about rural communities, there's not a lot of alternatives. And so where I lived, I lived in Oxford Township so I was five or six miles away from the village if anyone's been there and on a dirt road, of course. And when M-2- -- when anything happened on M-24, we all take the dirt roads to go south. I mean, I always did. People around there always did. And even though --

MR. WIRTH: Senator Bayer?

SENATOR ROSEMARY BAYER: Yup.

MR. WIRTH: That's the three minutes.

SENATOR ROSEMARY BAYER: Oh, I'm so sorry. Much longer than I expected.

MR. WIRTH: No, that's okay.

SENATOR ROSEMARY BAYER: Okay. Well, so the last line would really be that it's not just about Oxford. Right? It would be great to have a way to have an exception. That would be one way to look at this issue, but also to look at it with the other extenuating circumstances that relate to suburban versus urban and versus rural (inaudible).

MR. WIRTH: Thank you. Thank you, Senator.

SENATOR ROSEMARY BAYER: Thank you. Bye-bye.

MR. WIRTH: Thank you.

DR. MCKENZIE: Thank you, Senator, for your comments. Any questions for Senator Bayer? Okay. Any further public comment?

MR. WIRTH: Oh, one more comment from Emily Busch also speaking on the Oxford topic.

EMILY BUSCH

MS. EMILY BUSCH: I'm Emily Busch and I'm a local Oxford mom. And I wasn't really sure what to expect when I came today, so thank you for the opportunity to speak. I am also -- selfless or shameless -- I'm running for House District 66, State Representative. And I'm here with a list of concerns from women in our community, anything from a Lego up the nose from a 4-year-old or all the way down to a car accident where a child couldn't make it to an ER fast enough.

So I'm incredibly surprised at I guess the process that all of these things have to go through in order for a local hospital to be built obviously where there's a need, but I didn't expect to hear an entire section on the wording of the psychiatric wording for adolescent and pediatric psychiatric needs hospital beds. I'm sure as you're aware there's still fallout from what happened on November 30th

and I personally have had friends where they've had to take their children into an ER, local ER, local, and they would sit overnight waiting for someone to psychiatrically evaluate their child with regard to the intention to harm him or herself. So I guess all that to say, again, I have a list of many moms that are saying that this is a necessity, but I can also say that none of them probably understand the process and the bureaucracy and everything that goes into building a hospital in Oxford. I appreciate Senator Rosemary Bayer coming on and expressing her personal experience and dirt roads and how long it takes to get places. And I know Supervisor Jack Curtis has done a phenomenal job in providing the figures and the statistics that do support. And unfortunately this traffic study where during COVID it shut down the road in addition to the fact we had construction, so it was obviously very skewed data.

So I guess just to go on record here to say as a concerned Oxford mom with a whole slew, again, people with croup, little kids with croup sitting in the backseat while they're gasping for air for a 45-minute drive to an ER, someone having an issue with a pregnancy. So another interesting aspect is this new designation of a hospital being just an emergency department, how that would benefit. I know that McLaren has announced their intention to improve the facility that we have. I know it's an ambulatory

facility. But clearly there are many more comprehensive medical issues that would require someone to go to a larger facility but to be stabilized locally before transferring to a larger facility I think would serve our community.

So I just wanted to say a few things as a layperson. I appreciate the process and this is absolutely, I guess, a wake-up call to understand all that goes into this. So thank you for allowing me to speak and please consider the hospital in Oxford.

DR. MCKENZIE: Thank you. I want to thank the -- are there any further public comments before I --

UNIDENTIFIED SPEAKER: Yes. We'd like to --

DR. MCKENZIE: -- I'll reiterate. Oh. Yes.

MR. PHIL LEVY: Hi.

PHIL LEVY

MR. PHIL LEVY: I'm so sorry. This is Phil Levy and I'm on here with Tom Hartle. We represent Mobile Insite which is an entity that was formed through the pandemic, because of the pandemic, to bring COVID-related screening services into the community. And we have developed a new vehicle, a mobile unit that has a small CT scanner that we can put in the unit. It's the size of an ambulance. And we would like to be able to bring this service to communities, working with public health departments for citizens of the state of Michigan that have been suffering from COVID and

long COVID symptoms related to persistent shortness of breath and other pulmonary symptoms. And effectively what we want to be able to do is bring free -- not charging a patient, not charging an insurance company, not charging anybody -- free clinical screening CT scans using our mobile unit to people who have persistent long COVID symptoms related to shortness of breath so that they can get the care potentially that they need. This is an underutilized modality for this purpose right now. It's very difficult for people with long COVID symptoms to get such screening services and we would like to request a -- you know, a waiver of Certificate of Need to be able to bring this important public health service to the community.

DR. MCKENZIE: Thank you for your comment. Any questions or comments from Commissioners? I think Commissioner Falahee?

MR. FALAHEE: This is Commissioner Falahee looking to the Department. The "service" that Mr. Levy's talking about, would that be a covered clinical service under any of the current standards under CON?

MS. NAGEL: Thank you for that question. We do not believe that it currently is a covered clinical service under CON. We -- excuse me, I'm sorry. Maybe I answered the wrong question. I don't believe that it's something approvable within the current standards is what I mean to

say, and that certainly the Department provides waivers in certain circumstances. It's usually when it does meet most of the criteria, but there's something extenuating or some sort of a circumstance that needs to be waived. In this case, you know, it's clearly an imaging modality of some kind that does fall under the CON-covered clinical services but isn't approvable in the current standards.

MR. FALAHEE: Commissioner Falahee. Thank you for reminding me or interpreting what I meant to say. So thank you, Beth. I understand now. Thank you.

MR. TOM HARTLE: And this is Tom --

DR. MCKENZIE: Currently cover but -- oh. Go ahead.

MR. TOM HARTLE: No. Finish your thought. I'm sorry.

DR. MCKENZIE: I think there's a question, so --

DR. KONDUR: (inaudible).

TOM HARTLE

MR. TOM HARTLE: As Dr. Levy mentioned, I'm a part of this. So in that last comment, does that mean that something --

MR. WIRTH: Mr. Hartle? I'm sorry. If you could wait one moment, please?

MR. TOM HARTLE: Oh, yes, sir.

DR. KONDUR: Commissioner Kondur. (inaudible) CT

scanning to extensive lung damage and these people are putting at risk for having a lot of cardiac events, too, hypoxia related. Is there any room to go under (inaudible) waiver to approve in the direction of CON?

MS. NAGEL: Within the current standards there is -- is that me? Am I doing that? Oh, okay. There is provisions for research related CT scanning. Those are for fixed, not for mobile. There isn't anything in the current standards that would give the Department the ability to say, you know, even though this is really good and it's free of cost and you're doing a public service, there isn't really anything in the standards that would allow us to waive this type of imaging.

DR. MCKENZIE: I have a question. I just noticed, you know, what I heard, Beth, was that this is covered under the CT standard, but it's currently not an approvable service. I also note that on the work plan that we have a CT informal workgroup, it's in the process of meeting right now, that gets into some of what we have discussed as a Commission about adding additional charges and that if things come up. But I guess the (inaudible) would be do we have the -- would it be an option for the Commission to request that since the CT workgroup is meeting, that this be something that be looked at? Is that an option available to us?

MS. NAGEL: Yes, that is a perfectly acceptable option.

DR. MCKENZIE: Okay. So I'm not making a suggestion. I just wanted to know what options were available. So --

DR. FERGUSON: The is Commissioner Ferguson. So serving our community is paramount and we know that there's large swaths of our communities that are underserved. That being said, as a radiologist, as a chest radiologist on a regular basis, if I were on any working group looking at this in-depth, I would want to know a whole lot more about what we're actually looking for. If we're looking for chronic lung damage post-COVID, that typically is in the patients who had truly critical COVID earlier on, ICU, intubated, whatever. Long COVID, different conversation. So I think there's a whole lot of data and information around here that we would have to go pretty deep on before I'd have great enthusiasm for waivers to our regular process. Clearly there are communities in need and I'm not trying to get in the way of need, but I would want to have a better understanding of medical necessity.

MR. PHIL LEVY: So if I can -- I'm not sure if it's appropriate to respond? Is that --

MR. WIRTH: I'm sorry.

DR. MCKENZIE: I think we -- I think have another

Commissioner point here and then -- yeah. Go ahead.

MR. FALAHEE: Yeah. So this is Commissioner Falahee picking up on what Commissioner Ferguson said and looking at Brien down the table. Given the bylaws changes we just approved, if we wanted to add this topic as a charge for the workgroup, what the Commission would need to do, Brien, would be to approve adding that specific charge under the new bylaws; is that correct?

MR. HECKMAN: (Nodding head in affirmative)

MR. FALAHEE: Okay. Answer was "yes" for those that didn't hear it. So I'm not making a motion at this point because I understand there must be at least one or two other people that may want to speak on this topic. But I just wanted to make sure what our options are going forward. Thank you.

DR. MCKENZIE: Thank you. Any other Commission questions right now for Dr. Levy? Okay. Do we have further public comment?

MR. WIRTH: I think Tom Hartle might want to speak on this Mobile Insite thing, too.

TOM HARTLE

MR. TOM HARTLE: Yeah. The only thing I wanted to add is that it's also very much educational which, while Dr. Levy handled the -- would be handling the clinical side and he can go into more detail, a large component of this, too,

is the dissemination and distribution of more education in the -- into the sort of these hardest hit communities. And certainly if we were to go into a workgroup, we could bring more detail and discussion as to what we're specifically speaking about and then with the health departments that we've talked about who are interested in these kind of services, my company CoherentRx, provides the infrastructure for 45 health departments across the state to get information on vaccines to case investigator, investigation forms throughout the state. We've been doing it for a number of years. So this is an extension of some of the work that Dr. Levy and I have been doing across the country -- or across the country -- across different counties and health departments in Michigan. So I just wanted to add that comment. Thank you.

DR. MCKENZIE: Thank you. Any further Commission questions? Any further public comment?

MR. WIRTH: I do not have any names in the chat wishing to provide public comment.

DR. MCKENZIE: Any other Commission discussion? Okay. So next on our agenda is the review of the Commission work plan which you have in your packet. And, Kenny, I believe you're going to walk through the work plan?

MR. WIRTH: So the work plan is in your electronic packet. Sorry. Let me get my screen back up here. So

based on the work that was completed at today's meeting, we will add public hearings for the two drafts of the Psych Beds language, one including the Med Psych language that we will work with LARA to finalize before sending out, and also the draft as presented today in your packet. We will also schedule -- or we will send -- we will have public comment for the PET Standard Advisory Committee. Their draft language, that'll happen sometime in October or November. And then we will also hold one for the proposed action taken on NICU Services and we will include that all in the updated work plan. And then MRI and MRT will be transmitted to the JLC and the Governor's Office for a 45-day review. So hopefully if things fall -- you know, the dominos fall the right way, we will have Psych Beds, PET and NICU back at the December meeting for final action.

DR. MCKENZIE: Great. Thank you for the update. Any questions on that? Commissioner Falahee?

MR. FALAHEE: I think the Commission needs to approve the work plan. I would make a motion to approve the work plan as Kenny just presented it.

DR. KONDUR: (inaudible)

DR. MCKENZIE: Thank you. We can take a roll call vote.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: (inaudible).

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:35 p.m.)

DR. MCKENZIE: Great. Thank you. This is where it usually rolls through pretty quickly, but we are making a little bit of a slight process change and have a little bit of a discussion -- oh. Can you hear me? Can others hear me? I'm sorry. You don't hear me. Can others hear me? Oh, it's you. Okay. All right. I'm trying to figure out the audio here in the room. So we are going to -- you can

see your future meeting dates on the agenda. I've got a little bit of back feed here.

UNIDENTIFIED SPEAKER: July 15th is a Saturday/

DR. MACALLISTER: July 15th is a Saturday I'm hearing?

DR. MACALLISTER: So just July 15th is a Saturday. I think it's supposed to be July 13th.

MR. WIRTH: Let me correct that real quick. Thank you for catching that. I'm just zooming through my calendar. Yes. Yeah, we'll correct that and we'll do the 13th; July 13th.

DR. MCKENZIE: Okay. Wonderful. So we are actually going to be voting on the meeting dates. So with the suggested correction of July 15th to July 13th, I would like to have a vote to approve this. We also wanted to have a bit of a discussion before we entertain that.

MR. WIRTH: Oh, I apologize. That should be June 15th, not July. My apologies. I found it. We have the room booked for June 15th, not July. Apologies for that.

DR. MCKENZIE: Thank you. And we'll make sure that we make that correction. And before I take a vote on future meeting dates, one of the items that we wanted to raise briefly, both myself as well as Vice Chair Falahee, have had some discussions about the context of our meetings. We have been doing this hybrid meeting. I know that it can

be a bit of a challenge. We've got back feed, we've got, you know, challenges sometimes hearing testimony that we continue to work through and so wanted to bring it before the Commission. We would still have to make accommodations for those that would have a disability because of the Open Meetings Act, but the idea that for those that are testifying or for those that are speaking at a Commission meeting that we would -- because the Commission has to be here in person -- we would ask that that happen in person as opposed to trying to accommodate and handle this virtually because of the challenges that we have just technologically. It actually adds probably additional time, additional complexity to the meetings. I will tell you as the chair it is -- it's already complicated handling this meeting and then adding in the dynamics of technology and if anything goes wrong, just the complexity there. So wanted to bring that before the Commission for discussion, you know, your thoughts. We certainly would need, you know, approval of the Commission in order to move forward with that, but wanted to bring it up. And Vice Chair, I'll ask you if you have anything else you want to add?

MR. FALAHEE: I hate to say it, but I just lost my Wi-Fi connection so I'm not tied up to the Zoom anymore. I agree with what Commissioner McKenzie said. It'd be a lot easier on all of us without echos, without reverberation.

MR. WIRTH: Just to reiterate what Commissioner Falahee said. It would be a lot easier if comments were provided in person to not have to deal with feedback and reverberation and the loss of Wi-Fi connection.

DR. MCKENZIE: So I'll open that up to Commission discussion and any thoughts.

DR. MACALLISTER: Commission MacAllister. Just was curious in regards to the proposal. Is that anyone making public comment would have to be in person, we would still be able to retain or attain written comment virtually? Is that accurate?

DR. MCKENZIE: I'm just saying because of the Americans with Disabilities Act that (inaudible) availability for those that have disabilities can request and send out the information. I'm trying to even recall (inaudible) previously. We did not. So it was not broadcast -- it was not broadcast virtually prior to the pandemic. We would need to make it available for those that would reach out individually and anybody could reach out to, you know, the Department or Assistant Attorney General Brien Heckman for those accommodations, but outside of that we would not be providing the accommodations.

MR. HECKMAN: So Assistant Attorney General Brien Heckman. So just to chime in. You would basically go back to the traditional sequence. So that if anybody had a

disability that would prevent them from attending, they'd notify the Department and then the Department can make a reasonable accommodation. Depending on what that reasonable accommodation is, that may be virtual participation. But the default is going to be the meetings are in person for everyone, without broadcast.

MR. WIRTH: And this is Kenny with the Department. We are still exploring other options for meeting spaces. There are some available elsewhere within the capital area. We're taking a little field trip after this to explore one option possibly that offer sort of, like, a Webex hybrid system in a board room. So we are still exploring options and I just wanted to add that point to this discussion.

DR. MCKENZIE: Thank you. So I would entertain any Commissioner thought or, you know, if we were to move forward in this direction I believe we would need a vote. Am I correct in that?

MR. HECKMAN: You should vote just to (inaudible).

DR. MCKENZIE: Yup; yup.

MR. HANEY: Commissioner Haney. And I would support being in person. The complexities that we just had trying to have this conversation kind of highlight the difficulties. Even sitting here being virtual just seems a little strange to me and it clearly doesn't work 100 percent of the time, at least in this environment, and I don't see

any reason at this point to not be in person.

DR. MCKENZIE: Thank you for your thought. So I have a motion from Commissioner Haney -- at least I think that was a motion -- to move this to in person outside of those that we would have to provide accommodation for. Do I have anybody that would second that motion?

DR. KONDUR: (inaudible).

MS. TURNER-BAILEY: Just a question/clarification. So we are voting on moving in person, but at the same time we're looking for alternate spaces that may be able to accommodate? Because when we started this, you might recall, we tried to do the microphones and we ended up with this setup because the microphones wouldn't work well in here. But there may be spaces where we could go back to the old, you know, use the microphones and continue with the Zoom. I mean, we have to be here anyway so I guess it doesn't, you know, from that perspective I don't have a lot of feelings about it. But in terms of just changing it over to in person, maybe we could -- I don't know. Maybe you would, you know, amend your motion to say assuming we can't find a reasonable way to conduct the meetings unless you just want to go in person no matter what.

MR. HANEY: I'm open to that.

MR. BRAD BARRON: Just to add to what -- this is Brad Barron. Just to add to what Kenny was saying. So the

state has various technology equipment throughout different buildings. This building is not one of them. So there is plans to add that equipment to these buildings, but this particular building there's been delays with shipping and parts availability and so forth. So what would essentially happen is there would be, I think, a camera in the center of the room and so it would pick up whoever was talking and make it much easier and hopefully more seamless of a process.

DR. MCKENZIE: So am I hearing interest to amend the initial proposal?

MR. HANEY: I'm willing to do that if that's the deal with the Commission, yeah. I'll amend.

DR. MCKENZIE: Any thoughts or discussion?

DR. KONDUR: (inaudible).

DR. MCKENZIE: Okay. All right. I think that Dr. Kondur was seconding the action to, yes, move in person assuming that there is not a better technology solution moving forward. And that would -- I -- am I to understand that that would be by the next meeting?

DR. KONDUR: (inaudible).

DR. MCKENZIE: Okay. Okay. So that's the -- that's the motion and the second that we have on the floor at this point. Is there any further discussion? Otherwise, we can vote on that. Okay.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: (inaudible).

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: I'm going to abstain.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:46 p.m.)

DR. MCKENZIE: Thank you all. I'm going to take a secondary vote, entertain a vote on the meeting dates amended to reflect the change to June 15th, 2023, that are reflected in your packet and on your agenda.

MS. TURNER-BAILEY: Commissioner Turner-Bailey.

So moved.

MR. HANEY: Commissioner Haney. I'll support.

DR. MCKENZIE: Thank you. And we can vote.

MR. WIRTH: Sorry. I was just getting the motions down. We have McKenzie?

DR. MCKENZIE: Yes.

MR. WIRTH: Falahee?

MR. FALAHEE: Yes.

MR. WIRTH: Kondur?

DR. KONDUR: Yes.

MR. WIRTH: Haney?

MR. HANEY: Yes.

MR. WIRTH: Engelhardt?

DR. ENGELHARDT-KALBFLEISCH: Yes.

MR. WIRTH: Guido-Allen?

MS. GUIDO-ALLEN: Yes.

MR. WIRTH: MacAllister?

DR. MACALLISTER: Yes.

MR. WIRTH: Ferguson?

DR. FERGUSON: Yes.

MR. WIRTH: Turner-Bailey?

MS. TURNER-BAILEY: Yes.

MR. WIRTH: Motion carries.

(Whereupon motion passed at 12:47 p.m.)

DR. MCKENZIE: Thank you. We've reached the end

of our agenda. Thank you. This was a long one. I appreciate you all hanging in. I will take a motion to adjourn.

MR. HANEY: Haney. So moved.

MR. FALAHEE: Support.

DR. MCKENZIE: All those in favor say "aye"?

ALL: Aye.

DR. MCKENZIE: Any against? Thank you all. See you in a few months. Drive safely.

(Proceedings concluded at 12:47 p.m.)

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