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IN RE: CON HOSPITAL BEDS SAC

COMMISSION MEETING

December 07, 2023



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

COMMISSION MEETING
BEFORE JAMES FALAHEE, CHAIRPERSON
333 South Grand Avenue, Lansing, Michigan
Thursday, December 7, 2023, 9:30 a.m.

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1 Lansing, Michigan

2 Thursday, December 7, 2023 - 9:30 a.m.

3 MR. FALAHEE: So we will call this meeting to
4 order, the Certificate of Need Commission. And I want to
5 start by having our new commissioner, sitting a few people
6 to my left, introduce himself. I told him he had either 45
7 minutes or 45 seconds. He chose 45 seconds or lower. And
8 then I'd like each of us around the table with an equally
9 short, cryptic comment, who are you and where do you work or
10 what do you want to say about yourself. So I'll turn it
11 over to as we say Commissioner Drake -- you now have
12 Commissioner in your title, Archie -- so Commissioner Drake.
13 And just a word of warning, make sure you talk into the mic.
14 And when you do have comments during a meeting, Marcy likes
15 it really if we say, you know, this is Commissioner Drake
16 talking, blah, blah, blah so she knows who it is.

17 MR. DRAKE: Just a few minutes; right?

18 MR. FALAHEE: Yeah.

19 MR. DRAKE: Got it. Got it. Well, good morning.
20 So I'm Archie Drake. I am Commissioner Archie Drake I guess
21 now for 45 seconds. I relocated to Michigan a year ago from
22 the state of Texas. About my background, my entire career
23 has been in health care, hospitals for the entire time out
24 of high school. I won't bore you with the details other
25 than saying registered nurse, then went into nursing

1 leadership positions and for the last 15 years I've been
2 serving in executive hospital roles. You know, the
3 opportunity to join this Commission is a privilege to me. I
4 was honored for the opportunity and look forward to working
5 with you all. I currently serve in Detroit as the CEO of
6 the Children's Hospital of Michigan. Relocated for that
7 position and it's been a privilege being in a great state.
8 So thank you for having me. I look forward to working with
9 you all.

10 MR. FALAHEE: Thanks. And then let's -- am I --
11 can you all hear me out there?

12 MR. WIRTH: Yes.

13 MR. FALAHEE: Okay. Maybe it's my voice. All
14 right. Let's start with -- Tiffani, if you can go,
15 introduce yourself and we'll go around the table? Thank
16 you.

17 MS. STANTON: Tiffani Stanton. I'm a policy
18 analyst in the Commissions and Special Projects section. To
19 my right, just stepped out, was Marcus Connolly. He's the
20 manager of the section.

21 MR. WIRTH: Kenny Wirth. I am a policy analyst in
22 the Commissions and Special Projects section.

23 MS. NAGEL: Good morning. I'm Beth Nagel. I'm
24 the senior deputy director for policy and planning here at
25 MDHHS.

1 MS. BHATTACHARYA: Good morning, this is Tulika
2 Bhattacharya. I manage -- so my name is Tulika
3 Bhattacharya. I manage the CON Evaluation section for the
4 Department and in my team we have the behavioral
5 specialists, the compliance analysts, and our section
6 secretary.

7 MR. HANEY: Good morning. I'm Don Haney,
8 administrator of Thornapple Manor, Barry County's Medical
9 Care Facility.

10 DR. ENGELHARDT-KALBFLEISCH: Good morning. Amy
11 Engelhardt and I am associate chief medical officer for
12 Henry Ford Hospital and medical director of their transfer
13 center in West Michigan.

14 DR. FERGUSON: Good morning. Welcome, Archie.
15 Eric Ferguson. I'm a practicing radiologist. I'm president
16 of and CEO of Advanced Imaging Alliance. I do a fair bit of
17 population health work within the Trinity system and some
18 hospital board work as well.

19 MS. TURNER-BAILEY: Good morning. I'm Renee
20 Turner-Bailey. I am a director of the Social Security
21 Department for the International Union, UAW.

22 DR. KONDUR: I'm Ashok Kondur, interventionalist,
23 medical director (inaudible) for Ascension Health.

24 DR. MCKENZIE: Good morning. Amy McKenzie. I am
25 a family physician. I work at Blue Cross Blue Shield of

1 Michigan as vice president of clinical partnerships and
2 associate chief medical officer.

3 MR. FALAHEE: Good morning, Archie. Chip Falahee.
4 When I'm not taking phone calls from the people in the
5 audience, my other -- my other job is general counsel and
6 legislative person for Bronson Health Care Group, Kalamazoo
7 area.

8 MR. HECKMAN: Good morning. Assistant Attorney
9 General Brien Heckman. I'm the parliamentarian and counsel
10 to the CON Commission.

11 MR. FALAHEE: Thanks, everybody. Another thing
12 before we get started, Beth and Tulika talked about the
13 people that assist them. One of them is in the audience and
14 he's going to be retiring, the bum, at the end of this month
15 so I want to get Perry Smith up here. And I want to say a
16 few words. And I've dealt with Perry for -- dealt with --
17 I've worked with, yeah. Dealt with was a Freudian slip.
18 Perry has worked for the Department for 16 years about;
19 right? Okay. And I've submitted dozens of CON applications
20 and whenever I do that, I say to the team, okay, triple
21 check your numbers because if you miss one number or it
22 doesn't fit, there's this guy named Perry Smith, he's going
23 to catch it and he's going to call me and he's going to
24 go -- here's what he says: Hi, Chip. I've got a question.
25 At that point I know there's something wrong with the

1 application. All right? But to Perry's credit, he's been a
2 terrific person to work with in the CON department, one of
3 many, many, many over the years, always willing to help to
4 say -- to answer questions, to say, yeah, let's -- why don't
5 you look at it this way or that way? And is he a
6 perfectionist? Yes, to his credit. So, Perry, I wanted to
7 publicly thank you for your years of service to all of us in
8 this room in the state of Michigan for reviewing hundreds of
9 applications and letting none of them get by without your
10 review. So, honestly, thank you so much for all you've
11 done. I just wanted to thank you. And if you want to make
12 a few words or comments, you're welcome to do so.

13 MR. PERRY SMITH: All right. Thank you. It's
14 been an honor and a privilege to work for CON almost 16
15 years working with Tulika and Beth and I couldn't ask for a
16 better job and better coworkers. So I'm honored that you
17 say what you're saying and grateful to be a member still of
18 CON for two more weeks.

19 MR. FALAHEE: Thank you, Perry. So if you've got
20 any applications you need to get in, get them in now,
21 please. Thank you. So there. All right. With that, let's
22 move into the business part of the agenda. Many of you who
23 watch the agenda and look at it go, whoa, that's a long
24 agenda. That's because we could not hold a September
25 meeting. Unfortunately we did not have a quorum. Since

1 then, the Governor has appointed additional commissioners.
2 Commissioner Drake is here. One other commissioner could
3 not be here because that person's on vacation. And we all
4 found out who got appointed and reappointed the day before
5 Thanksgiving. So we're happy to have almost a full
6 contingent. There's still one more commissioner that needs
7 to be appointed by the Governor, but we're happy to have the
8 people around the table.

9 So let's call the meeting to order. The review of
10 the agenda, there hasn't been any change in the agenda since
11 it was sent out to us yesterday or the day before, but I
12 entertain approval of the agenda before us as the final
13 agenda for the purposes of this meeting.

14 DR. MCKENZIE: I will move.

15 MR. FALAHEE: Motion on the floor. Support?

16 DR. KONDUR: Second in support.

17 MR. FALAHEE: Thank you. Any discussion? All in
18 favor say aye.

19 ALL: Aye.

20 MR. FALAHEE: Great.

21 (Whereupon motion passed at 9:39 a.m.)

22 MR. FALAHEE: Next is declaration of conflicts of
23 interest. And -- and for Commissioner Drake's purpose, what
24 that means is if you as a commissioner see anything on the
25 agenda that potentially impacts you personally or in your

1 case Children's Hospital only, there's nothing wrong with
2 that.

3 MR. DRAKE: Sure.

4 MR. FALAHEE: Just to disclose it. And one of the
5 tests is if it's something that affects all hospitals,
6 that's not a conflict of interest. But if it's something
7 that's directed, in your case, Archie, to Children's
8 Hospital, then you disclose it. That's why it's always an
9 agenda item.

10 MR. DRAKE: Okay.

11 MR. FALAHEE: So does anyone with that intro have
12 any conflicts of interests to declare? Okay. Hearing none
13 we'll proceed. Next, review of the minutes. Our last
14 meeting was June 15th. Hard to believe it's almost six
15 months ago. The minutes are in the packet. I've reviewed
16 them. They look good to me. But I would entertain a motion
17 to approve or any comments or questions if you have?

18 DR. MCKENZIE: Motion to approve.

19 DR. FERGUSON: Second.

20 MR. FALAHEE: Thank you. Any discussion? All in
21 favor say aye.

22 ALL: Aye.

23 MR. FALAHEE: Opposed? Okay. Great. Those are
24 approved.

25 (Whereupon motion passed at 9:40 a.m.)

1 MR. FALAHEE: So now let's move into the agenda
2 items. And, yes, it is a long agenda. We'll see how it
3 goes. I promise there will be a break. If it gets to be
4 about 11:30-ish and we're still here, I'll make sure we take
5 a break and then proceed after that with whatever is left
6 over. So the first item is Open Heart Surgery Informal
7 Workgroup, the report from Dr. Pruitt whom I know is on a
8 laptop somewhere. But Kenny or Tiffani, I'll let you go
9 ahead and introduce this, please.

10 MS. STANTON: Yep. So all the recommended
11 language in front of the Commission reached a consensus.
12 The Department is including technical edits across the
13 standards to require a notification to the Department no
14 later than 30 days after the planned decrease or
15 discontinuation of the CON service. Proposed action from
16 the Commission will require a motion, a second and a vote to
17 approve. Commission proposed action will move to -- will
18 move the language to a public hearing and to the JLC. A
19 report and language for final action will be brought back to
20 the CON Commission at the March meeting. And we do have Dr.
21 Pruitt on Zoom available to give his report. Can you hear
22 me, Dr. Pruitt?

23 DR. ANDREW PRUITT: I can. Thank you very much,
24 Tiffani. Yeah, if there's any questions, I tried to keep
25 the report brief, but I'm happy to address any concerns or

1 any questions.

2 MR. FALAHEE: Dr. Pruitt, this is Chip Falahee.
3 Can you go ahead and just briefly summarize the report then?
4 And then we'll open it up for questions. Thank you very
5 much.

6 ANDREW PRUITT, M.D.

7 DR. ANDREW PRUITT: Sure. Be glad to. You can
8 see the charge that -- that we were asked to review at the
9 top. It is basically regarding Star Ratings for programs
10 and in particular Star Ratings with respect to the
11 performance of aortic valve replacements. There were
12 several programs who received -- received basically a
13 non-rating. I think this was interpreted as a no star or
14 very poor rating when in fact all it meant was that their
15 volume was too low for any statistical meaning to be
16 attached and so therefore no rating. And so to -- you know,
17 and this came about because of the change in technology in
18 heart surgery over the past ten years. Fully 80 plus
19 percent of aortic valve replacement is now done trans --
20 with transcatheter valve technology and not through open
21 heart surgery. As a result, many programs have low volume
22 of what -- what the -- of the category of what's called
23 isolated aortic valve replacement and basically that means
24 the operation involved replacing the aortic valve and
25 nothing else. So there were several programs with a

1 non-rating due to that. So as it turns out fortuitously the
2 STS has -- is rolling out in 2024 a new metric that takes
3 into account your total book of work. It's called a
4 multiprocedural Star Rating. And basically it looks at the
5 -- there's six operations that have risk stratification and
6 it's going to look at all six of those operations. And it
7 includes things like aortic valve with CABG, aortic valve
8 with tricuspid valve, aortic valve with mitral, aortic valve
9 with maze procedure, in addition to mitral valve surgery,
10 mitral valve repair, mitral valve replacement. So it sort
11 of takes into account for the program the entirety -- mostly
12 the entirety of their book of work. There are still some
13 operations that don't have a risk category or a risk
14 stratification model yet and those are in progress.

15 So we changed the language to not just include
16 AVR, isolated AVR as a Star Rating category to evaluate
17 programs, but added the multiprocedural. And if anyone
18 receives a non-rating, they just basically need to let the -
19 - the Commission if there's a question know that well, we
20 didn't get rated because our -- our volumes are too low to
21 have statistical meaning. I think that's it in a nutshell.
22 I hope I didn't talk too long.

23 MR. FALAHEE: Okay. Thanks. Any questions from
24 the commissioners? Commissioner Ferguson?

25 DR. FERGUSON: Dr. Pruitt, thanks for your hard

1 work on this. This is Commissioner Eric Ferguson. So you
2 mentioned that -- adopting a new composite structure that
3 the STS is adopting next year. Not wanting to pick too deep
4 into this, but is there anything controversial about it? So
5 it's a new -- new approach that's not yet implemented,
6 therefore may or may not be proven. I don't have an
7 objection to it if it's really just kind of a technical
8 pooling of material and we think it's going to be
9 meaningfully representative of quality. Was there any
10 controversy in your committee as you worked through this or
11 was this a pretty straightforward yeah, this is the way to
12 do it?

13 DR. ANDREW PRUITT: Pretty straightforward. So
14 the Star Ratings and the STS database and our use of that
15 database for quality, you know, dates back into late 90's as
16 far as widespread adoption and it even dates back further
17 than that, the use of risk stratification models. And so I
18 don't -- there were no questions raised about this new risk
19 stratification for a multiprocedural. In fact, most people
20 welcome it for the reasons that I stated earlier. There's
21 going to be a changing landscape probably in the future as
22 far as what specific procedures and which ones your volumes
23 are going to drop because they're going to, you know, be
24 passed into the transcatheter realm or which ones are going
25 to rise because maybe these transcatheter therapies don't

1 pan out like they're supposed to. So we're not -- I think
2 this one is a good look at a program top to bottom. And
3 within this state most of the low volume programs I will
4 tell you are heavy with coronary bypass grafting as their
5 primary procedure anyway, so that's a very good -- already
6 we have a good way to look at the quality of that program
7 since, you know, the biggest book of their work is coronary
8 surgery, but nonetheless, it's nice to have something to
9 fall back on. There may yet be programs that even the
10 multiprocedural risk model may come back with a null rating,
11 but those programs will always have a coronary risk
12 stratification Star Rating and we can always fall back onto
13 that with -- with respect to looking at quality.

14 DR. FERGUSON: Thank you. Sounds well thought
15 out. Thanks.

16 MR. FALAHEE: Great. Thanks. Other questions?
17 I've got a couple, but I want to open it up. Okay. I'll --
18 Dr. Pruitt, this is Chip Falahee picking up on what Dr.
19 Ferguson -- Commissioner Ferguson said. Thanks for the
20 effort and the time you put into this, for volunteering to
21 head up the workgroup and the meetings and all that. I very
22 much appreciate it. So a question for you. As you said --
23 I'll refer to it as TAVR. TAVR procedures have just really
24 taken off over the last six, seven years and now -- what? --
25 you said -- I think -- I believe you said 80 percent of

1 aortic valve replacements are done that way. And maybe this
2 isn't a question as -- so much for you as both the
3 Department as well. So right now I think TAVR procedures
4 don't count as open heart procedures; is that right?

5 MS. BHATTACHARYA: That is correct.

6 DR. ANDREW PRUITT: I would say that that's a good
7 way to put it. So most -- so for instance, my own hospital,
8 we count it as part of our surgical volume with respect to
9 the surgery program because surgeons by CMS rules are
10 supposed to be there. In fact, at our place it's basically
11 a co-surgeon effort. We're both integral in the -- in the
12 procedure. And so we count it towards our total heart
13 surgery volume and not just, you know, it doesn't fit
14 overall so in ways we're double counting because it also
15 fits over in the interventional cardiology volume. But
16 because it takes up, you know, our time and we're integral
17 in -- in evaluating patients and deciding which go for TAVR,
18 which go for open heart surgery, they -- the regulations
19 also still mandate that a surgeon has to see these patients
20 before they can go get their TAVR. It wasn't about five --
21 four, five years ago where the regulations stated that a
22 patient actually had to see two surgeons before they could
23 go get their TAVR and that was relaxed when the rules
24 changed and opened it up for all comers as far as the -- the
25 ability to receive a TAVR. And so it -- most places we do

1 count it as part of surgical volume, but you're not wrong.
2 It's not really an open heart and far from an open heart
3 procedure. And we look at it in our state, you know, our --
4 it's quality collaborative. We look at it separately
5 because the risks and the complications are different and
6 it's a very different procedure so we kind of evaluate it
7 separately. But I gave you a long answer for sort of a
8 short yes.

9 MR. FALAHEE: But I appreciate the long answer.
10 That helped me out. And as you were beginning to talk,
11 Tulika commented and confirmed that just what you said, yes,
12 TAVR's right now are not counted as open heart. The one --
13 not caution, but the one thing I think we need to watch --
14 watch is as TAVR procedures expand and can do more of the
15 heart muscle and all that, should they be counted ever as
16 open heart? And I -- I don't know. And if I'm -- you can't
17 predict the future, but that's just something to watch out
18 for.

19 DR. ANDREW PRUITT: Yeah. Understood. I would
20 suggest this to you. It looks like from the last two or
21 three years that transcatheter valve therapy has reached its
22 max at least with the current technology. So we've been at
23 about 80 to 82 percent of our aortic valves are
24 transcatheter valves and it's been that way for the last two
25 or three years. So I think it's as -- as much of -- there's

1 still patients who this technology is not right for, for a
2 variety of reasons and we're still sort -- we're still
3 sorting out who those people are, but for the most part I
4 think it's fairly settled.

5 MR. FALAHEE: Great. Thank you. That was very
6 helpful. Other commissioners have other questions?

7 DR. KONDUR: Commissioner Kondur. I have one
8 quick clarification to the Department. Why don't we
9 consider counting TAVR? Because the surgeon is also
10 doing -- cardiothoracic surgeons are also doing TAVR's in
11 the majority of hospitals and if you don't count -- a lot of
12 hospitals don't meet the number, the Star Rating or minimum
13 required number to meet annualized. So is there any
14 consideration down the road? Because we're dealing day to
15 day right now with more sicker and sicker patients later
16 part of their life. And the surgical waters are coming down
17 and you see the trend, any hospital in Michigan. So the
18 percutaneous approach is like a TAVR, tricuspid valves is
19 going up. Is there any consideration from the Department to
20 count those towards the surgical volume that will justify
21 Star Rating as well as meet the requirement of -- minimum
22 requirement of the procedures?

23 DR. ANDREW PRUITT: So let me say that it sounded
24 like your question had to do with counting them with respect
25 to judging the risk stratification star model?

1 DR. KONDUR: Yeah.

2 DR. ANDREW PRUITT: It's very -- and that's what I
3 caught. Is that correct?

4 DR. KONDUR: Correct.

5 DR. ANDREW PRUITT: Okay. So the reason is
6 because they're different procedures. They will never be
7 able to be lumped together with open surgical procedures
8 because the risks are different. It's the reason that
9 transcatheter valve has taken off. You know, if you take an
10 85-year-old person, it's not uncommon for his mortality with
11 open surgery to be four or five percent. With a catheter
12 valve it's .8 percent. So that's a little bit of a easy low
13 lying fruit; right? That's very simple. He goes to TAVR.
14 So you can see that the risk model is much different for
15 catheter valves than it is for open heart surgery valves.
16 So they're never going to be lumped together, so to speak,
17 but at the same token we need to keep our eye on it because
18 quality in that arena is just as important as in any of your
19 open heart surgery. And so -- and I may not have explained
20 this well. We -- from a heart surgery standpoint we look at
21 our TAVR volume, we look at our TAVR outcomes, we
22 troubleshoot our TAVR outcomes. And, you know, we also have
23 a combined interventional cardiology or
24 cardiology/cardiothoracic surgery initiative called
25 Michigmal (phonetic) and we troubleshoot this together as a

1 unit. And so we have to keep our eye on it and you -- I
2 think it's reasonable to count it towards your total volume
3 when you're looking at programs and, you know, do they meet
4 their CON volume numbers. You could throw it easily -- say
5 it's counted toward those volume requirements, but from a
6 risk model you can't -- you can't put them together. That's
7 a totally different procedure. And maybe I answered a
8 different question than you had.

9 DR. KONDUR: I agree.

10 MR. FALAHEE: But before I -- so this is
11 Commissioner Falahee again. Thanks for that answer, Doctor,
12 because I guarantee you Tulika's going to have a comment
13 because I know that out in the hospital world and in the
14 physician world -- you know, do we or don't we count TAVR's
15 as part of our open heart surgery cases? And I think, Dr.
16 Pruitt, you explained why -- why at the end there why, yeah,
17 it should count. Others, reasonable minds say no, it
18 shouldn't count. So I think it's something we need to look
19 at as it grows and grows. Tulika, I saw your hand up.

20 MS. BHATTACHARYA: Thanks, Chip -- Chairman
21 Falahee.

22 MR. FALAHEE: That's all right.

23 MS. BHATTACHARYA: It's the Department's response,
24 so I had a sidebar discussion with Beth. So a few things.
25 It's not that TAVR procedures are not being counted. They

1 are being counted as part of the cardiac cath volume. So
2 the question is can we count the TAVR procedures as open
3 heart surgery case and as part of your open heart surgery
4 maintaining its case volume. Right now the way the CON
5 standards are written, we simply cannot. If you want it to
6 be counted, there needs to be some changes in the Open Heart
7 Surgery standards, number one. Number two, as far as
8 tracking TAVR procedures and open heart surgical cases,
9 yeah, we can track that. We can ask a separate question in
10 our annual survey, number of open heart surgical cases,
11 adult/ped, and number of TAVR procedures, adult and ped, and
12 bring you back the report. You know, we can start asking
13 next year and then the Commission make -- can make the
14 decision how they want to fold the numbers into one bucket
15 for open heart surgical services or they want to keep it
16 separate. But right now they're not folded into one bucket
17 as open heart surgery cases.

18 MR. FALAHEE: So in --

19 DR. ANDREW PRUITT: Yeah, I can see both sides of
20 that very easily. You know, if the volume requirements have
21 to do with repetition and they do and it's -- it's not an
22 open heart case. There's no question about it. It's
23 completely different perioperatively, intraoperatively,
24 postoperatively. It's a completely different procedure.
25 And so it doesn't really lend itself to being counted as

1 something that surgeons -- it's a different skill set.
2 Maybe I should put it that way. And so from that
3 perspective it's a different arena and it doesn't really
4 help your open heart skills. Let me put -- I guess that's a
5 better way to -- to look at it. And I think that's what
6 volume requirements are about; right? More reps tend to be
7 better. So it's not helping your open heart reps whereas if
8 you are looking at total open heart volume, yeah, everything
9 we do has a base as far as the skill set and then there's
10 differences depending on whether I'm putting a valve in,
11 whether I'm doing coronaries, whether I'm repairing
12 something, whether I'm doing aneurysm surgery. But the base
13 of the procedure is very similar.

14 So in that sense it would not make sense to -- to
15 keep -- you know, to put it in the CON. But it also has
16 become part of what the surgeon's armamentarium should be
17 along with the interventional cardiologists. And so we
18 would be -- I don't know how much you want to look into this
19 or how important it is right now. The procedures, again, as
20 far as volume of TAVR cases seem to have peaked and with
21 respect to both the total number that we're doing per year
22 and the percent of TAVR's -- or percent of aortic valve
23 replacements that are transcatheter valve.

24 MR. FALAHEE: Okay. Great. Thank you. Other
25 questions, comments? Okay. Dr. Pruitt, again, thank you

1 very, very much for all your work and for your explanations
2 that even this layperson could understand. So thank --
3 thank you very much for all that. Appreciate it.

4 DR. ANDREW PRUITT: You're more than welcome.

5 MR. FALAHEE: So we have in front of us the
6 proposed report -- well, the report and it's up for, as
7 Tiffani said, proposed action. And what that means is if
8 the Commission so chose, it could take action to approve the
9 language and then move it forward to a public hearing and to
10 the Joint Legislative Committee. So I'd entertain any
11 motions to that effect or further discussion amongst the
12 Commission members.

13 DR. FERGUSON: Commissioner Ferguson. Question
14 for the Department. Does the Department have commentary on
15 the proposal from the workgroup?

16 MR. CONNOLLY: Marcus from the Department. Being
17 a part of the workgroup, everything went well. There was no
18 really contentious issues. So at this point we don't have
19 any qualms with the current language that's being proposed.

20 DR. FERGUSON: Thank you.

21 DR. MCKENZIE: Commissioner McKenzie. Motion to
22 move forward the language for a public hearing.

23 MR. FALAHEE: And to the Joint Legislative?

24 DR. MCKENZIE: And to the Joint Legislative.

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

1 MR. FALAHEE: Any discussion? The only thing I'll
2 add is I think that we'll need to keep an eye on the TAVR
3 and whether to count it as open heart surgery because
4 hospitals' volumes are going down as more and more TAVR
5 procedures happen. So I think that's just something to keep
6 on our calendar, if you will. Any other comments? If not,
7 we have a motion on the floor and the support. All in favor
8 please say aye.

9 ALL: Aye.

10 MR. FALAHEE: Any opposed? Okay. That motion
11 carries.

12 (Whereupon motion passed at 10:00 a.m.)

13 MR. FALAHEE: Thank you very much. Very good
14 discussion. Next item, MRT, Megavoltage Radiation Therapy,
15 MRT Services, again, a workgroup. Again, this is for
16 proposed action. So Dr. Siddiqui. Is Dr. Siddiqui
17 available, Kenny?

18 MR. WIRTH: He is.

19 MR. SIDDIQUI: Can you see me and hear me?

20 MR. WIRTH: He is on Zoom and I can introduce this
21 real quick.

22 MR. FALAHEE: Okay. Thank you.

23 MR. WIRTH: And then I can pass it over to you,
24 Dr. Siddiqui.

25 DR. SIDDIQUI: Thank you.

1 MR. WIRTH: So all recommended language in front
2 of the Commission today reached consensus in the workgroup.
3 The Department is including the technical edit across all
4 standards that requires notification to the Department no
5 later than 30 days after any planned decrease or
6 discontinuation of the CON service. There's some written
7 testimony in your packet from Marshfield Clinic. Again, the
8 workgroup did reach consensus during the workgroup process.
9 This comment came in afterwards. Proposed action from the
10 Commission today will require a motion, a second and a vote
11 to approve. Commission proposed action will move the
12 language to a public hearing and to the Joint Legislative
13 Committee. A report and language for final action will be
14 brought back to the CON Commission at the March meeting.
15 Dr. Siddiqui?

16 M. SALIM SIDDIQUI

17 DR. M. SALIM SIDDIQUI: Thank you, Kenny. Good
18 morning, Chair Falahee and esteemed members of the CON
19 Commission. As Kenny mentioned, I'm Dr. Salim Siddiqui,
20 senior staff radiation oncologist at Henry Ford Health and
21 the chair of the informal workgroup on Megavoltage Radiation
22 Therapy. I have the pleasure to present the findings. You
23 have the copy of the report before you. I will try to just
24 briefly summarize. I'll start by just reviewing the
25 charges. Charge 1 was to review provisions related to the

1 initiation of new MRT services in HSA 8; charge 2 was to
2 review all weights, additive values and associated
3 definitions; charge 3 was to review the current regulations
4 surrounding proton beam therapy; that is, high megavoltage
5 radiation therapy, HMRT; and determine if language should be
6 added for the initiation of MRT service with an HMRT unit;
7 and charge 4 was just for completeness to consider any
8 technical changes from the Department.

9 We had five sessions which if you recognize the
10 amount of work that had to be done in those five sessions,
11 we split up into subgroups to address charge 2 and charge 3.
12 The subgroups had stakeholders from the various
13 representation that was present at the -- the meetings to
14 address those charges. That was a significant amount of
15 work. But we were able to get the work done and to
16 summarize that work into the report that you have before
17 you. For charge 1, the summary is that we recommend
18 reducing the distance requirement from initiating a new MRT
19 service in HSA 8 from 90 to 45 driving miles. That charge
20 we were able to address probably in the first 15 to 30
21 minutes of the first meeting. I think that was a quick
22 reflection of how we all recognized there was a need to
23 change this to improve access for all the rural and
24 micropolitan communities who currently face significant
25 barriers to accessing these lifesaving treatments.

1 Charge 2 and charge 3, these were herculean tasks
2 and we did rely on the subgroups and the larger informal
3 workgroup to try to move the ball forward on these charges.
4 For charge 2, we proposed basically revising the ETV
5 calculation method. Our goal was to make it more reflective
6 of the actual treatment time on the machine more agnostic of
7 the technology type and more adaptable to future changes.
8 And we provided those definitions for the various terms used
9 in the ETV calculation and I believe they're in section
10 10(4) table one and they're in the report to just ensure
11 clarity and consistency. I would say that we met all of our
12 initial goals for that work except for making the overall
13 process easier and in the final meeting or so there was some
14 discussion about changing the entire process to be more
15 reflective of just the treatment time on the machine
16 analogous to the way that surgical scheduling times are
17 done, but that's something to address in the future likely
18 SAC. But for the purposes of the charge, we were able to
19 certainly move the work significantly forward and improve
20 the process by being reflective of actual treatment time,
21 agnostic of technology type and more adaptable for future
22 changes.

23 The third charge regarding HMRT, we recommended no
24 changes to the current standard. We acknowledged that there
25 is still significant underutilized HMRT units in the state.

1 And instead of adding more units and using those resources
2 for more units, we encouraged collaboration to remove the
3 logistical barriers between the physicians and providers
4 across our state to access the current existing HMRT units.
5 We believe these recommendations will significantly improve
6 the delivery, accessibility, while maintaining the quality
7 of radiation therapy services in our state. We certainly
8 look forward to these being incorporated and implemented
9 into the standards.

10 And I want to thank the Commission and Chair
11 Falahee for the privilege and honor to serve as the chair of
12 the informal MRT workgroup. This work would not have been
13 possible without the robust attendance and broad
14 representation at the informal workgroup meetings and the
15 subgroup meetings and I want to thank all of those who
16 attended and sacrificed their time and dedicated their
17 sincere efforts to do this important work for the state and
18 for our Michiganders. And lastly but certainly not least, I
19 want to thank Mr. Kenny Wirth and the other Department staff
20 for the herculean work that's done during the meetings,
21 behind the scenes, in between to make this work possible in
22 a timely manner. Thank you, again, for your time and
23 consideration.

24 MR. FALAHEE: Great. Thanks, Dr. Siddiqui. This
25 is Commissioner Falahee. I'll return the thanks to you.

1 Often when the chair and the vice chair of the Commission
2 are looking for people to chair a workgroup or a Standards
3 Advisory Committee, we get a list of people who are on the
4 potential SAC or potentially interested in a workgroup and
5 then I know what I do, I reach out to my CEO friends at the
6 hospitals across the state and say, hey, would Dr. So and So
7 be any good? Sometimes I get a quick response, don't pick
8 this person, but sometimes I get a response like I did with
9 Dr. Siddiqui and -- he'd be great. He'll be able to tackle
10 whatever comes his way no matter how complicated it is. So
11 thank you, again, for -- for that and blame Bob Riney, you
12 know. Go talk to Bob and blame him.

13 DR. M. SALIM SIDDIQUI: Thank -- thank you.

14 MR. FALAHEE: But are there any public comment
15 cards about this? Then we'll open it up for Commission
16 discussion. And, Dr. Siddiqui, if you can hang on and see
17 if we have any questions from public comment perspective or
18 from the Commissioners, that'd be great. Thank you.

19 MR. WIRTH: We don't have any public comment
20 cards. There was a letter in your Commission packet related
21 to this.

22 MR. FALAHEE: Right. Okay. Great. Any questions
23 from the Commissioners? Commissioner Ferguson?

24 DR. FERGUSON: I have a question and then there
25 will be follow-up question to that. You mentioned that

1 there's two proton therapy units at least in the notes.

2 Where are those two units geographically?

3 DR. M. SALIM SIDDIQUI: Yes. So one is with -- in
4 Flint and the other is in I believe Royal Oak. One is with
5 the Corewell system and the other is part of the McLaren
6 system.

7 DR. FERGUSON: Yeah. I'm less concerned with the
8 system and more concerned with the geography. I'd like to
9 make a comment with respect to charge 3 and then actually
10 it's, frankly, a similar comment with respect to charge 1.
11 I understand that the two that we have may be underutilized,
12 but that doesn't mean that the needs of the rest of the
13 people of the state of Michigan are being fully served. So
14 I have some -- some reservation over that. It's not clear
15 to me that whether it's the people of West Michigan or the
16 UP or whatever are necessarily going to travel to southeast
17 Michigan for services. And we trip over this with some
18 regularity and I guess I would, not wanting to micromanage
19 it, encourage some consideration around not viewing that as
20 adequate services and that maybe we should liberalize things
21 and maybe there is a role for additional geographic
22 coverage.

23 With respect to micropolitan and rural services
24 and the change to 45 miles for HSA 8, essentially it's the
25 same comment in reverse which is if there are population

1 groups that are too far away to get services, why does it
2 matter if you're in a rural UP county or a rural southern
3 Michigan county? If you're too far, you're too far. And I
4 understand it's more rural counties across broader area, but
5 the same notion applies and I want to make sure that we're
6 not discriminatory to our population anywhere. And so I
7 guess I would feel better if things were scripted around
8 these are the practical aspects of delivery and you need to
9 have, whether it's X volume or X distance or X support
10 services than saying, oh, you live in this kind of
11 arbitrarily defined set of counties called HSA 8 rather than
12 HSA -- I don't even know what they all are, I mean, you
13 know, 3, whatever 3 is. I'm uncomfortable with that notion.
14 I don't know if you have comments on that or if other
15 Commissioners or -- or the Department have responses?

16 DR. M. SALIM SIDDIQUI: Absolutely; absolutely. I
17 mean, that's an important part. When we look at one of the
18 -- the charges of the CON Commission which is access, but
19 there are two other legs in the stool of the CON Commission
20 which is quality and cost. So that little letter H that
21 comes before MRT in charge 3 makes a world of difference,
22 Commissioner. The MRT service in terms of non-proton
23 therapy services, linear accelerators that do the bulk of
24 the treatment across the state, across the nation, across
25 the globe, that access -- we certainly do not want

1 limitations in that access and we certainly know that that
2 kind of access can be achieved at a much more reasonable
3 cost than that of HMRT units which cost ten to 100 times as
4 much as a standard MRT linear accelerator.

5 In terms of quality, we want to assure that across
6 the board and that part, you know, I think is equivalent.
7 Whether it's an MRT or HMRT, that's something that we will
8 always be the vanguards of. But the cost is what makes the
9 two different. It's that letter H that makes charge 1
10 significantly different from charge 3. And when we look at
11 the access, as we said in the report when we considered the
12 access for those patients who would have the greatest
13 benefit, that is the one that is -- that is those patients
14 where there is the strongest clinical evidence, the highest
15 quality evidence for the benefit of HMRT, there is way --
16 there is much more access than an insignificant
17 underutilization of that technology. And so that -- that's
18 -- that's where the distinction comes in. If HMRT units
19 were the same cost as traditional MRT units, this would be a
20 moot point but the reality is they're not and we have to be
21 mindful of how we use our resources for health care not just
22 in our state, but across our nation. Does that address your
23 concerns?

24 DR. FERGUSON: They're valid points. I'm not sure
25 that I'm completely satisfied. I'm not sure that anyone

1 would actually invest in HMRT in West Michigan. It's just -
2 - it's uncomfortable that the two units that we have,
3 understanding that they're expensive, are both in the same
4 relative geography. Ideally they would be more spread out.
5 I understand that we're in the situation we are and we can't
6 change the world. That's fine.

7 DR. M. SALIM SIDDIQUI: Many states, Commissioner,
8 do not have HMRT units at all and those where you find the
9 most rampant abuse of this technology are states that have
10 no CON Commission. And I have to believe that the
11 collective wisdom of the CON Commissions across our nation
12 all recognize that access to an HMRT unit is not necessarily
13 the best or the most cost effective use of resources.

14 MR. FALAHEE: This is Commissioner Falahee. I
15 think Commissioner Ferguson was reading my notes because I
16 also have the same comments, questions, concerns or thoughts
17 about access more so with the HRMT's (sic). I was involved
18 when this was first discussed at the CON Commission -- I
19 wasn't on the Commission, I was out in the audience -- 15,
20 20 years ago when proton beam units were \$100 million. Now
21 I think they're about I'll guess \$25 million and the space
22 that was required for them has drastically dropped. I live
23 in the Kalamazoo area. I would have to drive two and a half
24 hours to Beaumont or McLaren so I have access questions. I
25 also have questions about -- we have standards that are very

1 old and the HRMT world is moving faster and getting cheaper
2 and less space, so maybe we need to look at the standards.

3 The other is that when it comes to workgroups --
4 and this is a workgroup and Dr. Siddiqui did a great job
5 with it -- workgroups are not Standards Advisory Committees,
6 SAC's. All right? Commissioner Drake, we call -- Standards
7 Advisory Committees, we call them SAC's. So it's weird --
8 weird, but that's what we call them. All right. Workgroups
9 are whomever chooses to show up. And hypothetically if --
10 if you -- if you have a widget and you're hospital A and B
11 and hospital C comes forward and they don't have the widget,
12 how do you think that vote's going to go if it's a
13 workgroup? Because as I understand it, workgroup votes it's
14 not by entity, it's by the people that are in the room by
15 consensus so that's a potential issue. And especially when
16 in the last 15 or 20 years as we all know there's been huge
17 hospital consolidation in the state so there aren't as many
18 players. And if you have to put together what the standards
19 require as a consortium, harder to do when you have fewer
20 systems in the state.

21 I'm not critical at all of what the workgroup did
22 by any means, but I think that this is an issue we need to
23 look at in our role for quality, cost and access as Dr.
24 Siddiqui and Dr. Ferguson said. Not now, but I think the
25 next time this comes up as part of the review standards, I

1 think those -- those issues merit attention and I think they
2 merit attention in my opinion in a SAC because with a SAC,
3 Commissioner McKenzie and I know, if we've got an issue that
4 splits right down the middle, we appoint equal
5 representation on that SAC so we get a robust discussion.
6 And what I have done in the past, I appoint as chair and
7 vice chair two people on opposite sides of the issue and
8 say, look, you're the experts, you figure it out. So I'm
9 not critical at all of the work that Dr. Siddiqui and his
10 team did. It was herculean in those -- those two items, but
11 I think it's something that we as a Commission need to look
12 at wearing our hats for quality, cost and access the next
13 time these come up as how best to -- to grapple with both
14 sides of the issue here. Other questions or comments?

15 DR. M. SALIM SIDDIQUI: I appreciate that, Chair
16 Falahee. That was part of the reason when we broke up into
17 the subgroups, we made sure that the stakeholders who were
18 the closest to charge 3 did the work between meetings to be
19 able to kind of hash out the potential arguments, concerns,
20 pros and cons for that charge so that the presentation to
21 the larger, informal workgroup would present it for a more
22 fair vote, a more fair consensus. The -- the big -- the big
23 hurdle was, again, the -- the idea of access for what
24 population, for how many patients and where is the clinical
25 evidence to justify that. But I agree with you that a SAC

1 would provide more opportunity for that kind of robust
2 debate, discussion and crafting of the standards.

3 MR. FALAHEE: Great. Thanks. And if ever we do
4 appoint a SAC, I do have your phone number, so --

5 DR. M. SALIM SIDDIQUI: It would be my privilege
6 and honor.

7 MR. FALAHEE: Great. Thank you. Other questions
8 or comments? Okay. Hearing none, as with our first agenda
9 item, a lot of similarity. We have proposed -- we have
10 language in front of us, a report. One option would be we
11 can reject it or we could say we'll approve it, take the
12 language and send it out for public hearing as well as send
13 it to the Joint Legislative Committee. That's also an
14 option. Kenny's looking at me like I left something out.

15 MR. WIRTH: No. I was just going to say we don't
16 have any public comment cards on this one.

17 MR. FALAHEE: Okay. Great. Thank you. So that's
18 where we're at. Anyone choose to entertain a motion? Make
19 a motion to that effect?

20 DR. ENGELHARDT-KALBFLEISCH: Commissioner
21 Engelhardt. I'll make a motion to take the language in
22 front of us and move it forward to public hearing and to the
23 Joint Legislative Committee.

24 MR. FALAHEE: Thank you. Support?

25 MR. DRAKE: Commissioner Drake. Second.

1 MR. FALAHEE: Thank you very much. Motion on the
2 floor. Any discussion? All those in favor say aye.

3 ALL: Aye.

4 MR. FALAHEE: Any opposed? Great. Thank you.
5 That motion carries.

6 (Whereupon motion passed at 10:20 a.m.)

7 MR. FALAHEE: Dr. Siddiqui, if you're still there,
8 thank you very, very much for all your hard work and we may
9 be in touch. Thank you.

10 DR. M. SALIM SIDDIQUI: Thank you.

11 DR. FERGUSON: Procedural question.

12 MR. FALAHEE: Commissioner Ferguson? Yes.

13 DR. FERGUSON: Just so I know how the process
14 works because I've never abstained from a vote before.
15 Because I neither cast for yes or no, I presume I end up
16 recorded as an abstained?

17 MR. FALAHEE: You will now because I --

18 DR. FERGUSON: I don't know, I'm just asking. I
19 don't know how it works.

20 MR. FALAHEE: What I can do going forward is ask
21 people to raise their hands. I'll do that instead. So --
22 but thank you.

23 DR. FERGUSON: I'm not trying to second guess your
24 process at all.

25 MR. FALAHEE: Nope.

1 DR. FERGUSON: I just am trying to learn the
2 process.

3 MR. FALAHEE: The process adjusts as needed so you
4 raise a good point. Thank you. So your -- you abstained
5 from that vote?

6 DR. FERGUSON: (No verbal response)

7 MR. FALAHEE: Okay. Thank you very much. All
8 right. Thank you one and all. Appreciate it. Thanks, Dr.
9 Siddiqui, one more time. Appreciate your hard work on this
10 one.

11 DR. M. SALIM SIDDIQUI: Thank you to the entire
12 Commission for this work and I wish all of you a happy
13 holiday season and a happy new year.

14 MR. FALAHEE: Thanks so much. Okay. Next we're
15 going to move into Hospital Bed Standards Advisory Committee
16 final report and draft language. I'm going to have -- who's
17 going to --

18 MR. CONNOLLY: Me.

19 MR. FALAHEE: Marcus. And then after Marcus makes
20 his comments, I got a few comments to make before we turn it
21 over to the chair of the SAC, Jenny Groseclose. So, Marcus?

22 MR. CONNOLLY: All right. All recommended
23 language in front of the Commission is supported by the
24 Department. The Department is including the technical edits
25 across all standards that requires a notification to the

1 Department no later than 30 days after any planned decrease
2 or discontinuation of the CON service. The Department is
3 also providing draft language that is being recommended to
4 address the initiation, replacement, and relocation of a
5 rural emergency hospital. This language was not approved by
6 the HB SAC. The HB SAC did not recommend language to be
7 added for REH as language created by the HB SAC REH subgroup
8 could not be supported by the Department. The Department
9 believes that this language is necessary to facilitate
10 conversion of an existing hospital to a rural emergency
11 hospital and to protect the temporarily delicensed hospital
12 beds during the approved period of temporary delicensure.

13 In the absence of REH language in the standards, the
14 Department does not have specific guidance in the standards
15 to determine if an REH facility would be able to relocate or
16 replace a temporarily delicensed bed as the public health
17 code explicitly states that a CON is required for these
18 activities.

19 The Department did provide draft language to allow
20 the replacement of temporarily delicensed hospital beds and
21 allow the relocation of temporarily delicensed beds under
22 certain conditions. The draft was not accepted by the HB
23 SAC REH subgroup. The Department recommends that the CON
24 Commission adopt the language presented relating to REH.
25 This language was not approved by the HB SAC REH subgroup or

1 the HB SAC, but the Department believes that it will
2 appropriately facilitate the conversion to an REH while also
3 providing some flexibility with regard to replacement and
4 relocation of the temporarily delicensed beds.

5 Proposed action from the Commission will require a
6 motion, a second and a vote to approve. The Commission
7 proposed action will move the language to a public hearing
8 and to the JLC. A report and language for final action will
9 be brought back to the CON Commission at the March meeting.
10 And then I will turn it over to Jennifer.

11 MR. FALAHEE: And before Jenny gets up -- so I've
12 been on the Commission since 2008 or '09. I have never had
13 as many phone calls, text messages, personal visits as I
14 have on this issue. And there are multiple sides here. I'm
15 not saying which one is right, which one is wrong. But as
16 you heard Marcus say, there were robust discussions, I'll
17 put it that way. Some diplomatically would say we had frank
18 and candid discussions. And as a result of those
19 discussions we've got recommendations from the SAC that
20 Jenny will talk about and then we've got a separate I'll
21 call it recommendation from the Department with language. I
22 have some thoughts about where to go from here, but I want
23 to get the benefit of Jenny's comments and then those in the
24 audience that have public comment. I haven't spoken to
25 Jenny about this since -- was it yesterday or the day

1 before? So -- and then one person in the audience I'll
2 candidly -- I won't say who they are -- they -- they said,
3 Chip, I drew the short straw. I was the one that was
4 selected to call you and talk about this.

5 So thank you all for your comments. That's what
6 we as commissioners want and need and we appreciate the
7 robust discussions. Those are also helpful. So thank you
8 for that. With that, Jenny? And Jenny's just a glutton for
9 punishment. She handled Hospital Beds and then she
10 volunteered for this and I'm, like, gosh, you know, now
11 what? But, Jenny, thank you sincerely for all your work on
12 this. It's been a herculean effort times five so thank you
13 very, very much. The floor is yours and you are not subject
14 to the three-minute limit.

15 MS. JENNY GROSECLOSE: So I -- do you want me -- I
16 have a presentation. Do you -- and REH is towards the end
17 of it or do we want to get into that one first? Shall I go
18 through all the charges and then --

19 MR. FALAHEE: Yeah, whatever you want. However
20 you want to work it. That's fine.

21 JENNY GROSECLOSE

22 MS. JENNY GROSECLOSE: Well, I'll -- while the
23 presentation is starting, I'm Jenny Groseclose. I work for
24 Munson Healthcare. I was the chair of the Hospital Bed SAC.
25 I co-chaired the previous Hospital Bed SAC three years ago.

1 Next slide.

2 This gives a flavor of the individuals that
3 participated on the SAC. Great representation, lots of
4 participation in the SAC meetings and in subgroups. Next
5 slide.

6 We had four meetings. I will be honest, I was
7 sensitive to everyone driving in, so we did have two
8 meetings that we -- just one we used as a subgroup time and
9 the last we felt we were complete in October and didn't use
10 the November meeting.

11 MR. FALAHEE: I'll -- yeah. This is Commissioner
12 Falahee. I'll interject. SAC's must meet in person.
13 Parenthetically (for now), check with me later in the agenda
14 as to what I just talked about.

15 MS. JENNY GROSECLOSE: Okay. Next slide. We had
16 five charges. The first was to review the limited access
17 area criteria that's currently in the standards. The second
18 was to draft language to support LTAC hospitals once the
19 host hospital had been closed. The third is looking at a
20 market survey that had been previously used in 2001. And
21 number four, REH, I mean, draft language for rural emergency
22 hospitals. And the fifth is the technical changes that has
23 been standard in any of the reviews. Next slide.

24 So for charge 1, limited access area, a quick
25 review of how it's currently stated in the standards.

1 There's five variables. One is establishing the travel time
2 source, so the software. We use ESRI. The second is what
3 would be considered geographically underserved. Right now
4 it's 30 minutes. And then, again, with geographically
5 underserved, what is the appropriate bed count. That
6 previous work was to set a threshold specific to the LAA and
7 that it would be at least ten beds. And then the fourth is
8 how does that geographically underserved population, what
9 percentage that would be tied to that, that's 50 percent.
10 And then there's the comparative review. Next slide.

11 So in the subgroup we had a very large subgroup.
12 Oxford Township participated in the subgroup. There were
13 two areas that we felt needed more review, more discussion.
14 Paul Delamater supported that detail. So the first is, is
15 ESRI still the correct source or software for travel time
16 and then is 30 minutes the appropriate travel time
17 reference? Next slide.

18 So the subgroup and SAC unanimously voted that
19 ESRI is still the best software source. We looked at models
20 of Google and Apple travel time tools. ESRI just offers a
21 product that can be widely used, consistent, and they all
22 seem to tie out. And then 30 minute travel time. So we
23 referenced the Michigan algorithm for trauma centers, level
24 I and II, which is 45 minutes. That tied well into the 30
25 minute travel time for an LAA. That when we looked at 20

1 and 25 minute travel times, there was concern about
2 preserving the existing hospitals within that map. And in
3 the appendix you'll see visuals if you wanted to reference
4 them. And that we wanted a source that was used throughout
5 the state of Michigan and that the current standards provide
6 that. Next slide.

7 So this is just a recap of why we felt that the
8 recommendation that was voted unanimously would be to remain
9 with our LAA standards that are currently in the Hospital
10 Bed limited access portion. Next slide.

11 MR. FALAHEE: Let me interject again.

12 MS. JENNY GROSECLOSE: Oh, yeah.

13 MR. FALAHEE: Do you want us to address questions
14 one by one by one? Would that help?

15 MS. JENNY GROSECLOSE: Yeah. Why -- why don't we
16 do that? Yeah.

17 MR. FALAHEE: Okay. Does anybody have questions
18 of Jenny about this topic? Okay.

19 MS. JENNY GROSECLOSE: Okay. Charge 2 was to
20 draft language to add -- to support LTAC's that were within
21 a hospital where the host hospital was closed. So the new
22 language appears in section 6, 6(2). I won't read it for
23 you. Next slide.

24 A little bit later in 6(2) and then in 9(6). So
25 within the approval requirements and then the project

1 delivery requirements. We had a subgroup that worked on
2 this detail along with the Department. And I should say for
3 LAA, the Department supported us as well. Okay. Next
4 slide.

5 Market survey. So this recommendation was to
6 potentially go back to using a market survey within
7 applications for hospitals and I believe it was discussed in
8 your January meeting. So this would be in section 7 for
9 replacement and section 6 for new hospitals. And the last
10 time this was present was in 2001, where now we are using a
11 very detailed calculation from Paul and team and actually it
12 was the Department that recognized that our current system
13 was appropriate. Kenny, Tiffani, if you want to add any
14 comments to that? Marcus? That the recommendation was to
15 not move forward with a market survey and the SAC
16 unanimously agreed.

17 MR. FALAHEE: Any questions about that? When
18 Jenny references Paul, that's Paul Delamater who's worked
19 with the Department for decades on issues like this. Okay.
20 Thank you.

21 MS. JENNY GROSECLOSE: Okay. Next slide. REH. I
22 -- I will do my best to share the detail behind REH and I
23 think we have some public comment. So the first slide is
24 just some detail behind the federal law and the state law
25 for rural emergency hospitals. Next slide.

1 So we had a extensive subgroup to talk about REH
2 and then the SAC. So there were six areas of focus when the
3 team was meeting to draft out language. So the first is
4 what type of application should it be? Should it be -- can
5 it be a CON waiver? If it is a CON, is it substantive or
6 non-sub- -- a non-sub application? What should it contain?
7 So the actual product within the application. Three and
8 four are in blue because they are the areas that we had a
9 challenge coming into a consensus and that would be for
10 replacing a rural area within that replacement zone. So can
11 an REH replace within a replacement zone? Relocate within a
12 replacement zone?

13 MR. FALAHEE: And this is Falahee. You might want
14 to tell folks what's a replacement zone?

15 MS. JENNY GROSECLOSE: Oh, a replacement zone. So
16 a replacement zone is a location where a hospital can
17 replace their entire hospital or a portion of their beds --
18 I think I'm accurate in stating that -- and it's specific to
19 what type of county you're in. Now, obviously in this
20 situation it would be a rural county, but there was a --
21 there was a disagreement on whether that should be allowed
22 within the REH standards. So the next is to relocate those
23 temporary delicensed beds to another hospital, kind of the
24 same flavor here. Some conversation about replacing the
25 beds within your hospital. So we have a hospital in

1 Frankfort, the beds are on the second floor, can we replace
2 them on a first floor in renovation? So that -- that --
3 that gives a -- kind of a visual. Number five is the
4 transfer time limit for REH's. Should there be? And that
5 would be to a level I or level II trauma center. And then
6 what to do about the hospitals that closed before December
7 2020? Okay. Next slide.

8 So this is kind of a recap of what I shared that
9 there was consensus. The Department was very involved in
10 the subgroup meetings and presentations to the SAC on the
11 areas that there was a discussion on it could be a nonsub
12 application which allows the approval time to be less, 45
13 days, than a full CON. I called them full CON's. That
14 there would be a grace period on submission and this was in
15 consideration of when you're sharing the news that you are
16 considering REH with your community, we didn't want the CON
17 to get ahead of that communication because when you submit a
18 letter of intent, it is public knowledge. So that was --
19 that was the conversation on timing and then the two areas
20 that we couldn't find an agreement on.

21 MR. FALAHEE: And this is Falahee. Yeah, let me
22 interject for those commissioners that don't live, eat and
23 breathe this stuff. So when you see at the bottom, the
24 first bullet about replace facilities or temporarily
25 delicense, that gets into the replacement zone and as Jenny

1 said there's two different ones. If you're in a county of
2 over I think it's 200,000, it's two miles. If your county
3 is under 200,000, the replacement zone is five miles. Okay?
4 That's replacement. That's different than, in the CON
5 world, relocate. All right. Relocate gets into another set
6 of factors which is your -- I believe it's called hospital
7 group. And hospital groups there's -- I don't know -- 10 or
8 12 of them in the state. There's a map that's available.
9 You can -- you can relocate within your hospital group. All
10 right? And so there is a question, should REH's be able to
11 relocate some or all of the beds that they have into that
12 hospital group? Just so everybody around the table here
13 understands what replacement means, what relocate means and
14 what the heck is a replacement zone. All right? Jenny, did
15 I say all that acc- --

16 MS. JENNY GROSECLOSE: Yes; yes.

17 MR. FALAHEE: Okay.

18 MS. JENNY GROSECLOSE: Thank you. Next slide.

19 A bit more detail behind -- and I'm going to get
20 ahead to -- the subgroup and SAC recommendation was to pause
21 on implementing REH detail within the standards because
22 there is protection for REH's right now under the law and
23 that if no CON standard is in place, the law still provides
24 the ability to create an REH. And there's a statement for
25 MDHHS. Next slide.

1 I don't know if I have this in the slide, but I'll
2 just give the background on the pause. I do kind of have
3 it. We know there's one application. It's Sturgis. We
4 felt we needed more time to really draft something because
5 there's still so much in play with the federal law, with
6 CMS, with state, with LARA. And in order to create
7 something this was how the subgroup and SAC felt -- and I
8 think there's public comment on it -- we just needed more
9 time. And that pushing it to November would maybe create
10 something that would have unintended consequences. So that
11 was our -- that was our take on it. Next slide. That might
12 be the end of it. Okay. So do we want to talk about REH?
13 And is this a good time for public comment on it as well?

14 MR. FALAHEE: Let's do -- this is Falahee again.
15 Let's get through the technical, charge 5, and then --

16 MS. JENNY GROSECLOSE: Okay. Yeah. Technical is
17 really easy.

18 MR. FALAHEE: I don't -- I highly doubt there will
19 be any public comments about the technical changes. If
20 there are, you're welcome to come first. But, Jenny, if you
21 could summarize those --

22 MS. JENNY GROSECLOSE: Yeah; yep.

23 MR. FALAHEE: -- then we'll go back to REH
24 discussion.

25 MS. JENNY GROSECLOSE: Okay. So there are some

1 technical changes. This is the meat of what was discussed.
2 There was an individual in our group that worked quite a bit
3 with the Department. Some DRG's needed to be updated to MS-
4 DRG's and so that occurred for substance use and for
5 obstetrics. And then language was drafted I believe by the
6 Department that's very helpful that when MS-DRG's need to be
7 updated that it doesn't require a SAC. That it can occur
8 without a hearing, the involvement of the Governor and that
9 -- and that it can be a communication with the Commission
10 when that's required. So that's the meat of the technical
11 changes. And did I -- do you have anything else to add to
12 this?

13 MR. FALAHEE: So this -- this is Commissioner
14 Falahee. Any questions about the technical edits? All
15 right. So let's go back to the REH charge because I don't
16 think there were any questions about 1, 2, 3 or 5, so let's
17 go to REH. Let's start with any questions of Jenny at this
18 point from the commissioners. We won't allow her to leave.
19 We may have follow-up questions. Okay? But any questions
20 at this point? Commissioner Ferguson?

21 DR. FERGUSON: I think that you referenced and our
22 packets referenced that there's some activity at the federal
23 level regarding some of this. What is that and is there a
24 reasonable expectation on the timeline and certainty of that
25 timeline?

1 MS. JENNY GROSECLOSE: So we relied heavily on
2 Carrie Linderoth and she would be able to provide the
3 updates -- I'm going to pull you right up here -- in all the
4 areas that REH is still being discussed.

5 MR. FALAHEE: So since -- this is Falahee. So
6 since Jenny passed this torch to Carrie Linderoth, I'll let
7 Carrie speak to that issue and answer Commissioner
8 Ferguson's questions maybe.

9 CARRIE LINDEROTH

10 MS. CARRIE LINDEROTH: Hi. I'm Carrie Linderoth
11 with Kelley Cawthorne. I worked on the one REH application
12 that's in the state. I think there's a lot of discussions
13 at the federal level just trying to make sure that this gets
14 streamlined. I wish I had an answer for you on the
15 timeline. Things at the federal government move pretty
16 slowly. But they are having a lot of things just deciding
17 exactly if they want to expand the possibility of REH right
18 now. It's pretty restrictive, but they're noticing that
19 there are facilities that could potentially qualify if they
20 tweaked a few words here and there. And so right now it's
21 very specific in the process. I really appreciate the --
22 the comments that Jenny made because -- and I think I've had
23 this conversation with pretty much everybody that was part
24 of the workgroup. Working with this process through CMS
25 made me incredibly appreciative of the Department because

1 things in Michigan work more smoothly and these facilities
2 are extremely disadvantaged when they're going to consider
3 going to REH and the federal process is very cumbersome and
4 very long and very intensive about just making sure, like,
5 everything is exactly how CMS would like to see it. And I
6 would like to qualify that with how they would like to see
7 it that day because that changed in this process. That
8 should have taken 30 days, I think it changed 30 times as we
9 were working through this. And so I think, you know, just
10 from my experience with the application here in Michigan
11 it's -- it's hard to tell exactly how CMS is going to look
12 at it next.

13 DR. FERGUSON: Thank you. Not knowing exactly how
14 this federal process plays out but knowing how other
15 processes might. So we're not at a end of a public comment
16 period with the feds or a preliminary final rulings or
17 anything? This is still in a conceptual state?

18 MS. CARRIE LINDEROTH: I mean, they -- they do
19 have a process set forth to be able to do it. I would say
20 that. I mean, it's not like there's anything at the federal
21 level prohibiting it. The main policy premise behind it is
22 that it's an opportunity for these facilities to be able to
23 explore whether or not this will allow them to stay open and
24 maintain essential emergency services for these communities.
25 The underlying qualification is there. They recognize that

1 it may not work once they do it and they want them to be
2 able to restore what they had and that would be inpatient
3 beds. And so that's the main crux of where the federal
4 rules are right now and a lot of it is, you know, is it
5 applied across the country? Some states have CON's, some of
6 them don't. And so it's really for us in Michigan
7 preserving the rights of those hospitals to be able to
8 reclaim those beds in the event that they want to go back to
9 inpatient services.

10 DR. FERGUSON: Thank you.

11 MR. FALAHEE: Yeah. This is Commissioner Falahee.
12 I think Carrie did a very good job. I've talked to Carrie
13 as well about this. Full disclosure, Sturgis is in the area
14 we're in. I know the folks at Sturgis. I've been there.
15 They came to us desperately hoping that Bronson would buy
16 them two or three times. Didn't happen. So I understand
17 exactly what Carrie is saying. In terms of where CMS is at
18 or the federal government is at, it reminds me of what's
19 called the Stark regulations. So first came the Stark law,
20 first set of regulations came out seven years later.

21 MS. CARRIE LINDEROTH: Just to give a little
22 anecdote, too, as far as the process and I'm going to lean
23 on Chip a little bit here. One of the required elements is
24 that a facility has to have a transfer agreement with a
25 level I trauma center which to us is pretty standard, you

1 know, what level I trauma center means. But CMS actually --
2 and Bronson very graciously agreed in Sturgis's instance and
3 I can share. This is all part of the public document. But
4 I think it was right before a holiday Chip had to go into
5 the hospital and take a picture of their level I trauma
6 certification that's on the wall to get CMS to agree. So
7 when I say the process is cumbersome, I say that also to add
8 some levity and joke to a situation, but it's -- it's
9 really, really intense.

10 DR. KONDUR: Commissioner Kondur. I know right
11 now at one facility (inaudible) applicant. Do you think --
12 foresee a lot of hospitals do -- follow the same process?

13 MS. CARRIE LINDEROTH: I think there's --

14 DR. KONDUR: (Inaudible) against status?

15 MS. CARRIE LINDEROTH: I think there's a number of
16 them that are considering it. I think their biggest concern
17 is I don't -- do I go down this path in the event is there
18 going to be a -- you know, a roadblock for me later?

19 DR. KONDUR: Yeah.

20 MS. CARRIE LINDEROTH: I think they just want to
21 have all of their options open. I can't speak for anybody
22 considering it, but I do think there's a few that are
23 looking at it and they're just trying to decide the cost
24 benefit of -- of pursuing the status. I mean, it is an
25 enhanced reimbursement for the outpatient services so that

1 just to be clear what it does provide. And it -- it has a
2 lot of minimum requirements as far as what services are
3 still required at the facility as far as ER and things like
4 that. But it's really -- it's a tough one because it's --
5 you know, as Jenny mentioned, the community discussions are
6 very intense and it involves labor contracts, it involves,
7 you know, board decisions and, you know, interested parties
8 and things like that and so every situation's a little
9 different. I suspect we'll maybe have one or two more, but
10 I don't think it's going to be every critical access
11 hospital in Michigan. I don't think that it'll go down that
12 path.

13 MR. FALAHEE: And some of these hospitals are
14 owned by the county or the city and I've had one hospital
15 that said the city commission just voted to buy a fire truck
16 and not replace our roof. So that tells you a little bit
17 what you're dealing with here. Thank you. Other questions?
18 Commissioner Ferguson?

19 DR. FERGUSON: First, please, if anybody else?
20 Otherwise I have -- before you go to other stuff, I have a
21 question for Jenny.

22 MR. FALAHEE: Yeah. Carrie, I think --

23 DR. FERGUSON: Question for Jenny and the
24 Department. So I'm hearing from the Department I think in
25 your preliminary comments that you're lacking guidance, you

1 don't know how to process this and you need some
2 clarification and you thus proposed some language?

3 MR. CONNOLLY: Yes.

4 DR. FERGUSON: Jenny, I'm hearing from the SAC
5 that in fact there is clarity, there is a path so the
6 Department should know what to do. Can we reconcile this?
7 Because I don't know what -- who --

8 MR. FALAHEE: Again, this is Falahee. You must be
9 reading my notes because I've got a thought in mind.
10 Jenny's aware of it. But go ahead and answer the question.

11 MS. JENNY GROSECLOSE: So when that conversation
12 would happen, Sturgis submitted a CON waiver and so we felt
13 that during the pause if a hospital were to convert, that
14 they could follow the same -- same process as Sturgis.

15 DR. FERGUSON: Department?

16 MR. CONNOLLY: Marcus with the Department. One of
17 the issues that we talked about internally is if we continue
18 to waive the process, would it be legally binding? And that
19 was one of the issues that we were grappling with internally
20 because we just wanted some type of language in place versus
21 just having a waiver because there's no legal binding
22 components to that.

23 DR. FERGUSON: I mean, it sounds like there's a
24 compromise in there somewhere.

25 MS. CARRIE LINDEROTH: I'd just like to add one

1 more thing. I realize you didn't ask, but the facilities
2 are still licensed hospitals and they are still subject to
3 the Hospital Bed standards and they're still subject to the
4 hospital license that is issued in LARA. So, I mean, I
5 think -- I think -- I don't want to lose sight of the fact
6 that while they are offering emergency services, they're not
7 offering inpatient beds, they're still a licensed hospital
8 offering outpatient services. They still maintain any
9 requirements -- for example, if they've got operating rooms,
10 they're still subject to the CON standards for Surgical
11 Services and things like that. So I don't think there is
12 any intention by the facilities to skirt any requirements
13 that are out there for hospitals and I don't want there to
14 be a classification that they're not a hospital because they
15 are still licensed as such and the federal government
16 considers them hospitals as well.

17 MR. FALAHEE: Thank you, Carrie, Jenny. Other --
18 hang on, Beth. Other comments, questions from the
19 commissioners? Okay. Beth Nagel?

20 MS. NAGEL: I just want to add a little bit on to
21 what Marcus said just to explain one thing. When we issue a
22 waiver, it legally says you are not subject to Certificate
23 of Need. And we -- we did that in one case. We don't love
24 that going forward. We don't think that that's a good
25 solution if this is to become a regular process for

1 Certificate of Need. The other thing that I would say just
2 to echo Marcus's comments is something that we heard in the
3 subgroup that was a little surprising to us is that these
4 rural emergency hospitals want to retain their ability to
5 relocate or replace. They were very clear with us on that
6 but then rejected language allowing us to do that. And so
7 without something that says in this case you can do X, Y and
8 Z, the Department's answer is going to be no. So if a rural
9 emergency hospital came to us and said I want to replace my,
10 you know, delicensed beds to a new location, without any
11 language in the standard, we have no way to evaluate,
12 approve or disapprove that application.

13 So I completely understand and appreciate that we
14 are early in the process of rural emergency hospitals, that
15 there is federal whatever moving around outside of our state
16 that could impact the process, but we are simply trying to
17 provide the Commission with what you need to make the
18 decision to support what we're hearing from the field if
19 that makes any sense.

20 DR. FERGUSON: Follow up on that, Beth. So I'm
21 hearing that if you grant a waiver, it's a broad-based
22 waiver. Is there either an opportunity that exists today or
23 an opportunity if we get some new code written that would
24 allow you to grant narrower waivers, meaning waiver from
25 single item rather than blanket CON waiver?

1 MS. NAGEL: So that is essentially an application,
2 what you're describing. When someone applies for anything
3 in Certificate of Need, we say, okay, here are the eligible
4 pieces that are relevant to your application and then we ask
5 you to address those things. So if we are -- and -- and --
6 and we would also say in your approval letter you're not --
7 these things are not applicable to you and so that is
8 essentially what an application is. Providing a waiver is
9 legally -- we cannot -- if we're saying you are not subject
10 to Certificate of Need, we can't then say except for, you
11 know, these few things. That would be in the place of an
12 application. We would need to grant an approval.

13 DR. FERGUSON: So do you have a process in the
14 application process to grant whatever -- I mean,
15 functionally I know you're calling it something different,
16 but grant the waiver on X term? Right? If there's a term
17 that says we have to serve apples every Friday, are you able
18 to say nope, we're going to waive that because they asked
19 for a waiver and we're going to skip that criteria?
20 Basically is there a way to escape whatever the restrictive
21 clause that, you know, Jenny's SAC team is worried about?
22 I'm trying to find some common ground here. I don't --

23 MS. NAGEL: Yeah. I appreciate that. Certainly
24 we can in our application process say you don't have to
25 serve apples on Friday or, you know, whatever. We can do

1 that. But without anything in any language in the standard
2 that addresses rural emergency hospitals, I'm not sure what
3 we would be doing with an application then.

4 MS. CARRIE LINDEROTH: I think one more thing,
5 too, is that the Public Health Code has a process in what is
6 required in order to temporarily delicense the beds and so
7 it's part of their licensing application. And admittedly
8 it's a -- you know, a smaller application than perhaps would
9 happen through CON. But it does require an applicant to
10 list what the alternative use of the space is, how many beds
11 are being delicensed, what the time frame is and, you know,
12 a number of other plans for the facility. And then the REH
13 process with the federal government requires that you have
14 to put forward a whole transition plan and it's pretty
15 extensive what you have to do and it explains what services
16 you're going to keep online, what services you're going to
17 defer temporarily. And as -- you know, in Sturgis's
18 example, they supplied the Department with a copy of that as
19 part of the waiver and it was specific to this project.
20 Anything else they would be working on would be subject to,
21 you know, CON in any other capacity and as such.

22 And so it's -- they're not, like, without a
23 process right now. They do have pretty extensive paperwork
24 that they have to file and detailed reports that go with it.
25 I think that's why we were really kind of looking to work

1 through this a little bit better as far as what would be
2 less duplicative in the sense, like -- we're doing that. We
3 are doing that and we're happy to supply that. It's
4 something that's public information. And I think where some
5 concerns come into play is the federal intent is for these
6 facilities to be able to come back online and we didn't want
7 standards that precluded them from being able to get their
8 beds back.

9 MR. FALAHEE: Thank you, Carrie. And that last
10 point is a key point on something that at least I think
11 there's a potential fix for. So, Beth?

12 MS. NAGEL: Could I ask what in the proposed
13 standard doesn't allow a hospital to get their beds back?

14 MS. CARRIE LINDEROTH: I think it's in Section 2,
15 the ability to extend the five-year period was at the
16 discretion of the Department. And it -- it put a need-based
17 methodology in there such that if the beds were needed, it
18 would essentially allow a competitor to come in -- the way
19 it's written would allow a competitor to come in and take
20 the beds and not give the incumbent provider the ability to
21 reclaim them. That may not be what's intended, but that's
22 how it's written right now and I think that was a concern
23 where we wanted to work through it.

24 MS. NAGEL: That's actually -- oh, I -- I guess
25 this isn't on. I'm just holding it. That actually came

1 from the statute. That's a drop and plug from the statute.
2 And certainly the Department doesn't regulate that. You
3 know, we don't have any influence on that, the statute that
4 was written.

5 MR. FALAHEE: I think there's some fine tuning
6 that could happen, but we have more public comments. Any --
7 for the moment, any more questions from the commissioners?

8 MR. DRAKE: Yeah. This is a commissioner. I have
9 a question. So I haven't seen any of these in Detroit, so
10 I'm a little vague on. Kind of give me a quick overview of
11 what these look like, number of beds, types of service, just
12 high level.

13 MR. FALAHEE: I'll do -- I'll -- this is
14 Commissioner Falahee -- since I know Sturgis. It's a small
15 community, southwest corner, very near the Indiana border
16 licensed for 89 beds. I don't think they've ever seen 89
17 patients. Knowing the CEO's there over the years, probably
18 average daily census, 15.

19 MS. CARRIE LINDEROTH: I think that's high.

20 MR. FALAHEE: 20? That's high? Okay. So that
21 tells you a little bit, at least the one that's applied for
22 REH and gotten it, that's what it's like.

23 MR. DRAKE: Okay.

24 MS. CARRIE LINDEROTH: And that's -- that one's
25 kind of atypical. Usually they would fall in the critical

1 access space and those are 25 beds.

2 MR. DRAKE: 25, right. Okay.

3 MR. FALAHEE: Okay. Jenny, do you have any
4 comments right now or do you want to open it up for public
5 comment knowing that you can be called back at any moment?

6 MS. JENNY GROSECLOSE: I -- I will wait to be
7 called back.

8 MR. FALAHEE: Thank you.

9 MS. STANTON: We have Amy Barkholz up first with
10 MHA.

11 AMY BARKHOLZ

12 MS. AMY BARKHOLZ: Good morning. I'm Amy
13 Barkholz, senior vice president and general counsel with the
14 Michigan Health and Hospital Association, and I'm here to
15 speak about the Hospital Bed Standards and specifically the
16 REH language and the charge and a lot's already been said,
17 so thank you. I'd like to thank the Department and the SAC
18 and Carrie and Chair Groseclose and the workgroup.

19 This was a very interesting and new issue, so I
20 know there was a lot to discuss and a lot of new ideas and
21 we submitted written comments in a letter, so I don't want
22 to rehash that. But I just want to make a couple points.
23 Hospitals that are considering the federal designation are
24 taking a giant leap of faith under very difficult
25 circumstances and I think Carrie kind of brought that out a

1 little bit.

2 Congress created the rural emergency hospital
3 designation to address a real problem that so many
4 struggling hospitals, small hospitals, in really
5 economically vulnerable communities are facing. Sturgis is
6 one of those and I think Chip tried to explain that pretty
7 well. They're sole hospitals in their community. They're
8 at grave financial risk of going out of business and they're
9 going to take all of the services, the outpatient, the
10 emergency, the lab, the primary care services with them if
11 they go out of business. So the designation allows these
12 qualifying hospitals with enabling state licensure laws to
13 maintain a hospital without inpatient beds which is kind of
14 weird, but it's not really that weird because these
15 hospitals really don't do a lot of inpatient things anyway.
16 The hospital is there, but it's really about their
17 outpatient, their emergency department, their lab services.
18 That's really the crux of what the services are in these
19 small communities.

20 The federal rule also provides a mechanism that
21 they've talked about for the hospital to convert their beds
22 back to inpatient beds in the future under some pretty
23 defined circumstances, but they're fuzzy yet as we talked
24 about because the rules are there but they haven't been
25 clarified by CMS because the program is so new. Michigan

1 stakeholders including the MHA, the legislature, the
2 Governor's office, LARA, MDHHS work together to get
3 legislation passed last session to facilitate REH's in
4 Michigan, but there's still a lot of uncertainty about how
5 the program will be administered by CMS. So adding more
6 state regulations at this time will create a lot of layers
7 of regulation on hospitals and it's going to create more
8 hesitation by these community boards who are desperate not
9 to relinquish the few services they have. So I think
10 they're looking at this, but they're not sure they're ready
11 to pull the trigger on this new idea.

12 So as we said, when the SAC met in October 5th,
13 they voted to hold off on proposing any further regulation
14 of REH's until the feds could offer more clarification.

15 MS. STANTON: You've reached the three-minute
16 limit.

17 MS. AMY BARKHOLZ: Okay. So our recommendation is
18 to follow the SAC's recommendation to pause on this. We
19 don't support the addendum language and we do feel that
20 REH's can be regulated by CON and for all of their other
21 services. Thank you.

22 MS. STANTON: Thank you.

23 MR. FALAHEE: Thanks, Amy. Any questions from the
24 Commissioners? Okay. Thank you, Amy. Next?

25 MS. STANTON: Up next is Tim Johnson with Eaton

1 Rapids Medical Center.

2 TIM JOHNSON

3 MR. TIM JOHNSON: Good morning. My name is Tim
4 Johnson. I'm the CEO of Eaton Rapids Medical Center. We're
5 a small, independent, rural community hospital located
6 between Lansing and Jackson. It was my honor and privilege
7 to serve on the HB SAC this summer and be part of the REH
8 subcommittee. So I was part of those discussions -- what
9 did you call them, Frank, Chip? Robust discussions. And I
10 can tell you I -- I have concerns with what the proposed
11 standards look like and I'm very much in favor of the SAC's
12 recommendation that we pause on these standards until we've
13 had some time to do some more work. So thank you. And I'll
14 take any questions anybody might have.

15 MR. FALAHEE: Any questions? I've got 28
16 questions for you because I knew you would -- okay. So
17 here's a question. The hospital you're CEO of, is it a
18 critical access hospital?

19 MR. TIM JOHNSON: It is, yes.

20 MR. FALAHEE: Okay. Are you considering REH
21 status at all?

22 MR. TIM JOHNSON: Not at this time, but I do see
23 that -- so our hospital has -- we've been losing money.
24 It's a struggle for small rural community hospitals. That's
25 why there's not many small independent hospitals left. So I

1 really don't think -- and this is just my personal
2 opinion -- I don't think any hospital wants to go to REH.
3 They do that because they have to. And so we're not at the
4 point that we have to now, but we certainly want to have
5 that option if that need arises.

6 MR. FALAHEE: And thanks, Tim. And then full
7 disclosure, Tim and I know each other real well. We served
8 on the MHA board for years, known each other a long time,
9 and I respect what he's doing at Eaton Rapids for many, many
10 years. What I'm hearing is -- tell me if I'm nuts about
11 this issue -- REH potential hospitals, my analogy is they
12 don't want to jump off the diving board until they're sure
13 there's water in the pool?

14 MR. TIM JOHNSON: That's a good way of putting it.
15 Good analogy.

16 MR. FALAHEE: And one way to make sure there's
17 water in the pool while we're waiting for the government to
18 do something is to say you can get your beds back if for
19 whatever reason two years, three years, five years later you
20 go times have changed, community has changed, we want the
21 beds back so we can be a hospital hospital again. Is -- am
22 I off base on that?

23 MR. TIM JOHNSON: No. Yep, you've nailed it.

24 MR. FALAHEE: Okay. Because I think in the
25 absence of something from the federal government, if we can

1 be of help to people trying to make that decision and say,
2 hey, you can get your beds back. Here are the rules to live
3 by, that would -- because it's an awful decision to have to
4 make. But if you have to make it and know that I can get my
5 beds back if things change, that might be helpful; correct?

6 MR. TIM JOHNSON: Yes; yep.

7 MR. FALAHEE: Okay.

8 MR. TIM JOHNSON: And I think that was -- my -- my
9 -- my number one concern going into this. And I think all
10 the -- and, again, nobody wants to be an REH. So they want
11 to be able -- and their hope going into this, I'm sure, is
12 to get back to being a full critical access hospital like
13 you said as things change and hopefully, you know, we know
14 the cycles go up and down, that maybe there's that chance
15 that they can get those beds back and it's very important
16 not only to the hospital, but to that small community that
17 that hospital is in.

18 MR. FALAHEE: Great. Other questions for Tim?
19 Great. Thanks for your comments. Appreciate it.

20 MR. TIM JOHNSON: All right. Thank you.

21 MS. STANTON: And then next we have Melissa Reitz
22 with McCall Hamilton.

23 MELISSA REITZ

24 MS. MELISSA REITZ: Still morning; right? Yeah.
25 Good morning. I'm Melissa Reitz with McCall Hamilton. I

1 also participated in the subgroup. I was not a member of
2 the SAC, but did participate in the subgroup discussions on
3 this topic. And I just wanted to say a few things.

4 First and foremost, I just felt like it was worth
5 saying that I feel like every member of the subgroup, their
6 number one goal was what can we do to help these rural
7 hospitals? We wanted to wherever possible take down
8 barriers rather than put up barriers. And so I -- I think --
9 -- you know, I don't think anyone in the subgroup was happy
10 with not being able to come to consensus on these
11 provisions, but ultimately just felt that in order to make
12 sure that we weren't putting up more barriers, that it was
13 better to leave things where they were. And I think
14 certainly all of the changes that were kind of percolating
15 regarding CMS certainly helped us feel better about that
16 ultimate recommendation. And so I -- I will say also,
17 however, that I was really pleased to see the -- the
18 progress that the Department made in the draft that they did
19 put forward.

20 The draft that you guys have seen in anticipation
21 of today's meeting is not what was presented to the
22 subgroup. And there was -- there has been a lot of progress
23 made toward recognizing the need for these facilities to be
24 able to have an option for replacing their physical plant
25 and be able to have some flexibility related to those

1 temporarily delicensed beds.

2 So I think I -- I just wanted to say that although
3 the Department's current version of that addendum I think is
4 greatly improved over what was presented to the SAC, I think
5 there's still a lot of work that needs to be done to it.
6 And so if the Commission is inclined to want to work toward
7 having an addendum in place, I just would encourage that
8 there be an opportunity for more work to be done on that
9 before it was put into the standards. Thank you.

10 MR. FALAHEE: Questions of Melissa?

11 MR. HANEY: I have just one. Commissioner Haney.
12 How soon could we commission additional work on that --
13 those standards if we were to adopt them -- not adopt them
14 today?

15 MR. FALAHEE: This is Commissioner Falahee.
16 Hypothetically and ignoring many, many discussions I've had
17 with people in this room, one option is we could approve the
18 language as is and approve the Department's language as is,
19 send them both out for public comment. Once that public
20 comment comes in, then let's assume there's still
21 differences of opinion on the REH language, form a workgroup
22 to discuss the issues, and whether those are frank
23 discussions or collegial discussions I don't care, but to
24 take the time. So to answer your question, Commissioner
25 Haney, in the perfect world I'd like something could maybe

1 be done by the March meeting of this group. Now maybe
2 that's too soon. I don't know what else is on the
3 Department's plate. The latest I'm thinking June. But I
4 think you can hear the back and forth and the discussions
5 and everybody is trying to come up with a solution which is
6 great, it's just what is that solution? I think it needs a
7 little more time and discussion. But I think at the
8 latest -- I'm looking at Beth -- is March maybe a push, June
9 not a push?

10 MS. NAGEL: Well, some of that will depend on the
11 Commission's January meeting where you set the work plan for
12 the rest of the year. But I think now, I mean, I would
13 certainly defer to Marcus -- I seem somewhat comfortable
14 with the June timeline.

15 MR. CONNOLLY: Yeah. I would agree with -- with
16 June. That'll give us enough time to kind of regroup and
17 discuss whatever we need to to get everything rolling.

18 MR. HANEY: Okay.

19 MR. FALAHEE: Commissioner Haney, does that --

20 MR. HANEY: That answers my question.

21 MR. FALAHEE: Okay. Great. Thanks.

22 MS. MELISSA REITZ: Can I ask a clarifying
23 question? Would you form the workgroup now or you would
24 wait until after the public comment to form the workgroup?
25 Because I'm thinking if you formed it now, it would give

1 more time to get to that June meeting.

2 MR. FALAHEE: I've had discussions this morning
3 going either way. All right?

4 MS. MELISSA REITZ: Well, if I can vote for one, I
5 would vote for sooner rather than later.

6 MR. FALAHEE: I don't think -- I don't think --

7 MS. MELISSA REITZ: I know I don't get a vote,
8 but --

9 MR. FALAHEE: I can see the merits to both and we
10 can have that discussion later.

11 MS. MELISSA REITZ: Yeah. Any other questions for
12 me?

13 MR. FALAHEE: Thanks, Melissa.

14 MS. MELISSA REITZ: Thank you.

15 MS. STANTON: That concludes the public comments.

16 MR. DRAKE: I -- I have a question for the SAC
17 chair, actually, if she can tell me about --

18 MR. FALAHEE: Nice try, Jenny, but Commissioner
19 Drake --

20 MR. DRAKE: And thank you for your work on this.

21 MS. JENNIFER GROSECLOSE: Oh, it has been a very
22 large learning experience and I enjoyed learning so much
23 about REH because we have critical access hospitals for
24 Munson, so --

25 MR. DRAKE: So it looks like we're at an impasse

1 on the language here and the recommendation from the SAC was
2 to kind of stand still for now.

3 MS. JENNIFER GROSECLOSE: Uh-huh.

4 MR. DRAKE: Is it -- I heard you mention the
5 losing of the beds and I seem to recall there was a five
6 year plus another five year potential. Is there anything
7 other than that time period of losing the beds that gives --
8 gave the SAC pause? Just so I'm clear.

9 MS. JENNIFER GROSECLOSE: So the -- the losing the
10 beds and then the language, the proposed language, I
11 understand that's from the statute, but I do think that
12 requires a workgroup conversation collectively with the
13 Department because that is a -- that's a huge barrier.

14 MR. DRAKE: Okay.

15 MS. JENNIFER GROSECLOSE: But the replacement and
16 relocation piece is another detail that I think could use
17 more collective conversations.

18 MR. DRAKE: Okay. So those two things?

19 MS. JENNIFER GROSECLOSE: Yep.

20 MR. DRAKE: Thank you.

21 DR. KONDUR: Commissioner Kondur. I have one
22 quick question. Not many hospitals are not looking to
23 become a emergency status -- rural emergency hospital
24 status. Is there any way we can just pause on charge 4 and
25 approve the rest of them as it is -- take a long time and to

1 have a clarity what need to be done to -- in agreement,
2 everybody agrees on the language?

3 MR. FALAHEE: This is Commissioner Falahee. What
4 I was thinking is we could send all of the charges out for
5 public comment and then I think we can -- I'd have to turn
6 to Attorney Heckman here. I think we can bifurcate. If --
7 if we've got five charges and we get public comments back
8 for four of them, we could then approve those four for final
9 action and then if we get public comments in a workgroup and
10 it says we're still working on charge 4 -- okay. Keep
11 working, keep heading to that, but in the meantime approve
12 the others? And -- Brien, does that make sense?

13 MR. HECKMAN: Yes. And that is accurate.

14 DR. KONDUR: Thank you.

15 MR. FALAHEE: Commissioner Ferguson?

16 DR. FERGUSON: So this is somewhere between a
17 question and maybe a request. It's probably, Beth, for you
18 and your friends in the Department, although, Jenny, you may
19 have some detail on this as well. This return of bed
20 licenses is seemingly a really important topic. I'm hearing
21 from you that we're constrained at least partially by the
22 statute as written knowing that change is (inaudible) hard.
23 I don't know what our authority is to add clarifications,
24 addenda, et cetera, et cetera that would solve this.

25 MS. NAGEL: Yeah.

1 DR. FERGUSON: And so the question is can you do
2 that? And if you don't know, maybe this is part of your
3 workgroup going back?

4 MS. NAGEL: Yeah.

5 DR. FERGUSON: Because it sounds like this is
6 important enough that we need to solve it.

7 MS. NAGEL: Uh-huh. I'm glad you asked that
8 question because I wanted to take a moment to clarify -- oh,
9 with the microphone. This -- the way that the statute is
10 written, it says that it's up to the Department to decide if
11 you can keep your beds essentially. It gives the Department
12 discretion. Sometimes we like that, to have that
13 discretion. But what we -- what we wanted to do and what we
14 attempted to do in the draft that we provided to you is,
15 okay, we have discretion, but here's how we're going to
16 evaluate. And essentially it says, hospital who's been an
17 REH for the last five years, do you want to keep your beds,
18 yes or no? If the answer is no, then they go out for a
19 competitive bid with the proposal. So I'm surprised that
20 it's being interpreted as you have to give back your beds
21 when it's pretty explicit that we give you a -- the right of
22 first refusal. But we -- we thought that it would benefit
23 the hospital community. I think the analogy was at earlier
24 about is there water in the swimming pool. We want to tell
25 you what that -- I mean, to continue the metaphor, what kind

1 of water is in the swimming pool so that a hospital could
2 make the decision on what they can do before deciding to
3 become a rural emergency hospital. So that was our intent.
4 I'm obviously hearing that perhaps we did not meet that mark
5 and I, you know, would certainly love the opportunity to
6 continue discussing it.

7 DR. FERGUSON: Great. Thank you.

8 MR. DRAKE: Beth, kind of -- it's Commissioner
9 Drake -- follow-up question to that. Let's say after five
10 years the hospital says I'm giving them up.

11 MS. NAGEL: Yeah.

12 MR. DRAKE: Would they then lose the privileges of
13 the other ancillary departments, you mentioned maybe surgery
14 or radiology, being hospital-based? What happens to then
15 the hospital departments?

16 MS. NAGEL: That's a -- that's a wonderful
17 question. And I think that there are some dependencies in
18 the standard with hospital beds and some of our other
19 services, although that's something we certainly would have
20 to explore and work out. You know, I think we spent a
21 little bit -- I'm looking at Tulika because it's usually in
22 her brain. We have spent some time thinking about that
23 knowing it was somewhat in the future, but -- but that is
24 something we'd certainly have to iron out. I don't know if
25 you want to add anything more to that?

1 MS. BHATTACHARYA: Thanks, Beth. So definitely
2 there are some CON services that you cannot offer if you are
3 not a licensed acute care hospital. So for everybody, it's
4 a new normal that there is a licensed hospital with no
5 licensed beds. So, for example, if you have OR's, where
6 they are offering outpatient surgery or inpatient surgery,
7 you can offer outpatient surgery anywhere but inpatient
8 surgery, you know, you have to be licensed acute care -- or
9 licensed hospital with beds. For example, open heart
10 surgery, cardiac cath, transplants, you have to be a
11 licensed acute care hospital. So if you are, "a licensed
12 hospital with no licensed beds," what do you do? But if
13 you're offering CT, PET, MRI, da, da, da, you don't have to
14 be a licensed hospital, how do you bill for those services?
15 CON does not play a role in billing. That's -- I mean, I
16 don't know. Maybe I should not say anything about that. So
17 there are CON services that require you to be a licensed
18 hospital with beds.

19 MR. DRAKE: With beds. That was --

20 MS. BHATTACHARYA: But there are some services
21 where you can offer -- continue to offer those --

22 MR. DRAKE: Okay.

23 DR. KONDUR: So one quick question. So back to
24 the same thing. Once you lose the acute care status and you
25 lose your site of service 21, how do they bill their

1 outpatient services? They need to reapply for the
2 outpatient radiology services?

3 MS. BHATTACHARYA: I -- I'm not an expert. I do
4 not want to answer the question.

5 MR. FALAHEE: I'll do -- this is Commissioner --
6 yeah, this is -- this is Commissioner Falahee. Those of us
7 in the hospital world would probably love it if the CON
8 Department could help us with billing, but it -- it's not
9 within its jurisdiction or bailiwick. But then this
10 Commission could be in charge of hospital billing which
11 would be fantastic both -- from both perspectives including
12 from Blue Cross Blue Shield perspective but that's not
13 something within the purview of the Department. Other
14 questions? There's no more public comment; correct?

15 MR. WIRTH: No.

16 MR. FALAHEE: Okay. Other questions of Jenny?
17 This has been a very, very good discussion. Jenny, anything
18 else you want to add?

19 MS. JENNIFER GROSECLOSE: I just want to thank
20 everyone for the hours and hours and hours of detailed
21 discussion and research and it isn't just specific to REH.
22 There was just a ton of work with LAA and the other
23 technical and draft language that's within the hospital bed
24 SAC standards. And the SAC members were so helpful, but the
25 subgroup, the non-SAC members are invaluable. And so I

1 don't know how I would have done it without everyone's help.
2 And -- and the Department -- the Department was very
3 involved, more involved than they have been in the past to
4 be quite honest and that's so wonderful to be collaborative
5 and working so that we can come up with something that
6 everyone agrees on, so --

7 MR. FALAHEE: Great. Jenny, thank -- thank you.

8 MS. AMY BARKHOLZ: Wait a minute. One more thing.
9 I think we have the problem solved here.

10 MS. CARRIE LINDEROTH: On the license piece?

11 MR. FALAHEE: So we have Amy Barkholz and Carrie
12 Linderoth. I think one or both of them wants to speak so
13 I'll consider this the submission of a public comment card.

14 MS. AMY BARKHOLZ: Public comment. So a rural
15 emergency hospital is a new licensure category in Michigan;
16 correct?

17 MS. NAGEL: Uh-huh.

18 MS. AMY BARKHOLZ: Okay. Critical access hospital
19 is a -- is a type of hospital in Michigan; correct? CON
20 does not have a separate provision in the Hospital Bed
21 Standards for critical access hospitals in the Hospital Bed
22 Standards. There's no need for a separate provision for
23 rural emergency hospitals. They are an acute care hospital.
24 They're a new form of acute care hospital. They're a --
25 they're an acute care hospital.

1 MR. FALAHEE: Let's -- okay.

2 MS. AMY BARKHOLZ: They are.

3 MR. FALAHEE: Whether they are or not, I want to
4 ask if commissioners have any questions of Amy because I
5 know Beth wants to make comments.

6 MS. AMY BARKHOLZ: Well, that gets to Commissioner
7 Ferguson's question. There really -- we don't need the
8 addendum. They're subject to CON. They don't need a
9 waiver. They are subject to CON. They're a licensed acute
10 care hospital. They must follow all the CON laws. So we
11 don't have a separate section for critical access hospitals
12 separate from other acute care hospitals in CON. That's a
13 licensure issue. They're an acute care hospital and there
14 seems to be confusion about that.

15 MR. FALAHEE: Okay. Thank you. Beth, I think
16 you're good. You want to speak?

17 MS. NAGEL: Yeah. I certainly appreciate that
18 comment and I will say there's no confusion on that, but I
19 do respectfully disagree. The rural emergency hospital is a
20 new concept in that it completely delicensures its beds.
21 Certificate of Need regulates licensed beds. Critical
22 access hospitals still have licensed beds. And so while
23 they may not be a new categ- -- while it may be a different
24 category under acute licensed care, the Department still --
25 the Department, and I mean MDHHS, under Certificate of Need

1 still regulates those inpatient beds that are inside that
2 critical access hospital. When we have an REH hospital,
3 there are no licensed beds.

4 This is a very big distinction for Certificate of
5 Need that has nothing to do with the licensing
6 classification of it. It has to do with do they have beds,
7 do they not have beds. Further, the public health code
8 gives the Department very clear guidance on things that must
9 be done inside Certificate of Need for a rural emergency
10 hospital. We felt very strongly that we needed to bring to
11 the Commission some kind of response to those charges in the
12 statute and that's what we did. It has nothing to do with
13 how licensing is classified an acute care hospital.

14 MS. AMY BARKHOLZ: Okay. More discussion.
15 Licensure licenses beds. That would be my only discussion.
16 Department of Licensure licenses beds. If something needs
17 regulation under CON, it's regulated by CON.

18 MS. NAGEL: And we regulate licensed beds.

19 MS. AMY BARKHOLZ: And so if there's no licensed
20 beds, no CON regulation.

21 MS. NAGEL: I agree with you. However, the state
22 statute creating rural emergency hospitals does not.

23 MS. AMY BARKHOLZ: Okay.

24 MS. CARRIE LINDEROTH: I think I --

25 MR. FALAHEE: Well, let's --

1 MS. CARRIE LINDEROTH: -- can I make one more --
2 I --

3 MR. FALAHEE: You can make one more comment. I
4 want to move this forward because after this discussion and
5 final vote on this we'll take a break.

6 CARRIE LINDEROTH

7 MS. CARRIE LINDEROTH: I think that this
8 discussion is wonderful in the sense that it really shows
9 how complicated this got at the workgroup level as well.
10 And there's a disconnect in -- in how the public health code
11 is interpreted as well because there's a large portion of
12 the rural emergency hospital component that is vested with
13 LARA and the part vested with MDHHS is to count the beds
14 which can be done by notice from the applicant. And so it
15 just depends on where you want to look at that
16 interpretation because, yes, it's important that we know
17 where the beds are, but they can be counted in LARA which is
18 where the public health code puts it with our statute
19 enabling REH.

20 MR. FALAHEE: Okay. Thank you, Carrie. Attorney
21 General -- Assistant Attorney General Heckman wants to make
22 a comment I am told.

23 MR. HECKMAN: Thanks, Chairman Falahee. This is
24 Assistant Attorney General Brien Heckman. I just wanted the
25 Commission to know that I agree with the Department's

1 position on the need for the standards and that's kind of
2 overall a view of why there's a distinction between a
3 critical access hospital and rural emergency hospital.

4 MR. FALAHEE: Okay. Thank you all. Jenny
5 escaped. I won't call her back, but I want to thank her
6 again. As you can imagine, we just had a little bit of a
7 taste of what's been going on in the meetings. So, Jenny,
8 thank you very much for leading it, volunteering once again.
9 I won't call you at least for another month. Yeah. No,
10 thank you very, very much. I appreciate it. Okay. So
11 great robust discussion and I appreciate that and the
12 engagement of the Commission. Any other Commission
13 discussion, thoughts, reactions, questions of the
14 Department?

15 MS. TURNER-BAILEY: Commissioner Turner-Bailey. I
16 have a question. I know that we've talked -- there's a lot
17 of things that need to be, you know, sort of further
18 discussed and that one question that came up early on is
19 whether or not if there is a waiver provided that then
20 waives an entity from being regulated by Certificate of
21 Need. And I felt I heard conflicting interpretations of
22 that and it seems like that's also one of the major
23 decisions that has to be made as we go forward. And, you
24 know, I heard what you said and I respect that completely,
25 but I -- it seems like that there's still disagreement on

1 that and that's one of those things that also needs to be
2 defined and clarified as we move forward.

3 MR. FALAHEE: Thank you. Other comments? I have
4 one question. As you heard, one of the potential decisions
5 the Commission could reach is to send all of the
6 recommendations, 1 through 5, out for public comment and
7 knowing that we may need to bifurcate number 4, the REH.
8 But one of the hypotheticals was not just sending it out to
9 public comment, but also as to charge 4, the REH, forming a
10 workgroup and which comes first, the public comment then the
11 workgroup or vice versa, the workgroup first and then the
12 public comment? I don't know, Beth, do you have any
13 thoughts about it? I know -- this sounds like a high school
14 debate problem, you could probably take either side of the
15 issue.

16 MS. NAGEL: Yeah. I think we would prefer if
17 we're going -- if it's going to go out for public comment,
18 to be able to collect that public comment and then form a
19 workgroup. I think that would be the -- at least our
20 preference. That said, you're right. We could six in one,
21 half dozen the other.

22 MR. FALAHEE: To Commissioner Haney's point
23 earlier about, you know, when? If we send it out to public
24 comment, could we say public comments must be submitted by X
25 date?

1 MS. NAGEL: Yes, we do; yeah.

2 MR. WIRTH: Yeah, we give a one-week period for
3 people's comments.

4 MR. FALAHEE: Okay. Because my thought is, again,
5 just me, we can send it out for public comment, put a
6 deadline on when those public comments need to come in, get
7 the comments, and then put together a workgroup to look at
8 those comments most of which probably not -- probably all of
9 which would be related to the REH charge 4. Kenny?

10 MR. WIRTH: Just one, I guess, background point.
11 With the legislature being adjourned until January 10th,
12 there's no one there to receive our proposed action letters
13 so we have to schedule that hearing for after the 10th so
14 that we can notify the legislature of the hearing period.

15 MR. FALAHEE: I might be in the back of my mind
16 thankful that the legislature is not there so we have more
17 time. Okay. So, okay, so we could put a time limit on it
18 and, Don, your point then we could form a workgroup.

19 MR. HANEY: Yeah. And do we have to come back as
20 a -- as a -- in this room to form the workgroup or --

21 MR. FALAHEE: I think if we craft a motion
22 correctly, no. And even if we craft it incorrectly, we're
23 back here in January.

24 DR. FERGUSON: A process question from Ferguson.
25 So if we go out to comment, comes back, workgroup does some

1 work, comes up with a creative solution to some of these
2 problems hopefully, so -- what? -- then it comes back to us
3 and then we go back out to public comment again?

4 MR. HECKMAN: If the language substantively
5 changes, yes. If we're just deleting a provision -- if the
6 language changes, yes. If we're just deleting some portion
7 of it, then no.

8 DR. FERGUSON: And then but -- but -- and I guess
9 the follow-up on that is it sounds like we're going out to a
10 second public comment regardless of process. Because if we
11 go straight to workgroup now, are you going to go out with
12 this or -- I'm trying to figure out how to shorten the
13 process by only getting one set of public comments rather
14 than two. Is that doable and would that be an argument for
15 going straight to workgroup?

16 MR. HECKMAN: No, I don't think it really is from
17 a practical standpoint. So where -- we're going to get the
18 public comment on the language as is and you guys are going
19 to move forward with it or you're not. And if you're not,
20 then, I mean, presumably you have to have a public comment
21 for the second period and it's going to involve different
22 language.

23 DR. FERGUSON: Thank you.

24 MR. FALAHEE: Marcus?

25 MR. CONNOLLY: Yeah. Kenny just made me aware of

1 our work plan and -- is it the earlier months, more --

2 MR. WIRTH: Yeah, January through March.

3 MR. CONNOLLY: Yeah, January through March where
4 we are open because once April picks up, we'll have more and
5 more SAC's and more groups that we'll have to work with. So
6 that will be a time where we'll be more available to
7 facilitate those groups so I just wanted to make everyone
8 aware of that.

9 MR. FALAHEE: Okay. Thank you very much.

10 Falahee. Other Commission comments, discussion, questions?
11 Okay. Let me -- let me summarize and throw something out
12 for you to hash at, reject or approve. Number one, I know
13 everybody that was on the SAC and the subgroups had the best
14 of intentions which is great and it was a very good group of
15 people. Most of them I know and you couldn't get a better
16 group of people to look at the issue. And I say that with
17 the Department as well. The Department was fully engaged
18 trying to do what it thought was -- was the best given the
19 situation. It's a new situation. This REH thing is brand
20 new for everybody. Tim is correct. Nobody wants to become
21 an REH. It's sort of the final straw, if you will. And I
22 know the folks at Sturgis, they didn't want to become an
23 REH, but reality takes over. And I think what we're trying
24 to grapple with is a new federal law, a state statute and
25 what do we do with this thing called temporary delicensed

1 beds and how do you handle those? And, oh, by the way,
2 under the federal law you get to get them back somehow --
3 someday, somehow to be determined later. So I think that's
4 why you have this kind of confusion or vacuum and nature
5 abhors a vacuum. So my goal would be to try to put some
6 details here with the best of intentions to address
7 everything that we've talked about this morning.

8 So as I talked about earlier, one of the thoughts
9 is to send the recommendations out for public comment and to
10 the JLC -- I make sure I get that in before I get a dirty
11 look from somebody on the other side of the table -- to send
12 them out for public comment, to set a deadline date for
13 those comments. And I have no -- nothing in mind as to when
14 that deadline date is. I think the sooner the better
15 because let's assume then that we get public comments only
16 on REH. Then to form a workgroup and part of it would be to
17 authorize that workgroup now, to look at those issues that
18 come up in the public comment about the REH charge number 4.
19 And then looking at final action because we always end --
20 this is proposed action, now it goes out for hearing and it
21 comes back to final. If -- and it sounds like we're allowed
22 to bifurcate the charges. So if we get --

23 MR. HECKMAN: When you move -- move for the
24 original charges and then and the addendum so that there's
25 two separated provisions. So you're sending to public

1 comment the SAC's ending or sending the addendum both.

2 MR. FALAHEE: The person on my right is telling me
3 what to do which is always great when another lawyer tells
4 another lawyer what to do. All right. No, I get it. What
5 Attorney Heckman is saying is, look, if we choose to go that
6 route, move it out for public comment and then also to
7 approve any addendum language coming forward?

8 MR. HECKMAN: No; no; no; no. So there's the
9 Department's addendum that was presented that's separate
10 from the SAC. So send the SAC's language and then send the
11 addendum prepared by the Department so you have two things
12 identified as going out.

13 MR. FALAHEE: Yeah. Thank you. That was in my
14 notes but I didn't look at it. Yeah, I want to send them
15 both. My proposal is send both out, the report from the SAC
16 and the Department's language for public comment with a
17 definite date like you must respond by X date. Following
18 that, we then -- assuming there are comments about the REH,
19 we today as part of the motion approve a workgroup to look
20 at those public comments and to work with the Department to
21 come up with potential solutions that will then come back to
22 the Commission. Kenny?

23 MR. WIRTH: Point of clarification. Is that
24 workgroup looking at all public comments or only public
25 comments related to REH?

1 MR. FALAHEE: It would look at all public
2 comments.

3 MR. WIRTH: For the HB SAC's work and the REH
4 addendum? Okay.

5 MR. FALAHEE: That -- that would be my thought.
6 If we get any public comments, who best to look at it than a
7 workgroup that's already experienced with the issue? And to
8 speed up the process, Commissioner Haney, to your point, I
9 want to get this resolved because there's unknowns out there
10 and, again, if you're looking at the diving board and you
11 want to jump, how about -- how deep's the water? Any
12 questions? Okay. Does anyone care to make a motion?

13 DR. FERGUSON: You just made one.

14 DR. MCKENZIE: I can take a stab at it. I'll make
15 a motion to send the Hospital Bed SAC language out for
16 public comment and to the JLC, but to bifurcate the language
17 from the standard versus the addendum when we send it out,
18 and also to form a -- to establish a deadline for that
19 public comment to be determined by the Department and the
20 Chair, and to form a workgroup to be able to respond to that
21 language.

22 MR. FALAHEE: And just for clarification, you're
23 saying for public comment both the SAC report and the
24 Department's language?

25 DR. MCKENZIE: Correct. That would be bifurcated

1 so there would be two separate.

2 MR. FALAHEE: Got it. Is there support for that
3 motion?

4 MS. TURNER-BAILEY: Commissioner Turner-Bailey.
5 Support.

6 MR. FALAHEE: Thank you very much. Discussion?

7 DR. KONDUR: So Commissioner Kondur. My
8 understanding is it goes to a public comment, so we review
9 the comments, work with the Department closely. If anything
10 more public comments related to the charge 4, intention is
11 to form a workgroup and back to the Commission meetings to
12 approve?

13 MR. FALAHEE: My reaction to that is I don't think
14 we have to wait for the Commission -- for the public
15 comments to come back to the Commission. I would like to
16 say the -- you know, that the workgroup can start working.
17 Yeah, speed is of the essence here.

18 DR. KONDUR: Correct. So the public comments
19 should be worked by the workgroup, so they work closely with
20 the Department, come up with the final language, comes to
21 the Commission so we approve. Oh, agree.

22 MR. FALAHEE: And that's where we could get --
23 final wording is all set for all of the charges except for
24 charge number 4 which is REH. That may take another -- the
25 next meeting of the Commission to do final action on that.

1 So we have a motion and a support. Any further discussion?

2 All in favor please raise your hand.

3 ALL: (All raise hands)

4 MR. FALAHEE: Opposed raise your hand. That
5 motion carries.

6 (Whereupon motion passed at 11:41 a.m.)

7 MR. FALAHEE: Thank you, everybody in the room.
8 Thank you, Commissioners, for a great discussion for a very
9 interesting new topic. Thank you very much. We're going to
10 take a break right now. Let's do a 10-minute break, then
11 we'll come back. Thank you all very much.

12 (Off the record)

13 MR. FALAHEE: Let's get back together again,
14 please. So this is Commissioner Falahee. Thank you all for
15 coming back from break on time, and with fingers crossed,
16 the remaining part of the agenda won't take as long as the
17 first part, so we'll see. I'll turn it over to Tiffani,
18 yes, to describe the next -- the issue, the CT Scanner
19 services which I will note, folks, final action. Not
20 proposed, final.

21 MS. STANTON: Yes. It did go out for the public
22 hearing. So at the June Commission meeting, the Commission
23 took proposed action on the informal workgroup's language
24 that was presented in the workbook. The draft language was
25 sent out to a public hearing and Joint Legislative

1 Committee. Testimony was received from four individuals
2 representing a total of two organizations in opposition of
3 the workgroup's language. Comments were not in support of
4 the draft language. They proposed alternate -- alternative
5 language to exempt the otolaryngology and chiropractic
6 services. During the workgroup process, the draft language
7 was unanimously approved. This includes the subgroup
8 recommendation detailed in the chair report that there
9 should be no change to the definition of CT Scanner, and
10 then further stated that non-dental use of the cone beam --
11 cone beam CT should still require a CON application.

12 Concern has been expressed that the added phrase
13 "for clarification of such as but not limited to
14 chiropractic utilization still requiring a CON review and
15 approval" is without bias -- or without basis. The
16 clarification was added to reduce the numerous questions
17 that are received from non-dental practices, particularly
18 chiropractic practices either requesting clarification if
19 they need to submit an application or requesting a waiver
20 for their service. We believe that the clarification will
21 greatly reduce the number of questions we receive about who
22 needs to submit a CON application. We can add the
23 clarification in the future to capture other areas of
24 medicine to ensure we are extremely clear about who needs to
25 apply for -- apply through the CON and who is exempt.

1 The informal workgroup considered whether to
2 provide an exception to carve out for chiropractic use and
3 determined not to create that exception at this time. No
4 public comments were received at the June CON meeting and
5 when proposed action was taken, all workgroup
6 recommendations reached a consensus. No workgroup
7 participants voted against the approving the recommendations
8 and all meetings were publicly posted open to any member of
9 the public. The Department is supporting the language as
10 presented and by the informal workgroup at the June meeting.

11 If the Commission chooses to take final action on
12 the language as presented, then the language will move
13 forward to the JLC and the Governor for the 45-day review
14 period. The review period must include not less than nine
15 legislative session days. The language -- if the language
16 is not -- disapproved, it becomes effective on the
17 expiration of the 45-day period. The language will be
18 forwarded to the legislature when they reconvene after
19 January 10th which is also when that 45-day period will
20 begin.

21 MR. FALAHEE: Okay. Thank you. That was a
22 mouthful.

23 MS. STANTON: Sure was.

24 MR. FALAHEE: Any public comment cards?

25 MS. STANTON: No, not for this one.

1 MR. FALAHEE: Okay. Great. So unlike our prior
2 agenda item, we have proposed wording, no public comment
3 cards, unanimity amongst workgroup. Any questions of the
4 Department by commissioners? Otherwise I think we can
5 proceed to a formal vote. Any questions? Okay. Then the
6 option on the floor is if we choose to take it to support
7 the language and present it and then take final action on it
8 and then the language will be sent to the Joint Legislative
9 Committee and the Governor, as Tiffani said, then for a
10 45-day review period. I would entertain a motion to that
11 effect.

12 DR. MCKENZIE: Commissioner McKenzie will move to
13 accept the language, sent it for public comment and to the
14 Joint Legislative Committee.

15 MR. HANEY: Commissioner Haney. Support.

16 MS. STANTON: It was already sent for --

17 MR. WIRTH: Final action.

18 DR. MCKENZIE: Oh, sorry.

19 MR. FALAHEE: Yeah. Public comment.

20 DR. MCKENZIE: Sorry. Sorry. Let me revise that.
21 Will move to finalize the language as present and send it
22 for -- I'm sorry --

23 MR. FALAHEE: JLC and the Governor for 45-day
24 review.

25 DR. MCKENZIE: -- JLC and Governor for a 45-day

1 review period. Thank you.

2 MR. FALAHEE: Is there support for that motion?

3 DR. ENGELHARDT-KALBFLEISCH: Commissioner
4 Engelhardt. Support.

5 MR. FALAHEE: Thank you. Any discussion with the
6 Commission members? All in favor please raise your hand.

7 ALL: (All raise hands)

8 MR. FALAHEE: Opposed, same sign? Motion carries.
9 Thank you very much.

10 (Whereupon motion passed at 11:57 a.m.)

11 MR. FALAHEE: Next, this one -- Kenny, do you have
12 the next? Okay.

13 MR. WIRTH: That is me. So next up we have
14 Nursing Home and Long-Term-Care Unit Beds and Services. At
15 the June Commission meeting, the Commission took proposed
16 action on the language in front of you today. The draft
17 language was sent to public hearing and to the JLC.
18 Testimony was received from one organization in support of
19 the workgroup's language, but with the request to include
20 additional items that did not reach consensus during the
21 workgroup process. I do remember back in June we had
22 comment from HCAM requesting the addition of language
23 regarding extensions for public health emergencies as well
24 as language that would allow a facility to temporarily close
25 in order to replace all existing beds, that those were not

1 added to the language and the language went out as
2 presented. We -- that is something that we'll keep on the
3 radar for the next workgroup as discussed in June, but the
4 Department is supporting the language as presented today.
5 If the Commission chooses to take final action on the
6 language as presented, then the language will be forwarded
7 to the JLC and the Governor for the 45-day review period.
8 It must include not less than nine legislative days and
9 since the legislature is adjourned right now, that will
10 begin on January 10th when we can send it to them.

11 MR. FALAHEE: Thank you, Kenny. Are there any
12 public comment cards on this one?

13 MS. STANTON: There are not.

14 MR. FALAHEE: Okay. So, again, much like the
15 first one, the one we just took final action on,
16 recommendation from a group, some comments about it but
17 really came forward unanimously, no public comments today.
18 So I would entertain a motion to take final action and move
19 it forward from there.

20 DR. ENGELHARDT-KALBFLEISCH: Commissioner
21 Engelhardt. I'll move to -- make a motion to get the final
22 action or final language forwarded to the Joint Legislative
23 Committee and the Governor for approval.

24 MR. FALAHEE: For the 45-day review period, too.

25 DR. ENGELHARDT-KALBFLEISCH: For the 45-day

1 review.

2 MR. FALAHEE: Yes, thank you. Is there support
3 for that motion?

4 MS. TURNER-BAILEY: Support.

5 MR. DRAKE: Commissioner Drake. Support for --

6 MR. FALAHEE: Thank you. I'm always -- yeah,
7 right.

8 MR. HECKMAN: It's a tie.

9 MR. FALAHEE: Pick one. Yeah. Thanks, Marcy.
10 I'm always picky about the right language because Kenny's
11 predecessor, some of you may remember Brenda Rogers and
12 Brenda was very direct so that's why I add the language. So
13 thank you very much. So there's a motion and seconded in
14 front of us. All in favor please raise your hand.

15 ALL: (All raise hands)

16 MR. FALAHEE: Opposed same sign? That motion
17 carries. Thank you very much.

18 (Whereupon motion passed at 11:59 a.m.)

19 MR. FALAHEE: Next we move to Psych Beds and
20 Services. And, Kenny, I think that's you.

21 MR. WIRTH: Yeah.

22 MR. FALAHEE: You and Tiffani are bouncing back
23 and forth.

24 MR. WIRTH: We're taking turns. So, again, at the
25 June Commission meeting the Commission took proposed action

1 on the Psych Bed informal workgroup language that's in front
2 of you today. The draft language was sent out to public
3 hearing and to the Joint Legislative Committee and no
4 testimony was received. The Department is supporting the
5 language as presented at the June meeting. If the
6 Commission chooses to take final action on the language as
7 presented, it would then be forwarded to the JLC and
8 Governor for the 45-day review period. There must be not
9 less than nine legislative session days within that period.
10 And, again, since the legislature is adjourned that will
11 begin on January 10th.

12 MR. FALAHEE: Thank you. Any public comment cards
13 on this one?

14 MR. WIRTH: No cards.

15 MR. FALAHEE: Okay. Thank you. As you recall, as
16 Kenny mentioned, we discussed this extensively in June.
17 That was probably the fourth or fifth meeting in a row that
18 Psych Beds and Services was in front of us. We all know
19 around this table and in this room it's still a huge issue
20 given the paucity of beds, psych beds for adults,
21 adolescents, children and the doctors, the social workers,
22 the nurses to support those patients. So it's still a huge
23 issue out there. I think this is a step in the right
24 direction. More steps needed, but it's a step in the right
25 direction. Any questions or comments or discussion from the

1 Commission members? Commissioner Ferguson?

2 DR. FERGUSON: I have a question on one of the
3 included tables, just need an explanation on reading it. I
4 think page 163, CON psychiatric bed need 2001 base year,
5 2026 planning year. If we just take an example, adult
6 current bed need --

7 MR. WIRTH: I think that might be our -- you might
8 be ahead with the recalculation of bed need numbers.

9 MR. FALAHEE: Right.

10 DR. FERGUSON: Okay. Apologize. That's fine.

11 MR. FALAHEE: Yeah.

12 MR. WIRTH: We -- we will get to that one.

13 DR. FERGUSON: All right.

14 MR. FALAHEE: That's coming up. So we have a
15 motion -- about to have a motion. Yeah. We haven't had a
16 motion yet.

17 DR. MCKENZIE: No.

18 MR. FALAHEE: No. We need a motion to that effect
19 similar to what we've done with the prior two.

20 DR. MCKENZIE: Commissioner McKenzie. I will move
21 for final action to support the language and forward it to
22 the JLC and the Governor for the 45-day review period.

23 DR. KONDUR: Commissioner Kondur. Second in
24 favor.

25 MR. FALAHEE: Thank you both very much. Motion on

1 the floor. Any discussion? All in favor say aye -- or
2 raise your hand. Sorry.

3 ALL: (All raise hands)

4 MR. FALAHEE: Opposed, same sign.

5 (Whereupon motion passed at 12:02 p.m.)

6 MR. FALAHEE: All right. Next Tiffani, and maybe
7 for the last time, Air Ambulance after over 20 years.

8 MS. STANTON: Yeah. So at the June Commission
9 meeting the Commission took proposed action for deregulation
10 of the Air Ambulance Services under the CON program. The
11 proposed action of deregulation was sent out to the public
12 hearing and to the Joint Legislative Committee. No
13 testimony was received. The Department is supporting the
14 proposed action of deregulation under the CON program that
15 was taken at the June meeting. If the Commission chooses to
16 take final action, the proposal for deregulation under the
17 CON program will be forwarded to the JLC and the Governor
18 for the 45-day period -- review period. And, again, as we
19 all know that they -- that will start after June 10 -- or
20 January 10th. Sorry.

21 MR. FALAHEE: And no comment cards?

22 MS. STANTON: No comment cards.

23 MR. FALAHEE: Falahee. Sorry. Okay. This one's
24 a bit different. We have a proposal for deregulation and
25 finally -- finally acting on it after -- it has been 20

1 years or so. So I would entertain a motion.

2 DR. MCKENZIE: Commissioner McKenzie. I will make
3 a motion to support the proposal for deregulation under the
4 CON program of Air Ambulance and forward that to the JLC and
5 the Governor for the 45-day review period.

6 MR. FALAHEE: Is there a --

7 MR. DRAKE: Second. Commissioner Drake.

8 MR. FALAHEE: Thank you. Commission discussion?
9 Okay. All in favor of the motion raise your hand.

10 ALL: (All raise hands)

11 MR. FALAHEE: Opposed, same sign? Great. That
12 motion carries.

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

14 MR. FALAHEE: All right. Maybe the last time we
15 have Air Ambulance on our -- our agenda. We'll see. All
16 right. Next, back to Kenny for Psych Beds and then the
17 recalculation of bed need numbers.

18 MR. WIRTH: Yes. So this is the item,
19 Commissioner Ferguson, that you were referring to. So back
20 at the June Commission meeting, the Commission set an
21 effective date of January 2nd for the recalculation of bed
22 need numbers provided by Dr. Delamater. So after the
23 discussion -- and there -- there was a request from the
24 Commission to review whether a six-month period of data
25 could be annualized and used as a base here. After

1 discussion, the Department determined that annualizing a
2 six-month period of data to be used as a base year would be
3 a stretch of the definition of base year and additionally
4 after we spoke with Dr. Delamater, he felt that the
5 difference between an annualized six-month period and a full
6 year would not yield much difference at all. So our request
7 of the Commission now is to determine when -- whether or not
8 to keep that January 2nd effective date or move it, bump it
9 back later on.

10 And to give you some more context on that, Psych
11 Beds is up for review in January. We are looking at a
12 workgroup or a SAC for Psych Beds next year to discuss other
13 issues that are still unresolved and we think that looking
14 at the methodology for determining bed need would be
15 something good for that SAC to look at. So today we are
16 recommending to push back the effective date of these
17 numbers because the Commission does need to set an effective
18 date, but recommending to push that back to June 1st of
19 2024, to give us time to meet with the Psych Beds group and
20 delay making these new bed numbers effective. So we won't
21 be reducing the number of beds, we'll be pushing back the
22 effective date of this until we can look at the methodology
23 and figure out if a change needs to be made. Does that
24 help?

25 DR. FERGUSON: It does. I mean, we just signed

1 off on challenges of making sure we had appropriate access
2 and trying to expand access and then these numbers are
3 coming through saying that we --

4 MS. NAGEL: Have too much.

5 DR. FERGUSON: -- have way too much and there's a
6 big disconnect here. And so I guess I'm glad to hear that
7 we're going to take a look at that methodology. I guess the
8 question in follow-up would be is pushing it off until June
9 enough time to re-work this? Like I don't know if this is
10 an easy fix or a hard fix.

11 MR. WIRTH: We're not sure how long it will take.
12 So in our discussion with Chip in our pre-Commission meeting
13 we said let's do it for June. We'll be able to come back in
14 January and March and we can decide whether or not to push
15 it back further to give a Psych Beds workgroup or a SAC more
16 time, but we didn't want to push it back to, you know, 2025,
17 because the Commission is supposed to set an effective date
18 within a period of time.

19 MR. FALAHEE: All right. Yeah. And this is
20 Falahee. I'll add the week prior to us getting together the
21 Vice Chair McKenzie and I get together with the Department,
22 review the agenda items and have a chance to understand,
23 okay, the why behind a lot of this. And the why for this
24 one as we saw, bed need went down. What? It doesn't match
25 what we're all seeing out there. So we said time out.

1 Let's take a time out. Let's push it at least to June 1st.
2 My hunch is it'll go beyond that, but let's -- let's allow
3 the data from what happened in 2020 and 2021 to sort of be
4 supplemented by more recent data so that it matches what we
5 think and know is going on in our facilities right now. So
6 that -- that's the why behind it.

7 DR. FERGUSON: So are you -- maybe I'm hearing two
8 different things. I'm hearing buy a little time for COVID
9 effect to wash out of the system to whereas I'm hearing
10 maybe look at the actual methodology. Are we doing both or
11 are we -- or are we just buying for time? Because they're
12 different approaches.

13 MR. FALAHEE: I think we're doing both.

14 DR. FERGUSON: All right.

15 MR. FALAHEE: We're letting COVID wash out of the
16 system by extending the date, but we're also giving time for
17 whether it's a SAC or a workgroup to look at is this the
18 right methodology to do it.

19 DR. FERGUSON: I would support that. I think we
20 need to do both.

21 MR. DRAKE: Yeah, I agree with that.

22 DR. MCKENZIE: This is Commissioner McKenzie. And
23 I think I asked this in our pre-meeting, but I don't recall
24 the answer and probably good to revisit anyway. So I don't
25 know if it's for the Department or for Assistant Attorney

1 General Heckman or for you, Commissioner Falahee, but is
2 there any limitations on how long we have to set the
3 effective date? So are there guidelines or restrictions
4 around how long the Commission has to be able to set the
5 effective date and the bed need?

6 MR. HECKMAN: This is Assistant Attorney General
7 Brien Heckman. There is not.

8 DR. MCKENZIE: Thank you.

9 MR. FALAHEE: So, Kenny, what you're looking for
10 is action, a vote from the Commission to reset the date
11 under this current suggestion/recommendation to June 1,
12 2024?

13 MR. WIRTH: Correct. And then we will do a full
14 review -- there's -- there was a public comment period in
15 October for Psych Beds. In January at the special planning
16 meeting for the Commission we'll review all those comments
17 with you and we'll make a recommendation most likely for a
18 SAC or a workgroup to look at Psych Beds and, you know,
19 delve into this and figure out what needs to change.

20 MR. FALAHEE: So -- go ahead.

21 DR. MCKENZIE: Commissioner McKenzie. I'll move
22 to push the effective -- or setting the effective date out
23 and revisit this in June.

24 MR. WIRTH: Well, we would be revisiting in
25 January, but we'll push the effective date to June 1st.

1 DR. MCKENZIE: Got it. So I will restate that.
2 Commissioner McKenzie. I would make a motion that we push
3 this topic to January to revisit and push the effective date
4 for the Psych Beds to June.

5 MR. FALAHEE: Is there support for that motion?

6 DR. ENGELHARDT-KALBFLEISCH: Commissioner
7 Engelhardt. Support.

8 MR. FALAHEE: Thank you. Any Commission
9 discussion?

10 DR. FERGUSON: I don't know process for your
11 amendment or anything. I guess I would ask for an active
12 validation come June before -- I don't want this to
13 accidentally default in and end up with major cuts. So is
14 there a way for us to have an active sign-off? Maybe it's
15 not necessary. Maybe we just need the Department to be
16 absolutely clear about bringing it back to us. I just don't
17 want to find ourselves inadvertently there. We cancel a
18 meeting, something happens, there's a snowstorm and all of a
19 sudden this kicks in and we got a big cut if that's coming
20 through.

21 MR. FALAHEE: I just had a little side chat with
22 Brien. Friendly amendment. We meet in June. Let's move
23 the date to after that June meeting. Let's pick July 1 as a
24 friendly amendment. Is that okay with the Department?

25 MR. WIRTH: (No verbal response)

1 MR. FALAHEE: Okay.

2 DR. FERGUSON: Thank you.

3 MR. FALAHEE: Would those that made the motion
4 accept that friendly amendment?

5 DR. MCKENZIE: Yes.

6 DR. ENGELHARDT-KALBFLEISCH: Support.

7 MR. FALAHEE: Great comment. Thank you very much.
8 Okay. We have a motion on the floor. All in favor raise
9 your hand, please.

10 ALL: (All raise hands)

11 MR. FALAHEE: Opposed, same? All right. That
12 motion carries. Thank you.

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

14 MR. FALAHEE: All right. Legislative update.

15 MR. WIRTH: All right. Legislative update. So
16 you've heard a few times throughout this legislature
17 adjourned early this year in November and they do not
18 reconvene until January 10th. So any items that received
19 final action or proposed action today are going to be
20 pending until the legislature resumes and we can transmit
21 the documents to the proper health committees. There were a
22 couple Open Meetings Acts changes we were looking --
23 monitoring, but since the legislature adjourned, there's
24 been no movement on those. There was one bill that went
25 through that allows municipal retirement boards to meet

1 virtually, but not state commissions so good for them.

2 And then there was also HB4834 which was
3 introduced on June 22nd. That is related to the comments we
4 received for CT to -- it would eliminate cone beam
5 tomography equipment from the definition of a covered
6 clinical service under certain circumstances and it was
7 specifically a carve out for otolaryngologists. So we have
8 shared our position through the Department through our
9 channels on that and much like our position expressed
10 earlier, it was discussed heavily in the workgroup and the
11 workgroup reached consensus on the recommendations. That's
12 the update.

13 MR. FALAHEE: Okay. Great. Thank you. And well
14 done on pronouncing otolaryngologist. All right. Now we
15 turn it over -- Administrative Update. Marcus, I think you
16 -- you go first; right?

17 MR. CONNOLLY: Yes; yes. Good news. I think
18 we've talked about this several times as far as the
19 appointments and reappointments. Just want to let everybody
20 know the appointments and reappointments have been made.
21 Chip Falahee, Debra Guido-Allen, Amy Engelhardt-Kalbfleisch,
22 Ashok Kondur have all been reappointed. We have two new
23 appointees have been made; Greg Salwin representing
24 companies that are self-insured for health coverage and
25 Archie Drake representing hospitals. Are there any

1 questions?

2 MR. FALAHEE: There is one other appointment that
3 still needs to be made, so we're now at 10. The Commission
4 is supposed to be 11. And I know the Governor's
5 appointments office is working on that one as well.

6 MR. CONNOLLY: Yep.

7 MS. STANTON: Which is for Schools of Medicine
8 seat. They're specified.

9 MR. WIRTH: And they are seeking applicants for
10 Schools of Medicine to seat on the Commission.

11 MS. STANTON: Yes. There was none received, so --

12 MR. FALAHEE: Okay. Marcus, anything else?

13 MR. CONNOLLY: Nope. That'll be it.

14 MR. FALAHEE: All right. Tulika? I think you
15 have a microphone somewhere.

16 MS. BHATTACHARYA: Yes. Thank you, Chairman
17 Falahee. It's been a long meeting so I will not take long.
18 The written reports are in your packet. We continue to
19 monitor the CON (inaudible) projects for implementation,
20 allowing for extensions when there is justification.
21 Sometimes we are observing, providers are choosing or
22 electing not to complete the project, so we are expiring
23 those as appropriate. There also have been some selective
24 compliance issues that were brought to the Department's
25 attention for, like, MRI services, surgical services, or

1 lack of lease renewal. There was one settlement agreement
2 related to open heart surgery and the request of a hospital
3 and the details are in your report. You will also see that
4 we are continuing to review and issue the decisions on a
5 timely basis within the time frame set forth in the law. As
6 you also will see that emergency CON applications have kind
7 of slowed down, back to the normal level. So in third and
8 fourth quarter we only had four emergency CON's and none of
9 those were for additional beds, they're for, like, other
10 unforeseen situations related to equipment and things like
11 that.

12 With that said, as you heard, Perry Smith, our
13 finance specialist, is retiring and we are filling that
14 position. We are done with interviews, actually. We will
15 soon have a new person. We can never replace Perry, but
16 there will be a finance specialist. We are still one
17 position short. Our project coordinator was promoted to a
18 review specialist position and we have not yet filled that
19 project coordinator position so she's kind of doing dual
20 roles for several months now. With that said, if there are
21 any questions, happy to answer.

22 MR. FALAHEE: This is Falahee. I'll just comment.
23 I know Tulika and her entire team are glad to get back to
24 "normal." It was abnormal for quite awhile and they
25 responded valiantly and quickly. So, again, thank you to

1 the Department for all that great work during COVID and all
2 that it brought to us. Any questions of Tulika? Okay.
3 Great. Thank you.

4 On the legal activity report, I wanted to mention
5 before I turn it over to Brien that it was brought to my
6 attention and two of the issues that I had had -- number
7 one, when we need to appoint people to SAC's there's a
8 conflict of interest rule that is currently applied. Those
9 were great when there were 165 hospitals in Michigan.
10 That's no longer the case. And if you're part of a system,
11 if any one of the hospitals in your system has a pending
12 application or a letter of intent, you're out. So that's
13 too broad. So I've had discussions with the Department and
14 with Assistant Attorney General Heckman about that, but
15 that's not the only thing I talked to them about.

16 The other was the requirements for SAC's to meet
17 in person. And I got comments as well from some of you in
18 the audience about that because it's been a lingering issue
19 with me. The best thing we can do for the good of the CON
20 program is to encourage participation from across the state
21 of Michigan. During COVID when we were online on Zoom, that
22 was great. But when you're trying to put people on a SAC
23 and they're in Marquette or they're in Traverse City and you
24 say, oh, by the way, you got to come to Lansing for a one
25 hour meeting and you have to be there in person, that is not

1 conducive to getting broad representation, especially from
2 our rural -- more rural communities. So I approached the
3 topic with the gentleman to my right and lawyer to lawyer we
4 went, oh, isn't there a way we could tweak something?
5 Right? And so I'll let him comment on it. But I think it -
6 - it would be a very large step in the right direction if we
7 could liberalize the conflict of interest rules and do what
8 we can do to no longer have SAC's be subject to the Open
9 Meetings Act so you could meet by Zoom if you wanted to.
10 So, Brien, with that, I'll turn it over to you for the rest
11 of the report too.

12 MR. HECKMAN: Thanks, Chip. Assistant Attorney
13 General Brien Heckman. So, yes, Chip and I and the
14 Department have had conversations about that. I think that
15 both of those goals can be accomplished. What I would
16 actually suggest is that a commissioner move to have the
17 AG's office draft some proposed modifications to the bylaws,
18 specifically regarding OMA requirements for SAC members to
19 facilitate participation as well as to remove or modify
20 conflicts of interest provisions tied to these letters of
21 intent and applications so that we can, again, allow for a
22 more robust participation.

23 At the end of the day, the conflicts provisions as
24 Chip has indicated are potentially more broader than needs
25 to be. I think it's certainly broader than are required by

1 law. And similarly the OMA requirements, the Open Meetings
2 Act requirements, SAC's don't technically have to abide by
3 them. We've been just doing so. And so there -- there may
4 be some -- some ground that we can kind of come with some --
5 some -- some -- some proposed modifications that kind of
6 honor the spirit of both of those without handcuffing the
7 Commission's ability to seat a SAC.

8 MR. FALAHEE: You want to take a motion now?

9 MR. HECKMAN: Yeah. Why don't we do that?

10 MR. FALAHEE: Okay. So thank -- thank you. So
11 I'd entertain a motion as Brien just said, number one, to
12 have the Department of Attorney General look at appropriate
13 language changes regarding Open Meetings Act and the
14 meetings of the Standards Advisory Committees and, number
15 two, to look at potential changes in the letter in the
16 conflict of interest provisions for those that can sit on a
17 SAC.

18 MS. GUIDO-ALLEN: This is Commissioner
19 Guido-Allen. I move to have the Attorney General's Office
20 review the Open Meeting Act as it pertains to the
21 Standard -- SA -- the SAC's -- the SAC's to allow a virtual
22 option to -- and broaden the participation across the state
23 and to review and make changes in the conflict of interest
24 provisions as they pertain to letters of intent.

25 MR. FALAHEE: Great. Is there support for that

1 motion?

2 DR. MCKENZIE: Support.

3 MR. FALAHEE: Any discussion? Any discussion?

4 All in favor please raise your hand.

5 ALL: (All raise hands)

6 MR. FALAHEE: Opposed? Thank you.

7 (Whereupon motion passed at 12:22 p.m.)

8 MR. FALAHEE: For the rest of the activity report?

9 MR. HECKMAN: Thank you, Chip. So the only thing
10 that we had kind of on our pending activity report was a
11 subpoena to Tulika Bhattacharya and that has been thankfully
12 withdrawn so she is not going to have to testify and I am
13 not going to have to drive to Detroit. So thank you.

14 MR. FALAHEE: All right. Thank you very much. It
15 will be welcome news if the motion that we just made gets a
16 favorable response from the Attorney General's Office and we
17 can have SAC's from people further north than Grand
18 Rapids/Flint line. So there. Next item is -- if there's
19 any other public comment that's come forward during the
20 meeting?

21 MS. STANTON: We have not received any additional.

22 MR. FALAHEE: Okay. Thank you. All right.
23 Kenny, review of the Commission Work Plan, please?

24 MR. WIRTH: Yeah. So we will make sure to add a
25 public hearing on there for the items that were approved for

1 final action -- or, sorry -- proposed action today and we
2 will take a look to see when we could slot in a Psych Beds
3 workgroup. I'm thinking between January and through to
4 March because we will have Surgical and Cardiac Cath overlap
5 in April, the SAC's. So we will wiggle in a Psych Beds
6 workgroup in there.

7 MR. FALAHEE: So you need the Commission to --

8 MR. WIRTH: Sorry. That's Hospital Beds. Thank
9 you. Yeah. Sorry.

10 MR. FALAHEE: No. We knew what you meant.

11 MR. WIRTH: Got Psych Beds on the brain right now,
12 but --

13 MR. FALAHEE: So you need the Commission to
14 approve the revised work plan?

15 MR. WIRTH: Correct. And just -- I know we
16 normally breeze through future meeting dates. We need a
17 motion and second on that, too.

18 MR. FALAHEE: Okay. Okay. All right. So first
19 approval of the revised Commission work plan.

20 MR. WIRTH: Yep.

21 MR. FALAHEE: Would anyone care to make a motion
22 to that?

23 DR. ENGELHARDT-KALBFLEISCH: Commissioner
24 Engelhardt. Move to approve the revised work plan.

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

1 MR. FALAHEE: Okay. Any discussion? All in favor
2 raise your hand, please.

3 ALL: (All raise hands)

4 MR. FALAHEE: Opposed? That motion carries.

5 (Whereupon motion passed at 12:24 p.m.)

6 MR. FALAHEE: Next, as Kenny mentioned, future
7 meeting dates for those of you who are looking, January 25,
8 March 14, June 13, September 19 and December 5. All of
9 those are in 2024. So apparently we need a motion to
10 approve those dates.

11 MR. WIRTH: Yeah.

12 MR. DRAKE: Commissioner Drake. I make a motion
13 to approve the future meeting dates as documented in the
14 agenda: January 25th, March 14th, June 13th, September
15 19th, December 5th all of 2024.

16 MR. FALAHEE: Support for that?

17 MS. GUIDO-ALLEN: Guido-Allen. Support.

18 MR. FALAHEE: Great. Thank you. All in favor
19 raise your hand.

20 ALL: (All raise hands)

21 MR. FALAHEE: Opposed? Great.

22 (Whereupon motion passed at 12:25 p.m.)

23 MR. FALAHEE: Anything else from the Department?

24 MR. WIRTH: No.

25 MR. FALAHEE: I will add, number one, thank you

1 all for your participation. I'm hoping that Commissioner
2 Drake decides to come back after this.

3 MR. DRAKE: The roughest thing is only (inaudible)
4 so I'll be back.

5 MR. FALAHEE: And so thank you all for your
6 participation. Seasons greetings to everybody. Thank you.
7 Safe travels wherever you may be going and we'll see many of
8 you back here in January. Thank you.

9 MR. WIRTH: Chip, motion to adjourn.

10 MR. FALAHEE: Oh, that's right. Motion to
11 adjourn. All in -- motion?

12 MS. GUIDO-ALLEN: Motion. Motion to adjourn.

13 DR. ENGELHARDT-KALBFLEISCH: Support.

14 MR. FALAHEE: Support. All in favor raise your
15 hand.

16 ALL: (All raise hands)

17 MR. FALAHEE: Opposed? Thank you. Okay.

18 (Proceeding concluded at 12:26 p.m.)
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CERTIFICATE

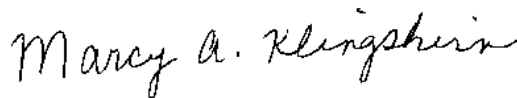
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I, Marcy A. Klingshirn, a Certified Electronic Recorder and Notary Public within and for the State of Michigan, do hereby certify:

That this transcript, consisting of 120 pages, is a complete, true, and correct record given in this CON Commission meeting on December 7, 2023.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am not interested in the outcome of this matter, financial or otherwise.

IN WITNESS THEREOF, I have hereunto set my hand this 19th day of December, 2023.



Marcy A. Klingshirn, CER 6924
Notary Public, State of Michigan
County of Eaton
My commission expires: March 30, 2029

COMMISSION MEETING
IN RE: CON HOSPITAL BEDS SAC

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