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STATE OF MICHIGAN  
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CERTIFICATE OF NEED (CON)  
COMMISSION MEETING

BEFORE AMY MILEWSKI, M.D., CHAIRPERSON  
Thursday, December 4, 2025, 9:30 a.m.

South Grand Building  
333 South Grand Avenue  
1st Floor, Grand Conference Room  
Lansing, Michigan 48933

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1 APPEARANCES

2  
3 Certificate of Need Commission Board Members Present:

4 Dr. Amy Milewski, Chairperson  
5 Debra Guido-Allen, Vice-Chairperson  
6 Dr. Amy Engelhardt-Kalbfleisch  
7 Tatiana Grant  
8 Karen Cheeseman  
9 Greg Salwin  
10 Joseph Egan  
11 Robert Gibson  
12 Dr. Mark DeLano  
13 Dr. Eric Ferguson

14 Michigan Department of Health and Human Services Staff  
15 Present:

16 Ninah Sasy  
17 Tulika Bhattacharya  
18 Beth Nagel  
19 Tiffani Stanton  
20 Marcus Connolly  
21 Katherine Tucker  
22 Justin Easter

23 For Michigan Department of Health and Human Services and  
24 Certificate of Need Commission:

25 CARL HAMMAKER, ESQ. (P81203)  
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Also Present:

Dr. Frank Soltys  
Ms. Dawn Shanafelt  
Dr. Paul Delamater  
Dr. Daniel Rito  
Patrick O'Donovan  
Melissa Reitz

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1                   Lansing, Michigan

2                   Thursday, December 4, 2025 - 9:31 a.m.

3                   DR. MILEWSKI: Good morning, everyone.

4 Welcome to our snowy December commission meeting.

5 For those of you that weren't here last year, we  
6 had a very difficult commute in, so it was a little  
7 easier, I think, for most of us to get here this  
8 year. But thank you for all of you who showed up  
9 here today to join us. So we do have a quorum.

10                   There are blue cards available for those  
11 that are attending. If you should want to make a  
12 public comment, please fill that out and hand it to  
13 someone with the department, Marcus, Tiffani,  
14 Katherine, or Justin. And I will remind those who  
15 are making comments, other than our work group  
16 report, that those are limited to three minutes.  
17 Our commissioners can ask questions that would  
18 surpass that, but please limit your initial  
19 comments to three minutes so that we can be  
20 efficient with our time here with the meeting.

21                   For those that don't know me, I am the  
22 chairperson, Commissioner Milewski. And our vice  
23 chair, Deb Guido-Allen. And other announcements  
24 that I wanted to make before we get started is we  
25 have had a commissioner that has resigned,

1 Commissioner Daniel Velez. We thank him for his  
2 time here on the commission, but he's no longer  
3 with us. And we do have a new commissioner,  
4 Commissioner Joseph Egan.

5 I'll take a minute and let you introduce  
6 yourself to the commission.

7 MR. EGAN: Great. Thank you. Good  
8 morning, everyone. So Joe Egan here. True  
9 Michigander. Born, actually, downtown in Hutzel.  
10 I work at Detroit Medical Center. Joe Egan.  
11 Again, true Michigander, so I was able to drive  
12 here quite safely.

13 So I've been with DMC for the better part  
14 of 15 years. I did my undergrad at Michigan State,  
15 grad work at the University of Pittsburgh. Did my  
16 fellowship under health care under Mike Dugan way  
17 back when. I went to DMC and spent my -- a bulk of  
18 my career really driving value-based care  
19 initiatives, so really quality outcomes, lower  
20 costs across the 10 portfolio, which really ranges  
21 from coast to coast.

22 DR. MILEWSKI: Thank you, and welcome.

23 And I will remind our commissioners when  
24 you speak, please use your name for -- because we  
25 have a recorder who's recording everything, and

1 also, use your mics so that everybody can hear you.  
2 So thank you.

3 Okay. So next up, we have the review of  
4 the agenda, which is before you. And you can see  
5 that our key issues here today are we have our NICU  
6 work group report as well as our county designation  
7 that has come for final action today. Are key, and  
8 then we have the rest of our standing items. So  
9 any comments on the agenda or changes? Otherwise,  
10 I need a motion.

11 MR. GIBSON: So moved.

12 DR. MILEWSKI: Thank you. Second?

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

14 DR. MILEWSKI: Thank you. All in favor?

15 COMMISSIONERS: Aye.

16 DR. MILEWSKI: Any against?

17 (Whereupon motion carried at 9:34 a.m.)

18 DR. MILEWSKI: Okay. Moving forward,  
19 next up, we have a declaration of conflicts of  
20 interest. And for those that are newer to the  
21 commission, this is if there's any items that we --  
22 are before the commission that we're voting on that  
23 you may have a conflict of interest, we ask that  
24 you declare that. And oftentimes, you will abstain  
25 as well from the vote on those things. The summary

1 of that is in your packet. So at this time, does  
2 anyone have a conflict of interest to declare?

3 Great. Hearing none, we'll move forward.

4 Our next item is our review of our  
5 minutes of September 18th meeting, and those are  
6 also contained in your packet. So if there are any  
7 changes or additions, please state those now.

8 Otherwise, I can take a motion on the minutes.

9 MS. GUIDO-ALLEN: Guido-Allen. Motion to  
10 approve the minutes of the September 18th, 2025,  
11 meeting.

12 DR. ENGELHARDT-KALBFLEISCH: Engelhardt-  
13 Kalbfleisch. Second.

14 DR. MILEWSKI: Thank you. All in favor?

15 COMMISSIONERS: Aye.

16 DR. MILEWSKI: Any against? Okay. The  
17 minutes from September 18th pass.

18 (Whereupon motion carried at 9:35 a.m.)

19 DR. MILEWSKI: Okay. Our next item on  
20 our agenda is our work group final report for the  
21 Neonatal Intensive Care Services event. And we do  
22 have SACs and work groups. This was a work group,  
23 and it was chaired by Dr. Frank Soltys, who will  
24 be, I think, coming forward to -- yeah, to give a  
25 report. And while Dr. Soltys is coming to the

1 podium, I just want to say how much we appreciate  
2 our chairs and vice chairs of our work groups and  
3 SACs. These are our experts who help lead this  
4 work, and we really could not do this without them.

5 So thank you, Dr. Soltys, for being here  
6 today.

7 DR. SOLTYS: Thank you for having me.  
8 About a year ago, I wouldn't have imagined that  
9 this world existed, and when -- I was told, when  
10 Chip asks you to do something, you just do it. And  
11 so when he asked, I just signed up. I would not be  
12 up here today as prepared as I am without a ton of  
13 help, so I got to say a few quick thank-yous before  
14 we get started.

15 Push the mic? Okay. There we go.

16 I got to say a few quick thank-yous  
17 before we get started. To the department, Justin,  
18 Marcus, Tulika, Dawn, Tiffani, everybody, thank you  
19 so much for helping me prepare, for guiding me  
20 through this process. It's my first time doing  
21 this, and I certainly, again, wouldn't be up here  
22 as ready as I am without you all.

23 And to the work group, tons of members,  
24 Jenny, Carol, Daniel, Melanie, Melissa, everybody,  
25 thank you so much. You all -- it was a pleasure to

1 be a part of this work group with so many  
2 passionate people.

3 Next slide, please.

4 Our work group had three charges, and  
5 you're going to hear a little bit about the first  
6 two, and then you'll probably hear a lot about the  
7 third one. When Chip asked me to do this, he said,  
8 oh, it's pretty easy. Everybody gets together.  
9 They all agree on the next best steps, and then you  
10 go and do a presentation.

11 Well, Chip, I love you, but it was a  
12 little bit more work than that.

13 And we got to have some disagreements  
14 about Charge number 3. To me, disagreements are  
15 never bad, though. So disagreements make life  
16 interesting. If we all always agreed on things,  
17 it'd be real boring. Disagreements are fun. So to  
18 me, it was a little bit of fun to hear just how  
19 passionate everybody can be about this work.

20 Charge 1 has to do with the outreach  
21 programs. Charge 2 having to do with aligning our  
22 NICU standards with some sort of national standard  
23 of care for neonates. And Charge 3 looking at some  
24 of our methodology.

25 Next slide.

1 I always forget the fourth one because  
2 it's, like, technical changes and basically  
3 correcting typos sort of thing, so our work group  
4 ended up meeting as a big group a total of six  
5 times. Now, I say as a big group because we broke  
6 off into subgroups for each of the individual  
7 charges, resulting in a lot more meetings and a lot  
8 more work than just meeting six times. But it was  
9 full of a ton of talented people, whether  
10 neonatologists, like myself and Daniel, NICU  
11 nurses, planners, policy leaders, people that do a  
12 lot of the work that I had known nothing about.  
13 We're all members and came from all different  
14 backgrounds, whether we were big academic centers,  
15 small community hospitals, like my little one over  
16 in Kalamazoo, and everything in between.

17 We also along the way needed to engage  
18 Dr. Paul Delamater, I think I'm saying his name  
19 right --

20 MS. STANTON: Yes.

21 DR. SOLTYS: -- because the methodology  
22 is over my head about how we determine how many  
23 beds are needed in all of this. And so we needed  
24 to engage him so that he, like everybody else,  
25 could drag me along and try to get me to keep up.

1 Next slide.

2 So quickly looking at Charge 1, and  
3 again, this has to do with outreach programs. So  
4 basically, when one hospital receives a patient  
5 from another, what's the process like after that?  
6 How do we follow up with that hospital? What kind  
7 of reviews do we need to do? And this was a little  
8 bit outdated because as health systems become  
9 bigger, the work group agreed that we don't  
10 necessarily need to have every hospital reach back  
11 out to another hospital and review it.

12 So for instance, if Bronson Methodist in  
13 Kalamazoo takes a patient or receives a patient  
14 from Bronson Battle Creek, we share a lot of the  
15 same staff. We share the same EMR. I see those  
16 people the next week, and we do follow-up  
17 ourselves. We didn't feel it was necessary to  
18 maintain an outreach program just to talk between  
19 the same healthcare -- within the same healthcare  
20 system. Excuse me. Now, if Bronson Methodist were  
21 to transfer a baby up to Helen DeVos in Corewell,  
22 we felt that was still necessary to have formalized  
23 case review and feedback.

24 We tailored the language at the end of  
25 this to take away this kind of nebulous social

1 support because that can be ever-reaching, so  
2 that's hard to really define. And there are a lot  
3 more formal definitions about case reviews and  
4 feedback. This ended up being unanimously approved  
5 by the -- by the work group, and the department has  
6 gone on to support these changes.

7 Moving on to Charge 2, Charge 2 was  
8 hoping to have us align our CON standards with  
9 maternal levels of care, which is -- makes sense  
10 when you think about it originally. You know,  
11 babies start with moms, so their care should  
12 coordinate appropriately. But when this subgroup  
13 ended up really getting into the nitty-gritty of  
14 maternal levels of care and what it meant, the care  
15 of neonates is drastically different. And I was  
16 glad that everybody was able to come to that  
17 realization.

18 So we moved to try to align our standards  
19 with standards from the American Academy of  
20 Pediatrics. They're the big, overseeing body kind  
21 of nationwide for not just general peds but all the  
22 subspecialties as well. The work group was able to  
23 approve moving towards that, which led to us  
24 needing to tinker with and change some definitions  
25 in Sections 9 and 12 mainly to try to align our

1 standards with them.

2 Next slide, I keep forgetting to say,  
3 next slide. That's my bad. I got this up here.

4 So our recommendations, and then we'll  
5 get to some definitions here in a moment, have to  
6 do with who can be director of our various programs  
7 in the state for neonates. So there are special  
8 care nursery programs, and there are NICU programs.  
9 A special care nursery director in accordance with  
10 AAP can be a board-certified or eligible  
11 neonatologist or a board-certified pediatrician  
12 with experience. And I'll get into our rationale  
13 here in a moment, but the definition on the next  
14 slide will hopefully make sense. And the director  
15 of neonatal -- NICU services, I should say, has to  
16 be a board-certified or board-eligible  
17 neonatologist, leaving off the pediatrician with  
18 experience, which is in accordance with the AAP.

19 Next slide.

20 So this goes on to define what those two  
21 terms mean. Obviously, I think we all know what a  
22 board-certified neonatologist is, someone who has  
23 completed all of the things you see under board  
24 eligible but has gone on to pass their boards. A  
25 board-certified pediatrician is someone who is

1 certified in general pediatrics. But they do not  
2 have either fellowship training, or they haven't  
3 passed boards for neonatal-perinatal medicine.

4 This is because, I think everybody can  
5 appreciate, neonatologists, there aren't a ton of  
6 us out there. It's really hard to recruit some of  
7 us to small, rural areas, not just in Michigan but  
8 across the nation. And really, if you have a  
9 pediatrician with experience in providing breathing  
10 tubes to babies when they need it, providing short-  
11 term assistance through a breathing machine,  
12 managing CPAP, then they should be able to direct a  
13 special care nursery.

14 Now, a neonatologist needs to be in  
15 charge of the NICU. And the difference with  
16 certified and eligible is that an eligible -- a  
17 board-eligible neonatologist, excuse me, is someone  
18 that completed their residency, completed their  
19 fellowship. They can have a license in Michigan,  
20 an unrestricted one, but they just haven't been  
21 able to sit for boards yet.

22 And the reason this comes up is because  
23 neonatal-perinatal medicine boards are only offered  
24 every couple of years. So let's say you graduate  
25 and it's not a year that they're offered. So

1 you've been practicing for a full year plus when  
2 your time to take boards comes around. But then  
3 you have life happen, right? You have an emergency  
4 family issue. For some reason, you still can't  
5 take your boards. You're going to have to wait  
6 another two years, so you'll be three-plus years  
7 out before you're able to take your boards. It's  
8 not to say that these people are bad neonatologists  
9 or bad physicians. They've just had things come up  
10 where they haven't been able to pass boards.

11 Now, the ABP, American Board of  
12 Pediatrics, who's in charge of the boards, they do  
13 put a cap on how long you can take. They say you  
14 can take seven years after you graduate a  
15 fellowship to pass your boards. At that time, if  
16 you have not passed boards, you are board  
17 ineligible and you need to go back and repeat a  
18 fellowship. So this isn't somebody that just never  
19 takes boards can always stay as a -- as a NICU  
20 services director. They have to pass boards at  
21 some point, or they are no longer eligible. Any  
22 questions about those two before we get to our next  
23 charge, 3?

24 Yes, sir.

25 DR. FERGUSON: Thanks for your work on

1 this. I may be getting lost in the semantics just  
2 a teeny bit. Do you mind going back just one  
3 slide, please? The first box, the point there, so  
4 I understand the notion of eligible neonatologists.  
5 Set that one -- set it aside. Board-certified  
6 pediatrician with experience serving as the SCN  
7 program director, so you're trying to open an  
8 opportunity given the shortages. And maybe I'm  
9 getting lost, but this sounds a little bit  
10 circular. Like, to be an SCN program director as a  
11 board-certified pediatrician, you have to have  
12 experience serving as a program director of an SCN?

13 DR. SOLTYS: So I see -- I think I see  
14 what your confusion is. Yeah. Like, you have to  
15 have experience as the board director. Yeah.

16 DR. FERGUSON: As opposed to, you know,  
17 maybe we're co-director or vice director --

18 DR. SOLTYS: Right.

19 DR. FERGUSON: -- or they've been there  
20 for 20 years and have done it a million times.

21 DR. SOLTYS: Right.

22 DR. FERGUSON: I -- are we going to get  
23 ourselves tangled up on a regulatory basis with  
24 that?

25 DR. SOLTYS: Yeah. And I think that's

1 where this definition from the AAP comes in, and  
2 perhaps we just need to add some language, with  
3 experience in treatment and stabilization of  
4 neonates or something along those lines, because I  
5 see what you're getting at with the circle.

6 DR. FERGUSON: Yeah. I think that may be  
7 helpful. Otherwise, you're going to box yourselves  
8 in, and you'll have to recruit people from out of  
9 state who've done it to get them in here or  
10 grandfather existing people.

11 DR. SOLTYS: Yeah. That -- that's a good  
12 point. Thank you. Yeah. So just a -- maybe a  
13 little addition of some language in there to  
14 clarify that point.

15 Any other questions on the first two  
16 charges? All right. Then we will move on to  
17 Charge 3.

18 DR. FERGUSON: Does anyone object to  
19 that? I mean, I -- I'm not trying to --

20 MS. GUIDO-ALLEN: No. I -- Guido-Allen.  
21 I think that if you just add experience in level II  
22 care, which you have in the definition --

23 DR. SOLTYS: Oh. Perfect.

24 MS. GUIDO-ALLEN: -- of board-certified  
25 pediatrician. And you can even say including

1 endotracheal intubation, et cetera --

2 DR. SOLTYS: Perfect.

3 MS. GUIDO-ALLEN: -- to make that much  
4 more clear. I agree with you.

5 DR. SOLTYS: Okay. Sorry. I don't know  
6 how we go about doing that now that I'm up here,  
7 but we'll figure it out, I guess.

8 All right. So moving on to Charge 3. So  
9 in Charge 3, we wanted to review the methodology  
10 for determination of kind of NICU bed need and in  
11 that process stumbled upon a whole lot of snags, if  
12 you will excuse my Southern Illinois lingo. When  
13 reviewing the methodology -- and again, we pulled  
14 in Dr. Delamater. He said, yeah, this looks like  
15 it could use an update, but let's look at the data  
16 this methodology is reliant upon first.

17 So we did that, and we found out things  
18 are not necessarily going as intended in terms of  
19 the annual report. So the goal in the annual  
20 report as it currently stands is to report only  
21 those infants, and I'll show you a definition in a  
22 moment, that are deemed eligible for NICU services,  
23 not to report infants that are under special care  
24 nursery, or SCN, services.

25 Well, only one NICU in the state was

1 doing that, so we were over-reporting. If babies  
2 were in a NICU bed, we counted them as a NICU  
3 patient whether they were NICU service eligible or  
4 SCN eligible. And I get to say we because I  
5 promise it wasn't just Bronson. It was, like,  
6 everybody except one. So we realized we have to  
7 update this data before we can update the  
8 methodology, so the group moved to take a closer  
9 look at the data and to take a look at some  
10 definitions before we can even approach, again, how  
11 we go about determining our beds.

12 Next slide, please.

13 So this slide, it's actually in your  
14 appendix if anybody has the slides. We moved it up  
15 a little bit because the rest of this conversation  
16 is really reliant upon understanding the difference  
17 between NICU services and SCN services. NICU  
18 services, as you can read, I know this is a very  
19 busy slide, but I'll try to break it down: are  
20 smaller babies, so babies less than 1,500 grams,  
21 which is about 3.3 pounds; are babies that are less  
22 than 32 weeks; are babies who need a breathing  
23 machine longer than those initial 24 hours for  
24 stabilization; are babies who need surgery or are  
25 immediately post-op and recovering; babies who need

1 medicines for their blood pressure or heart rate or  
2 stabilization of the cardiovascular system; or any  
3 baby on TPN.

4           So the TPN is a system where we give them  
5 protein and lipids and electrolytes through an IV  
6 because they, for one reason or another, can't  
7 tolerate all the milk they need to in order to  
8 survive. And that's really about it in the current  
9 state in terms of what NICU services defines. And  
10 then SCN services is pretty much -- are pretty  
11 much, excuse me, everything after that.

12           Any questions on this before we move  
13 forward? There are times while you're here --  
14 where you will hear SCN services talked about as  
15 level I or II services and NICU services talked  
16 about as level III or IV services, and that has to  
17 do with the next slide, which is really more about  
18 facilities than it is about the baby. The AAP has  
19 these levels of NICU care, and you can see they go  
20 from taking care of healthy babies at level I to  
21 the sickest babies you can imagine, who need  
22 heart/lung bypass and all sorts of things, at level  
23 IV. So when we talk about level I and II, level  
24 III and IV, we really don't mean the baby, him or  
25 herself. We mean the level of care.

1 Next slide.

2 So the work group ended up approving  
3 three actions, one of which was to expand the  
4 definition of NICU services to include infants who  
5 had previously received NICU services. So this is  
6 your baby who was born at 25 weeks gestation. And  
7 I don't know everyone's background, so I'm sorry if  
8 this is pandering. But 40 weeks is typically how  
9 long you go, so a baby that barely made it halfway.  
10 I'm going to try not to get into a rationalization  
11 too much, but that's who this would include.  
12 It's -- a baby until they graduate from the NICU  
13 would be included in the NICU services.

14 The department wanted to add some  
15 language to state that these patient days of care  
16 would not be reported in the annual survey, which  
17 seemed contradictory to the work group because why  
18 would we change the definition if we're not going  
19 to bother reporting it? And so this is -- we did  
20 not as a work group agree with the language added  
21 at the end there, which I believe is also included  
22 in the final CON standards.

23 Another recommendation from the work  
24 group so that we could get to the crux of how our  
25 NICU beds are used was to report those infants in

1 NICU beds that are SCN level service. And so if  
2 you have a baby who is a, for instance, you know,  
3 34-week gestation infant but who is stable, who is  
4 really just working on feeding but happens to be in  
5 a NICU bed, we would report that baby but as an  
6 SCN, as a level I or II baby, so that we can kind  
7 of get to the crux of how our beds are being used.

8 Next slide.

9 So we have a couple slides coming up to  
10 explain our rationale. This one, I'd really like  
11 to point out. A, we thought this would lead to  
12 more --

13 Oh. Next slide. Sorry. Next one.  
14 Thanks, Melissa.

15 We really wanted to point out that  
16 getting the reporting accurate to what's happening  
17 clinically is, we felt like, of the utmost  
18 importance. We also realized that the current data  
19 are insufficient to do just that because everybody  
20 is just reporting everyone, and that wasn't really  
21 the goal in the first place of the annual survey in  
22 terms of figuring out what our NICU utilization may  
23 be. The final thing is, again, to really figure  
24 out with our NICU beds who's being treated in those  
25 beds. Is it level III/IV, or NICU service babies,

1 or is it level I/II SCN babies?

2 If we could move to the next slide,  
3 please.

4 And there were some concerns which I  
5 think are extremely valid about -- because any time  
6 you try to expand a definition, there's always  
7 going to be concerns, right? We're expanding  
8 criteria. This will lead to more babies being  
9 under NICU service than what are under there right  
10 now. However, it still won't be raising some of  
11 the issues that you're going to see in this  
12 concerns column. So one is that we are going to be  
13 increasing the bed need exponentially because we  
14 have -- we are reporting more NICU service babies.

15 Well, we'll actually be reporting less,  
16 except for one hospital, because everybody else was  
17 just reporting everybody, whether you were an SCN  
18 baby or a NICU service baby. So if we now knowing  
19 we need to report only NICU service babies but  
20 expanding this definition to include those former  
21 NICU patients, it's still going to be less. So the  
22 numbers are going to come down.

23 The other thing that has come up, and I  
24 think it's a big sticking point here, is location.  
25 And people say, well, just because you're an SCN

1 patient doesn't mean you have to leave the NICU.  
2 You can provide that care in the NICU. You can  
3 provide that care in an SCN. You can provide that  
4 care on a peds floor.

5 But the reason, and the one I feel is  
6 from a clinician standpoint the most important, is  
7 if you talk to a neonatologist worth their salt,  
8 that former 25-week baby shouldn't leave the NICU  
9 because they're going to have screenings from a  
10 subspecialty standpoint, one of which is called  
11 retinopathy of prematurity, or ROP. This is a  
12 problem where your blood vessels don't grow  
13 correctly because you were born premature and you  
14 had to use them before you were ready. It's  
15 actually the reason Stevie Wonder is blind if  
16 anybody is a Stevie Wonder fan.

17 Well, these kids, they receive screening  
18 for this at a weekly and sometimes twice-a-week  
19 basis, so you can't have them anywhere. So I  
20 understand the point of, like, well, you could care  
21 for them in the NICU, but I don't have a NICU that  
22 expands and contracts magically based on if my SCN  
23 patients are in there or not. These patients are  
24 NICU patients and should be treated as such. They  
25 need -- often need a lot of therapies moving

1 forward that are often not available at SCNs. They  
2 need term-equivalent brain MRIs often because brain  
3 bleeds are a common problem in NICU babies. So to  
4 match how we actually move to use our NICU, these  
5 former NICU patients should be counted as NICU  
6 patients.

7 The other couple things here, it was  
8 brought up a couple of times in some of our  
9 meetings that billing should -- reporting, excuse  
10 me, should mirror billing. And not to sound crass,  
11 I hope nobody is in billing. I hope nothing  
12 mirrors billing, right? Like, mirrors -- billing  
13 is for profit, not for the patient. And that's  
14 how -- just how America is, and that's fine. But  
15 we're a for-profit healthcare system, so I don't  
16 want that to mirror billing at all. It's also -- I  
17 can't tell you how many prior auths I've been on  
18 the phone with. I don't want to do that when I'm  
19 thinking about how to report our babies. So that  
20 point I really can't agree with too much.

21 Otherwise, I think the biggest point,  
22 again, I want to bring home, is that, you know,  
23 from a clinical standpoint, we feel these former  
24 NICU patients need to stay in the NICU and  
25 therefore should be in our utilization data. Any

1 questions about Charge 3 before we move on?

2 MR. EGAN: Joe Egan. You mentioned --  
3 you said everyone was reporting kind of everything.  
4 Do we have kind of a data list by hospital to  
5 validate that to be correct?

6 DR. SOLTYS: I don't know if I ever saw a  
7 data list, but I can tell you, in the meeting, we  
8 had almost every NICU across the state represented.  
9 And I believe it was just Helen DeVos that was  
10 taking the time to parcel out who's a NICU patient,  
11 who's an SCN patient in our NICU, and report it the  
12 correct way. I can tell you, Bronson, I know for a  
13 fact, we are just reporting everybody. Several  
14 other members were saying, yeah, we just report  
15 who's in our NICU. I remember Sparrow, they  
16 actually have a separate NICU and SCN, separated  
17 physically. But if you were in their NICU, whether  
18 you were SCN services or not, they reported you as  
19 a NICU service patient.

20 MR. EGAN: Okay. So then there was some  
21 verbal confirmation, but we don't have kind of the  
22 data behind it?

23 DR. SOLTYS: I do not, no.

24 MR. EGAN: Thank you.

25 DR. SOLTYS: Any other questions? All

1 right. Then we'll move on to the next slide.  
2 Charge 4, where we needed to outline and separate a  
3 couple of things, one was some -- were some  
4 equipment issues. The CON standards used to read  
5 that you had to have a portable X-ray and blood gas  
6 analyzer. So people -- kind of like our circle  
7 before, people thought your blood gas analyzer had  
8 to be portable. It does not, so we moved that down  
9 so that it's on its own separate line as just you  
10 need to have a portable X-ray, next line, blood gas  
11 analyzer. And then we changed some language,  
12 including referencing your average and NICU service  
13 patient days, moving that from Section 7 to Section  
14 2 for consistency's sake.

15 Next slide.

16 And then at the -- in this report, but  
17 you all already approved this back in June, are  
18 just our county designations. So for completeness,  
19 we would -- we thought we'd include this in our  
20 presentation today. And that's, I think, it. How  
21 muddy was that? Done? Okay.

22 DR. MILEWSKI: Thank you very much for  
23 the report.

24 Did we have questions from the  
25 commissioners?

1 DR. FERGUSON: I suspect there'll be a  
2 fair bit of conversation, including questions. I  
3 would love to hear from the department. I know  
4 that this is a -- there are some different opinions  
5 here. I'd love to hear the department's side and  
6 then, I think, come up with some questions after  
7 that.

8 DR. MILEWSKI: Can I -- before we hear  
9 from the department, can I -- I do have one  
10 question that I want to clarify with him.

11 DR. SOLTYS: Sure.

12 DR. MILEWSKI: Mr. -- sorry. Dr. Soltys.

13 DR. SOLTYS: Oh. You're fine. I'm just  
14 impressed you said it correctly.

15 DR. MILEWSKI: So the expansion of the  
16 definition, I just wanted to clarify my  
17 understanding, wasn't to include reporting or  
18 counting of all SCN that were level I or level II  
19 that ended up in a NICU bed for whatever  
20 operational reason there was but only those that  
21 were at one point a level III or level IV that then  
22 became a level I or II?

23 DR. SOLTYS: Correct. Yes.

24 DR. MILEWSKI: Because they improved or  
25 they grew or --

1 DR. SOLTYS: Yeah. Basically, because  
2 they got older. Exactly right.

3 DR. MILEWSKI: And the level I, level II,  
4 level III, level IV designations are things that  
5 aligned with billing?

6 DR. SOLTYS: With AAP kind of levels of  
7 care.

8 DR. MILEWSKI: AAP levels of care.

9 DR. SOLTYS: Yeah. For facilities,  
10 really. Yeah.

11 DR. MILEWSKI: Okay. Okay. Thank you.

12 DR. SOLTYS: Of course.

13 DR. MILEWSKI: Any other questions for  
14 Dr. Soltys?

15 MR. EGAN: Joe Egan.

16 DR. MILEWSKI: And we can recall him,  
17 too, so --

18 MR. EGAN: Just from your experience,  
19 from a discharge perspective, what percentage of  
20 babies are discharged at level III versus level II?

21 DR. SOLTYS: So as the definition  
22 currently stands, it would be very difficult to  
23 discharge a baby from a NICU services standpoint  
24 because all of these services are invasive, and  
25 therefore, it's kind of the reason for the

1 expansion of the definition. You know, to say that  
2 all of these babies are then special care nursery  
3 babies before they go home is not lining up with  
4 what we do clinically.

5 DR. MILEWSKI: Thank you.

6 Okay. Now I will, I guess, go to the  
7 department and ask for input and feedback on the  
8 position of the department.

9 MS. BHATTACHARYA: Good morning,  
10 commissioners. My name is Tulika Bhattacharya. I  
11 manage the CON evaluation session. First thing, I  
12 wanted to thank Dr. Soltys and everyone that  
13 participated in the work group so passionately and  
14 purposefully and brought their thoughts and ideas  
15 and emotions, which is very important for a  
16 standard like NICU.

17 So if you look at the draft language, Dr.  
18 Soltys' report, and our comments, we -- I think we  
19 are agreeing on everything in that -- on the  
20 contentious charge if we can call it contentious.  
21 Just one clarity to what Dr. Soltys said. The  
22 department never said that the patient days of care  
23 in the licensed NICU bed, which are not technically  
24 at NICU level as defined, will not be reported. We  
25 never said that. In fact, we always said it should

1 be reported, but for integrity of data reporting  
2 and for clarity, it should be reported based on the  
3 level of care.

4 Even if you look at the draft language in  
5 that number, what is it now, 7, the continued care  
6 of infants that remain in a NICU bed after  
7 providing any of the above 1 through 6, we are  
8 saying, "However, these patient days of care shall  
9 not be reported as NICU patient days of care but  
10 shall be reported in the department's annual survey  
11 as SCN patient days." So it will still be reported  
12 as inpatient days of care, and here is why.

13 If you don't collect the data separately  
14 for numbers 1 through 6, and then 7, everything is  
15 being reported in one bucket. And what is the  
16 downside of that? You don't know the distinction.  
17 What was number 1 through 6, and what is number 7?  
18 So if we collect the data separately and if the  
19 methodology calls for some sort of, you know,  
20 integration of the two data or, you know, 80  
21 percent or 100 percent of NICU data and then maybe  
22 50 percent of this number 7 or whatever is the  
23 decision from the commission and the expert, then  
24 you have a choice to do that in the future.

25 But if everything is reported in one

1 bucket, like we found out through this work group,  
2 which the department did not know that in the  
3 annual survey everybody was reporting NICU plus  
4 everything else provided in a NICU license bed. So  
5 that is the downside of not separating the data for  
6 reporting purposes. Then you don't know what is  
7 the status of NICU care and these -- you know, the  
8 other -- the number 7 that you are adding.

9           And then the second thing I wanted to --  
10 we said this in the work group. Maybe we need to  
11 say it again. It is never -- was the department's  
12 intention or goal or anything to affect the care,  
13 the treatment care. Decisions made by the doctors  
14 and the discussions between the doctors and the  
15 families -- these families is their -- it's their  
16 decision to make. All we are asking, that after  
17 your calendar year is over -- also, please keep in  
18 mind, it's not a live data reporting.

19           You are not reporting on a weekly,  
20 monthly, quarterly basis. It's annual reporting,  
21 which we launch in April or May of the year. So it  
22 is for the previous calendar year. All the  
23 decisions, all the patients, hopefully they're at  
24 home, so you are just reporting after the fact what  
25 was the level of care. Was it a NICU patient? Was

1 it an NICU graduate who had to stay in a NICU bed?  
2 Rightfully so. We are not trying to affect any of  
3 those decisions.

4 Once again, please, if you have any  
5 questions, Dawn and I and other department staff  
6 are happy to answer that. We are just asking for  
7 data clarity and for a better methodology in the  
8 future. We need to have right data.

9 MS. GUIDO-ALLEN: Guido-Allen. So  
10 Tulika, on Page 10 of the packet that we got from  
11 NICU staff, number 3, require hospitals to  
12 separately report level I and level II infants  
13 receiving care in licensed NICU beds would meet  
14 your requirement if on the annual survey we did a  
15 total patient days cared for in the NICU, if then  
16 you did a subset of level III/IV and then a subset  
17 level I/II and then work with Dr. Delamater to --  
18 once we have that data to use the elements to come  
19 up with a meaningful methodology, for example, an  
20 adjusted occupancy rate for the level I to IIs in  
21 the NICU to give us utilization?

22 MS. BHATTACHARYA: Yes. That is our  
23 goal.

24 MS. GUIDO-ALLEN: Dr. Soltys, would that  
25 meet?

1 DR. SOLTYS: It would, but I still don't  
2 agree with this idea that number 7 lumps everybody  
3 into one bucket because, as you just said, it  
4 doesn't. We actually went on to specify that  
5 later. And number 7 is still NICU care. I think  
6 that's the biggest thing, is, like we tried to  
7 point out, these former 25 and 26-weekers still  
8 need to be in a NICU. So I understand you're not  
9 saying they need to go somewhere. They can stay in  
10 the NICU, but we're not dictating care. But  
11 eventually, when you look at the methodology,  
12 you're not including NICU patients in your NICU is  
13 my argument here. If we exclude them and just  
14 consider them SCN babies, then it's -- it will  
15 eventually look like we don't need as many NICU  
16 beds as we actually need.

17 MS. GUIDO-ALLEN: I don't think what I  
18 said was the special care nursery babies would be  
19 an adjusted, not negated, right?

20 DR. SOLTYS: Yes.

21 MS. GUIDO-ALLEN: Not that we take  
22 them --

23 DR. SOLTYS: Right.

24 MS. GUIDO-ALLEN: -- completely out of  
25 the utilization.

1 DR. SOLTYS: Right.

2 MS. GUIDO-ALLEN: That with Dr.  
3 Delamater's assistance with hopefully a work group  
4 of NICU experts, that they would come up with a  
5 weighted score that that level would get --

6 DR. SOLTYS: Yeah.

7 MS. GUIDO-ALLEN: -- that would then  
8 contribute to our overall utilization by NICU.

9 DR. SOLTYS: Yes. Yes. I agree with  
10 you.

11 MS. GUIDO-ALLEN: Okay.

12 DR. SOLTYS: Sorry I didn't directly  
13 answer your question. I was also --

14 MS. GUIDO-ALLEN: Thank you.

15 DR. SOLTYS: I apologize.

16 MS. GUIDO-ALLEN: Dawn?

17 MS. SHANAFELT: Hi. Thank you, everyone.  
18 I'm Dawn Shanafelt. I'm the director of the  
19 Division of Maternal & Infant Health at MDHHS. And  
20 I had the pleasure of meeting with the work group  
21 on more than one occasion, as well as I'm familiar  
22 with maternal levels of care verification, a  
23 variety of things that we're discussing today.

24 I think it may be helpful to share that  
25 our certificate of need for the NICU/SCN standards

1 are based on the AAP neonatal levels of care  
2 verification. And they're based on that for very  
3 important reasons, to assure that all babies that  
4 are cared for in the state of Michigan are  
5 receiving the highest level of care that they need.  
6 All babies -- or each individual baby needs to  
7 receive individualized care based on their health  
8 status and their number of weeks gestation that  
9 they were born, their birth weight, and a variety  
10 of other needs or specific criteria that each of  
11 the babies have.

12 So in Michigan, we oversee special care  
13 nursery beds, which would be level II, and then  
14 NICU, which is level III and IV. And then the rest  
15 of the babies, which thankfully, the majority of  
16 the babies that are born in state of Michigan, fall  
17 under well newborn nursery, which is level I, which  
18 means they're born and they go home with their --  
19 with their families without needing additional  
20 intervention at a higher level of care.

21 Why I think the clarification is needed  
22 just when we're discussing these standards is for a  
23 few reasons. Babies who need special care nursery  
24 care are cared for in either an institution that  
25 has a special care nursery, and we're grateful to

1 have numerous, 14 or 15 I believe, in the state of  
2 Michigan that provides special care nursery care,  
3 which again, is really, really critical to have in  
4 our state.

5 We also have our NICUs in the state of  
6 Michigan. Our NICUs provide not only NICU-level  
7 care, which is level III and IV, but they also, per  
8 the standards, provide special care nursery level  
9 care. So for the clarification purposes, not all  
10 babies that are in a NICU are in a NICU receiving  
11 NICU-level care. They might be receiving -- they  
12 might be special care nursery babies.

13 For example, sadly, we have a huge  
14 problem in the state of Michigan where we have  
15 babies that are born substance exposed. Many of  
16 those babies receive care in special care nursery.  
17 They need to be in the hospital for longer periods  
18 of time while their bodies adjust to no longer  
19 receiving substances that they may have received in  
20 utero, so that's just one example.

21 So I want to make that clear, that many  
22 neonatal level care standards, first of all,  
23 they're not simply facility standards. They were  
24 created by March of Dimes and the AAP because we  
25 wanted to assure that babies across the United

1 States receive the highest level of care and honor  
2 the individualized care that they need and assure  
3 that the facilities that they're receiving care in  
4 are meeting those standards so that they aren't --  
5 their health isn't potentially jeopardized so you  
6 don't have a very sick baby at a hospital that  
7 isn't able to keep the baby long-term and equipped  
8 to handle that. They're moved to the highest level  
9 of care that they need. So that's one thing. This  
10 is very patient-specific, and I think that's why  
11 everyone is so passionate. We care about the  
12 infants and families in the state of Michigan.

13 The second item that I want to mention is  
14 that, again, all babies that are in the NICU aren't  
15 necessarily -- as I said, moment ago but I'll say  
16 more succinctly, they may not have been in the  
17 NICU -- admitted to the NICU to receive level III  
18 and IV care. They may not be a 25-week baby. They  
19 may be a baby that had challenges regulating their  
20 body temperature, feeding challenges that require  
21 them to stay in a hospital for a longer period of  
22 time. They may have been exposed to a substance,  
23 an illicit substance or a prescribed substance,  
24 where they need a bit more time. And if they are  
25 lucky enough to be able to receive care at one of

1 our great NICUs in the state, they're in the NICU.  
2 But they are not in a licensed NICU bed. They are  
3 receiving special care nursery services.

4 So again, that's -- the distinction is  
5 really clear. We want all babies in Michigan to  
6 receive the highest level of care that they need.  
7 And in order to assure that we have access for the  
8 babies in our state, we need to assure that our  
9 data is accurate and that our licensing and  
10 regulation of NICU beds and expanding NICU beds or  
11 increasing numbers at various facilities when  
12 needed.

13 We know population shift, that happens,  
14 right? Or hopefully, there's a -- or there may be  
15 an increase in the number of babies born in a  
16 particular area in the state, and so that means  
17 that, using the methodology, there may need to be  
18 more beds. People may move from the west side of  
19 the state to the east side or to Northern Michigan,  
20 amazing place, or the upper peninsula or something,  
21 and that would require more beds because we have  
22 more babies born per the methodology and more  
23 babies that need specialized services.

24 So I -- it's really important that we  
25 have accurate data to assure that we are meeting

1 the needs of the families of the state and then  
2 also to assure that babies are receiving the  
3 highest level of care that they need medically. So  
4 I think that we are all on the same page when it --  
5 when it comes to that. We all want the best  
6 possible outcomes, and we want to assure the  
7 highest level of care is being received that a --  
8 that a family or baby patient needs. But in order  
9 to do that, we need accurate information, and we  
10 need accurate data. So all babies that are in NICU  
11 are not receiving NICU-level care necessarily. And  
12 again, the department would never prescribe  
13 decisions for clinicians, whether it's physicians  
14 or mid-level providers or others. We're simply  
15 saying we need accurate data.

16 So my final point, for example, if you  
17 have 20 licensed beds, theoretically, you could  
18 have ten babies in there that are NICU, who were  
19 born extremely tiny, that had congenital anomalies  
20 and need heart surgery. And we want them to  
21 receive the care that they need, and they may stay  
22 there probably the entire time until they go home  
23 to their parents. You also will have babies that  
24 are there that essentially are receiving step-down  
25 care. Thankfully, they're healthier, and they

1 don't -- they may not need to be -- well, they  
2 wouldn't be at this point, but they don't need to  
3 be intubated. They are receiving that care that's  
4 needed, where you have one nurse caring for two  
5 babies. They're there to be stabilized and to grow  
6 a bit and have any challenges addressed and get to  
7 go home to their families. So I just -- again, I  
8 want to make that distinction. This is extremely  
9 patient-driven. It's much more than facility-  
10 driven.

11 DR. MILEWSKI: Thank you. I actually  
12 have a question. I'm sure other commissioners may  
13 as well, that, Dawn, I'd like to direct to you, as  
14 well as to Dr. Soltys because what I'm hearing in  
15 this -- and I agree with you. There may be babies  
16 in the SCN, they get admitted to a NICU bed. They  
17 never had that level III to IV care in this. But  
18 what I'm hearing clinically is that SCN group is  
19 different than what the clinical teams are seeing  
20 in terms of need from the group that started off in  
21 the III to IV and that then are moving down as they  
22 age up.

23 And so I'm not sure that the reporting  
24 methodology -- I think the concern here that I'm  
25 hearing is that the reporting methodology is when

1 you start counting those babies that were initially  
2 a III to IV that then moved to a II but need to  
3 stay in a NICU bed -- that that bucket is so big  
4 that it may start underestimating the need for a  
5 NICU bed.

6 I may be incorrect, but that's kind of --  
7 I'm trying to summarize what I'm understanding of a  
8 very complex topic. So can you respond to that in  
9 terms of what you're suggesting from the reporting  
10 standpoint and how we account for that to be able  
11 to meet the clinical need? Because I also hear the  
12 department saying, we're not trying to step in  
13 front of the clinical need, but we need better  
14 data. But I think what's been put on the table,  
15 I -- I'm -- maybe I'm misunderstanding, doesn't  
16 seem like it may be meeting the need in terms of  
17 estimating that bedtime that's needed for those  
18 IIIs and IVs that then move down.

19 MS. SHANAFELT: It -- that's -- you're  
20 exactly correct in your understanding. And I think  
21 that's why we go back -- I go back to the point  
22 that Tulika made that reporting is annually. So  
23 when you report annually, you can go back and look  
24 at the number of patient days where patients were  
25 in licensed NICU beds, number of patient days where

1 a patient was in a special care nursery bed or they  
2 were in a non-licensed bed. It might be in the --  
3 in the actual NICU. So for example, you may have a  
4 NICU -- our NICUs in Michigan vary. Some have  
5 individual rooms for patients. The majority have a  
6 large NICU, where all the NICU babies are in one  
7 particular area. So -- and back to my example,  
8 this isn't any specific hospital at all. So 20 --  
9 if you have -- if you're licensed for 20 NICU beds,  
10 your unit may also have room for four, six  
11 additional babies.

12 And particularly, I'll go back to my  
13 example of babies that sadly stay in the NICU  
14 longer or may stay in the NICU longer if you have  
15 babies that have been substance exposed. The  
16 pendulum is swinging in Michigan. We won't get  
17 into that. But, for example, you could have four  
18 babies that are there that are essentially what as  
19 nurses call feeders and growers. They're -- they  
20 were born just a little bit early. They're doing  
21 well, but they still need to be monitored. They  
22 still need to be in the hospital.

23 And so when you report your days of NICU  
24 care, you report the days of NICU care for babies  
25 that are receiving licensed NICU care, which is why

1 we have licensed NICU beds. And the department's  
2 approach was that -- to assure that we have  
3 accurate data, we understand that's extremely -- it  
4 can be extremely challenging, but many of our  
5 hospitals, and I won't say specific names, but did  
6 say that they are able to distinguish how many  
7 babies are receiving licensed NICU-level care and  
8 how many babies are receiving special care beds.  
9 And they do that for staffing ratios. They do that  
10 to monitor their census, to know if they're able to  
11 receive a baby coming in from another place in  
12 Michigan.

13 So the bottom line, I don't want to --  
14 it's complicated, but we would just really need  
15 accurate data to assure that we are meeting the  
16 needs of the babies in the state special care  
17 nursery-wise, NICU-wise. It's really important.  
18 It isn't to cause challenge. It's -- NICU beds are  
19 licensed for a reason, and in order to determine if  
20 you need additional licensed beds, we need accurate  
21 data. And that data comes in a variety of ways,  
22 from vital records, from birth information for  
23 babies, and then obviously from, importantly, the  
24 clinicians in our state when they report on their  
25 annual report.

1 MS. NAGEL: If it's okay, if I could just  
2 add. This is Beth Nagel. I wanted just to make  
3 two quick points. The first point is that this  
4 isn't the first time that in the process with  
5 certificate need we found a massive data error. I  
6 think probably about, I want to say, a decade ago,  
7 we found out, you know, some nursing homes were  
8 only reporting quarterly data on their annual  
9 survey. And so we had to go back and, you know,  
10 get everyone on the same page on how to report,  
11 and, you know, it s a mess. But in the meantime,  
12 we paused the methodology so that we wouldn't  
13 report a lower need of nursing home beds and then  
14 adversely affect the field.

15 And so I think that option is on the  
16 table for this, too. We found out during the  
17 course of this work group that the data wasn't  
18 being reported in the way that we thought it was,  
19 right? NICU days versus SCN days, they were  
20 getting mashed up in the NICU facilities. And so  
21 you know, we could certainly do the same thing  
22 here, put a pause on the bed need, put a pause on  
23 running the methodology, while we gather additional  
24 data.

25 Again, I want to underscore the point

1 that we are not trying to change how babies are  
2 cared for in Michigan at all. We just want the  
3 level of care reported accurately to the  
4 department, not to adversely affect the  
5 methodology, not to, you know, lower the number of  
6 NICU days in the state, but to really have an  
7 accurate hand on what -- how many babies need NICU-  
8 level care and how many need SCN-level care.

9 I fully understand and appreciate that  
10 one specific patient could spend, you know, five  
11 days at level III, five days at level II, and then  
12 run back to level III or IV. I completely  
13 understand that. That is the same in many of our  
14 other services as well that get reported, and so  
15 we're just asking for consistency of reporting for  
16 the purpose of making sure that we have the  
17 necessary services for every baby in the state.

18 Without accurate data, we truly don't  
19 know. And that is an important part of certificate  
20 of need. Kind of the -- you know, the girding of  
21 certificate of need is on accurate data, and that  
22 is really what we are pushing for. It's not a  
23 policy change with how babies are treated or cared  
24 for in any way. Thank you.

25 MR. CONNOLLY: So I'm sorry.

1 DR. SOLTYS: Sorry. Go ahead, Marcus.

2 MR. CONNOLLY: Yeah. I just wanted to  
3 see if Dr. Delamater wants to make comment. I seen  
4 he put something in the chat.

5 DR. DELAMATER: Hi, everyone. Can you  
6 guys hear me all right? Can I get a thumbs up or  
7 something from Tiffani?

8 MS. STANTON: Yes.

9 DR. DELAMATER: Oh. Great. Awesome.  
10 I -- before I start, I want to echo a few of what  
11 folks have said about the nature of the working  
12 group and the subgroups. This was like -- I wasn't  
13 able to participate in everything, but I was able  
14 to participate a lot. And the groups were great  
15 and did a lot of good work here. It's interesting  
16 as someone, like, that we started this -- you know,  
17 the aim of this one was -- or this charge was a  
18 methodological one, was about thinking about  
19 methodology, and then it turned towards data and  
20 definitions. And I do want to come back to a  
21 little bit of that.

22 I also want to echo what Tulika and Dawn  
23 and Beth said about that the disagreement really is  
24 about, like, data and semantics and reporting.  
25 It's not about care. And I -- obviously, I -- as a

1 professor, I -- I'm sitting here in semi-warm North  
2 Carolina compared to you guys. But I do have my  
3 Michigan map here for everyone.

4 You know, that -- we're really -- we're  
5 really just trying to get the data right here. And  
6 so I want to say -- point out, currently, the  
7 methodology actually does not use the utilization  
8 data that's reported. It uses only live birth  
9 data. So as of right now, the bed need methodology  
10 does not use this data. One of the things we were  
11 talking about in the group was we want to use this  
12 data for the methodology, to make a better one.  
13 And then we realized that there were some issues in  
14 the reporting, and so then we went down this road.

15 And so one of the things that I want to  
16 say about why I disagree with adding that number 7  
17 to the -- to the definition is that the high-  
18 occupancy standards then may still -- do use the  
19 use utilization data. And what hasn't really been  
20 defined here that I'm struggling with is, are those  
21 babies that are on the way down transitioning  
22 through levels of care, right -- are they still  
23 counted as NICU, or are they reported separately as  
24 SCN? Because I think the standards would then have  
25 to change to reflect high-occupancy isn't just --

1 you know, doesn't -- isn't just the utilization  
2 data you're reporting with all babies.

3 I will also say if we cannot distinguish  
4 level I and II babies in a NICU service or it,  
5 like, reported in NICU data -- if we can't  
6 distinguish them, I'm going to be here in three  
7 years saying we can't use this data for a  
8 methodology because it doesn't reflect the need for  
9 NICU services. And so I'm a little concerned that  
10 if we go down this road that we're going to be back  
11 here in a year or two years saying, well, we  
12 can't -- we still can't use the data because none  
13 of us feel confident in that these are actual NICU  
14 babies needing NICU services at the time that they  
15 were reported. And so I just wanted to point those  
16 things out, and I'll stop there.

17 DR. SOLTYS: Do you mind if I just  
18 address a couple of things?

19 DR. MILEWSKI: Yeah. Yeah.

20 DR. SOLTYS: And then I'm going to stop  
21 talking in circles and let other people talk  
22 because I'm kind of tired of standing. So first,  
23 the examples given, you know, by Dawn, none of  
24 those babies are NICU service babies in the first  
25 place. So I guess I don't understand why we're

1 talking about substance-exposed babies, why we're  
2 talking about hypoglycemic babies, why we're  
3 talking about 34-week babies who just need time to  
4 mature. They would not be in the NICU services  
5 anyway. We are not talking about putting everybody  
6 in one bucket because I totally appreciate, trust  
7 me, you don't have to explain to me, half our  
8 patients are probably not NICU patients. They're  
9 probably SCN patients. It's appreciating the  
10 fragility of these former NICU patients and that  
11 they cannot be thrown into the same category as  
12 substance-exposed babies, babies who just need to  
13 learn to grow and eat. They're not the same, and  
14 so all of those examples wouldn't be NICU service  
15 babies under this recommendation.

16           The other concern about there being high  
17 occupancy rate or the high-occupancy provision and  
18 applying for that, your occupancy is not going to  
19 get higher than it is right now. It's -- everybody  
20 has been reporting everything. So while I can  
21 appreciate that concern, it -- the numbers and  
22 talking to -- and I'm not sure who you heard is  
23 able to report accurately because we only heard of  
24 one NICU. That -- those numbers are inevitably  
25 going to go down if we can correct the reporting.

1                   And then finally -- I lost it. I'm done.  
2 Thanks.

3                   DR. MILEWSKI: Go ahead.

4                   DR. FERGUSON: Ferguson here. So I  
5 appreciate that everyone is trying so hard to care  
6 for the patient. I appreciate the clinical  
7 expertise and the regulatory expertise. I  
8 appreciate that the department is asking for  
9 improved data, which makes sense, and that if I  
10 understood your earlier comment that you're  
11 committed to not using the new data under the old  
12 model but rather using it to develop insights for  
13 perhaps an improved future model.

14                   We seem to be tripping over and over and  
15 over around the spectrum of intensity between the  
16 lower end of category II and the upper end of  
17 category II, right? We have -- and so my clinical  
18 question is, is there a meaningful way, not too  
19 complicated hopefully, to distinguish, like, the  
20 true IIs and the II-pluses or whatever you --  
21 whatever term you want to put on that in terms of  
22 either because of a clinical indication, or maybe  
23 it's a history. Maybe you were a III and you  
24 qualify as a II-plus for the next ten days. I have  
25 no idea. Like, I'm not close enough to it. But

1 I'm asking because if we're trying to get decent  
2 data to act on, we're going to go through all of  
3 this, and if we can't break down this concept of II  
4 a little bit more precisely, I'm afraid we're going  
5 to be back at the same point four years from now or  
6 whatever it may be. So is there any way to parse  
7 this?

8 DR. SOLTYS: I can say it won't be easy,  
9 as you were hoping. That's all I can say. I mean,  
10 because it is infants, the thing that is so  
11 difficult about caring for them is that they don't  
12 have the reserves we all do. We can all get sick  
13 and still walk around and be okay, but an infant  
14 gets -- you know, RSV, for instance. If a NICU  
15 infant gets RSV, they're high risk to die. Us, we  
16 get a little cough. And so it's very hard to  
17 predict which of those infants is going to go on to  
18 be perfectly fine because if that were the case, if  
19 we knew they were all going to do that, I -- we  
20 probably wouldn't be up here talking about this.  
21 It -- it's just so hard, unfortunately.

22 MS. NAGEL: I'm sorry, Doctor, but this  
23 is retrospective data, right? You don't have to  
24 predict unless I'm misunderstanding it. We're  
25 asking for you to be able to say patient A spent

1 ten days in NICU and four days in SCN. I'm not --  
2 we're not asking you to predict that when a patient  
3 is admitted.

4 DR. SOLTYS: Right. And I don't know off  
5 the top head. I can't tell you how often we have a  
6 kid who -- and if there's a number of days they  
7 were -- they were NICU and then went to SCN, how  
8 many of those went back. I don't know the answer  
9 to that.

10 MS. NAGEL: Yeah. And I think that's the  
11 exact issue we're trying to get at. We would like  
12 to know the answer to that. I think that's  
13 important data for our methodology, to be able to  
14 answer that. And that's the only thing we're  
15 trying to get an answer to, is, you know, in April,  
16 we'll ask you, hey, last year, how many patient  
17 days were NICU, and how many patient days were at  
18 SCN? So I understand, you know, that it would be  
19 hard in real time, but we're asking  
20 retrospectively.

21 And to your point, Commissioner Ferguson,  
22 there may be a way to break it out even further.  
23 There may be a way for us to ask, you know, how  
24 many of these babies spent time in both SCN and  
25 NICU service. There may be very different ways to

1 get to the heart of -- to answer to that question.  
2 And I think that's something we'd be willing to  
3 explore.

4 DR. MILEWSKI: And very similar. I mean,  
5 the notes that I wrote down was this feels like a  
6 discussion of two buckets versus three buckets.  
7 And I think what I'm hearing is that three buckets  
8 are necessary in order to get to the complexity of  
9 the clinical issue that we're dealing with and what  
10 is happening operationally on the ground.

11 So I guess what I'm curious on is, is  
12 there a feasibility to report out, you know, level  
13 III/IV NICU? Was a level III/IV; is now SCN. Was  
14 never a level III/IV and is SCN only; has never  
15 been. And like, that seems like it would resolve  
16 the issue, provide the data that is necessary to  
17 come up with an appropriate methodology  
18 operationally.

19 So I guess I would ask the department, is  
20 that feasible from your end? And then the question  
21 is, is that feasible from a reporting end on the  
22 hospital side?

23 MS. NAGEL: Go ahead. Tulika and I were  
24 both going to answer, but I'll defer to her.

25 MS. BHATTACHARYA: So this is Tulika. I

1 think it's -- excuse me. Step back. If you look  
2 at the SCN reporting for the annual survey, so  
3 there are, let's say, four different services that  
4 are listed as SCN-level service. We request the 13  
5 SCN hospitals to report for each service how many  
6 patient days of care, admissions, discharges, et  
7 cetera.

8 So what I foresee or envision moving  
9 forward, the NICU data reporting can also be broken  
10 down by the different buckets. So the NICU-level  
11 services, NICU patients that were -- that became  
12 SCN level, and maybe a third bucket where SCN-level  
13 babies if they had to admit into a NICU bed for  
14 whatever reason, for treatment reasons, that is  
15 another bucket. But everything will get reported  
16 if a patient was treated in a licensed NICU bed.

17 And before this work group, the  
18 department was simply not aware of this data-  
19 reporting anomaly, so that's why we only ask simple  
20 questions. You have 20 NICU beds, so report how  
21 many admissions or discharges and how many patient  
22 days of care because we were simply not aware of  
23 this problem. But now that we are, we will try to  
24 make it easier for the provider to report by  
25 breaking down the buckets.

1 DR. MILEWSKI: Thank you.

2 Do commissioners have any other questions  
3 for Dr. Soltys? Otherwise, I'm going to allow him  
4 to take a seat. He has been standing a very long  
5 time.

6 DR. SOLTYS: I can answer yours. Yes.  
7 We can get that data and report it that way --

8 DR. MILEWSKI: Okay.

9 DR. SOLTYS: -- because so many are based  
10 upon birth weight and birth age, so so many of  
11 those would be very easy to figure out.

12 DR. MILEWSKI: Good. Thank you.

13 Any other questions for Dr. Soltys?  
14 Great. Thank you.

15 DR. SOLTYS: Thank you, all, very much.  
16 This was fun.

17 DR. MILEWSKI: And we're not done. We  
18 still haven't even opened up for public comment  
19 yet.

20 Okay. So I'm going to look back to the  
21 department and see if we have public comment on  
22 this topic.

23 MR. EASTER: We do, yes. Well, I'll go  
24 through the prior talking points first, then public  
25 comment.

1 DR. MILEWSKI: Oh, thank you.

2 MR. EASTER: All recommended language  
3 presented today reached consensus with the work  
4 group. The department is including the technical  
5 edit that requires notification to the department  
6 no later than 30 days after any planned decrease or  
7 discontinuation of the CON service. This technical  
8 edit -- technical edit was added to the draft  
9 language after the conclusion of a normal work  
10 group and was not included as language that was  
11 voted and approved by the work group. It is a  
12 technical edit that the CON Commission previously  
13 voted to be added across all standards.

14 The department is recommending no changes  
15 to the neonatal intensive care services definition  
16 as the CON review standards for NICU are intended  
17 to regulate the NICU level of service provided and  
18 allocation of the infant receiving care. However,  
19 if the commission agrees with the language  
20 recommended by the board, the department suggests  
21 adding the language in blue.

22 Sorry, Tiffani.

23 MS. STANTON: Yeah. Sorry. The --

24 MR. EASTER: It's right there.

25 "However" -- and this is the language in

1 blue. "However, these patient days of care shall  
2 not be reported as NICU patient days of care but  
3 shall be reported in the department's annual survey  
4 as SCN patient days." This language supports how  
5 the department plans to administer it on the annual  
6 survey. We intend to track the SCN and NICU  
7 patient days separately," as Tulika said earlier.  
8 Proposed action from the commission will require a  
9 motion, second, and a vote to approve. Commission  
10 proposed action will move the language from a  
11 public hearing to the JLC. A report and language  
12 for final action will be brought back to the CON  
13 Commission at the March meeting.

14 Commissioner Milewski, would you like to  
15 see the three options or public comment first?

16 DR. MILEWSKI: I think we should do  
17 public comment, and then we can look at the three  
18 options for those.

19 MR. EASTER: We do have public comment.  
20 Daniel Rito from Henry Ford Health.

21 DR. RITO: Hi there. I'm Daniel Rito.  
22 As division head of neonatology and medical  
23 director of the Henry Ford NICU in Detroit and the  
24 special care nurseries in West Bloomfield, Clinton  
25 Township, and Wyandotte, and as an active member of

1 the work group, I want to express my strong support  
2 for the work group-proposed revision on the  
3 definition of NICU intensive care services. During  
4 discussion of Charge 3, it became evident that this  
5 change is essential to align the CON standards with  
6 the realities of the modern NICU branches across  
7 Michigan. The current definition doesn't reflect  
8 how care is currently delivered across most of the  
9 state and updating it will ensure consistency with  
10 best practices.

11 Across most NICUs in the state, when an  
12 infant is in a NICU-level -- requires NICU-level  
13 care, they're admitted to a NICU-licensed bed,  
14 where they stay until they're discharged, even as  
15 their condition improves over time. Moving a  
16 recovering baby to an unlicensed bassinet  
17 classification isn't practical or safe. These  
18 infants often require renewed respiratory support  
19 or infectious workup, specialized nutrition through  
20 all of this, and you can't provide those services  
21 in an unlicensed SCN bassinet. Switching them  
22 between beds disrupts their care and adds  
23 unnecessary stress to their families.

24 It's important to remember, and this  
25 point has been made, that convalescent NICU

1 patients are kind of like your II-plus patients.  
2 They're not the same as the babies that never  
3 required an intensive level of care. These  
4 requiring -- these recovering infants require  
5 specialized access to services, as has been alluded  
6 to earlier, like pediatric ophthalmology and  
7 comprehensive therapy programs that are only  
8 available in NICUs, not special cares. Forcing  
9 these patients into special care would compromise  
10 their care, but -- and -- by not accounting for the  
11 care, and it would underestimate our true NICU-  
12 licensed bed need as we would have fewer beds  
13 available if a new patient was delivered that did  
14 require intensive care.

15 By adopting this change, we'd recognize  
16 the critical continuum of NICU care that NICUs  
17 provide. It ensures every day spent in a NICU-  
18 licensed bed is counted as appropriate and  
19 necessary, helping infants transition safely  
20 between the different levels of care before they go  
21 home. Limiting NICUs from accounting all levels of  
22 care within their units won't save money. In fact,  
23 it's likely to cost us more. Patient -- payments  
24 are based on the actual level of care determined by  
25 InterQual criteria largely, not whether a baby is

1 in a licensed NICU bed or an unlicensed special  
2 care bassinet.

3 If we restrict how occupancy is measured,  
4 we'll end up with fewer available NICU beds and  
5 more unnecessary transfers. These transfers come  
6 with additional higher costs, special transport  
7 teams, ambulance and helicopter services, advanced  
8 equipment, and more importantly, they disrupt the  
9 continuity of care being provided and add emotional  
10 and logistical challenges to these families that  
11 are already in a very difficult time. If we  
12 exclude special care level care of recovering  
13 infants that are still in NICU beds, we risk higher  
14 statewide healthcare costs, operational  
15 inefficiencies, as well as patient safety issues.

16 The best solution is to maintain the  
17 flexibility in how we use the NICU beds currently  
18 and recognize the full spectrum of care currently  
19 being provided. This recommendation, as was stated  
20 earlier, was unanimously supported within the work  
21 group, and it's a practical and patient-centered  
22 solution that protects the quality of care and  
23 helps us to manage our resources in all of our  
24 NICUs appropriately. Thank you.

25 DR. MILEWSKI: First, I want to thank you

1 for your participation in the work group and also  
2 being here today to share on this complex topic, so  
3 we really appreciate it.

4 Questions from the commissioners?

5 DR. ENGELHARDT-KALBFLEISCH: I guess I  
6 had one. So Commissioner Engelhardt-Kalbfleisch.  
7 Obviously, your scope is very broad, and you're  
8 very familiar with the AAP guidelines. I guess,  
9 under the department's proposed changes of  
10 language, like, you mentioned a lot of  
11 disadvantages and potential harm or increased costs  
12 that could come. Are there any potential  
13 advantages from your clinical standpoint?

14 DR. RITO: To making the change?

15 DR. ENGELHARDT-KALBFLEISCH: Yeah.

16 DR. RITO: I mean, I think -- well, I  
17 mean, it comes to keeping patients in an  
18 appropriate place. So a lot of the care that we  
19 provide in the NICU is involving the parents and  
20 the family as much as we can. I mean, these are  
21 ultimately where these patients need to go home to,  
22 and so the more that we can keep that family as one  
23 cohesive unit and not potentially transfer a  
24 patient from Traverse City to Grand Rapids for a  
25 three, four, five-month NICU stay is important. As

1 was -- it was up on the screen earlier, the AAP  
2 levels of care, at the top of each of those levels,  
3 it talks about -- and it talks about what the  
4 capabilities of a unit, and that's what it's  
5 describing. And it talks about what is that -- a  
6 level IV includes level III and level II. A level  
7 III includes level II as well.

8           And so yeah. They need to be able to  
9 care for it all. And if you look at -- in there,  
10 it talks about pediatric ophthalmology. We don't  
11 need pediatric ophthalmology in the -- in the first  
12 day or two, when we have a 25-weeker on a vent. We  
13 don't need pediatric ophthalmology until they're  
14 not on a vent anymore. We don't need pediatric  
15 ophthalmology, we don't need therapy services until  
16 they're starting to work on feedings. They're not  
17 on TPN largely at that point.

18           So a lot of the services that are  
19 required in an NICU for some of our smaller  
20 patients are not being utilized until they're in  
21 that convalescing period. And so I think that this  
22 language change, the number 7, captures that to be  
23 able to accurately represent what -- how we're  
24 using our NICUs and how they need to be used.

25           DR. ENGELHARDT-KALBFLEISCH: Thank you.

1 MR. EGAN: Joe Egan. I'm a little  
2 confused because you mentioned kind of, like, real  
3 -time clinical care, right? To me, this is more of  
4 an exercise of retrospective adjudication of the  
5 correct buckets that Beth and Tulika mentioned. So  
6 can you just clarify that, how this Charge 3  
7 affects real-time clinical decision that you  
8 mentioned earlier?

9 DR. RITO: So it -- it's more down the  
10 road that if we're -- if we're making decisions  
11 where we now have limited the amount of patients  
12 that we're counting, now you're going to  
13 potentially limit. So to the 20-bed limit that  
14 we're -- that was being used in -- in a -- as  
15 an example earlier, if 20 babies are currently  
16 requiring InterQual level level III, level IV care,  
17 and potentially you have another ten babies that  
18 are in the convalescing period and you have another  
19 five that are -- that are in unlicensed bassinets,  
20 so they're not counted in, they have 20 licensed  
21 NICU beds. They have then some other space that  
22 they're able to utilize. And many times, our  
23 patients are small, and so we can physically pair  
24 them up and make them physically within the same  
25 space and still use it.

1           Then if we're utilizing all those space  
2 and -- but we're not counting those ten that are  
3 convalescing that still need NICU care -- and  
4 that's where this comes in, that we're -- those  
5 babies physically need to be in an NICU. That --  
6 no, in the county today, in the -- what I'm doing  
7 today, it doesn't make a difference, but then when  
8 we're using these numbers on down the road to say,  
9 well, you only needed 10 NICU beds, when really  
10 you needed 20 NICU beds, that's where it comes into  
11 then -- that's when it comes into affecting patient  
12 care.

13           Not today, but it affects patient care in  
14 potentially three -- in three years when we look at  
15 it again and there are some NICUs currently that  
16 are at-capacity limit because they have patients  
17 that are receiving NICU level of care as well as  
18 convalescing. And so their NICU is full. They  
19 don't have space. And -- as well as there are  
20 babies that are born physically in that hospital  
21 that -- there isn't a separate special care  
22 nursery, and so they're also in there.

23           But if they have another baby that  
24 requires an intensive care level, they don't have a  
25 space to physically put that patient in, so that

1 patient now needs to get transferred out if they  
2 don't have the appropriate number of beds that  
3 actually meets the needs.

4 MR. EASTER: Can I ask a follow-up  
5 question just for teaching me a little bit about,  
6 like, real world clinical from both your  
7 professional experience and from the work group?  
8 So understanding that there's a finite number of  
9 NICUs in this state and a finite number of special  
10 care nurseries, do all of our facilities in the  
11 state that have a NICU have a physically separate  
12 special care nursery, physically separate from  
13 well-newborn nursery? I'm sidestepping the -- I  
14 understand that not all level III services -- this  
15 whole notion of different buckets, so I'm not  
16 trying to target those II-plus or whatever.

17 DR. RITO: No.

18 MR. EASTER: But just does everyone who  
19 have a NICU have a physically separate SCN, or by  
20 definition, are we needing to shuffle some in  
21 the --

22 DR. RITO: So I cannot speak for every  
23 NICU across the state. My understanding in  
24 discussion with all the members that were in the  
25 work group, Sparrow has a separate physical space.

1 I don't know that it is large enough to accommodate  
2 all the patients that meet the definition of only  
3 receiving a special care level of care, but I knew  
4 that they do have a physical separate space.

5 That is the only NICU that I know of that  
6 has a separate physical space that was mentioned in  
7 the work group. I know that in talking, Bronson  
8 doesn't have it. Henry Ford doesn't have it. I --  
9 DeVos, I know, spoke that -- I mean, they have,  
10 obviously, a number of spaces, and they were  
11 actually separating. And they were talking about  
12 them all being the same. Those are the ones that I  
13 can speak most about, but to the best of my  
14 knowledge, no.

15 MR. EASTER: Thank you.

16 DR. ENGELHARDT-KALBFLEISCH: Reason for  
17 that --

18 DR. RITO: And the children's hospitals  
19 wouldn't necessarily be --

20 DR. ENGELHARDT-KALBFLEISCH: The reason  
21 for that is because the staff are the same. The  
22 physicians are the same. The inefficiencies of  
23 separating the spaces, it's already a very costly  
24 service to run. To separate them out is even --

25 MR. EASTER: I -- I'm not -- I'm not

1 suggesting we should.

2 DR. ENGELHARDT-KALBFLEISCH: No. But  
3 yeah.

4 MR. EASTER: I'm just trying to figure  
5 out what, like, real world reality is.

6 DR. ENGELHARDT-KALBFLEISCH: That --  
7 that's the rationale of why.

8 MR. EASTER: Yeah. Thank you. Yeah.

9 MS. NAGEL: Dr. Delamater did have a  
10 question.

11 DR. DELAMATER: It's -- sorry. It is  
12 more of a comment. I feel like we've lost the plot  
13 a little bit on this, and we're -- it feels like  
14 some of the worry is that -- I feel like this could  
15 be remedied by reporting, right? If we can report  
16 accurately, that's what the department wants.

17 Now, I think there is some fear that with  
18 reporting changing or with, like, how -- having to  
19 put the -- report the patient days by level  
20 regardless of where service occurred, by level,  
21 that somehow NICU beds are going to start  
22 disappearing, and that's not the reality of what  
23 anyone wants at all. And as the methodologist that  
24 talks about this, that would allow us, me working  
25 with the department, to make sure that care across

1 the spectrum provided in NICUs is reflected in the  
2 methodology.

3 This -- the -- so it feels like what's  
4 happening is there is fear that utilization of NICU  
5 beds will look lower, and so they're -- so the  
6 remedy here is to change the definition of what  
7 NICU is to count more, okay? And that's if we ask  
8 for separate reporting of the -- of the level IIs  
9 and level I's that are -- that remain in a NICU. I  
10 feel like if this was a small, isolated type event,  
11 there wouldn't be such a hubbub about it, and so I  
12 feel like there's quite a bit of this happening.  
13 But the thing is, you don't fix something like this  
14 by changing the definition.

15 And the other thing I want to bring up is  
16 this is a working group. To change the definition  
17 of the standard may be better for a SAC. We were  
18 never actually going to try to make a new  
19 methodology and get it implemented. We were going  
20 to do recommendations for a methodology and then  
21 have that be actually codified in a SAC when we  
22 have more varied representation on the group. And  
23 so I feel like we've -- again, back to my initial  
24 point, we have just lost the plot on what's being  
25 asked here.

1                   This isn't about asking any care to  
2 change whatsoever. It is an ask of retrospective  
3 reporting to reflect the level of service provided.  
4 That's it. That is, like, full stop, and then the  
5 facilities can do whatever they want.

6                   DR. MILEWSKI: Thank you.

7                   This is Commissioner Milewski. I do  
8 agree that this has become a very complex issue  
9 with -- you know, and I think the good in this is  
10 that everybody cares. We recognize that families  
11 and babies are in a very difficult situation. I  
12 think the -- what I'm hearing from some of the  
13 conversation around the table is commissioners are  
14 very concerned that we get this right, so to that  
15 end, we've been having some sidebars on how do we  
16 address this. And we're going to continue to go  
17 back to public comment, but I do have a question  
18 for the department.

19                   If we were to consider -- because I agree  
20 on the complexity of this, with Charge 3 on the  
21 methodology, typically, those are things in my time  
22 at the commission that have been handled by a SAC.  
23 And so if we were to pause on this given everything  
24 that we've learned -- the department learned the  
25 reporting was different than what they thought,

1 right? I don't think we want any unintended  
2 consequences. It's a concern of mine as well as, I  
3 think, other commissioners. We don't want to do  
4 anything that would reduce the existing NICU, that  
5 need, beyond what is appropriate clinically. If we  
6 were to pause on this and pull out Charge 3 and  
7 take that back to a SAC to look at the entire  
8 remedy methodology for NICU, would that be a SAC or  
9 a work group, number one? And also feasibility of  
10 getting this prioritized because I don't think it  
11 can wait until 2028 given all we know.

12 MS. NAGEL: Thank you, Commissioner  
13 Milewski. We completely agree. We do not want any  
14 unintended consequences from this, certainly not to  
15 families in Michigan. Yeah. And the answer to  
16 your question is, yes, to both questions. I think  
17 this should be a SAC. This is changing the  
18 definition of a service. These services are  
19 codified in statute. This is a big -- this is a  
20 big change, and I do think it would make sense to  
21 have a SAC to do that.

22 I also think we need a SAC to look at the  
23 methodology. However, to Paul's point, right now,  
24 we know we don't have good data for that  
25 methodology. And so you know, we -- with looking

1 at the data we have now, we can't say we know the  
2 level -- we would be able to change a methodology  
3 using the utilization data to be able to forecast  
4 the need for NICU or SCN services.

5 So I do think we need a SAC. I think we  
6 need to look at this more closely, especially the  
7 definition piece and the methodology piece.

8 However, I am concerned that we wouldn't be able to  
9 change the methodology without that data. So my  
10 recommendation would be to continue the work that  
11 the SAC -- or that this work group put forward  
12 minus the change to the definition, have a SAC in  
13 the future look at it and make the recommendation  
14 for what kind of data we need for a methodology,  
15 and then change the methodology. I think it needs  
16 to be multiple steps, unfortunately.

17 DR. MILEWSKI: That's helpful. We've --  
18 I am not the expert on this. I -- you know, I'm  
19 kind of close to it. You know, what I have heard  
20 is reporting in two buckets, which seems  
21 insufficient. So what is the recommendation of  
22 getting to the right level of reporting to account  
23 for what we're hearing clinically as concerns?

24 MS. NAGEL: Yeah. We would be happy to  
25 work through what makes the most sense to at least

1 give us a chance to have data to report on a  
2 methodology. It sounds like we need more than two  
3 buckets, and we need to be able to work with  
4 providers and experts in the field to be able to  
5 get those right in time for our annual survey,  
6 which is in the spring. So we do have some time.

7 DR. MILEWSKI: So potentially working  
8 with the chair of the work group?

9 MS. NAGEL: We certainly could do that if  
10 agreeable.

11 DR. SOLTYS: They won't say no. It's  
12 fine. Whatever you need.

13 MS. NAGEL: Call Chip.

14 DR. MILEWSKI: I was going to say Chip is  
15 getting a phone call after this. Thank you. Thank  
16 you.

17 Any other questions right now for our  
18 current presenter? Thank you so much.

19 DR. RITO: Thank you.

20 MR. EASTER: We do have one more public  
21 comment, Patrick O'Donovan from Corewell.

22 MR. O'DONOVAN: Good morning. Good  
23 morning. I think it's still morning. I have a  
24 bunch of comments here. But all these points have  
25 been made, so I'm just going to be brief and make a

1 couple of comments. In the most recent discussion  
2 about gathering data and doing a SAC to update the  
3 methodology, I think that that's fine, but I think  
4 we have to look at the difference between how the  
5 department is interpreting what NICU services  
6 constitutes versus what the work group did.  
7 There's a distinct difference there, and if we do  
8 nothing and the department takes the more limited  
9 view of what constitutes an NICU day of care, it's  
10 going to result in lower patient days than what the  
11 work group is recommending. So I think that that  
12 needs to be remedied in some way.

13 In terms of the data collection and the  
14 buckets, I -- if I'm hearing correctly, we're  
15 talking about, you know, the level -- it's  
16 primarily the level II care. You could ask in the  
17 survey to differentiate between level IIs in the  
18 NICU who were previously at III or IV and those  
19 level IIs in the NICU who were never a III or IV.  
20 And I think even the work group is -- would agree  
21 that you could exclude the IIs that were never III  
22 or IV because it wasn't a progression of care.

23 So I think that addresses the -- you  
24 know, the -- some of the data reporting issues.  
25 But as, you know, Corewell Health, we would

1 recommend changing the definition to what the work  
2 group said unless there's -- you know, if there's a  
3 pause to allow for those patient days to include  
4 the levels II that progressed from a level III or  
5 IV. So I appreciate the opportunity to comment.

6 DR. RITO: Thank you.

7 DR. MILEWSKI: Thank you. So if I can  
8 clarify, the concern is that if we were to pull out  
9 Charge 3 and try to wait on a SAC while we gather  
10 better data, there could be the unintended  
11 consequence of the different definitions impacting  
12 the bed need.

13 MR. O'DONOVAN: Right. If the level IIs  
14 that were part of a progression of care were now to  
15 be excluded, then the occupancy rate is going to  
16 look lower than it actually is.

17 DR. MILEWSKI: Thank you.

18 MS. NAGEL: That's not how I wanted to  
19 announce that I have a comment. Okay. We'll try  
20 it again. So I just wanted to point out -- Dr.  
21 Delamater said this, and please correct me if I'm  
22 wrong. But I believe he said, and I believe it to  
23 be true, that the bed need methodology does not use  
24 the utilization data today. It's just vital  
25 records, babies born. That's it. So it -- that

1 won't be impacted. What could potentially be  
2 impacted is high occupancy. The high occupancy  
3 rate right now in the standard does use utilization  
4 data, so that is what the risk is. It's not  
5 overall utilization. It's just high occupancy.

6 Tulika?

7 MS. STANTON: Also, to add to Beth's  
8 point, NICU is one of the bed standards where there  
9 is no maintenance occupancy requirements for NICU  
10 beds, no 50, 40, 80 percent occupancy. So it  
11 doesn't matter what is your occupancy. The  
12 department is never going to look at it or say, oh,  
13 you are not at a certain level, so therefore you  
14 have to be licensed less. So that is also not a  
15 requirement in the standard. So the only place  
16 where occupancy will play a role right now is high  
17 occupancy, are you running at 80 percent, do you  
18 need more beds, and maybe the future methodology if  
19 you want to base it on utilization of the  
20 hospitals.

21 MR. EASTER: Just a direct question with  
22 respect to that, and maybe I misunderstood an  
23 earlier comment that you made. Would the  
24 department be willing to, during this period of  
25 trying to better understand real world what's

1 happening while we get new data, not use the new  
2 data to determine high occupancy exclusions; use  
3 the old way of doing it for high occupancy  
4 exclusions until we understand the new data? Like,  
5 so if the concern is that the new data is going to  
6 skew high occupancy numbers, just do it the old way  
7 until we actually have enough data. And we can  
8 seat the SAC, and they can analyze it and figure  
9 out what's the new way to do this. I think  
10 everyone is afraid of destabilizing the old system  
11 while we're trying to get new data.

12 MS. NAGEL: I'll tell you. I'll have  
13 Tulika answer the nuts and bolts of that, but we  
14 have the same concern. And we do not want to  
15 destabilize NICU services in any way. So I'll say  
16 I don't know the mechanics of it. Tulika does.  
17 But we would be willing to do whatever is necessary  
18 to make sure that that isn't a consequence of  
19 collecting better data.

20 MS. STANTON: So right -- excuse me. So  
21 right now, the way we understand the NICU  
22 standards, the licensed NICU beds are for NICU  
23 patients. Through this work group, we were told  
24 that the 21 hospitals that reported patient days of  
25 care, they also included SCN-level data. And let

1 me tell you, the hospitals did say they're able to  
2 separate NICU-level patient days of care and SCN  
3 patient days of care. So for full transparency,  
4 the department did receive two high-occupancy  
5 applications, and I won't name the hospitals unless  
6 they want to come forward. Those two hospitals  
7 submitted high-occupancy application, and when we  
8 asked the questions, they admitted 40 to 60 percent  
9 of their NICU patient days of care are actually not  
10 NICU patient days. So therefore, we said, you  
11 don't meet the high-occupancy requirements in the  
12 standards, and the applications were withdrawn. So  
13 that is the current practice.

14 MR. EASTER: I mean, I guess my concern  
15 is, though, if the request is to come up with  
16 better data, we need to not change it up until we  
17 understand that better data. So my specific ask  
18 is, if we're going to commit to going down a path  
19 of better data, I would ask that you commit to not  
20 acting on that until we have it, understand it, we  
21 can seat the SAC, we can do the analysis, and  
22 figure out what a future count looks like rather  
23 than saying, oh, you know, the new way of looking  
24 at the data says you don't qualify for a high-  
25 occupancy exclusion. Like, that's what I think

1 we're trying to avoid.

2 MS. NAGEL: I would -- I -- we want to  
3 avoid that. However, what you're asking us to do  
4 would be to disregard our interpretation of the  
5 standard. And I think we would need -- I'd turn to  
6 our legal expert, Carl. I think that we would need  
7 a motion from the commission to say, for the  
8 purpose of high-occupancy calculations between now  
9 and when a new methodology comes into play, the  
10 commission directs the department to include SCN  
11 days in that calculation.

12 Carl?

13 MR. HAMMAKER: Yeah. If that's the path  
14 we want to go down to fundamentally continue  
15 treating the data as it has been treated,  
16 unbeknownst to the department, for the last number  
17 of years, I think that is the type of motion we  
18 would do so that we would continue to handle the  
19 data the way that it's been handled for high-  
20 occupancy bed applications for the past several  
21 years going forward until a new data methodology is  
22 established through the SAC. And then at that  
23 point, we could change over.

24 MS. NAGEL: Thank you.

25 MR. EGAN: Just -- I'm sorry I'm going

1 back to this. This is Joe Egan. You know, the  
2 comment about, "Everyone is doing it, but we can't  
3 prove or document which hospital has reported  
4 what," concerns me. I feel like we're making  
5 unknown decisions on the unknown, right? Sorry.  
6 I'm new to the commission so I'm vocal on my first  
7 day, so I apologize. But I just -- I'm very data  
8 -driven, so to make decisions on this with no data  
9 seems a little shortsighted to me.

10 DR. MILEWSKI: I appreciate the comments.  
11 Any other questions for our current presenter?

12 DR. ENGELHARDT-KALBFLEISCH: I guess I  
13 have one more question, more for the department. I  
14 appreciate, like, the rationale for excluding the  
15 SCN babies that are substance-exposed or maybe 35-  
16 weekers that we're monitoring the temperature.

17 What I'm still trying to, like, wrap my  
18 head around is the ones that start as level III and  
19 IV and, like we've heard from our experts, that  
20 require that NICU level of care still but, like,  
21 then if you're excluding them from the count but  
22 that's the service they clinically require what the  
23 advantage is to counting or pooling them  
24 separately, especially if the intent -- like, we  
25 heard it's bad for them to be transferred in and

1 out of the NICU or to other facilities, so how does  
2 that help us to, like, count them separately if the  
3 intent isn't to necessarily care for them in a  
4 different way? Like, how is that information  
5 helping us?

6 MS. SHANAFELT: So that would give us  
7 accurate data to make decisions based on. So for  
8 example, babies that are admitted to a NICU as NICU  
9 level III or IV and then -- versus babies who are  
10 admitted to a NICU that improve, hopefully, and  
11 step down in care to a level -- to special care  
12 nursery, which happens in adult units all the time,  
13 right? Someone is in intensive care unit, and then  
14 they go to cardiac step-down.

15 But in the case of a NICU, they're not  
16 moving anywhere, so I -- it would give us data --  
17 better data to understand how many babies are being  
18 admitted at NICU level and how many babies are  
19 stepping down, how many babies are being admitted  
20 at special care nursery level and maybe stepping  
21 up. It -- so it would give us better information  
22 about the status of -- the number of care days in  
23 each level of care in the state. So that's one  
24 thing.

25 And then a clarification point for the

1 landscape of Michigan. Almost zero -- I'll say it.  
2 I've visited almost every single birthing unit in  
3 the state. They don't have well newborn nurseries  
4 anymore. Babies are cared for at the bedside by  
5 their -- with their parents. Babies that need  
6 special care nursery care are transferred to a  
7 facility that has special care nursery services,  
8 whether that's a separate unit or whether that's a  
9 hospital that runs a NICU that can care for special  
10 care nursery babies and NICU babies. They are in  
11 the same unit, so they are not going to be moved  
12 unless the parent and the clinician decides that  
13 they want to be moved closer to home or there's  
14 some other type of reason why -- that they decide  
15 that.

16 But we're not trying to, again, impact  
17 care and continuity of care, so why would we want  
18 that data? To be able to see the variation between  
19 levels I, II, III, IV. And if -- in the case of  
20 collection of data, it's levels II, special care  
21 nursery; III and IV, NICU. That would be why.

22 MS. NAGEL: And if I could just add to  
23 that, the charge to the work group was to change --  
24 look at how we could change the methodology based  
25 on the AAP guidelines, and so we can't do that if

1 we don't know where the babies are. So if that is  
2 not the desire of the commission, to look at this  
3 or to change this, then I guess it's a moot point.  
4 But if that's what the commission wants us to do,  
5 which was directed at a special meeting in January  
6 of this past year, to be able to do that, we're  
7 telling you what we need to be able to do that.

8 DR. ENGELHARDT-KALBFLEISCH: I appreciate  
9 that. I'm just trying to better understand. Like,  
10 adults, they're not still receiving that ICU-level  
11 of care when they step down, but we're hearing  
12 today that the infants are. So I'm just trying to  
13 decipher, like, how we're utilizing the data and  
14 how that data drives decisions that impact our  
15 babies. Thank you.

16 DR. MILEWSKI: Any other questions from  
17 the commissioners? And if not, I'm going to try to  
18 present options.

19 MR. O'DONOVAN: We have no more public  
20 comment either.

21 DR. MILEWSKI: Thank you.

22 Okay. This is a complex one. This is  
23 going to test my brain here a little bit. We have  
24 four charges before us. Three of them are pretty  
25 straightforward. One needs a modification based

1 upon discussion, which sounds like it was agreeable  
2 to the work group lead. So I think we're going to  
3 pull those three out separately. Two, I think, can  
4 go straight, and then one needs a modification just  
5 based upon the issue that Commissioner Ferguson  
6 brought up related to the leads, the program  
7 director issue.

8 So I think we're going to -- that's how  
9 we're going to handle those. And then Charge 3 is  
10 obviously the one that is separate and distinct.  
11 So if it's okay with the commission, maybe we  
12 handle 1, 2, and 4 first, and then I'll present  
13 options for Charge 3, which I have written down  
14 just to make it less complicated for our brains.

15 DR. FERGUSON: Question on the technical  
16 edits of 4. Justin, when you were presenting, you  
17 showed a variety of technical edits. I want to  
18 make sure that if we approve 4 that doesn't mean  
19 that we're necessarily approving this whole tieback  
20 into Charge 3.

21 DR. MILEWSKI: Into Charge 3?

22 DR. FERGUSON: Right. Like, so it's just  
23 all the other edits that you have but not that  
24 specific line that you have, right?

25 MR. EASTER: Correct.

1 DR. FERGUSON: Okay. Just making sure we  
2 don't inadvertently --

3 MS. STANTON: Yeah. And to me, the  
4 department -- the 30-day language was the only  
5 other technical edit that we added, so that  
6 wouldn't be -- that was included in there.

7 DR. MILEWSKI: So charge -- I believe it  
8 was Charge 1 and 4 that did not need any changes,  
9 at least not that were discussed by the  
10 commissioners. So I will entertain a motion.

11 MS. GUIDO-ALLEN: Guido-Allen. Motion 1  
12 is to approve charges 1 and 4, move to public  
13 hearing and to the JLC and to the governor for the  
14 45-day review period.

15 DR. MILEWSKI: So any support for that  
16 motion?

17 DR. FERGUSON: Second. Ferguson.

18 DR. MILEWSKI: Thank you.

19 Any discussion or questions? Okay. And  
20 we'll go around for a vote.

21 Commissioner Ferguson?

22 DR. FERGUSON: Yes.

23 DR. MILEWSKI: Commissioner DeLano?

24 DR. DELANO: Yes.

25 DR. MILEWSKI: Commissioner Gibson?

1 MR. GIBSON: Support.

2 DR. MILEWSKI: Commissioner Egan?

3 MR. EGAN: Yes.

4 DR. MILEWSKI: Commissioner Salwin?

5 MR. SALWIN: Yes.

6 DR. MILEWSKI: Sorry. Commissioner

7 Cheeseman?

8 MS. CHEESEMAN: Yes.

9 DR. MILEWSKI: Commissioner -- sorry.  
10 Commissioner Grant?

11 MS. GRANT: I'm going to abstain due to  
12 tardiness.

13 DR. MILEWSKI: Yep. Commissioner  
14 Kalbfleisch?

15 DR. ENGELHARDT-KALBFLEISCH: Support.

16 DR. MILEWSKI: And Commissioner Guido-  
17 Allen?

18 MS. GUIDO-ALLEN: Support.

19 DR. MILEWSKI: And Commissioner Milewski,  
20 support.

21 Sorry. I apologize. I am terrible at  
22 names, so thank you for your help.

23 MS. GRANT: It's all good.

24 (Whereupon motion carried at 11:13 a.m.)

25 DR. MILEWSKI: Okay. So that passes.

1 Next up, we will entertain a motion on Charge 2.

2 MS. GUIDO-ALLEN: So Guido-Allen. Motion  
3 to approve Charge 2 with the following edit: The  
4 board-certified pediatrician for the special care  
5 nursery program director, the definition would add,  
6 after the word experience, in level II care,  
7 including endotracheal intubation, assisted  
8 ventilation, and CPAP management.

9 Does this have to go to public hearing  
10 or --

11 MS. NAGEL: Yeah. But this is just  
12 proposed, so it would go to public hearing anyway.

13 MS. GUIDO-ALLEN: Proposed. Okay.

14 DR. MILEWSKI: I just want to provide a  
15 clarification. Commissioner Milewski. Would we --  
16 are you recommending that we would remove the  
17 experience as an SCN program director and replace  
18 that with the definition in the level II care?

19 MS. REITZ: No. No. Do you want me to  
20 explain? Yes.

21 DR. MILEWSKI: Sure.

22 MS. REITZ: It's really more of a missing  
23 comma.

24 MS. NAGEL: She needs a microphone. I'm  
25 sorry.

1 MS. REITZ: Thank you.

2 I just want to say it's more of, like, a  
3 missing comma than anything else. That SCN program  
4 director language is referring to what is required  
5 to be an SCN director -- program director. So to  
6 keep that language in, you might -- I'm feeling a  
7 little bit under, like, the -- it might -- and I  
8 would love to hear what the AG's office has to say,  
9 but it might just need a comma because the actual  
10 experience required is included in the definition  
11 of board-certified pediatrician.

12 And so in that section -- I think it's  
13 Section 9 language, it's not -- it's intended to  
14 read -- I'm going to read it like we intended it to  
15 sound. "A board-certified or board-eligible  
16 neonatologist or a board-certified pediatrician  
17 with experience," pause, "must be serving as the  
18 SCN program director." I think a comma might take  
19 care of it.

20 DR. MILEWSKI: Yeah. Between experience  
21 and serving?

22 MS. REITZ: Yes. Yeah. Exactly.

23 DR. MILEWSKI: The way it reads, it looks  
24 like you have to have experience as a program  
25 director in order to set in the rule, which ends

1 up --

2 MS. REITZ: Totally.

3 MS. NAGEL: And, Melissa, you said --

4 DR. MILEWSKI: Oh, I'm sorry.

5 MS. GUIDO-ALLEN: Why can't we just word  
6 it the same as we did for the NICU, shall serve as  
7 the director?

8 MS. NAGEL: That's what I think is  
9 missing, is must or shall.

10 MS. REITZ: Yes. I like that.

11 MS. NAGEL: Yeah. So experience, comma,  
12 must be -- or shall be serving.

13 MS. REITZ: Shall serve as.

14 MS. GUIDO-ALLEN: Shall serve as.

15 DR. FERGUSON: Yes. Shall serve as.

16 MS. GUIDO-ALLEN: Sorry.

17 MS. STANTON: Thank you. That was  
18 Melissa Reitz for the record.

19 DR. MILEWSKI: So would you like to amend  
20 the --

21 MS. GUIDO-ALLEN: I do. So the motion is  
22 to approve Charge 2 with the following edit: The  
23 definition for the special care nursery program  
24 director, a board-certified or board-eligible  
25 neonatologist or board-certified pediatrician with

1 experience shall serve as the director of the  
2 special care nurseries.

3 DR. MILEWSKI: Thank you. A Herculean  
4 effort there.

5 Is there support for that motion?

6 DR. FERGUSON: Second.

7 DR. ENGELHARDT-KALBFLEISCH: Engelhardt-  
8 Kalbfleisch. Support.

9 DR. MILEWSKI: Thank you. Any discussion  
10 or questions? Otherwise, I'll entertain a vote.

11 Commissioner Ferguson?

12 DR. FERGUSON: Yes.

13 DR. MILEWSKI: Commissioner DeLano?

14 DR. DELANO: Yes. Support.

15 DR. MILEWSKI: Commissioner Gibson?

16 MR. GIBSON: Support.

17 DR. MILEWSKI: Commissioner Egan?

18 MR. EGAN: Support.

19 DR. MILEWSKI: Commissioner Salwin?

20 MR. SALWIN: Support.

21 DR. MILEWSKI: Commissioner Cheeseman?

22 MS. CHEESEMAN: Support.

23 DR. MILEWSKI: Commissioner Grant?

24 MS. GRANT: Support.

25 DR. MILEWSKI: Commissioner Engelhardt?

1 DR. ENGELHARDT-KALBFLEISCH: Support.

2 DR. MILEWSKI: Commissioner Guido-Allen?

3 MS. GUIDO-ALLEN: Support.

4 DR. MILEWSKI: Commissioner Milewski is  
5 support.

6 (Whereupon motion carried at 11:17 a.m.)

7 DR. MILEWSKI: Great. So we made it  
8 through three-quarters of it. Okay. Next up, we  
9 have Charge 3. And I stuck it in my notes here.  
10 Okay. From the discussion that I've heard, I  
11 believe we have two options.

12 Option 1 would be to vote on Charge 3 for  
13 either inclusion in the standard or not to include,  
14 which the language around that is to expand the  
15 definition to include those babies that were  
16 previously NICU-designated IIIs and IVs that now  
17 are SCN into the overall NICU methodology, okay?  
18 So vote on Charge 3. Work -- and there's a couple  
19 of parts to this. Work on the reporting  
20 methodology and then seat the SAC to address the  
21 bigger need around the methodology of initiation  
22 because it's not currently tied into.

23 So we would charge the chair of the work  
24 group to work on the reporting methodology with the  
25 department as well as chair of the commission and

1 vice-chair of the commission, okay, and define  
2 those buckets that we talked about. So there's  
3 three parts to this: voting on Charge 3, inclusion  
4 or dis-inclusion; voting to work on the reporting  
5 methodology and defining those buckets with the  
6 work group lead in the department; and then the  
7 last piece would be to seat the SAC to address the  
8 overall methodology more broadly.

9           Option 2 would be to pull Charge 3 out,  
10 basically table it and say we're not going to vote  
11 on this but instead to direct the department to  
12 manage high-occupancy need, which was an option  
13 that was outlined by Beth Nagel, so that we don't  
14 have any unintended consequences of the new  
15 collection of data; work on the better data pieces,  
16 again, defining those components of how we want to  
17 collect data; and then seat a SAC to address the  
18 methodology. So basically holding on the decision  
19 around the expansion, deferring that to the  
20 decision of the SAC but then directing the  
21 department, you're not -- you know, how to address  
22 the high-occupancy need in the meantime so that we  
23 don't have the unintended consequences.

24           So those are the two splits that I see.  
25 There's components that are similar in terms of

1 working on the methodology of reporting as well as  
2 seating a SAC. It's really around how we want to  
3 handle Charge 3.

4 DR. FERGUSON: Just a question about the  
5 practical limitation of your first option -- the  
6 first option, which is adopt and then, I think,  
7 work with the chair to figure out how to do the  
8 data in a more useful way. My concern, and maybe  
9 I'm not quite understanding it, is, doesn't the  
10 language say how we do the data? Like, doesn't the  
11 language say that we have to split or count  
12 whatever? So if we're trying to come up with a  
13 better way to count data, we've just prescribed how  
14 it's going to be counted, so I'm not sure what --

15 DR. MILEWSKI: Sorry.

16 DR. FERGUSON: -- we'd be working.

17 DR. MILEWSKI: It would have just been  
18 the work group's recommendation, which did not talk  
19 about how to collect the data. That was the  
20 department's recommendation. It would not be to --

21 DR. FERGUSON: So it wouldn't include  
22 this other edited language?

23 DR. MILEWSKI: That's right. It would  
24 not include that.

25 DR. FERGUSON: Okay. That's all I'm

1 trying -- I'm just trying to make sure that I  
2 understand what --

3 DR. MILEWSKI: It should not include  
4 that. It would only include what the work group  
5 will find on and recommend if it was to have that  
6 inclusion. Great clarification. Thank you.

7 MS. GRANT: And I do have another  
8 question. So when I looked at the packet, the  
9 binder, the work group basically said they had  
10 their recommendation. So for the second one of  
11 pulling the chart out, that means we're -- we would  
12 say yes to all of the recommendations of the work  
13 group except for those three; is that correct; is  
14 that right?

15 DR. MILEWSKI: Yes. We just voted on --  
16 those are the ones we just voted on. So those are  
17 all going to move forward for -- and this isn't a  
18 final action, none of this. So this is proposed  
19 action.

20 MS. GRANT: Okay.

21 DR. MILEWSKI: So we're just on Charge 3,  
22 which is that methodology change.

23 MS. GRANT: Got it now. Okay.

24 DR. MILEWSKI: Yeah. And the option is  
25 we either vote it in, or we advise the department

1 to hold off on changing high occupancy.

2 MS. GRANT: Got it.

3 DR. MILEWSKI: And I'm going to ask Beth  
4 for that language if we move that direction.

5 DR. FERGUSON: Is there a way to -- maybe  
6 what I'm hearing -- I'm just trying to understand.  
7 I'm interested in getting better data as quick as  
8 we can, but at the same time, I'm also interested  
9 in not actually changing other things. With the  
10 first proposal, it sounds like we would start to  
11 get data potentially this spring because you'd be  
12 working quickly to -- because you've been  
13 authorized to collect data and you would be moving  
14 quickly. My concern is with the second, would we  
15 not be able to start getting data until after the  
16 SAC is completed all the way? Or can we -- in  
17 either case, I'd love to get data soon.

18 DR. MILEWSKI: Sorry. I don't think  
19 either one that I laid out changes that. Both  
20 would immediately charge the work group lead to  
21 work with the department on getting better data.

22 DR. FERGUSON: Okay.

23 DR. MILEWSKI: Both would immediately  
24 charge the department on seating a SAC to work on  
25 the methodology. The only difference here is

1 whether we want to change the methodology to  
2 include those higher-needs special care nursery, if  
3 you want to call them II-A's or II-Bs, whatever you  
4 want to call them, that we don't currently have a  
5 good definition for our handle on, what we heard  
6 about clinically today, or if we want to pause on  
7 adding that and just address the unintended  
8 consequence of collecting more data around this by  
9 saying the department will continue to implement  
10 high occupancy the way that they do today.

11 So it was basically saying we're going to  
12 keep everything the same. We're just going to  
13 increase reporting but not allow that reporting to  
14 be utilized to change anything on high occupancy  
15 until the SAC has been seated. That's what Option  
16 2 is.

17 MS. NAGEL: May I just clarify? Your  
18 first -- the Option A would be to adopt the yellow  
19 language?

20 DR. MILEWSKI: That's correct.

21 MS. NAGEL: And your Option 2 would be to  
22 adopt -- not adopt the yellow language?

23 DR. MILEWSKI: Not adopt the yellow  
24 language.

25 MS. NAGEL: Thank you.

1 DR. MILEWSKI: But charge the department  
2 on the high occupancy piece that was suggested  
3 earlier to not get an unintended consequence. Any  
4 further discussion or leanings, and then we can --

5 DR. FERGUSON: Can I ask the department  
6 point-blank? So in many ways, these are actually  
7 quite similar because in both ways, we're trying to  
8 get data. I can take a guess, but does the  
9 department have a formal opinion on A versus B?

10 MS. NAGEL: We do. We -- if we were a  
11 voting member, we would vote for the second option.

12 DR. FERGUSON: Okay.

13 MR. EGAN: Yeah. And just to add, they  
14 are very different. One is changing today versus  
15 looking at the data to potentially change in the  
16 future.

17 DR. MILEWSKI: Would the council recall  
18 anybody who has testified previously if there are  
19 any other questions? Otherwise, we're going to  
20 need to move forward on a motion.

21 DR. FERGUSON: I would love to hear  
22 Commissioner Guido-Allen's opinion if you're  
23 willing to share it.

24 MS. GUIDO-ALLEN: I -- I'm trying to  
25 think of a motion in my -- hang on.

1 DR. MILEWSKI: Give us a minute. We'll  
2 get there.

3 MS. GUIDO-ALLEN: All right. Here's my  
4 motion. We are going -- my motion is to postpone  
5 any changes to Charge 3; direct the department to  
6 manage high occupancy as status quo, so no changes;  
7 direct the department to work on methodology or  
8 better data for -- and then seat a SAC to use that  
9 data to come back to us with an improved definition  
10 methodology.

11 DR. MILEWSKI: The only amendments I  
12 would maybe propose to that would be to charge the  
13 department to work with the work group --

14 MS. GUIDO-ALLEN: With the work group.

15 DR. MILEWSKI: -- to define the way that  
16 we're going to collect data for recording in the  
17 future.

18 MS. GUIDO-ALLEN: Agreed.

19 DR. FERGUSON: I'll second that.  
20 Ferguson. Second.

21 DR. MILEWSKI: Thank you.

22 Any further discussion or questions?

23 MS. NAGEL: I am so sorry to belabor  
24 this. I just want to make sure with Carl if we  
25 need something more specific than -- about how to

1 calculate high occupancy because how we are --  
2 because the way it's -- the way it was said, how  
3 we're doing it now, how we did it now is we asked  
4 applicants to not submit their SCN data, to just  
5 submit the level III and IV data, and then those  
6 applications were withdrawn. And so if we want to  
7 do it in a way that holds harmless, the commission  
8 would need to direct us to include SCN data that  
9 was delivered in a NICU.

10 MR. HAMMAKER: That works for me, or  
11 yeah. I was anticipating using the previously  
12 submitted data that included the SCN data, but I  
13 like the specificity of this here -- how you're  
14 stating it.

15 MS. GUIDO-ALLEN: So amended to say the  
16 high occupancy would include all of patient days  
17 reported as NICU. Perhaps that.

18 MS. NAGEL: I think that that works, too.  
19 Yes.

20 MS. GUIDO-ALLEN: Thank you.

21 MR. EGAN: I'm sorry. Do we have clarity  
22 on what was actually submitted?

23 DR. MILEWSKI: What we heard in testimony  
24 was that the majority of facilities were submitting  
25 both their SCN and their NICU days. We don't have

1 it by facility, and we're not going to. So --

2 MR. EGAN: Okay.

3 MS. GUIDO-ALLEN: That will be part of  
4 the methodology, though, that we will come up with,  
5 is that we will be able to know by NICU the days,  
6 special care, which patients -- which babies went  
7 from level III or IV down to level II and then  
8 which were there as truly special care nursery from  
9 the get-go.

10 MR. EGAN: Okay. So for clarification,  
11 we'll form the SAC as you mentioned, but for a  
12 previous submission, it's including III, IVs, and  
13 IIs or whatever was submitted.

14 DR. MILEWSKI: Yeah. It's basically  
15 holding static what we believe is happening today  
16 so that we can collect better data and seat a SAC  
17 to come up with the recommendation for the future.

18 MR. EGAN: Okay.

19 DR. MILEWSKI: Any other questions or  
20 discussion? That's a great clarification. Okay.  
21 If not, then I will forward a vote.

22 Commissioner Ferguson?

23 DR. FERGUSON: Support.

24 DR. MILEWSKI: Commissioner DeLano?

25 DR. DELANO: Support.

1 DR. MILEWSKI: Commissioner Gibson?

2 MR. GIBSON: Support.

3 DR. MILEWSKI: Commissioner Egan?

4 MR. EGAN: Support.

5 DR. MILEWSKI: Commissioner Salwin?

6 MR. SALWIN: Support.

7 DR. MILEWSKI: Commissioner Cheeseman?

8 MS. CHEESEMAN: Support.

9 DR. MILEWSKI: Commissioner Grant?

10 MS. GRANT: Support.

11 DR. MILEWSKI: Commissioner Engelhardt-  
12 Kalbfleisch?

13 DR. ENGELHARDT-KALBFLEISCH: Support.

14 DR. MILEWSKI: Commissioner Guido-Allen?

15 MS. GUIDO-ALLEN: Support.

16 DR. MILEWSKI: And Commissioner Milewski  
17 is support.

18 (Whereupon motion carried at 11:29 a.m.)

19 MS. NAGEL: Can I clarify for the record  
20 that the -- that the motion included the amended  
21 language of days provided in the NICU?

22 MS. GUIDO-ALLEN: It does.

23 MS. NAGEL: Thank you.

24 DR. MILEWSKI: Thank you, all. I know  
25 that was a complex issue to get through. And for

1 our first-time commissioner, we do sometimes have  
2 complicated issues. A lot of them are less  
3 complicated, so -- which is our next one.

4 How is everybody feeling? Do we need a  
5 quick break? And I'm seeing no nods that people  
6 need a break, so we'll -- I think our next issue is  
7 pretty quick.

8 DR. SOLTYS: Sorry. I don't know how any  
9 of this works. I'm new here. So what just got  
10 approved? Option 1 or Option 2?

11 DR. MILEWSKI: Option 2.

12 DR. SOLTYS: That's what I thought.  
13 Okay. Thank you.

14 DR. MILEWSKI: You're welcome.

15 Okay. I'm going to keep us moving on our  
16 agenda. So we next up have our -- basically our  
17 county designation recommendations, and just  
18 historically, there were changes in the way the  
19 counties were designated. This was not being  
20 handled consistently across the standards, so the  
21 commission directed the department to take a look  
22 at all of the standards so that we could apply  
23 rural designations consistently across the  
24 standards.

25 So I will turn it over to Katherine, who

1 will try and provide a better description of that  
2 than I have to summarize.

3 MS. TUCKER: Okay. At the September  
4 commission meeting, the commission took proposed  
5 action on the draft language -- languages for NICU,  
6 Psychiatric Beds and Services, Litho, MRI, Cardiac  
7 Catheterization Services, CT Services, MRT  
8 Services, PET Services, Hospital Beds, Open-Heart  
9 Surgery Services, Nursing Home and Hospital Long-  
10 Term Care Units, Surgical Services, and -- I'm  
11 sorry, and Surgical Services that are in front of  
12 you today. The draft languages were sent out for a  
13 public hearing and to the joint legislative  
14 committee.

15 No testimony was received from any  
16 organizations. The department is supporting all  
17 language as presented. There were additional  
18 technical edits added to Section 14.3 of the  
19 Hospital Beds Review Standards and Section 12.3 of  
20 the Psychiatric Bed Review Standards presented  
21 today for final action. The technical edits are to  
22 update information to ensure any state or federal  
23 code deficiencies are accurately reported within  
24 LARA.

25 If the commission chooses to take final

1 action on the language as presented, then the  
2 language will be forwarded to the JLC and to the  
3 governor for the 45-day review period. The 45-day  
4 review period must include not less than nine  
5 legislative session days. If the language is not  
6 disapproved, it becomes effective upon the  
7 expiration of the 45-day period. Are there any  
8 questions?

9 DR. MILEWSKI: Any questions for the  
10 department? Okay. The changes are included in  
11 your packet.

12 Do we have any public comment?

13 MS. STANTON: No.

14 MS. TUCKER: No public comment.

15 DR. MILEWSKI: Okay. And while these  
16 standards were handed in groups, there were three  
17 different groups because of how we bucketed the  
18 standards from similarities and language, I have  
19 been advised that we are able to take action on the  
20 group as a whole. We just have to include that in  
21 our motion. So any commission discussion? Okay.  
22 Hearing none, this is our final action item. So I  
23 will entertain a motion or final action.

24 MS. GUIDO-ALLEN: Guido-Allen. I move  
25 for final action the department recommendations --

1 the department recommendations for NICU, psych beds  
2 and services, lithotripsy, MRI, cardiac  
3 catheterization services, CT services, MRT  
4 services, PET services, hospital beds, open-heart  
5 surgery services, nursing home and long-term care  
6 units, and surgical services forward to the joint  
7 legislative committee and the governor for the 45-  
8 day review period.

9 DR. MILEWSKI: Thank you. We have a  
10 motion before us. I will need a second.

11 MR. GIBSON: Second.

12 DR. MILEWSKI: Thank you.

13 Any commission discussion or questions  
14 before we vote? Okay.

15 Commissioner Ferguson?

16 DR. FERGUSON: Support.

17 DR. MILEWSKI: Commissioner DeLano?

18 DR. DELANO: Support.

19 DR. MILEWSKI: Commissioner Gibson?

20 MR. GIBSON: Support.

21 DR. MILEWSKI: Commissioner Egan?

22 MR. EGAN: Support.

23 DR. MILEWSKI: Commissioner Salwin?

24 MR. SALWIN: Support.

25 DR. MILEWSKI: Commissioner Cheeseman?

1 MS. CHEESEMAN: Support.

2 DR. MILEWSKI: Commissioner Grant?

3 MS. GRANT: Support.

4 DR. MILEWSKI: Commissioner Engelhardt?

5 DR. ENGELHARDT-KALBFLEISCH: Support.

6 DR. MILEWSKI: Commissioner Guido-Allen?

7 MS. GUIDO-ALLEN: Support.

8 DR. MILEWSKI: And Commissioner Milewski  
9 is support. So those pass. Thank you very much.

10 (Whereupon motion carried at 11:34 a.m.)

11 DR. MILEWSKI: And next up, we have our  
12 legislative update, which I'm going to turn it over  
13 to Justin.

14 MR. EASTER: Senate Bill 148 -- sorry.  
15 Senate Bill 148 was introduced on March 13th. The  
16 intent of the bill is to allow an exemption for CT,  
17 PET, and MRI services from being required to obtain  
18 a certificate of need. This bill is still in the  
19 Health Policy Committee in the Senate.

20 DR. MILEWSKI: Thank you.

21 Any questions? Okay. And next up we  
22 have administrative updates, and I'll turn it to  
23 Marcus and followed by Tulika.

24 MR. CONNOLLY: Marcus from the  
25 department. Recently, we just ended the CT SAC.

1 Currently, we are having our last nursing home  
2 meeting December 18th. We start next week with the  
3 heart/lung/liver SAC that we discussed in  
4 September, and my team is currently working on the  
5 January special commission meeting for all the new  
6 work plans and SACs and work groups we'll have in  
7 2026. And that will be it.

8 DR. MILEWSKI: Thank you. And Tulika?

9 MS. BHATTACHARYA: Thank you. So there  
10 are two reports in your packet. The first one is  
11 on the program activity. You can see the numbers  
12 of letters of intent, applications received,  
13 decisions issued in that report. And I'm proud to  
14 say that we continued to meet the deadlines and  
15 process things on time. We did receive three  
16 emergency applications this quarter. Two of them  
17 were withdrawn by the applicant. They did not need  
18 the emergency approval anymore. One was approved.

19 The second report is on the committee's  
20 activities for the department. So we continue to  
21 follow up on the approved CON projects, whether  
22 they are complete, if they need extensions, things  
23 like that, and if a CON is not meeting its  
24 requirements or the service has discontinued, we  
25 expire their CON. So the reports or the numbers

1 are in front of you. There was one specific  
2 service -- specific compliance action for an MRI,  
3 and the details are in your packet. If there are  
4 any questions, I'm happy to answer them.

5 DR. MILEWSKI: Thank you, Tulika.

6 Okay. Our next update is from Carl  
7 Hammaker on our legal activity report.

8 MR. HAMMAKER: AG Carl Hammaker. The  
9 written activity report was in your packet. There  
10 is no current litigation either in state or  
11 admitted in the administrative tribunal regarding  
12 either the department or the CON Commission.

13 DR. MILEWSKI: Thank you very much.

14 The next topic is any open public  
15 comments.

16 MS. TUCKER: None at this time.

17 DR. MILEWSKI: Okay. Thank you. We're  
18 going to go through the commission work plan.

19 MS. STANTON: Yes. This is Tiffani with  
20 the department. Our work plan for 2026 so far  
21 basically includes the heart/lung/liver SAC that  
22 was determined last meeting. We do have the CT  
23 report and the nursing home report anticipated at  
24 the March meeting for proposed action on both. And  
25 then we'll have final action for the NICU services

1 come that March meeting as well. Our January  
2 meeting will have a discussion report on all six of  
3 the standards that are open for review due to the  
4 county designation, keep in mind all six -- the  
5 county has a designation recommendation that was  
6 approved by the commission. All six of these  
7 standards that have the discussion report will be  
8 fulfilled in January with a SAC or work group to be  
9 able to review them further. So at the end of  
10 January, this will look a lot different. But at  
11 this time, those are the additions that we have.  
12 And we can get an approval, please.

13 DR. MILEWSKI: Will the work plan be  
14 updated with the SAC that was just decided today  
15 for NICU services?

16 MS. STANTON: Is that --

17 MS. NAGEL: Yes. However, we will need  
18 to talk through with Dr. Delamater how much data he  
19 would need before a SAC works on it. Is it one  
20 year or two, you know? So I don't know that it  
21 will show up on this work plan.

22 DR. MILEWSKI: Okay. Thank you.

23 We need a motion for approval of the work  
24 plan.

25 MS. CHEESEMAN: Commissioner Cheeseman.

1 A motion for approval of the work plan as outlined.

2 DR. MILEWSKI: Do I have a second?

3 MR. SALWIN: Salwin supports.

4 DR. MILEWSKI: Thank you.

5 Any discussion? Okay. Then I will take  
6 a vote. All in favor?

7 COMMISSIONERS: Aye.

8 DR. MILEWSKI: Any against? Okay. The  
9 work plan passes as it is stated.

10 (Whereupon motion carried at 11:39 a.m.)

11 DR. MILEWSKI: And future meeting dates,  
12 they are listed on your agenda. January 22nd is  
13 our next meeting. That's our special commission  
14 meeting where we talk about the work we have for  
15 the coming year. We have March 12th, June 11th,  
16 September 17th, and December 3rd. So I appreciate  
17 everybody's attendance. Do I need a vote on the  
18 meeting dates, or are we okay?

19 MS. STANTON: We voted on those at the  
20 last meeting.

21 DR. MILEWSKI: Okay. Thank you. So then  
22 we'll just take a motion to adjourn.

23 DR. ENGELHARDT-KALBFLEISCH: I'll say it.  
24 Motion to adjourn.

25 DR. MILEWSKI: Thank you. Second?

1 MR. EGAN: A question for you.

2 DR. MILEWSKI: Okay.

3 MR. EGAN: Just on the charts, we just --  
4 because this was happening a little fast and this  
5 is my first meeting. So my understanding is that  
6 the Charge 3 does not include the department's  
7 language on, "However, these patient days of care  
8 shall not be reported," correct?

9 DR. MILEWSKI: Correct. Or the sentence  
10 before that.

11 MR. CONNOLLY: Yeah.

12 MS. NAGEL: Yeah. It didn't include --

13 MR. CONNOLLY: No change.

14 DR. MILEWSKI: It didn't include the work  
15 group's recommendation or the department's  
16 recommendation on that charge. We basically tabled  
17 those and asked basically to build better reporting  
18 to direct the department to work with the work  
19 group chair about what that reporting should look  
20 like and then seat a SAC, which it sounds like  
21 that's going to be somewhat dependent on that data,  
22 and then also to hold steady how we are  
23 interpreting high-occupancy needs. So basically,  
24 keep everything steady in terms of the way we're  
25 holding beds for NICUs today.

1 MR. EGAN: Thank you. Okay. Okay.

2 Thank you.

3 DR. MILEWSKI: Yeah. It was a confusing  
4 one for all of us. Thank you.

5 So do I have a second to adjourn?

6 MS. GRANT: Second.

7 DR. ENGELHARDT-KALBFLEISCH: Second.

8 DR. MILEWSKI: All in favor?

9 COMMISSIONERS: Aye.

10 (Whereupon motion carried at 11:41 a.m.)

11 DR. MILEWSKI: Have a wonderful holiday,  
12 everybody. Thank you.

13 (Meeting concluded at 11:41 a.m.)

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CERTIFICATE

I, RACHELLE ROBERTS, a Certified Electronic Recorder and Notary Public within and for the State of Michigan do hereby certify:

That this transcript consisting of 110 pages, is a complete, true, and correct record of the Certificate of Need Commission Meeting on December 4, 2025.

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 15th day of December 2025.

*Rachelle Roberts*

Rachelle Roberts, CER 9585  
Notary Public, State of Michigan  
County of Montcalm  
My commission expires: April 29, 2027