HENRY FORD HEALTH

November 4, 2022

Dr. Amy McKenzie
CON Commission Chairperson
South Grand Building, 4th Floor
333 S. Grand Avenue
Lansing MI 48933

Dear Commissioner McKenzie,

Henry Ford Health (HFH) would like to offer comments on Certificate of Need review standards for Neonatal Intensive Care Services/Beds (NICU) and Special Newborn Nursing Services:

HFH supports the technical edits made in the standards, clarifying section 9(1)(b) to ensure continuously available and onsite means 24 hours per day/7 days per week, as well as the other technical edits. HFH supports the CON Commission's final vote to move forward at the December meeting.

Respectfully,

Dr. Daniel Rito
Division Head, Neonatology Services
Henry Ford Health
2799 W. Grand Blvd.
Detroit, MI 48202

November 9, 2022

Dr. Amy McKenzie, MD
Chairperson, Certificate of Need Commission
Michigan Department of Health and Human Services
South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

Re: Certificate of Need Review Standards for Psychiatric Beds and Services

Chairperson McKenzie,

Thank you for this opportunity to provide public comments regarding the CON Review Standards for Psychiatric Beds and Services. As participants in the Psychiatric Beds Informal Workgroup that met from October 2021 through April 2022, we are joining together in this letter to request that the CON Commission not yet take final action on the changes to these standards and instead make some additional modifications before finalizing them.

As noted in the workgroup report, a majority of the organizations represented at the workgroup meetings supported a revision to Section 11(3)(d), the comparative review criterion which measures Medicaid participation. Because the support for this change was not unanimous, the Department, did not include the change in the draft presented to the Commission. During your last meeting, Commissioner Ferguson suggested the idea of a compromise solution that would award half of the 10 points based on the current methodology (based on the Medicaid participation at the applicant facility and any commonly owned facilities located **anywhere in the State**) and the other half of the points awarded based on the proposed methodology (based on the Medicaid participation at the applicant facility and any commonly owned facilities located **within the health service area where the beds are being proposed**). We very much appreciate Commissioner Ferguson's suggestion and have created the attached proposal, including draft language, to effectuate it.

We believe that there is no better predictor of Medicaid participation than the participation of an applicant in the region where the beds are being proposed. However, we believe this proposed compromise is better for public policy than no change at all. We appreciate your time in considering our request. If you are interested in discussing this further, please reach out to Melissa Reitz at melissa@mccallhamilton.com or (517)749-9503 and she would be happy to facilitate a group discussion.

Sincerely,

Henry Ford Health
MyMichigan Health
Munson Healthcare
Pine Rest Christian Mental Health Services
Sparrow Health System

Alternative Charge 5 Proposal

Charge 5: Review the comparative review criteria related to Medicaid participation [Section 11(3)(d)] to address unintended inequities caused by the large variation in Medicaid population in the various Heath Service Areas (HSA's) developed within the standards.

Background:
A subcommittee was formed to review Charge 5, discuss potential solutions, and bring back a recommendation to the full workgroup. During six subcommittee meetings the following areas were explored:

1. Medicaid Cost Report versus an Alternative
2. Most Recently Reviewed & Accepted Report versus Most Recently Submitted
3. Submit Full Medicaid Cost Report versus Full Electronic w/ Paper Excerpt
4. Which facilities' Medicaid participation should be measured

Consensus was reached within the subcommittee on suggested changes to address items 1-3 but consensus could not be reached on a recommendation for item 4. Subcommittee recommended changes for items 1-3 were as follows:

1. Retain the use of the Medicaid Cost Report for measuring Medicaid participation.
2. Require submission of most recently submitted Medicaid cost report to ensure current data is being utilized.
3. Submit full cost report electronically with only the relevant excerpts provided in the paper application.

Because consensus in the subcommittee could not be reached for item 4, a summary of discussions, language considered, and the subcommittee vote was presented to the workgroup for consideration and discussion at the full workgroup level. The recommendation for item 4 brought to the workgroup included limiting the use of Medicaid data to only those facilities under common ownership or control located within the same Health Service Area as the proposed project.

Consensus also could not be reached at the workgroup level, resulting in a vote of 8 organizations in favor and 4 organizations opposed to making these changes. When brought forward to the CON Commission on September 15, 2022, a suggestion was made by Commissioner Ferguson that perhaps there could be a compromise of awarding ½ of the points based on the Medicaid participation within the planning area and ½ of the points based on Medicaid participation statewide. The following reflects that proposed compromise:

Amend Section 11(3)(d) as follows:
(d) A qualifying project will have points awarded based on the ranking of the applicant's Medicaid days as measured as a percentage of total days as set forth in the following table. For purposes of scoring, the applicant's Medicaid percentage will be the cumulative of all Title XIX and Healthy Michigan PLAN inpatient psychiatric days divided by the cumulative of all inpatient psychiatric days at all currently licensed Michigan hospitals under common ownership or control with the applicant. For purposes of evaluating this criterion, an applicant shall submit ELECTRONICALLY the most recent ~~reviewed and accepted~~ SUBMITTED Medicaid cost report for each currently licensed hospital under common ownership or control in MICHIGAN ALONG WITH AN EXCERPT OF THE REPORT SHOWING THE TITLE XIX AND HEALTH MICHIGAN PLAN PATIENT DAYS WITH THEIR PAPER APPLICATION.

MEDICAID DAYS	POINTS AWARDED
Applicant with highest percent of Medicaid days	5 points
All other applicants	Applicant's percent of Medicaid days divided by the highest applicant's percent of Medicaid days, then multiplied by 5
EXAMPLE BELOW	
The highest applicant has 58.3% Medicaid days	5 points
Applicant with 55.3% Medicaid days	(.553 / .583) X 5 = 5 points
Applicant with 51.3% Medicaid days	(.513 / .583) X 5 = 4 points

Percentages of days shall be rounded to the nearest 1/1000 and points awarded shall be rounded to the nearest whole number, i.e., numbers ending in .5 or higher, round up, and numbers ending in .4 or lower, round down.

Add Section 11(3)(e) and renumber remaining subsections:

(E) A QUALIFYING PROJECT WILL HAVE POINTS AWARDED BASED ON THE RANKING OF THE APPLICANT'S MEDICAID DAYS AS MEASURED AS A PERCENTAGE OF TOTAL DAYS AS SET FORTH IN THE FOLLOWING TABLE. FOR PURPOSES OF SCORING, THE APPLICANT'S MEDICAID PERCENTAGE WILL BE THE CUMULATIVE OF ALL TITLE XIX AND HEALTHY MICHIGAN PLAN INPATIENT PSYCHIATRIC DAYS DIVIDED BY THE CUMULATIVE OF ALL INPATIENT PSYCHIATRIC DAYS AT ALL CURRENTLY LICENSED MICHIGAN HOSPITALS UNDER COMMON OWNERSHIP OR CONTROL WITH THE APPLICANT AND THAT ARE LOCATED IN THE SAME HEALTH SERVICE AREA AS THE PROPOSED INPATIENT PSYCHATRIC BEDS. FOR PURPOSES OF EVALUATING THIS CRITERION, AN APPLICANT SHALL SUBMIT ELECTRONICALLY THE MOST RECENT SUBMITTED MEDICAID COST REPORT FOR EACH CURRENTLY LICENSED HOSPITAL UNDER COMMON OWNERSHIP OR CONTROL IN THE SAME HEALTH SERVICE AREA AS THE PROPOSED INPATIENT PSYCHIATRIC BEDS ALONG WITH AN EXCERPT OF THE REPORT SHOWING THE TITLE XIX AND HEALTH MICHIGAN PLAN PATIENT DAYS WITH THEIR PAPER APPLICATION.

MEDICAID DAYS	POINTS AWARDED
APPLICANT WITH HIGHEST PERCENT OF MEDICAID DAYS	5 POINTS
ALL OTHER APPLICANTS	APPLICANT'S PERCENT OF MEDICAID DAYS DIVIDED BY THE HIGHEST APPLICANT'S PERCENT OF MEDICAID DAYS, THEN MULTIPLIED BY 5
EXAMPLE BELOW	
THE HIGHEST APPLICANT HAS 58.3% MEDICAID DAYS	5 POINTS
APPLICANT WITH 55.3% MEDICAID DAYS	(.553 / .583) X 5 = 5 POINTS
APPLICANT WITH 51.3% MEDICAID DAYS	(.513 / .583) X 5 = 4 POINTS

PERCENTAGES OF DAYS SHALL BE ROUNDED TO THE NEAREST 1/1000 AND POINTS AWARDED SHALL BE ROUNDED TO THE NEAREST WHOLE NUMBER, I.E., NUMBERS ENDING IN .5 OR HIGHER, ROUND UP, AND NUMBERS ENDING IN .4 OR LOWER, ROUND DOWN.

Trinity Health

Trinity Health Michigan

November 10, 2022

Amy L. McKenzie, MD
Chair, CON Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933

RE: Public Comment for Acute Inpatient Psychiatric Beds Certificate of Need Standards

Dear Chairman McKenzie:

Trinity Health Michigan thanks the CON Commission, the Michigan Department of Health and Human Services' ("MDHHS'"), the CON Informal Workgroup on Psych Beds and Services and Dr. Subodh Jain's collective hard work in developing the proposed revisions to the CON Review Standards for Psychiatric Beds and Services (the "CON Review Standards").

I am writing to convey Trinity Health Michigan's position on the proposed revisions to the CON Review Standards for Psychiatric Beds and Services. While Trinity Health Michigan supports MDHHS' proposed language as it relates to the proposed standards, I am compelled to highlight two key points for consideration.

First, as we have commented before, Trinity Health Michigan has concerns about proponents recommending changing language in the comparative review criteria that measures Medicaid Patient days. Both current and proposed CON Review Standards include language in the comparative review criteria that measures Medicaid Patient days by including the applicant and any psychiatric hospitals/units owned by the same legal entity (based on the entity's Corporate ID Number issued by LARA) as the applicant anywhere in the state of Michigan. Proponents of changing current language argued for measuring Medicaid patient days based on psych hospitals/units under common ownership or control with the applicant in the same Health Service Area – something we feel would limit access to psychiatric services for those most vulnerable and could raise antitrust issues.

Furthermore, the current and proposed CON Review Standards are consistent with the Public Health Code by giving the most comparative review points to those facilities that are accepting any Medicaid patient from anywhere in the state. For reasons we stated in prior public comments, Trinity Health agrees with the MDHHS' position on retaining current language.

Secondly, Trinity Health Michigan does not support changing the definition of "medical psychiatric unit" in the Addendum for Special Population Groups (the "Addendum"), as proposed in the second set of revised standards as we feel it strays too far from the CON Commission's original intent to creating med psych beds as a pool of beds to treat a "special population" – specifically, patients in med-surg hospitals requiring hospitalization for both medical and psychiatric issues. In essence, applicants would be able to obtain med psych beds as a way to circumvent the regulatory framework.

While Trinity Health Michigan supports the concept of med psych beds as originally intended, we believe that MDHHS should convene another workgroup to discuss the issues related to med psych beds. The revisions to the Addendum were rushed without thorough review of the issues. We believe that bringing interested parties together to work through some of these issues will result in feasible language.

In closing, I appreciate your openness to considering Trinity Health Michigan's input as it relates to protecting the current definition of Medicaid Patient Days and the original intent of a special pool Medical Psychiatric Beds/Unit. Thank you for the opportunity to provide comment regarding these issues. I would be happy to respond to any questions.

Sincerely,

Rob Casalou

Rob Casalou
President and CEO
Trinity Health Michigan & SE Regions

Universal Health Services, Inc.

November 10, 2022

Amy L. McKenzie, MD
Chairperson, Certificate of Need Commission
Department of Health and Human Services - Certificate of Need Policy Section
5th Floor South Grand Building
333 S. Grand Ave.
Lansing, MI 48933
MDHHSConWebTeam@michigan.gov

Re: Public Comments to Proposed Rules

Dear Dr. McKenzie:

I am writing on behalf of Universal Health Services, Inc. ("UHS"), which operates Cedar Creek Hospital, Forest View Psychiatric Hospital, Havenwyck Hospital and Beaumont Behavioral Health, regarding proposed revisions to the Certificate of Need (CON) Review Standards for Psychiatric Beds and Services (the "Psych Bed CON Standards") by the Michigan Department of Health and Human Services (the "Department") following the proposals of the Psychiatric Beds Informal Workgroup (the "Workgroup"). UHS thanks the Department, the Workgroup and the CON Commission for their collective work on these important issues.

As you know, at the direction of the CON Commission, the Department has published two sets of proposed revisions to the Psych Bed CON Standards. The first set of proposed revisions leaves in place the current definition of "medical psychiatric unit" from the existing Psych Bed CON Standards and labelled as "Draft Psych Beds Standards" on the Department's CON Meeting website (the "Draft Psych Bed Standards"). The second set of proposed revisions (the "Draft Med Psych Standards") is the same as the Draft Psych Bed Standards, but also proposes a definition of "medical psychiatric unit" that drastically changes the substantive scope of "medical psychiatric" beds under the Addendum for Special Population Groups of the Psych Bed CON Standards, and which was not the result of consensus of the Workgroup stakeholders.

1. UHS Supports the Draft Psych Bed Standards as Drafted.

Specifically, UHS supports: (1) adding a definition of "Common Ownership and Control," which is consistent with how the Department has historically interpreted the term under the existing Psych Bed CON Standards and is relevant to the awarding of comparative review points (as discussed below); and (2) leaving the formula for the calculation of comparative review points in Section 14(3)(d) of the Psych Bed CON Standards as currently drafted.

With respect to the calculation of comparative review points under the current Psych Bed CON Standards, the Department awards points based on the Medicaid patient days of psychiatric facilities or units under common ownership or control with the applicant anywhere in the State of Michigan. This is consistent with Section 22230 of the Michigan Public Health Code, under which acceptance of Medicaid patients must be heavily weighted in the CON Standards. Section 22230 states:

> "In evaluating applications for a health facility as defined under section 22205(1)(c) in a comparative review, the department shall include participation in title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v, as a distinct criterion, weighted as very important, and determine the degree to which an application meets this criterion based on the extent of participation in the Medicaid program."

MCL 333.22230.

Heavy weighting of Medicaid patient days on a statewide basis gives effect to the requirements of the statute and is also good public policy. CON applications for psychiatric beds subject to comparative review often come down to these points. During the Workgroup meetings, the Department explained that Medicaid is a statewide program and accordingly, Medicaid patient days should be measured on a statewide basis, not based on the geographical confines of a CON planning area. UHS supports the heavy weight given to statewide Medicaid patient days on a statewide basis as an indication of willingness to serve this population – including Medicaid patients anywhere in the state, not just within the applicant's own planning area. This promotes access to psychiatric services for the state's entire Medicaid population. Therefore, the current Psych Bed CON Standards and the Draft Psych Bed Standards both reward applicants who are able to show an institutional/organizational commitment to serving the Medicaid population regardless of where the patient is located.

Leading up to the drafting of the Draft Psych Bed Standards, the Workgroup considered a proposal to change the Medicaid patient day formula to award comparative review points based on Medicaid patient days for psychiatric facilities or units under common ownership or control *only within the same CON planning area as the applicant facility*. Proponents of the change have raised that there is an "unintended inequity" in allowing Medicaid patient days from facilities under common ownership or control with an applicant, but outside of the CON planning area. However, we believe there is nothing inequitable about rewarding applicants that have the strongest track record of treating Medicaid patients anywhere in Michigan from receiving the most points and that doing so is consistent with Section 22230 of the Code.

During the Workgroup meetings, proponents of changes to the Medicaid patient days language also compiled data to suggest that most patients come to a psychiatric facility from within the CON planning area. The data was based roughly on Michigan Pre-Paid Inpatient Health Plan ("PIHP") regions, which are not entirely consistent with CON planning areas. Although the data reflects many patients are likely placed within their home CON planning area, approximately 25% of the patients are not. The current Psych Bed CON Standards and the Draft Psych Bed Standards reward applicants for treating that additional 25% of Medicaid patients. The current Medicaid patient day criterion measures facilities that are going above and beyond to accept any Medicaid patient needing placement whether within the CON planning area or not. That is appropriate and should continue to be reflected in CON policy.

The data further does not tell the complete story, as a psychiatric hospital or unit must have a contract with a PIHP to accept Medicaid patients. While most psychiatric facilities have

contracts with a PIHP in its usual service area (county or immediate county regions), there is no requirement for a psychiatric facility to have a contract with a PIHP outside of its usual service area. Therefore, psychiatric facilities who choose not to enter into contracts with PIHPs outside of their CON planning areas will naturally be more likely to only accept patients from within their own CON planning area. This rebuts the assertion of the proponents of changing the Medicaid days formula during the September 15, 2022, CON Commission meeting that changing the formula does not impact the incentives for psychiatric providers to treat Medicaid beneficiaries from outside of their respective usual service areas.

Although certain areas of the State may have more Medicaid beneficiaries than other areas, proponents of changing the formula did not present any evidence to confirm that areas with more Medicaid beneficiaries also have higher inpatient psychiatric admissions. Additionally, Medicaid beneficiaries are being placed all over the state by facilities willing to accept patients outside of their CON planning area to help alleviate inpatient placement backlogs.

The proposed change, if implemented, would allow a facility that deflects a higher number of Medicaid patients than other providers in the CON planning area (perhaps to maintain a more attractive payor-mix and profitability) to still win in a comparative review. This is poor public policy and inconsistent with Section 22230 of the Public Health Code.

The language in both the current and the proposed revisions to the Psych Bed CON Standards is consistent with Section 22230 of the Public Health Code by giving the most points to those facilities that are accepting any Medicaid patient from anywhere in the state. Therefore, the Draft Psych Bed Standards should be adopted as drafted.

2. <u>The Draft Med Psych Standards are Problematic and Must be Further Reviewed and Discussed in an Informal Workgroup or Standard Advisory Committee setting.</u>

During its meetings to review the Psych Bed CON Standards, the Workgroup uncovered a legal issue relating to the requirements for medical psychiatric units under the Addendum to the Psych Bed CON Standards. Specifically, Section 6(1)(a)(ii) granted authority to freestanding psychiatric units to treat patients requiring medical surgical hospitalization under a collaboration agreement with a licensed medical surgical hospital, authority for which is not granted under either the Mental Health Code (which regulates psychiatric hospitals) or the Public Health Code (which regulates both the certificate of need program and medical surgical hospitals).

The Department proposed to fix this "technical" problem with the language in the Addendum to Psych Bed CON Standards by modifying Section 6(1)(a)(ii) to remove the requirement that the patient require hospitalization in a medical surgical hospital. This would ultimately permit an applicant to build a freestanding psychiatric hospital with only medical psychiatric beds, as long as it had a collaboration agreement with a medical surgical hospital. When it became clear that the proposed fix would not have consensus in the Workgroup, the Department retracted its suggestion, indicating that the substantive change of language would require further informal workgroup or standard advisory committee review.

However, at the last CON Commission meeting, the CON Commission, without having reviewed the language, requested that the Department revive the language and send it out for public comment, despite (1) the lack of consensus among Workgroup stakeholders; and (2) the fact that this was not a "technical" fix of, but rather a substantive revision to, the Psych Bed CON Standards. This creates potential precedent for Workgroups to recommend substantive changes to the CON Review Standards without being directed to do so by the CON Commission through a formal charge and creates a path for substantive changes to be made to the CON Review Standards without review by and consensus of industry stakeholders through a Workgroup, which is how substantive changes to the CON Review Standards are typically made.

In addition to the procedural issues the Draft Med Psych Standards pose, there are numerous substantive issues with the language the Department has proposed. Perhaps most significantly, it strays from the original intent of the CON Commission in promulgating the Addendum for Special Population Groups. Medical psychiatric units were originally intended to be within the footprint of a licensed hospital to align with the medical community's definition of a medical psychiatric unit. The Department's proposed language in the Draft Med Psych Standards strays far from this industry definition.

For example, the American Psychiatric Association recently defined "Medical/Psychiatric Unit Bed" as "a bed *in a general hospital inpatient unit* that provides simultaneous hospital level of care for both medical and psychiatric conditions." [1] This definition is in line with the CON Commission's original intent for medical psychiatric units under the Addendum for Special Population Groups.

A journal article assessing the discharge of psychiatric patients from emergency departments directly to psychiatric units highlights some of the potential problems with creating a new expansive category of beds for the medical psychiatric population that can operate as freestanding facilities. The authors, a group of psychiatry professionals in Wisconsin, pointed out that freestanding psychiatric facilities "are not connected to a general hospital and consequently have limited ability to care for complex medical problems."[2] The group highlighted that it is inappropriate for freestanding psychiatric hospitals to care for patients with complex medical problems, due to the limited medical resources of freestanding psychiatric hospitals that either impact or are impacted by staffing issues, inability to manage complex medical issues and facility psychiatry-related exclusionary criteria. The authors highlight the following additional challenges: (1) pre-existing or current medical conditions (particularly infections or end-stage diseases); (2) administrative burdens impacting staffing or requiring advanced equipment/training; and (3) abnormal laboratory results that psychiatric clinicians are not comfortable managing. According to the authors, "these variations in capacity to handle non-psychiatric medical illnesses continue

[1] APA. (2022). (rep.). The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions (May 2022) (emphasis added).

[2] Thrasher, T. W., Rolli, M., Redwood, R. S., Peterson, M. J., Schneider, J., Maurer, L., & Repplinger, M. D. (2019). 'Medical Clearance' of Patients with Acute Mental Health Needs in the Emergency Department: A Literature Review and Practice Recommendations. WMJ: official publication of the State Medical Society of Wisconsin, 118(4), 156–163.

to be a rate-limiting factor for global acceptance criteria to an inpatient psychiatric unit," especially freestanding psychiatric facilities. These issues are extremely relevant to patients being admitted to freestanding psychiatric hospitals composed of medical psychiatric unit beds.

We are not suggesting that there are no circumstances in which patients with medical comorbidities can be treated in a freestanding psychiatric hospital. We simply believe that the language needs to be more carefully thought out in a public setting with input from appropriate stakeholders, rather than drafted by the Department and select interested parties behind closed doors. An example of an issue that should be more carefully thought out is that the Draft Med Psych Standards include the following types of medical conditions that could be treated at a freestanding medical psychiatric hospital: dialysis, wound care and intravenous or tube feeding. These are the only examples in the Draft Med Psych Standards, but the examples do not take into account that (1) the amount of time taken to administer dialysis in a freestanding psychiatric hospital (hours at a time several times per week) may defeat the purpose of being in the psychiatric hospital setting, since daily regular psychiatric treatment may not be available for those patients; (2) freestanding psychiatric hospitals are typically not staffed to take care of complex wounds; and (3) intravenous and tube feeding creates both staffing issues and safety issues for patients, in an environment in which anti-ligature precautions are required by law. More work is needed in the informal workgroup or standard advisory committee setting to carefully craft language that is appropriate for the clinical settings that these requirements will apply to.

Additionally, not placing any limitations on the scope of treatment of medical conditions by medical psychiatric units (which may be freestanding psychiatric hospitals) creates other problems. If the CON Commission adopts the Draft Med Psych Standards that does not include limits on the types of medical care that can be provided in medical psychiatric units, it will essentially be turning medical psychiatric beds into garden variety psychiatric beds. This is because treating patients with "medical conditions" is so broad that it would include patients that have minor medical conditions, including routine injuries that occur within the psychiatric patient population that are easily treated in a general psychiatric unit rather than a medical psychiatric unit. This would allow medical psychiatric units to compete directly with general psychiatric units, by not serving any "special" population as was initially intended. The CON Commission would therefore be creating a pool of garden variety psychiatric beds that would constitute a workaround for applicants in a planning area with no adult or child/adolescent psychiatric bed need or applicants who are unsuccessful in obtaining CON approval for adult or child/adolescent psychiatric beds through the comparative review process.

Finally, broadening the definition of medical psychiatric unit beds will create unintended enforcement issues. The Department is not equipped to police whether the patients even have a medical problem that allows them to be treated in a medical psychiatric bed, or whether a patient's medical condition that justified admission to a medical psychiatric unit continues to warrant admission to that unit after the medical condition has been stabilized or resolved. While the Department of Licensing and Regulatory Affairs can enforce against psychiatric hospitals that exceed their scope of practice by improperly treating patients that require care at a medical surgical hospital (which would be a violation of the medical surgical hospital licensing requirements), a psychiatric unit that exceeds its authority to operate on the other side of the spectrum (by treating

patients that do not have or no longer have a medical condition at all) would go unregulated. This is another issue that should be fully fleshed out by an informal workgroup or standard advisory committee before the CON Commission adopts language expanding the definition of medical psychiatric units.

For these reasons, UHS supports the CON Commission adopting the Draft Psych Bed Standards as drafted and deferring adoption of the Draft Med Psych Standards pending further review and discussion in an informal workgroup or standard advisory committee setting.

Thank you for the opportunity to provide these comments.

Sincerely,

Jenifer Nyhuis
Michigan Group Director
Universal Health Services

4857-9309-1390.5

Corewell Health™

corewellhealth.org

October 27th, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 5th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Dear Chairperson McKenzie,

Corewell Health thanks the CON Commission for the opportunity to provide written testimony on the CON Review Standards for Psychiatric Beds and Services.

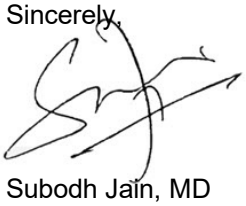
Corewell Health supports the proposed modifications to the standards. In particular, we strongly encourage the Commission approve the change to the definition of "Medical psychiatric unit." The current definition requires the patients using these beds to be diagnosed with a medical condition requiring hospitalization. However, the beds can be granted to freestanding psychiatric hospitals that do not have an acute care hospital license. According to the Department of Licensing and Regulatory Affairs, only hospitals that have an acute care license are legally allowed to admit patients meeting the current definition.

The proposed definition serves two purposes. Firstly, to allow flexibility so that freestanding facilities can use these beds for patients who have medical conditions requiring treatment, but not at an acute care inpatient level (dialysis, wound care, etc.). Secondly, the language allows acute care licensed hospitals who add these beds to be able to treat those patients who do need acute care level of treatment, while also needing behavioral health treatment.

This flexibility is critical as Michigan faces a significant need of behavioral health services. We urge the Commission to adopt the proposed language without delay.

We appreciate the Commission's consideration of our comments. Should you have any questions regarding these comments or if you would like any additional information, please contact David Walker, Advisor, Corewell Health Government Affairs, David.Walkerii@spectrumhealth.org.

Sincerely,



Subodh Jain, MD
Division Chief, Psychiatry & Behavioral Medicine
Corewell Health

MUNSON MEDICAL CENTER

MUNSON HEALTHCARE

November 1, 2022

Chairperson Amy L. McKenzie, MD
Certificate of Need Commission
c/o Michigan Department of Health and Human Services
Certificate of Need Policy Section
South Grand Building, 5th Floor
333 S. Grand Ave
Lansing, Michigan 48933

Dear Chairperson McKenzie,

Munson Medical Center thanks the CON Commission for the opportunity to provide written testimony on the CON Review Standards for Psychiatric Beds and Services.

Munson Medical Center supports the proposed modifications to the standards. Specifically, we encourage the change to the definition of "Medical psychiatric unit." The current definition requires the patients using these beds to be diagnosed with a medical condition requiring hospitalization. However, the beds can be granted to freestanding psychiatric hospitals that do not have an acute care hospital license. According to the Department of Licensing and Regulatory Affairs only hospitals that have an acute care license are legally allowed to admit patients meeting this current definition.

We believe the goal of the proposed definition is to allow flexibility so that freestanding facilities can use these beds for patients who have medical conditions requiring treatment, but not at an acute care inpatient level (dialysis, wound care, etc.) while also not prohibiting acute care licensed hospitals who add these beds from still treating those patients who do need that acute care level of treatment while also needing behavioral health treatment.

This flexibility is critical as our state faces a significant need of behavioral health services. We urge the Commission to adopt this language.

We appreciate the Commission's consideration of our comments. If you have any questions regarding these comments or if you would like any additional information, please contact Jennifer Groseclose, Strategic Business Consultant CON, Munson Healthcare, jgroseclose@mhc.net.

Sincerely,

Matt Wille
President and CEO
Munson Medical Center

November 4, 2022

Dr. Amy McKenzie
CON Commission Chairperson
South Grand Building, 4th Floor
333 S. Grand Avenue
Lansing MI 48933

Dear Commissioner McKenzie,

Henry Ford Health (HFH) would like to offer comments on Certificate of Need review standards for Positron Emission Tomography (PET) Scanner Services:

HFH appreciates the work completed by the Workgroup in 2022. HFH supports both the modified methodology for computing the projected PET data units and the technical edits made to the standards. HFH supports the CON Commission's final vote to move forward at the December meeting.

Respectfully,

Denise Brooks-Williams
Senior Vice President, CEO Market Administration
Henry Ford Health
2799 W. Grand Blvd.
Detroit, MI 48202