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

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

Via Zoom Video Conference

Thursday, June 18, 2020, 9:30 a.m.

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Via Zoom Video Conference

Thursday, June 18, 2020 - 9:34 a.m.

MR. FALAHEE: As chairman I will call the meeting to order. Just a couple of housekeeping things in advance given the uniqueness of this meeting since we're not in person. For those of you that are familiar with the blue card process where if you want to talk about an issue you would submit a blue card to Tania, what I'd like you to do, those of you that are on the Zoom call and through Zoom, you could send a private chat note to Tania saying that you would like to testify about a certain topic. And then at the end of any Commission comment or Department comment, we'll be sure to get those people. And then those of you that aren't -- or that are calling in, what we'll do is at the end of each topic -- if I forget Brenda or somebody will remind me -- I'll just say is anyone interested in speaking on the issue. And for those of you that are regulars, you know that witnesses are limited to three minutes of testimony and we'll hold to that. Also, to move things along now that we know we have a majority of the Commissioners here, on each item that calls for a vote, if it's okay for the Commission members, what I propose to do is rather than going through and doing a roll call of each of the Commission members and whether you're for or against something, what I would do is just ask if there's any member

of the Commission that objects, perfectly fine to object if you do, and that might be a shorter way to figure out whether a motion carries or not.

Beth or Brenda, anything I left out that you want to add in terms of logistics?

MS. ROGERS: No. This is Brenda. The only other thing is we are still recording the meetings and it will be transcribed, so, again, just please identify yourself every time before you speak and then -- yeah, there was one other item. Sorry. It'll come to me.

MR. FALAHEE: Okay. All right. I see --

MS. ROGERS: That was the main -- that was the main one.

MR. FALAHEE: Okay. I see Marcy there, so I know she's recording. So, great. All right. Let's call this meeting to order. Thank you for everyone for rearranging your schedules and participating electronically instead of in person.

The first item on the agenda you can see it on the screen there and it can be in front of you as well, is the review of the agenda. The final agenda came out yesterday to the Commission members. Does anyone have any comments, questions or concerns about the agenda that came out yesterday? Hearing none, I will ask for a motion to approve and I will do that by asking if there are any objections to

that motion to approve, otherwise, we will consider a motion to be accepted. But I need the motion to start with, please.

MR. MITTELBRUN: Motion to approve as presented, Mittelbrun.

MR. HUGHES: Commissioner Hughes, motion to approve, second.

MR. FALAHEE: Thank you. Any discussion? Is anyone -- any other Commission members object to that motion? Hearing none, that motion is accepted. Agenda is approved.

(Whereupon motion passed at 9:38 a.m.)

MR. FALAHEE: Next agenda item is declaration of conflicts of interests. Do any of the Commissioners have any conflicts of interest to declare based on the agenda we just approved? All right. Moving along. For those of you on the call not familiar with the CON process, we don't go this fast for every agenda item.

Next, review of the minutes of our last meeting, January 30, which seems like a long time ago. I call it B.C., before COVID. So the minutes are in our packet. I'm assuming all of you have read the minutes. If no concerns about them, I would entertain a motion to accept the minutes as presented from January 30.

DR. GARDNER: Commissioner Gardner, motion to

accept.

DR. MCKENZIE: Commissioner McKenzie, second.

MR. FALAHEE: Okay. Commissioner McKenzie seconded. Thank you. Any discussion? Does any Commissioner have any objection to that motion? Hearing none, the minutes are approved.

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

MR. FALAHEE: So let's go into our first item and that would be a non-substantive, technical, if you will, correction to the psych beds and services language. And, Brenda, as usual I'll turn it over to you to summarize for the Commission what's going on and what we should potentially do about it. Thank you.

MS. ROGERS: Thank you. And before I do that -- this is Brenda -- my other thought was just if you're not speaking, to have your -- be on mute so that way if there's any background noise and stuff it doesn't affect the other people and stuff. That was my other thought earlier. Okay.

So with the psych bed standards, we recently discovered that there were a couple of more or less typographical errors that were in the standards that were approved and that became effective back on November 12th of 2019, so just late last year. And you have the language in the packet. Just quickly summarizing on lines 624 of the draft language, it's a table and it has to do with the cost

per bed and points awarded, so it's part of the comparative review.

Inadvertently, that ten points should have been seven points. That is what the workgroup approved and ultimately presented to the Commission and that's what should have been in there. And if you look at the example right below it, it does correctly identify the seven points. And then the other change is switching around some words. So instead of reading "applicant's cost per bed divided by the lowest applicant's cost," we're changing it around to read "lowest applicant's cost per bed divided by the applicant's cost." That properly reflects the example. So alls we are doing are making -- suggesting those two corrections. It doesn't -- it's not a substantive change to the standard in that we are just asking to be able to correct this. And if the Commission approves the Department to make this correction, the effective date of the standards will still remain November 12th, 2019, and it does not have any impact on any applications that have been submitted up to this point. Thank you.

MR. FALAHEE: So, Brenda, this is Chip. This would be what we would call a technical non-substantive correction to the language; correct?

MS. ROGERS: Correct. And it does not meet -- and we've already vetted this with Carl, and Carl can chime in

in case I'm missing anything, but this does not need to go through the entire public hearing/legislative process. It's truly just correcting a couple of typographical errors.

MR. FALAHEE: Thank you. Again, this is Chip again. Does anyone have any -- any Commissioners have any questions of Brenda about the language or the correction? Any discussion amongst the Commissioners? If not, I would entertain a motion to approve the corrections as presented retroactive to the effective date of November 12 of '19.

MS. ROGERS: Chip, I'm sorry.

MS. BROOKS-WILLIAMS: So moved, Commissioner --

MS. ROGERS: I'm sorry. This is Brenda. You do have public comment on the agenda. I don't know if you want to ask if there is --

MR. FALAHEE: Oh, sorry about that. My fault. Is there anyone that -- Tania, I'm assuming you don't have any "blue cards." So I'll ask if anyone would want to testify or make comments about this correction? Okay. Hearing none.

MS. BROOKS-WILLIAMS: This is Commissioner Brooks-Williams --

MR. FALAHEE: Denise, you went on mute.

MS. BROOKS-WILLIAMS: I did. I was off.

MR. FALAHEE: Yeah, I know.

MS. BROOKS-WILLIAMS: Sorry. No worries.

Commissioner Brooks-Williams. I'm sorry. I was just moving that we accept the corrections as presented retroactive to November and I think that's all we need.

MR. HUGHES: Commissioner Hughes, second.

MR. FALAHEE: Thank you. Motion made and seconded. Any Commission discussion about the motion before us? Okay. Thank you. Do any Commissioners object to the motion? Hearing none and seeing no one trying to speak with their mute button on, we will take the motion as accepted as presented.

(Whereupon motion passed at 9:44 a.m.)

MR. FALAHEE: Moving on next to CT scanner services and a workgroup. Dr. Remes, this is your chance to unmute yourself. And what we have in front of us is the final report of the group. Anybody that has read the report knows and can see the great amount of effort that's gone into this. And as one who prior to being on the Commission sat on several work groups and SACs, thank you, Doctor, for you and your whole team because I know it's the whole team that gets involved in this. Thank you for many, many hours of hard work, for a thorough analysis of the CT and for your recommendations.

So what I'd like to do if it's okay with the rest of the Commission is turn it over to Dr. Remes. You are not limited to three minutes.

DR. GEOFFREY REMES: Thank you.

MR. FALAHEE: If you could do it in three minutes, I'd be worried. But you go ahead and then what we normally do, just so that you know, is once you make your presentation, you can anticipate some questions from the Commissioners and then we'll go to public comment and then Commission discussion and then Commission proposed. So if that's okay with everyone, Doctor, the floor is yours. Thank you very much.

GEOFFREY M. REMES, M.D.

DR. GEOFFREY REMES: Thank you. Thank you, Mr. Chairman. And I would first like to thank the workgroup participants as well as the Department for their assistance, as well as yourself for the opportunity to have done this. I've prepared a set of slides. I don't know. Brenda, can you display those? It's just an outline of what the charges are and what the conclusions were, the recommendations.

MS. ROGERS: Yeah, this is Brenda. I believe Tania can have -- can show those on the screen.

MS. RODRIGUEZ: Yes, I'm trying to pull those up right now.

DR. GEOFFREY REMES: Well, why don't we get started? I'll just go through this while you're getting that ready. The CT CON workgroup met five times and we concluded on February 27th of 2020. We did a survey of CT

times to try and accurately determine what -- what numbers we should actually be using here for times and for the CT equivalent analysis. We did multiple approaches to the data analysis including some geographic work and we came up with a set of recommendations.

The first charge was to determine if freestanding, off-campus emergency department, ED's, should be exempt from meeting maintenance volume requirements for their first CT scanner. And what our recommendation is -- and then we can discuss it if there's questions -- the workgroup recommends exemption of freestanding, off-campus ED's from maintenance volume requirements for their first CT scanner provided the facility meets the definition of a freestanding off-campus ED of a hospital licensed under Part 215 of the code, or a freestanding surgical outpatient facility licensed under Part 208 of the code that treats emergency patients 24 hours a day, seven days a week, and complies with the medical control authority protocols and is authorized by medical control authority to receive ambulance runs. Are there any questions regarding -- there we go with the slides. Are there any questions regarding the recommendations for the first charge?

MR. FALAHEE: This is Commissioner Falahee. Doctor, just what was the rationale for this recommendation? If you could just sort of summarize it for us on the

Commission, please?

DR. GEOFFREY REMES: Sure. Well, the practice of emergency medicine really requires CT scanning, otherwise it's extremely limited. And we had specific questions about a freestanding ED and what type of patients would be presenting themselves. And a lot of that is determined by the medical control authority in terms of the ambulance runs and what they would be receiving. This had really no impact at all on costs since it's a CT scan that's going to be performed at the freestanding facility versus at the hospital. It doesn't change initiation and it really increases patient access and that's kind of where we were coming from to, to reach this conclusion. And we felt that, you know, if a -- if the facility meets the requirements of a freestanding, outpatient surgical facility or of a freestanding ED licensed by a hospital, we felt that that was -- that was a very reasonable thing to do.

MR. FALAHEE: Thank you. Other questions from the Commissioners? I like the idea of going through each charge and addressing the questions or comments there. So any other Commissioner questions about this charge number one? Okay. Carry on.

DR. GEOFFREY REMES: Charge number two, review the definition and requirements of a dedicated pediatric CT scanner. And at the present time there's really only two

dedicated CT scanners -- pediatric CT scanners in the state. And at the present time we recommend that there be no change; however, the Commission could consider updating the definition of what a pediatric patient actually is -- next slide, please -- a pediatric patient actually is, as described by the American Academy of Pediatrics. There is this gray zone between 18 and actually 22, up to the 22nd birthday, so including 21.

And what has happened is a lot of pediatric patients with very serious diseases -- and I've outlined a couple of them under the rationale of the document that I submitted. Examples would be: Cystic fibrosis, congenital heart disease, metabolic diseases, conditions that a lot of pediatric patients would have succumbed to much earlier in life going back 15, 20, 25 years. These patients are living considerably longer now. And by living longer, the people that are treating them continue to be the pediatric specialists and subspecialists. And so at some point we were thinking that the Commission could consider updating the definition, but this would be something for another charge at this point.

MR. FALAHEE: Doctor, it's Commissioner Falahee again. So the American Academy of Pediatrics, I take it they've recommended a change in definitions or they've approved one already for that academy?

DR. GEOFFREY REMES: I don't know if they've actually approved them. We had several papers presented to us by one of the pediatric radiologists from the University of Michigan that indicates that this gray zone, the American Academy of Pediatrics recognizes this and recognizes that pediatric doctors are still treating patients in that age group.

MR. FALAHEE: Other questions --

DR. GEOFFREY REMES: Any other --

MR. FALAHEE: Yeah, go -- thank you. You took the words out of my mouth. Other questions from the Commissioners on this issue? There's no recommendation, but consider updating the language of the definition. Other questions? Okay. Let's move --

MS. BROOKS-WILLIAMS: This is Commissioner Brooks-Williams. I'm so sorry to be delayed. So when we say -- so it's no recommendation meaning we'll consider the -- I'm just a little confused by the -- do we want to consider the language by the pediatric -- the Academy of Pediatrics or no? Is the recommendation to consider that language or is it truly no recommendation?

DR. GEOFFREY REMES: We're simply suggesting that at some point in the future the Commission may want to consider -- the change is -- it's not limited. If you do change that, it's not limited to CT is the issue.

MS. BROOKS-WILLIAMS: Oh, okay.

DR. GEOFFREY REMES: It changes a lot of other things.

MS. BROOKS-WILLIAMS: Because it is a domino. Okay.

DR. GEOFFREY REMES: Exactly. And so it's something that you may want to consider doing in the future, but right now we left it alone.

MS. BROOKS-WILLIAMS: Okay.

DR. GEOFFREY REMES: Does that make sense?

MS. BROOKS-WILLIAMS: It does make sense, yes.

DR. GEOFFREY REMES: Thank you.

MR. FALAHEE: Falahee. Other questions from the Commissioners? All right. We'll move on to charge number three, Doctor.

DR. GEOFFREY REMES: Charge number three, review the CT maintenance requirement, volume requirements. And the first recommendation -- we have several recommendations here. The first recommendation is to reduce the maintenance volume from 7500 CT equivalents to 5,000 CTE or CT equivalents for all services with one fixed CT scanner. And what this would do -- the analysis that we did here was to survey a number of scanners to determine how long it was taking to produce each of a number of different studies, and what their hours of operation were. And we used 80 percent

as the capacity taking into account cancellations, no-show, down time, pre-scanning time, all that sort of thing. And 5,000, we obtained that number a couple of different ways. We obtained it -- it came out the same statistically if we went out two standard deviations, and it also brought into compliance there were hundred -- let's see. We have 38 out of 108, or 35 percent of the CT scanners were in compliance using 7500, and if we decrease it to 5,000 that increased compliance to 47 out of 108 which is about 43 percent. It brought an additional nine scanners into compliance. So that was recommendation number one. Any discussion or questions about that?

MR. FALAHEE: Hearing none, keep moving.

DR. GEOFFREY REMES: Charge number -- well, still charge number three, recommendation number two is to reduce the maintenance volume from 3500 CTE's to 1500 CTE's for all mobile CT scanners. And here the rationale was that, again, we did this analysis and we used an operating capacity for a mobile CT scanner of approximately 50 percent. And, again, that includes things like cancellations, no-shows, pre-time, down time, travel time, and docking time for the scanner. A little different than a fixed scanner. And we felt that 1500 was a reasonable maintenance requirement given the number of scanners that were not in compliance and it had no impact to cost. It has no impact on patient care. It

maintains patient care and it does not change initiation of service. Questions? Hearing none, I'll move on to our third recommendation.

And our third recommendation for charge three is to add a new category for -- actually add two new categories in computation of the CT equivalent numbers. And those are for CT guided non-ablation procedures and for CT guided ablation procedures. And more and more interventional type procedures are now being done under CT guidance and particularly there's procedures that are being done with ablation such as ablation of liver tumors and so forth. They're done a number of different ways. But there was two clear sets of procedures, those with ablations and those not ablations.

The ones -- the CT guided procedures with ablations we're recommending a conversion weight of 8.0 for an adult and 8.25 for a pediatric patient or a special needs patient; and for the non-ablation procedure, 4.0 for an adult and 4.25 for a pediatric or special needs patient. And the way that we obtained these numbers is 15-minute intervals for CT -- for CT's was one -- one CTE. And the procedures which are done without ablation are scheduled for approximately one hour and those with ablation are scheduled for approximately two hours. And doing that computation, we come up with the 4.0 for non-ablation procedures for adults

and the 8.0 for ablation procedures in adults. Questions regarding that?

MR. FALAHEE: And this is just to remind everyone. These are questions of the Commissioners only. We'll open it up to public comment or questions after doctor finishes going through all the recommendations. Carry on.

DR. GEOFFREY REMES: Thank you. And the fourth recommendation for charge three was to reduce the maintenance volume from 7500 to 2500 CTE equivalents for services with one fixed CT scanner located outside the 20 mile radius from the next closest CT scanner. And most of these scanners are north -- if you draw a line across Michigan at about the level of where Clare is and go north from that, most of these scanners that are very isolated are north of Clare. And we felt that this continued to maintain because most of these scanners are not really in compliance based on the maintenance volume requirements and this would more or less protect some of those and basically no impact to cost. It did not change initiation of services and it maintains patient care and access which was of concern when you get to some of these more isolated areas. Questions?

MR. FALAHEE: Questions for -- thank you. Questions from the Commissioners about that?

MR. DOOD: Lindsey. I was wondering what percentage becomes into compliance using this test?

DR. GEOFFREY REMES: If you -- currently 12 of 23 scanners go into this category and 12 of those 23 were out of compliance. It brought eight of those 12 scanners back into compliance.

MS. GUIDO-ALLEN: Guido-Allen. Does reducing the requirement have any impact on the quality of the scan or the competency of the CT technician, or even the readers?

DR. GEOFFREY REMES: No, it shouldn't. As far as the -- it should not affect the quality of the scan at all. It shouldn't affect the equipment or anything like that. And as far as the readers go, some of those studies are being read onsite by radiologists that are actually there, some of them are being read offsite remotely which is becoming a very standard practice now in radiology.

MS. GUIDO-ALLEN: What about competency of the technician with the reduced volume that they're doing? Any concern around that quality?

DR. GEOFFREY REMES: Not -- you know, I really can't speak well to that, but I can't see how that would really, the quality -- of course the more that you do, the better you are at doing them. I mean, that's very clear no matter what it is. But I think in this particular instance, you know, the way these scans are done I can't see how that would really affect the quality for the types of scans that they're doing.

MS. GUIDO-ALLEN: Okay. Thank you.

MS. BROOKS-WILLIAMS: This is Commissioner Brooks-Williams. The geographic radius 20 miles, can you talk a little bit about does that apply universally across the state? Is that too far for some areas?

DR. GEOFFREY REMES: Well, what we felt was that 20 miles -- we tried to do a geographic analysis. It was -- we tried it a couple different ways, actually, and the Department actually helped with this, and then we kind of tapped a resource. One of the workgroup members had a resource at Michigan State. And we tried a number of different ways to evaluate this. It is very difficult to geographically analyze this. And we came up with 20 miles. It seemed to work. Like I said, it brought -- you know, it brought -- of 12 scanners, it brought eight of them back into compliance and we thought that was a good thing and it was a good starting point and we can see how this goes and then revisit. The Commission can revisit this in the future and adjust that if necessary.

MS. BROOKS-WILLIAMS: Thank you.

MR. FALAHEE: Other questions from the Commissioners?

MR. HUGHES: I have one. I know this is a very difficult topic and, again, the rest of my Commissioners that have heard me before, please bear with me again. But I

do represent payers on this. And always focused on quality here and some of the questions were great on that, but another aspect of this and part of our charge is cost. And when you look at CT scans in particular, the cost variances are dramatic. And I just wonder if that was addressed at all in any of these evaluations, and if we do reduce this and allow other places to stay open -- or to be in compliance is obviously a better term -- I'm guessing it's going to be a lot of the ones when I look at the data here that are a lot more expensive than some of the other ones. And I just -- I think that has to be a component that when we're evaluating these things needs to be worked into the discussion here because there's no reason some people in the state should walk into door A and pay four times for a CT scan when ten miles down the road they can pay a quarter of that. And somehow that should be in this discussion. I just wanted to get that out there.

DR. GEOFFREY REMES: As far as cost goes, we really did not do an analysis of that. That was felt not to be really part of this charge. Of course that's something that could be looked at and worked into this, but it's -- we did not evaluate that.

MR. MITTELBRUN: This is Commissioner Mittelbrun. I just wanted to agree with Commissioner Hughes wholeheartedly because many of our groups now have been

forced to hire those agencies that research and identify those of lower cost, then we have to incentivize our participants to go to those lower cost providers for the exact same service. It would be nice if we could have a little -- well, less of a variance in cost, more consistency.

MR. HUGHES: Thank you. That's great. Working some transparency into the regulations would be helpful and there's a lot more correlation between low cost and higher quality, too. Some things are just procedures without a reader, but if I showed you some of the data right now, you guys would be horrified.

MR. FALAHEE: Great. Thanks for those comments, both you guys. Thank you. Other comments, questions from the Commission members? If not, I see one question from Tom -- and I'm going to not even attempt your last name, Tom. But if you could introduce yourself and say from what organization you are from and then summarize your question? I can see what you typed out here, but if you want to expand on it? So if you could unmute yourself and --

DR. TOM BOIKE: Hi. Can you hear me okay?

MR. FALAHEE: Yeah. I can hear you. Thank you.

TOM BOIKE, M.D.

DR. TOM BOIKE: And thank you for the opportunity to speak and for organizing this meeting in this fashion. I

just have now two questions.

MR. FALAHEE: What organization? Could you pronounce -- pronounce your last name and your organization, please?

DR. TOM BOIKE: So my name is Tom Boike. I'm a radiation oncologist, a physician with Michigan Health Care Professionals in the kind of greater Detroit area. We're a multi-specialty physician group.

So my first question is on charge one for the freestanding, off-campus ED CT scanners. Will these scanners also be able to schedule non-emergent scans? So will they have kind of an ability to do routine scans or will they be for emergency only use? And then on charge three, you know, I certainly appreciate discussion on cost as we participate in a large ACO -- actually, I think the largest physician led ACO in the state. And so my concern is cost and quality. So if you reduce the CTE's to 2500, you know, how do these centers maintain adequate full-time staffing? Was there some criteria looking at, you know, how many scans they had to do to maintain staffing or do they have to raise cost in order to have that staffing present? Thank you.

MR. FALAHEE: Doctor?

DR. GEOFFREY REMES: To address question number one with respect to are they scheduling other types of scans

that are non-emergent scans, that was a question that I also had and the answer to that is, yes, they are also scheduling other studies at these facilities. The emergent studies do take priority to the scheduled studies, but they are scheduling other examinations as well. And as far as question number two goes, the, you know, quality based on the volume of scans that they're performing, we did not evaluate that. But I do not think that the volumes drop so low given the types of scans that they're doing. These are pretty much very straightforward scans: CT of the head, chest, abdomen and pelvis. There should be no impact to quality.

MR. FALAHEE: Thank you. Dr. Boike, any further questions, comments?

DR. TOM BOIKE: I mean, my only comment then is, you know, if they're able to put a CT scanner for a freestanding, off-campus ED and have low CTE requirements but be able to schedule routine exams, that seems like kind of contradictory for its use. Now, granted if we put a CT scanner somewhere, we want it to be used. And then also as we think about the cost of these services, once a CT scanner is placed, you know, it operates for several years and is depreciated, the main cost of operation is the staff and maintaining the high quality staff. So, you know, I think that should be looked at as you come up with these

regulations. I appreciate everyone and certainly your time and all the effort you put into it.

MR. FALAHEE: Thank you. What would -- the process for this, these are draft language so just to anticipate what the Commission may do so those on the call know. These will then, assuming the Commission takes action on the proposed language, would go out for public comment, public hearing. So any that have public comments, questions, or concerns can raise it then and then it comes back to the Commission for final review. Just so everyone is aware of that. Any other -- I don't see any other chat notes. Is anyone else that's on the call interested in speaking or asking a question about this issue? Okay. Hearing none, Brenda, would you like to summarize potential next steps so that the Commission is aware of that and then we can have Commission discussion if any?

MS. ROGERS: Yeah, this is Brenda. As Chip just stated, this is up for proposed action. So should the Commission do that today, then we will schedule it for public hearing and submit it to the Joint Legislative Committee for their consideration and it will come back to the Commission at its September meeting for potential final action. And at that point in time, the Commission can take final action as is, or if there are comments received from the public and/or the Joint Legislative Committee, it can

also make changes at that point as well. Thank you.

MR. FALAHEE: Thank you, Brenda. Any questions amongst the Commissioners? Any discussion? Hearing none, I would entertain a motion along the lines of what Brenda just said if someone is so inclined?

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams. I guess I'll say so moved unless we want Brenda to help me repeat exactly what it is that we're needing to state. Is that acceptable, Brenda, if I just say "so moved" based on you just having said it, or do I need to repeat it?

MS. ROGERS: Yeah. So I can restate it for you. This is Brenda. So your motion is to take proposed action on the language as presented and move forward to the public hearing and to the Joint Legislative Committee.

MS. BROOKS-WILLIAMS: Thank you. Just like we were in person, Brenda.

MR. FALAHEE: Is there support?

MR. MITTELBRUN: I just have one question. This is Commissioner Mittelbrun. Do we have to identify -- at least if I can read my notes correctly -- that we're talking about charge one and charge three? Charge number two was for future consideration; correct? So do we need to identify the two charges that are -- or charge one and charge three?

MS. BROOKS-WILLIAMS: I think, Tom, because two was technically no recommendation.

MR. MITTELBRUN; Okay.

MS. BROOKS-WILLIAMS: That was kind of my earlier question. I just assumed it's acceptable, but I agree.

MS. ROGERS: This is Brenda. Actually what you're really doing is we've already provided the draft language with all those changes -- recommended changes in it, so that's really what you're taking action on is the draft language.

MS. BROOKS-WILLIAMS: Okay.

MR. FALAHEE: Right; exactly.

MR. MITTELBRUN: All right. Thank you.

MR. FALAHEE: Is there support for the motion?

MS. GUIDO-ALLEN: Commissioner Guido-Allen, support.

MR. FALAHEE: Thank you. Any Commission discussion? If not, does any Commissioner object to the motion that's before us? Hearing none, that motion is approved and it moves forward to public hearing and to the Joint Legislative Committee. Thank you.

(Whereupon motion passed at 10:16 a.m.)

MR. FALAHEE: Dr. Remes, thank you for all your work, you and your whole team. I thank you very much. You're welcome to drop off the call unless you have nothing

better to do. Again, thank you very much and we appreciate all your effort and we may call on you again if we have more questions as this goes through the process. Thanks so much.

DR. GEOFFREY REMES: Thank you very much and thank you for the opportunity.

MR. FALAHEE: Thank you. Okay. Let's move on to agenda item seven, neonatal intensive care services beds, and this is Commissioner Oca as the NICU workgroup chairperson. This is just an interim report which is in our packet. Commissioner, I don't know if you wanted to add anything to that or not?

DR. OCA: No, I -- it's pretty succinct where we are at this point. We've been able to meet pretty consistently throughout our COVID challenges, and it's been a very, as you can imagine, exciting discussion related to all these charges. I'm happy to report that at least four of our seven charges have been completed and we have draft language as needed that will be reviewed by both the Department and the group at our next meeting.

Our most heated discussions obviously come through the use of a high flow nasal cannula which is our charge one. In order to help us discuss this more logically and practically we do have an ongoing survey that's currently being conducted to gather some data from our special care nurseries and we feel -- the workgroup feels that this data

will help to assist us to address this in the most appropriate manner. As well as our charge six, in looking at the definition of NICU services in our current standards that we are having ongoing discussion about that. And I hope that within our next two meetings we will be able to conclude our discussion and conversation and have appropriate draft language regarding each of these charges.

MR. FALAHEE: Thank you very much. Very good summary both just now and in writing. So thank you and thank you for working through all of the curves that COVID has thrown us in terms of getting people together and getting data back to the workgroup. Again, thanks so much. Look forward to the final report. Any questions from the Commissioners about that? Okay.

Hearing none, we'll move on to agenda item eight, nursing home long-term care beds. And, Brenda, I'll turn it over to you. You've done a great job of summarizing it in our packet, but if you'd like to go ahead, that'd be great.

MS. ROGERS: All right. Thank you, Chip. This is Brenda. So the Commission took proposed action on this language. As you'll recall, this was to put a temporary fix into the standard of adding language that requires a planning area to have an occupancy rate of 85 percent or more to be able to begin operation of a new nursing home or hospital long-term care unit bed, or to increase the number

of beds in an existing licensed facility. What this would do would help to ensure that beds go to areas where needed as the SAC continue to do its work on a bed or bed need methodology.

So, again, you took proposed action, we held a public hearing on February 11th on behalf of the Commission. Testimony was received from several organizations and one individual and that testimony -- the written testimony as well as the public hearing transcript was provided to you along with a memo just providing a brief overview of the testimony. So based on everything up to this point and the testimony received, the Department does still support the language that was originally presented. And today if you decide to take final action, then the language will be forwarded to the Joint Legislative Committee and the Governor for the 45-day review period. And you will be receiving an interim report from the SAC which has also been provided to you. They just recently wrapped up their work on a bed need methodology, so that will be coming to you at a later date. Thank you.

MR. FALAHEE: Thank you, Brenda. Any questions from the Commissioners of Brenda? Okay. Hearing none, in terms of what we would call a blue card if we were there in person, I see that Pat Anderson would like to support the change. Pat, do you want to say anything else for the

record? If so, unmute and go ahead. I don't hear anything so we'll just take it as that -- she'd like to support the nursing home --

MS. PAT ANDERSON: Sorry, Chip, I just unmuted.

MR. FALAHEE: Okay. Go ahead, Pat.

PAT ANDERSON

MS. PAT ANDERSON: Still learning technology. Just want to thank the Commission for re-looking at this and support of it. And as you'll see, the SAC is completing their work and moving forward, so it'll be fun in September to share what we've done. But we would appreciate if this could move forward, this language. Thank you.

MR. FALAHEE: Thank you, Pat. Tania, I don't see any other what I'll call blue cards so I'll open it up. Does anyone else that's on the phone only have any wish to comment about the standards that are in front of us right now? Okay. Hearing none -- I always wait to give people a chance to unmute. I've learned from our incident command center that when we have a couple hundred people on the call, it takes awhile sometimes for people to know they need to unmute. So hearing none, what we have in front of us as Brenda very well summarized is some proposed action and I would like to ask if there's any questions amongst the Commissioners. If not, what we have is we have the option to take final action on this language and then if we so

chose and made that motion and approved the motion for final action, it would go to the JLC, the Joint Legislative Committee, and the Governor for the 45-day review period. So number one, any discussion amongst the Commissioners? Number two, if no discussion, I'd open it up to a motion along those lines, if so willing.

MR. MITTELBRUN: Chip, Commissioner Mittelbrun. Motion to move forward with final action moving forward to the JLG (sic) and the Governor's 45-day review period.

MR. FALAHEE: Thank you, Tom. Is there support for that motion?

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

MR. FALAHEE: Thank you. Give everybody a chance to digest it. Then I'll say is there anyone on the Commission that objects to that motion? Hearing none, the motion is approved. Thank you all for your hard work on this. Thank you.

(Whereupon motion passed at 10:25 a.m.)

MR. FALAHEE: Then we'll move on to agenda nine. As we talked about just now with Standard Advisory Committee hot off the press, a written interim report. And I think I saw Don Haney on here. Don, are you on the call? Maybe not. I thought I saw him. In any event, there is a written interim report. We can go ahead and just accept that and we will get the final report as we talked about earlier at our

September meeting. Brenda, anything else about that at all you want to raise?

MS. ROGERS: This is Brenda. No, not at this time. Thank you.

MR. FALAHEE: Okay. Great. Thank you. I should add when we go back on the legislative days and the 45-day review period, as all of you know there needs to be a certain number of legislative days for the clock to tick. There's a question about how many legislative days there will be. We're not sure how long the legislature is going to be in session. It is summer. It is an election year, so we don't know. So that's an unknown.

So with that, let's move to item ten, PET Scanner Services and a presentation. Just so everybody knows, those of us -- I was approached and then the Department was approached by BAMF Health to make a presentation about something they wanted to talk to the Commission about, some technology, and I said sure, ten minutes to talk to the Commission. No action necessarily needed here, but we wanted to hear the presentation. And I see Dr. Chang is there -- and Roger, good to see your face momentarily. So, gentlemen, I'll turn it over to you and we'll start the ten-minute clock ticking and we'll be glad to answer -- we'll ask questions at the end if that's okay with you.

DR. ANTHONY CHANG: Yeah. So I'm wanting to thank you, Chairman, for this opportunity for me to present in front of the Commissioners. And I'm just wondering should I share my screen to operate a PowerPoint or I should use the PDF files?

MS. RODRIGUEZ: You can share your screen.

DR. ANTHONY CHANG: Okay. Let me do that.

MR. FALAHEE: We won't count this against the ten minutes.

DR. ANTHONY CHANG: Can anyone see my screen?

MR. FALAHEE: Yup. I got it. Thank you. Everyone else okay? All right. Good. Go ahead.

DR. ANTHONY CHANG: Thank you. Good morning. My name is Anthony Chang. I'm the founder and CEO of BAMF Health. So I really appreciate this opportunity we can present this lifesaving project with the Commissioners.

I was a researcher and considered as well a pioneer in the monitoring imaging field for the past 15 years. And we know there's a lot of lifesaving technology has been invented in the United States and has been proven in clinical trials in other countries like Germany, Europe and also like Australia. However, those technology is not available to our citizens over here and that is not okay and that's why we have -- we start BAMF Health about four years ago.

So BAMF Health is here purposely trying to serve the unserved and underserved patients and we are trying to achieve intelligence-based precision medicine through AI-enabled molecular imaging and theranostic, or you can call it molecular targeted radiation therapy.

So in a nutshell, the technology we have is what allowed us to detect disease which nobody can detect right now by current technology and we can treat diseases which cannot be treated by current technology. So I want to show you some example. And all these example is actual clinical trial we performed in Germany diligently for the past four years. So what you see over here (indicating) is actually one of our patient from West Michigan. He has -- his prostate cancer has been recurrent and everybody knows the prostate cancer is coming back, but by current technology CT/MR, nobody can see where the tumors are. So we send him to Germany to use our technology, just one single shot of the IV injection and through PET-CT technology, all the marker we found four small lesions. So not only we can identify it, but also we can actually start to tackle it and right now this patient is cancer free and it has been three years.

And this (indicating) is actually another case we have. It's everything you here -- you see over here for the black spot, those are metastatic prostate cancer. This is

the end-end stage over here (indicating). In US usually you have to move into hospice care. But through our molecular targeted radiation therapy, three IV injection later, we got a complete remission for this patient. And this is not only case. I want to share more amazing result with you. I mean, sometimes, you know, myself cannot believe that. This is actually another prostate cancer case. On your left over here (indicating), if you can see my arrow over here, you'll see a skeleton over there. That's not a bone scan. This is every single bone is filled with prostate cancer or metastasis. And you can look at it, his PSA is 1800. The normal PSA for men is about zero to five, depends on the age. So this is end-end stage and people will think he has several weeks to live. But after the several treatment for this kind of molecular targeted radiation therapy, a year later not only he is still alive, he's cancer free. And this (indicating) is just another case. Prostate cancer has filled with abdominal area, end-end stage. Five IV injection later, almost a year later it's complete remission. And we can also apply this kind of treatment to some cancers other than prostate cancer. So this is actually some example for some cancer called neuroendocrine tumor. This is what Steve Jobs had. In US the average life expectancy from diagnosis to deceased is about 22 month. And when we apply this kind of technology, not only we can

identify all the tumors in the liver and we can actually make the -- the patient come, have a complete remission. In Germany there's a patient has lived over ten years mark after this kind of treatment.

So why this kind of useful technology invented in the United States, but our citizen and our people over here cannot have any access to that? That's because there is so many -- we have several -- three major obstacles over here. Number one, we're lack of the infrastructures. We need a radiopharmacy to be able to, like, manufacture these kind of tracers and so we can treat these patient, but all our radiopharmacies over here or 99 percent of radiopharmacies here are outdated; are outdated. So we cannot manufacture these novel tracers at a commercial scale at affordable price. Second, this radioactive tracer have a short half-life. The half-life is about two minutes to 12 hours. So for if you cannot have the scanner right next to a radiopharmacy means the shipping is almost impossible because once the tracer get into the scanner, everything is decayed. And the third thing is the PET scanner right now is still -- is also pretty old so they cannot offer enough efficiency, enough resolution, enough sensitivity and also offer enough throughput allowed us to scan more patients.

So to sum it up, that's why you can see 90 percent, even 95 percent of the PET scan right now in the

United States still using a 30 years old tracer called FDG. And that's -- all our CON protocol is actually depends on the application for the FDG can apply instead of this disease can cover by the new disease, new tracers.

So here in these slides I have to summary all the problems over here (indicating), and then there are solutions. The solutions are first we need a modern, standardized cyclotron-equipped radiopharmacy allowed us to manufacture wide variety of radiotracers at a commercial scale, at affordable price. Second, we need a cutting edge new type of PET scanners, meaning whole body PET and PET/MR allow us to apply these new tracers to de- -- to detect the new diseases like neurological related disease, cancer disease, cancer and, like, cardiology disease. And that these things cannot be solved without each other. So the ultimate solution is actually to have something put everything together, put the cutting edge PET scanner right next to modern cyclotron equipment so we can serve the unserved and the underserved patients in Michigan and in the United States.

So this is a charge we request. We request a new CON category, allowed us to put a fixed novel PET scanners right next to the cyclotron-equipped radiopharmacy. Why do we want to do this? Because while we only -- only when we have this kind of facility and infrastructure, it will allow

us to serve those patients with different type of cancer, cardiac disease, neurological disease including mental disorder, depression, PTSD, including dementia, Alzheimer, Parkinson, childhood epilepsy, endometriosis, chronic pains, and also the most important part to me, to my heart is actually for pediatric patients. And I will explain why.

So let's take a look the whole-body PET. What is whole-body PET? If you remember the image you just saw before, all the images actually from half of a head to, like, maybe the end of your pelvis area. That's because the field of the conventional PET is actually not large enough and if you want to scan for the whole body, you're going to take a very, very long time. It's not just efficient. So we basically just assume all the cancer will not go lower to your pelvis and just ignore those kind of fact which is not true. So when we have a whole-body PET, that actually offer us 40 times more sensitive -- higher sensitivity than conventional PET. What does that mean? It means, number one, we can scan the patient 40 times faster. Meaning for a 40-minute scan right now it would only take one minute, and actually in clinical study we actually show people, we can -- we can take a 30 second scan for each patient and still achieve the same quality. And the second, we can actually use 40 times less radioactivities to the patient, still be able to achieve the same result as the current PET

can do. And we all know for radiation dose, the lower the better. And so that's actually another great advantage when we actually apply whole-body PET to the plenum.

And the third thing is that that's why it is critical for a pediatric patient. A lot of pediatric patients, child patients, their disease can be benefit by PET technology. The reason they are not doing PET are two. Number one, we are worry about a radiation dose we inject to the kids will actually affect their development. Number two, because we need them to stay in the PET scanner for 40 minutes to scan, so usually we need to sedate a patient and that may have some neurological effect and that's why only if it's really, really necessary, then we can -- we can actually -- we will do the PET to the kids. When you apply the whole-body PET with 40 times sensitivity, every kid can stay in the scanner for 40 seconds without moving and we can inject way less radiations to the kids. So all of a sudden it will make this technology available to the kid patient with cancer, with epilepsy, with some neurological disease and then we open a brand new field to them and we can serve them way better. So that's a big advantage of using whole-body PET.

And these (indicating) are just some images of whole-body PET with extremely high resolution, high sensitivity, and we can serve more patients with high

throughput.

And a PET/MR right next to the -- to the radiopharmacy will allow us to use extremely short half-life tracer to look at cardiac disease and also neurological related disease. I want to mention there's one cardiac PET tracer. It's FDA approved and the insurance reimburse which has been proven it's very, very useful for diagnosis of cardiac disease noninvasively, but it's not available to most of the hospital. Why? It is because the half-life is only two minutes. You have to have a cyclotron right next to your PET scanner, then you can perform these kind of studies. And so for -- we have already over 50 PET/MRI scanner installed in the United States to serve the patients. In Stanford they have five PET/MR in one building. But we still only have zero in Michigan. Why is that? Is because, I mean, the tracer are not available so we can -- it doesn't make sense to put a MR over here.

So it is a powerful tool. You can see the imaging over here (indicating). Not only we can see the heart, but we can show which part of heart has stenosis, has inflammations. It's just that clear. For the brain images we can show which part of that -- of brain is affected by the Alzheimer's disease and we can track the neuro fiber to know which part we can cut up -- we should cut, which part we should treat. So this is actually why we need to have a

modern radiopharmacy adjacent to PET scanners with whole-body PET and PET/MR.

So BAMF Health is not just saying it. We're actually building a modern radiopharmacy in Grand Rapids right now and Doug -- partner with MSU and Doug Meijer Medical Innovation Building. The ground has been broken in November 2019. We're trying to open it in February 2022. And this (indicating) is actually the pictures of what the building is going to look like. The radiopharmacy will be located at the first floor and this (indicating) will be our diagnosis clinic locate -- we're going to put in a whole-body PET and the PET/MR right next to the radiopharmacy. And the second floor will be our therapeutic clinic over here so we can offer the very good patient experience and quality of care to our patients over here. And this (indicating) is actually the photo we took by this -- just this week. The top floor has been finished so it's very, very exciting moment.

So this is actually my presentation. The request and charge is actually we hope that we can work with the CON Commission to initiate a new category of fixed, novel PET scanners including whole-body PET and the PET/MR adjacent immediately to modern cyclotron-equipped radiopharmacy so we can actually serve unserved and the underserved patients in Michigan and the United States. Thank you for your time.

MR. FALAHEE: Thank you very much. Very informative. Let's start by any questions from the Commissioners, please?

MR. HUGHES: I have a couple. So I'm sorry. This sounds great in theory and all that kind of stuff, but I don't quite understand what it is in the regulations that are preventing that from happening now. I didn't kind of connect the dots. And whatever it is in the regulations that is preventing it, what are they designed to do that is a good thing that we're stopping this, if you could start with that? And then I'd love to hear a little bit more about the cost of the facility and the cost of the treatment.

DR. ANTHONY CHANG: Yeah. So there are several question. I heard one is the regulatory part and the cost of -- facility cost of the treatment.

So number one, I think the biggest problem we have over here in Michigan is actually the CON regulatory around the PET is based on a condition we can have by using FDG. So, when we are trying to initiate a PET applications, I mean, we need to offer the information about, oh, what kind of disease we can treat and patient population, but all those kind of diseases -- the available tracer called FDG. What we are trying to do over here is everything but FDG. So PET is actually the technology allowed us to use the wide

variety of the tracer designed to look for different kind of diseases so we can make an early diagnosis and really know the molecular activities happening in the patient's body. And the wide variety of trace- -- we are going to have different kind of tracers for each type of cancers and Alzheimer disease, Parkinson, like PTSD, dementia or cardiac disease and those are the things has not been considered or included by current CON regulatories. And that's why for us to apply this kind of initiation through the current CON regulatory is very hard because this is a brand new categories. So that's actually -- that's actually number one.

And the number two thing is actually the -- the actually requirement for the conventional -- the regulatory of the CON right now is actually focused on the PET's capability using for diagnosis purposes. So like, for example, you actually have a cancer and we can use FDG and you can use FDG as a diagnosis or staging. But for our usage, we're going to use the PET not only for early diagnosis and a staging tool, but also going to use as a monitoring tools along the way while we are treating the patients. This is actually a brand new concept in the uses of a patient of the PET and which has been proven is very useful while we were doing clinical trial in Germany. So -- and that's actually the -- not included in current CON

regulatory, too, and that's why we will -- we are propose this kind of charge and allow us to bring this new technology to Michigan and also to the United States.

So in regards to the cost of this kind of facility, number one -- and the radiopharmacy depends on how big or how small. I mean, the basic price is about 10 to 15 million dollars to build a radiopharmacy, but once you build a radiopharmacy, it can actually last for about 20 to 25 years. They have about a cyclotron inside and all the facility allowed us to manufacture wide variety of the drugs.

And for the clinic, what we are trying to do is actually the flagship in Grand Rapids over here so the scanner whole-body PET is about 13 to 15 million dollars and PET/MR is 3 to 5 million dollars. The -- and that's basically the price tag of this type of facility. However, I want to mention is even the price, that sounds high, but it is -- but the benefit and the impact will be very, very high, too. Because right now if you -- you can have enough accessibility of the PET scanner, of PET scan using the novel tracers, we can significantly lower the cost of overall costs of health care. Meaning we can prevent a lot of unnecessary procedures and also catch disease way earlier. Based on our study in Germany, we actually have already approved using this new technology in treating

prostate cancer. We can actually prevent 50 percent unnecessary conventional radiation therapy. For example, a lot of prostate cancer patients when they PSAs start going up, we still cannot see where it is, then we -- based on the current protocol, we have to do something called a salvage radiation. Meaning just you radiated the whole pelvic or prostate bed, just assume the tumor is there. But we also know 50 percent of the patients, their prostate cancer is not there because based on our study what now we can see where they are, we know 50 percent of patients that the prostate cancer has been moved out of the pelvic area. So that just for the external being salvage radiation therapy, 50 percent is actually not necessary. And so by using this technology, we can actually prevent unnecessary procedure including surgery, radiation therapy, and also the potential side effect which will last for a long time.

So be able to make the correct, precise diagnosis and even this facility at first begin looks high, but overall cost is going to be for the health care for this kind of devastating disease will actually significantly lower because we don't waste the medical resource and doing unnecessary procedures over there.

So and then in regards to the cost of these kind of procedures, in Germany the price is about $15,000 -- 15,000 Euros for one procedure, meaning one diagnosis and

one treatment. In the United States we're thinking the price will be higher, but because the efficiency of our radiopharmacy right next to the PET scanners we don't waste the radioisotopes so we don't see that will actually keep significantly higher than the -- than -- than the Germany price. But so that's actually the short answer for -- for your questions.

MR. FALAHEE: Are there other -- Denise, I see you raising your hand. Commissioner Hughes, do you have any follow-up questions?

MR. HUGHES: No. I'm going to listen to the others first in case I do.

MR. FALAHEE: Your initial question, Commissioner Hughes, is one I'm going to eventually turn to Tulika and Brenda and Beth and say why can't we do this now and --

MS. BROOKS-WILLIAMS: Uh-huh (affirmative).

MR. FALAHEE: -- (inaudible). So that's a heads up to Brenda and Beth and all. Denise?

MS. BROOKS-WILLIAMS: Well, my question -- Commissioner Brooks-Williams -- is very similar to yours, Chip, to say what is the path, right. So I understand what Dr. Chang is saying are some of the barriers, and I think Bob's questions are great as well. But, I mean, how does something like this come to be? Is this a Commission, you know, exercise or is it the Department research reviewing it

and bringing forth language that would include it in the standards?

MR. FALAHEE: Right. And we have a new tech committee that hasn't met in awhile so, again, Denise, you're exactly along the same lines I'm at as, okay, where do we go from here? What's standing in the way, if anything, now under CON? And before I turn that over to Brenda and Tulika and Beth, I want to know if anybody else has anything they'd like to ask questions about amongst the Commissioners?

MR. ROGER SPOELMAN: Chip? Can you hear me?

MR. FALAHEE: Hang on, Roger. Roger, hang on one second. We're not going to do public comment on this because this is just a presentation. But I knew that Dr. Chang and Roger were here on behalf. So Roger, if you want to add anything and then I'm going to turn it over to Brenda, Beth and Tulika about the CON questions we asked. So, Roger, go ahead.

ROGER SPOELMAN

MR. ROGER SPOELMAN: Great. Thank you very much. My name is Roger Spoelman. I'm a former Trinity Health executive, retired, but I failed retirement and I got connected with Dr. Chang and I'm happy to serve as the chairman of the board of BAMF Health.

But I just wanted to add one thing to Anthony's

presentation, that currently in the United States because of the limitations of this technology, the length of time it takes to scan, the fact that we only have one unique tracer which doesn't -- by the way, this tracer does not work for prostate cancer because prostate cancer doesn't respond to FDG which is sort of a -- it's a -- I call it -- I'm a layperson, but it's kind of an amped up glucose. Prostate cancer doesn't respond to glucose. Many cancers do. But because of that, this -- and then currently there are about a million to a million and a half PET scans utilized in the United States per year and that's due to the fact that the technology is old as Dr. Chang mentioned and it's been sort of a dormant discipline in medicine and the advent of this new scanner, full body, rapid cycle, high resolution scanner has given rise to the development of these other unique tracers that Dr. Chang has developed with his colleagues in Germany and elsewhere. So I just wanted to make that comment. So thank you very much for allowing me to comment.

MR. FALAHEE: Yeah. Thank you, Roger. Welcome back from retirement by the way.

MR. ROGER SPOELMAN: Thank you. I'm having a blast.

MR. FALAHEE: Good. Let me turn it over to the people that always sit to our right to see what they've got to say about this, what next steps are. Is there anything

standing in the way now? Where do we go from here?

MS. NAGEL: Hi, Chip, and the Commission. This is Beth sitting to your right today. We had a similar, a more, I guess, expanded presentation from Dr. Chang and his colleagues sometime before COVID-19. I couldn't tell you when it was exactly. But so it was awhile ago and that meeting was really exploratory to see how this technology that they're offering fits in the standards, the current CON standards. And we really found that it was kind of like, you know, taking a square peg and trying to put it into a round hole. The technology that they're presenting does not fit into the current PET standards today. And I think they've explained a little bit very technically about it and I don't -- I couldn't even wade into the waters of their technical explanation except to say that the way that the current CON standards envision the utilization of the PET technology is completely different than the technology that they're presenting. And so from our perspective we said, you know, please present this to the Commission to see if there's appetite amongst the Commission to direct the current -- there's a PET workgroup on your work plan for later this year -- to add to that charge something to explore this -- if this technology -- what the parameters are and if it should be put in the current PET standards. So what we're really asking, at least from the Department

perspective, is to amend the current workgroup charge that you set at your January meeting for PET to include exploring this type of technology.

MR. FALAHEE: Okay. Thanks for that explanation. When Dr. Chang was presenting I kept thinking what's standing in the way now. So thank you for explaining that. And any questions amongst the Commissioners of Beth and what she was just talking about? Beth, would we need like a formal motion then to add this topic to the PET work group?

MS. NAGEL: Yes, I believe so.

MR. HUGHES: This is Commissioner Hughes formatting a motion to add to the PET workgroup language to investigate this area more closely.

MR. FALAHEE: Thank you.

MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams, support.

MR. FALAHEE: Thank you both. Any discussion amongst the Commissioners? Okay. Hearing none, following the format we've used earlier, is there any objection to that motion? Hearing none, that motion carries.

(Whereupon motion passed at 10:56 a.m.)

MR. FALAHEE: So Dr. Chang, thank you. I got a hunch you'll be attending some meetings of the workgroup.

DR. ANTHONY CHANG: Thank you very much. Thank you for all your time and attention. I really appreciate

that.

MR. FALAHEE: Great. Thank you. Roger? Roger, good to see you.

MR. ROGER SPOELMAN: Thanks everyone. Great to see you all.

MR. FALAHEE: Thank you. Thank you both.

MR. ROGER SPOELMAN: Bye-bye.

MR. FALAHEE: So let's move on to our remaining agenda items. The next would be a legislative update and that's under me. It will be real short. The legislature like all of us in the health care business, it's been all COVID all the time and they're just now starting to look at some other health care issues, but we're not certain how much longer as I said earlier the legislature will be in session. They may be adjourning here very shortly for the bulk of July and August, we're just not sure. So it's more of those stay tuned and we'll see what happens. It is an election year and normally in election years they like to be out campaigning in the summer months. That's pretty much what I've got from the legislative update. So I'll then turn it over to Tulika for the CON evaluation section update. Tulika, please?

I mean, before Tulika starts I got to say wearing a hospital hat and I know many of the Commissioners wear hospital hats, too, Tulika and her Department, Larry

Horvath, LARA and their Department did yeoman's work during the COVID surge to bring up extra hospitals -- up extra hospital beds. I just want to thank her and everybody publicly for doing that and for all the work they've done. It's rare that I have the opportunity to talk to Tulika on a Sunday afternoon about expanding beds. So she and her whole team put in countless hours. So, Tulika, thank you on behalf of all of us in the health care community.

MS. NAGEL: Chip, this is Beth. If I could -- I think that Tulika is too humble to mention this, but I wanted to just give a couple comments as well. I just wanted to say that Tulika and her staff processed over 100 emergency Certificate of Need applications and made a determination in the matter of less than 24 hours in most of those cases. And just for some context, we do about 200 to 250 applications a year. So doing 100 in the matter of a couple of weeks is really tremendous and really speaks to the teamwork and to the dedication to the job and the dedication to the citizens of Michigan that Tulika and her staff routinely display. So they really have done an impressive job and it has been recognized widely throughout the Department that they are some unsung heroes of this entire response, the Department's response to this unprecedented pandemic. So I just wanted to thank them and give you a little context of exactly what they've done which

is an unimaginable workload.

MS. BHATTACHARYA: Hi. This is Tulika. Thanks, Beth, and thank you, Commissioner Falahee. I will accept all of those on behalf of my team and on behalf of the Department. It's not always that CON, we get thank yous from people, but these last three months really showed us why we chose the profession of civil service and happy to help and we were happy that we could be there when you guys needed us.

So we provided all of the reports in your packet and I apologize, there were too many of them because we missed the March meeting. So there are two quarterly reports in your packet for compliance activities and program activities. As Beth was saying, we continue to review applications and issue decisions on a timely basis and you can see those in the reports that we provided.

Just a little bit of details on the emergency CON's. Since the reports ended in the second quarter which is end of March, you don't see all of the statistics in there. So out of the 100 emergency CON applications, there were 80 for hospital beds, 11 for nursing home beds, two for psych beds and five for swing beds. And through these emergency applications we approved a total of 4,871 hospital beds, additional beds; 314 additional nursing home beds; 47 psych beds; and 77 swing beds. There were also three

emergency CON's for emergency lithotripsy host sites at locations where services were needed. And as far as the -- sorry, lost my thought.

In your packet there are also two special reports reporting to the Commission the results of our statewide compliance reviews for MRI services and PET scanner services. The PET scanner services, they were -- we found all of the services in compliance and there were only one network that was out of compliance and there was a settlement agreement -- there is a settlement agreement between that provider and the Department. For MRI service, I cannot say the same thing. Volume was or still is a widespread issues. Services are struggling to meet their maintenance volume. So in MRI, we ended up having 68 settlement agreements, 36 of them are for mobile networks, 12 of them are for host sites, seven are for hospitals and 13 are for freestanding facilities. So most of the mobile networks are struggling to meet their maintenance volume of 5500 MRI adjusted procedures per unit.

Other than that, in this year FY2020, we are proposing that we want to do statewide compliance review for surgical services, but given everything is going on and depending on our workload, we'll see how far we go with that. But my team is working very hard to do -- to review all of the surgical facilities and evaluate their volume and

other product delivery requirements under the standards. They were approved and we will bring the results back to the CON Commission at a later date. We are also doing the statewide compliance review for air ambulance services.

With that said, I'm happy to answer any questions from the Commission.

MR. FALAHEE: Any questions from the Commissioners? I will add those of us in the hospital business and others as well know that pursuant to the Governor's executive order, we ceased surgeries and procedures middle of March and we're still in the process of ramping them up. So any entity that is having their surgical volume looked at, they're not going to meet the criteria because of what we've gone through and will continue to go through. So, Tulika, just so -- I know you're aware of it, but just so you know. Any questions from the Commissioners about what Tulika presented to us? Okay. Thank you. Tulika, anything else?

MS. BHATTACHARYA: No. I don't think so. Thank you for your time.

MR. FALAHEE: Okay. Well, thank you again. Appreciate everything you did and Larry Horvath as well. So thanks to everyone for all the work. Next we'll turn it over to the next agenda item which is the legal activity report. Carl, I know you're on the phone somewhere.

MR. HAMMAKER: Thank you, Chip. Yes, this is Carl Hammaker from the Attorney General's Office. As everyone knows the courts basically have shut down during COVID are now just in the process of reopening, so I don't have a lot of updates regarding ongoing litigation. The only thing I'll note that's new, there was a new administrative appeal to a comparative review for psychiatric beds that was filed and it is scheduled for a prehearing coming up. Otherwise, there hasn't been any movement in the ongoing litigation that's noted in my written reports. Otherwise, we continue to be available to offer advice to the Commission and the Department.

MR. FALAHEE: Carl, thank you. Offering advice may impact the next agenda item as our future meeting dates, September 17 and December 10. I don't know if we'll be getting together in person or this way again. Carl, just a question down the road, depending on what executive orders are in place or not, or whether there's a state of emergency in place or not, we'll probably have to turn to you just before the September meeting, you know, maybe even December to say can we still meet via Zoom or must we try to meet in person? We don't need an answer now because we don't know what things will be like in September, but just a potential heads up for you.

MR. HAMMAKER: Thank you, Chip.

MR. FALAHEE: All right. Next agenda -- we've done future meeting dates -- item 15, public comment. Is there anyone on the call that would like to make any public comment, please?

MS. NAGEL: This is Beth. Just a reminder, that if you're on the phone line and not on Zoom itself, you need to press *6 to be unmuted.

MR. FALAHEE: Thank you, Beth, for that reminder. Okay. Hearing none, we'll continue on. Brenda, the review of the Commission work plan, please?

MS. ROGERS: This is Brenda. Sorry. I lost my connection earlier, so -- but I am back. So you have the draft work plan in front of you. The only potential change that I didn't catch because I was not connected was what was the decision on the presentation made?

MR. FALAHEE: We're going to add -- we're going to add that as an agenda item for the PET workgroup.

MS. ROGERS: Oh, okay. All right. So we're going to add a charge to the PET --

MR. FALAHEE: Yes.

MS. ROGERS: -- workgroup. Okay. Thank you. So that will be -- that really doesn't impact the work plan, so to speak, but we will update the charge then based on that. So I believe the work plan as drafted in front of you is what we would recommend taking action on today. Thank you.

MR. FALAHEE: So we would need a motion and a second to accept the work plan as it's been presented; correct, Brenda?

MS. ROGERS: That is correct.

MR. FALAHEE: I'd entertain a motion for that.

MS. BROOKS-WILLIAMS: So moved, Commissioner Brooks-Williams. I move that we accept the work plan as presented.

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

MR. FALAHEE: Thank you both. Any discussion? Any objections to that motion? Motion carries. Thank you.

(Whereupon motion passed at 11:09 a.m.)

MR. FALAHEE: Next item, election of officers. And this is the time when every year we select a chair and a vice chair. Currently I'm the chair, Tom is the vice chair. Much to my surprise, I thought I was term limited. I'm not. I still have one year left if you so chose. But we need to elect a chairman and a vice chairman for the ensuing year.

MS. BROOKS-WILLIAMS: This is Commissioner Brooks-Williams. I move that we elect Chip Falahee as our chair and Tom Mittelbrun as our vice chair.

MR. FALAHEE: Is there support for that motion?

MR. HUGHES: Commissioner Hughes, second.

MS. GUIDO-ALLEN: Guido-Allen -- yup, second. (inaudible) Robert.

MR. FALAHEE: Any discussion? All right. Any objections to that motion other than Tom and I? No. All right. That motion -- no objections, that motion carries.

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

MR. FALAHEE: Thank you all. Thank you for your continued somewhat faith in what Tom and I do to lead it. I will note that if you go to the CON Commission web site -- and Beth and Brenda and Tulika and Carl and I talked about it last week along with Tom, five of us 11 Commissioners have had our terms expired. Denise and I, our terms expired in April of 2019. We have made repeated -- we've talked to the Appointments Office repeatedly and still haven't heard anything back, so who knows? I know that at some point we've got five out of 11 now that are sort of in limbo. If it gets to be more and it's a quorum, then I think that's a serious issue and we need to do something to move it forward. I'll continue to keep contacting the Governor's Appointments Office. I know that Beth and Carl have the ability to get ahold of that, too. I see the Governor is making appointments in between all of her executive orders, but it's something we -- that I've never seen happen in 30 years of doing CON work, so just a heads up for everybody.

Anything else to come before the Commission before we do a motion for adjournment? I want to thank everybody for putting up with this new format. I thought it went

well. If anybody has any thoughts or suggestions about what we could do better next time, by all means get those to me and Tom or to Beth and Brenda, glad to put those into place, if you will. Anything else? All right. If not, I would entertain a motion to adjourn.

MS. BROOKS-WILLIAMS: So moved.

MR. HUGHES: Chip, before we do --

MS. BROOKS-WILLIAMS: Oh, sorry.

MR. HUGHES: Oh, I think I would second that, but do we change our name to the lame duck CON Commission?

MR. FALAHEE: Not yet. Not at this point. But thank you. All right. So is there a motion to adjourn?

MS. BROOKS-WILLIAMS: So moved, Commissioner Brooks-Williams.

MR. HUGHES: Second.

MS. LALONDE: LaLonde, second.

MR. FALAHEE: Any objections? All right. Thank you. All right. That motion is approved. Thank you, everyone. Stay safe. We'll see you all wherever. All right. Thanks very much. Bye-bye.

(Proceeding concluded at 11:13 a.m.)

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