1 STATE OF MICHIGAN
2 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
3 CERTIFICATE OF NEED COMMISSION
4
COMMISSION MEETING
5
BEFORE AMY L. MCKENZIE, M.D., CHAIRPERSON
6
333 South Grand Avenue, Lansing, Michigan
7
Thursday, March 17, 2022, 9:30 a.m.
8
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10 ERIC FERGUSON, M.D.
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Certified Electronic Recorder
21 Network Reporting Corporation
Firm Registration Number 8151
22 1-800-632-2720
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1 Lansing, Michigan
2 Thursday, March 17, 2022 - *9:35 a.m.
3 DR. MCKENZIE: Good morning, everyone. Can
4 everybody hear me okay? Okay. Great. We're going to -- I
5 know we had a couple technological challenges at the last
6 meeting and we're trying to mitigate those, so please put in
7 the chat if you are having difficulty hearing the different
8 commissioners. During the meeting today, given that we are
9 hybrid as well as in-person, I would ask as a reminder to
10 myself as well, commissioners to speak loudly. We do have a
11 couple people in the room as well in addition to our
12 reporter. So we all need to remember that even though we
13 can hear ourselves, that we need to speak up so that those
14 in the room can hear us as well.
15 So I'm going to call us to order today. We do
16 have the requisite group here to meet a quorum, and kick us
17 off and wish everybody a Happy St. Patrick's Day. So I
18 appreciate you being here this morning. I do want to remind
19 as we walk through the meeting today we have several here in
20 person for public comment and I know that we have people
21 joining us online as well, so please during your public
22 comment period, I just -- just a quick reminder that those
23 public comments are restricted to three minutes. That's
24 typically what we provide to all who are providing public
25 comment. For our commissioners, if you can remain on mute

1 when you're not speaking and then when you are speaking,
2 come off of mute on your technological device on Zoom in
3 order to be able to speak. Hopefully we can have everyone
4 heard today. Okay. So those are my reminders at the outset
5 of the meeting today.
6 Our first order of business is a review of the
7 agenda which is in front of you and you should have received
8 that in your packet. So I'll give you a moment. And I will
9 take a motion unless there are any additions to the agenda
10 today.
11 MR. HANEY: Don Haney, move to approve the agenda
12 as presented.
13 MR. FALAHEE: Commissioner Falahee supports.
14 DR. MCKENZIE: Thank you. Any discussion? Okay.
15 I'm going to do consent agenda on this. All in favor?
16 ALL: Aye.
17 DR. MCKENZIE: Any against? Okay. The agenda
18 passes.
19 (Whereupon motion passed at 9:37 a.m.)
20 DR. MCKENZIE: Next order of business is
21 declaration of conflicts of interest. That conflict of
22 interest is in your packet. Are there any commissioners
23 that needs to declare a conflict of interest?
24 MR. WIRTH: Can you put -- put your mute on.
25 DR. MCKENZIE: Okay. Can all of the commissioners

1 mute if they're not speaking?
2 DR. FERGUSON: I'm muted. I can't hear any audio.
3 UNIDENTIFIED SPEAKER: It's coming through your
4 speakers.
5 DR. FERGUSON: No, I realize that. It wasn't two
6 seconds ago.
7 DR. MCKENZIE: Okay. We're going to hold for just
8 a minute. We have a technological issue. Thank you,
9 everyone, for your patience. Okay. So hearing no conflicts
10 of interest, our next order of business is review of the
11 minutes. The minutes are in your packet. I'll give you a
12 moment to review those and then I need a motion.
13 MR. HANEY: Don Haney, move approval of the
14 minutes.
15 DR. MCKENZIE: Thank you. Do I have a second?
16 MR. FALAHEE: Commissioner Falahee, move approval.
17 DR. MCKENZIE: Thank you. Consent agenda on this.
18 All in favor?
19 ALL: Aye.
20 DR. MCKENZIE: Any against? Okay. Minutes pass.
21 (Whereupon motion passed at 9:39 a.m.)
22 DR. MCKENZIE: The next item on the work plan as I
23 mentioned at the outset, our last meeting was a little bit
24 challenging as we were trying to manage our first real
25 hybrid meeting with technology. And one of the things that

1 got left off was the approval of the work plan at the last
2 meeting. So you will see two work plans on your agenda
3 today, one at the beginning which is a hangover from our
4 last meeting, and then one at the end where we're going to
5 be approving the work plan for this meeting. So the work
6 plan from January 27th is in your packet for all of the
7 commissioners and I will open it up for any discussion or
8 concerns. We did review the work plan last time, so I'm not
9 going to have anybody walk through it. It is there for your
10 review. And if there's no discussion, then I can entertain
11 a motion.
12 MR. FALAHEE: This is Commissioner Falahee. I'll
13 move for approval of the work plan as tried to be approved
14 at the January 27th meeting.
15 DR. FERGUSON: Ferguson, I'll second that.
16 DR. MCKENZIE: Thank you. All in favor?
17 ALL: Aye.
18 DR. MCKENZIE: Any against? Okay. January 27th
19 work plan is passed.
20 (Whereupon motion passed at 9:41 a.m.)
21 DR. MCKENZIE: Our next item on the agenda is
22 Heart/Lung and Liver Transplantation Services. And then
23 just to set context and reminder for those that were not at
24 our last meeting, this was an item that was brought in to
25 public comment and it was somewhat late breaking. We

1 received it within a couple days of the meeting. And
2 therefore, as opposed to action, the Commission determined
3 that we wanted to place this onto this March agenda in order
4 to allow time for additional public comment related to the
5 transplant standards. So I do have a public comment from
6 Mercy Health St. Mary's, Dr. Matt Biersack. And if Dr.
7 Biersack wants to head to the podium, he can present. I'll
8 just remind you that your public comment is three minutes
9 time frame. So -- there are also some materials in your
10 packet, some slides that were submitted related to this
11 item, so, for the commissioners to review. And give us just
12 a moment, everybody, on the meeting as we get -- make sure
13 that Dr. Biersack can be heard by everybody who's on the
14 hybrid portion of the meeting.
15 MATTHEW BIERSACK, M.D.
16 DR. MATTHEW BIERSACK: Okay. So as mentioned, I'm
17 Dr. Matt Biersack. I appreciate being able to speak to you
18 all this morning. We're a ministry of Trinity Health and
19 I'm here to follow up on a public comment that was first
20 submitted in October and then addressed again at the
21 February meeting, specifically requesting review of the CON
22 standard for Liver Transplant Services. Both for two-fold
23 reasons: to respond to changes in population and patient
24 need and as well to improve access and outcomes related to
25 this population.

1 I think there's a few compelling reasons to do so.
2 First, that the standard has not changed since 1988 and the
3 underlying causes and incidents of disease that lead to
4 transplant or that are treated with transplant have
5 continued to grow. The American Cancer Society reported
6 this year that the incidence of liver cancer, particularly
7 hepatocellular carcinoma, has more than tripled since
8 approximately the time when the standard was last reviewed.
9 The CDC has reported that the incidence of chronic liver
10 disease and cirrhosis have steadily increased over the last
11 15 to 20 years, and the population growth has been
12 substantial. And if you look at the next slide --
13 especially within lower western Michigan. So the population
14 across the state has grown approximately 30 percent in --
15 excuse me, in west, lower western Michigan 30 percent since
16 the standard was last reviewed. If we look at the
17 population rates of growth within the county areas of
18 Ottawa, Kent and Allegan, they're far outpacing Southeast
19 Michigan where the only transplant centers are located. And
20 it looks like that that will continue to be a trend. And
21 that distance from transplant center has a substantial
22 impact.
23 And a couple points here I really want to focus on
24 is that, you know, I think it is contributing to a lower
25 percentage of transplants when we compare the growth of

1 transplantation to national standards. Michigan has grown
2 only 159 percent, nationally it's been 377. And research
3 has shown that there's adverse consequences to this and
4 that's why, you know, I'm really imploring for an early
5 review, and that's that there's lower likelihood to be
6 placed on a wait list, lower likelihood to receive a
7 transplant and a patient's greater likelihood of death. And
8 I think publicly available data around transplant has really
9 reaffirmed this. If we look per capita the rate of
10 transplant in the three-county area of Wayne, Oakland and
11 Macomb is 30 percent higher than Kent, Ottawa and Muskegon.
12 If we look at the rate to wait list per capita, it's 35
13 percent higher in that three-county Detroit area than it is
14 for Kent, Ottawa and Muskegon. So in response to a comment
15 that was made at the February meeting, I don't think that
16 this is just about a supply issue. I think it's about an
17 access issue. And I think the state has real disparities
18 and for that reason shouldn't wait on this review.
19 You know, I think we have a wealth of experience
20 at Mercy Health St. Mary's in transplant and we're well
21 positioned to look at this and support looking at a new
22 standard. We've had a busy kidney transplant program for
23 some time and there's some question as to why we didn't
24 bring this forward earlier. But we have had a change of
25 leadership and that leadership, including me as president of

1 the organization, has really looked at how we best serve our
2 community and the broader needs of west Michigan residents.
3 And so I just appreciate the time this morning. I think the
4 data is fairly clear and I'd just kindly ask for your
5 consideration to review this request prior to its normal
6 cycle.
7 DR. MCKENZIE: Great. Thank you to Dr. Biersack.
8 Before I ask if there's any other public comment, does
9 anyone from the Commission have any questions for Dr.
10 Biersack?
11 MR. FALAHEE: Dr. Biersack, this is Commissioner
12 Chip Falahee. It's weird when you're in hybrid mode.
13 There's, like, a slight delay. So I may be echoing myself
14 and echoing to you, so I apologize in advance for garbled
15 nature.
16 I understand change of leadership. Welcome to
17 your role at head of St. Mary's. A question I've got is we
18 have this set up in our work plan to look at on a regular
19 basis like we do all the other CON standards. So I get with
20 the change of leadership, "Hey, we should look at this."
21 But I think we as a Commission need to look at it on a
22 statewide basis and look at that as a whole and keep with --
23 why shouldn't we keep with the current cycle of standards of
24 review for this like we have for everything else? I mean,
25 here we have -- I don't disagree. I live in Kalamazoo and

1 I've had friends that have had transplants in Ann Arbor and
2 the Detroit area. They've gone fine. So I get the issue of
3 the west Michigan issue. But why take this off cycle?
4 DR. MATTHEW BIERSACK: I think it goes back to
5 what I mentioned about a growth in terms of the diseases and
6 conditions that are treated with transplant and a growth of
7 that population. So if we wait an additional two years, you
8 know, what we're not serving in my opinion residents in west
9 Michigan who are going to be impacted by, again, a lower
10 likelihood to be wait listed, lower likelihood to be
11 transplanted. And for those patients who are on the wait
12 list a greater likelihood of death. And so that's, in my
13 opinion, the lives and morbidity that we could avoid by
14 waiting -- by not waiting an additional two years.
15 MR. FALAHEE: Thank you.
16 MS. GUIDO-ALLEN: Commissioner Guido-Allen.
17 Question for you. Can you hear me?
18 DR. MCKENZIE: Can you unmute?
19 MS. GUIDO-ALLEN: Oh. Can you hear me? Help us
20 understand what the impact of an additional liver transplant
21 site would -- how would that impact the availability of
22 organs for transplant? You can't hear me?
23 MS. NAGEL: We can't hear you on the Zoom.
24 DR. MCKENZIE: It's we can't hear you on the -- on
25 the Zoom. Are you muted?

1 MS. NAGEL: Are you unmuted?
2 MS. GUIDO-ALLEN: Oh, I'm sorry. No.
3 MS. NAGEL: Oh. Sorry about that.
4 MS. GUIDO-ALLEN: Okay. Can you hear me now? So
5 I just want to know what would the impact of a fourth
6 program in our state due to the availability of trans- -- of
7 organs to be transplanted, especially now with the fact that
8 organs move state to state and don't stay necessarily in
9 Michigan?
10 DR. MATTHEW BIERSACK: You know, it's a great
11 question and I think this is one of the questions that
12 ideally would be served by a workgroup with specialists in
13 the space, an advisory committee, et cetera. I think what
14 the data clearly shows is there is disparate access of two
15 centers and that that puts an undue hardship on transplant
16 recipients. And so, you know, I would hope that that would
17 be questions that would be wrestled with in that type of
18 review.
19 MS. GUIDO-ALLEN: Thank you.
20 DR. MCKENZIE: Any other questions by the
21 Commission for Dr. Biersack?
22 MR. HANEY: I have a question. Transplants are
23 very complex. The whole process is very complex. And the
24 acute care setting and the state is still dealing with the
25 pandemic and the backlog of cases that have -- procedures

1 that have been built up during the pandemic. And taking the
2 resources of the folks that are still trying to struggle
3 with all of that to do a workgroup kind of off cycle seems a
4 little counterproductive to me right now. How would you
5 address that?
6 DR. MATTHEW BIERSACK: I think thankfully I think
7 we are seeing a return, if you will, to normal acute care
8 operations over the last month at least, you know, we're
9 seeing that in a number of the systems within west Michigan.
10 And I, you know, your point is well taken. We all face
11 competing priorities and certainly responding to the backlog
12 of medical conditions, et cetera, that has kind of become
13 the situation now that we've addressed COVID for the last
14 two years is certain an important priority, but I don't
15 think it can take the eye off how we manage chronic disease.
16 I think we saw the -- how detrimental that can be in 2020
17 when we saw increases and incidents of death from
18 cardiovascular disease and neurocognitive disease, et
19 cetera. So I would -- I would -- I would encourage us to
20 not only think about COVID at this point in time but how we
21 manage what I think is another important chronic disease
22 that we face both as a state and as a local community and
23 address it accordingly.
24 DR. MCKENZIE: Any other questions for Dr.
25 Biersack? Thank you very much.

1 DR. MATTHEW BIERSACK: Thank you. Appreciate the
2 time.
3 DR. MCKENZIE: I'm going to ask Kenny who's doing
4 double duty with tech issues and monitoring the chat if
5 there's any other public comment that we have related to
6 Heart/Lung and Liver Transplant Services?
7 MR. WIRTH: Yes. Yes, so we have Dr. Abouljoud
8 from Henry Ford who'd like to speak.
9 REPORTER: Okay. I cannot hear that audio at all.
10 It's not coming out of here (indicating).
11 MR. WIRTH: I'm sorry, Doctor? Hold on.
12 DR. MARWAN ABOULJOUD: Yes.
13 MR. WIRTH: I'm sorry. We were having a problem
14 with the audio and the court transcriber we have.
15 DR. MARWAN ABOULJOUD: Yes.
16 MR. WIRTH: Would you mind starting again? I'm
17 sorry.
18 DR. MARWAN ABOULJOUD: Yeah. No problem. No
19 problem. From the beginning?
20 MR. WIRTH: Yes. Sorry.
21 DR. MARWAN ABOULJOUD: All right. Sure thing.
22 Sorry about that. Let me know if there's any other
23 interruption.
24 MARWAN ABOULJOUD, M.D.
25 DR. MARWAN ABOULJOUD: My name is Dr. Marwan

1 Abouljoud, director of the Transplant Institute at Henry
2 Ford, and I'm also joined by Ms. -- joined by Ms. Liz Reed
3 who's the vice president of transplant. And, again, I
4 represent Henry Ford Health System regarding Trinity's
5 request to have the Transplant Services standard review
6 ahead of schedule. And we do not support this request to be
7 reviewed early ahead of the schedule as mentioned earlier.
8 The request is geared toward changing the standard
9 to allow for more transplant programs in the state of
10 Michigan. We do not feel this is a necessity and could even
11 be detrimental to overall transplant access in Michigan in
12 the long run. We believe there is no added benefit for
13 Michigan to have another program in the state given that the
14 limiting factor in transplantation is not due to the lack of
15 transplant centers, but lack of suitable transplantable
16 donor organs and we continue to struggle with that.
17 Each year in Michigan approximately 220 liver
18 transplants are performed. The number has changed by mainly
19 10 percent over the last five years and mostly from
20 increased usage of risky organs or increased risk organs and
21 innovation in the use of these organs. Each of the three
22 transplant programs or centers in the state have capacity to
23 do more liver transplants. And adding an additional
24 transplant program will not decrease the number of
25 transplants, but rather dilute the number of transplants

1 performed in each of the existing centers which can impact
2 outcomes.
3 Demonstrated in the literature that there may be a
4 higher number of transplants performed by a center that is
5 needed to correlate with better outcomes and that number has
6 varied between 25 and 50 liver transplants, particularly
7 over 50 liver transplants to accommodate the increase of
8 organs. And this will have an impact on graph and patient
9 survival. It also decreases complications throughout the
10 transplant process. And most transplant centers when they
11 begin early, it takes over five years to settle in and get
12 those numbers anywhere near what we think is adequate for
13 quality.
14 As you consider this request, we encourage you to
15 keep in mind the following: program startup is extremely
16 expensive. It is not a kidney program. This is a much more
17 complicated and with staffing shortages, especially in the
18 pandemic, getting the skilled people will be very difficult
19 with increased resource costs and also possible recruitment
20 from adjoining transplant centers would expect these lives
21 and would impact the ability to deliver service at those
22 centers.
23 A new program will not to lead to more transplants
24 in Michigan. It dilutes the number of transplants that each
25 centers perform impacting quality. The most important

1 limiting factor I would say again is organ availability, not
2 programs at this time.
3 One of the key arguments is the issue of proximity
4 in southeast Michigan to, for patients to a transplant
5 center and the geographic outcomes on quality of
6 transplantation. This may be true in other states or other
7 published literature --
8 MR. WIRTH: Sorry, Doctor.
9 DR. MARWAN ABOULJOUD: Yes?
10 MR. WIRTH: If you could wrap up in a, you know,
11 few more sentences, we've run out of time.
12 DR. MARWAN ABOULJOUD: You bet. You bet. The
13 Transplant Institute at Ford has opened 32 outreach clinics
14 throughout the state including in Grand Rapids and northern
15 Michigan and eastern Michigan of which nine are liver
16 outreach clinics. And the outcomes of the liver program
17 exceeds national average and also it does not show a
18 difference in the geographic distribution of our patients.
19 And also, the number of patients transplanted for community
20 across the state of Michigan is very comparable. So --
21 MR. WIRTH: Sorry, Doctor.
22 DR. MARWAN ABOULJOUD: -- the shortage is outreach
23 clinics and would be happy to answer any questions.
24 MR. WIRTH: Doctor -- thank you.
25 DR. MARWAN ABOULJOUD: Thank you for your time.

1 DR. MCKENZIE: Thank you, Doctor. I'll ask if
2 there's any Commission questions?
3 DR. ENGELHARDT-KALBFLEISCH: I have a question.
4 This is Commissioner Engelhardt. I just want to make sure I
5 understand you correctly. In terms of the quality of the
6 transplants and survival data compared to national data. I
7 believe what I heard is that for residents on the west side
8 of the state there hasn't been any difference in your
9 program in terms of quality benchmarks and access. Is that
10 what I'm hearing?
11 DR. MARWAN ABOULJOUD: Yeah. Outcomes of
12 transplant patients and recipients across the state is no
13 different by geography. The percentage for population is no
14 different by geography and this is from the transplant
15 center. And the area where patients are listed is not the
16 primary driver whether patients get transplanted or not, but
17 whether the donors are recovered and within states or
18 markets, especially with the current organ application.
19 Thank you, Dr. Engelhardt.
20 DR. ENGELHARDT-KALBFLEISCH: Thank you.
21 DR. MCKENZIE: Thank you. Any further Commission
22 questions? Okay. Thank you, Dr. Abouljoud.
23 MR. WIRTH: We do have one more public comment
24 from Dave Walker at Spectrum Health. Dave?
25 DAVE WALKER

1 MR. DAVE WALKER: Good morning. Thank you for the
2 opportunity to provide comment on the CON standards for
3 Heart/Lung and Liver Transplantation Services. As Kenny
4 mentioned, my name is Dave Walker and I'm here on behalf of
5 Spectrum Health. We appreciate the comments made by Mercy
6 Health, however, we respectfully ask that the CON Commission
7 maintain the current review schedule and reconsider
8 Heart/Lung, Liver at its normally scheduled time in 2024.
9 Now, we're not saying the standards are perfect.
10 They were last updated in 2012, and rather given the already
11 full plate of standards scheduled for revision this year and
12 the continued ongoing response to COVID-19 pandemic and
13 catchup from the first surgeries and so forth, we believe
14 that these standards can wait and be taken up in the normal
15 cycle in 2024. Thank you, again, for the opportunity to
16 provide feedback on this proposal and I would be happy to
17 answer any questions CON commissioners may have.
18 DR. MCKENZIE: Thank you, Mr. Walker. Any
19 questions from the commissioners? Hearing none, is there --
20 thank you very much, Mr. Walker, for your testimony today.
21 Is there any further public comment?
22 MR. WIRTH: I do not see any further comment in
23 the chat.
24 DR. MCKENZIE: Okay. Thank you. So I will open
25 it up for Commission discussion, but before I do that, it

1 might be helpful to outline what the possible options are.
2 So I don't know if that -- Kenny, you would like to kind of
3 outline what our -- what our options are based on the
4 testimony and then we can open it up for Commission
5 discussion?
6 MR. WIRTH: Yeah. So this is Kenny with the
7 Department. Options would be for the Commission to decide
8 what proposed action you'd like to take today: if you'd
9 like to charge the Department with drafting language for
10 your review, workgroup or SAC to take a look at what the
11 charges you come up could be. So it's, you know, entirely
12 up to the Commission today to decide whether or not to do a
13 workgroup, SAC, or have the Department draft language.
14 DR. MCKENZIE: Sorry. I was getting off of mute.
15 Thank you. So if I understand it correctly, our options are
16 taking no action, the standards are up for review, the
17 standard process would be in 2024; to look at if we want to
18 put this on an agenda, you know, in future year; or seating
19 a SAC or workgroup now. I would remind everybody that we do
20 have, you know, we are not -- no longer under the full
21 pandemic options so a SAC is really, if we have a SAC, it's
22 going to have to meet in person. The only options for
23 virtual participation is with a workgroup. We have had some
24 difficulties at times seating SACs in particular and
25 sometimes challenges in seating workgroups even. So, and

1 there is, you know, we have a number of other things moving
2 forward. You have the work plans in front of you. So
3 that's an option as well, or drafting language. Given that
4 there's, you know, multiple portions of testimony I think
5 that, you know, if we were going to move forward with any
6 action, you know, a workgroup or a SAC's input probably
7 would be warranted. We have differing opinions on this
8 issue and it is an issue that oftentimes is discussed, you
9 know, during those workgroups and SACs. And I don't know if
10 any other -- I'll open it up for Commission discussion and
11 other's thoughts at this point.
12 MR. FALAHEE: This is Commissioner Falahee. I get
13 the issues here. Being in Kalamazoo, I'd love a
14 Heart/Lung/Liver program in Kalamazoo or in Grand Rapids
15 instead of east Michigan, but I think what we've got here is
16 a situation where we've heard testimony on either side of
17 the issue and I think that it makes sense so we get a full
18 flavor of what's going on that we don't do anything right
19 now, that we leave it as is to look at again like we do the
20 other standards every three years. Look at it in 2024.
21 This was up. I understand, Doctor, you weren't there in the
22 leadership role, but it was up and wasn't brought forward.
23 I think it makes sense to wait. I don't think a workgroup
24 is appropriate for this issue. Having been on this
25 Commission for a few years, a workgroup does not work when

1 you've got issues on either side and you're going to have
2 five people saying one thing on one side and five people
3 saying something on the other. And that's, that requires a
4 Standard Advisory Committee, a SAC that we call. And,
5 again, as Commissioner McKenzie said, those need to be in
6 person. I don't want to get that in the way of this, but I
7 think it would merit a SAC. And the other issue is that we
8 on the Commission, we have to balance quality, access and
9 cost and try to look at all of those three issues. And
10 we've heard some people say the quality is the same, it
11 won't be impacted, access is okay now even for those that
12 live in west Michigan because there are clinics available,
13 and cost could potentially go up here to the extent a
14 program came in. So those are all open questions that I
15 think merit a full discussion, but I think that discussion
16 can and should wait until 2024 on the normal cycle. Those
17 are my comments. Thank you.
18 DR. FERGUSON: Commissioner Ferguson. Comment and
19 question in part about process and part about philosophy and
20 part about precedent. I understand that we have a standard
21 review cycle and that makes a lot of sense in part to create
22 structure, in part to create a safety net to make sure that
23 we look at things periodically. I don't know the history of
24 how we use for off -- how off cycle reviews are utilized. I
25 would suggest that if we believe that there is a potential

1 gap in care, that being open to off cycle review is
2 important because, again, I view the cycles of review kind
3 of as the safety net to make sure that we're looking at
4 things periodically and I'm not trying to create more work
5 for us. But if we think that there might be -- not that
6 there is. We don't know; right? That's the whole purpose
7 of having a SAC or a workgroup or whatever. But that there
8 might be a meaningful gap that for whatever reason was
9 overlooked in the past. I think we owe it to the population
10 to consider looking at it.
11 So I guess I would advocate short of some very
12 clear historic precedent on you don't do off cycle reviews
13 which, again, seems to me contrary to the philosophy of what
14 we're trying to do, that we at least consider looking at it.
15 Now, again, I'm not passing judgment on what a SAC outcome
16 should look like. That's the purpose of the SAC. But I
17 think we've heard -- yeah, we've heard conflicting
18 commentary. And to some extent that to me actually speaks
19 to the need to look at it is we don't know if there's a
20 need, but we should be open because somebody -- I think, you
21 know, at least one party has made a strong case that there
22 may be a gap. So I would advocate doing an off cycle
23 review, unless I'm missing some historical precedent here
24 that I'm unaware of.
25 DR. MCKENZIE: This is Commissioner McKenzie. It

1 is the ability of this Commission to make that
2 determination, that's why we're discussing this today. So
3 there's not a historical precedent. I think there are some
4 complexities around it that we've discussed, but there's not
5 a precedent. So if there's a, you know, a need, that
6 flexibility exists within the Commission and at the
7 commissioners' discretion. So I guess, you know,
8 Commissioner Ferguson, I would ask, you know, is that -- are
9 you intending to make a motion with your comments?
10 DR. FERGUSON: The first part was a dialogue
11 around it just to hear what others would have to say, but
12 unless I hear something otherwise, I would like to proceed
13 with a motion but I'd like to make sure that we have time to
14 dialogue either before or after a motion.
15 DR. MCKENZIE: That's fair. So -- go ahead.
16 MR. FALAHEE: Yeah. This is Commissioner Falahee.
17 I guess as a long-servant historian on the Commission, it is
18 rare to go off cycle because three years has tended to be
19 enough. As we go through it, things don't change that much
20 within the three-year cycle. And then from a workload issue
21 if we take one item off cycle, that just pushes other items
22 down and we've already got right now -- Kenny, correct me if
23 I'm wrong -- two workgroups and one SAC?
24 MR. WIRTH: We have two workgroups that are
25 wrapping up right now, then we're going to have a -- sorry.

1 We have two workgroups going right now that are wrapping up.
2 We'll then have a SAC starting end of April and an MRT
3 workgroup over the summer, and then we have a CT and a
4 Nursing Home workgroup starting up around September in the
5 work plan.
6 MR. FALAHEE: Right. Commissioner Ferguson, I
7 don't want to -- that workload doesn't get -- that's not a
8 reason to say no, it's just -- it's a logistical issue with
9 what the Department can handle and what that means. Even if
10 we said today, go --
11 DR. FERGUSON: Right.
12 MR. FALAHEE: -- there's three or four others in
13 the queue ahead of that.
14 DR. FERGUSON: Uh-huh (affirmative).
15 MR. FALAHEE: So that's the just why it's rare --
16 DR. FERGUSON: Yup.
17 MR. FALAHEE: -- for the Commission to take
18 something off cycle.
19 DR. FERGUSON: Right. That's fair.
20 MR. FALAHEE: Just logistics.
21 DR. FERGUSON: I guess the motion that I would put
22 forward -- and somebody can help me craft the language
23 because I won't get it structured quite right -- would be to
24 ask the Department to draft language that the Department
25 deem to be appropriate if we want to review these standards

1 off cycle and bring back to the Commission here to vote nay
2 or yea on adopting that off cycle review. Or do we decide
3 up front on that? I mean, I guess that's the question. And
4 this is where I need help with process.
5 MS. NAGEL: Could I ask for clarification, Dr.
6 Ferguson? Are you asking for the Department to come back
7 with language to accomplish a specific goal at the next
8 meeting?
9 DR. FERGUSON: Setting aside the motion. I would
10 like to proceed with considering an off cycle review. My
11 question is, is what's the best way to entertain that? Is
12 it a we commit here to an off cycle review and hand it to
13 you to sort out, or do we ask you how would we sort out an
14 off cycle review and you come back to us with a up or down
15 vote on proceeding with off cycle review? There's two ways
16 to do -- to do it and this is where I don't understand
17 process enough.
18 MR. FALAHEE: And this is Commissioner Falahee.
19 Actually, I think there's a third way to do it. And the
20 third way to do it is for the Commission now to vote up or
21 down on doing an off cycle review.
22 DR. FERGUSON: That's fine.
23 MR. FALAHEE: If the Commission said yes to that,
24 then the Department would then proceed and then -- let's say
25 we said yes to an off cycle review, yes to a Standard

1 Advisory Committee, then the Department would probably --
2 and then the Commission would say, sorry, we entrust to the
3 chair and the vice chair of the Commission to have the
4 nominations fulfilled for the Standard Advisory Committee
5 and for the chair and the vice chair to select a chair and
6 vice chair of the SAC, then the Department can move forward
7 like any other SAC.
8 DR. FERGUSON: Okay.
9 MR. FALAHEE: So I think --
10 DR. FERGUSON: That's fine with me. I mean, I'm
11 fine with that. I mean, I know we may disagree on the
12 outcome of that, but from a process perspective I'm
13 perfectly fine with a putting forward a proposal for an off
14 cycle review.
15 DR. MCKENZIE: And this is Commissioner McKenzie.
16 I would agree with Commissioner Falahee on, you know, that
17 recommendation.
18 DR. FERGUSON: That structure? Yeah.
19 DR. MCKENZIE: Yeah. Because when we have -- when
20 we have differing opinions on each side I think it warrants
21 discussion as opposed to the Department drafting language
22 where there's a lot of kind of open questions still. Right?
23 DR. FERGUSON: Okay.
24 DR. MCKENZIE: So the proposal then, or the motion
25 that I'm hearing is to put forward Heart/Lung and Liver

1 Transplant for an off cycle review --
2 DR. FERGUSON: Yes.
3 DR. MCKENZIE: -- with the Department and the
4 chair and vice chair to help determine the pathway of that
5 and seat or nominate the leadership of either a workgroup or
6 a SAC?
7 DR. FERGUSON: If that is the appropriate process,
8 that is a perfect motion and I will go with that motion.
9 DR. MCKENZIE: (inaudible), Chip?
10 MR. FALAHEE: You captured it correctly, that's
11 right.
12 DR. FERGUSON: I apologize for bumbling through
13 this. I'm trying to honor process a little bit here being
14 new to process.
15 DR. MCKENZIE: No, appreciate that. So there's a
16 motion on the floor. We would need a second and then we can
17 have some discussion or if there's any questions or
18 discussion now, we can also entertain that.
19 MR. FALAHEE: This is Commissioner Falahee. Just
20 to move it forward, I'll go ahead and support the motion and
21 then I'm going to turn to Beth and Kenny and others. We
22 have -- what? -- we have seven commissioners here today. So
23 it's not a quorum of those that are present that need to
24 vote in favor or to get anything passed, it needs to be six
25 because that's a quorum of the entire 11-member Commission.

1 So just everybody to remember that. But I'll go ahead and
2 support the motion so we can engage in any discussion we
3 want about it.
4 DR. MCKENZIE: Thank you. Is there any discussion
5 about the -- about the motion that's on the floor before
6 voting to open this up for off cycle review? Commissioner
7 Haney?
8 MR. HANEY: Yeah, Don Haney. For me, I think to
9 look at something off cycle there'd have to be a compelling
10 reason to do so. Hearing that there's an excess of capacity
11 for transplants and that there is not a loss of quality from
12 the location within the state, I don't see that compelling
13 reason at this time.
14 DR. MCKENZIE: Any other Commission discussion or
15 input? Okay. Hearing none then we will do a vote on the
16 motion and we'll do this roll call.
17 MR. WIRTH: McKenzie?
18 DR. MCKENZIE: Yes.
19 MR. WIRTH: Falahee?
20 MR. FALAHEE: Vote no on the motion.
21 MR. WIRTH: Engelhardt?
22 DR. ENGELHARDT-KALBFLEISCH: Vote no.
23 MR. WIRTH: Ferguson?
24 DR. FERGUSON: Yes.
25 MR. WIRTH: Guido-Allen?

1 MS. GUIDO-ALLEN: No.
2 MR. WIRTH: Lalonde?
3 MS. LALONDE: No.
4 MR. WIRTH: Haney?
5 MR. HANEY: No.
6 MR. WIRTH: Motion doesn't carry.
7 DR. MCKENZIE: Okay. Thank you.
8 (Whereupon motion failed at 10:15 a.m.)
9 DR. MCKENZIE: So without the motion carrying, I
10 don't know if there's any further discussion or -- on this
11 or we just move to the next item?
12 MR. FALAHEE: This is Falahee. I don't think we
13 have any further discussion. That's why I wanted to support
14 the motion so we could have a decision one way or the other.
15 Lacking anything to move it forward I think we just stay on
16 the current cycle that we're in now. Thank the people from
17 St. Mary's for arguing on behalf of West Michigan, but I
18 think we'll keep the current cycle that we have now.
19 DR. MCKENZIE: Sorry. I was having trouble
20 getting off of mute. Thank you very much for those that
21 came and testified today. We appreciate it and appreciate
22 the input and the comments from the commissioners as well.
23 So our next item on the agenda is the legislative
24 update which there are -- is information in your packet
25 related to the legislative items that are up currently.

1 There are a number of house bills that are largely related
2 to the administrative processes, and then a number of senate
3 bills as well. I don't know, Commissioner Falahee, if you
4 have any additional comments that you want to relate on the
5 legislative updates?
6 MR. WIRTH: Chairperson McKenzie --
7 MR. FALAHEE: No, I think --
8 DR. MCKENZIE: Yes?
9 MR. WIRTH: -- real quick. It wasn't included in
10 the packets, but I can provide more information.
11 DR. MCKENZIE: Oh, I -- okay. Apologize. Thank
12 you.
13 MR. WIRTH: No, that's okay.
14 MR. FALAHEE: I'll just -- this is Commissioner
15 Falahee. I'll just add that as Commissioner McKenzie said
16 there are a number of bills floating through the Senate
17 Health Policy Committee. They've been introduced in the
18 Senate Health Policy Committee, they're still there. That's
19 not uncommon as the committee figures out what to do about
20 it. I don't think there's anything of significant import
21 for the Commission. We'll just wait and see what happens as
22 the legislature continues to deal with these bills.
23 DR. MCKENZIE: Yeah, and we can continue to
24 provide updates as well. As Commissioner Falahee mentioned,
25 you know, there's a number of things going around. Several

1 of them frankly appear to be largely administrative
2 processes around CON, some of which exist today but are just
3 reinforcing the need for that -- those to continue to move
4 forward.
5 So our next item is administrative update and we
6 have CON policy that I'll turn over to Kenny.
7 MR. WIRTH: Yes. This is Kenny. Thank you. So
8 just a quick update on policy section. Hospital Beds review
9 standards, at the December CON meeting the Commission voted
10 to take final action on one portion of the sort of the
11 second wave of the review of Hospital Beds. I don't know if
12 you all remember, but there was an initial change that was
13 made. That was voted on in June. And then there was
14 another one shortly after that about observation beds.
15 That's the one that was just appr- -- or just finished its
16 40-day review period and became effective on February 28th.
17 The MRI workgroup completed its list of charges in February.
18 Due to scheduling conflict Dr. Mukherji wasn't able to
19 present at today's Commission meeting, so we'll have him
20 back in June for that presentation. The Psych Beds
21 workgroup is on track to finish at its next meeting in
22 April. We'll have Dr. Jain here in June to present the
23 workgroup's recommendations then.
24 PET SAC is set to end its nomination period
25 tomorrow. We do have enough currently for that, so we

1 should be able to keep PET SAC and start that late April.
2 And then CT review standards, there was one mis-reference in
3 there. There was a reference back to one section of Section
4 14 for volume requirements within section 15. That
5 referenced the wrong subsection, so we made that small
6 technical change. But I just wanted you all to be aware
7 that we just changed a subsection in there to reference the
8 correct section.
9 DR. MCKENZIE: Thank you very much. Any questions
10 for Kenny on those items? And we'll move us along to the
11 CON evaluation section update and this is in your packet so,
12 and I'll turn it over to Tulika to review.
13 MS. BHATTACHARYA: Kenny, can I share my screen,
14 please?
15 MR. WIRTH: Yeah. Let me find you.
16 MS. BHATTACHARYA: Try it now?
17 MR. WIRTH: Yeah.
18 MS. BHATTACHARYA: Can everyone see it?
19 MR. WIRTH: Yup.
20 MS. BHATTACHARYA: Okay. Good morning. This is
21 Tulika. There are several reports in your packet. The
22 first one that I'd like to go over is the first quarter
23 report for program activity for FY2022. As you can see in
24 the report, we received 79 LOIs and a number of applications
25 and issued several decisions for nonsubstantive and

1 comparative and we continue to meet our legal deadlines for
2 issuing the decisions.
3 The second report that I would like to go over is
4 our compliance activity report. Once again we continued to
5 follow up our approved projects which is an important part
6 of the CON program. We don't just approve projects, but
7 also follow them up to make sure that the services are
8 actually being implemented. We continue to receive request
9 for extension due to delays, you know, construction start,
10 delivery of equipment and things like that and we are
11 working with the providers to approve those extensions where
12 it is justified and possible. We also completed the
13 statewide compliance reviews for MRT and Cardiac Cath
14 services. There are two separate attachments in your packet
15 detailing the reviews like what actions we have taken.
16 What -- where the compliance issues with the facilities
17 which I'll go over in a minute. And for this year, calendar
18 year 2022, the Department is proposing that we will do a
19 compliance review for CART CT scanner services utilizing the
20 2019 CON annual survey data. However, we will also review
21 the 2020 data for facilities where it is beneficial to them.
22 For example, if someone did not meet their volume or any
23 other requirements based on the 2019 data and they met it
24 utilizing the 2020 data, then we will use the 2020 data for
25 them.

1 So now going to the Cardiac Cath compliance
2 review. As you can see, we reviewed all 56 facilities in
3 the state that offers Cardiac Cath service and which
4 resulted in eight facilities where we could not determine
5 that they are in compliance so they -- the facility and the
6 Department signed a settlement agreement and so they are
7 under the settlement proposal at this point.
8 For MRT services, we surveyed and reviewed all 69
9 facilities in the state and resulting in 17 facilities
10 receiving a settlement proposal because they're mostly out
11 of compliance for volume and then one was due to, or three
12 due to accreditation requirements. So we are continuing to
13 work with those facilities to bring them back up to
14 compliance. Any questions before I go to the annual report?
15 DR. FERGUSON: This is Commissioner Ferguson.
16 Just out of kind of educational background, what typically
17 goes into the settlement agreements?
18 MS. BHATTACHARYA: So --
19 DR. FERGUSON: Like the range of options or common
20 range of options? I know the full range of options is
21 enormous, but the common range of options?
22 MS. BHATTACHARYA: The range of options are
23 depends on what is the compliance issue and how many
24 compliance factors were identified by the Department and we
25 also look at what has been the historical performance of

1 that facility. So the range of options that we propose in
2 the settlement proposal: corrective action plans. What are
3 your plans to improve, for example, volume? What are your
4 plans to regain or hire new staff because of staffing
5 issues? What are your plans for completing that
6 accreditation process? Because what we heard from many
7 providers, the pandemic has, you know, affected, like, the
8 onsite reviews by those accreditation organizations. Like
9 their staff were not able to travel, for example, to go to
10 their site so things like that. And we also gave them a
11 specific time frame, agreed upon time frame, and the
12 provider will say, "Okay, after two years we will be able to
13 achieve these." Options also include civil fines and/or
14 charity care for that particular service.
15 DR. FERGUSON: Okay. Thank you.
16 MS. BHATTACHARYA: Okay. Now I would like to
17 present some of the tables in the annual report. I will not
18 go over all of those pages. So this is our 33rd report to
19 the CON Commission. As you can see, this year we received
20 396 letters of intent, 309 application, and we approved
21 about, or 258 projects approving approximately $1.4 billion
22 of new capital expenditures for Michigan. We also received
23 57 amendments to CON-approved projects.
24 The next table that I would like to point out, so
25 out of the 396 LOIs, we managed to process 99 percent on

1 time which is a 15-day deadline for the Department to
2 process it and 37 of those LOIs ended up being waivers that
3 the projects did not need CON review and approval.
4 The next one -- sorry. So this Table 2 shows the
5 type of applications we reviewed, mostly nonsubstantive and
6 then the next level is substantive. And very few
7 comparative and that has always been the case with the
8 exception of FY2020 where we had lots of nursing home
9 applications. Now, just to note here, so all of those
10 nursing home applications that were part of the 2020 review,
11 after we issued the proposed decision there -- new review
12 standards became effective so all those denials were
13 remanded back to the Department for re-review under the new
14 standards. So, you know, there is a repeat -- repeating of
15 the numbers, but we excluded that. But just so you know
16 that was part of our review cycle.
17 And next one is, again, just to show to the
18 Commission that we do take our timeliness very seriously and
19 we maintain that. So when you look at the average review
20 cycle in Table 4, so the legal deadline for nonsubstantive
21 is 45 days, our average was 37. For substantive, it is 120
22 and our average was 105. And for comparative it is 150 and
23 our average was 122. We continue to process and approve
24 emergency applications although nothing as we did in FY20,
25 but we did approve 26 emergency CONs in FY21, mostly for

1 beds, but for other services as well, like a temporary use
2 of MRI or CT, things like that to kind of ease the level or
3 all those backlogged patients that are now coming back into
4 the health care system because they are holding up their,
5 you know, elective procedures. Okay.
6 So the proposed decisions, again, as you would
7 notice for FY20 and FY21, there have been an uptake in the
8 number of projects that we have disapproved, but that is
9 mainly due to the nursing home applications and there was
10 psychiatric bed applications as well.
11 Also, the Table 11 is the comparison of what is
12 happening in terms of the volume, also which is an
13 indication, you know, like what the providers are doing in
14 terms of their capital expenditure, modernizing their
15 equipment and things like that. So you would see a slight
16 decline in the number of LOIs, applications and decisions
17 that we have issued so -- but we'll continue to watch that,
18 what happens as we are kind of coming out of the pandemic.
19 The new capacity is always very interesting, so we
20 try to give you a sense of how the past year was in terms of
21 approving new capacity in our state. So, for example, there
22 was one new open heart surgery site last fiscal year. There
23 were no new hospitals, however, 165 new hospital beds were
24 approved under the high occupancy provision. And please
25 keep in mind these do not include the emergency CON

1 applications because those are temporary surge in bed
2 capacity. There were -- actually we have seen an uptake in
3 the number of swing beds. So we approved six new swing bed
4 programs in the state and a total of 55 new swing beds
5 because the legislature took action to revise the
6 requirements for application for swing beds and that has
7 opened up the process and more and more hospitals are
8 applying for swing beds. We also approved two new nursing
9 homes and 95 new nursing home beds. There were five new
10 psychiatric hospitals and 327 new psychiatric beds. These
11 include the special pool of beds as well, not just general
12 adult and child adolescent beds.
13 Compliance action, again, we don't just process
14 and approve applications. We also monitor the progress of
15 the projects to make sure that those are being implemented
16 and we also do the statewide compliance monitoring to make
17 sure that when a facility is offering the service, we are
18 meeting the project delivery requirements that they agree
19 to.
20 I think that will be all, but, you know, the whole
21 report is in your packet. If you have any questions now or
22 if you see something, you have a question, you can always
23 reach out to me and just send me an e-mail.
24 DR. FERGUSON: This is Commissioner Ferguson.
25 Just a question a couple slides back up where you were

1 showing total sites for the different overseeing services.
2 That one (indicating). So I know that when we do our
3 periodic review we have a chance to kind of assess existing
4 units or beds or sites and see how that feels and compare.
5 Do we ever do kind of a global look and kind of compare to
6 national average? Knowing that the states are different and
7 demographics in states are different which -- so I know it's
8 a very crude measure, but, like, on a population basis, the
9 honest truth is despite being in health care my whole career
10 and being in Michigan and being here and being involved in
11 leadership, I don't actually have a decent understanding of,
12 you know, are our hospital beds compared to national average
13 high or low? Are our PET units high or low? That might be
14 of interest at some point. I know it's just kind of
15 educational background, but it flavors our role. So I
16 don't -- I don't know, do we ever look at that or is that
17 only done when we do the every three year review type of
18 thing?
19 MS. BHATTACHARYA: If I can say or make the
20 initial comment and I think I'll turn it over to Beth. So I
21 have to admit that every year when we prepare the report
22 there is not a conscious effort to look at other similar
23 states with the similar population as Michigan and how many
24 of -- like, how many air ambulance, how many open heart, how
25 many hospitals, nursing homes they have. No, we don't do

1 that on an annual basis. However, when we have those list
2 of services that come up every year, for example, Cardiac
3 Cath or Surgery or Open Heart or Transplants, we do look at
4 what is the current level of service in the communities, in
5 the planning areas in Michigan and, you know, if there is a
6 need to revisit the requirements. For example, for rural or
7 micropolitan counties, if there -- if there is a barrier or
8 if something is stopping the providers for applying for new
9 services in those communities and appropriately adjust our
10 standards requirements because things change.
11 DR. FERGUSON: Thank you.
12 MS. NAGEL: I think the only other thing that I
13 would add in reference to the Department looking at other
14 states is that there are a few other states that provide as
15 much data publicly available as Michigan does. When we
16 have, you know, dug deep into other states it was a long,
17 drawn out process to get that data made available to us and
18 it was rarely in usable formats. And so, you know, I would
19 say that's kind of, you know, kudos to Tulika and her staff
20 for the great data collection that they do, but it is
21 unfortunate that we don't have some of these, you know,
22 measures that we can look at other states. I would also say
23 other states do not update their standards the same way that
24 we do as well. So, you know, each CON program, you know,
25 kind of what they said, if you've seen one, you've seen just

1 one and I would say that that has been our experience as
2 well.
3 DR. FERGUSON: Thank you.
4 MR. FALAHEE: This is Commissioner Falahee. I'll
5 just add to that. Sometimes there are, like, regional
6 studies done. Cost, for example, for health care. I know
7 the automobile companies have done it two or three times.
8 Michigan State University did a survey maybe ten years ago.
9 And Michigan State showed that in health care if you build
10 it, they will come.
11 DR. FERGUSON: Right.
12 MR. FALAHEE: And I think that was not just in
13 Michigan, but ultimately --
14 DR. FERGUSON: Yeah.
15 MR. FALAHEE: -- if you build it, they will come.
16 And then the other studies, RAND Corporation and the
17 automobile companies, when they look at it, they look at it
18 not by a number of hospitals or MRIs, they look at it as
19 what's the cost per employee?
20 DR. FERGUSON: Right.
21 MR. FALAHEE: And what they found as recently as
22 two years ago, Michigan is at the very low end of cost,
23 medical cost, per employee within the automobile companies
24 and then RAND Corporation did a study two years ago that
25 looked at about 15 or 20 different states and where their

1 costs were per capita, if you will. And, again, Michigan
2 was at the very, very low end of that. That doesn't answer
3 your question, Commissioner Ferguson, but it just shows -- I
4 agree with what Beth and Tulika said, it's hard to get the
5 data and it's not always apples to apples.
6 DR. FERGUSON: Yeah.
7 MR. FALAHEE: It's not even fruit to fruit
8 sometimes. You just don't know what you're getting.
9 DR. FERGUSON: I'm not -- I'm not suggesting that
10 being essentially in variance compared to a national norm is
11 bad, but it is useful to know when we are and to make sure
12 that, okay, yeah, that makes sense. We actually want to be
13 where we're positioned. It's just one more reference point.
14 MR. FALAHEE: I agree.
15 DR. MCKENZIE: Yeah. And Commissioner Ferguson,
16 just to add on, you know, I can totally understand the
17 request and the desire. I agree with, you know, Beth and
18 Tulika. Just from looking at, you know, data that we have,
19 you know, in my setting it's difficult to find comparative
20 data. Also, you know, we all hear it, we say it, "health
21 care is local." Right? And so comparing across different
22 populations can sometimes not even give you, you know, what
23 you hope it would give you. And, you know, it's really our
24 job to balance, you know, as Chip was mentioning, you know,
25 there are figures out there and looking at cost, but we're

1 also balancing quality and we know that, you know, if you
2 aren't delivering a certain number of services, that quality
3 is impacted. Right? And, you know, some of the things we
4 know about the state and the balance that this creates is
5 we're delivering high quality care and ensuring that, you
6 know, we have access, quality and cost and those are all in
7 balance. So appreciate all the comments.
8 I just would add a comment that, you know, I know
9 that report must take a tremen- -- I can't imagine the
10 number of hours it takes. It's a tremendous amount of data.
11 And it's really -- you know, I loved seeing the additional
12 services that were being added. I think it's very -- it's
13 tremendously helpful. And so kudos to the Department and,
14 Tulika, to you for helping to lead that report. It's really
15 nicely done. So thank you.
16 MS. BHATTACHARYA: Thank you, Madam Chairman
17 and -- sorry.
18 MR. FALAHEE: I'd like to add my comments to that.
19 Tulika, once again, great job with the report. As usual I
20 flyspeck it and I think the -- I think I'm unmuted. Okay.
21 Good. Sorry. Double, triple muting, whatever. Tulika,
22 thank you again. As always, great report, great results.
23 As a hospital person and dealing with Tulika and her
24 Department through the last two years, they've been nothing
25 but phenomenal to address the needs of the hospitals as they

1 go through emergency applications, as they go through
2 declining volume. They've just been stellar in all of their
3 work. And hypothetically, if I'm familiar with the
4 compliance reports, hypothetically I hear that they're very
5 helpful there as well. They will look and work with the
6 hospital and come up with the full range of options as
7 Tulika said. And being in the hospital field, everyone
8 understands it and appreciates the hard work that they're
9 going through to resolve those issues.
10 MS. BHATTACHARYA: Thank you, Commissioner
11 Falahee. And before I give the floor back to Kenny, I
12 cannot end my presentation without some shout-outs to my
13 staff. Lots of data, lots of hours. So shout-out to
14 Ashley, our project coordinator not only processing all of
15 these LOIs and applications, but helping us prepare and
16 doing the number crunching. Also a shout-out to our
17 compliance analysts, Cliffany and Amanda, for doing an
18 excellent job with the statewide compliance review and all
19 other compliance review.
20 And last but not the least, our review specialist
21 Joette, Perry, Marcus and Shannon. We not only had the
22 effect of pandemic on our volume, but also lot of staff
23 turnover. Amanda is new. We also have a brand new
24 secretary, Rachel, and our follow-up analyst Susan. But
25 the -- not only just did their job, but also did these other

1 responsibilities that were not in their role just to keep up
2 what the -- our applicants and the people in the state
3 expect from us. So it's, like, huge shout-out to my team
4 and each one of them just stepped up to the plate and
5 beyond. Thank you.
6 DR. MCKENZIE: Thank you, again, Tulika. So next
7 on our agenda we have the legal activity report and there is
8 a written report in your packet. And I'll turn it over to
9 Assistant Attorney General Brien Heckman if he has any
10 comments.
11 MR. HECKMAN: Thanks, Madam Chairwoman. So the
12 litigation between Pine Rest and the Department involving
13 Pine Rest Havenwyck Hospital's psychiatric bed comparative
14 review is resolved. The parties have submitted their
15 closing briefs. We're just --
16 MR. WIRTH: Amy, if you just want to unmute
17 yourself?
18 MR. HECKMAN: I got it.
19 DR. MCKENZIE: I can unmute.
20 MR. HECKMAN: I got kicked out of my meeting.
21 DR. MCKENZIE: Here. Come --
22 MR. HECKMAN: All right. Sorry. So the
23 litigation involving Pine Rest Havenwyck Hospital and the
24 Department is resolved. The parties have submitted their
25 closing briefs. We are just waiting on a decision from the

1 administrative law judge after which I would expect an
2 appeal by the losing party. That's the only matter that I
3 have an update on. So, thanks.
4 DR. MCKENZIE: Thank you. Next on our agenda we
5 have time for public comment. So I will open it up for
6 public comments and turn it over to Kenny.
7 MR. WIRTH: Yes. Thank you. We do have one
8 person who would like to make comment, Jack Curtis from
9 Oxford Charter Township. Mr. Curtis, your comments are
10 limited to three minutes so you can begin whenever you are
11 ready.
12 JACK CURTIS
13 MR. JACK CURTIS: Great. Good morning members of
14 this Commission. The reason for my comment today is to call
15 to action for the MDHHS and its committee to reevaluate,
16 reconsider the recent modification to the CON standards for
17 the local area access methodology when a town is being
18 considered and it's impact on Oxford.
19 I was informed that in December of 2021, the
20 requirements and provision methodology for the LAA process
21 were changed and now Oxford no longer fits the LAA need
22 requirements. For two years it was proven by your studies
23 that Oxford and its neighboring communities were underserved
24 with hospital beds. In fact, 117 beds in the 2018 study and
25 then up to 121 beds in the 2019 study. Now with the

1 standards and methodology changed, the new revised study
2 shows Oxford is no longer justified for any need for beds in
3 the Oxford area.
4 I asked Meghan Groen to include the map where I
5 put together showing the nearest hospitals to Oxford. It's
6 16 miles of very congested roads. The use of the ESRE
7 traffic volume data, it's totally skewed for the following.
8 During a reconstruction of the M-24 corridor, traffic lanes
9 were closed from 2019 in Orion and 2020 in Oxford Township.
10 And with a vast number of people working from home during
11 the pandemic, this lowered the traffic volume significantly.
12 There are 80,000 residents within a ten mile radius of
13 Oxford who are at risk of not making it to the hospital.
14 As proven on November 30th, 2021, when lights and
15 sirens and a frantic need to get six wounded children and
16 one teacher to the hospital, the fastest to arrive -- not
17 during rush hour traffic -- was 20 minutes. That's lights
18 and sirens, 20 minutes. The longest was 35 minutes. This
19 is totally unacceptable. Victims were transported by police
20 cars and private citizens until all mutual aid ambulances
21 arrived. While some of the injured had to remain for
22 extended periods, parents reported it took over 40 minutes
23 each way to visit their injured children making several
24 trips a day.
25 Having a hospital in Oxford that day would not

1 have made a difference to the four children who were
2 murdered, but I offer the following. Each emergency trip to
3 these hospitals from Oxford takes an ambulance out of our
4 community for several hours. All firefighters must be
5 paramedics with ALS certification due to this extended
6 travel time. And with the lack of qualified paramedics,
7 hiring them has also been a challenge.
8 I'd asked Meghan to also include for your reading
9 an amicus curiae brief by our community which was supplied
10 to show proof of our concerns in getting area residents to
11 the nearest hospital when the first time for Oxford was
12 rejected due to some skewed data. Also, emergency monies
13 are now being utilized to address the mental health care
14 needs of the community over the next five years having a
15 clinic being built inside of an obsolete real estate office.
16 When in 2018, the LAA study was released, four
17 hospital systems purchased or have on contract large
18 acreages of parcels here in Oxford. A hospital system even
19 went on to spend close to a million dollars preparing to
20 come here and is willing to build here now, but has no
21 chance due to these changes. During the M-24 construction,
22 Oxford Township installed $2.5 million of sanitary sewer
23 lines in preparation for this area based on these possible
24 needs. Oxford truly and wholly request that a recently
25 changed requirement and provisions for the limited access

1 areas be reviewed and Oxford be reconsidered for a much
2 needed hospital system. Come visit us. I'll drive you to
3 the hospital. It's longer than 30 minutes. Please accept
4 our plea for a hospital in the Oxford area. Thank you.
5 DR. MCKENZIE: Thank you, Mr. Curtis. We
6 appreciate your testimony today and I know that it's -- you
7 know, that your community has been through a lot and so we
8 definitely appreciate you being here today to advocate for
9 the community. I would ask the commissioners if there's any
10 questions for Mr. Curtis at this time?
11 I think it might also be helpful -- I know that
12 there were some recent changes that were cited around the
13 Hospital Bed standard and just so that we all can recall,
14 that Hospital Bed standard, the SAC was seated quite awhile
15 back and the Commission took final action I believe it was
16 in June, so long before -- and it took finally 'til, you
17 know, December I think that things were enacted. But I
18 would appreciate maybe a walk through. I think it would be
19 helpful, Beth or Kenny, whoever is best positioned to be
20 able to help walk us through that as well as what the
21 changes were that were approved that were being referenced
22 by Mr. Curtis.
23 MR. WIRTH: Yes. Thank you. So just to walk
24 through the timeline of the changes made. The Commission
25 took proposed action on the SAC recommendations in June of

1 2021. Those went to public hearing in July and then came
2 back to the Commission in September for final action and
3 then those were effective November 12th. So that SAC -- I
4 don't know, Beth, if you want to fill in what the SAC looked
5 at for those?
6 MS. NAGEL: Sure, Kenny. So included in your
7 packets, just the overview of what the SAC looked at and
8 particularly related to the limited access areas. The
9 SAC -- as Kenny noted -- worked for six months to re-do the
10 limited access area methodology. You'll recall the previous
11 methodology was finding many areas that were very small in
12 population that were incompatible with other parts of the
13 standard that required 50,000 people to be served within
14 those limited access areas. It was also finding areas that
15 didn't have any population at all, subparts of zip codes.
16 And so this SAC looked at the best way to determine this
17 higher level of need outside of the regular Hospital Bed
18 methodology and so they did a couple of things. I put these
19 on the slides in your packet. But what they did, the
20 biggest change was since that original limited access area
21 provisions were put in the standard a new more sophisticated
22 method of travel time has been identified. It's much more
23 complete, much more thorough and much more timely updates.
24 And so the new methodology is based on that new travel time.
25 And the SAC looked at what it meant to be underserved or a

1 limited access area and determined that an underserved area
2 is defined as a place located more than 30 minutes of travel
3 time to another hospital.
4 So as the standards were -- became effective in
5 December, a new map of limited access areas was placed on
6 our web site. It's a more sophisticated map so you can see
7 down to the crossroads essentially of where each limited
8 access area is located. As you'll note, the SAC did many
9 other things in their six-month duty, but this was their
10 charge number one which was to review those provisions for
11 the limited access areas.
12 MR. WIRTH: And I do want to add that there were
13 two groups that looked at Hospital Bed standards. There was
14 the SAC initially which finished its work in May, then there
15 was a workgroup after that, after the Commission took
16 proposed action to look at observation status beds. And
17 that proposed action was taken in September, came back to
18 the Commission in December, and then became effective in
19 February of this year. That was a very narrow scope for the
20 workgroup and they only looked at the observation bed
21 status. So that one, you know, LAA had been determined back
22 in, you know, June or September of 2021 when the Commission
23 took its final action on that, that set of charges.
24 DR. MCKENZIE: Thank you. That was a helpful
25 refresher. So to summarize, there were -- you know, there

1 was a SAC which, you know, is again -- oh, am I on mute?
2 Oh, no, I'm not. Sorry. Which to summarize is a more
3 formalized group. They have to finish their work over a
4 period of six months and it requires a certain level of
5 subject matter expertise to be able to sit and inform the
6 Hospital Bed, you know, methodology and that was what was
7 followed. And this Commission took action, the limited
8 access area was one of the things that was looked at. What
9 Mr. Curtis is bringing forward is the changes that ensued as
10 a result of those approved, you know, changes to the
11 methodology. So there are probably a number of possible
12 options. I want to ask, you know, is there any additional
13 public comment before I open this up for a discussion with,
14 on this particular item?
15 MR. WIRTH: I am not seeing any in the comments.
16 MS. NAGEL: I do have one additional thing I'd
17 like to add. I'm sorry.
18 DR. MCKENZIE: Yeah.
19 MS. NAGEL: Just that when the -- when the SAC
20 looked at the limited access area, they put it on a timeline
21 to be updated similar to the Bed Need methodology. So where
22 there are dramatic changes in population or travel time or,
23 you know, any of those factors that affect the methodology,
24 those will be updated and brought back to the Commission at
25 the same schedule as our regular Bed Need methodology as

1 well.

2 DR. MCKENZIE: And, Beth, what would be the timing

3 for the next routine kind of -- or, you know, when this

4 would next come before the Commission, the Bed Need

5 methodology if it stays on the normal pathway?

6 MS. NAGEL: I would ask Tulika for the definitive

7 answer and it looks like she's looking for it right now.

8 But I know that it is two years generally. I don't know

9 where we are in those two years. Kenny may know.

10 MR. WIRTH: 2023 is going to be the next --

11 MS. NAGEL: Next year, 2023.

12 DR. MCKENZIE: Okay. So taking no action, this

13 comes before the Commission again in 2023?

14 MS. NAGEL: Correct.

15 DR. MCKENZIE: Okay.

16 MR. WIRTH: Hang on. Correction.

17 MS. NAGEL: Okay. Now Kenny is coming up with a

18 definitive answer.

19 MR. WIRTH: I have a correction. The review year

20 for Hospital Bed standards is 2023, the Bed Need methodology

21 will be updated in November of this year.

22 DR. MCKENZIE: In November of this year is what

23 you said?

24 MR. WIRTH: The next updated due date for Bed Need

25 is November 1st, 2022, and then Hospital Groups will be

1 updated in August of 2024.
2 DR. MCKENZIE: Okay. So what I heard was that
3 there is the next kind of review against the Bed Need
4 methodology is November of this year, and the next review is
5 2024 for the overall methodology?
6 MR. WIRTH: 2023.
7 DR. MCKENZIE: 2023. I'm sorry. 2023. So let me
8 reiterate that one more time for the Commission. The next
9 review against the current methodology meaning time frames,
10 travels, limited access areas is November of this year based
11 upon information that the Department gathers. The next
12 review of the methodology, the Bed Need methodology, is set
13 for 2023. So, okay, now understanding that, what are the
14 potential options before the Commission today? If someone
15 wants to walk through and outline that from the Department,
16 that would be very helpful.
17 MS. NAGEL: The Commission has a whole range of
18 things that they can look at today in response to this
19 public comment. One, you could ask for a SAC or a workgroup
20 to look back at the language or the methodology that the
21 other SAC created. You could ask the Department to come
22 back with language. You could wait 'til the next review
23 cycle. There, you know, I think those are kind of your
24 regular tool chest of things that you can do and those are
25 available at this point as well.

1 DR. MCKENZIE: Okay. Any questions for the
2 Department on those items that are before us as options?
3 DR. FERGUSON: This is Commissioner Ferguson,
4 question. The recent review of the limited access area
5 standards, knowing that any change in standard probably
6 resulted in some areas with a tighter standard and some
7 areas are more liberal, so there was probably some shifting
8 around of who's eligible and who's not eligible and that
9 there's -- call it winners or losers or tighter or more lax
10 standards. Acknowledging that, the primary intent is a
11 wiser distribution. Was there any guiding philosophy
12 going -- coming out of establishing those standards or any
13 subsequent assessment that said that the net effect of the
14 new standards was a net tightening of the part of the
15 population eligible for this or in that loosening of it on a
16 statewide basis? Again, acknowledging that there's
17 individual winners and losers in isolated communities.
18 MS. NAGEL: That's a really good question, Dr.
19 Ferguson. And I think because the SAC started with the
20 basis that the -- what they had been looking at was outdated
21 and was coming up with some results that didn't really make
22 sense given the principals of the methodology, I don't know
23 that they looked at tightening or loosening the way you're
24 describing at it -- describing it, but they looked at what
25 is most accurate for the principles of a limited access area

1 and I would say that is what they came out of it. I mean,
2 they looked at data, you know, with hospital travel times
3 and ambulance response times all over the state and came up
4 with this, you know, what they came up with and brought to
5 the Commission last year.
6 DR. FERGUSON: I'm just trying to make sure that
7 we didn't inadvertently find ourselves tightening it
8 globally kind of almost without knowing it, thinking that
9 we're just doing a wise process of redefining a standard and
10 then you get to the end and it's like, "oh," and I don't
11 know. That's why I'm asking. I'm not suggesting we did
12 that. I'm asking if we did that.
13 MS. NAGEL: Again, I'm not sure that the SAC would
14 be -- from my participation in the SAC, I would be able to
15 editorialize on (inaudible).
16 DR. FERGUSON: Yeah. Okay. Thank you.
17 DR. MCKENZIE: Yeah. If I could clarify, though.
18 My understanding from kind of what was described was that
19 when they got through the Hospital Bed Need methodology that
20 they were identifying areas where it just didn't make sense;
21 right? And so they took up this limited access issue and
22 brought back recommendations to --
23 DR. FERGUSON: Right. Which is appropriate.
24 DR. MCKENZIE: -- the Commission around how that
25 should be defined. So any further questions or discussion?

1 MR. FALAHEE: This is Commissioner Falahee. I
2 just want to add when the SAC is created and especially
3 here, we for years, if not decades, have relied on outside
4 experts in this, specifically Professor Paul Delamater, to
5 go through this and to look at it with a very fine tooth
6 comb: travel patterns, population density, all of that. So
7 that is a very thorough review that we as the Commission and
8 the SAC have relied on with -- for Paul and he's testified
9 in front of us I don't know how many times to explain it to
10 us lay people when it comes to geographic testing and all
11 that. So it's a very thorough review that we do like we do
12 with, for example, Heart/Lung/Liver that we talked about
13 today or any of the other standards where we do a thorough
14 review. And in this one it sounds like we're going to get
15 new numbers this year and then a whole new analysis next
16 year. So even if we decided hypothetically to appoint a SAC
17 today, the results of that SAC wouldn't come back before
18 November of this year where we're going to get updated data
19 anyway. So I'm not sure if there's a need to do anything
20 since it's happening already. So that's my two cents'
21 worth.
22 DR. MCKENZIE: Yeah, I mean, this is obviously a
23 very -- it's a -- it's a very difficult situation; right?
24 It's, you know, what -- what's described. It's, you know,
25 how you -- how do we address the issue in a way that makes

1 sense. Right? So, you know, I don't know if there's any
2 further discussion? You know, we know we're going to be
3 getting updated numbers against the methodology that worked
4 to help define what a limited access area is. You know, if
5 there's further discussion or interest in, you know, making
6 a motion, you know, we can discuss that.
7 MR. WIRTH: Chairperson McKenzie? We do have one
8 more public comment.
9 DR. MCKENZIE: We have another public comment?
10 Okay. I'll turn it over to you.
11 MR. WIRTH: One moment, please, and I will get the
12 microphone up there. Okay. This is going to be Chief
13 Scholz from Oxford Charter Township.
14 PETER SCHOLZ
15 MR. PETER SCHOLZ: All right. Thank you. And
16 picking up a little bit more on what Supervisor Curtis has
17 said. Our area here when you're talking about a limited
18 access and codes and everything, I would hope that you don't
19 just fit it in to a couple of boxes as far as responses. We
20 have one road that we can travel on to go north to Lapeer or
21 south towards Pontiac for Rochester. One road. Traffic is
22 busy all day, and it doesn't matter whether it's a rush hour
23 on in the morning, rush hour in the afternoon. When I
24 transport someone to the hospital right now, my turnaround
25 time -- call comes in until my truck is back in service --

1 and keep in mind that's anywhere's from two to three
2 employees that are taken out of the community -- I'm looking
3 at between two to two and a half hours that I'm losing the
4 manpower and the truck. Right now staffing is short and
5 tight. It's not getting any better. We've had open
6 positions now for over a year and a half we've been trying
7 to hire for firefighter paramedics and there are none to be
8 found. Total time leaving the township is extreme. Yes, it
9 may be -- you know, when you take miles by, you know, 20
10 miles or 30 miles is one thing, but at the same thing
11 time-wise because you just can't get down the road.
12 When Supervisor Curtis referred to the November
13 30th incident, again, our travel time was -- you know, it
14 wasn't rush hour. It was around, you know, 1:00 o'clock in
15 the afternoon and yet we still had lights and sirens and,
16 you know, going faster than we normally would, we're still
17 stuck in traffic because of all the police that were
18 responding to the call, the traffic that was on the roads,
19 and literally lights and sirens going straight to Pontiac on
20 one single road going south, we still had over a 30-minute
21 response time. That's ludicrous. That doesn't make any
22 sense that we should have to, you know, put up with that.
23 So I think you definitely need to look at each one
24 closer on a case by case basis instead of trying to say,
25 okay, well, it fits the 20 miles or 30 minutes, or whatever

1 it is like that. You need to look at it a little bit more
2 broadly. Thank you.
3 DR. MCKENZIE: Thank you, Mr. Scholz. Any
4 questions from the Commissioners? Any further public
5 comment with all that's come in? Okay. Any further
6 discussion from the Commissioners? Okay. So hearing none,
7 the standard course would be that we will have additional
8 information coming to us in November around that Bed Need
9 methodology with defined limited access areas. So, and then
10 the methodology is set to be reviewed in 2023. So thank you
11 both for your comments.
12 Okay. Our next item is the review of the
13 Commission work plan for March 17th, 2022. That is in your
14 packet today. Any Commission discussion on the work plan?
15 Actually, Kenny, are you going to walk through the work
16 plan? Sorry.
17 MR. WIRTH: Yeah, I can do that. Yes. So no
18 changes out of today's meeting that I've identified, so this
19 work plan that you'll see up here (indicating) is what the
20 updates would have been at the January meeting that we voted
21 on approving that work plan at the beginning of this
22 meeting. So we have MRI and Psych Beds wrapping up. We
23 will have -- PET is going to be starting in April, and then
24 we have MRT workgroup May to August. We're hoping that that
25 workgroup will move a little quicker since it's a very

1 limited scope of the charges they'll be working on. So
2 regardless, we'll have that presentation in September. And
3 then CT and Nursing Home workgroups will also begin in
4 September. If there are any questions, happy to answer.
5 MR. FALAHEE: So, Kenny, let me make sure. What
6 we approved at the outset of this meeting is in effect what
7 you're showing up on the screen right now?
8 MR. WIRTH: Correct; yes. So at the outset of
9 this meet -- and the outset of this meeting was it would
10 have been the -- at the January meeting you would have
11 approved the work plan with the changes identified during
12 the meeting. So the work plan that you saw earlier on was
13 the work plan without those changes. This (indicating) is
14 the work plan with those changes implemented.
15 MR. FALAHEE: So then -- this is Falahee and I'll
16 make a motion to approve the work plan that's before us
17 right now on the screen and I'll make that motion.
18 MR. HANEY: Don Haney. I'll support.
19 DR. MCKENZIE: Thank you. All in favor?
20 ALL: Aye.
21 DR. MCKENZIE: Any against? Okay. Great. Thank
22 you.
23 (Whereupon motion passed at 11:11 a.m.)
24 DR. MCKENZIE: So our future meeting dates are on
25 your agenda for you, June 16th is our next meeting. We have

1 a meeting September 15th and December 8th. So mark your
2 calendars for those. Appreciate everybody being here today.
3 I know we were wrestling with a number of issues here today
4 and appreciate all the comments of the commissioners and
5 your attendance. So if there's no further comments, then I
6 will accept a motion for adjournment.
7 MR. FALAHEE: Falahee, make that motion.
8 MS. LALONDE: Lalonde, second.
9 DR. MCKENZIE: Thank you. All in favor?
10 ALL: Aye.
11 DR. MCKENZIE: Any against?
12 (Whereupon motion passed at 11:12 a.m.)
13 DR. MCKENZIE: All right. We will see everybody
14 in June. Thank you very much.
15 (Proceedings concluded at 11:12 a.m.)
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