STATE OF MICHIGAN

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF NEED COMMISSION

COMMISSION MEETING

BEFORE JAMES FALAHEE, CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, January 25, 2024, 9:30 a.m.

RECORDED BY: Marcy A. Klingshirn, CER 6924
Certified Electronic Recorder
Esquire Deposition Solutions
Firm Registration Number 8035

COMMITTEE MEMBERS:	AMY L. MCKENZIE, M.D., VICE CHAIRPERSON ARCHIE DRAKE AMY ENGELHARDT-KALBFLEISCH, D.O. ERIC FERGUSON, M.D. DEBRA GUIDO-ALLEN, R.N. DONALD HANEY ASHOK KONDUR, M.D. GREG SALWIN RENEE TURNER-BAILEY
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	BRIEN WINFIELD HECKMAN, ESQ. (P76006) Assistant Attorney General PO Box 30736 Lansing, Michigan 48909 (517) 335-7632 HeckmanB1@michigan.gov
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA MARCUS CONNOLLY BETH NAGEL TIFFANI STANTON

TABLE OF CONTENTS

Lansing, Michigan

Thursday, January 25, 2024 - 9:32 a.m.

MR. FALAHEE: Good morning, everybody. I don't know if this is working or not, but better than the static in the background. So my name is James "Chip" Falahee. I recognize some very many familiar faces and some unfamiliar faces so that's good. Let's call the meeting to order of the CON Commission.

The first item of -- not on the agenda is introduction of a new commissioner. And what I'm going to do is have Greg introduce himself and then us go around the table so he has a sense of who are these people and what do they do when they're not acting as CON Commissioners. So let's do that.

Greg, if you would like to introduce yourself? Use the microphone so everybody can hear you.

MR. SALWIN: Sure. All right. Hopefully everyone can hear me. Hi, Greg Salwin. I work for Stellantis. I run U.S. Health Care programs. I'm representing large employers with the CON Commission and very happy to be here and look forward to working with everybody.

MR. FALAHEE: Great. Thank you. And Greg and Commissioner Drake were on an orientation call a couple days ago with some of the Department and myself and neither one said, I quit. So we're very happy about that. So we'll

see.

So why don't we go around the table? Marcus, I'll start with you. We'll just go all around the table of who we are and what role we have and everybody'll --

MR. CONNOLLY: Okay. Hi. My name is Marcus Connolly. I am the Commissions and Special Project manager. I've worked for CON for the past six years. I started off as a specialist and I took the management role last December. I'll pass it over to Tiffani.

MS. STANTON: Good morning. I'm Tiffani Stanton. I am the CON policy analyst. I actually came from LARA where I spent five and a half years doing licensing for health and occupational professions. And just as a note while we're getting going, please speak up really loud. Our mics have been having a lot of issues if you couldn't tell starting, but we're also short mics, so thank you.

MS. BHATTACHARYA: Good morning. My name is Tulika Bhattacharya. I manage the CON Evaluation Section. So we do all the reviews of applications, following up projects for timely implementation and compliance monitoring of all of the approved facilities in state. I have been with the program for almost 22 years, became a manager in 2012. And I have nine in my team; four specialists, four analysts and our secretary.

MS. GUIDO-ALLEN: I'm Debbie Guido-Allen. In my

day job I am the president at Corewell Health Dearborn Hospital and on this Commission for quite a few years now representing nursing.

DR. FERGUSON: Hi. I'm Eric Ferguson. Been on the Commission for a couple years now. I'm independent physician. My day job is as a radiologist and the physician lead for Huron Valley Radiology Advanced Imaging Alliance. We're based in Southeast Michigan.

DR. ENGELHARDT-KALBFLEISCH: Good morning. I'm Amy Engelhardt-Kalbfleisch. I am an internal medicine physician. Have served on the Commission for number of years now and I am the chief medical officer of Henry Ford Hospital. And I represent osteopathic physicians on the Commission.

DR. KONDUR: Morning. I'm Ashok Kondur. Day job, I'm a interventional cardiologist and that (indiscernible) for the Providence Health System and I'm on Commission for close to three years and I represent non-self insured segment.

MR. HANEY: Good morning. I am Don Haney. I am a long-term care skilled nursing administrator currently at Sanilac and I've been on the Commission two years, two, three years.

MR. DRAKE: And good morning. I'm Archie Drake. I am -- been on the Commission now for a month. And in my

day job I serve as the CEO of the Childrens Hospital of Michigan and I represent hospitals.

MS. TURNER-BAILEY: Good morning. I'm Renee Turner-Bailey with the International Union, UAW. I'm representing labor. I'm the director of our Social Security department. And I've had several stints on the Commission, but most recently I think this is my third -- my third year.

DR. MCKENZIE: Good morning. Amy McKenzie and I am a family physician. My day job is I am vice president and associate chief medical officer at Blue Cross Blue Shield of Michigan and so I represent state health cares. And I've been on the Commission for a number of years. I've forgotten.

MR. FALAHEE: Chip Falahee. If you call me James, I know it's a sales call. I'm Chip Falahee in my day and sometime night job I do the legal work and legislative work for Bronson Health Care System down in the Kalamazoo area. Gosh. I was -- I've been on the Commission -- Governor Whitmer appointed me and then Snyder and then Whitmer, so I've been on awhile. I've been doing CON work since 1980. So happy you're here. Happy we've got such great representation verbally around the table.

Last but not least?

MR. HECKMAN: Thanks, Chip. This is Assistant Attorney General Brien Heckman. I'm the parliamentarian and

attorney assigned on behalf of the Department. I've been on in this current role for around two years and for the most part you won't hear from me. But it's been nice to meet all of you.

MR. FALAHEE: It's not always bad when you hear from a lawyer. So, but I also -- I -- I was remissed (sic) last time. Our court reporter, Marcy, is always here trying to keep track of what the heck we say when we talk over each other or we mumble. So to help Marcy out, please remember to say who you are when you're talking so she has some sense. I will sometimes do that, sometimes I'll forget. But, so let's try to remember and that'll help Marcy out. So thanks, everybody for being here.

The first official item is the review of the agenda. Tiffani sent it out to us. Any questions about that agenda as presented? If not, I would entertain a motion to accept the agenda as final.

DR. MCKENZIE: Motion to approve, Commissioner McKenzie.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch, second.

MR. FALAHEE: Got a motion on the floor. Any discussion? All in favor say aye.

ALL: Aye.

MR. FALAHEE: All opposed, same sign? Okay. That

motion carries.

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

MR. FALAHEE: Next item, declarations of conflicts of interest. Does anyone have any one given the final agenda we just approved that you think may create a conflict of interest for you? Okay. Hearing none, we'll move on.

Next, minutes of our meeting on December 7 and the minutes are in the packet. As usual the Department did a great job in my opinion of keeping track of what we said and what we thought we did. I'd entertain a motion to approve those minutes.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Englehardt-Kalbfleisch, motion to approve the minutes as presented.

MR. DRAKE: Commissioner Drake, second.

MR. FALAHEE: Great. We have a motion on the floor. Any questions? Any discussion? All in favor of the motion say aye.

ALL: Aye.

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

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

MR. FALAHEE: Okay. Let's move into the agenda now. We'll move forward with the first item. And we have bed count updates, Nursing Home Long-Term Care Unit, and I

see there's Paul on the screen. Paul, I hope you can hear us. We are having some audio difficulties, but bear with us and we hope we can hear you. So go ahead.

DR. PAUL DELAMATER: Hi, everyone. Can I get an audible "yes" if you can hear me?

MR. FALAHEE: Those of us in the front of the room, Paul, can hear you, but we're working our best.

DR. PAUL DELAMATER: Okay. Do you want me to hold on a second or do you want me to go ahead and start?

MR. FALAHEE: Hang -- hang on just a second. Try again, Paul.

DR. PAUL DELAMATER: How about now? Can you hear me now? How is --

MR. FALAHEE: It's -- it's very, very faint.

DR. PAUL DELAMATER: Oh, no. I have a very loud voice. I usually don't need the mic when I'm in the room, so sorry.

MR. FALAHEE: Trouble is we're getting a lot of static in the background and you couple that with your faint voice and it's very hard to hear you. How about -- the people in the back of room, can you hear him at all?

UNIDENTIFIED SPEAKER: (No audible response.)

MR. FALAHEE: I didn't think so. Okay.

DR. PAUL DELAMATER: How about now? Can you guys hear me?

MS. STANTON: Can you try now, Paul?

DR. PAUL DELAMATER: Is it -- how we doing now? We joke around campus that we've been doing Zoom meetings for years now and we're still always fussing around with it.

MR. FALAHEE: Paul, hang in. We're trying to do something here. If it doesn't work, we may have to go to a plan B.

(Off the record.)

MS. STANTON: Paul, can you try speaking now?

DR. PAUL DELAMATER: Oh, yeah. Of course.

MS. STANTON: There we go.

DR. PAUL DELAMATER: How about now?

MS. STANTON: Yes.

MR. CONNOLLY: Yes. There you go.

MR. FALAHEE: That's better. Sorry about that, everybody.

MR. CONNOLLY: Yep. Apologize.

MR. FALAHEE: We will continue to try to work out the audio difficulties. It's been three years running so we'll see what happens come the March meeting.

All right. So, Paul, it's Chip Falahee as chair. We're going to do our best to hear you and if we have trouble, it's not on your end. It's on our end. I'll -- I'll let you know somehow if it's not working out.

DR. PAUL DELAMATER: Okay. Chip, I can hear you

fine. Some of the people I can hear really well, others I'm -- I -- it sounds a little difficult, but, yeah. So do you want me to go ahead?

MR. FALAHEE: Yeah. Go ahead, please. That's fine.

DR. PAUL DELAMATER: Okay. Hi, everyone. I'm Paul Delamater. I am a associate professor at UNC Chapel Hill. The reason why I am joining by Zoom is because I'm here, but I used to go to school and grew up in Michigan for those of you who don't know me. And I've been working with the Department and the Commission since approximately 2010 or '11, and I assist with methodologies and working through some data issues.

So I'm going to give you a short summary of what happened with the Nursing Home Bed Need update and then I'm willing to take questions. I've got a suggestion on what we can do. So I -- I apologize that this is happening now. I actually got a little delayed this fall and didn't get it going until recently.

But I found an issue with what -- in one of the parts of the Nursing Home Bed Need, which we updated right as COVID was starting, was there is a projection of what we think patient day utilization or nursing home use is going to look like in the future and we use a linear trend to do that. At the time we had never seen a massive change in

nursing home utilization that could be captured that -- that was like a yearly change. Everything that we have ever seen in the past was -- was kind of slow even though it was -- you know, nursing home use has been dropping in many age groups.

So we put this method in to project future use looking at past trends and what happened was COVID kind of fundamentally changed how nursing homes get used, especially in that 85 plus age group. And the way the method is written -- it's very, like, narrowly prescribed which data we have to use. With using a base year of 2022, we then have to use a data from 2019 to determine the trend to -- predict out in the future. And what we have is the last year of pre-COVID and one COVID year, and what happened was it makes this -- it's kind of like non- -- it doesn't make sense, the trend, and then the projection that we get for our planning year which is 2027. And it is all just because like we have never seen anything like this happen before.

I feel like there's maybe a couple more methodologies that we have to keep an eye out in the -- in the upcoming years because we used, you know, three to four to five years of past data. But what it is, is it's just a kind of an unreasonable prediction of future nursing home use given this shock that happened in between 2019 and 2020 due to COVID.

My suggestion here is that we just delay if possible the bed need numbers until as soon as we get the 2023 annual survey data because then we can use 2020 and 2023 and we won't have this large, huge drop that -- in the trend. And that's basically a wrap on it. I don't have any other suggestions as far as, like, what to do right now other than wait.

I do think we should maybe open this up in a workgroup in -- in a year or something or later this year to just handle this one little part of the methodology. I have some ideas about ways we can make a -- like, a tweak to the methodology just to make sure that this part doesn't happen again.

MR. FALAHEE: Okay. This is Commissioner Falahee. Paul, thank you. Let me see if -- if other commissioners have any questions. Paul has submitted his report. It's in our packet. And what he's recommending is the first sentence of the last paragraph of that report. If anybody has any questions, now's your chance.

MS. GUIDO-ALLEN: Guido-Allen. I just have one question, Paul. When you say HLTAC, is that the same as in a long-term acute care hospital with the H at the end?

DR. PAUL DELAMATER: Yeah. It's hospital long-term care unit.

MS. GUIDO-ALLEN: Okay. So it's LTACs. No?

UNIDENTIFIED FEMALE SPEAKER: Just different.

MS. GUIDO-ALLEN: Okay. So what, somebody in the gallery is saying it's different.

MR. FALAHEE: No, I don't -- yeah, this is --

MS. GUIDO-ALLEN: What is -- what is the difference?

MR. FALAHEE: This is Falahee again. So what Commissioner Guido-Allen is talking about is a long-term acute care unit, an LTAC, which usually are located within acute care hospitals but they are separately licensed hospitals often with a different entity.

MS. GUIDO-ALLEN: Correct.

MR. FALAHEE: And I'm not sure, Paul, if what you're talking about here affects those. I don't think it does, but any comments?

DR. PAUL DELAMATER: Sorry. Yeah, this is -- these are just, like, facilities are a little different than a traditional nursing home. I can't remember what the -- it's -- this -- these ones are different than the -- yeah, the long-term acute care ones.

MR. FALAHEE: Okay. That's what I thought.

DR. FERGUSON: Can we -- have to get a definition of it? It sounds like we have a definition --

MS. MELISSA REITZ: Tulika can probably -- now that she's back. I don't mean to put you on the spot.

They're wanting to understand the difference between an LTAC and an HLTCU.

MS. BHATTACHARYA: Oh, okay.

DR. FERGUSON: Want to know what an HLTCU -- TAC is.

DR. PAUL DELAMATER: It should be in the standards. Let me pop that up.

MS. BHATTACHARYA: So the long-term acute care beds are essentially hospital beds that are used for -- used by LTAC hospitals which resides within a host acute care hospital. The host hospital provides the bed space, staffing, et cetera, whatever is needed. So those are hospital beds.

But hospital long-term care units, again, it's licensed under the nursing home license. So those are nursing home beds, but they are -- we've been licensed -- acute care hospital or close proximity to a licensed acute care hospital but those are licensed nursing home beds. Comes out of the nursing home bed inventory. But the LTAC beds are hospital beds, comes out of the hospital bed inventory. Two separate inventories.

DR. FERGUSON: So the term NH-HLTAC is a typo or what does that stand for?

MS. BHATTACHARYA: It's a typo.

DR. FERGUSON: Got it.

MS. BHATTACHARYA: So it should be HLTCU.

DR. FERGUSON: Thank you.

MR. FALAHEE: Other questions? Commissioner Drake?

MR. DRAKE: Yeah, this is Commissioner Drake. I don't know if you hear me or not. I'm going to speak -- are you able to hear me?

DR. PAUL DELAMATER: (No audible response.)

MR. DRAKE: Okay. Perfect. In looking at the recommendation, I notice that you're going to compare 2020 to 2023. I'm curious as to why we wouldn't use 2019 and 2023 knowing there's still a lot of the noise that you mention in the 2020 data.

DR. PAUL DELAMATER: So -- so we use -- so we used 2019 and 2022. The -- the problem is the switch from 2019 to everything after 2019. Once we moved to the 2020 data, -- like, 2020, 2021, and 2022 are actually -- appear quite stable. It was like nursing homes use was coming down and then it, like, had a shelf and then it keeps coming down a little bit.

MR. FALAHEE: You cut out there, Paul.

MR. DRAKE: But he's making sense.

MR. FALAHEE: It's always nice when a professor cuts out but the class still understands what you're doing based on your hand gestures.

MR. DRAKE: Okay. I understand what -- I understand.

DR. PAUL DELAMATER: So -- so the standard is written in for this, like, four -- it's four years -- can you hear me now?

MS. STANTON: Yeah, we can't -- we still can't hear you, Paul. It's yours this time.

DR. PAUL DELAMATER: Can you guys hear me?

MR. CONNOLLY: Yep, we still can't hear you, Paul.

DR. PAUL DELAMATER: Oh, they lost me. I'll keep talking. I'll just keep talking. I'm used to people not listening.

MR. FALAHEE: Let me ask -- this is Falahee. Let me ask Marcus and Tiffani if we can continue, but we can't hear Paul. I think we've heard the substance of what he wanted to say. There -- there's also the county designations. I think we can summarize those and see if there's any questions. So if we continue to have difficulties, maybe we can move on?

But, Paul, can you try talking again?

DR. PAUL DELAMATER: How about now? Can you guys hear me?

MR. FALAHEE: There you go. There you go.

MS. STANTON: Yes.

MR. CONNOLLY: We can hear you.

DR. PAUL DELAMATER: So what I was saying is -- I just put in the chat. I don't know if you guys can see that. This -- this -- like, the data, the -- the most recent data we have minus three years is written, like, into the standards and into the methods. So we can't modify that. We have -- like, by law we have to follow that. And that's why I said just delay because then if we have 2023, then we can use 2020 data and still follow the methodology that way.

MR. DRAKE: Okay. And -- and thank you for that response.

MR. FALAHEE: So let me address. Marcus or Tiffani, do we need a formal motion then to approve the recommendation about holding off? I think we probably do.

MS. STANTON: Yes.

MR. CONNOLLY: Yes, we do.

MR. FALAHEE: Okay. So Professor Delamater is suggesting we delay the adoption implementation until the data from 2023 is available and then we would result in using data from '20 and '23 to determine the trend to project pure utilization rates.

Would someone care to make a motion to that effect?

MR. HANEY: This is Commissioner Haney and I'll make a motion to that effect.

MR. FALAHEE: Is there support for that motion?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt-Kalbfleisch, support.

MR. FALAHEE: Great. Thank you. Any discussion? Any questions? Commissioner Ferguson?

DR. FERGUSON: Ferguson here. So I support the notion of waiting until we have 2023 data in order to take another look at it. I would encourage us not to default into the exact same methodology in case we end up with the opposite run of basing it off of a depressed COVID years and then an uptrend. But I don't know which version or flavor you're pursuing with this motion.

MR. FALAHEE: I think the -- this is Falahee. The version or flavor I'm pursuing is exactly as written and I think as Professor Delamater said, maybe a workgroup down the road to address what may happen given the actual numbers and making sure our formula isn't off kilter.

DR. FERGUSON: That's fine.

MR. FALAHEE: Paul, is that -- is that a fair summary?

DR. PAUL DELAMATER: Yeah. Very much so. And I -- Commissioner Falahee, I would not suggest doing, like, a full SAC on this because we really -- we spent a lot of time and we're happy with the method. I think we can just, like, do this one part to make sure we put some safeguards

up.

MR. FALAHEE: Great. Okay. Thank you. Commissioner Ferguson, does that answer the question?

DR. FERGUSON: That's fine.

MR. FALAHEE: Fine? Okay. Any other questions?

MS. GUIDO-ALLEN: This is Guido-Allen. Is there any concern with really only having two and a half good months of 2020 data for the analysis or no? Only because COVID hit March of 2020, the state, March 20th, around there at 10:00 o'clock.

DR. PAUL DELAMATER: So that --

MS. GUIDO-ALLEN: Go ahead.

DR. PAUL DELAMATER: -- so that's a -- that's a great question. It looks like to me we have -- we have hit a kind of a new normal and I -- given what we've already seen since 2020, 2021, and '22, I think we're -- I'm actually looking at this as is -- is it bad to have two months of pre-COVID data in the 2020 data rather than, like, ten months of or nine months of post-COVID?

Just looking at what I see, I feel like this is probably the new normal. And I -- use was already trending downward in this age group. I think it just -- especially in this age group. What you're look -- what was in the report was 85 plus. And -- and I don't know if I see a bounce back to that. I think maybe if anything happens it

spreads along at this level until it starts kind of heading back down again.

MS. GUIDO-ALLEN: Okay.

MR. FALAHEE: Okay. Any other questions? Okay. We have a motion on the floor. All in favor of the motion say aye.

ALL: Aye.

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

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

MR. FALAHEE: Paul, while we still have you by a string, you want to talk about the county designations, give us an update and then we'll see if anybody has any questions? This isn't so much -- this is not CON-driven. This is federally driven based on census data, but we wanted Paul to explain it and see if any of us had any questions about it. Paul?

DR. PAUL DELAMATER: Okay. So -- so every ten years the -- the Census Bureau once they get the counts and then do their calculations of things, it takes about three years after the actual census, they release kind of new official county designations where they designate counties metropolitan or micropolitan and then everything else is just not metropolitan or micropolitan and so it becomes rural in our -- in the way that kind of everyone who uses

this data looks at it.

This -- this idea of what is -- what is urban, what is rural is a -- is a bit sticky and I think that we've done a great job in Michigan of just like saying, Hey, the federal government has some definitions of that. They do the work for us. Let's just roll with their definitions. It's -- there's a nice methodology and it's easy to find and stuff.

And so our standards rely on this federal designation of which counties are metro, micro or rural. And then what we usually do in our methods kind of broadly is any counties that are metro are treated as urban and counties that are micro or what we call rural are treated as rural. And then the standards use these in a plethora of different ways from whether it be slightly deviations in our Bed Need methodologies, slightly different expectations for what utilization rates should look like, you know, like the percent of -- of the -- of a facility that should be used.

I think there's some evaluation cards on the -- on the end of people who have gotten a CON or gotten projects approved that -- that there may be some difference for that. But it's kind of spread across the standards in -- in a lot of different ways. But in general, the idea is that we want to account for the difference in kind of expectations around supply, demand, need, use of services in urban and rural

places. All right. So that's the -- the shortest explanation I can do on this.

The new designations came out at about mid last year and so I did a quick analysis of -- of what had changed in Michigan and there was a little bit of movement. A couple of counties jumped into metro and a couple moved from metro out, or one moved from metro out. I think that this will have a relatively small effect statewide as far as the methods go only because we -- we don't really -- I mean, we use it here and there in our methods, but it -- it's not something like a substantive change of the need methodology. It's just a county here or there gets reclassified.

It might have some effects on those counties themselves, but they have changed their category and so, you know, the idea is that, well, if you were non-rural, if you were urban and -- and -- or you were rural in the past and now you're classified as urban, something has happened in the last ten years that makes you jump into that classification so maybe we should treat you like an urban county.

And so I would suggest, you know, just going through all the standards, making sure that we find everywhere where this is referenced and just updating it to this -- this new designation.

MR. FALAHEE: Okay.

DR. PAUL DELAMATER: And I'm happy to take any questions.

MR. FALAHEE: Great. Thanks, Paul. Any questions? Personal interest. I know that Van Buren County -- I'm in Kalamazoo and we have one -- two hospitals in Van Buren County. We always were amazed that Van Buren was considered urban. We look at the cow to people test and Van Buren County -- any of you been to South Haven -- that is not exactly urban. It -- it was re-categorized to rural and which makes a lot more sense for those people who live out there. And I know Attorney General Heckman's from that area as well. So that's, that's the impact of these can sometimes impact what goes on within the CON world.

So I think it makes sense as -- as Professor Delamater just said to look at the standards, re-designate these counties pursuant to the federal designations and see if that has any impact. And let me look to the Department. Do you need a motion to do that or is that --

MR. CONNOLLY: Yes.

MR. FALAHEE: Okay. You need a motion. So the motion to the effect of looking at the designations based on the 2020 U.S. Census, there is the classification metro, micro and rural, and making those apply and designating the counties as such as part of the CON process. Is that it?

MR. CONNOLLY: Yes; yep.

MS. STANTON: To the applicable standards.
MR. FALAHEE: To the applicable, right.
MR. CONNOLLY: Yep, applicable standards.
MR. FALAHEE: Okay. Would anyone care to rephrase what I just botched through to make a motion?
MR. HANEY: Can I have a -- I have a question.
MR. FALAHEE: Sure.
MR. HANEY: So like in our business we say that we'll reimburse mileage at the current IRS rate. So when the IRS rates change we don't have to come back and update the policies. Should we have a motion that says something that we'll follow the CMS metropolitan designations in the standards so we don't have to motion this every ten years or --
MR. FALAHEE: Yeah. Paul, did you hear Commissioner Haney's question?
DR. PAUL DELAMATER: Yeah. I think -- I'm trying to remember how it's in the standards now. I'm sorry I don't know exactly the -- the wording. I think it might be in there that we use that, but -- but then we've been, like, extra careful to make sure. I think we might have the years, like, baked into the standards. But I -- I actually like the idea of just kind of taking the county thing out of every standard individually and having, like, just a list of the counties and then all the standards just say we use this

list which gets updated every ten years or something like that, or as data becomes available.

I don't know from a process standpoint how hard that would be to do that, but it -- it feels like one of those things that instead of going to have to change, like, 12 standards every ten years, we could just change the one document and then it kind of auto populates in all these standards.

MR. FALAHEE: Right; yep.

MR. HECKMAN: Okay. Assistant Attorney General Brien Heckman. So, Paul, you're suggesting that the standards be modified to adopt by reference the standards so that as opposed to incorporating them in the standards that are going to be updated? Tulika, is that what your team is planning on doing?

MS. BHATTACHARYA: Yeah.

DR. PAUL DELAMATER: Yeah.

MS. BHATTACHARYA: So right now the counties are in an appendix in the standard, so we'll have to go to each and every standard and change it so it will be easier if we can just make a reference.

MR. FALAHEE: Okay. So we'll -- I just talked to Attorney Assistant AG Heckman. We don't need a motion because the Department's going to adopt these by reference. Everybody comfortable with that? Nodding heads.

MR. HECKMAN: The Department's going to present standards --

MR. FALAHEE: That adopt --

MR. HECKMAN: -- in the future that adopt these by reference.

MR. FALAHEE: Okay.

MR. HECKMAN: Is that what your team wants to do, Tulika?

MR. CONNOLLY: We can do that.

MR. HECKMAN: Do you want the motion to just give you marching orders?

MS. BHATTACHARYA: (No verbal response.)

MS. STANTON: Well, our clarification was that --

MR. FALAHEE: Okay. Never mind. All right.

MS. STANTON: -- we have to go through the whole review process.

MR. FALAHEE: I want to move forward because we -- we need to get moving on this. In spite of the transmission difficulties, we want to get moving through it. Okay. So I think we need to have a motion put together on the floor and then support for that. Would anyone care to make a motion?

DR. MCKENZIE: I can try. This is Commissioner McKenzie. And I'd like to make a motion that the Commission direct the Department to draft a standard which would reference this -- adopt by reference the standards following

the census guidelines that would renew every ten years.

MS. BHATTACHARYA: For the county designations.

DR. MCKENZIE: For the county designations.

MR. FALAHEE: Support?

MR. HANEY: Commissioner Haney. I'll support that.

MR. FALAHEE: Great. Thank you. Any questions? All in favor of the motion say aye.

ALL: Aye.

MR. FALAHEE: Opposed same sign? Okay. That's approved.

(Whereupon motion passed at 10:09 a.m.)

MR. FALAHEE: Paul, I think we're all set. Thank you very much for all your help and putting up with the transmission difficulties. We apologize. Thank you.

DR. PAUL DELAMATER: So good to see or to hear everyone. I didn't get to see anyone. I'll -- maybe I'll be able to come to Michigan for -- for a meeting this year or something.

MR. FALAHEE: That would be great.

DR. FERGUSON: Thank you.

DR. PAUL DELAMATER: Bye, everyone.

MS. STANTON: Bye.

MR. FALAHEE: Sorry, everybody, for the transmission difficulties and we're still going to have

audio difficulties. I think if necessary I'll just turn this off and shout. It's frustrating.

Let's move on to the next item on the agenda which is Bone Marrow Transplantation Services. And I'll turn it to Tiffani to do a summary for us.

MS. STANTON: Yes. So there was the public comment period that was held from October 6 through October 20th of 2023. We received testimony from four organizations. The summary of these and the comments are all included in the binder. The testimony received was in support of continued regulation of BMT services.

The Department supports continued regulation for the BMT services and is recommending that the Commission charge the Department with making the technical revisions and approval at a later date. The revisions include adding the 30-day language to the standards.

MR. FALAHEE: Any questions of Tiffany so far? Okay. Any public comment?

MS. STANTON: No.

MR. FALAHEE: So what the Department is looking for is if the Commission so chooses to authorize the Department to make any technical revisions into the standards and submit those to us at a later date.

MS. STANTON: Correct. It would require a vote, a motion and a second.

DR. MCKENZIE: Commissioner McKenzie. And I'll make a motion that the Commission charges the Department with making technical revisions to the BMT Services standard and that those be presented to the Commission for a later review.

MR. FALAHEE: This is Falahee. Is there support for that motion?

MR. DRAKE: Commissioner Drake, support.

MR. FALAHEE: Great. Thank you. Any discussion?

MS. GUIDO-ALLEN: Question.

MR. FALAHEE: Question.

MS. GUIDO-ALLEN: Guido-Allen. Do we also in the motion have to say that we support that BMT services continue to be regulated or no?

MR. FALAHEE: (No verbal response.)

MS. GUIDO-ALLEN: We don't have to say that. Okay.

MR. FALAHEE: Other questions? Okay. All in favor of the motion please say aye.

ALL: Aye.

MR. FALAHEE: Opposed, same sign? Okay. Great. Thank you.

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

MR. FALAHEE: Next, Heart/Lung and Liver Transplantation Services. I have a strong suspicion this

one will not go as quickly as the one we just did on Bone Marrow, so -- but that's okay. It's important. So I'll turn it over to Tiffani to do a summary and then I know we have public comments because I have spoken to people that are out in the audience waiting to go. Okay. Tiffani?

MS. STANTON: All right. So, again, the public comment period was held October 6th through October 20th of 2023. We did receive testimony from five organizations. The summary of these are also included in the binder. Testimony was received. All was in support of regulation for Heart/Lung, Liver services.

The Department supports continued regulation for the Heart/Lung, Liver services and is recommending that a Standard Advisory Committee be formed to review some of the items brought forward. These include reviewing the modifications to improve access to liver transplantation services. And then the Department is also requesting to make the technical revisions of adding the 30-day language that is being added to all the standards.

So if a Standard Advisory Committee is to be seated, the written charge will need to be drafted and voted on by the Commission, or the Commission may instruct the chair to write a charge consistent with the language presented at today's meeting. The term of the SAC would expire within six months from the first meeting unless the

Commission specifies an earlier date. And the Commission chairperson would appoint SAC members consistent with the statutory requirements and the CON Commission bylaws. The chairperson would also appoint the chair and vic chair person for the SAC.

After the SAC completes their work, the SAC chairperson would bring the SAC's recommendation to the Commission at a future meeting.

MR. FALAHEE: Thank you, Tiffani. This is Falahee. Any questions before we open it up for public comment? Obviously there will be time for us to have discussions later and in questioning witnesses as well. Okay. Hearing none. I guarantee you there's public comment on this.

MS. STANTON: Yes. We have nine.

MR. CONNOLLY: Yes.

MR. FALAHEE: Okay.

MS. STANTON: Starting with David -- and I apologize on the last name -- Baumgartner from Trinity Health.

MR. FALAHEE: Let me ask the folks from Trinity. Is there a certain order you'd like to present in?

MS. STANTON: we did receive four.

UNIDENTIFIED SPEAKER: (inaudible.)

MR. FALAHEE: Okay. All right. Thank you.

DAVID BAUMGARTNER, M.D.

DR. DAVID BAUMGARTNER: My name is David Baumgartner. I'm a retired physician who lives in Grand Haven and practiced in Grand Rapids when I was in practice. I'm here because I had a liver transplant in 2012. I was diagnosed in 2010 with liver cancer and -- by my primary care doctor and was referred to University of Michigan for liver transplant.

I went there pretty quickly thereafter starting the summer of 2010 and got excellent care there. I went through a whole series of tests and treatment over an extended period of time over about 18 months until I was needing to have achieved enough stability to go through a transplant and I went on the liver transplant list in December of 2011. Fortunately, I was able to receive a transplant in May of 2012, and I had a fairly uneventful postoperative course and have done very well since then.

I -- I'm really grateful for the care that I got during that period of time. It was a very intense period with all the treatment that was required. I had many, many trips from West Michigan down to Ann Arbor to receive the treatment and the evaluation. In fact, my liver specialist who was part of the liver transplant program provided most of that treatment until I was able to meet my surgeon several months before I had the transplant.

I wanted to point out that my -- I was lucky because my employer was very supportive, my wife's employer was very supportive, and we had a lot of opportunity with a lot of resources to get all this done even though it required frequent trips. I still continue to go to Ann Arbor for follow-up care to this day, even though my transplant was over ten -- was back in 2012.

And I just wanted to say that when I went back into practice after my transplant, I -- I had a number of patients who I referred for transplant who were unable to get it because they did not have the resources to travel across the state to a program that could handle the problem. So I just wanted to ask the Commission to consider widening access to liver transplant. It made a huge difference in my life and I know it could do so for many other people.

MR. FALAHEE: Thank you, Doctor. Any questions? Thank you. Thank you very much. I think all the witnesses know, but we have a three-minute time limit on witness testimony and then if the commissioners have questions, there's no limit on that. So just so future witnesses -- thank you.

MS. STANTON: All right. Next up we have Matt Biersack with Trinity Health.

MATT BIERSACK, M.D.

DR. MATT BIERSACK: Good morning. I'm Dr. Matt

Biersack. I serve as president of Trinity Health in Grand Rapids, Michigan. We are the -- we operate the only adult kidney transplant program in West Michigan. It's a 50-year old program that has now done close to 3,000 transplants. And I appreciate the opportunity to provide comments this morning.

We believe that a liver transplant program in West Michigan is essential. It'd be a greater access to transplant and a greater likelihood that Michigan residents are wait listed, receive a transplant, and survive advanced liver disease. Unfortunately, we think Michigan is falling behind. Liver transplants is growing in the U.S. faster than in Michigan and of the 41 states that have liver transplant centers, Michigan ranks 25th in transplants per capita. And at the same time we know the incidents of liver disease is increasing and projected to continue to do so.

We believe the number of Michiganders who are being wait listed and transplanted can and should be much bigger, but that they aren't because of geographic proximity. We know patients with limited economic means and minority populations do not have equal access to liver transplant due to geographic distance.

A '21 -- a 2021 study confirmed that a patient's source of insurance and their distance from a center most highly correlated with whether that minority population

would ever join a wait list. We're concerned that Michigan's lack of access to transplant centers is limiting the number of Michiganders being wait listed and it's exacerbating a health care inequity. Another study in VA patients showed that veterans who were eligible for transplant but a greater distance from a transplant center, was associated with a lower likelihood of being wait listed, a lower likelihood of receiving a transplant, and a greater likelihood of death.

A new distribution policy in 2018 caused a radical change for distributing livers. As a result, a center in West Michigan would not necessarily compete with Michigan's existing programs for available organs. In fact, a West Michigan-based program would instead have priority access to livers coming from Wisconsin, Illinois, northern Indiana and a large portion of northern Michigan that falls outside the 150 nautical mile radius around southeast Michigan. A West Michigan center would, in fact, enlarge the geography from which Michigan receives livers.

Unfortunately, we know that the current cap hasn't adapted to population changes, it hasn't adapted to changing indications, and an increasing number of patients with advanced liver disease. We've heard here previously that there is capacity, but capacity does not equate to access.

In West Michigan we're growing and the number of

residents deserve access to transplant closer to home. This will increase the number of patients wait listed, transplanted, and will save lives. A fourth program in West Michigan would expand access to patients who don't have the means or ability to travel across the state.

We're asking that the CON Commission review the current standards to assure that West Michigan is being adequately served and to update the comparative review standards before you. Thanks. And happy to take questions.

MR. FALAHEE: Okay. Any questions of the commissioners? I've got one. This is Falahee. You just -- you summarized your ask. Can you expand on it if you want to or if there's another witness that's going to do that, that's fine, too. So what's your specific ask of the Commission?

Let's assume the Commission -- let's assume -- I'm just going to throw this thing out. Let's assume the Commission approves the Standard Advisory Committee, a SAC. We always have to look at what the potential charges are for the SAC and sometimes the Commission will designate the vice chair and the chair to come up with those charges. So what charges would you suggest that the SAC have as it goes about its business?

MR. MATT BIERSACK: Yeah. Appreciate that, Chip. My ask is that we look at whether or not really the

residents in West Michigan are being adequately served.

MR. FALAHEE: Okay. Great. Thank you. Other -- any questions from the commissioners? Okay. Thank you very much.

MR. MATT BIERSACK: Thank you.

MS. STANTON: Okay. All right. Next up is Damon Bedi from Corewell Health.

DAMON BEDI, M.D.

DR. DAMON BEDI: Good morning. Chairperson Falahee, Vice Chair McKenzie, and Members of the CON Commission, my name is Dr. Damon Bedi. I'm a transplant surgeon and section head of multiorgan transplant at Corewell Health, William Beaumont Trinity State Hospital. I've also had the pleasure of serving as the director of transplant outcomes and quality for 11 years now there. Thanks for the opportunity to provide comments about the Heart/Lung and Liver Transplantation services to the CON that we're discussing today.

Based on the facts that are before us today, Corewell Health does not believe another liver transplant program is needed in Michigan at this time. While others will speak or you'll hear about high level of access that Michigan residents have to liver transplant services, I wanted to highlight the high quality of care that is being presented here in Michigan given the quality and access that

we have.

Michigan's one year graft survival for liver transplant is 92.2 percent which is above the national average. By geographic region in our state, patients from Grand Rapids have a high survival rate of 95 percent. In addition, per the CDC, Michigan's mortality for end stage liver disease is half the rate for the U.S. which speaks to the high level of access and quality care that patients with advanced liver disease are receiving here in Michigan.

In order to maintain this high level of quality, liver transplant centers need to perform a significant number of transplants annually and it takes a long time, take it from our program, it takes a long time for a new liver transplant program to reach that critical mass and some estimate that critical mass to be about 40 or more liver transplants per year.

Corewell Health's program is the newest liver program in the state having done its first liver transplant in 2010. The program has just now reached this critical mass volume due to in part to cooperative relationships that we've developed with liver disease clinicians across the state including those in West Michigan receiving care at Corewell Health's western hospitals. As you will hear, patients in West Michigan can receive much of their pre- and post-transplant care locally and only have to travel to

Southeast Michigan for the transplant surgery event itself.

A critical point to note is that adding another liver transplant program in Michigan likely will not increase liver transplants volumes as those are limited by the number of available organs. Instead, doing this may simply result in the number of transplants being done at the existing centers to go down and that probably would dilute the experience and hence negatively affect quality. In fact, diluting experience and reducing the liver transplant volume of each program tends to make transplant programs overly risk adverse, avoid taking on challenging patients, and allowing organs that are maybe considered marginal by some programs to go unused.

Given the high level of quality and access that Michigan residents currently have who are seeking liver transplant, I continue to believe that we do not have any need for changes in the current CON guidelines. However, if the Standard Advisory Committee -- okay. Thank you.

MR. FALAHEE: You -- go ahead and finish your --

DR. DAMON BEDI: Well, I just wanted to say if the Standard Advisory Committee is formed, we believe that the charge and ask as you were saying earlier is to -- looking into researching and documenting whether there is or is not an access problem and only if there is should the SAC then look into ways to address that problem. Thanks for the

opportunity to speak.

MR. FALAHEE: Okay. Thank you very much. Any questions? I've got one.

DR. DAMON BEDI: Sure.

MR. FALAHEE: So you talked about the finite supply of liver -- livers out there. The prior witness talked about it sounds like there's a different geographic area from which, let's say, a hypothetical service in Grand Rapids would draw from versus in Southeast Michigan. Can you help me understand that, if that's true?

DR. DAMON BEDI: I think it is a good point. Right now livers are allocated based off of transplant donor hospitals, the donor hospital itself. So if you live within 150 or 250 miles of that donor site, then you do have access to organs so that's true. You know, if you have a donor hospital in Wisconsin and you're listed here in Grand Rapids, you're within 150 miles or you're not within 150 miles. So while you gain some access, you lose some access. I think it's a -- kind of a little bit of a shell game but it's hard to really know what the impact is. Even the OBTN is still looking into this as it's only been a few years of -- of being in effect.

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

DR. ENGELHARDT-KALBFLEISCH: And a clarifying question. When you said you gain some access, lose some

access, does that mean, like -- I just want to understand the geography because it's complicated.

DR. DAMON BEDI: Yeah.

DR. ENGELHARDT-KALBFLEISCH: Cities east, like major metropolitan cities to the east, we could potentially lose access from that?

DR. DAMON BEDI: That's correct. So if you're listed in Grand Rapids, you may have access across the lake: Milwaukee, Wisconsin centers, even maybe in Chicago, but you would lose access to Pittsburgh, Rochester, New York, Cleveland. It's all based on a circle of 150 or 250 miles. Eventually it's 500 miles for the sick -- for the sick patients. But the reality is, is that what -- I think the point for that and for the previous speaker to -- to make is a good one which is there may be more organs that you're able to get access to that Michigan wasn't getting access to previously, but it doesn't mean that you're getting more organs necessarily because you're -- you're cutting out a part of the circle that was there for the southeast programs.

DR. ENGELHARDT-KALBFLEISCH: Thank you.

MR. DRAKE: This is Commissioner Drake. I have a question. So the previous witness who was a former patient spoke to his journey and I want to thank him for share -- for sharing his journey with us.

DR. DAMON BEDI: I agree.

MR. DRAKE: I heard three phases of care. There was that pre-transplant, the actual transplant, and then the post-transplant.

DR. DAMON BEDI: Yeah.

MR. DRAKE: I would presume post-transplant care is -- it's infinite. Okay. Can you give us an idea of the time, the average time frames of that preop versus the average kind of acute phase of the transplant journey?

DR. DAMON BEDI: That's a great question. You know, the -- the pre-transplant -- I think the previous speaker and the patient, thank you for sharing your experience -- is probably anywhere between six months to a year for liver transplant patients. So they're -- they're quite acutely ill, they have complicating factors that expedite their transplant unlike a kidney transplant patient that may be on the list for a long time. So I would say about six months to a year is the approximate amount of time.

MR. DRAKE: Okay.

DR. DAMON BEDI: The transplant event itself being called in, you're usually in the hospital for about a week to ten days. Many centers have various amounts of sort of obligations that they ask families to stay in town for about a month, sometimes a little bit longer. I can speak to

Corewell, when we have patients that come from the west side of the state, we consider that local so we don't actually ask patients to stay in the southeast Michigan area. Once they're done with their transplant, that ten days has gone by, we actually allow the patients to return back to their home.

And then the post-transplant phase of care is a -- a more complicated one. It is infinite. Programs will oftentimes ask patients even through telemedicine or in person to come back once a week, once every other week. But I do think that post-transplant care as being local, you deliver now through all of the outreach clinics that also provide post-transplant care by Henry Ford, by University of Michigan, and by Corewell.

DR. FERGUSON: Loop back around at the risk of being redundant which would be clarifying question or point to be very, very explicit. A hypothetical additional facility in West Michigan, while that facility may not have access to more potential donors because, while it would pick up the opposite coast of Lake Michigan, it might lose Pittsburgh. But would not the people of the state of Michigan have a net pickup in potential access to organs? Because we would have access into multiple states, multiple directions. I understand that there has to be a match, right, so you're --

DR. DAMON BEDI: Yeah.

DR. FERGUSON: -- there's the question of match. But in terms of potential donor population expands by some number of organs because there's millions of more total --

DR. DAMON BEDI: I'm sure there's a more eloquent question -- answer to your -- to your question. I think it's possible. It is possible that there may be more organs coming in to the state. I -- the concern I have, though, is that you continue to dilute that experience and so who's really willing to take those?

DR. FERGUSON: Yeah. That part I -- that side of it I understand. Thank you.

DR. DAMON BEDI: Yeah.

MS. GUIDO-ALLEN: Question. Dr. Bedi, can you share -- and I should have asked that, the other physician -- share the resources, you know, you -- you said the program started in 2010.

DR. DAMON BEDI: That's correct.

MS. GUIDO-ALLEN: The resources, the -- that are required for a liver transplant program, the commitment from the -- you know, can you just give us a -- an overview of what it takes to run a liver program?

DR. DAMON BEDI: Yeah. So there are transplants that we consider to be kind of easier to be done, some organs, and others that are really needing a huge network

of -- of physicians and care team providers and I would say the liver transplant sort of falls into that area if it's not -- no one is saying anything is easy, but it's not really as easy to start up a liver transplant program. The referral providers that you need, you have to have a huge network.

The investment in the hospital is not just, you know, a couple of -- of beds here, but you need an entire ICU that's dedicated towards taking care of not just transplant patients, but patients who have liver failure leading into the transplant itself. The network of hepatologists, the transplant hepatologists and surgeons that you need have to be high caliber physicians. And then the anesthesia team, having a solid cardiovascular team, having interventional radiology teams and radiology specialists are -- you know, it's -- it's a huge number of -- of specialty physicians. The infrastructure beyond that performs (inaudible), like pharmacists and dieticians and social workers, access to local addiction prevention agencies.

It's -- it's a good question. I think what I can say is that it's -- it's a broad spectrum of specialists that you need to get there.

Our experience is that one of the other aspects of it does take time to feel comfortable taking on marginal

patients, taking on marginal -- consider marginal organs and that time is, you know, five to ten years' worth of just trying to grow the program.

MS. GUIDO-ALLEN: Thank you.

MR. FALAHEE: Other questions? Great. Thank you very much for your time.

DR. DAMON BEDI: Thank you. Appreciate it.

MS. STANTON: Next up, Andrew Shreiner with Corewell Health.

ANDREW SHREINER, M.D.

DR. ANDREW SHREINER: So, good morning Chairperson Falahee, Vice-Chair McKenzie and Members of the CON Commission. My name is Andrew Shreiner. I'm a physician and the section chief for gastroenterology for Corewell Health West. Thank you for the opportunity to provide comments on the CON review standards for Heart/Lung and Liver Transplantation services.

So you've heard from and we'll hear from additional experts on this topic through written comments and here today. I would like to offer some thoughts from my personal experience and our team's experience caring for patients in West Michigan in need of a liver transplant.

So as you've heard, patients in West Michigan can receive their pre- and post-transplant care locally and then only have to travel to the east for the transplant itself.

There's currently a well-established network of clinics that ensure patients can receive the bulk of their care close to home.

At Corewell Health, we have developed a close collaboration between our west and east programs. In Grand Rapids, we have established a liver clinic in the last few years composed of a Board Certified transplant hepatologist, two advanced practice providers, and specialties trained staff including nurses and a social worker. Patients with advanced liver disease are cared for in this clinic and identified as possible candidates for liver transplant. Our hepatologist spearheads their pre-transplant evaluation and presents these patients to the liver transplant selection committee operating at the Corewell Health East Beaumont site. Together they decide if patients are recommended for liver transplant.

Once patients have stably recovered from their transplant surgery performed on the east side, our west side liver clinic will resume care closer to home. Other clinics on the west side of the state have established working partnerships with liver transplant programs on the east side as well. As you've heard, patients on the west side of the state have some of the best transplant outcomes in the state. Notably the one year graft survival rate for Grand Rapids region is 95 percent, Kalamazoo is 96 percent and

here in Lansing is 100 percent.

So given the high level of access and quality for liver transplant in Michigan, Corewell Health does not believe any changes are needed to the current CON standards. However, if a Standards Advisory Committee is formed, we believe the charge should focus on documenting whether there is or is not an access problem and only if there is, should the SAC consider ways to address the problem. Thank you.

MR. FALAHEE: Thank you very much. Questions?

DR. MCKENZIE: I have a question. Commissioner McKenzie. I don't know if it's going to be a super easy one to answer. It's not certainly a super easy one to ask. But I'm going to try to pull together a couple pieces that are rolling around in my head with this question.

I did hear concerns about dilution because that can definitely impact quality in terms of transplants. But I also heard data related to that transplants are trending higher for liver out of state than they are in state and we know that there's rising obesity rates and more indications related to NASH for liver transplant. And so, you know, I also heard from the testimony given earlier, you know, of concerns about people not even getting on the list and I have concerns about health and equity. I think we all do as well.

And I guess the question that I have is, is there

any quantification of that? Do we have any sense of that or are there any studies related to that, that if patients are having to drive further to actually get the transplant that they may never even enter care? Right? They may never sign up or get on the list. Do you have a sense of that or how we would even get our arms around that or is it a concern of yours?

MR. ANDREW SHREINER: Yeah. I think we -- we did hear already, you know, that the mortality rate for advanced liver disease in Michigan is -- is relatively low compared to -- compared to the national rates. So that implies, you know, overall good care in the state. I think we have information that's been provided with some of the written materials that patients on the west side do have transplant rates, you know, similar to patients on the east side suggesting they -- they do have access.

And so, you know, certainly, you know, we're making efforts to provide care locally as we described. We certainly, you know, don't want to hear that patients, you know, need to travel back and forth unnecessarily, you know, many times over this journey. And so, you know, what has been established currently is efforts to provide, you know, good care close to home and then, you know, rely on the real expert, high level care that's needed for the transplant surgery at those centers that, you know, have that

experience and expertise. So does that answer question, your question?

DR. MCKENZIE: Thank you.

MR. FALAHEE: Let me -- this is Falahee. Let me -- let me ask it this way. We -- we may not know what we don't know about people that aren't even bothering to -- you know, they may have liver disease, but they may say, I can't go to southeast Michigan. I can't afford to go. I don't have transportation to go. I don't have the money to go. How are we catching those people, assuming they're up? And I know it's, --

MR. ANDREW SHREINER: Yeah.

MR. FALAHEE: -- I should have asked the professor about this, but I'm sorry I'm asking you.

MR. ANDREW SHREINER: Yeah, yeah. Well, I think we heard, too, that we just -- we need an extensive network of providers, you know, in all the communities in Michigan to help funnel patients to -- to transplant centers. So, you know, you can be on the east side of the state and still be relatively remote from, you know, the Detroit area. So, you know, we need, you know, a network of primary care physicians, you know, to refer to specialists who can then further, you know, kind of evaluate and identify people for transplant. So, you know, certainly, you know, geography may be one limitation.

I think we heard some other information about, you know, other socioeconomic factors, insurance coverage, you know, there's a variety of things that may limit access. Geography is certainly, you know, one that's relatively easy to understand. Probably not the -- the only factor. Nonetheless, you know, I think we need an extensive network, you know, into all of our areas to try to help, you know, provide access.

MR. FALAHEE: And then one other question I've got and it may not be in your bailiwick and if it's not, that's fine. We've got other witnesses. When you're trying -- when you're on -- put on a wait list, is one of the factors that goes into that how far you live from the location of where the transplant itself will occur? So if you're -- if you're in Ann Arbor, you're going to get a score and put on a wait list. If you live in Grand Rapids or South Haven, will you be further down on the wait list because you're further away from southeast Michigan?

MR. ANDREW SHREINER: So that is a nuance question. I think some of my colleagues, --

MR. FALAHEE: That's fine. That's fine.

MR. ANDREW SHREINER: -- you know, who are performing transplants can probably answer that better.

MR. FALAHEE: Okay. Thank you very much.

MS. GUIDO-ALLEN: Guido-Allen. Can I ask you a

question? And I -- maybe you don't know. But can you explain outreach clinics?

MR. ANDREW SHREINER: Sure. Yeah. So --

MS. GUIDO-ALLEN: What does -- where are they? What does that mean to that -- to -- from an access standpoint?

MR. ANDREW SHREINER: Yeah. So, you know, within our model, for instance, you know, we can think of it as kind of the -- the hub and spokes. So, you know, Corewell on the west side, you know, Grand Rapids is kind of where you have concentrated services and big, you know, hospitals with a lot of capability and capacity. And then we have outreach clinics, you know, at various distances kind of around, let's say, Grand Rapids, you know, in various directions. And so, you know, those tend to be, you know, smaller and smaller volume. But in, in total, you know, they form a network that helps to identify and -- you know, patients with a need and then kind of refer them, you know, into the -- into the area where we have, you know, higher level care options.

MS. GUIDO-ALLEN: Thank you.

MR. FALAHEE: Other questions?

MR. DRAKE: I would say -- this is Commissioner Drake. He posed a very important question I think I'd like to know the answer to at some point. And just to rephrase

it in my head, you know, if Commissioner McKenzie and Chip here were -- all things equal medically -- because we know there's medical nuances: size, weight, blood type -- but if all things were equal medically, would where they live factor in their priority? I would like to get that answer myself.

MR. ANDREW SHREINER: I mean, we can open it up. I think other people in the room could probably answer that pretty --

MR. FALAHEE: Yeah, we'll -- I'm sure we'll get an answer sooner or later. But there's still -- there's still -- there's witnesses. You have to go, but you're excused. Thank you very much. Thank you. And I will add that sometimes the commissioners come up with questions and -- and the -- the witnesses just, Wow, I don't know, and that's perfectly okay to say because there are others that can probably answer those questions. So thank you very much. And if there aren't, just keep in mind, folks, that's one of the questions the Commission has.

Tiffani, next -- next witness. Can everybody hear Commissioner McKenzie and I because no microphone. All right. Good. Okay.

MS. STANTON: Okay.

MS. TURNER-BAILEY: Excuse me, Chip?

MS. STANTON: Oh, I'm sorry. Go ahead.

MS. TURNER-BAILEY: I can hear you, but it's very hard for me to hear everyone else that's speaking to be honest.

MR. FALAHEE: Okay. All right.

MR. DRAKE: We'll have to speak louder.

MR. FALAHEE: All right.

MS. STANTON: Yeah. We're -- we're to the point we're about to cut out all the mics so we really have to really pitch up. Arlene Elliott on behalf of a Michigan resident.

ARLENE ELLIOTT

MS. ARLENE ELLIOTT: Good morning. My name is Arlene Elliott and I'm here on behalf of Susan Knauf and she is at home taking care of her 96-year-old father so she could not come. She wrote a letter instead and asked me to read it in. She wanted to write to share her experience when,

"My husband, Bob, received his liver transplant 9 years ago at the U of M. My husband and I live in Byron Center, a two-hour drive from Ann Arbor. My husband and I traveled to U of M many times for checkups and consultations before the transplant took place. Three of my children came with us to the information meeting but three could not because of the cost and distance.

The week before the liver transplant, my mother, who was in hospice and dying of cancer, was near death. I had been, with my family, keeping vigil for 8 days waiting for her eminent death when they called Bob and told him of the availability of a liver. At first, he said he might turn it down because of what our family was going through at the time. But the person at U of M explained to me that if Bob turned it down, he might not get another opportunity. We made the decision at 4 p.m. that he should go and he had to be there by 7 p.m. I made it just in time to see him before they started the surgery. I left my dying mother, with great sadness, who did pass away at 8 p.m. that very evening. Had it been closer to home in Grand Rapids I may have been able to stay with her longer and still be with my husband, too.

All six of my children came to the U of M and waited for Bob to get the transplant, some coming from Grand Rapids, up north, and even out of state. The surgery was successful but my children had to stay in hotels for a few days wanting to make sure all was well. If it had been closer to home they could have stayed with friends and relatives at a cost much less to them in order to support their father and I. I stayed in Ann Arbor for three weeks only leaving one

day to attend my mother's funeral. All but one of my children had to go home to jobs and children and could not really visit at such a great distance which made it harder for me.

Due to complications, for three months we had to make trips back to the U of M to stay a few nights. These trips were costly for gas and for the hotels. It would have been more convenient if we had a facility closer to home. We also had to buy a new car because with so many trips I did not want Bob to make so many long trips in the small car we had.

I would like to say we are very grateful for the gift we were given and we wish more people had this opportunity. We met many people at the U of M who hoped for the same opportunity but did not do a transplant either because of the expense or the travel time. We are fortunate we had the means to do this, even though it did take a lot out of our retirement budget. It also cost my children some expense to be able to support us in this, and many families and support systems do not have that ability. Ultimately it is important to the family -- to the patient to know that his or her caregiver has adequate support.

It is my understanding that regulations are preventing Trinity Health from starting a liver

transplant program in Grand Rapids. I hope this Commission will consider changing those regulations to allow this. If you make this change, I think more eligible patients will get liver transplants, and they will be able to avoid the hardships we experienced. Sincerely, Susan Knauf."

MR. FALAHEE: Thank you, Arlene. Any questions? Thank you. Thanks for sharing.

MS. STANTON: Next up Dr. Chris Sonnenday with Michigan Medicine.

CHRIS SONNENDAY, M.D.

DR. CHRIS SONNENDAY: Morning. Thanks so much for the opportunity to speak. I will truncate my comments slightly not to be repetitive and to provide some time maybe to comment on some of the issues that have been discussed. I'm a liver transplant surgeon and currently serve as the transplant center director for U of M Health.

As an introduction I would just say I think it's worth reflecting on the progress in liver transplantation within the last four decades. Liver transplantation was an experimental therapy clearly in the 1980's and has rapidly become the definitive treatment for advanced liver disease and certain cancers without standing short of long-term outcomes.

I would argue, though, that the challenge to our

field more than anything else, more than organ shortage, more than technique, immunosuppression, et cetera, is access, access to care. We need to make certain that this transformative therapy is available to more patients with access to transplant dictated by need and not by other factors that have unfortunately influenced access such as socioeconomic status, insurance status, or proximity to a transplant center. These are challenges that we as a transplant community need to all confront directly in partnership and collaboration with our institutions and communities.

As you've heard there are some concerning data to suggest that Michigan as a state is underperforming in access to liver transplantation. Liver transplants performed in the U.S. have grown between 52 percent from 2012 to 2022, more than 10,000 done in 2023 as a matter of fact, while liver transplants performed in Michigan only increased 28 percent over the same time period. And according to CDC data, the age adjusted death rate for chronic liver disease in the state of Michigan has risen 55 percent over that same time period versus about 26, 28 percent nationally.

Furthermore, multiple studies have demonstrated that the distance the patient lives from a transplant center is enforcely proportional from their likelihood of receiving

a transplant. All three of the excellent programs in Michigan are in southeast Michigan which arguably restricts that to -- to residents of other regions.

A common argument against expanding the number of programs in the state, one that I actually personally have made myself as has my institution, is that transplant access is dictated by donor availability, not center number or location. But I think that argument is less applicable today than it has been in the past. The number of liver transplants performed in the state has increased for 11 years in a row, a growth rate that has not been fully realized in Michigan. More importantly, the policy that you heard referred to earlier that allocates livers from deceased donors to candidates changed from a local first system to a national system based on the location of donor hospital and therefore patients in West Michigan at a center in West Michigan would have differential access to a huge population center in Chicago, Milwaukee, et cetera.

Currently the state CON standards for Heart/Lung and Transplant allow for three adult liver programs. That's a 25-year old standard. We argue that the CON Commission create a Standard Advisory Committee of expert evidence-based assessment of the liver transplant sections of the CON standards. We all really need to collaborate around expanding access to this therapy. Thank you. I'm

happy to take questions.

MR. FALAHEE: Thank you very much. Questions? I'll start. Thank you. Can you answer the question that Commissioner Drake phrased better than the question I phrased?

DR. CHRIS SONNENDAY: Yeah. It's a great question. So to -- I'll reiterate and make sure I'm answering the right question. Your question was if patient location, area of residence, dictates their status on the list?

MR. DRAKE: Yes.

DR. CHRIS SONNENDAY: So the short answer to your question is no because status on the liver transplant waiting list is a needs-based system. It's -- it's based currently on something called MELD 3.0, which I won't bore you with the multi-varied analysis, but is essentially lab-based factors. It also considers sex. The -- but proximity dictates access in a different way. Right? So, and I'll tell you how we experience this.

Where a patient lives, especially this time of year, dictates how easily they can get to our center. And I've had the experience of calling a patient myself in northern or western Michigan in January or February when we have an organ in hand and they have not had the ability to get to us and that's despite using Angels of Mercy Flight

Services, local police, all kinds of resources. Proximity to a transplant center is important and, remember, those are the people who get on the list. We're not talking about the denominator of people who can't even consider that investment.

I think Dr. Baumgartner gave a very compelling testimony as the letter that was read about what a family can do to make sure their loved one gets a transplant. But that's a family that could do it. And all of us anecdotally see patients in outreach clinics or get called for urgent transfers for patients with decompensated disease who just don't have the resources to get to Ann Arbor or Detroit or to Royal Oak. And I think that's the concern that I -- that we're missing, the denominator of people like that.

MR. FALAHEE: Thank you.

MR. DRAKE: He answered the question.

MR. FALAHEE: Okay. Other questions?

DR. CHRIS SONNENDAY: Can I make one comment on the quality argument? Because I think it's a really good --

MR. FALAHEE: Sure. Go ahead.

DR. CHRIS SONNENDAY: -- one that Dr. Bedi made. So first of all I'll say there's -- there are few people I respect more than Dr. Bedi, but I disagree with his argument and I'll tell you why. Because his own program proves that it's a fallacy. Right? So when -- when they opened their

program in 2010, our volume dropped by about 15 percent as they built that program. So that was one thing that changed.

The second thing that changed, our payer mix changed. Interesting, right? Because the people of southeast Michigan have good insurance, wanted to go to their local center appropriately. They built a great program. Our -- our payer mix shifted to more publicly insured patients, Medicare and Medicaid, and that persists to this day and I actually am proud of it now because I think it means we're serving a population that we weren't previously.

And lastly, what has happened in the state of Michigan is the number of transplants has increased now ten years in a row. We did 270 or just under 300 transplants total when you include liver donors and deceased donors in 2023. And that's despite adding a program. So the pie didn't just get carved up differently. The -- the whole tide rose and the outcomes at all three programs has already been stipulated are excellent. So I think the -- the success at Corewell Royal Oak proves that adding an additional program doesn't have to mean a detriment to quality of care to the residents of Michigan.

MS. GUIDO-ALLEN: Guido-Allen. I have a -- I have a quick question for you. With -- we all know that it's

difficult to have specialized physicians, physicians of any type come to Michigan unless they're married to somebody from Michigan who wants to move by their family. I think we've all experienced that.

To -- to start a liver transplant program will require many resources; physicians, APPs, nurses, social work, dieticians, the whole gamut that provides that support. And knowing what I think all health systems are going through right now, all -- everybody as far as workforce, whether health care or not in this state, how long will it take to develop another program to the extent that we would be assured of quality and access, et cetera?

DR. CHRIS SONNENDAY: It's a great question, so -- and one that we -- our institution has considered a lot ourselves. You know, I think the -- there's some stipulations. So first of all, if it -- if a liver transplant program is created in the presence of an already existing program like Dr. Biersack argued about at Trinity to -- you know, they already got a long-standing excellent kidney program. Could they add a liver transplant program with that?

So a couple things about that. Number one, yes, because a lot of the resources are similar; pharmacy, nursing, support, et cetera. Number two, the CON standards currently and I think appropriately require that a liver

transplant program be created at a site where there's already a kidney treatment program existing. There's lots of reasons for that we can discuss, but I think that's actually an appropriate standard.

So if -- with that lead-in, you know, I think it would probably conservatively take two years at least to create a liver transplant program. Part of that is the recruitment of appropriate staff. Part of it is the assuring the institutional perioperative resources in the operating room, ICU, some of the things you've heard about exist. And then there's the UNOS application process and a fair amount of payer relations that would have to take place and there's a significant financial investment for any institution that does this. Most new liver transplant programs I've consulted with, a few around the country that have -- that have done this, you know, have to eat the first ten transplants they do essentially to -- to create payer contracts.

So it's not an insignificant resource at a time that I would agree we are very lean, but I don't think that's a reason to shy away from at least considering the access, you know, implications of this. It's a great question.

MR. FALAHEE: I think we've exhausted our questions for the moment. Thank you.

DR. CHRIS SONNENDAY: Thank you all. Appreciate it very much.

MR. FALAHEE: Thank you very much. And before the next witness comes up, I -- I'll remind people that often the Commission will instruct the chair and the vice chair to work on who gets seated on a potential SAC and who gets to be the chair and the vice chair of the SAC. And this chair in the past has made a very good point of appointing a chair and vice chair from different sides of the fence if you say. All right? And they know each other professionally.

And the last time we did this was CAR-T. All right? And I -- I went up to the two physicians afterwards whom I both knew and they knew each other. They respected each other. They were on the opposite sides of the fence. I said, Congratulations, A and B. You're the chair and you're the vice chair. Work it out. All right?

So I'm just saying, Dr. Bedi and Dr. Sonnenday, just get ready for a phone call maybe. All right? But I say that in seriousness. We're commissioners. We have physicians around the table. We don't have any transplant physicians around the table. All right? And we need to rely on the experts to tell us what's going on access-wise, quality-wise, cost-wise. And who better than the experts in the field to hash that out in a committee and come back to us? That's what best serves the people of the state of

Michigan. So that, that's what our goal is as a commission.

So, again, I appreciate what the witnesses are saying. I know there's more to come. I've talked as chair to both sides of the -- of the fence in the last two weeks. Very, very much respect the talent, the expertise, the professionalism of everybody that was on those phone calls with me and that's up here today. We're all here to do what's best for the patients in Michigan and I'm glad that we've got great people that are working on it and will continue to work on it when they might get appointed to a SAC. So there.

Tiffani, next witness?

MS. STANTON: Yes. We have Tom Stankewicz from Trinity Health.

TOM STANKEWICZ

MR. TOM STANKEWICZ: Good morning. My name is Tom Stankewicz and I am the strategy leader for Trinity Health Grand Rapids. I'd like to thank the CON Commission allowing me to have this opportunity to share letters of support Trinity Health Grand Rapids received from state and local legislators as well as several from the organizations. While time prevents me from reading all of them, I do want to share with you a couple themes and then also submit them for the public record and for your review if you hadn't already received them.

The people and the organizations that advocate for Liver/Transplant CON standard provisions or to seat a SAC include: Bryan Posthumus, Mark Huizenga, House Representatives Kristian Grant, John Fitzgerald, Rachel Hood, Carol Glanville, Phil Skaggs; as well as Lisa Knight and Milinda Ysasi, 2nd Ward Commissioners from the City of Grand Rapids; Vanessa Greene, CEO of Grand Rapids African American Health Institute; Megan Erskine, CEO of Catherine's Health Center; Jennie Knight, executive director of the Grand Rapids LGBTQ Healthcare Consortium; and Minnie Morey, executive director of West Michigan's Asian American Association. While each shares slightly different views, key themes, including making sure West Michigan residents have access to Liver Transplant, the standards were developed more than 30 years ago.

The current cap of three programs all are located in southeast Michigan reducing access and creating hardships, emotional and financial, for patients and families as you heard in previous testimony. The population has grown in that 30 years in West Michigan and well beyond double digits compared to the state and southeast Michigan where that growth has been dwarfed. The lack of access to liver has exasperated health and equalities as well.

I stop there and just want to share one other comment which, Chip, you raised which is you've asked very

great questions, you've heard really solid testimony from both sides. And the reason we seat a SAC or you all seat a SAC is to have the experts hash these things out and come back with a recommendation. So thank you.

MR. FALAHEE: Thank you. Any questions? Great. I'll just note I was going through my packet. I've only got one letter from a legislator. So I understand from this witness and, Sean, from talking to you, that there must be more so they at least didn't make it into the pack.

MR. SEAN GEHLE: I think it was probably, Mr. Chair, after your cutoff, so we'll make sure that you get a copy and all the commissioners get a copy of the legislative letters.

MR. FALAHEE: All right. Thank you. Tiffani, any other witnesses?

MS. STANTON: Two more.

MR. FALAHEE: Okay. That's -- that's, fine.

MS. STANTON: Jenna Beekman (sic) from Trinity Health is next.

JENNA BECKMAN

MS. JENNA BECKMAN: Good morning. My name is Jenna Beckman. I am from Trinity Health, but I am coming to you today as a daughter of someone who's currently going through the process of getting listed for a liver transplant.

He is currently being seen at Henry Ford and he's getting fantastic care. However, he lives in rural northwest Michigan which is a three and a half hour drive each way for every appointment that he has to have. I've heard a lot of comment that there's satellite offices that he can be seen at. That is not necessarily the case for people who have complicated medical history like my father does. In fact, since last April he has been able to be seen at the satellite office twice. Some of the appointments that we see over at Henry Ford are only 30 minutes long because they are checkups with a cardiologist, with his liver transplant team, and we have to make the three and a half hour trip both ways for that 30-minute appointment.

I will also mention that my father has no other family besides my brother and myself. So that means that between the two of us, we are transporting him who is not in good health. It is a long travel for him to get over there. It is a lot of work for us to get him there and get him the care that he needs, and we are sacrificing stuff in our own life to make sure that he gets that care. My brother and I both work full time. I -- we both thankfully work for companies who are very gracious in allowing us to be able to get him the care that he needs, but I myself also have a family. I have two small children. And there are times where I have to miss stuff for them to get him over to the

other side of the state because there's nobody else. And the type of care that he needs, we don't have the options on the west side of the state.

Henry Ford tries to coordinate care. When they do, we might be over there for several days at a time in which that is hotel costs that we are incurring as well to, again, make sure that he gets the care that he needs which is also several days away from my family, away from my children. They know that grandpa needs care, but they also know that mommy's not there for their soccer game. Mommy's not there to take them to dance class.

So I ask for there to be some consideration in that it's not just the quality of care. The access is hard and it impacts families. And though we do want the best outcome, we are doing our best to get him the care that he needs, it is very difficult and it has been a long journey and it doesn't end when he gets his transplant. As we've talked and heard, it is infinite and that difficulty to get him where he needs to go will only continue. Thank you.

MR. FALAHEE: Thank you for sharing your story. Thank you. Questions? I have one question. You mentioned that you were able to go to the -- I'll call it the "local clinic" twice over a certain span of time. In that same span of time, how often did you go to Henry Ford?

MS. JENNA BECKMAN: Depends on the month and where

he's at in his workup. Recently it's been every other week at the very minimum. We were there several weeks in a row each different days for about a month straight.

MR. FALAHEE: Okay. Thank you. Any other questions? Thank you very much.

MS. JENNA BECKMAN: Thank you.

MS. STANTON: All right. Last but certainly not least, Dr. Kim Brown from Henry Ford Health.

KIM BROWN, M.D.

DR. KIM BROWN: Good morning. I think it's still morning. I'm Kimberly Brown. I'm a transplant hepatologist, actually, at Henry Ford Hospital and the associate medical director for the liver transplant or the -- actually the entire transplant program.

So we believe that access is actually critically important not just for the west side of the state, but for all people in Michigan. And to that end, we currently operate 13 outreach clinics that do allow for both pre-transplant care as well as listing, as well as post-transplant care across the state of Michigan. In fact, if you draw a 50-mile circle around each of those centers, we provide access within 50 miles for about 90 percent of the patients who live in this lower part of Michigan. We soon will have one in Marquette which will provide access hopefully to the Upper Peninsula as well. And this is

really critical, I think, for providing access as you've heard from some of our patient representatives for our patients. It actually -- it's not access to a center. It's actually access to a transplant professional because that's how you get listed for transplantation.

When we talk about organ availability, that's critically important as well. You've heard that maybe on the west side of the state you would have access to organs further into Wisconsin and this is true. But many of those donor hospitals are actually in rural areas, not in trauma center areas and so there's no guarantee that actually access where a patient listed on the west side of the state would be better than losing some of the access from Pittsburgh, for example, or Cleveland, for example, or Columbus.

Quality care is very critically important as well. You heard that transplant rates within the state of Michigan are equal to or better than national standards. And if you look at one-year graft survival, patients on the west side of the state, including Grand Rapids and Kalamazoo, actually have the highest transplant rates as well as graft survival of all the patients in Michigan.

To the commissioners' point, cost is a critical concern as well. To build a transplant center requires acquisition of a number of things. Even if you have an

existing transplant center yourself with respect to laboratory services, et cetera, you still have to hire a redundant number of transplant surgeons, physicians, transplant infectious disease, social workers, chemical dependency, specialists, et cetera, to build that program. And furthermore, in order to acquire CMS approval, you have to perform at least ten transplants prior to CMS approving to pay. So for those ten transplants and before payers or Medicare or Medicaid will reimburse, that's additional cost actually to the center.

So given I think the quality, the cost, and the access issues that we presented, at least Henry Ford Hospital feels that the issue to access and to access to high quality care is really not an issue and we respectfully ask the Commission not to support the recommendation to develop a Standard Advisory Committee.

MR. FALAHEE: Thank you, Dr. Brown. Questions?

DR. ENGELHARDT-KALBFLEISCH: I have a question. The Commission is obviously concerned about health care equity and -- and that's a responsibility we take very seriously. In terms of support, whether it be for transportation or financial support for families, as we've heard a lot of patient witnesses, can you talk about anything that exists in that space if there is something?

MS. JENNA BECKMAN: Yeah. No, it is a very good

question because access is not just, you know, where you live. It's also what your resources are. I know at Henry Ford, and that may be true for the other centers as well, we have a patient support fund that is funded that we can provide some funds for patients if they have to stay locally, if they can't afford a hotel, or if they have to travel from a distance. So hopefully most of their care can be done locally. Many of these centers that we have are on the west side of the state as well as Grayling, as well as the middle part of the state as well. So we're really looking at all people in Michigan. But to your point, we do have dollars available to help patients and families who have restricted funds for travel.

DR. ENGELHARDT-KALBFLEISCH: Thank you.

MR. FALAHEE: I've got a question along those lines and thank you. And Dr. Brown was one of those many that were on a Zoom call with me or phone calls as well. So thank you for the time you've taken.

A question. I mean, Ms. Beckman just talked about her family situation with her dad and that's why I asked her about how many can you do locally versus going to Henry Ford. Obviously, Henry Ford's a great program. U of M, Corewell Beaumont's a great program. You still have a distance issue. How do you -- how would you address that? We've got two visits locally, unknown number of visits at

Henry Ford. How do you grapple with that result?

DR. KIM BROWN: It's very -- it is very challenging. I agree. I mean, ideally you would have a person like myself or Dr. Sonnenday in every city in Michigan, right, so that patients could walk across the street or go -- go locally. But the reality of that is that in order to build a transplant program, the resources involved are so intense, not just on the level of I'm a liver specialist. It has to do with radiology and cardiology and all of the other factors.

So complexity of the patient really drives a lot of that. There are many patients who are seen once in Detroit and then are seen locally for the entire rest of their care until the point of transplant, and then we trans back -- you know, transfer back locally. But it does really -- it is impacted by the -- the intensity of the patient's situation really.

MR. FALAHEE: Thank you. Anyone else? Thank you, Dr. Brown. Appreciate it. Tiffani?

MS. STANTON: That's the last one we have.

MR. FALAHEE: Well, number one, I want to thank all of the witnesses for excellent, you know, from the heart testimony both from personal experiences, professional expertise, and professional experience. So, number one, thank you.

At -- at this point, any Commission discussion? Any thoughts before we proceed to whatever we decide to do vis-a-vis a motion? Any questions? Any discussion?

DR. FERGUSON: I'll make a comment.

MR. FALAHEE: That, too.

DR. FERGUSON: So acknowledge this inexperiential (sic), call it a bias, I guess. So I have a family member who underwent transplant successfully, fortunately, but I understand the challenges of doing that remotely or distance. They had to travel for it and it worked, but it's hard.

So with that backdrop, we have a geographic distribution or I guess I would argue problem with distribution of our current transplant centers relative to the population in the state of Michigan and it's either a real or perceived imbalance, and I think it is incumbent upon us to look at that, to seat a SAC, and to explore whether or not people of West Michigan have appropriate and adequate access.

MR. FALAHEE: Thank you for your comments and sharing your personal story. Thank you. Commissioner Drake?

MR. DRAKE: Commissioner Drake. I'd like to comment as well. And I want to thank everyone who testified today as well as the phone calls I had from -- and to

paraphrase Chip -- both sides of the aisle. It was really good.

You know, a couple things. This is complex. But, you know, as I was sitting, listening to people and, you know, not even transplant related, let's take sickle cell disease. And there are many hospitals in Detroit that can take care of that disease and it's very possible to the patients, but we still have -- that patient population is saying -- wrote some notes here -- you know, transplant, sickle cell, you name the current disease, there are hardships. They could be financial, they could be emotional, socioeconomic. There is also some issues around people engaging in no health care before it gets too advanced.

So I love the idea of a SAC, but there needs to be more -- more discussion. But let's not just focus on doing a fourth center or a third -- is three enough? It really is about the -- is there a problem we need to solve through there being -- unless they're to solve -- solve the problem. What is the problem? What charge is that? Should we create and want to really work this beyond the number of centers?

MR. FALAHEE: Thank you. Other comments? Questions?

MS. GUIDO-ALLEN: Guido-Allen. I have a question. We have a cap in our state on a number of different

services, liver transplant being one of them. Any guidance from the Department on how other states, you know, do they have caps? Could we -- could we look at access in those -- you know, for comparative review?

MR. CONNOLLY: Marcus from the Department. That is something that we did not research when we were doing our analysis, but it's certainly something that if the Commission wants us to, we can look into. In our position is in support of a SAC. So if that's something that we could research for the SAC committee during that time, we're more than happy to do that.

MS. GUIDO-ALLEN: Thank you.

MS. TURNER-BAILEY: Chip? This is Commissioner Turner-Bailey. One of my comments is -- is kind of unrelated to Certificate of Need. It may be -- there may be an opportunity here for those who are providing coverage and care for transplants to think about what's -- what's the best way to do that? Why should a person who maybe is a little bit further away have to pay for hotels, et cetera, when they're trying to get their loved one or themselves to get care? So I know there's a lot of representation in this room that they have influence on those kinds of decisions and I would encourage everyone to consider is -- are we doing this the right way? I mean, do we just have to keep building things closer to people because they can't afford

to stay in a hotel? To me, that doesn't -- that's not the right approach to this. So that's -- that's my -- my comment on -- on that exhibit.

With regards to a Standard Advisory Committee, I think it's -- I feel with all of the testimony that we've heard today we almost have no choice but to seat one no matter how we really -- you know, how we really feel about it. I do think, though, that it's important to go into SAC not assuming that there's a problem, but giving the SAC a charge to determine whether there is a problem, an access problem and what that problem might be. So that's how I would be willing to support a SAC and a charge for a SAC.

MR. DRAKE: That's what I was trying to say.

MS. GUIDO-ALLEN: Guido-Allen. Can I just provide? There are federal regulations on what you can provide to patients and families financially and caps on that as well.

MS. TURNER-BAILEY: Understood. I understand.

MS. GUIDO-ALLEN: That's why the doctor from Henry Ford said that there's, like, a restricted fund or donated funds that they can utilize for patients. But, I agree. I wish we could do that.

MS. TURNER-BAILEY: Having a cap doesn't mean you can't do it, though, in my opinion.

MS. GUIDO-ALLEN: Within the letter of the law,

yeah.

MS. TURNER-BAILEY: Agreed.

MR. FALAHEE: This is Falahee. What Commissioner Guido-Allen is -- there's some laws out there, regulations, I don't profess to agree with them, that says if hospitals gives X money to patients that could be perceived as an inducement to refer, and then people go to jail.

MS. GUIDO-ALLEN: Yeah.

MR. FALAHEE: So, but there are ways around that through foundations and other private sources of funding. So I -- I understand exactly --

MS. TURNER-BAILEY: Well, again, this is Commissioner Turner-Bailey. As I started my comments, I know this is not a CON issue. It's not a CON issue.

MR. FALAHEE: Right.

MS. TURNER-BAILEY: And I am aware of, you know, some of the limitations that are out there because we are working with employers every day to try to think about how to adequately provide high quality coverage. So I just -- I just feel like it's important that we say that so that we're just not always trying to handle the problem from the back end.

DR. MCKENZIE: Yeah. This is Commissioner McKenzie. I'll just add on because I -- I think, you know, from a payer side we see it as well and we recognize, like,

you can't have this expertise on every street corner. We know that; right? And there are things that, you know, payers are doing in conjunction with employers, looking at travel benefits and things like that where there's reimbursement and things. So just in case anybody wasn't aware, I think many of you are, but I just wanted to add that.

MS. TURNER-BAILEY: Thank you. I agree.

MR. FALAHEE: Other comments?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt. I -- I think this is obviously a very complex topic. We have heard expert witness on both sides of this issue and I think as a Commission trying to weigh the quality, the cost, the access, do you think if we move forward with the SAC addressing that question "do we have an access problem" makes sense given that there appears to be a lot of debate about that.

MR. FALAHEE: Other comments?

MS. TURNER-BAILEY: This is Commissioner Turner-Bailey. I had a question which I didn't ask to any of the experts. Just speaking about the re- -- I know we had several questions and comments about the resources necessary and I guess my question is are we also considering, like, actual physical resources, like did -- did the building have to be built or is this something that

would take place within existing facilities? I -- I guess I don't know the answer to that question and I'm curious about that piece as well.

MR. FALAHEE: I'll -- I'll take a stab, but then I would welcome any of the witnesses that testified if they want to talk about it. I think the answer is it depends. It depends on what current facilities you have in existence right now. So I'll just speculate that if you've got already a kidney transplant center, you may not need to build a brand new building. You might be able to expand on that one or somehow re-purpose some of that building. I think it's going to be very fact and circumstance dependent based on what you've got in existence already.

And I'll open it up to any of those other people if they want to get up and give a 10-second comment, like, Chip, you're right or, Chip, as usual, you're wrong.

MS. TURNER-BAILEY: I would appreciate that. Thank you. And then I also, I guess, would want to think about that in the context of looking at a SAC. So the -- you know, what's -- how does that affect what the outcomes of the SAC -- of a SAC might be?

MATT BIERSACK, M.D.

DR. MATT BIERSACK: Chip, I think you're right. This is -- this is Matt Biersack from Trinity Health Grand Rapids. And this is certainly a question that we've looked

at as we've explored this. That given the capability that a center like us already has with a well-established and very robust kidney transplant program, physical plant is -- is not, you know, as much of a consideration as it is some of the programmatic elements that some of the other experts testified on.

We know that there's a number of resources; social work, financial counselors, clinic staff, et cetera that can be leveraged. So we see this as an opportunity to not be as costly of a venture when we're expanding on an existing transplant program that already exists.

MR. FALAHEE: Thanks, Matt. Appreciate it. Other comments or questions?

MR. DRAKE: I do. And this is maybe a newbie question for me on the CON. So there's been a lot of talk about a fourth center. Does the CON simply say there's four or does it say where? What would prohibit me from opening up Archie Drake Hospital and beating anybody in this room to be the fourth center?

MR. FALAHEE: I'll answer that and Tulika will tell me whether I'm right or wrong. Right now under the current standards there's only three that are permitted.

MR. DRAKE: Is it by name or by --

MR. FALAHEE: By -- no, there's just -- no, not by name.

MR. DRAKE: Okay.
MR. FALAHEE: It's just there shall be three.
MR. DRAKE: Okay.
MR. FALAHEE: And that's been in existence for 25 or 30 years.
MR. DRAKE: Okay.
MR. FALAHEE: BMT is the same way.
MR. DRAKE: Okay.
MR. FALAHEE: All right. It's not by location. It just says there shall be three.
MR. DRAKE: Okay.
MR. FALAHEE: All right. So if Archie Drake Hospital filed an application to put up a new liver transplant center in Petoskey --
MR. DRAKE: Up in the UP.
MR. FALAHEE: Up in Marquette.
MR. DRAKE: Yep.
MR. FALAHEE: All right. Tulika and her Department would kindly say no, you don't comply. But there's -- it's not site specific. They don't mention any names at all. None of the standards --
MR. DRAKE: It was just a clarification.
MR. FALAHEE: Yeah, right. Okay. Tulika, is that correct?
MS. BHATTACHARYA: Yes, that is correct.

MR. FALAHEE: Thank you.

MS. GUIDO-ALLEN: So Guido-Allen. To -- to add on to that question. If we seat a SAC and say is there an access problem, right, and -- and hypothetically they come back and say yes, it would be up to us to say how many more centers we would add to the cap? No? And how is it determined where that will go and --

MR. FALAHEE: Very good question which I would like to include in a potential charge with the committee. All right? Number one, is there an access? I'm thinking off the top of my head here. Right? Is there an access problem? We've heard that from multiple people. Is there an access problem? If there is, then what? All right?

MS. GUIDO-ALLEN: Then what?

MR. FALAHEE: Do we say there will be four? There will be five? There will be six? Do we not say anything and we'll just -- instead of putting a number on it we use a volume requirement? It's a hypothetical. All right? And if we have certain applicants that each think may -- let's say we have two applicants and we may end up in comparative review at that point. All right? That's one potential outcome of a SAC and what charges go into that SAC. I think there's been great discussion today about what the issues are beyond is there an access problem. So if we say, yes, there is. Then what?

MS. GUIDO-ALLEN: Then what?

MR. FALAHEE: All right? And I think it's the "then what" that the SAC would need to look at if we choose to do one and then come back to us to pepper the daring witnesses with more questions. All right? That's how I look at it, top line info. And as a reminder, sometimes the Commission will say as part of a motion we designate the chair and the vice chair to put together the charges based on the talk, the discussion that we've had today. So, but that's how I look at it, Commissioner Guido-Allen, top of my head.

MS. GUIDO-ALLEN: Thank you.

MR. FALAHEE: Other questions? Anyone care to make a motion?

MR. HANEY: I think I agree with you in terms of letting the experts weigh in on all this because it is quite complicated. So I'll make a motion to seat a SAC for the purpose of determining if there's an access issue and if there is an access issue, based on geography, socioeconomic, other factors, then what is the best approach to resolving that access issue?

MR. FALAHEE: Would part of that motion potentially include instructing the Department to see what other states have done with this issue?

MR. HANEY: I think that would be a great

addition.

MR. FALAHEE: Anyone care to support that motion?

DR. KONDUR: Commissioner Kondur, second and support.

MR. FALAHEE: Discussion? All in favor of the motion say aye.

ALL: Aye.

MR. FALAHEE: Opposed, same sign? Motion passes.

(Whereupon motion passed at 11:32 a.m.)

MR. FALAHEE: Thank you for a very good discussion not just amongst the commissioners, but the witnesses. Thank you all very, very much. Personal stories, thank you for sharing them. Professional opinions, differentials in professional opinions, thank you. They're all healthy and we're all here to get the best access, quality, and cost for the residents of the state of Michigan. That's what we're all about. So thank you very much. Good discussion.

MS. GUIDO-ALLEN: Can we do a five-minute?

MR. FALAHEE: Yep. That's where I was headed next. Five-minute, seven-minute break. Thank you.

(A recess was taken.)

MR. FALAHEE: Okay. Let's get started. Thank you for a great discussion. As I said earlier, my hunch is the remainder of the agenda won't take two hours. It may take less than that. All right.

Next item, MRI services. And, Marcus, I'll turn it over to you for a summary, please.

MR. CONNOLLY: Yes. A public comment period was held from October 6 through October 20 of 2023. We received comments from six organizations which are included in your electronic binder. All comments received were in support of continued regulation of MRI services. The Department supports continued regulation and recommends that an informal workgroup be formed to review some of the items brought forward.

These items include adding project delivery requirements to Section 15 to include mobile host site, patient safety similar to CT CON standards; two, clarifying what "immediate availability" means in Section 15(2)(e); three, revising Section 2(1)(vv) to clarify the definition of "teaching facility" and which providers are allowed to receive the additional teaching factor; four, improving access to MRI services in rural and micropolitan statistical area of counties; five, revise Section 2(jj) definition of "mobile MRI unit" to operate at minimum once per quarter; six, revision section of 4(4)(b) to add MRI mobile host site have been -- have been in operation for at least 12 months.

The Department is also requesting to make technical revisions including updating the county designation which is in your binder as well. It also add in

the 30-day notice language to all standards.

If a workgroup is to be seated, then a written charge need to be drafted and a vote on by the Commission, or the Commission may instruct the chair to write the charge consistent with the language presented at today's meeting. The Commission chair will also appoint a chairperson for the workgroup. After the workgroup has concluded, it will bring its recommendation to the Commission at a future meeting. The workgroups are open to the public and are not limited to a six-month timeline.

MR. FALAHEE: Great. Thank you, Marcus. Any questions at this point from the commissioners of Marcus's summary? Okay. Any witness testimony?

MS. STANTON: Yes. We do have two. First up, Randy Parker with Corewell Health.

RANDY PARKER

MR. RANDY PARKER: Hello. I just had to check my watch to make sure I could still say good morning. We got 14 minutes. So good morning, Chairperson Falahee and Vice Chair McKenzie and Members of the CON Commission. My name is Randy Parker. I'm an MRI safety officer at Corewell Health West. Thank you for the chance to comment on this today.

I'm here today to discuss a patient safety screening process that has increased access to MRI services

for a specific and currently underserved patient population and that population is patients with complex medical implants. These implants such as pacemakers, defibrillators, stimulators, certain programmable shunts, and certain cochlear implants are among those. We also accept non-FDA approved cardiac devices or non-FDA approved devices on a case-by-case basis such as non-MR conditional pacemakers and ICDs, abandoned cardiac leads and most recently we started accepting external temporary pacemaker systems as well.

These devices require in-depth research, identification, and coordination before MRI imaging. There are also patients who have suffered injuries from shrapnel or other metallic foreign bodies and those require a in-depth risk analysis or risk assessment by subject matter experts, typically a radiologist expertly trained in MRI safety like an MRI M.D. or an MRI physicist.

We have leveraged, documented best practices and peer reviewed literature to develop a patient screening process and protocols that allow patients with medical implants or imbedded metal objects to be able to receive MRI studies safely. This program has provided greater access for challenging patients who -- challenging patients who would otherwise not be able to receive that care. In fact, we receive referrals from other facilities because we

provide a more thorough evaluation of patients with complex safety scenarios.

It takes a considerable amount of time to perform this screening. In fact, there was a national survey performed within the last few years that suggests that a given MRI location will spend approximately six to ten hours per week researching implants for safety and that is per MRI machine. Additionally, we established imaging conditions that a techno- -- or we established imaging conditions that a technologist must follow may require longer time on the MRI unit as we have to run the machine at a lower energy. This often results as patients needing two time slots to complete one exam.

Given all of this, we respectfully request that the Commission add a charge to a potential MRI workgroup to consider additional additive factors to be provided for facilities that perform this type of service. We believe that the workgroup will have an opportunity to review all applicable information and data and determine if additional additive factors should be considered to help improve access to this patient population. Thank you again for your time and answer any questions you may have.

MR. FALAHEE: Thank you. Question?

MS. GUIDO-ALLEN: Guido-Allen. With all of the -- the process that you just described, what happens when the

provider, the physician, the radiologist determines that an MRI would be unsafe to do with that -- a patient for whatever reasons, the reasons that you listed, what's the next steps then?

MR. RANDY PARKER: Alternative imaging.

MS. GUIDO-ALLEN: So provide -- provide a discussion about --

MR. RANDY PARKER: Yeah, exactly. So the -- the radiologist is ultimately deemed the captain of the ship so they -- they would make that call as to whether to accept or deny that patient. So, and those conversations occur with the radiologist where we consult, like I said, best practices or peer reviewed literature, maybe there's a clinical study that was done recently that we could look into and see if our facilities can adopt. That's actually what happened with the external pacemakers, the temporary pacemakers that we just started doing. There was a study that was published that actually laid out a very thorough protocol that we were able to adopt and follow in order to scan. We've seen two patients now and those were cardiac (inaudible).

MR. FALAHEE: So this is Falahee. A question. Your request is to add as a charge adding additive factors for those that deal with complex medical implants. What -- what would the additive factors do, I mean, in terms of

getting another MRI you get extra credit, if you will?

MR. RANDY PARKER: Well, the reason that we submitted this is because there are other things that are already considered when it comes to the weighting of certain MRI exams like pediatric patients or a patient with sedation or they go under general anesthesia. And as a matter of fact, in order to accept patients with these types of implants, particularly the pacemakers, we require a lot of the same services that those -- that those ones do. The patients have to be monitored by a trained RN or provider during the entirety of the exam. There's physicians that had to come in and program the device into a safe mode or turn stimulation off or something like that in order for the patients to even go into an MRI machine. So that's -- that's where that --

MR. FALAHEE: Without commenting -- this is Falahee. One more. Without commenting on the merits yea or nay -- I'm looking at the Department, primarily Tulika -- would that be something that at least a charge could be added, not knowing whether there -- the yes or no on that issue?

MS. STANTON: We did have that included on there. That was something that we did review in the analysis. It was just hard -- the Department has not received enough evidence to support the need for the charge.

MR. FALAHEE: For that specific component of the charge?

MS. STANTON: For, like, the implants or metallic form bodies being considered.

DR. FERGUSON: Didn't receive it to even look at it or to opine on it?

MS. STANTON: We only received the one comment.

MR. FALAHEE: Yeah, right, right.

MR. CONNOLLY: Marcus from the Department. We didn't receive enough evidence to support it like any other people because I was the MRI specialist for, like, five years. We haven't had a lot of comments based on this. This is the first time that it came up. And after we talked internally, we felt like it was something that we didn't want to support, but if the Commission feels like it's something that they want to, we have no problem putting it as a part of the charge.

DR. FERGUSON: So do you want comments now or questions now? Do you want me to hold my comment?

MR. FALAHEE: I would never want you to hold a comment.

DR. FERGUSON: It's your cross, it's your table.

MR. FALAHEE: No. Go ahead.

DR. FERGUSON: So I think as many of you know, I am a practicing radiologist. This really is an important

topic. It's becoming more important very, very quickly and it's becoming various versions of standard of care in terms of how far to be putting the envelope safely in providing MR services to patients with implants. It takes enormously more effort to safely image these patients.

I -- I was just involved in helping establish guidelines for use on a national level on this topic through indirectly overseeing the body that did the research on it. I would strongly support including looking at this in whatever charge we come up with. Again, not taking a stance on whether we should make a change or what that change would be, but I do think it should be included in anything we do.

MR. DRAKE: This is Commissioner Drake. You know, also spent all my life in hospitals. What I've seen over time that maybe, Marcus, may be different from your time as now, every sub-specialist is putting a clip, a coil, something in someone's body. And what's interesting to me that I've learned about this looking at it, there's no such thing as a true MRI safe device. Am I correct in that?

MR. RANDY PARKER: If it's not made of metal.

MR. DRAKE: Exactly, exactly.

MR. RANDY PARKER: Yeah.

MR. DRAKE: And these are. So -- so with -- what I've seen is the radiologist, the -- the MR techs are doing all this due diligence just before the patient can ever get

to the scanner table. And to his point, I've even seen research studies now where there's a particular brand of heart coil that's now being used in the brain and that was never opined upon. So it really has a changed a lot, most recently with all the new invasive stuff. So I -- I have seen evidence of just being more effort, more time to get one patient on the table.

MR. RANDY PARKER: If I could make a comment just to kind of, I guess, painting a clearer picture as to, like, the type of volume that we're inspecting. In 2023 alone, we actually -- at Corewell Health, we actually developed a platform to be able to track these things. And just cardiac devices alone we did 1,433 MRI exams on patients with either a pacemaker or a defibrillator. Approximately 10 percent of those were non-FDA approved for, but were accepted to only be image. And then you're talking another almost 500 MRI exams done on other devices that required some sort of in-depth research, ancillary assistance from a different department or -- or entity.

MS. GUIDO-ALLEN: Guido-Allen. Marcus, maybe also that previously these patients were denied MRIs, right, so just didn't do them. And through the evolution of being able to do it safely and the studies that are out there, it's becoming much, much more prevalent.

MR. FALAHEE: Yeah. It's not -- this is Falahee.

It's not a knock on the Department. One of the advantages of having a Commission like this, you get different expertise around the table and it's -- it's not something that's within your realm, you don't know about it and then here it is. So, yeah, I think it -- we'll see what the motion says, but I think we've raised good arguments for adding this as a -- a charge to it.

And it's not the Department recommends. It's up to the Commission to figure out what to do with that. There are times when we agree and there are times when we respectfully disagree. So thank you. Or add to it. Tulika?

MS. BHATTACHARYA: Mr. Chairman, if I can make a comment to further elaborate on what Marcus was saying? The Department's posi- -- what we put in the document is just our recommendation. Obviously the expert, the commissioners can always make a decision that is different than that.

What we are trying to say is in Section 16, if you look at the different factors, there are about 13 to 15 different factors already in the standard for -- actually there is one for cardiac MRI procedures that was added recently in the last revision; functional MRI, MRI-guided intervention. So over the years we have added additional factors and what -- I'm sorry, I forgot your name -- what this doctor is saying, there is no prohibition in doing

these MRI scans if it can be done safely. Obviously Corewell or any other hospital is doing it.

The question is do we need to add another additional factor on top of the existing 15 or so that we have. So that's why maybe the group of experts can look at what we currently have. Can this type of implants or scans including implants be added to one of the existing factors or do we need to add a new factor? That's all we are trying to explain to you how it currently works and what is this new request.

MR. FALAHEE: Thank you. This is Falahee. Thank you for the explanation. Commissioner Ferguson?

DR. FERGUSON: Building on that a little bit. So if there are already appropriate modifiers in there, that's fine. We can look at it, confirm that. Unless anyone misinterpret a comment, a cardiac MR is fundamentally different than doing an MR in a patient with a cardiac device. Even though it sort of sounds the same, it's decidedly not the same and there are separate challenges in both realms.

MR. FALAHEE: Thank you.

MR. RANDY PARKER: Thank you.

MR. FALAHEE: Thank you very much.

MS. STANTON: Next comment is Glenn Houck from Michigan Medicine.

GLENN HOUCK

MR. GLENN HOUCK: Good morning. Thank you for taking the time to let me speak today. My topic is a little bit different than be my colleagues. But I would say for someone that helped establish the MRI program for implanted defibrillators in Michigan Medicine, I also support looking at the weighting of implanted devices and metallic devices. As maybe you do or don't know, that a metallic device could be categorized as safe for a certain scanner and then we can review it two years later and the safety standards have changed and it could make it unsafe or change the imaging. So I do support that initiative as well.

But I'm here to advocate on behalf of asking the committee and the group to reevaluate the adding a charge to a workgroup to look at what can be scanned on the inoperative scanners. Current state are MR/ORs are only allowed to scan patients that are either under general anesthesia or are admitted patients.

We are currently getting a high demand for new, innovative procedures, MR-guided procedures that take a long time on a clinical scanner, three to five or more hours. And in an area like Michigan Medicine where we're resource restricted and space restricted, if we put these type of procedures on a clinical scanner, it's going to take away access for up to eight routine MRIs in a time when we have

high patient demand, turnaround time issues, and just plain access in that.

Some of the procedures that we're being asked to develop is focused ultrasound ablations in the brain, non-invasive. These patients can be outpatients, they don't require sedations. They're also looking at focused ultrasound in other parts of the body. We started MRI-guided prostate biopsies and more which take more than two hours of scan time, MSK soft tissue and bone biopsies in the MRI bore. And then we also have MRI-guided RF and cryo ablations that are coming down. So each one of these exams takes roughly anywhere from three to five hours. Current state if they're not an inpatient or under general anesthesia, we would have to put them on our clinical scanners instead of utilizing one of our two intraoperative MR/OR scanners which have capacity to do this.

So what we're asking is to just add the charge to look at the MR/OR requirements and allow some of these MR and/or guidance to be added to be able to be scanned on those systems where we now have access and staff.

MR. FALAHEE: Thank you. I'm looking at the summary that the Department provided us and I'm trying to figure out where what you're asking for is in here because there's different options. Because I see -- one, two -- three boxes prompted by requests from University of Michigan

Health.

MR. GLENN HOUCK: Yeah. It is the one with the outpatient procedures on the intraoperative which is the --

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

MS. STANTON: The MRI-guided procedures without --

MS. GUIDO-ALLEN: Outpatient MRI procedures.

MS. STANTON: -- general anesthesia?

MR. CONNOLLY: General anesthesia.

MR. GLENN HOUCK: Yeah, yeah. And those scans that are used in the intraoperative scanners in the MR/OR. That's why I also wanted to come today to clarify that ask, what we were asking.

DR. MCKENZIE: It's the outpatient procedures without anesthesia?

MR. GLENN HOUCK: Yeah. Currently if you want to use an intraoperative MR, they either have to be an inpatient status or under general sedation and we have a lot of new, innovative MRI-guided procedures that take a very long time that may not be inpatient needed or deep sedation. Some of them are mild sedation, many of them are no sedation at all. But we cannot utilize the MRI resource because it doesn't fit the definition of inpatient or general anesthesia.

MR. FALAHEE: Okay. Any response? Sorry. Commissioner Drake?

MR. DRAKE: Commissioner Drake. Then what you want to do then is run outpatients through your ORs.

MR. GLENN HOUCK: Only specific MR-guided procedures that take --

MR. DRAKE: Right. Okay. Now I'm following. Okay. I get what you're saying now.

MR. GLENN HOUCK: -- because it's taking away access from other critical care patients if we do it on the clinical scanners.

MR. DRAKE: Okay.

MR. FALAHEE: Any response back from the -- I know it's quick, but any response back from the Department?

MR. CONNOLLY: Marcus with the Department. I know when we initially met internally we looked at that particular question and kind of just referring back to what Tulika just explained, we looked at Section 16 and we thought that would kind of cover everything. But the explanation you gave is a little bit different so I'm going to refer to Tulika to get her thoughts on it.

MS. BHATTACHARYA: So maybe a clarification question for us. So right now in the standards there are provisions for a hospital to get a hospital-based iMRI.

MR. GLENN HOUCK: Yes. We have that.

MS. BHATTACHARYA: Okay. So are you requesting that an outpatient center, like an outpatient surgical

center, can also get an iMRI like a hospital?

MR. GLENN HOUCK: What we're requesting is for our patient population that have orders for these MR-guided procedures to be able to utilize those resources, even if they are not inpatient or under deep sedation. So, like, we have patients that come to -- like, for the focused ultrasound. They will be neuro patients. We are advocating to be able to utilize that resource to do those procedures rather than have to do it on a clinical scanner where it's going to take up a huge block of time. Because we have -- we have access on the intraoperative scanners because they're less utilized than because of the restrictions, but being able to do those will allow us to keep our access for our other critically ill patients, but also start to build these innovative and their very patient-centric treatments.

MS. BHATTACHARYA: So let's say your hospital has the iMRI. You're asking to allow you to do more different types of procedures versus what the standard allows you to do right now?

MR. GLENN HOUCK: Correct.

MS. BHATTACHARYA: Okay.

MR. DRAKE: Yeah, Commissioner Drake. This is how I see it as well. What you're asking is to change the standards for the intraoperative MRI?

MR. GLENN HOUCK: To be able to do -- yeah.

MR. DRAKE: Right. That's -- that's the standard change I think.

DR. FERGUSON: I think -- this is Ferguson. So there's a -- in my mind there's a distinction between how cases are counted and how one can apply for certain types of scanners, including an intraoperative spec scanner. I think that's slightly different than what you're asking which is we have a expensive resource that's underutilized. Can we please use it? And I think it's reasonable to ask the Department or whatever workgroup we end up forming to look at that.

MR. FALAHEE: Right.

DR. FERGUSON: And then without passing judgment on a stance on it, but expensive resources that are underused is not helping the people of the state of Michigan or the cost of care in the state of Michigan.

UNIDENTIFIED MALE SPEAKER: That's true.

MR. GLENN HOUCK: And in the current state we don't get credit for what we do on the MR/ORs even towards our CON count so we're not even asking to consider that. We're just asking to basically be able to use the resource to provide this therapy on issues.

DR. FERGUSON: Yeah. And that may be the compromise. It's reasonable there.

MR. HANEY: This is more of a billing question is

when billing insurance or Medicare or Medicaid, is that going to be an issue if you move it from setting A to setting B because it hasn't been done in setting B before or are other states using that setting and --

MR. GLENN HOUCK: Well, most of these in other states are being done as outpatient procedures. So we would actually be doing a disservice to do it as an inpatient because we would be taking away a bed from a patient that really needs to be inpatient. So, no, they're -- the billing, we can still bill as a clinical MR on the intraoperative scanners typically.

MR. FALAHEE: Other questions? Another potential charge to the extent we choose to proceed. Great. Thank you for your expertise and comments.

MR. GLENN HOUCK: Thank you.

MR. FALAHEE: Other witnesses?

MS. STANTON: No.

MR. FALAHEE: Thank you. Commissioner discussion or questions? I think that -- where is it? -- Marcus laid out very well for us the -- I counted seven charges that were in the page 3 of our packet and then based on what we heard from the two witnesses here about additive factors and then allowing patients to -- allowing more leeway for the procedures that aren't all for the units that aren't always used and there's free time on them, there's a need. Let's

let them use it. Those I think to me would be two justifiable additional charges for this workgroup.

So what I would entertain as a motion if someone choses -- chooses to make it: number one, appoint a workgroup, allow the chair and vice chair to put together the charges based on what the Department recommended and the discussion that we had today about the two additional charges and then allow the chair to appoint a chair of the workgroup.

MR. HANEY: Commissioner Haney. I'll make that motion.

MR. FALAHEE: Thank you. Support?

MS. GUIDO-ALLEN: Guido-Allen. Support; second.

MR. FALAHEE: Great. Any discussion? All in favor say aye?

ALL: Aye.

MR. FALAHEE: Opposed? Great. Thank you.

(Whereupon motion passed at 12:10 p.m.)

MR. FALAHEE: Very good. All right. Our every meeting topic, Psych Beds and Services. Is Dr. Jain in the room today? No, he's not. Okay. Marcus, go ahead.

MR. CONNOLLY: Okay. A public comment period was held from October 6 through October 20 of 2023. We received comments from six organizations which are included in the electronic binder. All comments received were in support of

continued regulation of Psych Beds and Services. The Department supports continued regulation and recommends that an informal workgroup be formed to review some of the items brought forward. These include: one, reviewing the reduction of the maintenance volume for special population pool beds from 80 to 60 percent; two, revising Section 2(t) to remove outdated terminology consistent with the mental health code.

The Department is also requesting to make a technical revision of updating the county designations and a copy of that is in your binder as well. If a workgroup is to be seated, then a written charge will need to be drafted and voted on by the Commission or the Commission may instruct the chair to write the charge consistent with the language presented at today's meeting. The Commission chair would also appoint a chairperson for the workgroup. After the workgroup has concluded, it will bring the recommendation to the Commission at a future meeting. Also, the workgroup are open to -- are open to the public and it is not limited to a six-month timeline.

MR. FALAHEE: Any questions of Marcus with his summary? Nicely laid out. Any cards?

MS. STANTON: Yeah. So we have Michael Nanzer with UHS.

MICHAEL NANZER

MR. MICHAEL NANZER: Hello. Thank you for your time. My name is Mike Nanzer. I'm the CEO of Forest View Hospital and representing the four UHS psychiatric facilities in Michigan. Collectively we operate 653 inpatient, residential and psychiatric beds. And what I'm asking is that we -- our charge be included in a workgroup review specifically to explore and create processes around flexing child and adolescent beds to adult usage. As a state we make great strides in improving access to child and adolescents and I'm not looking to do anything that's going to compromise that whatsoever.

But these are the facts just from our hospital from 2023. Our four hospitals operated at a 92 percent occupancy for adults which is essentially full. During those same three months -- June, July, and August of last year -- we operated at 63 percent capacity for child and adolescents. The child and adolescent population flexes along with the school year. We are at capacity during school, we drop off to next to nothing sometimes during the summer and holiday months. Problem is during those months we can't flex the beds the other way. So last year alone our four hospitals turned away 3,918 adults that we could have cared for. We had the beds, we had the staff, we weren't allowed to bring them in.

One of our examples, Havenwyck Hospital, one of

the largest ones in the state, has a 54-bed adolescent unit. It ran at a 43 percent occupancy during this time frame while the adult population was 96 percent. We could have easily taken those patients, preserved access, moved them to a smaller unit and opened up those 54 beds for adults. Instead, we ended up turning away over 1200 adults that we could have taken care of. We had the nurses, we had the beds, we had the capacity to take care of them.

So, again, I'm not looking to restrict access at all for adolescents. It's one of the areas I'm personally specialized and focus in and what we're asking for is not going to impact that. We're not looking to undercut CON at all. We want to make sure this is appropriately regulated so it is used appropriately so that during these -- these summer months and other periods we are able to flex, to say yes to the people at our door and not turn them away while at the same time I'm looking at open beds.

This is a common trend for us. Last year the number was 2400. My prediction for this year, if nothing else changes, we're looking at 4,- to 5,000 just from our facilities alone. So this is a growing crisis and I'm really hoping we can prioritize this and get something done because it is not a complicated fix. We have the op- -- operational ability to take care of this population safely.

MR. FALAHEE: Thank you very much. Questions?

DR. FERGUSON: So how -- and we don't have to solve it here, but maybe just give an example or two briefly. On the one hand it makes perfect sense to say here's some unused beds, we're going to flip them over and then when the demand comes back we go the other direction. What safeguards do you put in place to make sure that actually occurs? And so that, in fact, that if there are pediatrics and adolescents who need beds, that they are, in fact, getting them and that we're not intentionally or unintentionally creating biases based upon on payers or whatever? There's a million different ways to end up in a biased scenario where we underserve the target audience if the primary target audience is peds and adolescents.

MR. MICHAEL NANZER: I think that's why corporate safeguards need to be on it. I think if you base it off seasonality which is what it's tied to, I think that's a safeguard as well. But I think also looking at the required minimums, use for occupancy on the beds is another good way to ensure that they are appropriately used because I share your concern on that, that that's something that has to be set up appropriately so that it is not abused. Because, again, I do not want to limit access to child and adolescents and that's a way that if we're not careful could have/should have.

But, I mean, from my standpoint, I think the

biggest issue seems to be tied to the seasonality. I think the solution that is based upon that could go a long way to addressing the issue.

MR. FALAHEE: Falahee with a question. Why the seasonality? I think I know, but if you could help? I've heard this from others as well. And we just opened a new psychiatric hospital in Battle Creek and they've talked to me already about seasonality. So help me understand the issue.

MR. MICHAEL NANZER: It's -- it's a multifactorial issue but it comes down to a couple things. Pressure of being in school is one of the biggest ones. I mean, there is huge pressure on kids to succeed, there's social pressure, there's peer group pressure. Those things if you have a preexisting condition or a developing one you're going to drive that to a higher level. The other aspect is you have more people doing the right thing and they have their eyes on these students.

We're spotting issues where during the summer months where, I hate to say it, they're a little less supervised so it's more likely that things are going to go longer before they're spotted. Whereas you have teachers, counselors, others who we've done a great job training over the last few years, they're picking up on these things and they're making appropriate referrals.

MR. FALAHEE: Okay. Thank you. That helped me understand.

DR. FERGUSON: So if this potentially good solution or partial solution to a problem helping out the adult population for three or four months of the year, what do you do with the adults the rest of the year?

MR. MICHAEL NANZER: It's a very good question and I don't have a full answer for. I can tell you, again, what I'm looking at is ultimately it comes down to every time summer comes around, I'm looking at open beds and telling a bunch of people I can't do anything for them.

DR. FERGUSON: That's fair. I mean, again, I don't want to be dismissive but, you know, a partial solution is better than no solution.

MR. MICHAEL NANZER: No. I mean, let's be very transparent. We do not have full level of services and we need to fully address the mental health crisis right now. We're definitely moving in the right direction, but, you know, we -- we need to continue to grow which we are doing as a state. We're making the right -- steps in the right direction but this -- you're not going to fix that aspect of it.

MR. FALAHEE: Yeah. And this is Falahee. I'll just add this Commission has done all it can to increase the pool of beds. Everything within our power we have done and

will continue to do I guarantee you knowing the makeup of this Commission and the dire need for beds, physicians, social workers, you name it to meet that.

Other questions? Thank you very much. Appreciate it.

MR. MICHAEL NANZER: Thank you.

MR. FALAHEE: Any other --

MS. STANTON: Yep. We have Dave Walker with Corewell.

DAVE WALKER

MR. DAVE WALKER: Good afternoon, Chairperson Falahee, Vice Chair McKenzie, and Members of the CON Commission. My name is Dave Walker and I am here on behalf of Corewell Health. In fact, I'm here because Dr. Jain asked me to come and deliver his message. So he's kind of in the room, but I'll try to do my best to fill his big shoes. And the Commission is very familiar with the issue that I'm -- I'm here to speak about today which is the average annual occupancy that special pool bed units must operate at.

There seems to be a universal agreement that this is an unreasonable requirement. Indeed, the reduction of this occupancy requirement to 60 percent was unanimously supported by participants during the last meeting of the last Psych Bed workgroup. However, there was concern raised

and this issue came up at the very last minute and there was not enough consideration of potential unintended consequences with a suggestion that a future workgroup consider the recommendation further in 2024 so here we are.

We appreciate the concerns raised and on the how this item was brought up. We understand it, but we respectfully disagree that a change cannot be made by spring. Today the Department has recommended the issue and one other seemingly technical issue be addressed by a workgroup.

I do not need to tell this Commission the amount of resources and staff it takes to develop and execute a workgroup. We believe that these two issues can easily be addressed by the Department drafting language and bringing it back for the Commission to approve. There are many opportunities for parties to weigh in on both of these changes including today's meeting, a future Commission meeting where the language is presented by the Department, and a public hearing and yet a third CON Commission meeting during the public comment period.

Alternatively, these issues go to workgroup, the same cast of characters from the last workgroup. Those who already have endorses changed will be pulled away from clinical and operational duties for one or two meetings and ultimately end up reaching the same conclusion.

We urge the Commission to allow the Department to make these two changes to drafting language and bringing back to the Commission to approve. Thank you again for your time this morning, or afternoon now. I'd be happy to answer any questions the Commissioners may have.

MR. FALAHEE: So, Mr. Walker, what you're saying is don't do a workgroup, the Department come up with some language, submit it back to the Commission?

MR. DAVE WALKER: Correct.

MR. FALAHEE: Thank you.

MR. DAVE WALKER: Yep.

MR. FALAHEE: Questions? Okay. Thank you.

MR. DAVE WALKER: Thank you.

MR. FALAHEE: Any other witnesses?

MS. STANTON: No. That would be the last one.

MR. FALAHEE: Okay. Thank you. Commission discussion?

MR. DRAKE: Commissioner Drake. I'd love to ask the Department what drove their recommendation for a workgroup for that?

MR. CONNOLLY: As Mr. Walker -- Marcus with the Department. As he mentioned the last workgroup in May that came up, like, the last half an hour of that meeting so we didn't get a chance to talk about it internally or give other members an opportunity that may have missed a meeting

hear about that potential change and the charge. So what we thought, my supervisor Beth and I, we thought it would be better to in the future workgroup address this so that way it could be vetted out with other health experts to look into it. So we thought it would be better just to kick it forward to a workgroup.

MR. FALAHEE: And I will add for the two newest commissioners we keep referencing this Dr. Jain who really isn't here, but is here in spirit. Dr. Jain has chaired I don't know how many SACs and/or workgroups on psych issues and he's been here as frequently as some of the commissioners are here. Right. He's very good. He loves what he does. He's with Corewell in Grand Rapids. And he came forward the last time he presented a report and said, This came up at the last minute, just like Marcus said. We didn't have a chance to look at it so we're not going to send a recommendation for it either way. So that's what happened.

MR. DRAKE: Okay.

MR. FALAHEE: So what we've got is we've got the -- in front of us the -- the three, if you will, potential charges for a potential workgroup and then Mr. Walker's suggestion that we not do a workgroup instead, and then we have the other comments we talked about with the child/adolescent summertime, changing that. So to me that

would be another potential charge to be added to what we've already got in front of us. Would anyone care to make a motion?

MS. GUIDO-ALLEN: Can I ask a question? Guido-Allen.

MR. FALAHEE: Sure.

MS. GUIDO-ALLEN: Workgroups have to be in person?

MR. FALAHEE: No. And tune in later for what is about to happen with SACs.

MS. GUIDO-ALLEN: Yeah. So maybe that --

MR. FALAHEE: That -- yes.

MS. GUIDO-ALLEN: -- would be easier.

MR. FALAHEE: Workgroups can be by Zoom so it -- for those that need to dedicate time to it, you don't have to drive to Lansing, have a one hour meeting, then drive an hour and 20 minutes back. Exactly right. Marcus?

MR. CONNOLLY: Yes. Just wanted to touch basis on the flex and the recommendation from the Department. We almost look at the -- the recommendation that the gentleman made as against the -- the spirit of what we initially did not too long ago and also when we look at the pilot program, that may also alleviate the flex and the way they wanted to be redefined. So as far as the flex that came up, the Department is not in support of it, but if the Commission wants us to look at that as well, we will.

MR. FALAHEE: Okay. All right. Thank you.

DR. MCKENZIE: I have more of, I guess a general comment. I think that it probably makes sense to seat a workgroup because of this flex bed issue. I hate to see beds go unused. The seasonality is real. But I think Commissioner Ferguson's question was the exact one I was thinking of is what are the unintended consequences. Right? There are exemptions to everything. It may -- you know, may be more financial benefit of flipping those beds to take care of adults versus some very complex pediatric and adolescent patients.

So I don't know what the right answer is. It isn't just an open ended flex. And I think that's going to have to be wrestled to the ground. It's harder to seat a SAC, so I think a workgroup makes sense from that standpoint. And if we're seating a workgroup, it probably makes sense then to just take up the second charge. If it was just the second charge alone, you know, the one, you know, I think we could entertain language, but since it came up at the last minute -- so that would be probably how I would propose it. So I'm happy to make a motion. I see others shaking their head and I in agreement. So I don't know if anybody has any other comments?

DR. FERGUSON: Make the motion.

DR. MCKENZIE: So I'll make a motion. So I'll

make a motion that we seat a workgroup to take up the proposed charges that the Department has suggested as well as the additional charge around the ability to flex the beds from child/adolescent to adult while also considering the potential ramifications and what would need to be done in order to do that with the chair and the vice chair to draft the charges as well as select the leadership of the workgroup.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt. Support.

MR. FALAHEE: Thank you. Questions? Discussion? All in favor of the motion say aye.

ALL: Aye.

MR. FALAHEE: Opposed, same sign? Great. It carries. Thank you.

(Whereupon motion passed at 12:27 p.m.)

MR. FALAHEE: Mr. Walker, would you inform Dr. Jain that --

MR. DAVE WALKER: I'll have him clear his schedule.

MR. FALAHEE: Did you win or lose your bet?

MR. DAVE WALKER: (Inaudible.)

MR. FALAHEE: Thank you. Okay. Now, we'll move through the rest fairly expeditiously, I think. Legislative update?

MS. STANTON: Yes. So we have been monitoring the Open Meetings Act. There is two House bills, 4693 and 4817. They were both introduced last year in May and June. No movement. So happy to state on that; right? So we're not anticipating -- they did just reconvene on January 10th, so still monitoring it. Hopefully updates in the near future, but not certain.

The other one that we are monitoring is House Bill 4834 which is relating to the Certificate of Need which, if you do recall, it was related to, like, the ENTs under the CT scanners and there is still no movement on that bill either.

So not really any updates. We're still monitoring them, but, yeah, they just reconvened so hopefully something, but maybe not. We'll see.

MR. FALAHEE: This is Falahee. I'll just add given that there's a equal vote split in the House, neither side is expected to do much in the House until the special elections occur and the earliest I think that two people could be replaced would be about middle of April which is typically budget season and the normal timing is everybody spends all the time on the budget in April and May, some June and then it's an election year. So what usually happens is the budget is approved and then, poof, talk about summer recess. This is summer and fall recess so the folks

can go out and campaign.

So the general consensus is that there won't be much activity going on in the House and potentially in the legislature itself and that their -- the bulk of the activity may occur in that wonderful period known as lame duck. So we'll wait to see. But I talked to Tiffani earlier. It's good to get the updates on what's going on and we'll just see what happens around those that potentially impact CON. So, great.

Any questions about that? All right.

We'll move on to administrative update. And the first one it's got my name next to it and here's why. Recall the last time we got together we had a long discussion about rural emergency hospitals and a Hospital Bed group that got together with the workgroup and we had a lot of good testimony, good questions, good discussion here. And then we said let's send it out for public comment including, you know, the workgroup recommendations and the recommendations from the Department, send that out to public comment, and then take that public comment, whatever it is, and send it back to a workgroup, figure out, okay, based on all the public comments, where do we go from here? All right.

And in discussing this with the Department, what -- what happens is, is about a week before we have this

meeting, the Department gets together with Commissioner McKenzie and me and says here's what's on the agenda, here's what's coming up, any questions, any comments. And we discussed this last week or the week before, whatever it was.

And in the past we have had commissioners that have chaired workgroups and SACs because they had expertise. We had one commissioner that was an NICU physician. She chaired a SAC. We had another commissioner -- actually, he was the chair I think at the time -- Suresh Mukherji -- who chaired a SAC about MRI or radiology stuff because that was his expertise.

So I -- with your indulgence and approval, I threw my hat in the ring to chair this workgroup. To look at the different issues wearing a hat not as a commissioner, but as someone that's been in the health care field for awhile and that has a -- the only rural emergency hospital in the state, Sturgis, in my backyard. And I know the folks at Sturgis. They came to Bronson four times and said, Help. All right.

So with your indulgence, I would chair that workgroup. I bounced that off of the Department and they said yes. Maybe that's why Beth isn't here today, because she just rues her decision or comment. But I would do that. And the timing would be to get it done as fast as possible.

I can't guarantee we'll have something for you at the March meeting. The June meeting I will not be here, but if there's some report I can give, do a written report and get that out. I can talk to Commissioner McKenzie about it as well. But just if you're okay with that, I'll throw my hat in the ring to chair that workgroup and we'll see if anybody dares join the workgroup at this point. So, there. And I just wanted to have full disclosure, make sure you are all all right with that. Thank you.

Next, Marcus, Commissions, Special Projects Section Update?

MR. CONNOLLY: Yes. Just want to make an announcement. I think it's kind of evident. Kenny Wirth is no longer with us. It's a big blow to our section because he did a great job and he normally was the one that would facilitate the CON meetings. But just want to let everybody know that we are in the process of hiring a specialist for his position in the future and we just added another analyst that'll start February 5th. So we're just working on trying to fill out our section to make sure that we're adequately staffed. So that's all the announcements I have.

MR. FALAHEE: Thank you. Tulika?

MS. BHATTACHARYA: Thank you, Mr. Chairman. I don't have any report today. But just maybe a couple announcements. So in 2024, the Department will do statewide

compliance review for Lithotripsy services and NICU Beds and Special Care Nursery services. Just so you know there are seven lithotripsy networks in the state with 76 total host sites, 57 of them are hospitals, 90 of them are freestanding centers. There is one fixed lithotripsy unit in Michigan at a hospital. And then our 21 hospitals with licensed NICU beds and 14 hospitals with special care nursery services. So we are going to review their project delivery requirements, their performance and things like that based on the CON standards.

Also, just like every year, the annual survey will be launched on March 6 and it will close on April 30th. We will send out notices and we will arrange webinars for training and Q&A sessions.

Oh, also, at the last Commission meeting you heard that our finance review specialist, Perry Smith, was retiring after 35 plus years of state service. So we were able to hire another finance specialist. His name is Zach Griffin. Zach, are you still here? Okay. He was here in the morning, but -- so -- so he is the new finance review specialist for the CON section.

MR. FALAHEE: And this is Falahee. When Tulika talks about the annual survey, that -- Commissioner Guido-Allen just grimaced.

MS. GUIDO-ALLEN: Sorry.

MR. FALAHEE: Anybody that works in a hospital and grimaced because it asks for everything under the sun but that's okay. And if you ever want to know what's going on within a hospital, read the survey. It's amazing the -- the detail that goes into it. So -- so -- I guess we thank you for doing that, Tulika. All right. Legal Activity report?

MR. HECKMAN: Assistant Attorney General Brien Heckman. The legal activity report is in the Board packet or the Commission packet. There's currently no litigation ongoing. I don't believe that any is expected.

What you will also find in your packet is a proposed resolution prepared by the Attorney General's Office amending the bylaws of the Commission to address two of the issues raised at the December Commission meeting, mainly those concerning conflicts of interest as well as the applicability of the Open Meetings Act for the SACs. The requirements that were previously or currently in the bylaws are -- are more restrictive than needs to be under the law and through the experience of COVID, I think everybody kind of came to the understanding that there's a benefit to having more robust participation, especially in the Upper Peninsula in regards to some of these SACs. So this proposed resolution will address both of those changes.

What -- what I would recommend is that one of the commissioners move to formally propose the language amending

the bylaws as drafted by the Attorney General's Office with a final vote at the next Commission meeting. While that time period is -- while we are waiting for the -- the final vote, the Department and I will formalize some procedures to use for those remote meetings.

MR. FALAHEE: This is Falahee. So the request is that the Commission put forth a motion to not approve the bylaws?

MR. HECKMAN: Right. So you're putting it up -- you're -- you're formally proposing the language --

MR. FALAHEE: Okay.

MR. HECKMAN: -- amending the bylaws with a vote, a final vote at the next Commission meeting.

MR. FALAHEE: Okay. Thank you.

DR. MCKENZIE: This is Commissioner McKenzie. I will move to formally adopt the language to change the bylaws.

MR. FALAHEE: With a final vote --

DR. MCKENZIE: With a final vote at the next Commission meeting.

MR. DRAKE: Archie Drake. I second.

MR. FALAHEE: Does that satisfy?

MR. HECKMAN: Uh-huh.

MR. FALAHEE: Great. Okay. Motion on the floor. Those of those who are about to serve on SACs, I'm sure

they're happy if we go through with this. All in favor of the motion say aye.

ALL: Aye.

MR. FALAHEE: Opposed? Thank you.

(Whereupon motion passed at 12:38 p.m.)

MR. FALAHEE: Anything else? Great. Thanks. Any public comment?

MS. STANTON: We do not. I did want a question for clarity for the Hospital Bed workgroup. Is that something you wanted to get a vote of approval or support from the commissioners in order to have you chair that?

MR. FALAHEE: I don't think we need one, but let me turn to Mr. Heckman to see if he thinks we need a formal motion.

MR. HECKMAN: You don't need one, but if you want one you can have one.

MR. FALAHEE: We don't need one. If anyone would like one, though, we can do that to make it --

MS. GUIDO-ALLEN: Official.

MR. FALAHEE: -- super official.

MS. GUIDO-ALLEN: Guido-Allen. Submit a motion to allow Chip Falahee to chair the workgroup.

MR. FALAHEE: Hospital Bed workgroup.

MS. GUIDO-ALLEN: Hospital Bed workgroup.

MR. FALAHEE: Yeah. Okay. Any support for that?

MR. HANEY: Commissioner Haney. I'll support that.

MR. FALAHEE: Great. Discussion? All in favor?

ALL: Aye.

MR. FALAHEE: Opposed? And I abstain. Okay. Thank you.

(Whereupon motion passed at 12:39 p.m.)

MR. FALAHEE: Thank you. So no public comment then?

MS. STANTON: No public comment.

MR. FALAHEE: All right. Thank you. All right. Tiffani, review the plan.

MS. STANTON: Yes. All right. All right. So I apologize for how small it is here. There was the copy that was provided in your binder. So based on -- kind of in line for pretty much everything that we discussed today, you can see for Bone Marrow we requested the Commission to allow the Department to present the language at a later date. We are requesting to push that to the June meeting to provide that language just to line up with other workgroups in the public hearing and procedures.

Cardiac Cath, we are in the nomination period currently. We will be starting that SAC in April with the final meeting in September and then hopefully to provide a report by the December meeting.

CT is up for public comment this year, so that will happen in October.

Heart/Lung/Liver, that one we are anticipating for that SAC to -- the nomination period to begin in June through September with the first meeting in October carrying into the following year.

And then the Hospital Bed workgroup, we are hoping to be able to start that next month. And then we started it with four, typically we'll do four to six meetings, so we started it with four. It could be more, could be less. If it is -- does take four, we did discuss having the report provided at the June meeting with final action at the September meeting.

For MRI, that would be the workgroup that we would start in June with a final report at the December meeting.

MRT, that one is in final -- that one will have the final action at the March meeting.

The NICU and Nursing Homes, both of those standards are up for review and they'll be presented at the October public comment period. And then -- just make sure I didn't skip any. No, it carries on.

So Open Heart, that will have the final action in the -- at the March meeting as well.

And then Psych Beds, that workgroup, we are -- if -- yeah, we did have the informal workgroup to start in

November based on the scheduling.

Our Surgical SAC is still continuing, hoping to have the report by the June meeting. And then Litho is up for -- the standard is up for public comment this year, so that will occur in the October meeting. And then of course we're still monitoring new technology.

MR. FALAHEE: Any questions of Tiffani about the work plan? I'd entertain a motion to approve the work plan as she just presented.

MR. HANEY: Commissioner Haney. So moved.

MR. FALAHEE: Support?

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt. Support.

MR. FALAHEE: Thank you. Any discussions? All in favor say aye.

ALL: Aye.

MR. FALAHEE: Any opposed, same sign? That carries. Great.

(Whereupon motion passed at 12:42 p.m.)

MR. FALAHEE: One last item, future meeting dates. They have not changed: March 14, June 13, September 19, and December 5. With that, again, I thank everyone for your participation, those in the audience, those around the table. Thank you all. Great meeting. Great discussions. I'd entertain a motion for adjournment.

DR. ENGELHARDT-KALBFLEISCH: Commissioner Engelhardt. Motion to adjourn.

MR. HANEY: Commissioner Haney. Support.

MR. FALAHEE: All in favor say aye.

ALL: Aye.

MR. FALAHEE: Opposed? Great.

(Whereupon motion passed at 12:43 p.m.)

MR. FALAHEE: Thank you, everyone.

(Proceeding concluded at 12:43 p.m.)

CERTIFICATE

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

That this transcript, consisting of 135 pages, is a complete, true, and correct record given in this meeting on January 25th, 2024.

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

IN WITNESS THEREOF, I have hereunto set my hand this 5th day of February, 2024.

Marcy A. Klingshirn

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