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

COMMISSION MEETING
BEFORE JAMES FALAHEE, CHAIRPERSON
BEFORE AMY L. MILEWSKI, M.D., VICE CHAIRPERSON

333 South Grand Avenue
Lansing, Michigan
Thursday, June 12, 2025, 9:30 a.m.

Marcy A. Klingshirn, CER 6924
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	TABLE OF CONTENTS	PAGE
1		
2		
3	I. Call to Order	6
4	II. Introduction of New Commissioners	6
5	III. Review of Agenda	9
6	IV. Declaration of Conflicts of Interest	10
7	V. Review of Minutes of March 13, 2025	10
8	VI. County Designation Informal Workgroup - Final Report	11
9	A. Public Comment	--
10	B. Commission Discussion	--
11	C. Commission Action	23
12	VII. Psychiatric Beds and Services Informal Workgroup - Final Report & Draft Language	141
13	A. Public Comment	--
14	B. Commission Discussion	--
15	C. Commission Proposed Action	151
16	VIII. Heart, Lung, and Liver (HLL) Transplantation Services SAC - Final Report & Draft Language	26
17	A. Public Comment	
18	1. Jesse Syring	68
19	2. Atsushi Yoshida, M.D.	74
20	3. Liz Reed	78
21	4. Marwan Abouljoud, M.D.	83
22	5. Makenzie Buchert	90
23	6. Tom Stankewicz	93
24	7. Shannon Striebich	97
25	8. Kelly Summers	107

1	B.	Commission Discussion	121
2	C.	Commission Proposed Action	135
3	IX.	Cardiac Catheterization Services SAC - Public Hearing Summary	152
4	A.	Public Comment	--
5	B.	Commission Discussion	--
6	C.	Commission Final Action	154
7	X.	Magnetic Resonance Imaging (MRI) - Public Hearing Summary	154
8	A.	Public Comment	
9		1. Glenn Houck	159
10	B.	Commission Discussion	--
11	C.	Commission Final Action	157
12	XI.	Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services - Public Hearing Summary	163
13			
14	A.	Public Comment	--
15	B.	Commission Discussion	--
16	C.	Commission Final Action	163
17	XII.	Election of Vice-Chair	164
18	XIII.	Legislative Update	165
19	XIV.	Administrative Update	
20	A.	Commissions and Special Projects Section Update	167
21	B.	CON Evaluation Section Update	167
22		i. 2nd Quarter Activity Report FY25	
23		ii. 2nd Quarter Compliance Report FY25	
24	XV.	Legal Activity Report (Written Report)	168
25	XVI.	Public Comment	

1	1. Melissa Reitz	169
2	XVII. Review of Commission Work Plan	171
3	A. Commission Discussion	--
4	B. Commission Action	172
5	XVIII. Future Meeting Dates	172
6	XIX. Adjournment	173
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
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1 Lansing, Michigan

2 Thursday, June 12, 2025 - 9:30 a.m.

3 MR. FALAHEE: So let's call the meeting
4 together, the CON Commission, for June the 12th.
5 And I'd like to welcome everybody.

6 The first item on the agenda,
7 introduction of new commissioners. One of those
8 commissioners is here, Tatiana Grant, and brand new
9 to the CON commission. Welcome.

10 MS. GRANT: Absolutely. Thank you.

11 MR. FALAHEE: Our -- our practice is that
12 when we have a new person joining us, tell us who
13 you are, whatever else you'd like to do -- tell us
14 within 30 seconds.

15 MS. GRANT: Understood.

16 MR. FALAHEE: And then let's go around
17 the table. We'll start with Greg and work around
18 the table to tell you who we are.

19 MS. GRANT: Got it. Okay. I just had --
20 good morning, everyone. My name is Tatiana Grant.
21 I am a Detroit native. I reside in Farmington
22 Hills. I am a entrepreneur. I own a full service
23 integrated marketing agency with an emphasis on
24 multicultural based out of downtown Detroit. And
25 then in Macomb County I own a Amazon Logistics

1 business. So we deliver around 6- to 7,000
2 packages in Macomb County every day, delivering
3 smiles.

4 MS. GUIDO-ALLEN: You go to my house.

5 MR. SALWIN: Oh, go ahead.

6 MR. FALAHEE: Yeah.

7 MR. SALWIN: Greg Salwin, Clarkston,
8 Michigan. Director at Stellantis. I represent a
9 large employer, plan sponsors. I've been on the
10 Commission about a year and a half now.

11 MR. VELEZ: Daniel Velez from Westland,
12 Michigan. I'm a nurse and nursing home
13 administrator and I represent nursing homes.

14 MR. FALAHEE: Tulika?

15 MS. BHATTACHARYA: Tulika Bhattacharya
16 from the Department.

17 MS. NAGEL: Good morning. Beth Nagel
18 from MDHHS.

19 MS. STANTON: Tiffani Stanton -- sorry.
20 Thank you. Tiffani Stanton from the Department.

21 MR. CONNOLLY: Marcus Connolly from the
22 Department.

23 MS. TUCKER: Katherine Tucker from the
24 Department.

25 MR. EASTER: Justin Easter from the

1 Department.

2 MR. HAMMAKER: Hi. I'm Carl from the
3 Attorney General's Office. I represent the
4 Commission and the Department.

5 MR. FALAHEE: Chip Falahee from
6 Kalamazoo. Been on the Commission 16 years, and
7 been doing CON work for about 40. So glad you're
8 on the Commission. Welcome.

9 MS. GRANT: Thank you.

10 DR. MILEWSKI: Good morning. Amy -- good
11 morning. Amy Milewski. I represent nonprofit
12 payers. Work at Blue Cross Blue Shield of
13 Michigan, and I've been on the Commission for, I
14 think, about five years.

15 DR. ENGELHARDT-KALBFLEISCH: Good
16 morning, everyone. I am Amy
17 Engelhardt-Kalbfleisch. I am from mid-Michigan,
18 but currently live in Clarkston and work in
19 Detroit. I've been on the Commission for probably
20 five to six years.

21 MS. GUIDO-ALLEN: I'm Debbie Guido-Allen.
22 I represent nursing. I am currently the president
23 at Corewell Health Dearborn Hospital. And I've
24 been on the Commission, I want to say, almost ten
25 years.

1 DR. DELANO: And I'm Mark Delano. I am
2 representing medical schools in the state of
3 Michigan. I am chair of the Department of
4 Radiology at Michigan State University.

5 MR. FALAHEE: And most importantly we
6 have Marcy making sure -- she keeps track of
7 everything you say.

8 So let's start by reviewing the agenda.
9 The agenda has been distributed in our packets that
10 the Department sent out. Any questions about the
11 agenda? If not, I would entertain a motion to
12 accept the agenda as presented, please.

13 MR. VELEZ: I would like to make a motion
14 to accept and approve today's meeting agenda.

15 MR. FALAHEE: Is there support for that
16 motion?

17 MR. SALWIN: Mr. Salwin supports.

18 MR. FALAHEE: Thank you. There's a
19 motion and support. Any questions? All in favor,
20 please say "aye."

21 ALL: Aye.

22 (Whereupon motioned passed at 9:34
23 a.m.)

24 MR. FALAHEE: Thank you. I -- I should
25 have -- I -- I -- I jumped the gun too soon before

1 we did the agenda. There's also a new almost
2 commissioner in the audience, as well. As many of
3 you know, this is my last meeting as a member of
4 the Commission. My successor on the Commission, I
5 think it's effective tomorrow, is Karen Cheeseman
6 there in the back of the room. Karen, you want to
7 stand up? Welcome. We'll -- yeah, we can applaud.

8 (Applause.)

9 MR. FALAHEE: Karen will be a great
10 addition to the Commission. I have warned her
11 about all of you. So she'll take over and I'm sure
12 do a great job. Karen is the CEO of Mackinac
13 Straits Hospital up in St. Ignace. No, she did not
14 drive down this morning. She drove down last
15 night, so there.

16 With that, declarations of conflict of
17 interest. Does anyone, given the agenda we just
18 approved, have any conflict of interest they'd like
19 to entertain or present? Okay. Hearing none we'll
20 move on.

21 Next item, the review of the minutes of
22 our meeting on March 13. Any questions or comments
23 about those minutes? If not, I would entertain a
24 motion to accept those minutes.

25 DR. ENGELHARDT-KALBFLEISCH: Commissioner

1 Engelhardt-Kalbfleisch, motion to accept the
2 minutes.

3 MR. FALAHEE: Second?

4 DR. DELANO: Second. Delano,
5 Commissioner.

6 MR. FALAHEE: Thank you very much. Any
7 questions? All in favor of the motion say "aye."

8 ALL: Aye.

9 MR. FALAHEE: Opposed? Great.

10 (Whereupon motion passed at 9:35
11 a.m.)

12 MR. FALAHEE: And, Commissioner Grant,
13 one thing I forgot to mention is when -- you'll
14 hear us when we say or we start to talk, please
15 identify who you are --

16 MS. GRANT: Okay.

17 MR. FALAHEE: -- so that Marcy can get a
18 sense of who said what. Thank you.

19 MS. GRANT: Understood.

20 MR. FALAHEE: And I sometimes don't do
21 that so I apologize in advance. All right.

22 First item of substance, the County
23 Designation informal work group, the final report.
24 You know, we've got two people here that have been
25 very, very, very involved in this. Jenny

1 Groseclose and Karol Clason. Full disclosure.
2 Karol works with me at Bronson, and so I work with
3 Karol every day on CON issues. And Jenny, as many
4 of you know, has been involved in many SACs,
5 workgroups and committees. So thank you very much
6 for the work you've done. And they're here to
7 present a summary of the workgroup report.

8 MS. JENNY GROSECLOSE: Good morning. So
9 we already have our introductions. Karol and I
10 co-chaired the team for County Designations, and
11 the focus is to review and have recommendations for
12 the standards that have county designations noted.
13 So next slide.

14 We had two workgroup charges. The first
15 is to review the standards where we're referencing
16 the U.S. Census Bureau's designations for rural,
17 micropolitan and metropolitan counties. So right
18 now there are three designations that are based on
19 the OMB and then to recommend those changes if we
20 find that potentially there's a different source
21 and -- and we'll get into that detail later -- and
22 then to recognize the compliance to those
23 requirements in the event that the U.S. Census
24 Bureau changes, and that U.S. Census Bureau is
25 typically a ten-year cycle. And then the second

1 charge is something that sits with every workgroup
2 and SAC and that's to see if there's any technical
3 changes, and the Department supports that work. So
4 next slide.

5 So we -- sorry, I'm aligning my laptop.
6 So we had three goals within the workgroup, and it
7 was to -- the primary one is to protect rural
8 access to healthcare in the standards where it's
9 recognized. The second is to assure consistency
10 among the standards, and that would be the language
11 definitions and source. And the third is to assure
12 the source for defining the rural areas makes
13 sense. Is it updated? Is it easily
14 operationalized? Is it easily accessible to the
15 individuals that are submitting applications?

16 We had a three-prong approach. The first
17 was to review and recommend potentially a different
18 source, so right -- so right now the source is OMB.
19 Oh, next slide. Sorry. So this is our three-prong
20 approach. So we -- again, we're identifying the
21 best source for rural counties or potentially rural
22 census tracts. The second would be are we going to
23 layer on an additional CMS designation that exists
24 for many of our hospitals? That's critical access,
25 sole community hospital, Medicare dependent, and

1 the rural emergency hospitals that you'll reme- --
2 might remember that we started talking about that
3 within the standards in the last year. And then
4 within the Surgical Services standards, there's
5 this additional pretty defined rural area that is
6 for licensed hospitals located in a city, village
7 or township with a population of 12,000 or less and
8 then within a county with a population of a 110,000
9 or less, and that's defined by the federal census.
10 So that -- that does exist in one of our standards
11 in that Surgical Services. Next slide. And
12 Karol's going to pick up the meaty piece.

13 MS. KAROL CLASON: Thanks. Okay. So our
14 workgroup did evaluate five different data sources.
15 Obviously, the OMB, which is the current source
16 that's been used in the CON today, in addition to
17 FORHP, so the Federal Office of Rural Health
18 Policy, which is what we're going to be
19 recommending to switch to. We also looked at MSU
20 Rural Health Center. They actually also produced a
21 map. Unfortunately with that group, we were unable
22 to get in contact with them and get a response, so
23 we don't know their methodology, how often it's
24 updated, et cetera. U.S. Census also in some of
25 their data sets had a column about percent rurals

1 and we looked at that. And then also the RUCA
2 codes which is used by the USDA, another
3 organization. When we were looking at these
4 sources, we did take into consideration was the
5 output logical, did it make sense, did it reflect
6 what we would believe is rural? We want to make
7 sure that it was at least updated along with the
8 U.S. Census, so every 10 years. Was it readily,
9 easily implementable? Did it also take into
10 account beyond county boundaries so that it'll look
11 at census tracts, there's a code level, and then
12 still being a trusted source used by the federal
13 agencies, et cetera. So we quickly actually
14 narrowed down to those top two, so OMB to -- oh,
15 thank you. See?

16 So the current that's in the standards
17 today -- technically actually in the standards
18 today is still the 2010 definition. So this is
19 reflecting the 2020 definition, and then to the
20 right is the FORHP definition. I will say, I want
21 to note that this is looking just at the county,
22 but FORHP does have a definition where they look at
23 census tracts. And if you looked at the appendix
24 section, the map with this census tract view is in
25 there. So that would pick up, like, I think it was

1 Oakland County and the northern areas. There are a
2 couple of little small pockets that actually are
3 rural. Very small, there's no hospital there, but
4 it looks a little bit more granular.

5 So as you can see, there are five
6 counties that differed among the two methodologies.
7 We then looked also at the -- off to the right top,
8 you'll see the OMB takes into account 53 counties
9 that are designated as rural where the fourth
10 definition says there's 58 counties that are rural.
11 You can see the population and the et cetera in
12 those areas. Down at the very bottom are those
13 five counties that differed where we actually
14 looked across all those different methodologies for
15 those five counties. So, again, MOB is saying --
16 or OMB is saying they're metro; FORHP is saying
17 they're rural; MSU had a little -- a mix, some were
18 rural, some were urban; census said mostly rural;
19 and then RUCA said metro. The group -- the group
20 really quickly came to the conclusion that FORHP
21 still made the most sense; it was most logical.
22 The other thing with FORHP, too, is that it was
23 designed for healthcare. So it's used for
24 healthcare brands. Right now with HRSA, it -- the
25 whole focus of it is -- really with HRSA is

1 healthcare access and protecting rural communities
2 whereas OMB, that's not the intent. It's more on
3 demographic analysis and more of a -- what was the
4 other part of that? -- healthcare and policy was
5 the only difference. And then economic versus
6 demographic analysis for the OMB.

7 So with that, we are recommending that we
8 switch to FORHP as the definition for rural
9 communities. You can see the impacted standards.
10 So almost all the standards has some kind of
11 reference to rural in them, so those are the ones
12 that would be impacted. The language change is
13 we're going to be adding a definition for rural
14 area and then metro counties. There will be a
15 footnote for the rural area and that will include
16 the link to the website where the people move up,
17 where they fall. And then in the body of the
18 standards you will see a lot of reference to just
19 calling it "rural area." So pretty simple changes
20 in terms of the standards. I say that, of course,
21 the Department may have a different view than
22 "simple." But in terms of language, it was a
23 pretty easy swap out.

24 MS. JENNY GROSECLOSE: So the second
25 piece is -- yep, next slide. The next piece is the

1 discussion on layering in those CMS designations
2 that already exists for what they consider rural
3 healthcare licensed hospitals. So critical access
4 hospital, Medicare dependant hospital -- I don't
5 believe we have one in the state of Michigan right
6 now -- sole community hospital and rural emergency
7 hospitals. And if you have the presentation, there
8 is a list of the hospitals in Michigan that apply
9 to the areas and we can also pull it up if you want
10 to reference it. But the considerations for the
11 additional layering in is that CMS has already
12 designated those hospitals to serve geographically
13 isolated communities with limited access to care,
14 and they rely on that designation to provide access
15 in their communities. The standards, some
16 standards already recognized critical access
17 hospitals as rural or micropolitan regardless of
18 their county. So for Munson Healthcare right now,
19 if we were to use OMB, we have two very rural
20 hospitals in Kalkaska and Frankfort that are
21 critical -- critical access and this would be the
22 overlay on supporting their critical services in
23 those very rural communities. And that they --
24 that we ensure consistency among the standards for
25 that rural CMS designation. Next slide.

1 So the workgroup unanimously agreed that
2 some sort of layering in of those CMS designations
3 would be -- would be appropriate, but that it
4 should be in a phased approach, which I'll get into
5 in our next slide. So, again, as Karol mentioned,
6 we had some recommendations of actual language
7 within the standards by being very consolidated and
8 recognizing it as a designated rural hospital, and
9 then within the definitions, adding those four CMS
10 designations. Next slide.

11 So here's our recommended phased approach
12 as discussed by the workgroup. That for Nursing
13 Home, NICU, Psych Beds, and Litho standards -- the
14 UESWL standards -- Litho standards, I'm going to
15 just call it for what I think of -- the -- the --
16 that we would apply at CMS rural designation
17 language, rural hospital designate -- designation
18 language. And for Nursing Homes it doesn't apply
19 because they're not a licensed hospital. For phase
20 two -- and this -- this had a bit of discussion --
21 we would use the upcoming SAC or workgroups to
22 discuss details on would we apply all four? Could
23 we potentially apply maybe three of them? Sole
24 community hospital seems to be the one that's
25 sensitive. And that would be for the Cardiac Cath

1 SAC or workgroup in 2026; CT is starting this
2 month, I believe, as a SAC; MRT or the LINAC
3 accelerator is in 2026; PET is in 2026; Hospital
4 Beds is in 2026, and Open Heart is coming up that
5 year as well. So we would use the workgroups or
6 SACs to define how we felt that should be applied
7 within the standards. And then the third is to
8 recognize we have this layering in, in our MRI and
9 Surgical Services standards. And, again, we would
10 -- we would discuss that in the next SAC or
11 workgroup, but as an awareness, it -- it does
12 already exist in two of our standards. Next slide.

13 And then the third piece was that really
14 clunky language of a rural city, village or
15 township with a population of 12,000 or less and a
16 county of a 110,000 or less, and this sits in the
17 Surgical Services standards. And the workgroup
18 felt, let's just keep it in there. We'll address
19 it in the next SAC or workgroup, but that that
20 really wouldn't be applicable for the other
21 standards. So we're just kind of taking a pause on
22 that definition, but we really didn't want to carry
23 that forward. Next slide.

24 Oh, here we're in the appendix. So are
25 there details that you think would be helpful to

1 share? They're probably sitting in your appendix,
2 or do you have any questions?

3 MR. FALAHEE: Thanks, Jenny. Thanks,
4 Karol. I forgot to ask if the Department had
5 anything they wanted to say before these two came
6 up.

7 MS. TUCKER: Great. All recommended
8 definitions presented to the Commission reached a
9 consensus. We have not received any public
10 comments from any organizations. Two of the
11 definitions are being recommended for 12 and 14
12 standards. Again, those definitions include rural
13 area and metropolitan counties. If the Commission
14 agrees on the suggested definitions, the Department
15 can implement them into the impacted standards and
16 bring them back to a future Commission meeting for
17 proposed action. If the third definition that's
18 designated rural hospital is approved, the
19 Commission may instruct the Department on how they
20 want the third definition implemented. Should the
21 Commission approve the two definitions of rural
22 area and metropolitan counties, the Commission
23 should consider a motion to approve the definitions
24 as presented and allow the Department to implement
25 them into the applicable standards and bring to a

1 future Commission meeting for proposed action. As
2 far as the third definition, designated rural
3 hospitals, the Department recommends following the
4 guidelines established by the workgroup.

5 MR. FALAHEE: Thank you. So any
6 questions of Jenny or Karol from the commissioners?
7 I will add that this is something that I dealt with
8 personally when Van Buren County in southwest
9 Michigan kept flipping back and forth depending on
10 the census. So sometimes it -- it was tied to
11 Kalamazoo metropolitan statistical area, sometimes
12 it was not, and it just didn't make any sense. So
13 I -- I'd like the recommendation to go to -- do we
14 call it FORHP?

15 MS. JENNY GROSECLOSE: FORHP.

16 MR. FALAHEE: FORHP. So thank you both.
17 This was a great workgroup. Marcus, one second.
18 It was great workgroup led by two terrific people,
19 and I knew they would -- the two of you and the
20 workgroup would be able to slog through all of
21 this. And I want to commend both of you for a job
22 very well done. Marcus?

23 MR. CONNOLLY: Yeah. I just wanted to
24 let the commissioners know that Dr. Delamater is
25 also on via Zoom. So if you have any questions,

1 you can ask him as well, because he was a big part
2 of the County Designation workgroup as well. So if
3 there's any questions, you can ask him as well.
4 He's on.

5 MR. FALAHEE: Thank you. I couldn't --
6 Paul, I couldn't tell if you were on there or not.
7 This is Chip. Do you have anything you want to add
8 to what Jenny and Karol had to say? I'll take that
9 as a no.

10 MS. STANTON: I'm sorry, Paul. We can't
11 hear you.

12 MR. FALAHEE: All right. I'm going to --
13 I'm going to move on because we had audio issues
14 last time and I don't want to replicate that this
15 time. No -- no questions from the commissioners?
16 Okay. And as Katherine said, in fact, we have a
17 motion to approve the recommendations of the
18 workgroup, and embedded within that motion are all
19 the items that Jenny and Karol said and moving
20 forward with the different timing rolled out on --
21 on the standards so it's not all at once. And
22 there were a lot of discussions behind the scenes
23 about that. I talked to several folks from the
24 Department about that. So before us is entertain a
25 motion to approve the recommendations of the

1 workgroup and then to send it out for public
2 comment and all the other measured works. So
3 anyone carry to make a motion? Looking to my left.

4 DR. MILEWSKI: This is Commissioner
5 Milewski. And I will make a motion that we support
6 the workgroup recommendations and direct the
7 Department to draft language that would be
8 reflective of the workgroup findings and then send
9 that language out for public comment.

10 MR. FALAHEE: Is there support for that
11 motion?

12 DR. ENGELHARDT-KALBFLEISCH: Commissioner
13 Engelhardt-Kalbfleisch. Support.

14 MR. FALAHEE: Thank you. Any questions
15 among the commissioners?

16 MS. STANTON: To clarify, you are asking
17 the Department to send it out for public hearing
18 versus bring it back for a proposed action? Is
19 that what you --

20 MR. CONNOLLY: Yeah.

21 MS. NAGEL: Yeah.

22 MS. STANTON: Okay.

23 MR. FALAHEE: This is Falahee. Tiffani,
24 say that again. I -- I missed.

25 MS. STANTON: I was writing down the

1 motion to send the -- to draft this -- the language
2 and then send it for public hearing or bring it
3 back for proposed action first.

4 MR. FALAHEE: No, Beth --

5 MS. NAGEL: Because there was no language
6 provided in your packet today, you can't take
7 proposed action on that language. So I think, you
8 know, we will send it out for public comment after
9 the Commission takes proposed action, so --

10 DR. MILEWSKI: I can amend --

11 MS. STANTON: Yes.

12 DR. MILEWSKI: Yeah. I will amend my
13 motion then to draft language, bring that back to
14 the Commission and then we can review that.

15 MR. FALAHEE: Thank you.

16 DR. ENGELHARDT-KALBFLEISCH: Commissioner
17 Engelhardt-Kalbfleisch. Support the amended
18 motion.

19 MR. FALAHEE: Great. Thank you both.
20 Any questions amongst the commissioners? All in
21 favorite of the motion please say "aye."

22 ALL: Aye.

23 MR. FALAHEE: Any opposed? That motion
24 carries.

25 (Whereupon motion passed at 9:53

1 a.m.)

2 MR. FALAHEE: Again, Jenny and Karol,
3 thank you very, very much. Appreciate it. Let's
4 move on to the next agent item, Psych Beds.
5 Someone who's no stranger --

6 MR. EASTER: I got -- I got an e-mail
7 from Dr. Jain that he has parked.

8 MR. FALAHEE: He just parked?

9 MR. EASTER: He just parked. He'll be
10 here in a couple minutes.

11 MR. FALAHEE: Should we move on then?

12 MS. STANTON: Well, I can add, too --
13 this is Tiffani from the Department. Paul did drop
14 in the chat -- we were having some issues. But he
15 does say "100% support Jenny and Karol's assessment
16 of the workgroup findings." So --

17 MR. FALAHEE: Okay. Good. Thank you.
18 All right. We can either wait for Dr. Jain or we
19 can move on to the next agenda item. I think I saw
20 Dr. Sonnenday here somewhere. Oh, behind the
21 column. All right. Thank you. What's the
22 preference of the Department?

23 MR. CONNOLLY: We can move on to the
24 Heart, Lung, Liver.

25 MR. FALAHEE: Okay. Let's do that.

1 MR. CONNOLLY: Just to keep everything
2 moving for time sake.

3 MR. FALAHEE: Okay. Great. Thank you.
4 There he is. Let me first turn to the Department,
5 then I will turn to Dr. Sonnenday. Public or
6 comments from the Department before we start?

7 MS. STANTON: Yes. This is Tiffani from
8 the Department. So all recommended language in
9 front of the Commission reached a consensus by
10 majority vote. There were two motions discussed
11 during the end of the last meeting. The first
12 motion was to accept the language as presented.
13 The motion failed to pass by majority vote by six
14 in favor and six opposed. The second motion was to
15 accept the language as presented and recommend
16 another SAC to review potential concerns that may
17 exist within sections five and section seven of the
18 review -- the heart lung liver standards. That
19 motion did pass; seven in support, with five
20 opposing. The Department is including technical
21 edit across the standards that is included across
22 all the standards to add the 30-day language, which
23 is the -- to notify the Department within 30 days
24 after the plan discontinuation of service or
25 decrease. The -- an additional meeting was added

1 to allow more time to finalize language that was
2 presented today. That additional language was
3 included in your binder. The additional meeting
4 did fall within the six-month requirement by the
5 bylaws. During the final meeting, there was a
6 suggestion to modify the definition of 2(i) in the
7 definition, which you'll see in your binder, which
8 is for "pediatric," by striking the age of 15 and
9 replacing the age of 18, as well as striking the
10 language from the definition that reads "or any
11 patient with congenital anomalies." The Department
12 is recommending to edit that strike, replace the
13 age 15 with the age of 18. However, the Department
14 is recommending not striking the language for that
15 reads "or any patient with congenital anomalies"
16 until it can just be discussed with a future SAC or
17 workgroup just to ensure that the language does not
18 affect the Heart, Lung side throughout the
19 standards. And I can -- I can show here while I
20 have that up, too. That's this part here that was
21 struck in green. So you'll see in your binders
22 that part was struck out. We're requesting that to
23 not be struck out until it can be reviewed, just as
24 it may have effects for the Heart, Lung part of the
25 review standards, and that wasn't fully vetted.

1 Furthermore, we have received the 16
2 comments from other organizations in support of the
3 language as presented. Those comments were
4 included in your binder as well. Proposed action
5 from the Commission will require a motion, second,
6 and a vote to approve. The Commission's proposed
7 action will move the language to a public hearing
8 and to the Joint Legislative Committee. A report
9 of the language and final action will be brought
10 back to the Commission at the September meeting.
11 Okay. And then so if the Commission does decide to
12 take the proposed action on the language today, we
13 recommend the Commission ask the interested parties
14 to submit comment during the public hearing for any
15 language or additional requirements that would need
16 to be updated in the sections throughout the
17 standards and that that can be considered at a
18 future meeting. And here's Dr. Sonnenday, his --
19 his report.

20 MR. FALAHEE: Okay. Then all set from
21 the Department?

22 MS. STANTON: Yeah.

23 MR. FALAHEE: I think I understood most
24 of it. We'll get back to that. First, let me --
25 let me publicly thank Dr. Sonnenday and -- he's not

1 here, but Dr. Bedi. When the both of you presented
2 here months ago, obviously very devoted, very
3 committed to patient care, what's best interest of
4 the residents of Michigan. And as I said in my
5 e-mails to you and Dr. Bedi yesterday, these two
6 gentleman did a phenomenal job heading up the SAC.
7 Because there are thorny issues, there are a lot of
8 political issues, patient care issues, what's best
9 for the patient issues, quality access/cost issues,
10 they dealt with all of them in multiple meetings
11 over six months. And I wanted to publicly thank
12 you and Dr. Bedi for doing a fabulous job. So
13 thank you. And I'll leave it to you to summarize
14 everything that happened.

15 DR. CHRISTOPHER SONNENDAY: That's right.
16 Easy job. No. Thank you so much, Chair Falahee.
17 And this has been a good experience. We've learned
18 a lot. I would also particularly call out Dr. Bedi
19 who's not here today for clinical reasons, but he
20 was a great co-chair and, you know, balanced and
21 thoughtful person. I'd like to thank all the state
22 staff, but particularly Tiffani and Marcus, who,
23 you know, grinded through this with us and a lot
24 of, you know, detailed language and really we're
25 grateful for their expertise and keeping us on

1 task.

2 So I will summarize just basically by
3 walking through my summative statement which was
4 distributed. As you know, we were asked to
5 consider three charges. To review liver
6 transplantation access issues based on geography
7 and socioeconomic factors and determine if there's
8 substantive need to support the expansion of liver
9 transplantation services. We were asked to review
10 the provisions for operating a transplantation
11 service under a joint sharing agreement in section
12 3(4), and recommend updates to outdated provisions
13 as well as annual volume requirements if necessary.
14 That specifically applies to pediatric programs
15 working in partnership with adult programs. And
16 then finally consider any technical changes to the
17 standards. So I will walk you through each of
18 those charges and our deliberations to that point.
19 Tiffani summarized that we did add a seventh ad hoc
20 meeting specifically around the language.

21 So for the first charge, which was to
22 review liver transplantation access issues based on
23 geography and socioeconomic factors. In
24 considering this charge, the SAC elected to
25 consider three specific domains of evidence to

1 consider expansion of liver transplantation
2 services. The first was to review the burden of
3 chronic liver disease and understand prevalence
4 across the state variation by geography impact on
5 socioeconomic status. The second was to review
6 current state of liver transplantation in the
7 state, understand the pathway from referral to
8 evaluation to waitlisting to transplant among the
9 three current liver transplant programs and how
10 access to transplant among referred patients might
11 vary by geography and socioeconomic status. And
12 finally, to review the supply of deceased donor
13 livers to liver transplant candidates in Michigan
14 and understand how access to deceased donor livers
15 could be -- could vary based on transplant center
16 location, particularly as the hypothetical center
17 was located outside of southeast Michigan where the
18 current programs are.

19 So for the first charge, a subgroup of
20 SAC members, which we referred to as subgroup one,
21 that considered the -- that -- that first domain
22 burden of chronic liver disease, they considered
23 national and state databases. The presentations
24 were prepared for the SAC and are in the public
25 record. Consultants were utilized by SAC members

1 from their institutions and other resources, and
2 concern was expressed about the possible bias and
3 perspective of those individual perspectives and
4 database -- data analyses. We spent a lot of time,
5 each of us, on the SAC specifically disclosing the
6 organizations we worked for, who we worked with,
7 consultants, et cetera. The subgroup one prepared
8 a summary which was presented to the entire SAC on
9 -- in the April meeting, and they drew conclusions
10 that are listed in my summative statement and I
11 will briefly summarize.

12 First of all, in terms of the burden of
13 liver disease in Michigan, there was data that this
14 has increased. The Michigan biostatistics graph
15 showed that the lowest point in age-adjusted
16 chronic liver disease occurred in 2006-2007, about
17 20 years ago. And since this time, that rate, the
18 -- the age-adjusted liver disease death rate has
19 steadily increased. When compared to other states,
20 we rank squarely in the middle of the country,
21 25th, in 2023 for liver-related death rate and
22 we've never ranked higher than 20th, meaning better
23 than 20th in -- in any year since 2018.

24 In terms of regional disparities, there
25 are significant -- there is significant variation

1 in liver disease death rates across counties and
2 planning areas. These disparities cannot be fully
3 explained by income levels or Medicaid enrollment.
4 Notably, planning area one, where the transplant
5 centers are currently located, is the only area
6 that's shown a relatively stable trend in liver
7 disease death rates.

8 We spent a lot of time looking at travel
9 distance and access on outcomes. Dr. Delamater,
10 who you previously referred to, helped us with that
11 as well. Peer-reviewed studies consistently show
12 that travel distance impacts both access to care
13 and health outcomes. As illustrated in the maps
14 and data reviewed by the SAC, the travel distance
15 to a transplant center is higher for western and
16 northern Michiganders. Specifically, nearly 3
17 million Michiganders live more than 100 miles from
18 a trans- -- liver transplant center. For the
19 purposes of illustration, a transplant center in
20 Grand Rapids would be with -- within 100 miles of
21 4.3 million Michiganders, nearly half of which, 2
22 million of which, are not currently within 100
23 miles of an existing transplant center. Of note,
24 further analysis of driving time distance did
25 reveal that 85 percent of Michigan residents live

1 within 60 minutes of hepatology outreach clinic run
2 by one of the three current states of Michigan.
3 Services available at those clinics, which include
4 hepatology evaluation, pretransplant testing, and
5 some posttransplant care vary by the location, and
6 patients are still required to travel to current
7 centers for their transplant episode and early
8 posttransplant care.

9 Subgroup one also called out the
10 population growth and planning area four. This
11 growth occurred after the CON limited the number of
12 liver transplant programs to three, and has led to
13 an increasing number of Michigan residents
14 traveling further distances to a transplant center
15 for liver transplantation.

16 And finally, we talked a lot in both
17 groups and the whole SAC about patient experience
18 and travel burden. The current data on liver
19 disease burden and related mortality does not
20 account for patient experience, particularly the
21 challenges associated with travel. No medical
22 studies have fully defined the burden of travel for
23 these complex patients, liver disease patients.

24 Upon presentation of subgroup one's
25 findings to the SAC, concerns were raised that the

1 time and expertise was limited to fully explore the
2 burden on -- of CLD, chronic liver disease. The
3 SAC did arrive at consensus, however, and I agree
4 with this statement, that the burden of chronic
5 liver disease in Michigan has steadily risen over
6 the past two decades, peaking during the pandemic,
7 with some leveling off in the last one to two
8 years. Further discussion during the April SAC
9 meeting emphasized that the burden of chronic liver
10 disease on patients and the ability to access
11 advanced hepatology and transplant care is
12 challenging to all patients, especially those of
13 lower socioeconomic status, for whom significant
14 travel to specialty care may not be feasible. It
15 was noted that the state of Michigan appears to
16 have a deficit in access to advanced hepatology
17 care across the state, which is largely provided in
18 outreach clinics supported by the -- the three
19 current liver transplant programs. Liver
20 transplant programs do tend to attract a gait- -- a
21 greater number and focus of hep- -- hepatologists.
22 So it was hypothesized by some members that a
23 transplant program located outside of southeast
24 Michigan could accelerate recruitment of additional
25 hepatologists to another location in the state.

1 Some SAC members did challenge this hypothesis,
2 however, as there's been a -- a national shortage
3 of transplant hepatologists with some unfilled
4 positions open in Michigan currently.

5 I'm going to move on now to the current
6 state of liver transplantation which we -- which
7 was addressed by a subgroup of SAC members which we
8 called subgroup two. Again, data from national and
9 state databases, including the national transplant
10 registered data from the Organ Procurement
11 Transplantation Network were considered and
12 discussed. These were prepared and -- and
13 presented to the SAC. They're all in the public
14 record. Subgroup two presented their data on this
15 domain in the April and May SAC meetings. While
16 the subgroup did an exceptional job of analyzing
17 data in a short time frame, limitations did exist
18 in terms of data available, specifically data that
19 is not currently publicly reported and therefore
20 would need to be pulled from individual transplant
21 hospitals was not available. These unavailable
22 data would be most relevant to the time frame from
23 transplanted value -- from referral to transplant
24 evaluation, and transplant evaluation to
25 waitlisting because currently referrals and

1 evaluations are not publicly reported.

2 Considerations for which objective data
3 are not available but are well known to the SAC
4 members and include the comp- -- complexity of the
5 patient's journey from diagnosis of chronic liver
6 disease to transplant. Factors that affect access
7 to transplant include transportation, financial
8 burden, time off work for patients and family, and
9 stress on caregivers. Complexity of transplant
10 evaluations, the volume and complexity required
11 pretransplant testing, delays in insurance
12 authorization, and distance from advanced
13 hepatology and transplant care were all cited by
14 SAC members as added patient burdens not measured
15 in available data.

16 Subgroup two presented data on insurance
17 type by planning, state planning zone. Patients
18 with public insurance (Medicare and Medicaid) range
19 from 36 percent in zone four to 47 percent in zone
20 five. Area deprivation index was presented by
21 county. That's a established validated measure of
22 variation in socioeconomic burdens by population
23 with areas of greater socioeconomic disadvantaged
24 highlighted by location across the state. Each
25 planning area actually has variable areas of high

1 deprivation, area deprivation index. Data was
2 presented on the severity of liver disease,
3 including liver-related deaths. Patient listed for
4 transplant MELD score, which is the current metric
5 used to judge priority for transplant during
6 listing for transplant by planning area residents.
7 Transplants performed, transplant rate by planning
8 area of residence was also reported. Transplant
9 rate was compared to liver-related death rate by
10 planning zone as a metric of the impact of the
11 transplantation.

12 Subgroup two offered the following
13 additional summative comments to the SAC. Outreach
14 clinics from the current three liver transplant
15 programs exist in each planning zone except for
16 zone three. There is variability in liver-related
17 deaths within the -- within the zones with zone
18 four, 139 per million residents annually having the
19 lowest, and zone six, 235 deaths per million
20 residents having the highest. Death from liver
21 disease is increasing by incidence in most areas
22 and higher than the national average except in
23 zones one and four. Waitlist additions by zone per
24 liver-related deaths is variable with the highest
25 in zone one (near the current transplant centers)

1 and the lowest in zone eight. Transplants
2 performed per liver disease-related death was
3 presented as a measure of transplant impact
4 relative to need. Zones one, five and seven had
5 the highest rates with the other zones all very
6 similar.

7 Upon discussion with the SAC, some
8 members proposed that a fourth liver transplant
9 program in Michigan could improve access to
10 transplant and lower liver disease-related death in
11 Michigan. Alternative considerations and concerns
12 were also raised. Concerns included the cost and
13 complexity of initiating a new program, including
14 institutional costs for resources and personnel,
15 and the cost to cover transplant-related charges
16 until insurance contracts are established.
17 Further, if transplant volumes decreased
18 significantly at the three existing liver
19 transplant programs, there was a concern that
20 quality could decrease. Uncertainty was also noted
21 about whether the expanding outreach efforts of the
22 three current programs could meet the needs of the
23 state without adding a fourth program.

24 The third domain we considered, subgroup
25 three, was deceased donor liver supply. Dr. Bedi

1 and myself took on this task reviewing the supply
2 of deceased donor livers to liver transplant
3 candidates in Michigan and to understand how access
4 to deceased donor livers may vary based on
5 transplant center location. We used for the
6 purposes of this discussion, a hypothetical west
7 Michigan center versus the programs in southeast
8 Michigan. Data from the OPTN was obtained,
9 analyzed, and presented to the SAC which then are
10 included in the public record.

11 The following conclusions from this
12 analysis were presented to the SAC. And I'll just
13 remind this, the -- the Commission that the ways
14 livers are currently distributed are in concentric
15 circles from the donor hospital location. So the
16 analysis showed that differences in donor supply
17 for the Grand Rapids and Detroit locations exist
18 between 150, which is the smallest acuity circle,
19 and 250 nautical mile allocation circles. Based on
20 recent historical data within 150 miles, the Grand
21 Rapids center would have access to more deceased
22 donors (5,600 versus 4,700), than a Detroit center
23 with approximately 50 percent of those donors not
24 within 150 miles of Detroit; unique donors not in
25 the same circle as Detroit. In general terms,

1 donors allocated within 150 miles of donor
2 hospitals are allocated to the highest MELD
3 candidates on the waiting list (sickest patients).
4 In addition, donors after circulatory death, DCD
5 donors, and age greater than 70 donors after brain
6 death, are also first allocated within the 150 mile
7 circle. Based on recent historical data within 250
8 miles -- which is the next largest allocation
9 circle -- the Detroit center would actually have
10 access to more deceased donors (11,500 versus
11 10,400) than the Grand Rapids center with
12 approximately 20 percent of those donors not within
13 250 miles of Grand Rapids or unique to the Detroit
14 center. In general terms, donors allocated within
15 250 miles of donor hospitals are allocated to
16 candidates with MELDs closer to the national
17 median. Expanded criteria donors (older donors,
18 some DCD donors, donors with medical complexity)
19 are often utilized by centers within 250 miles of
20 donor hospitals by centers with a high organ offer
21 acceptance rate which is true actually of all the
22 current Michigan centers.

23 So taken in summary, a Grand Rapids
24 center and Detroit center would have access to
25 similar numbers of deceased numbers based on

1 historical data, though the locations of those
2 donor hospitals will vary.

3 Current analysis of median MELD at
4 transplant by donor hospital location does suggest
5 that candidates listed at a hypothetical Grand
6 Rapids center could need to achieve a higher median
7 MELD at transplant, probably about one to four
8 additional points, versus candidates at a Detroit
9 center. The degree to which this would affect
10 access to transplant for such candidates is
11 difficult to predict. A lot of it is based on
12 center behavior.

13 Upon discussion with the SAC it was noted
14 that a Grand Rapids center would have at least nine
15 liver transplant centers within 150 miles towards
16 Detroit, Indianapolis, et cetera, versus four with
17 a Detroit center. A Grand Rapids center would also
18 therefore have more waitlisted patients within 150
19 miles versus a Detroit center. These data further
20 support the idea that candidates at Grand Rapids
21 center could need to achieve a higher median MELD
22 to transplant -- again, we estimated one to four
23 points -- versus candidates at a Detroit center.
24 Again, the degree to which this would affect access
25 to transplant for candidates at Michigan center

1 broadly is hard to predict.

2 It is difficult to model how the presence
3 of a Grand Rapids center would affect access to
4 transplant for the patients at -- at the existing
5 three liver transplant programs, and such impact
6 would depend on the size of the waiting list of the
7 new program and the other programs, MELD score of
8 the patients at the various programs, and center
9 behavior regarding organ offer acceptance.

10 Ideally, a fourth transplant program expands access
11 to transplant for patients not currently being
12 transplanted in Michigan. The number of
13 transplants performed statewide at all programs
14 would increase. SAC members noted that this is
15 what occurred when additional heart and lung
16 transplant programs were added in Michigan.

17 So I wrote a summative statement to try
18 and put all that together. Based on the available
19 data as summarized above, the SAC believes that
20 there is evidence to support expansion of liver
21 transplantations to four adult programs. This
22 recommendation was achieved by a majority vote,
23 with eight members voting in support of expansion
24 and six voting against. One additional voice in
25 support of expansion was submitted by a SAC member

1 who was not in attendance during that meeting, the
2 May meeting, via e-mail after the conclusion of the
3 meeting. Based on population density and need, a
4 fourth program should be located outside of
5 southeast Michigan, ideally serving the growing
6 populations of west and/or northern Michigan.

7 SAC members in favor of expansion to four
8 adult programs cited the burden of chronic liver
9 disease in the state, the growing population in
10 west and northern Michigan, and the significant
11 patient burdens faced by patients who live a
12 distance from a transplant center that are not
13 fully addressed by the current or -- or future
14 outreach clinics. Several members emphasized the
15 proximity to a transplant center has particular
16 benefit and access to candidates of lower
17 socioeconomic status who may not have the resources
18 to travel to distant centers. Supporters of
19 expansion to four adult programs did not believe
20 adding a fourth program would significantly dilute
21 either transplant volume or quality at the three
22 current centers.

23 SAC members who exposed ex- -- sorry --
24 who opposed expansion to four adult programs cited
25 the relatively uniform rate of transplants per

1 liver-related deaths across the state planning
2 zones regardless of proximity to one of the three
3 current transplant centers. They -- they also
4 voiced the belief that the outreach clinics
5 currently provided by the three programs appear to
6 meet the liver transplant needs of the state.
7 Concerns were specifically raised about the
8 potential to dilute volume at the current liver
9 transplant centers, which could result in a
10 decrease of quality of care for recipients of that
11 program. In addition, SAC members cited the
12 challenges of recruiting transplant hepatologists
13 and surgeons to a new program and concerns were
14 also expressed that adding a fourth program could
15 increase competition for donor organs, thus raising
16 the median MELD score those patients need to reach
17 to achieve such -- to receive transplantation.

18 All of the SAC members voiced concerned
19 that we did not comprehensively consider costs in
20 answering this charge. We did not have publicly
21 available data to understand cost of care and the
22 timeline prevented acquiring institutional level
23 data on transplant associated costs. Concerns were
24 expressed by SAC members about institutional costs
25 of starting a new transplant program typically

1 requires the institution to absorb the cost of
2 initial transplants, 10 typically to meet CMS
3 conditions of participation. Investment in
4 personnel is substantial to be -- begin a new
5 program; and, depending on the hospital, physical
6 plant and capital resources may be required to
7 support for transplantation. In addition, some SAC
8 members voiced that payer groups could see
9 increased charges in the form of increase of cost
10 of care at a new program relative to established
11 programs.

12 In addition, SAC members also have
13 acknowledged that the medical and nonmedical cost
14 faced by patients who do not have access to
15 transplant is substantial. Patients with
16 compensated services are admitted frequently and
17 can be complex and their care needs often
18 overwhelming the resources available at
19 nontransplant hospitals. Even in patients who can
20 gain access to transplant at distant centers
21 consume significant personal resources in terms of
22 travel, lodging, time off work, and associated
23 caregiver burdens. These costs are hard to
24 quantify, but SAC members universally agree they
25 are substantial.

1 I will now move on to charge two, which
2 is a little simpler. Charge two is to review the
3 provisions for operating a transplant service under
4 joint sharing arrangement in section 3(4), and
5 recommend updates to outdated provisions as well as
6 annual volume requirements.

7 The SAC reviewed the current language in
8 section three and discussed the need to optimize
9 language to preserve liver transplant access for
10 children in Michigan. So, again, as a reminder,
11 this specifically refers to a pediatric program
12 that's operating a partnership with an adult
13 program.

14 The SAC agreed on the following
15 recommendations to the current standards: Licensed
16 sites participating in a joint sharing arrangement
17 should be located within five miles of each other.
18 This provides specificity to prior language
19 requiring licensed sites to be, quote unquote,
20 "geographically close enough" to facilitate
21 cost-effective sharing of resources and staff.
22 Removing -- we've also recommended remove the
23 requirement that two licensed sites participating
24 in a joint sharing agreement must apply jointly
25 under the same OPTN certification. Removing this

1 requirement aligns this section of the standard
2 with current OPTN policy. And in terms of
3 clarifying volume requirements, participating in
4 joint sharing agreements, a minimum of 12
5 transplants performed in the second 12 months of
6 operation following the date on which the first
7 plant -- transplant was performed. For the
8 purposes of calculating these 12 transplants, we
9 recommended that adult and pediatric transplant
10 volumes should be combined, and each of the adult
11 and pediatric programs should perform at least one
12 transplant annually. And currently the -- the
13 joint sharing arrangements in the state would all
14 meet that standard.

15 Charge three. Consider any technical
16 changes from the Department to the review standards
17 of the public health code.

18 So we held a supplementary meeting on May
19 29th to review the consensus summary that I just
20 gave to you and suggested edits to the Certificate
21 of Need standards for Heart, Liver and Lung
22 Transplantation. That discussion focused really
23 entirely on the proposed edits to 2, 3, and 5(1)
24 specific to the charges we were given. The SAC
25 proposed edits to those sections that were -- to

1 those sections were supported as Tiffani previously
2 summarized by seven to five majority vote and are
3 marked in the standards draft that you're going to
4 get.

5 However, SAC members expressed
6 significant concerns about some of the remaining
7 content of the standards that appear outdated or
8 inaccurate. We did not have time to thoroughly
9 consider appropriate edits to the standards given
10 the time allowed, but I will summarize some of our
11 concerns.

12 A point system to decide between program
13 applications if more than one program applies to be
14 a fourth program does eliminate some important
15 nuance in the decision to approve one location
16 versus the other in the comparative review process.
17 But as it may be the only means of providing
18 objective metrics, the elements being scored need
19 to be meaningful in a justified comparison. The
20 current point system, as noted in section seven,
21 provides outdated or are irrelevant criteria that
22 have not been reviewed in many years. For example,
23 the SAC already proposed restrictions on the
24 planning areas eligible for a fourth liver
25 transplant program. So awarding points based on

1 the HO -- HSA location seems irrelevant. Removing
2 this from the point system leave only points
3 awarded on indigent on -- and medical and surgical
4 volume, which is definitely important, but should
5 probably not be the only elements in a points
6 rating system. The eligible death standards that
7 is included in the standard language has been
8 challenged in recent years, both as a metric to
9 measure hospital and OPO performance, so it may not
10 be the best element to include in a scoring system.
11 An alternative proposal may be to include a
12 statement that any hospital awarded a Heart, Liver
13 and Lung program must have an organ donation and
14 issuance program in good standing with the local
15 OPO as is required of all hospitals. The
16 requirement that a hospital for a Heart, Liver and
17 Lung program should have a record offering, quote,
18 "pre- and post-transplant care," end quote, is
19 poorly defined and would be hard to measure. It
20 also may be unnecessary. In the case of a liver
21 program application, this standard would already
22 have been met by having another transplant program,
23 i.e., kidney, which is required by the standards.

24 The language contained in section eight,
25 which is called project delivery requirements, was

1 not reviewed in the SAC discussion, but reviewing
2 the language by the chair and the vice chair after
3 the meeting with the state staff revealed concerns
4 about accuracy. It mentions that a program should
5 meet CMS conditions of participation in an OPTN
6 program requirements, but then as additional
7 details that are either redundant to the CMS and
8 OPTN requirements, or perhaps unnecessary for a
9 liver transplant program. Examples include certain
10 education and research components that are
11 mentioned and not well defined and, again,
12 mentioning compliance with the Uniform Anatomical
13 Gift Act, which as I mentioned above, has some
14 shortcomings in terms of the measurement. The data
15 submission requirement that is also mentioned in
16 that section seems redundant to the robust data
17 reporting requirement of all transplant programs to
18 the OPTN, probably reflecting when those standards
19 are written.

20 So in summary, as it relates to the
21 language in the standards, the SAC members
22 expressed concern that the comparator review
23 standards needs to be comprehensively reconsidered.
24 The importance of these standards and the scrutiny
25 required deserves attention by a group of experts

1 dedicated to that task as it was beyond the
2 realistic scope of the SAC in the time allotted.
3 The SAC members supported the proposal that the CON
4 Commission consider a formal process to revise
5 section seven and eight of the standards, including
6 appointing a separate SAC committee, if necessary.
7 That concludes my remarks.

8 MR. FALAHEE: So is anybody that just
9 listened to even part of that understands this was
10 a very complicated set of issues, and that's -- I
11 knew that going in and that's why I was very
12 thankful to Dr. Sonnenday and Dr. Bedi agreed to
13 chair and co-chair. So, again, thank you very
14 much. I will throw it out for questions from the
15 Commission first. I know we have public comments
16 because I saw the blue cards going back and forth.
17 I've got a couple of questions for Dr. Sonnenday.
18 But other commissioners first?

19 MS. GRANT: I -- I have a list of
20 questions. Can you share what the OPTN policy is
21 for the travel burden for Heart and Lung? What is
22 that standard? Because I keep hearing "travel
23 burden," but I'm not understanding how this
24 compares to other. Is it that different?

25 DR. CHRISTOPHER SONNENDAY: Yeah, it's

1 not defined in -- in OPTN standards. So -- and
2 probably intentionally to some degree, right,
3 because the OPTN policy does not dictate where
4 people go to get their transplant. In fact, there
5 are people that choose to seek care outside of
6 their state or even current policy allows patients
7 to be considered at multiple transplant centers.
8 So there's not language in OPTN policy that
9 restricts, you know, where people are cared for.
10 And, you know, there -- there is literature about
11 the effect of travel distance from transplant
12 centers, and actually a little bit is -- of it is
13 conflicting, you know. But as a general theme,
14 distance from transplant center does appear to
15 dictate access to care.

16 MS. GUIDO-ALLEN: Did you have any more?

17 MS. GRANT: I do, but I'm going to go
18 back to my notes.

19 MS. GUIDO-ALLEN: Commissioner
20 Guido-Allen. I have a quick question. In regards
21 to the burden of liver disease in Michigan, it's
22 been steadily increasing. Is -- is there a
23 breakout of how many of the chronic liver disease
24 deaths were actually eligible for transplant?

25 DR. CHRISTOPHER SONNENDAY: Yeah.

1 MS. GUIDO-ALLEN: Or is it just the
2 bucket?

3 DR. CHRISTOPHER SONNENDAY: It's a great
4 question. It's not well defined. I mean, one
5 struggle nationally in terms of understanding the
6 burden of chronic liver disease is it's not as well
7 recorded in detail as, say, for example, end stage
8 renal disease because of the dialysis care and CMS
9 requirements. You know, I think we have some
10 reasonable data about etiology of liver disease,
11 but that doesn't dictate eligibility for
12 transplant. There's also, of course, you know,
13 information about age and other factors that affect
14 transplantation. But as some of my colleagues here
15 in the audience who do liver transplantation now,
16 that's a moving target, too, so --

17 MS. GUIDO-ALLEN: Thank you.

18 MR. VELEZ: Commissioner Velez here. Do
19 we have a data as far as how many residents from
20 West Michigan travel to southeast Michigan or other
21 state to -- to have a liver transplant annually?
22 And secondly, are there any data supporting that
23 the existing programs can adequately meet the need?

24 DR. CHRISTOPHER SONNENDAY: Good
25 questions. So there are data about where people

1 get transplanted. It's actually in the public
2 record. It was presented by one of the subgroups.
3 It varies by year, but there's, you know, 10 to 20
4 patients a year at least that leave the state for
5 liver transplantation care. If you look at the
6 West Michigan patient population specifically, they
7 travel to all three of the transplant centers. You
8 know, like the -- if you give each center a
9 different color dot, the -- it looks like a mosaic
10 on that side of the state. So it is -- it is, you
11 know, something that all three of the current
12 centers serve.

13 I think the date -- your question on
14 whether the current programs meet that need is a
15 good question. And there was data presented to the
16 SAC and discussed at length about the fact that the
17 transplant rate, the listing rate or the transplant
18 rate relative to liver disease death rate wasn't
19 perfectly correlated with distance from centers.
20 Zone four, for example, which is a huge growing
21 population center, actually, it has reasonable
22 access to transplant if you look at that specific
23 metric. What's tricky and I think what we
24 struggled with is, you know, those capture people
25 if they're -- if the denominator is accurate.

1 Right? So because of the -- some of the reasons we
2 were just discussing, liver disease is not well
3 captured. We don't know patients -- we don't know
4 much about patients that don't make it to
5 transplant centers. We know a lot about patients
6 that make it to transplant centers because they
7 have publicly reported data. But our concern about
8 patients that don't, particularly those of lower
9 socioeconomic status, was trouble.

10 DR. MILEWSKI: Hi. Great report. Thank
11 you so much for being here today and leading the
12 SAC. Commissioner Milewski. I have two questions.
13 Can a patient be waitlisted in more than one
14 location at different transplant centers is my
15 first question.

16 DR. CHRISTOPHER SONNENDAY: Yes.

17 DR. MILEWSKI: Okay. And then on the
18 analysis that you had of the 150 mile versus 250
19 mile and access to organs, with the further
20 distance, 250 miles, is there more technology
21 that's needed, you know, perfusion to keep those
22 organs as they're being transplanted as you look at
23 the further distance of that concentric circle?

24 DR. CHRISTOPHER SONNENDAY: Yeah, it's a
25 good question. The -- so as I said to your first

1 question, yes, you can be listed at multiple
2 programs. You know, it's interesting. It used to
3 be -- before the concentric circle allocation
4 system where -- where organs were allocated kind of
5 locally first, locally meaning kind of the OPO
6 region and the region, et cetera, there actually
7 wasn't much of an advantage to be listed -- listed,
8 say, at the Michigan programs because you were on
9 the same list. But now that the -- the distance
10 from the donor hospital dictates the order of
11 priority, it -- it can vary and patients do get
12 listed in multiple programs and I actually
13 encourage people to consider that.

14 As far as your question about kind of the
15 impact of distance on donor supply? You know,
16 historically, that has been a huge factor. And,
17 you know, as recently as, you know, seven or eight
18 years ago, about 65 percent of the liver
19 transplants performed in Michigan came from
20 Michigan donors. Now it's about 15 percent. And
21 the reason for that is partially the allocation
22 system, so we can go out to wherever we need to go
23 to get organs for the neediest patients. And part
24 of it is technology. So all of the Michigan
25 programs now use perfusion devices or -- or preser-

1 -- procurement techniques of various types that
2 allow us to mitigate some of the ischemic time
3 injury. We're routinely -- I know Henry Ford is,
4 too -- putting in livers from, you know, states
5 away after 12 to 18 hours on a perfusion device,
6 something we never would have considered before.
7 So and that's part of the reason why our ability to
8 predict how much kind of a new program that has
9 different distance parameters would affect access
10 is tricky for two reasons. One is that, so organs
11 are traveling further, dis- -- the impact of
12 distance is getting wanted by the preservation.
13 The second thing -- and this is a little bit of an
14 unknown, too, given the current state of OPTN and
15 other factors. But, you know, liver allocation
16 will eventually be moving to what is known as a
17 continuous distribution allocation model. So
18 instead of kind of categories of distance that
19 dictate or it'll be part of a composite score that
20 dictates where organs go. And that may blunt a
21 little bit also to the -- the exact impact of
22 distance. And -- and lastly and most importantly,
23 the thing that is most predictive of how quickly
24 someone gets transplanted off the waiting list is,
25 number one, their position on the list, so their

1 MELD score. But number two and maybe equally as
2 important as that is the behavior of their center.
3 Centers that have -- are aggressive and pursuing
4 donors have a high organ offer acceptance rate and
5 transplant rate, which actually fortunately all
6 three of the current liver transplant programs in
7 the state do, do more transplants and get people
8 off to those faster.

9 MR. FALAHEE: I'm going to call an
10 audible here for a second. Beth has asked that we
11 pause for a moment. So, Dr. Sonnenday, with --
12 with your permission --

13 DR. CHRISTOPHER SONNENDAY: Of course.

14 MR. FALAHEE: -- we'll do that for
15 something. Who knows what? When Beth says do
16 something, I'm going to follow that advice.

17 MS. NAGEL: I appreciate that. Yeah, so
18 I -- I hope you don't mind. Pardon the
19 interruption. As Chip mentioned, this is his last
20 meeting, and this is also a hefty agenda so I did
21 promise a few interruptions. So if you'll bear
22 with us. The first is from Director Hertel from
23 the Department of Health and Human Services.

24 DIRECTOR ELIZABETH HERTEL: Hello, Mr.
25 Chair.

1 MR. FALAHEE: Hello, Madam Director.

2 DIRECTOR ELIZABETH HERTEL: I have to
3 interrupt. I have to leave quickly because I have
4 to go pick up actually one of Chip's biggest fans,
5 my kid, who is starting marching band and wanted
6 you to know he's playing the sousaphone now, so --

7 MR. FALAHEE: All right. We had dinner
8 last year.

9 DIRECTOR ELIZABETH HERTEL: We had dinner
10 last year.

11 MR. FALAHEE: And great, great kid.

12 DIRECTOR ELIZABETH HERTEL: And just
13 talked Chip's ear -- ear off. He was really great.
14 So I'm here today, obviously, because I want to
15 make sure that we take a moment to honor Chip
16 Falahee as his term on the Certificate of Need
17 Commission is coming to a close. I don't know if
18 you've mentioned this today, but I want to
19 acknowledge that he has done this for 16 years,
20 which is fantastic, and we are, at the Department,
21 so grateful for your continued participation and
22 willingness to be part of this Commission. You
23 spent two years as vice chair and then nine years
24 as chair, because I don't know why, but thanks. We
25 are so fortunate, all of us, including myself and

1 Beth, and I know the staff here, benefitting from
2 your leadership and the experience that you have in
3 healthcare policy and law. We know that the
4 colleagues on the council have said that we really
5 appreciate working with you. You really are able
6 to bring some levity and humor to subjects that are
7 a little dry sometimes and can be rather
8 controversial at times. And we're really
9 appreciative that you're able to manage that so
10 well and make sure that people are always looking
11 at the things that we're doing for the best
12 interests of the patient. Also importantly, as
13 hopefully you experience today, he knows how to
14 keep a meeting moving. So I -- I saw your agenda,
15 and I know that'll be apprec- -- appreciated. And
16 that leadership has definitely made it possible for
17 this Commission to take on some pretty significant
18 and complex topics, which include allowing Cardiac
19 Catheterization procedures in outpatient --
20 outpatient surgical centers so that they're able to
21 offer more options; adding specialized newborn
22 nurseries for CON regulation, which provide
23 consistent care statewide for families with
24 newborns that need a little bit of extra care
25 before they go home; and addressing a crucial need

1 for behavioral healthcare services, which has been
2 especially proven in the inpatient bed for
3 specialized psychiatric care. We also are grateful
4 for your facilitation of a nearly ten-year process
5 -- now that this is done you can leave -- of
6 transferring the oversight of the air ambulance
7 providers from the Commission to EMS licensing.

8 Chip, so grateful for your diplomacy,
9 your kindness, your tireless efforts to have
10 improved healthcare quality and access for everyone
11 in the state of Michigan, and incredibly grateful
12 for your continued service on the CON Commission
13 and making a lasting difference for so many people
14 in Michigan to be able to receive high quality care
15 close at home.

16 On behalf of the Department and the
17 people of the state of Michigan, I want to thank
18 you. We wish you the best, and I want to present
19 to you a small token of our appreciation, a tribute
20 from the Governor and the Lieutenant Governor. So
21 if you could come up?

22 (Applause.)

23 MR. FALAHEE: Thank you.

24 DIRECTOR ELIZABETH HERTEL: Again,
25 apologize for the interruption, but I appreciate

1 the opportunity to acknowledge Chip. He's taught
2 me a lot personally and been a great mentor in my
3 career and really thank you.

4 MR. FALAHEE: And Beth used to sit at
5 this table and provide us with advice. So we
6 learned from her as well. Thank you so much for
7 being here. Thank you for your kind words. Say hi
8 to Jack.

9 DIRECTOR ELIZABETH HERTEL: I will.

10 MR. FALAHEE: At band camp, sorry.

11 DIRECTOR ELIZABETH HERTEL: I will.

12 Thank you, everybody. Have a great day.

13 MR. FALAHEE: Thank you so much.

14 (Applause.)

15 MR. FALAHEE: Back to reality.

16 DR. CHRISTOPHER SONNENDAY: I appreciated
17 the break.

18 MR. FALAHEE: Are there other questions
19 from the commissioners? I have a couple, but --
20 Commissioner Grant?

21 MS. GRANT: I do. And thank you for
22 reminding me, you said at the beginning --
23 Commissioner Grant. I heard you say a few times
24 that there were some items that either were lacking
25 institutional data or there was not expertise or

1 time, but there were concerns from the committee.
2 And this is out of ignorance. Is there a way to
3 move forward and improve the language and the
4 changes that didn't have the concerns and request
5 additional time for these items where there wasn't
6 the data, there wasn't expertise, or there wasn't
7 the time to address?

8 DR. CHRISTOPHER SONNENDAY: Yeah, that's
9 -- that's more or less what we did. The motion we
10 voted on that Tiffani summarized at the beginning
11 was to -- we voted to approve the -- the edited
12 language in the standards that addressed our
13 specific charges. And then there was concern and
14 -- and that was part of the motion, but the
15 language, particularly additional language in -- in
16 sections five and seven -- and I will say myself,
17 this is my own addition to section eight, which I
18 mentioned at the end of my report, should probably
19 also be considered. They're just updated. They
20 were written at a time when there were different
21 standards in the field and different regulations.

22 MS. GRANT: Okay. Thank you.

23 MR. FALAHEE: Other commissioner
24 questions? I've got 28 questions.

25 DR. CHRISTOPHER SONNENDAY: Okay. I'm

1 ready.

2 MR. FALAHEE: Just -- just a comment to
3 Commissioner Grant's question. I know that there
4 were things that the SAC would have loved to have
5 gotten to, but by law they're -- you're limited to
6 six months. And I -- it's a great summative
7 report. And I understand there's concerns or
8 questions about antiquated wording, wording that
9 needs to be looked at. And to your question, Dr.
10 Grant, there -- there are multiple ways to address
11 that. There's a recommendation here from the SAC
12 to do another SAC. I think there's other -- I
13 respect that completely. I think there's other
14 ways to do that as well. For example, sometimes we
15 will charge the Department with come up with the
16 technical edits that are needed, and if in
17 developing those technical edits you need to seek
18 advice from others, do that and then submit that to
19 public comment as well. So we -- we worked through
20 a process to get the best wording possible, and
21 that's how we've done that in the past, and I think
22 that's a potential here as well. So that -- I
23 really didn't have any questions about the SAC
24 itself, having been involved in SACs. They're very
25 detailed. This one was especially detailed. I

1 thank you for everything you've done. If you can
2 stick around?

3 DR. CHRISTOPHER SONNENDAY: Yep.

4 MR. FALAHEE: Because I know we got
5 comment cards. I may turn to you and say, Dr.
6 Sonnenday, what do you have to say about that?

7 DR. CHRISTOPHER SONNENDAY: Yeah. Happy
8 to.

9 MR. FALAHEE: If you don't mind?

10 DR. CHRISTOPHER SONNENDAY: No, of
11 course.

12 MR. FALAHEE: Thank you very, very much.
13 I appreciate it.

14 DR. CHRISTOPHER SONNENDAY: No problem.

15 MR. FALAHEE: So let's start with -- any
16 other commissioner questions? Okay. Let's open it
17 up to public comment in no order of priority or
18 alphabetical order even.

19 MR. EASTER: It's how it was submitted.

20 MS. STANTON: Yes.

21 MR. EASTER: You want to --

22 MS. STANTON: It doesn't matter.

23 MR. EASTER: Oh. All right. Jesse
24 Syring from Corewell Health.

25 MR. FALAHEE: And for those that are new

1 to the CON process, if your cohorts haven't told
2 you, it's a three-minute time limit. Justin will
3 hold cards up in front of your face to remind you
4 where we're at. So thank you very much.

5 JESSE SYRING

6 MR. JESSE SYRING: Good morning. My name
7 is Jesse Syring. I'm the director of transplant
8 programs at Corewell Health William Beaumont
9 University Hospital transplant center, and I have
10 the pleasure of working very closely with Dr.
11 Damanpreet Bedi, the vice chair of this Heart,
12 Lung, Liver Transplantation SAC that we've been
13 discussing this morning. Unfortunately, he could
14 not be here today due to an important surgical
15 commitment.

16 I would say as the director of the
17 transplant program, I'm responsible for ensuring
18 that our programs uphold the highest standards of
19 quality and patient care while maintaining fiscal
20 accountability. My role is to ensure our programs
21 maintain quality outcomes, and ensure the financial
22 sustainability of our operations.

23 So as commissioners review the SAC's
24 recommendations, I encourage you to take into
25 account a few key considerations. First, while the

1 SAC was instructed to evaluate the quality
2 implications of adding a fourth liver transplant
3 program, this aspect -- excuse me -- this aspect
4 was overlooked. Studies consistently show that
5 higher volume transplant centers yield better
6 outcomes, including lower mortality rates and
7 shorter hospital stays. Introducing a new lower
8 volume program could present challenges not only
9 for the new facility, but also for the existing
10 transplant centers, potentially fragmenting patient
11 caseloads and affecting overall care quality.

12 Second, the financial impact of
13 establishing the fourth program was not addressed.
14 This wasn't due to a lack of available data, but
15 rather the SAC's initial focus on geographic
16 access, which took up much of the allotted time,
17 leaving limited opportunity for broader discussions
18 on cost implications.

19 Thirdly, even if there are access
20 concerns, the assumption that a new program is the
21 best solution may be premature. More cost
22 effective alternatives, such as expanding satellite
23 clinics, could be a more practical approach to
24 improving access. A fourth program would benefit
25 only a small subset of Michiganders, leaving

1 broader issues related to ongoing liver care and
2 chronic disease management unresolved.
3 Additionally, the proposed language itself presents
4 some challenges. In its final meeting the SAC
5 acknowledged that certain sections such as
6 additional requirements for liver transplantation
7 services, section five, and a comparative review
8 standards, section seven, are outdated and need
9 revision. Despite this, the current proposal moves
10 forward -- forward with changes to planning areas
11 and addition of a fourth program without updating
12 the criteria for applications. Moving ahead with
13 outdated standards raises concerns about fairness
14 and equity in decision making.

15 Given these factors, Corewell Health
16 respectively urges the Commission to pause
17 consideration of the recommendation for a fourth
18 transplant program and the incomplete draft
19 language. Instead, we advocate for forming a new
20 SAC to complete the necessary work ensuring cost,
21 quality and alternative solutions are thoroughly
22 explored and that application review standards are
23 modernized.

24 MR. FALAHEE: Thank you very much. Any
25 questions from the commissioners? So I've got a

1 few. You said the quality issue was overlooked. I
2 would respectfully disagree based on what I heard
3 from Dr. Sonnenday and what's in the report. It's
4 often difficult and we've heard arguments before.
5 One of the benefits of sitting here for 16 years is
6 we've heard the arguments of higher volume equals
7 higher quality. I've heard that for several
8 different types of surgeon -- services. There's
9 also the fact that we have, as the SAC found issues
10 of, care in West Michigan and the growing
11 population in West Michigan; and I think those have
12 to be balanced against each other. Yes, I
13 understand the quality reports. I've read the
14 quality reports, Cardiac quality, open heart. I
15 get it. But I think we have to do a careful
16 balancing of quality, access and cost and not any
17 one is -- is more important than the other. But to
18 say it's overlooked, I -- I would just respectfully
19 disagree with that.

20 On the cost issue, quote, "not being
21 addressed," I think it was addressed because it's
22 addressed as well as it can be. Yes, there are
23 costs to start up any new program, whether it's
24 open heart surgery, outpatient care center, liver
25 transplant program, those costs are really a

1 function of that entity deciding to take on those
2 costs in the best interest of patient care. And,
3 again, so I think we have a balancing act there.

4 And I understand -- correct me if I'm
5 wrong -- that the recommendation or your suggestion
6 is that we pause and appoint a new SAC to look at
7 the other issues you identified. Some of those
8 issues I think we could, if -- if the Commission
9 agreed, go with a technical edit change and submit
10 that to public comment to make sure that's concise
11 and accurate as well. So those -- those are my
12 comments. Thank you very much. Other questions or
13 comments from the commissioner?

14 DR. ENGELHARDT-KALBFLEISCH: I have a
15 question. Commissioner Engelhardt-Kalbfleisch. So
16 obviously Corewell is an existing transplant center
17 in southeastern Michigan, but also has a site in
18 Grand Rapids. Are there reasons you wouldn't want
19 to do a second transplant center in Grand Rapids?

20 MR. JESSE SYRING: I think that's
21 actually a great question. I think the short
22 answer is we don't believe that a fourth transplant
23 center is necessary. That's the short answer. You
24 know, investment and expansion in satellite centers
25 by the three current transplant centers we think

1 will allow greater access for patients across all
2 of Michigan, including a, you know, improvement on
3 the ability to treat higher acuity care for both
4 the pre- and the post-transplant patients before
5 their transplantation, and then obviously after,
6 better serves the population of Michiganders. I
7 can speak from Corewell Health's perspective that
8 we have a very robust process for pre- and
9 post-transplant care with the referral process from
10 Corewell Health West to Corewell Health East. And
11 the collaboration that we see between the providers
12 on the east side and the west side, they attend our
13 selection committee meeting for patients that are,
14 you know, a west side resident that are being
15 referred to us. We have regular collaboration
16 meetings on process. They do virtual consults. So
17 we think that that pipeline and that process, along
18 with expansion and investment in satellite clinics,
19 is the best way to serve those, the Michiganders.

20 DR. ENGELHARDT-KALBFLEISCH: Okay. Thank
21 you.

22 MR. JESSE SYRING: You're welcome.

23 MR. FALAHEE: Thank you very much.
24 Appreciate it.

25 MR. JESSE SYRING: You're welcome. Thank

1 you.

2 MR. FALAHEE: Dr. Sonnenday, I'm not
3 asking you to come up now, but maybe once all the
4 witnesses are -- I say "witness." I shouldn't --
5 this is cross-examination. Once we've heard all
6 the testimony, I may ask Dr. Sonnenday to make some
7 comments. Next?

8 MR. EASTER: Dr. Yoshida from Henry Ford
9 Health.

10 MR. FALAHEE: All right. Thank you.

11 ATSUSHI YOSHIDA, M.D.

12 DR. ATSUSHI YOSHIDA: Mr. Chairman and
13 other members of the Committee, I am Atsi Yoshida.
14 I am the chief of liver transplant and chief of
15 transplant surgery at Henry Ford Hospital. I've
16 been a transplant surgeon at Michigan for about 25
17 years, probably more than most people here. And I
18 have several strong points against development for
19 the program in Michigan.

20 A lot of the discussion, I was the -- the
21 lead of a subgroup two in the SAC committee, and I
22 wanted to kind of focus on a few things that were
23 kind of argued one way versus another way. I'm
24 going to probably present a different perspective
25 on that.

1 So I think, yes, everybody understands
2 there's a very large population in western Michigan
3 and they don't have a transplant center presently,
4 and that's one of the big pushes for that. But my
5 biggest concern and why I would not want to have
6 one there and I would not want to be transplanted
7 on the west side Michigan is mostly due to organ
8 access. As Dr. Sonnenday mentioned, organ access
9 in West Michigan may include more patients because
10 it goes parts of Illinois and Wisconsin. But in
11 actuality, even though there's equal number of
12 patients, equal number of -- equal number of
13 donors, the actual number of patients on that list
14 in that 150 mile area is about 539, including
15 Illinois and Wisconsin, versus 365 metro Detroit
16 area. In addition to that, the number of programs
17 you compete against is seven in the present system
18 in Detroit versus 12 in Illinois and Wisconsin.
19 More importantly, Illinois and Wisconsin at all
20 other centers focused in Chicago and the metro
21 Milwaukee area. So basically the entire state of
22 Illinois and the entire state of Wisconsin is in
23 that circle that you're competing against in Grand
24 Rapids. As -- as a consequence, the MELD score in
25 that area is really high. It's as high as 31

1 versus 27 or 26 here, and ours is dropping pretty
2 dramatically in our side of the state. And I think
3 that big jump of four points, even though I said
4 one to four, it all depends how you look at it,
5 four points are a lot. It can vary the death rate
6 while on the waitlist pretty dramatically up to 20
7 percent to 40 percent, depending how you look at
8 it. And I think that's a big issue that we have
9 there in that perspective.

10 The second major point I want to make
11 sure that we talk about today is when group one
12 developed their information regarding socioeconomic
13 status in res- -- parts of Michigan, they looked at
14 -- they didn't look at -- they looked at ADI index
15 as a certain perspective, but I want you to take a
16 look at it from a different point of view. The ADI
17 index is probably the lowest in region four of all
18 the areas. Four is the lowest. One is low --
19 lowest, too, but the majority of it is from
20 northwest Detroit. Detroit area itself, the Wayne
21 County, has 1.77 million people and has the lowest
22 ADI index, and that's the same size as region four
23 in Western Michigan. So I want to make sure that
24 you kind of know that, that they have the lowest
25 liver-related death ratings in four, and also

1 lowest rate of -- lowest index of ADI index, as
2 well as the Medicare -- Medicare population base is
3 also the lowest in that area as well, too. So I'm
4 not sure we're really helping people in region four
5 as much as we're trying to help people in five, six
6 and seven.

7 MR. FALAHEE: Thank you very much. Any
8 questions from the commissioners?

9 MS. GUIDO-ALLEN: Commissioner
10 Guido-Allen. Thank you, Dr. Yoshida. Can you just
11 clarify for us if indeed a fourth liver transplant
12 program opened on the west side of the state, would
13 that not increase the -- the number of transplants
14 that happened in the state of Michigan for our --
15 our communities, and wouldn't the waitlist then be
16 shorter?

17 DR. ATSUSHI YOSHIDA: The waitlist is
18 relatively short already in the -- in the southeast
19 area. Their -- their biggest issue of West
20 Michigan is that if you have someone on the list,
21 the first teams you're competing against are within
22 Chicago and Wisconsin, not with Detroit in general.
23 And as a consequence, all those organ donors you
24 think you might get in Illinois are competing
25 against that versus if you're in southeast Detroit,

1 for the most part, you're only competing against
2 parts of small portions of Ohio and Indiana and the
3 Michigan area. So you actually have a huge benefit
4 of going to southeast Michigan from a point of view
5 of transplant earlier, which is death; right? So
6 death is related with MELD score.

7 MS. GUIDO-ALLEN: Thank you.

8 MR. FALAHEE: Other questions? Okay.
9 Doctor, thank you very much for being here.

10 DR. ATSUSHI YOSHIDA: Thank you.

11 MR. EASTER: Liz Reed, Henry Ford Health.

12 LIZ REED

13 MS. LIZ REED: Thank you. Good morning.
14 My name is Liz Reed. I'm the vice president of --
15 of the Henry Ford Transplant Institute. You can
16 tell from the accent I'm not from Michigan. I've
17 been here about four years. Prior to that I ran
18 transplant programs in Texas and Kentucky.

19 The point I'd like to talk today about is
20 cost. But when we look at the three things that
21 drive healthcare -- access, quality and cost --
22 access, are Michiganders disadvantaged on not
23 having access to liver transplant? No. We have
24 very -- we have three very valuable transplant
25 program that have capacity. Quality, all three of

1 our liver transplant program, adult liver
2 transplant program, have stellar outcomes that
3 exceeds the national average.

4 But cost is another issue. I think all
5 us who are doing liver transplant has seen our
6 costs of liver transplant increase threefold over
7 the past two to three years. Why is that? We see
8 a steady increase in cost for the standard
9 acquisition charge of OPOs, but the other is the
10 need for technology. About 40 percent of all organ
11 donors that are coming from marginal brain death
12 cases are DCD cases as Dr. Sonnenday mentioned.
13 That's about 40 percent -- 46 percent of the
14 organs. And what do you need to do? You have to
15 have technology to assess and optimize the function
16 of these organs to ensure that you can have a
17 successful transplant. But I think what we have to
18 always remember, transplantation -- liver
19 transplantation is part of the continuum of chronic
20 liver disease. With chronic liver disease, that's
21 why we have been very successful at Henry Ford,
22 University of Michigan and Corewell in putting
23 specialty clinics within our cities and areas
24 around the state of Michigan. Not only are they
25 dealing with pre- and post-transplant care, they're

1 also dealing with disease management. Liver
2 disease is on the rise. Forty-six percent of
3 Americans, including Michiganders, have fatty liver
4 disease. A lot of those will go on and develop --
5 and develop more chronic liver disease that will
6 require transplantation. And that's not even
7 mention alcohol-related liver disease. Both of
8 those are the two drivers for transplant. But with
9 effective management, we even -- if we look at our
10 current stats, only 30 percent of those will go
11 into transplant. You know, we can effectively
12 manage those disease process. It's more cost
13 effective and -- and I think as we look at having a
14 fourth liver transplant program, is that needed? I
15 think what we need to do is to make sure that we
16 get these specialty cares in the areas of Michigan
17 that -- that do not have access. I think -- I
18 think Henry Ford has done that well. I think
19 Michigan has done that well. And I think Corewell
20 -- if you look at the fact that Henry Ford has
21 eight liver plant sites around Michigan and
22 conducts 24 liver clinics a month.

23 So in closing, I think what we see is
24 that the -- it's not so much how close to how you
25 -- how close you live to a transplant center, but

1 how close you are to having access to specialty
2 care. And thank you for this opportunity.

3 MR. FALAHEE: Thank you. Let's see --
4 any questions from the commissioners?

5 MS. GUIDO-ALLEN: Yes. Guido-Allen.

6 MR. FALAHEE: Yes.

7 MS. GUIDO-ALLEN: Thank you, Liz. You
8 said that --

9 MS. LIZ REED: Oh, you want me -- sorry.

10 MS. GUIDO-ALLEN: -- you said that the
11 cost for liver transplant programs has gone -- gone
12 threefold?

13 MS. LIZ REED: Yes.

14 MS. GUIDO-ALLEN: So can you share with
15 us the reimbursement that you're receiving?

16 MS. LIZ REED: That's an excellent --

17 MS. GUIDO-ALLEN: Is that not threefold?

18 MS. LIZ REED: No, unfortunately not.
19 And you bring up a very valid point. In order to
20 have effective negotiation with the payers, you
21 have to have outcomes. And we've all struggled,
22 all three centers, with decreased margins for liver
23 transplantation. So, but because of our results,
24 we're in a better position to negotiate better
25 reimbursement. This will be a challenge for our

1 small center or our new center coming online.

2 MS. GUIDO-ALLEN: Thank you.

3 MS. LIZ REED: Thank you.

4 MR. FALAHEE: Thank you very much.

5 DR. ENGELHARDT-KALBFLEISCH: I have a
6 question.

7 MR. FALAHEE: Whoop.

8 DR. ENGELHARDT-KALBFLEISCH: One more
9 question.

10 MS. LIZ REED: Oh, I'm sorry.

11 MR. FALAHEE: You can't leave yet.

12 DR. ENGELHARDT-KALBFLEISCH: Sorry.

13 MS. LIZ REED: That's okay.

14 DR. ENGELHARDT-KALBFLEISCH: Not quite
15 done.

16 MS. LIZ REED: Am I anxious to leave?
17 No.

18 DR. ENGELHARDT-KALBFLEISCH: So
19 Commissioner Engelhardt-Kalbfleisch. How -- I know
20 you said you're from out of state.

21 MS. LIZ REED: Uh-huh.

22 DR. ENGELHARDT-KALBFLEISCH: And I heard
23 one and the other people that presented I think
24 gave comment, say at least in Illinois and
25 Wisconsin, those centers are clustered more in

1 metropolitan areas. How does that compare with the
2 rest of the country?

3 MS. LIZ REED: I take a look at the
4 Midwest. It's very common for the transplant
5 centers to be clustered in their major cities.
6 Look at Illinois. Where are their transplant
7 centers? Chicago. You only have -- you look at
8 Wisconsin, where are their transplant center? One
9 in Madison, one in Milwaukee. In Houston, I mean,
10 we -- all our trans- -- in Texas majority of the
11 transplant centers are either in Houston or in
12 Dallas. There's a smattering small ones, but the
13 major ones are concentrated in the large cities.
14 But of course outrea- -- or I should say satellite
15 efforts are -- it's almost a standard of care most
16 transplant centers utilize to reach the
17 communities.

18 DR. ENGELHARDT-KALBFLEISCH: Thank you.

19 MS. LIZ REED: Okay.

20 MR. EASTER: Marwan -- I'm going to
21 butcher the last name here. He knows. Henry Ford
22 Health.

23 MARWAN ABOULJOUD, M.D.

24 DR. MARWAN ABOULJOUD: Thank you. Yeah.
25 Thank you, Commissioners and staff for the

1 preliminary effort. The last name is Marwan
2 Abouljoud. It took me eight years to learn it
3 myself. So thank you for the time. I've been at
4 Henry Ford now for about 31 years. And I came in.
5 I was start to build a liver transplant program of
6 national caliber and with improved access and
7 improved outcomes and innovations. And
8 subsequently became president of the American
9 Society Of Transplant Surgeons and did work on
10 access and minorities, among other things.

11 One of the things that became obvious at
12 the time was Detroit was an understood area of
13 transplantation, and certainly across the state,
14 access to transplant was problematic. So we went
15 up and studied the mortality of patients with liver
16 disease among hospital discharges across the state
17 of Michigan, and to our surprise, the mortality
18 correlated with lack of access to a specialty
19 clinic near the neighborhoods, but not to the
20 proximity to a transplant hospital. And we
21 repeated the data and analyzed the data multiple
22 times, and it did not make sense. So after that,
23 we embarked on a project, which is first of its
24 kind across the United States, was to put satellite
25 clinics where we value our specialists, work with

1 local communities and collaborate through
2 transplant hubs with hospitals and practitioners
3 and it basically managed liver disease, especially
4 with the rising instance of liver disease, and try
5 to manage it upstream so it does not reach
6 transplantation needs. We also managed the most
7 pre-transplant and post-transplant patients. And
8 we geographically positioned those clinics to have
9 a minimized radius for the traveling patients so
10 that it's successful. So they spread out across
11 the state, eight clinics north, east, west and
12 central and southeast Michigan.

13 And fast forward, we went back and
14 studied the outcome of patients who are referred to
15 those clinics, so Henry Ford patients, for the past
16 18 years over those time periods. And this data
17 hopefully will be presented at the liver disease
18 meeting this fall. And our observation correlated
19 with the following. That if you are closer to a
20 satellite clinic, you're more likely to be
21 evaluated for transplant, you're more likely to be
22 listed, and more likely to be transplanted, and you
23 are less likely to die from liver disease. And the
24 interesting thing about the correlation with the
25 distance to the clinic, but not the distance to the

1 transplant hospital. And also over time, there was
2 a decrease in the distance felt by patients to
3 those clinics.

4 So our study is the first of its kind
5 ever to prove this kind of finding because the way
6 we strategized and positioned those clinics in
7 Michigan and it speaks again towards the investment
8 that we need to put in place. Investing in local
9 access to care, multispecialty clinics, working
10 with local communities and through innovations and
11 care delivery, but rather place -- then placing
12 transplant centers which sit at the end of the road
13 down the street with you all. And I think in the
14 context of the rising cost care like Liz Reed
15 mentioned, we all face the same challenges, and
16 this will be a cost effective way and fiduciary of
17 the gift, if you will, to divest the problem.
18 Thank you for your time.

19 MR. FALAHEE: Thank you very much.
20 Questions from the commissioners? Thank you very
21 much. Appreciate it.

22 MS. GUIDO-ALLEN: I have a quick
23 question.

24 MR. FALAHEE: Whoop. I'm sorry.

25 MS. GUIDO-ALLEN: We heard previous

1 testimony that shared that access to the clinics,
2 the satellite clinics, was limited and patients
3 with chronic liver disease were not able to access.
4 However, you're -- you're sharing that your
5 experience with the Henry Ford eight satellite
6 clinics has been accessible and with better
7 outcomes.

8 DR. MARWAN ABOULJOUD: Yes; yeah.
9 Outcomes --

10 MS. GUIDO-ALLEN: Can you help us
11 understand the --

12 DR. MARWAN ABOULJOUD: Of course; of
13 course, yes. Of course. Our clinics, the way they
14 are located and the number of these off clinics are
15 adapted to the need. So the Grand Rapids clinic,
16 for example, is five days a week. We -- whereas in
17 other clinics it's one day a week like at Grayling.
18 So they are all geographically very well situated
19 and positioned and work in collaboration with local
20 providers. The only gap we've had in the past few
21 years was a one-time episode with the Grand Rapids
22 clinic, which is our busiest clinic. It was built
23 in collaboration with Spectrum Health at the time,
24 and Ms. Tina Freese Decker and others, we worked
25 well together on that. But then when the merger

1 with Corewell happened, we were actually given a
2 two-week notice to evacuate the clinic. Dr.
3 Elmouchi was rather firm on this, and so I sat with
4 Tina and we negotiated an interval, but still was a
5 full week in basic departure from an established
6 clinic, finding another place for the clinic and
7 transitioning the care of those patients. That
8 created a raucous for us for about three, four
9 months after we settled in. That's the only gap in
10 the problems we have.

11 MS. GUIDO-ALLEN: Thank you.

12 DR. ENGELHARDT-KALBFLEISCH: I have a
13 question. Earlier we heard comments about the MELD
14 score and the mortality and about organ
15 availability and maybe only like a four-point
16 difference. Could you explain to us what, like, a
17 four points difference in a MELD score would kind
18 of equate to in terms of change in mortality risk?

19 DR. MARWAN ABOULJOUD: Sure; certainly.
20 The -- the -- the number MELD score multiple for
21 end stage liver disease basically looks at
22 mortality of patients in the three months interval
23 following that designation of that number. A four
24 point difference is likely to move for increased
25 mortality over 15 to 20 percent. So small numbers

1 make a big difference in predicted mortality. And
2 the beut (sic) of those clinics that we've had is,
3 is that we've shown there is a decreased MELD score
4 over time of the patients we've been evaluating and
5 transplanting which means, again, the same
6 principle with casting patients upstream. And the
7 beut of those clinics we're also putting in, like,
8 a walk health clinic, we're putting alcohol liver
9 disease clinics to preempt the epidemic of liver
10 disease and catch upstream and minimize the need
11 for liver transplant. So we're not focused on the
12 -- on transplant patients with our clinics, but
13 rather preventing them from going downstream to
14 needing a transplant.

15 DR. ENGELHARDT-KALBFLEISCH: Okay. Thank
16 you. You said 15 to 20 percent?

17 DR. MARWAN ABOULJOUD: Yes.

18 DR. ENGELHARDT-KALBFLEISCH: Okay.
19 Thanks.

20 DR. MARWAN ABOULJOUD: You -- you -- I
21 may have to correct myself on the exact numbers
22 here, but the number would --

23 DR. ENGELHARDT-KALBFLEISCH: Well, no, I
24 just -- an approximate.

25 DR. MARWAN ABOULJOUD: -- but it would be

1 significant.

2 DR. ENGELHARDT-KALBFLEISCH: Yeah.

3 DR. MARWAN ABOULJOUND: Be significant.

4 DR. ENGELHARDT-KALBFLEISCH: Okay. Thank
5 you.

6 MR. FALAHEE: Other commissioner
7 questions? Doctor, thank you very much.

8 DR. MARWAN ABOULJOUND: My pleasure.

9 MR. FALAHEE: I pity you working with Dr.
10 Elmouchi and trying to negotiate with him.

11 MR. EASTER: Makenzie Buchert, Children's
12 Hospital of Michigan.

13 MAKENZIE BUCHERT

14 MS. MAKENZIE BUCHERT: Good morning. My
15 name is Mackenzie Buchert, and I am the director of
16 transplant services at the Children's Hospital of
17 Michigan. I was a member of the Heart, Lung, Liver
18 SAC, and I want to express my gratitude to Dr.
19 Sonnenday, Dr. Bedi, and the Department, and all
20 of the other SAC members for their hard work.

21 I would also like to share my support for
22 the changes being recommended under charge two,
23 section 3(3) and 3(4) to update the provisions for
24 the joint sharing arrangements. However, I also am
25 here to express my concerns for the SAC

1 recommendations surrounding charge one. As was
2 identified in the report, the SAC simply ran out of
3 time to complete the work. No fault of the
4 committee, but rather a function of the time limits
5 set on the Certificate of Need statute and the
6 tremendous amount of work that was required to
7 fully explore these charges.

8 Energy was spent exploring the question
9 of whether an access problem exists. But the --
10 the time that the SAC was prepared to make the
11 decision on that question, little time was spent to
12 explore the cost and quality implications of adding
13 a fourth program to the state. In addition,
14 language to effectuate adding a fourth program was
15 rushed through review. The only provisions
16 addressed were the definition of the planning area
17 to create two planning areas in the state and the
18 language to add a fourth program to planning area
19 two.

20 The committee never looked at any other
21 requirements for initiating a fourth liver
22 transplant program, the project delivery
23 requirements for operating that program, or the
24 comparative review criteria for determining among
25 multiple applicants who will be granted the

1 Certificate of Need for the fourth program. These,
2 in my opinion, are not technical edits. These
3 would require experts in the field of
4 transportation to make these changes.

5 As you heard from Dr. Sonnenday at the
6 last meeting of the SAC, we agreed that the work
7 was not complete and that our recommendation should
8 include the need for another SAC to continue this
9 work, specifically looking at sections five and
10 seven for substantive cha- -- updates. And here to
11 strongly urge you to hold off on moving forward
12 with the prop- -- proposed language to public
13 hearing and instead form another SAC to continue
14 this work.

15 I'm no expert in the CON application
16 process, but it is my understanding that if the
17 language presented to you today becomes effective
18 as written, there is nothing to stop applicants
19 from applying for the fourth liver program, while
20 another SAC works to address the -- the initiation
21 and comparative review process. The Department
22 would be required to review those applications
23 under the outdated provisions. And by the time a
24 future SAC recommendation made it through the
25 process, the fourth program would have already been

1 granted to one of the applicants, and the changes
2 desired and how that program will be operated will
3 have missed the opportunity to apply.

4 As is noted in the staff report, the
5 comparative review criteria have not been reviewed
6 substantially in over 25 years. There are only
7 four criterion in total, and half of them would not
8 distinguish between applicants. I urge the
9 committee to take time to get this right. Thank
10 you.

11 MR. FALAHEE: Questions from the
12 commissioners?

13 MS. GRANT: I -- I do. I'm sorry.
14 Commissioner Grant. You said that you agreed with
15 what sections?

16 MS. MAKENZIE BUCHERT: There were two
17 charges, charge two, section 3(3) and 3(4) specific
18 to the joint sharing arrangements for pediatric
19 programs.

20 MS. GRANT: Okay. Thank you.

21 MR. FALAHEE: Thank you.

22 MS. MAKENZIE BUCHERT: Thank you.

23 MR. EASTER: Tom Stankewicz. Yep, that.
24 Michigan resident.

25 TOM STANKEWICZ

1 MR. TOM STANKEWICZ: Good af- -- or good
2 morning. My name is Tom Stankewicz and I'm a
3 resident of western Michigan for more than 30
4 years, and I thank the Commission and the
5 Department for allowing me to speak today.

6 I'm not here to provide you with
7 additional data regarding liver transplant, but
8 rather to share what we know about Michigan's
9 experience when Corewell West started its heart
10 transplant program in 2010. I know you hate last
11 minute handouts, but as the saying goes, a picture
12 is worth a 1,000 words.

13 In the first chart on the sheet, you will
14 see the number of heart transplants performed by
15 Michigan's three transplant centers for five years
16 before 2010 and for the years after 2010 when
17 Corewell West began providing services. In this
18 chart you can see the existing transplant facility
19 saw minimal impact, the University of Michigan
20 being a bit flat since 2010, and Henry Ford showing
21 growth. In the second chart, you can see that the
22 total number of heart transplants in Michigan has
23 grown, and in 2024, Michigan recorded the highest
24 number of heart transplants in the state history
25 thanks in part to Corewell's program in West

1 Michigan. On the second page you can see how
2 Michigan's growth and heart transplant compares to
3 national trend. Here you can see Michigan matches
4 exactly the growth seen nationally, 95 percent. Of
5 course, we don't know whether Michigan might have
6 achieved this heart transplant growth without
7 Corewell West, but given the success of the
8 Corewell's program, I am doubtful Michigan would
9 have kept up. On the chart on the bottom you can
10 see that during the same time period from 2010 to
11 '24, liver transplant growth in Michigan has lagged
12 behind the nation. Liver disease is growing and
13 liver transplant is growing. But in Michigan, we
14 have not been as successful in keeping up. I
15 believe this is partly due to the access barriers
16 the SAC identified.

17 Before we leave this page, I want you to
18 look closely at the liver transplant totals. Liver
19 transplants are two and a half times more common
20 than heart transplants, and yet all Michiganders
21 must go to southeast Michigan for liver transplant.
22 I bring these data to you -- I bring these data
23 before you because I am hopeful they will address
24 concerns regarding dilution of volumes at existing
25 facilities. Here's evidence to alleviate those

1 fears. But more importantly, I'm hopeful that
2 these data will help this Commission in its
3 discussion about cost to consider the very real but
4 invisible human cost of disease burden and death
5 when Michigan lags behind.

6 Liver transplant is a life saving
7 procedure, and Michigan is falling behind. I
8 challenge you to weigh the human cost of limiting
9 Michigan to three liver transplant programs. Thank
10 you.

11 MR. FALAHEE: Thank you. Any questions
12 from the commissioners? Thank you very much.
13 Thank you for being here. Thank you. Just one?
14 Sorry.

15 MS. GRANT: Yeah. And this is ignorance.
16 What does OPTN, your database, what does that stand
17 for?

18 MR. TOM STANKEWICZ: Organ -- Organ
19 Procurement Transplant Network. Sorry.

20 MS. GRANT: Organ Procurement --

21 MS. STANTON: It's in the Heart, Lung,
22 Liver standards as well. So in the binder, if you
23 go to the draft section, it is in there. It's the
24 Organ Procurement Transplant Network.

25 MS. GRANT: Thank you.

1 DR. ENGELHARDT-KALBFLEISCH: I have a
2 question. Commissioner Engelhardt-Kalbfleisch. I
3 know you said you're a citizen of the, I think,
4 west side of the state. Do you have any
5 affiliation with any healthcare?

6 MR. TOM STANKEWICZ: Yes. I work for
7 Trinity in Grand Rapids.

8 DR. ENGELHARDT-KALBFLEISCH: Okay. Thank
9 you.

10 MR. FALAHEE: Thank you.

11 MR. EASTER: Shannon Strie- -- Striebich,
12 Trinity Health.

13 MS. SHANNON STRIEBICH: Chip, I'm so
14 happy I'm catching your last meeting. This is --

15 MR. FALAHEE: Maybe you're happy. You
16 don't know what questions I'm going to ask you.

17 SHANNON STRIEBICH

18 MS. SHANNON STRIEBICH: Well, I know.
19 That's true. I probably should have waited to see.
20 So good morning, and thank you for the opportunity
21 to speak this morning. My name is Shannon
22 Striebich. I serve as the president and CEO of
23 Trinity Health Michigan. So the Michigan region of
24 Trinity. I have spent my healthcare career in
25 Michigan. I did get my master's degree at the Ohio

1 State University, which causes a lot of angst for a
2 lot of my friends, but I came straight to Michigan
3 after completing my master's degree. I did a
4 post-graduate fellowship with the Detroit Medical
5 Center, spent a little bit of time at Children's
6 Hospital, and I joined Trinity and I've somehow
7 been with Trinity for 23 years, which doesn't seem
8 possible, but here I am.

9 As a healthcare leader in Michigan, I
10 believe and I know that -- that my colleagues
11 across the state that work in healthcare believe
12 that we have a fundamental responsibility to work
13 in service for our communities, to simplify and to
14 make access easy for those that we serve.

15 So I'm going to talk a little bit about,
16 of course, the topic of the morning, liver
17 transplant and start with a story about a patient,
18 Dr. David Baumgartner, that some of you may
19 recognize his name. He was a long practicing
20 infectious disease physician. I think he retired
21 in 2018 and spent his career in Grand Rapids. He
22 actually received a liver transplant from the
23 Southeast Michigan Transplant center in 2012. He
24 had received great care in the years of evaluation
25 prior to his surgery, and in the 13 years of

1 follow-up care. But even as a physician, a former
2 hospital administrator, he served as the chief
3 medical officer at our Grand Rapids facility. He
4 describes in detail the hardships and travel time,
5 expense and the isolating lack of nearby family
6 support. Others have shared similar experiences
7 with that burden of hospitalizations that lead up
8 to transplant, the hotels, the gas, the stress on
9 patients, stress on families as they struggle to
10 stay close together. The SAC has reviewed the
11 abundance of data in support of adding another
12 transplant program -- program outside of the
13 greater Detroit market and the evidence around
14 distance to centers and health outcomes, and I'm
15 grateful that we're all more informed now and
16 understand the need.

17 The Michigan vital statistics graphs show
18 that the lowest point in age adjusted chronic liver
19 disease deaths occurred in 2006 to 2007. Since
20 that time, Michigan's age adjusted liver disease
21 death rate has steadily increased when compared to
22 other U.S. states -- sorry. Can I have more than
23 30 seconds, Chip?

24 MR. FALAHEE: Keep going.

25 MS. SHANNON STRIEBICH: Okay.

1 MR. FALAHEE: I'll -- I'll let you know.

2 MS. SHANNON STRIEBICH: Thank you.

3 Michigan ranked 25th in 2023 for its liver-related
4 death -- death rate and even ranks worse than some
5 states that don't have any liver transplant
6 centers. In our immediate region including Ohio,
7 Indiana, Illinois, and Wisconsin, Michigan has the
8 highest liver-related mortality and the highest
9 nonalcoholic liver mortality rate. Michigan's not
10 making forward progress on liver disease as an
11 underlying cause of death. And in 2024, Michigan
12 ranked 24th in total liver transplants per 100,000
13 among the 39 states that had a liver transplant
14 center. West Michigan we know is the fastest
15 growing region in the state of Michigan. The CON
16 Commission has recognized this in the past and has
17 provided for West Michigan residents to have access
18 to other transplant programs which we've talked
19 about this morning, Heart, Lung, Liver, et cetera.

20 MR. FALAHEE: If you can --

21 MS. SHANNON STRIEBICH: Yeah. So by
22 opening another transplant center in Michigan, we
23 have an opportunity to choose to advance Michigan
24 to be among the best in liver, and we have the
25 opportunity to improve access for families. I know

1 that cost is a concern. Cost exists in terms of
2 dollars. We do not believe that the infra- -- or
3 we believe that we can leverage the infrastructure
4 that we have in place already to add another
5 transplant program, so that cost addition would be
6 minimal. And there's other costs to consider, too,
7 the cost of stress, the cost of quality of life, et
8 cetera.

9 MR. FALAHEE: Thank you.

10 MS. SHANNON STRIEBICH: I'll stop. Thank
11 you.

12 MR. FALAHEE: Thank you very much.
13 Appreciate it.

14 MS. SHANNON STRIEBICH: Thank you.

15 MR. FALAHEE: Questions from the
16 commissioners?

17 DR. ENGELHARDT-KALBFLEISCH: I have a
18 question. Commissioner Engelhardt-Kalbfleisch.
19 And I don't know if this is for you or if someone
20 else can answer, but just obviously travel is
21 expensive. I'm curious in terms of, like, the
22 existing programs that -- that we have, if there's
23 things available to mitigate the cost really for
24 hotel burden, meals, things like that. So we
25 haven't really heard any comment about that. So

1 just curious if our existing programs have programs
2 available for families and patients to mitigate the
3 cost.

4 MR. FALAHEE: This is Falahee. Let me
5 turf that to Dr. Sonnenday because I know it came
6 up when we had our first public hearing about this
7 several months ago, and I think it was discussed in
8 the SAC. So if I can defer that one?

9 MS. SHANNON STRIEBICH: Yeah.

10 MR. FALAHEE: Other questions from the
11 commissioners? Okay. Thank you. We have -- do we
12 have other public comment?

13 MR. EASTER: One more.

14 MR. FALAHEE: Let me call another
15 audible. Beth has asked me to pause once again.
16 This is apparently the last pause, so I -- the
17 chair wasn't aware of this, so I apologize to
18 everybody. I -- I am. But, Beth, I'll turn it
19 over to you for who knows what.

20 MS. NAGEL: Okay. Thank you so much
21 again for the pause. I believe that there is
22 another presentation. Okay. And there is and it's
23 about to happen.

24 MR. FALAHEE: Oh, I didn't see these two
25 hiding behind the column. Had I known, I would not

1 have paused. Right?

2 MR. MATT LONGJOHN: Hi, Chip.

3 MR. FALAHEE: Good morning. Good
4 morning, Representative Hall (sic) and
5 Representative Rogers. Good morning.

6 MR. MATT LONGJOHN: Members of the
7 Commission, please introduce -- excuse the
8 interruption. We're here today -- I'm State
9 Representative Matt Longjohn.

10 MS. JULIE ROGERS: State Representative
11 Julie Rogers.

12 MR. MATT LONGJOHN: We are here today to
13 honor Chip's service to the state.

14 MS. JULIE ROGERS: Wait. I thought this
15 was a roasting of Chip Falahee.

16 MR. MATT LONGJOHN: Oh, no, that comes
17 later.

18 MS. JULIE ROGERS: Oh, okay.

19 MR. MATT LONGJOHN: We know Chip as not
20 just a member of this Commission, but as a member
21 of our community. And, you know, I actually -- I'm
22 -- I'm the only physician in the House or the
23 Senate, but I'm still learning things. I've only
24 been here, like, four or five months. And I know
25 Chip best through our wives singing together in --

1 in choir in Kalamazoo. So that being said, his --
2 his commitment to the state, his service on this
3 Commission is noteworthy. And I just want to start
4 by reading just a -- a couple little bits here, and
5 I'll pass it to my colleague.

6 "LET IT BE KNOWN," that it is a privilege
7 and honor -- that -- "that it is a privilege to
8 honor Chip Falahee for his distinguished service on
9 the Certificate of Need Commission, an 11-member
10 independent body appointed by the Governor to
11 ensure the cov- -- that covered healthcare services
12 meet cost, quality and access standards for
13 patients across Michigan.

14 Chip's service on the Commission spans 16
15 years and three Governors. Originally appointed in
16 2009 by Governor Jennifer Granholm to represent
17 hospitals, Chip was reappointed by Governors Snyder
18 and Whitmer due to his depth of knowledge of the
19 healthcare field and talent for building consensus
20 among different groups to achieve good public
21 policy."

22 MS. JULIE ROGERS: "In his 16 years of
23 service on the Commission, Chip served as a
24 vice-chair for 2 years and chair for 9 years, a
25 testament to the strength of his leadership and the

1 strong support of his -- his fellow Commissioners.
2 When not attending CON Commission meetings or
3 moderating work groups or committees, Chip could
4 often be found over the years meeting directly with
5 lawmakers" -- like us -- "to answer their questions
6 about the state's Certificate of Need program or
7 testifying before a legislative committee about how
8 Michigan's CON program seeks to balance cost,
9 quality and access to ensure the best care for our
10 Michiganders.

11 IN SPECIAL TRIBUTE, therefore, we honor
12 James (Chip) Falahee for 16 years of outstanding
13 (sic) service and commitment to the health of
14 Michigan patients through his service of the
15 Certificate of Need Commission. His legacy will
16 endure in the fair and open process he created to
17 review new healthcare technology and ensure that
18 all patients have the best possible access to high
19 quality and cost-effective care. We wish him
20 continued success in his new endeavors."

21 And this is a bipartisan tribute, which
22 we would have it no other way, signed by Rep
23 Longjohn, myself, Rep Hall, Senator McCann, our
24 esteemed Lieutenant Governor Garlin Gilchrist, and
25 Governor Whitmer. Congratulations. Please come

1 forward so we can present this.

2 (Applause.)

3 (Off the record interruption.)

4 MS. JULIE ROGERS: And -- and -- and I'm
5 just going to a former chair's privilege and say
6 that we have a lot of battles that we put to the
7 side. So congratulations and I wish you well.

8 MR. FALAHEE: Thanks a lot, Julie. Thank
9 you. Thank you all. Thank you. Thank you.

10 (Applause.)

11 MR. FALAHEE: I got to keep this moving
12 -- moving -- meeting running longer. Thank you
13 very much, everyone, for the grace and the -- I
14 didn't know these interruptions would be here. So
15 thank you very much. Let's get back to this. I
16 think we have one more witness.

17 MR. EASTER: Yes, sir.

18 MR. FALAHEE: Thank you.

19 MR. EASTER: Kelly Summers, Trinity
20 Health.

21 MR. FALAHEE: And while Kelly comes up, I
22 think after this discussion, then we'll take a
23 break and go back to -- Dr. Jain is still here.
24 We'll get back to that item on the agenda. So
25 we'll finish our discussion on Heart, Lung, Liver,

1 get the Commission action, and then we'll take a
2 break.

3 KELLY SUMMERS

4 MS. KELLY SUMMERS: All right. Thank
5 you. My name is Kelly Summers. I am a registered
6 nurse and the clinical services manager for the
7 kidney transplant program with Trinity Health Grand
8 Rapids. And I'm proud to say I'm a lifelong
9 resident of West Michigan.

10 For patients with end stage liver disease
11 or acute liver failure, time is critical. Long
12 distance travel time to eastern Michigan can delay
13 early pre-transplant care, increase risk of
14 decompensation en route, and it can deter
15 vulnerable populations from pursuing transplant
16 altogether. Establishing a liver transplant
17 program on the west side would bring life saving
18 care closer to thousands of patients and correct a
19 longstanding regional inequity.

20 West Michigan hospital systems have
21 existing transplant programs for all other organs
22 except liver, serving thousands of patients and
23 having better than expected patient outcomes. Our
24 existing programs provide a strong operational and
25 clinical foundation for the addition of liver

1 transplant. Leveraging these existing transplant
2 platforms means the incremental cost of adding
3 liver transplant is significantly lower than
4 building a program from scratch.

5 Some may argue that West Michigan
6 residents already have adequate access to liver
7 transplant or that the current infrastructure is
8 sufficient and that patient outcomes have not
9 suffered. While on the surface it may appear that
10 access exists, this fails to account for the hidden
11 burden and real world consequences of centralized
12 transplant services. The claim that West Michigan
13 has sufficient access to liver transplant care is
14 based on outdated assumptions about what access
15 actually entails. In reality, functional access
16 requires proximity, equity, early engagement, and
17 sustained support, none of which are reliably
18 present without a local transplant program.

19 We also must look forward into our
20 future. Liver disease is rising. Current state
21 does not account for the projected increase in
22 liver disease. Building a program now in West
23 Michigan where the transplant infrastructure
24 already exists is a strategic forward-thinking
25 solution that avoids crisis management in the near

1 future. This is not just a medical necessity, it's
2 a public health imperative. Grand Rapids has ideal
3 anchor institutions that can deliver this service.
4 The real cost of inaction is lives lost to
5 preventable delays, disparities in care and under
6 utilized organs. Investing in a liver transplant
7 program in West Michigan is not just viable. It's
8 necessary to deliver on the promise of equitable,
9 accessible and high quality transplant care for all
10 Michiganders. By voting yes on changing the
11 standard, Michigan will reduce avoidable deaths on
12 a liver waitlist, improve quality of life for West
13 Michigan residents, contain long-term costs by
14 intervening before complications escalate. This
15 expansion is not only feasible, it's vital. Please
16 vote yes today. Thank you.

17 MR. FALAHEE: Thank you very much.

18 Questions?

19 MS. KELLY SUMMERS: Everyone wants to
20 break.

21 MR. FALAHEE: Yeah. Thank you very much.

22 MS. KELLY SUMMERS: Thank you.

23 MR. FALAHEE: Dr. Sonnenday? I saw you
24 taking notes.

25 DR. CHRISTOPHER SONNENDAY: I've got 12

1 pages of notes. No. I'll be -- I'll be brief.

2 In terms of the specific question asked
3 -- asked about mitigating travel burden and other
4 costs. It's a great question. So there are --
5 there are resources available to patients to
6 mitigate travel costs, lodging, travel, time off
7 work from advocacy groups. So there are public
8 groups and foundations that can provide that.
9 There are payer mechanisms that allow that, that
10 will reimburse for travel and for lodging. One
11 challenge that the truest low socioeconomic status
12 patients have is that it's -- it's a reimbursement.
13 It's not up front. So they have to be able to pay
14 the hotel, you know, so to speak, to stay there.
15 There are private organizations, there's a good one
16 in Detroit, there's a great one in Grand Rapids,
17 that provide transplant housing for fam- -- short
18 term for families and patients.

19 The ability of the transplant centers to
20 provide that care is really limited by current, you
21 know, statute and -- and the opinions of our
22 attorneys in terms of collusion. We -- we had a
23 transplant house at the University of Michigan for
24 decades. It was -- you know, they're kind of
25 lauded nationally, and we had to shut it down

1 because it was seen as coercive. So, you know,
2 those -- those are limited options particularly to
3 the most lowest socioeconomic status patients.

4 I'll make a couple comments in response
5 to the members that spoke. You know, I will say
6 that I concur with what was said. That the quality
7 of care in liver transplantation in the state of
8 Michigan is outstanding at all three centers. I
9 don't contest that. I think those of us on the SAC
10 that voted in favor of expanding is a -- is the
11 concern we don't provide enough. And I do think
12 there's a practical aspect to this. You know,
13 Grand Rapids or the West Michigan kind of
14 metropolitan area is one of the largest areas in
15 the Midwest that does not have a liver transplant
16 program. The others are Toledo, Fort Wayne,
17 Springfield, Illinois. You know, I totally defer
18 to the CON Commission about how these decisions are
19 made, but I suspect you will either make this
20 decision now or you'll make it, you know, in
21 another five years. I mean, there's just not the
22 -- the size of a metropolitan area such as that's
23 the case.

24 There's a lot of concern about adding a
25 program. I have that concern. Our institution has

1 that concern. I can tell you when a heart and lung
2 program was added in the state, no one fought that
3 more vociferously than the University of Michigan.
4 But the natural experiment tells us that we were
5 wrong. Right? The number of transplants in the
6 state for heart and lung has increased, the quality
7 has not decreased. And, you know, with all due
8 respect to my colleague, Mr. Syring, you know, the
9 Corewell liver transplant experience proves that a
10 lower volume program can provide outstanding care,
11 and they've done that relatively rapidly. You
12 know, that program has only been in existence 13
13 years, something like that. So -- so, you know,
14 volume is important, but it doesn't directly
15 correlate with the quality in all cases.

16 And then the last thing I would say is
17 that -- and the SAC spent a lot of time discussing
18 this and I will just say this is my personal
19 opinion now. I'm not speaking on -- on behalf of
20 the SAC. But this question of access and the
21 outreach clinics was discussed a lot. And Henry
22 Ford is truly a national leader in the provision of
23 satellite clinics for liver transplantation. All
24 of us imitate their -- their model.

25 You know, it's interesting -- or my

1 lessons from this have actually been drawn from
2 kidney transplantation. So the University of
3 Michigan has had a similar satellite program for
4 kidney transplantation across the state for 20
5 years in different locations. It's been seen as,
6 you know, remarkably successful from the standpoint
7 that our program remains the largest in the state
8 and does a lot of transplants. It's been
9 illuminating, though. There are still patients
10 that we see at these satellite locations who,
11 despite all the care that we're providing, tell us
12 they can't get to Ann Arbor for their transplant.
13 And even more tragic is when they come to Ann Arbor
14 for their transplant, they're an inpatient in our
15 hospital, they're -- they are waiting to leave, and
16 their caregivers can't get time off work to come in
17 to learn their new meds and get them out of the
18 hospital. That is a real thing. That happens
19 every week in our hospital. And that's despite us
20 having, I think, outstanding psychosocial resources
21 and support for patients.

22 So I think the -- the deficit here is not
23 kind of the well-healed and well-insured. It is
24 the lowest socioeconomic status members of the
25 state. And my -- again, my personal opinion, not

1 as chair of the SAC, is that transplant access will
2 only continue to grow not just in Michigan, but
3 around the country, by putting transplant centers
4 in different areas where patients have access.

5 And, you know, some of this is a kind of regulatory
6 and to some degree financial issue. You know,
7 based on current CMS and OPTN regulations,
8 transplant programs are dictated by hospital, you
9 know, designated by hospital. That may or may not
10 be the best model in perpetuity. You know, we need
11 to be able to operate and provide transplant
12 services more locally, perhaps under networks or
13 collaborative agreements or other things. That's
14 beyond my work or the work of the Commission. But
15 I think the point is the solution to this is not to
16 just make big transplant centers bigger. We're
17 going to have to figure out ways to get
18 transplantation closer to patients.

19 I guess the last comment I'll make is --
20 was related to Commissioner Grant's question about
21 the OPTN. So the Organ Procurement Transplantation
22 Network is the federal registry; essentially
23 federal organization. It's currently or has been
24 the -- run by a single subcontractor, UNOS, for --
25 for decades, just until recently when it was broken

1 up. But that's publicly available data. Sorry.
2 You can go online and -- and look that up and --
3 and that's what we used in a lot of our
4 discussions. I think that was --

5 MR. FALAHEE: Any questions?

6 DR. CHRISTOPHER SONNENDAY: Oh, last
7 comment.

8 MR. FALAHEE: Yeah; sure.

9 DR. CHRISTOPHER SONNENDAY: I -- I
10 completely agree. I thought that Makenzie
11 Buchert's comments about the additional language in
12 the statute totally reflects the discussion that we
13 had in the SAC and the concern that, you know, we
14 need to get that part right, and we did not focus a
15 lot on that. So I concur completely with her
16 comments about that.

17 MR. FALAHEE: Great. Again, thank you
18 for your comments as chair and your personal
19 comments as well. Thank you. Any questions of Dr.
20 Sonnenday?

21 DR. MILEWSKI: This is Commissioner
22 Milewski. The one key question that I have is
23 related to your last comments about "we didn't have
24 enough time to get the language right" and
25 balancing that against the recommendation to seat

1 another SAC, which for those of us that have been
2 working on the Commission for awhile know --

3 DR. CHRISTOPHER SONNENDAY: Gives you
4 chest pain, yeah.

5 DR. MILEWSKI: -- yeah. That's going to
6 take, you know, awhile in terms of, you know,
7 balancing the other work that's in front of the
8 Department; pulling together a SAC is no small
9 feat. And the time frame in balancing that against
10 knowing that we have patients that are struggling
11 today, right, with our other recommendation of we
12 need a fourth center in -- in Michigan is what the
13 recommendation was. And I think we want to get the
14 language right. So to Commissioner Falahee's
15 earlier comments, is there a potential for, you
16 know, another alternative? And I guess I wanted
17 your thoughts about, you know, we heard comments
18 earlier about these are not technical edits. But
19 is there a potential -- I wanted your opinion -- of
20 gaining input from experts along with the
21 Department, there are key areas that were honed in
22 on, I think, within the standard that the -- that
23 the additional language is that, you know, if there
24 was another alternative around having Department
25 work with key experts, maybe the chair and co-chair

1 for the SAC, would that be something that you think
2 could be a workable solution? It would not extend
3 the time of us implementing language, you know,
4 extensively.

5 DR. CHRISTOPHER SONNENDAY: Yeah. A
6 great question. It's what I spent thinking about
7 driving up here today because I knew someone would
8 ask that. You know, I -- I will say first as
9 chair, the SAC -- the SAC voted, passed a motion
10 that they thought an additional SAC should --
11 should consider that portion of the standards. So
12 that is the SAC's answer. In terms of personally
13 answering your question, you know, what I -- what I
14 think is part of the problem with the standards as
15 written, and I totally understand why they were
16 trying to give the CON Commission kind of an
17 objective criteria to choose between relative
18 application based on a point system, which, again,
19 personal opinion now, seems kind of contrived. And
20 the problem is the elements of the point system as
21 written, a lot of them don't apply anymore. So if
22 you want a points-based system, somebody's got to
23 go back to the drawing board and figure out other,
24 you know, criteria. I don't know what the
25 precedent is in other CON standards. I don't know

1 how comparative review is done typically. So maybe
2 that is something that could be drawn upon to
3 consider that. I mean, as you know well, the --
4 the crite- -- the conditions of participation set
5 out by CMS for transplant programs and the OPTN
6 requirements for transplant programs are well
7 delineated. They are not subtle. And any program
8 putting in an application would have to meet those.
9 How you then decide between relative applications
10 between those is -- is tricky; right? You know, it
11 should be based on kind of access of patients to
12 that center? Should it be based on indigent care
13 as it's commented on in the current standards? I
14 don't know the answer to that. It's complicated.
15 So, you know, I guess, to -- to cop out a little
16 bit on the answer to the question, I don't know
17 what the precedent is from other CON comparative
18 review standards, but the point system as written
19 in that document doesn't apply anymore.

20 MR. FALAHEE: Other questions?

21 DR. DELANO: It's Commissioner Delano.

22 I've got a question regarding some statements that
23 as I heard them regarding quality and using the
24 Grand Rapids heart transplant, the Heart, Lung
25 Transplant standard or experience as a way to

1 inform a decision. One thing that can be done to
2 prevent surgical outcome is to have better
3 selection criteria for your -- your -- the patients
4 that you're treating. I'm wondering if there's any
5 insight you might share on how more stringent
6 selection criteria could influence that research
7 quality and get a natural qual- -- quality in Grand
8 Rapids for a transplant? Are there more
9 compromised patients being treated elsewhere?

10 DR. CHRISTOPHER SONNENDAY: Yeah. Great
11 question. And -- and I am only a expert by
12 association in heart and lung transplant, running a
13 transplant center. But -- but I do know, you know,
14 and I feel like I have expertise in liver
15 transplantation and I watched the Corewell program
16 open their liver program. You know, I think most
17 new programs do start -- start off trying to hit
18 fastballs down the middle. Right? So they're
19 relatively stringent in both their donor and
20 recipient selection. I think the -- as we've
21 discussed a lot today, the thing that drives -- you
22 know, is most important from a patient standpoint
23 is access to the waitlist and therefore
24 transplantation. And over time, any program that
25 wants to serve their community has to -- to

1 liberalize those standards. And actually, in the
2 current regulatory environment, the hardest thing
3 to do is operate a small program. You want to
4 operate a larger program where each outcome is not
5 -- doesn't kind of hit you as much.

6 I -- I will just say that one other thing
7 that we haven't talked a lot about in this but is
8 kind of in behind your question is that it's not
9 just about access and total number, it's also about
10 choice. Right? So patients should have the choice
11 of where to go for transplantation because
12 selection varies. And I'll give you a very pointed
13 example of that from this week. So I -- on last
14 Friday or Saturday, we turned down a patient for
15 transplant that went to Ford for another opinion.
16 On Tuesday night we accepted a patient and transfer
17 from Corewell, turned down at their center to be
18 considered at our center. And on Wednesday morning
19 we transferred a patient to Corewell to be
20 considered at their center that we had turned down.
21 Why is that? Because the patients have the ability
22 of choice. And you can imagine that if there was a
23 fourth program that was more kind of geographically
24 better suited, that expands choice, too. So it's
25 not just about total numbers and -- it's about

1 having a choice and differences in -- in
2 programmatic approaches.

3 MR. FALAHEE: Anything else from the
4 commissioners? Thank you, Dr. Sonnenday.

5 DR. CHRISTOPHER SONNENDAY: Okay. Thank
6 you.

7 MR. FALAHEE: You're welcome to stick
8 around, or you can leave, take care of --

9 DR. CHRISTOPHER SONNENDAY: There might
10 be another celebration.

11 MR. FALAHEE: I apologize. Okay. This
12 is the time -- for Commissioner Grant to know -- we
13 have Commission discussion amongst ourselves, if
14 you will, with 60 people listening and questioning
15 what -- what the heck are they doing. And then we
16 seek the input of the Department as well. That's
17 how that goes.

18 Let me first start off mentioning seeking
19 input of the Department. So questions that come up
20 about the need for a SAC to look at various
21 sections or -- well, maybe we can do it through the
22 Department with some, quote, "technical changes."
23 I know there's been comments about are they really
24 technical or they're substantive? I look at it as
25 someone, as you've heard too often, with 16 years

1 of experience on the Commission. And I did my
2 first CON application I think in 1981. So I've
3 done a few CON applications as well. Candidly,
4 I've seen Heart, Lung, Liver, that can kicked down
5 the road and kicked and kicked and kicked. Full
6 disclosure, I live in Kalamazoo, so I'm one of
7 those people in West Michigan. And I'd like to
8 move this forward. That's my personal bent. But I
9 also rely on my friends at the Department because
10 they're invaluable in refining standards, making
11 changes, sending them out to public review, public
12 comment. So if people look at it and go, "you got
13 this one wrong," okay. Let's come back and work on
14 it and get it right. So my question to Beth or any
15 -- my friends across the way, is this something
16 that you think that could be handled, or do you
17 honestly -- and you're always honest -- think that
18 a SAC is needed for that?

19 MS. NAGEL: This is Beth. That's a -- a
20 great question. And I think that we -- we have
21 seen complex and controversial issues be handled in
22 -- in a variety of ways to come back to the
23 Commission. One of them is certainly seating a SAC
24 to work through some of -- of -- of those issues.
25 That does give me some pause considering the work

1 plan that's on your agenda is a pretty hefty work
2 plan of -- of other issues that this team and --
3 and you all will have to, you know, spend the rest
4 of the year and into next year working through. I
5 don't know when we would be able to seat a SAC.
6 And those are our limitations. I also worry about
7 the limitations of taking our top transplant
8 experts in the state offline for a period of time
9 to work through some of these issues. So I have
10 concerns about seating a SAC.

11 I do think it is possible that through
12 public hearing, we could get information about what
13 does need to be changed, because that is one thing
14 that I can't confidently say, yes, that, you know,
15 we can do it this way or we can do it that way
16 because we don't really have documentation on what
17 exactly needs to change. It came up so late in the
18 -- in the process. So I think, you know, a prudent
19 first step might be getting some of that
20 information back through public comment to be able
21 to really understand the scope and the magnitude of
22 the changes that we're looking at, and then I think
23 you all have better information on deciding the --
24 the path forward. So, you know, I don't know that
25 that was a direct answer to your question, but I

1 think a first step might be to gather that
2 information.

3 MR. FALAHEE: That was a direct answer,
4 so don't worry. But then I'll have a direct
5 question in response. So your first step. We have
6 in front of us a SAC recommendation. We can accept
7 it, we can modify it, we can reject it as the
8 Commission. Looking at a crystal ball, is it -- is
9 there a potential -- let's say we voted to approve
10 the SAC's recommendations with the exception of the
11 recommendation to create another SAC to look at,
12 quote, I'll call it "technical changes" and then
13 send or hold a public hearing. Let's say we as a
14 Commission approve the SAC's recommendations, but
15 for the last one. Then would the next process step
16 be a public hearing so that the public could
17 comment on what needs to be edited within the HLL
18 standards?

19 MS. NAGEL: Uh-huh; yeah; yes. You would
20 be taking proposed action on the language that the
21 SAC brought forward and that part of the -- that
22 proposed action is a public hearing. I would
23 recommend the Commission have direct questions in
24 that -- in that public hearing, like "what do you
25 think needs to be changed in section seven" or, you

1 know, whatever the questions are. But something
2 very specific to react to.

3 MR. FALAHEE: Right. Could the
4 Commission -- and the -- Commissioner Grant, this
5 is typical. We're kicking things around, trying to
6 find solutions to complicated issues. If the
7 Commission approved the SAC recommendation but for
8 the one, could it hold off on sending it out to
9 public comment until after the public hearing so
10 that we could combine everything into one package,
11 if you will? The public hearing on the technical
12 changes?

13 MS. NAGEL: Yes. So what would
14 essentially happen process-wise -- and I'm sort of
15 seeing it in my mind, so bear with me for a moment.
16 If you took proposed action on the language that
17 was provided today and held -- held a part of that
18 process, hold a public hearing, you get great
19 information back from that public hearing and you
20 get a list of things that needs to change in
21 section seven. It would then have to be proposed
22 action again and a public hearing again before
23 final action could be taken. Alternatively, you
24 could get -- you could do proposed action, have a
25 public hearing, and let's say we get nothing. Then

1 it is eligible -- no changes need to be made or
2 whatever, then it is eligible for final action at
3 the next Commission meeting. So there are kind of
4 two options.

5 MR. FALAHEE: Right. Okay.

6 DR. MILEWSKI: Commissioner Milewski.
7 Building on that. If we were to take proposed
8 action on this language, get a whole bunch of
9 feedback around edits, not that need to be made on
10 this particular section, but to related sections,
11 do we have the ability to then wait on taking final
12 action on this section until we get all of the
13 other pieces, a comparative review language
14 situated and out as a full package --

15 MS. NAGEL: Yes.

16 DR. MILEWSKI: -- before we would take
17 final action?

18 MS. NAGEL: Yes. Thank you for repeating
19 that for -- yes.

20 DR. MILEWSKI: Thank you.

21 MS. GUIDO-ALLEN: So can you repeat that
22 for me -- Guido-Allen -- for me? My big concern is
23 around the comparative review. That's not public
24 comment; correct?

25 MS. NAGEL: Yeah.

1 MS. GUIDO-ALLEN: The comparative data on
2 what you -- we would ask the public to -- would be
3 criteria?

4 MS. NAGEL: Yeah; yeah; yeah. It would
5 be the entire set of standards would go to -- to
6 public comment.

7 MS. GUIDO-ALLEN: You would create the
8 new criteria from public comment?

9 MS. NAGEL: So today --

10 MS. GUIDO-ALLEN: Dr. Sonnenday said that
11 the -- and then in here it says, "SAC members
12 expressed concern that the comparative review
13 standards need to be comprehensively reconsidered."
14 Are we saying that we would reconsider public
15 comment on how we change the standard?

16 MS. NAGEL: Yes. That is what -- yes.

17 DR. MILEWSKI: My --

18 MS. GUIDO-ALLEN: Go ahead.

19 DR. MILEWSKI: -- my understanding is we
20 could take proposed action on the language which
21 didn't include the comparative review section, but
22 then as we send it out for public comment, also add
23 in a series of questions about other sections so
24 that we would get public comment not just on the
25 area that we're taking proposed action on, but

1 other related sections on comparative review to get
2 all of that information back. And what Beth just
3 acknowledged is that we could wait on any final
4 action on this section until we brought forward new
5 language on the other sections that are presenting
6 a concern.

7 MS. GUIDO-ALLEN: Based on the summ- --
8 summation of the SAC concerns, in my opinion, and I
9 know it's only my opinion, that the -- the edits
10 that are required, the changes that are required,
11 the updates that are required seem much more
12 substantial -- substantive than technical. When
13 you read page 100 and 101 it -- it's concerning.

14 MR. FALAHEE: This is Falahee. I
15 understand the concern, but I would rather try to
16 approach it through, in quotes, call it "technical
17 change." I understand there's differences of
18 opinion about is it technical, is it substantive.
19 I -- I would rather try to resolve the issues and
20 make any necessary edits to the language in the
21 sections through a give and take public hearing,
22 public comment, refinement, bringing it back to the
23 Commission. I'd like to give that -- personal
24 opinion -- a shot first. If the Commission later
25 decides "no, this is indeed substantive, there are

1 a lot of countervailing factors, we need a SAC,"
2 well, at least then we've tried to move it forward
3 and it didn't work. That's fine. But that's where
4 I think there's another alternative to do it that
5 way. To give that alternative a shot.

6 DR. ENGELHARDT-KALBFLEISCH: Commissioner
7 Engelhardt-Kalbfleisch. I am hearing arguments
8 kind of on both sides I'll say. I agree that some
9 of these seem to be substantive and there are a
10 number of areas where the SAC said they ran out of
11 time. And as the Commission we're charged with
12 really balancing not only access, like, from a
13 geography standpoint, it seems to make sense. But
14 I am concerned when I hear testimony that costs
15 have tripled and arguments on both sides of the
16 aisle about quality, and as a Commission we're
17 charged to really address cost, quality and access.
18 Given that vote was, like, eight to six, it wasn't
19 as overwhelming as some of the other votes that
20 we've had held. I think it makes sense maybe to
21 have experts weigh in as opposed to the back and
22 forth with public comments.

23 So, again, my personal opinion, but just
24 given the back and forth controversial nature and
25 the expertise required to sort all of this out, I

1 would be concerned with things -- certain things
2 forward, specifically about the comparative review
3 criteria just given, I think, the substantive
4 nature of some of the issues, so --

5 MR. FALAHEE: Sorry. Would that -- would
6 you support moving forward without a SAC to try to
7 address those issues, or are you saying you think a
8 SAC is needed? And we'll put a motion out either
9 way. We vote it up or down. I'm just -- I'm
10 trying to --

11 DR. ENGELHARDT-KALBFLEISCH: As much as I
12 hate to say it because I appreciate all the
13 complexity that goes along with a SAC, I -- I think
14 a SAC just given the expertise, the kind of
15 controversy back and forth. Like, we want to get
16 this right, given some of that language hasn't been
17 changed or updated in 25 years. I think having a
18 SAC really so that we know we have experts working
19 to help these issues would be, I think, A, the
20 highest likelihood to make sure we get it right
21 and, B, that we have the right people weighing in
22 on this, so --

23 MR. FALAHEE: Okay.

24 MS. GUIDO-ALLEN: Guido-Allen. The same,
25 you know, the SAC members suggested, recommended

1 another SAC. Likely they're going to be the same
2 people sitting on the next one. But they
3 specifically called out the recommendation for
4 another SAC to work through these -- these edits
5 and the rest of the issues around cost and quality.

6 MR. FALAHEE: Right. This is Falahee. I
7 understand that. We as a Commission, we can -- I
8 said accept recommendations, reject --

9 MS. GUIDO-ALLEN: Yep.

10 MR. FALAHEE: -- or modify. So that's
11 why we're having this discussion.

12 DR. MILEWSKI: Yeah. Commissioner
13 Milewski. I -- I do understand the concerns, and
14 it's not that I don't share them, but I also have
15 significant concerns about how long this standard
16 of, you know -- and a statement even to get to this
17 point of recommending, you know, a liver transplant
18 program. I mean, we already have heart and lung,
19 you know, and renal transplant label on the west
20 side of the state. Liver is growing exponentially
21 in terms of need. And so, you know, I guess the
22 question to the Department is if we were to follow
23 the recommendation of seating another SAC, when
24 realistically would we be able to do that and when
25 realistically would we have the outcomes of that?

1 Because I think that's what we're balancing here.

2 MS. NAGEL: I would have to look at the
3 work plan in more detail, but I -- I'm going to
4 take my educated guess right now that we wouldn't
5 get a SAC until next year; calendar year.

6 MS. STANTON: Tiffani from the
7 Department. Also consider the County Designation,
8 having the six standards that will need a workgroup
9 or SAC that were just approved to -- and put the
10 definition, which those are all open for next year
11 as well.

12 And even just to explain the process. If
13 we were to take proposed action, that does go for
14 the public hearing. So bringing that to the public
15 hearing, if there are specific questions similar to
16 how we have done before, those questions can be
17 answered by the public. We at the Department can
18 work with the Commission, we can work with the CON
19 chairs, we can work with SAC chairs kind of
20 implementing those requests or suggestions and
21 bring it back technically for final action.
22 However, that's where the Commission has the
23 ability to accept those substantive changes, which
24 then would have to send it back for the proposed
25 action. So it's not a done deal having to go

1 forward, but that is part of the process. If that
2 helps kind of alleviate some of those questions.

3 DR. MILEWSKI: So what I'm hearing -- I'm
4 just trying to do some math in my head. If we were
5 to follow the recommendations of seating a SAC to
6 address some of these concerns as opposed to
7 sending out proposed action on the language and
8 getting a public hearing and getting additional
9 feedback, the proposed SAC, seating that, wouldn't
10 happen until next year, six months of SAC debate,
11 coming back to the Commission, we're talking about
12 a potential delay of maybe two years of allowing
13 for another program. Would that -- is my math
14 about right?

15 MS. NAGEL: I think that's a fair
16 estimate, yes.

17 DR. MILEWSKI: Okay. Thank you.

18 MR. FALAHEE: I will point out to seat a
19 SAC takes roughly -- once the Commission says put a
20 SAC together -- minimum three months. Minimum.

21 MR. CONNOLLY: Marcus with the
22 Department. And just to give a little insight.
23 The last time we had a Heart, Lung, Liver
24 nomination, it took -- what would you say?

25 MS. STANTON: Five months.

1 MR. CONNOLLY: Five months trying to get
2 the SAC together. So please keep that in mind.
3 That may delay it as well. And I talked with
4 somebody a couple days ago and it's looking like
5 the language may not go into effect until 2027,
6 just depending on our work plan and when we can fit
7 it in. So those are things to consider as well if
8 we're trying to keep the language moving.

9 DR. ENGELHARDT-KALBFLEISCH: Commissioner
10 Engelhardt. Question.

11 MR. FALAHEE: Yeah.

12 DR. ENGELHARDT-KALBFLEISCH: If we seated
13 a SAC, do they have to take, like, a full time or
14 could they bring recommendations forward sooner?

15 MR. FALAHEE: In a perfect world, they
16 wouldn't need to take six months. Given these
17 issues, we might come back in six years. But, no,
18 I don't think -- I think six months is probably the
19 expectation.

20 DR. ENGELHARDT-KALBFLEISCH: Okay.

21 MR. FALAHEE: Yeah.

22 MS. GRANT: Commissioner Grant.
23 Question. Is there a hybrid solution that
24 leverages ex- -- experts in this and the internal
25 team at the Agency?

1 MR. FALAHEE: Yes, there's a hybrid
2 solution. It's called a workgroup. And it's those
3 issues that aren't substantive in nature or with a
4 lot of conflicting, competing interests. All
5 right? So, for example, the first agenda item
6 today on the County Designation was a workgroup.

7 MS. GRANT: Okay.

8 MR. FALAHEE: And in the past, when we
9 know we have substantive issues or competing
10 priorities one way or the other, usually a
11 workgroup doesn't work because a workgroup is not a
12 set group of people. It's whomever shows up at the
13 meeting.

14 MS. GRANT: Oh, okay. Gotcha.

15 MR. FALAHEE: But good question. But
16 that's -- that's how it was structured. So I think
17 given -- this -- if we chose not to proceed, it --
18 it's our -- if we chose to proceed with a SAC, it
19 would table it.

20 MS. GRANT: Understood.

21 MR. FALAHEE: Other Commissioners? This
22 side of the table has engaged in a lot of
23 discussion. Any -- any other thoughts? Otherwise,
24 I think we need to put a motion on the table just
25 to -- to -- to vote and then move forward based on

1 that motion.

2 DR. MILEWSKI: Commissioner Milewski. I
3 will put a motion forward to accept the workgroup
4 recommendation except for the SAC and move forward
5 the proposed language to public hearing with a
6 recommendation that we also add a number of
7 questions around the areas within the standard that
8 would be drafted by the chair and co-chair in
9 conjunction with the Department, soliciting
10 feedback on other areas and edits that would be
11 needed within the Heart, Lung, Liver Transplant
12 standard.

13 MR. FALAHEE: So there's a motion there.
14 Is there support for that motion?

15 MR. VELEZ: I support the motion.

16 MR. FALAHEE: Hang on one second.

17 MR. HAMMAKER: Just a supporting
18 clarification. The Department offered one change
19 to the SAC's proposed language regarding the
20 definition of pediatric. Did you have a position
21 on whether or not you want to adopt the
22 Department's recommendation?

23 DR. MILEWSKI: Thank you for that
24 reminder. Yes, I would also recommend that we
25 adopt the Department's recommendation on the

1 language change.

2 MS. GRANT: I have a clarifying question.

3 MR. FALAHEE: Let me make sure.

4 MS. GRANT: Oh.

5 MR. FALAHEE: With that addition, is
6 there still support for the motion?

7 MR. VELEZ: Commissioner Velez. Yes, I
8 still support the motion.

9 MR. FALAHEE: Okay. Great. Commission
10 discussion.

11 MS. GRANT: Okay. Commissioner Grant. A
12 clarifying question. For the motion that's on the
13 table, is the condition of moving forward, but with
14 this -- the separate workgroup that I think is in
15 here, is that specific to sections five, seven and
16 eight that were addressed by the existing SAC as
17 the main concerns? Is that what we're saying?

18 DR. MILEWSKI: Sorry. My motion did not
19 include seating a workgroup or a SAC. It just
20 included sending the language out for public
21 hearing which all areas of the public, general
22 public, facilities can all comment. But was to
23 draft specific questions about other areas of the
24 standards that were felt to be in need of edits and
25 any proposed language around that would be -- so

1 we'd have to draft those questions out for public
2 comment as well, not just public comment on the
3 proposed language.

4 MS. GRANT: Got it, I think. Okay.

5 MR. FALAHEE: Any other questions about
6 the motion? For Commissioner Grant's benefit,
7 sometimes what we will do, the Commission will say
8 to the chair and vice chair, "please draft the
9 questions in this case that you would like to go
10 out to a public hearing" so that the people out
11 there say, "okay, here's -- here's what's being
12 teed up to look at." Now they may say, "no, you
13 need to look at number sections 9, 12, and 10 as
14 well." But that's the purpose of teeing it up with
15 specific questions, and then the chair and the vice
16 chair work with the Department to get those
17 questions put together.

18 MS. GRANT: Okay.

19 DR. MILEWSKI: I would also add just for
20 awareness, this is not final action. All of this
21 -- all this will do is solicit input on the
22 existing language as well as whatever questions we
23 put forward, and we'll be back here discussing all
24 of that information. And we can choose not to take
25 final action, we can choose to do something

1 different, we can choose to seat a SAC at a point.
2 It's up to the Commission how we decide to act.

3 MS. GRANT: Okay.

4 MR. FALAHEE: Thank you. Other questions
5 about the motion? Okay. We have a motion on the
6 floor. All in favor, please raise your hand. One,
7 two, three, four -- five. All opposed? Three.
8 The motion does not carry. We need a majority of
9 six. The motion does not carry.

10 MS. NAGEL: Is that --

11 MR. FALAHEE: Beth?

12 MS. NAGEL: Can I talk to Carl quickly?

13 MR. FALAHEE: Please.

14 MS. NAGEL: Carl, I believe for final
15 action it is six.

16 MR. FALAHEE: Oh, for final action.

17 MS. NAGEL: But for all other action it's
18 a quorum of those present and attending.

19 MR. HAMMAKER: I believe Beth's right.
20 Let me pull up the bylaws.

21 MR. FALAHEE: It is rare for us to have
22 only eight commissioners here. While we're waiting
23 for Carl to do some quick legal research, after
24 this we'll take a break. I promise. And then
25 we'll go back into -- we'll start right out with

1 Dr. Jain.

2 MR. HAMMAKER: Consult with Beth.

3 MR. FALAHEE: Okay.

4 (Off the record interruption.)

5 MR. HAMMAKER: And so reviewing the
6 bylaws, the only action that requires a -- a
7 majority of all appointed and serving Commissioners
8 is final action. Everything else will be by a
9 majority vote of those present at the meeting.

10 MR. FALAHEE: So based on that, motion
11 carries.

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

14 MR. FALAHEE: And we will move forward
15 and the -- I'm assuming, the chair and vice chair
16 -- easy for me to say because I won't be in that
17 role -- will work with the Department to develop
18 questions for a public hearing.

19 Thank you all for very, very good
20 discussions. Thank you in the audience. I don't
21 know if Dr. Sonnenday is here still? There he is.
22 Yes, thank you. Thanks to everyone that commented,
23 that participated, and every member of the SAC as
24 well. Let's take a break for 10 minutes please.

25 (Off the record.)

1 MR. FALAHEE: Dr. Jain, please proceed.

2 DR. SUBODH JAIN: Thank you. And thank
3 you for adjusting the agenda for me. I would
4 highly advocate for faster e-chargers so that I
5 could come on time, and that was my reason for
6 being late and being pushed down the agenda. So
7 sorry about that.

8 Thank you, Chairperson Falahee and the
9 Commission for the privilege and honor that I had
10 to lead this workgroup. I would also like to
11 extend my deep appreciation for our Department, and
12 they have been extremely helpful for me to navigate
13 through some complex conversations. And also all
14 the members of this workgroup. I -- I would
15 suggest that even though there were decisions and
16 disagreements, there was a lot of respect towards
17 the patient in the middle, and most of the
18 agreements or disagreements were based on seeing
19 how we serve the patients of -- a patient and
20 citizens of Michigan in a very complex environment
21 in behavioral health.

22 So with saying that, I would like to
23 present the report, final report of the workgroup.
24 We were mostly on consensus on almost everything.
25 There were a couple of things that were worded and

1 we did not have full consensus, but very wide
2 majority however it came about. So I would start
3 reading on those charges if you allow me to start
4 there. Thank you.

5 So the Psychiatric Beds and Services
6 workgroup as charged by the Certificate of Need
7 Commission met four times and concluded its work on
8 March 20th, 2025. The charges and recommendations
9 are as follows. Charge one: Review the reduction
10 of maintenance volume for special population pool
11 beds from 80 to 60 percent. Recommendation from
12 the workgroup was lowering the maintenance volume
13 for special pop- -- population from 80 to 60
14 percent given that special pool beds are subject to
15 several special requirements. One of these is a
16 higher occupancy requirement than general pool
17 beds. Lowering the occupancy rate to be consistent
18 with adult general pool beds allows providers to
19 take care for a specific patient population, often
20 the most difficult to place, without being held to
21 any impractical occupancy requirement. So this
22 phenomenon is also felt more acutely in smaller
23 units where there will be empty beds and then they
24 could not maintain this requirement. So I was very
25 thankful for our members to come together and --

1 and recommend this with consensus.

2 Charge two: Review Section 2(t)
3 definition to remove outdated terminology,
4 consistent with Mental Health Code. Recommendation
5 from the workgroup agreed to the Department's
6 updated proposed language removing outdated
7 terminology from the definition of "mental health
8 professional" and changes "Licensed Professional
9 Counsel" to instead say "Licensed Professional
10 Counselor." So the rationale is the terms used in
11 section 2(t) do not reflect current terminology.
12 These terms need to be updated to align with modern
13 practices. So it was met with consensus.

14 Charge three: Consider revising section
15 2(n) definition of "Flex bed" to include converting
16 an existing child and adolescent psychiatric bed to
17 an adult psychiatric bed in an existing adult
18 psychiatric service. Recommendation: The
19 workgroup recommended no changes at this time.
20 Rationale: While many workgroup members agreed in
21 principle with the concept of a child and
22 adolescent psychiatric being flexed for adult
23 patients, the workgroup recommended no changes at
24 this time due to an overwhelming majority of
25 workgroup -- workgroup members feeling there was

1 too much potential for pediatric patients to lose
2 access while beds were flexed to adult. Ultimately
3 the workgroup participants voted against moving the
4 proposal with three votes in favor and 13 votes
5 against and therefore no changes were being
6 recommended at this time.

7 Charge four: Is review the average
8 occupancy rate calculation in section 8(2) and
9 recommend revisions to clarify the calculation that
10 should be utilized. After thorough discussion, the
11 workgroup supported removing the specific formula
12 in section 8(2) and instead utilizing the average
13 occupancy calculation provided in section 2(c), the
14 definition of "average occupancy rate." The
15 current provision requires applicants requesting
16 additional general pool bed at an existing licensed
17 inpatient psychiatric facility could demonstrate
18 that they're already meeting an average occupancy
19 rate of at least 70 percent before they can be
20 approved for those -- for more beds. The provision
21 provides a formula for calculating occupancy that,
22 according to language, is supposed to be different
23 from the otherwise defined average occupancy rate
24 in the definition section. However, the formula
25 does not make sense as it requires the applicant to

1 divide inpatients days of care by inpatient days
2 rather than dividing by some version of bed days.
3 So consolidating to one definition making this
4 calculation clear and consistent with current
5 Department practice and this was met with consensus
6 and Department supported this one, too.

7 Charge five: Review the high occupancy
8 provisions in section 8(3), specifically the
9 requirement regarding no beds available in planning
10 area where the beds are being requested and
11 recommend if any changes should be made to address
12 a more immediate bed need. So the workgroup agreed
13 to remove the requirement that no beds be available
14 in the planning area in order to apply for high
15 occupancy. At the encouragement of the Department,
16 the workgroup is also recommending that --
17 recommending language that instructs the Department
18 to hold from add- -- from adding high occupancy
19 beds to the inventory until after any pending
20 potential comparative review applications in the
21 same planning area have been issued a final
22 decision. This change will help facilities
23 experiencing high occupancy to obtain more beds and
24 bring them online faster while ensuring applicants
25 planning to apply for beds currently available in

1 the inventory will not be adversely impacted by a
2 facility applying for high occupancy bed -- beds
3 that would otherwise reduce or eliminate the bed
4 need in the planning area.

5 Charge six: Consider if provisions
6 should be allowed -- should be added to allow for
7 the reallocation of special pool beds from
8 underutilized pools to pools without beds available
9 and/or consider recommending a different allocation
10 of available beds from the existing pools.

11 Recommendation was that the workgroup recommends no
12 changes at this time. Despite some facilities
13 indicating they still struggle to place geriatric
14 patients, because only 40 percent of the approved
15 beds have been operationalized, the workgroup
16 agreed to wait on recommending any changes until
17 after all the beds have been operationalized, and
18 then a reassessment of whether facilities to
19 struggle to place the geriatric patients.

20 Charge seven: Review the use of term
21 "provisional license" in section -- section
22 11(3)(c) and determine if changes to that provision
23 should be made to align with current terminology
24 used within the Michigan Department of Licensing
25 and Regulatory authority -- Regulatory affairs.

1 Recommendation: The workgroup recommends no
2 changes. The Department recently changed their
3 process, allowing applicants to document compliance
4 with section 11(3)(c) by just submitting a
5 screenshot of "Verify a License" webpage which
6 resolved the concern expressed by LARA. We met
7 with LARA and we -- we went over that so this was a
8 medical consensus and we would not make any
9 changes.

10 Charge eight: Consider any other
11 technical changes from the Department, for example,
12 updates or modifications consistent with other CON
13 review standards and the Michigan Public Health
14 Code. Recommendation: The workgroup agreed to two
15 standard technical updates the Department
16 identified. In addition, the workgroup also
17 supports a Department's -- supports a Department
18 request to modify the language in section 8(3)
19 related to high occupancy calculation to clarify
20 that CON approved but not yet operational beds are
21 included in the denominator. The Department
22 explained that it has always been their practice to
23 include CON-approved but not yet operational beds
24 in the denominator while calculating a facility's
25 occupancy for high occupancy beds, even though it's

1 -- it is not clearly stated in section 8(3).
2 Although a vast majority of workgroup supported all
3 of the Department's technical updates, we know that
4 there are a few members who felt this high
5 occupancy calculation change was substantive and
6 not technical in nature and were not supportive.
7 However, this was left for further discussion in
8 case the -- the Commission feels that way.

9 MR. FALAHEE: Thank you, Dr. Jain. I
10 forgot to say thank you when you first got up
11 because you've been doing this -- I think you must
12 have been in front of us 25 times. Exaggeration.
13 But thank you for your continued guidance and
14 leadership on anything having to do with Psych
15 Beds. We know it's critical, and you've been very,
16 very, very instrumental in moving this forward. So
17 thank you very much.

18 DR. SUBODH JAIN: Appreciate it.

19 MR. FALAHEE: I had one question. The
20 last one you talked about, this change in 8(3) --
21 and maybe I need to look at Beth as well. I don't
22 know where -- where you left it. Help me out.

23 MR. EASTER: I know Tulika was --

24 DR. SUBODH JAIN: I know we -- we left it
25 that it could require further discussion, but we

1 did not do any changes. Tulika, you had something
2 different?

3 MS. BHATTACHARYA: Hi. This is -- oh.
4 I'm sorry. This is Tulika from the Department. So
5 Chairman Falahee, are you asking the workgroup
6 approved this language or what's the Department's
7 rationale for the language?

8 MR. FALAHEE: All of the above.

9 MS. BHATTACHARYA: So on the workgroup
10 question, I would defer to Chairman -- Dr. Jain.
11 But as far as the Department's rationale, so when
12 you think about what is high occupancy and how the
13 current requirements are in the CON standards. So
14 let's say I'm a hospital. I applied and got
15 approval for high occupancy beds; let's say ten
16 beds. I have not yet made those operational and I
17 come back to the Department again. I'm still at
18 high occupancy. I discount the ten beds, so
19 therefore give me ten more beds. But I still have
20 -- because -- so if we don't take into account
21 approved but not yet operational beds, we are
22 missing a big part of the equation. And that's how
23 we have always done the calculation, because we
24 believe the -- if we leave out this explanation and
25 additional language, we believe the CON standards

1 tell us to do the calculation that way.

2 MR. FALAHEE: And -- and I understand
3 that. It sounds like a trick I would have tried.
4 But Walt Wheeler who was here -- I don't know if
5 he's here yet -- Walt would not have let me get
6 away with it. But I -- I like that potential
7 loophole in high occupancy. So thank you for
8 pointing that out.

9 DR. SUBODH JAIN: So the workgroup
10 recommended that we -- we go with the Department's
11 recommendation as such, but there were some
12 members. So I'd like to capture that sentiment as
13 well (indiscernible) on some members, but the
14 majority was with the Department.

15 MR. FALAHEE: Okay. Thanks, Dr. Jain.
16 Any -- any comments from the Department, then I'll
17 open it up to comments for the Commission. I was
18 trying to move stuff along, so I skipped the
19 Department preface. I'm sorry.

20 MR. EASTER: I was going to say I'll say
21 the part that I should have said before Dr. Jain
22 went up there. All recommended language in front
23 of the Commission reached a consensus from the
24 workgroup and we have not seen any public comments
25 from any organization.

1 MR. FALAHEE: Okay. Great. Questions
2 from the Commission? Do you have any cards then?

3 MR. EASTER: No.

4 MR. FALAHEE: Okay. So this is one of
5 those, Commissioner Grant, when sometimes there is
6 agreement and we can move it forward. But the
7 prior discussion was a great substantive discussion
8 of the work.

9 DR. MILEWSKI: This is Commissioner
10 Makenzie -- or Milewski. Sorry. And I will make a
11 motion to adopt the proposed language and the
12 recommendations of the workgroup and move forward
13 the language for public hearing as well as to the
14 JLC.

15 MR. FALAHEE: Is there support for that
16 motion?

17 DR. ENGELHARDT-KALBFLEISCH: Commissioner
18 Engelhardt-Kalbfleisch. Support.

19 MR. FALAHEE: Thank you very much. Any
20 discussion? All in favor please say "aye."

21 ALL: Aye.

22 MR. FALAHEE: Great. That motion
23 carries.

24 (Whereupon motion passed at 12:32
25 p.m.)

1 MR. FALAHEE: Dr. Jain, thank you once
2 again. Sorry your EV charger -- appreciate --
3 appreciate you being here.

4 DR. SUBODH JAIN: That's my -- that's --
5 that's my mismanagement, too. But I thank you,
6 Chairperson Falahee just, again, for your service
7 and for allowing me to participate and -- and learn
8 more about public policy, to advocate for mental
9 health, and what you are an advocate for behavioral
10 health in our state all along. So thank you very
11 much.

12 MR. FALAHEE: Great. Thank you very
13 much. Okay. Moving on. Next, Cardiac Cath. And
14 this time I will remember to go to the Department
15 first. So, Justin?

16 MR. EASTER: You still have me. At the
17 March Commission meeting, the Commissioners
18 proposed action on the SAC's language that is in
19 front of you today. The draft language was sent
20 out for public hearing and to the Joint Legislative
21 Committee. Testimony was received from eight
22 organizations in support of -- to support of the
23 SAC's language. Comments were in support of the
24 draft language with a non-technical amend- --
25 amendment to move coronary atherectomy to before

1 the exception list in section 2(s), definition of
2 elective PCI as you'll see up on the board, too.
3 And I'll pause for any questions or just for that
4 amendment.

5 MR. FALAHEE: And the -- the language,
6 and we've received several letters approving that
7 change in the language.

8 MR. EASTER: Correct.

9 MR. FALAHEE: So the Department's
10 recommending that go through as well; correct?

11 MR. EASTER: Yes.

12 MR. CONNOLLY: Yep.

13 MR. FALAHEE: Okay. All right. And the
14 Department would -- when you say the -- the
15 Department supports the language as presented, it
16 includes all of that --

17 MR. EASTER: Correct.

18 MR. FALAHEE: -- switch in language?

19 MR. EASTER: Yes.

20 MR. FALAHEE: All right. Thank you. Any
21 questions from the Commission members?

22 MR. EASTER: And then -- well, I'll -- an
23 additional comment was in support of the draft
24 language consideration include a UP PCI pilot
25 program to expand access concern about access to

1 PCI services in the UP, and their service is not
2 accruing. And the Department is supporting the
3 language as presented.

4 MR. FALAHEE: Any questions from Justin
5 about what he has presented to us?

6 DR. MILEWSKI: Commissioner Milewski. I
7 will propose that the Commission take final action
8 and move the language forward to the JLC and the
9 Governor for a 45-day review period.

10 MR. FALAHEE: Is there support for that
11 motion?

12 DR. ENGELHARDT-KALBFLEISCH: Commissioner
13 Engelhardt-Kalbfleisch. Support.

14 MR. FALAHEE: Thank you very much. Any
15 Commission discussion or questions? All in favor
16 of the motion please say "aye."

17 ALL: Aye.

18 MR. FALAHEE: Opposed? That motion
19 carries.

20 (Whereupon motion passed at 12:35
21 p.m.)

22 MR. FALAHEE: Justin, thank you very
23 much. Katherine, MRI. Turn it over to you,
24 please.

25 MS. TUCKER: At the March Commission

1 meeting, the Commission took proposed action on the
2 formal workgroup language that's -- that we select
3 here today. The draft language was sent out for a
4 public hearing and to the Joint Legislative
5 Committee. Testimony was received from three
6 organizations in total. One organization in
7 support of the workgroup's language. Therefore,
8 Henry Ford Health. A comment was submitted in
9 regards to costs pertaining to Interactive Magnetic
10 Resonance Imaging for Michigan Medicine. A comment
11 was submitted to consider and support recognition
12 of registered nurses as qualified person able to
13 monitor patient's adverse reactions during MRI
14 contrast-enhanced procedures and this was submitted
15 by Michigan Medicine.

16 Okay. The Commission has the option to
17 accept the language as presented today with
18 registered nurse struck out or accept the language
19 as presented at the March Commission meeting
20 regarding registered nurse being included as
21 qualified personnel. Now, if the -- if the
22 Commission chooses to take final action, the
23 language will be brought forward to the JLC and the
24 Governor for the 45-day review period. The 45-day
25 review period must include nine legislative session

1 days. If the language is not disapproved, it
2 becomes effective upon the expiration of the 45-day
3 period.

4 MR. FALAHEE: This is Falahee. Let me
5 ask a question. Remind me about the registered
6 nurse in or out issue, the language. Refresh my
7 memory on that.

8 MS. TUCKER: Okay. So there was a -- a
9 question whether a registered nurse should be
10 considered qualified personnel. The registered
11 nurse was not included as registered personnel as
12 far as the CMS guidelines were concerned, but they
13 were included in the ACR guidelines.

14 MR. FALAHEE: So there's a discrepancy
15 between CMS and nurse -- American College of
16 Radiology?

17 MS. TUCKER: Yes.

18 MR. FALAHEE: In -- in the hospital
19 world, CMS controls.

20 MS. TUCKER: Yes.

21 MR. FALAHEE: Does anyone in the hospital
22 world disagree with that?

23 MS. GUIDO-ALLEN: I was the one who
24 brought up the discrepancy and will not support
25 having the registered nurse listed as direct

1 supervisor -- supervision.

2 MS. STANTON: We have provided the draft
3 as well. That does exclude that being added. It's
4 highlighted.

5 MR. FALAHEE: Oh, it's out. Okay.

6 MS. STANTON: Yeah.

7 MS. GUIDO-ALLEN: Thank you.

8 MR. FALAHEE: All right. So -- so if we
9 approve the recommended language, that language is
10 in front of us with registered nurse taken out?

11 MS. STANTON: That is correct. And as
12 Katherine stated, the March 1 would include it.
13 Would have included. So if you are accepting the
14 language as presented today, then that's what that
15 removed. If you're accepting it how it presented
16 at March, would include it.

17 MR. FALAHEE: I think from what I'm
18 hearing, the intent of the group is to accept the
19 language in front of us on the screen with
20 "registered nurse" taken out.

21 MS. STANTON: Correct.

22 MR. CONNOLLY: Yes.

23 MR. FALAHEE: All right.

24 DR. MILEWSKI: Commissioner Milewski. I
25 will recommend that the Commission take final

1 action on the language as presented today with
2 "registered nurses" removed and that will move it
3 forward to the JLC and the Governor for the 45-day
4 review period.

5 MR. FALAHEE: Is there support for that
6 motion?

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

9 MR. FALAHEE: Thank you. And for
10 Commissioner Grant, the JLC is the Joint
11 Legislative Committee. Technically it goes to them
12 for review. I've spoken to legislators over the
13 years. They're not aware that there is a Joint
14 Legislative Committee nor -- nor are they aware
15 that they're on it. But we still have to submit it
16 to the State.

17 MS. GRANT: Understood.

18 MR. FALAHEE: So there's a motion on the
19 floor. All in favor of the motion please say
20 "aye."

21 ALL: Aye.

22 MR. FALAHEE: Thank you. That motion
23 carries.

24 (Whereupon motion passed at 12:40
25 p.m.)

1 MR. FALAHEE: Justin?

2 MR. EASTER: A couple public comments.

3 MR. FALAHEE: Oh, I'm sorry.

4 MR. EASTER: For MRI. Tracey Dietz,
5 Henry Ford?

6 MS. TRACEY DIETZ: Go ahead and -- I
7 withhold given the time taken and everything
8 going --

9 MR. FALAHEE: Okay. Thank you.

10 MR. EASTER: And then Glenn -- Glenn
11 Houck?

12 GLENN HOUCK

13 MR. GLENN HOUCK: Hello. My name is
14 Glenn and I'm from Michigan Medicine. I'm -- I'm
15 not an M.D. I'm a clinical operations for
16 radiology.

17 I would like to say that if the Committee
18 votes to exclude the nursing monitoring contrast
19 reactions following a based algorithm will
20 significantly impact our patient care. This is
21 currently already in practice that we have R.N.'s
22 on third shift at ambulatory sites monitoring
23 contrast reactions and then partnering with a
24 faculty that is not on site for contrast reaction
25 care. So I just wanted to bring our concerns up to

1 the Committee that that will limit our ability to
2 grow and expand our MR fleet to -- to impact
3 patient care as we have significant wait times
4 because we wouldn't technically then be able to
5 count those exams done during the time that we have
6 nurses towards our CON qualifications if I
7 understand correctly, which may be wrong.

8 MR. FALAHEE: Well, thank you. But so
9 this gets back to the registered nurse issue.
10 Commissioner Guido-Allen, I know she has something
11 to say.

12 MS. GUIDO-ALLEN: Guido-Allen. The
13 registered nurse per CMS, the federal registry does
14 not list an R.N. as being within their scope of
15 practice to be able to monitor patients as direct
16 supervision for MRIs with contrast. That is -- and
17 -- and my concern is if you're billing Medicaid and
18 Medicare for those studies, you're not following
19 that guideline.

20 MR. GLENN HOUCK: What is monitoring of
21 the patients? So they're monitoring for contrast
22 reaction.

23 MS. GUIDO-ALLEN: It's direct
24 supervision. Direct supervision. And if you give
25 me a minute, I'll pull up the verbiage of how it's

1 stated.

2 MR. FALAHEE: What -- yeah.

3 MR. GLENN HOUCK: So if it's just
4 supervision of the MRI itself --

5 MS. GUIDO-ALLEN: No; no; no. It's the
6 contrast.

7 MR. FALAHEE: It's the contrast.

8 MS. GUIDO-ALLEN: You can utilize APP's.

9 MR. GLENN HOUCK: Right.

10 MS. GUIDO-ALLEN: Just not a registered
11 nurse without a advanced degree.

12 MR. FALAHEE: Let's do this. Instead of
13 having Commissioner Guido-Allen pull up language
14 that's exceedingly hard to find, let's do this.
15 Let's leave -- we've already approved the motion.
16 Let's leave it as -- but hang on. You don't have
17 to leave the podium yet. Here's my thought. If --
18 if we find out that the language isn't as we think
19 it is, we can always come back and say, hey, guess
20 what? There's been a change. We can reconsider
21 that as a Commission.

22 MR. GLENN HOUCK: Okay. Thanks.

23 MR. FALAHEE: But that's my understanding
24 of the language as well. I dealt with it at
25 Bronson just a few months ago in terms of who can

1 supervise on a contrast.

2 MR. GLENN HOUCK: Okay.

3 MR. FALAHEE: Thank you.

4 MR. GLENN HOUCK: Thank you.

5 MS. GUIDO-ALLEN: It's right here. I'm
6 sorry. It is as of 5/28/85 -- '25, up-to-date for
7 CMS. Under direct supervision in -- in office
8 settings means that,

9 "A physician or other supervising
10 practitioner must be present in the office suite
11 and if you're in an ambulatory setting, that's the
12 suite and immediately available to furnish
13 assistance and direction throughout the performance
14 of the service. This does not mean that the
15 physician or other supervising practitioner must be
16 present in the room when the service is performed."

17 So it -- it does not include an R.N.
18 It's a physician or a provider, APP.

19 UNIDENTIFIED SPEAKER: He's good. Remove
20 it. You can do what you're doing and have remote
21 supervision. That's what she just said.

22 MR. FALAHEE: We'll leave the language as
23 is, our approval as is. Thank you for your
24 thoughts. Other public cards?

25 MR. EASTER: That's it for MR.

1 MR. FALAHEE: Thank you. So we've taken
2 final action on MR and we can move on to the next
3 agenda item? Okay. Great. And this one is
4 Tiffani's.

5 DR. MILEWSKI: All right. We'll make
6 this quick. So at the March Commission meeting,
7 the proposed action on the Litho standards. Draft
8 language was sent to a public hearing and Joint
9 Legislative Committee with no testimony received.
10 The Department is still supporting the language.
11 So the Commission chooses to take the language,
12 final action on the language, the language will be
13 forwarded to the JLC and Governor for the 45-day
14 review period with not less than nine legislative
15 session days.

16 MR. FALAHEE: And, Tiffani, any public
17 comment cards on this one?

18 MS. STANTON: (No audible response.)

19 MR. FALAHEE: Okay. Thank you. Any
20 Commission questions about what's in front of us on
21 this one? If not, I'll entertain a motion.

22 DR. MILEWSKI: Commissioner Milewski. I
23 would recommend that the Commission take final
24 action and move the language forward to the JLC and
25 the Governor for the 45-day review period.

1 MR. FALAHEE: Is there support for that
2 motion?

3 DR. ENGELHARDT-KALBFLEISCH: Commissioner
4 Engelhardt-Kalbfleisch. Support.

5 MR. FALAHEE: Thank you very much. Any
6 Commission discussion? All in favor of the motion
7 please say "aye."

8 ALL: Aye.

9 MR. FALAHEE: Opposed? That motion
10 carries.

11 (Whereupon motion passed at 12:46
12 p.m.)

13 MR. FALAHEE: Okay. Next item. Tiffani?

14 MS. STANTON: Yes. The election of
15 officers. So the commissioners will need to
16 nominate a vice chair. So Amy will take over as
17 chair as required by the bylaws. And then at the
18 September CON Commission meeting, we will hold our
19 annual election for chair and vice chair. Whoever
20 is nominated as vice chair today cannot partake in
21 the voting processes for that respective position.
22 And then following any discussion, the Commission
23 will need to take the motion, second, and a vote to
24 elect a vice chair.

25 MR. FALAHEE: Thank you. So thi- -- this

1 is all because, as -- as you might have known, this
2 is my last Commission meeting. And I apologize for
3 the interruptions, but thank you for them. I would
4 like to nominate Commissioner Guido-Allen to be the
5 vice chair. And she's been on the Commission for
6 at least 10 years, very knowledgeable even when it
7 comes to CMS regulations. So I would nominate
8 Commissioner Guido-Allen to be the vice chair. Is
9 there support for that motion?

10 MR. VELEZ: Commissioner Velez. I
11 support the nomination.

12 MR. FALAHEE: Thank you. Any discussion?
13 All in favor, please say "aye."

14 ALL: Aye.

15 MR. FALAHEE: With one abstention.

16 (Whereupon motion passed at 12:47
17 p.m.)

18 MR. FALAHEE: Congratulations.

19 MS. GUIDO-ALLEN: Thank you. Thanks,
20 all.

21 MR. FALAHEE: Legislative update.

22 MR. EASTER: Senate Bill 148 was
23 introduced on March 13th after that Commission
24 meeting -- one clar- -- I want to say it was after
25 the Commission meeting. The intent of those bills,

1 exemption for CT, PET and MRI services from
2 obtaining a Certificate of Need. This bill is in
3 Health Policy Committee in the Senate.

4 MR. FALAHEE: And I'll give a little bit
5 of color on that. This -- this is a bill that as
6 -- as Justin said, would exempt MRI, CT and PET
7 pretty much from CON. All you have to do under the
8 bill is submit a letter of intent, that's it,
9 without any formal approval by the Department or
10 this group if it's needed. And it hasn't been
11 intro- -- it's been introduced by Senator Santana.
12 It hasn't come forward yet into the Senate. And as
13 I am -- often do, I meet with legislators about CON
14 issues. I met with -- I still call him Senator
15 VanderWall because he was a senator for a long
16 time. But I met with now House Member VanderWall,
17 who shares the House Health Policy Committee. And
18 he and I go back many years. We've had many
19 discussions about the CON. And it hasn't even gone
20 to the House yet because it hasn't come out of the
21 Senate yet. It is not on his radar at all. His
22 big concern right now is Psych Beds and how can we
23 get psychiatrists, social workers, nurses, to go
24 into the psychiatric field? Because we have beds
25 that are open and unoccupied, but we don't have

1 people to staff those beds. So that's
2 Representative VanderWall's big issue right now.
3 But this is a potential challenge to CON and a
4 carveout from CON. So I think we as commissioners
5 and the Department need to watch it and be aware of
6 what happens to it. So that's where it's at right
7 now. Any questions?

8 Next, administrative update. I will turn
9 it over to Marcus.

10 MR. CONNOLLY: As of now, the
11 administrative updates, we started NICU in May with
12 two meetings in, and everything is going well. The
13 end of June, we will start our CT SAC. We have
14 everything in place. We just have to do the
15 orientation for the chairs. And in July, we'll
16 start the nursing home workgroup. So that's what
17 our -- that's what are on our agenda for the next
18 two months.

19 MR. FALAHEE: Thanks, Marcus. Tulika,
20 turn it over to you, please.

21 MS. BHATTACHARYA: Thank you. So the CON
22 program activity report and the compliance activity
23 reports are in your packet. For the sake of time,
24 it's been a long meeting, I'm not going to go over.
25 But we continue to process applications and issue

1 decisions on a timely basis. If you have any
2 questions, please, I'm happy to answer. Also, just
3 as a reminder, we are in the process of doing
4 statewide compliance review for PET scanner and
5 Open Heart Surgery Services this year. When we
6 have completed the work, we will bring back the
7 results to the Commission in the format of a
8 report.

9 MR. FALAHEE: Thanks, Tulika. Thanks
10 for, as always, a great job by the folks in the
11 Department there that handle the applications and
12 the approvals and many, many questions we pepper
13 you with. So thank you. Any questions of Tulika?
14 Turn it over to Mr. Hammaker for update.

15 MR. HAMMAKER: Carl Hammaker, Attorney
16 General's Office. Legal activity report is in your
17 packet. There's no ongoing litigation that
18 involves the Department, related CON, or the
19 Commission itself.

20 MR. FALAHEE: Thank you very much. Any
21 other public comment?

22 MS. STANTON: No; no.

23 MS. TUCKER: Yes, we -- yes.

24 MS. STANTON: Okay.

25 MS. TUCKER: We have -- we have one

1 public comment by Melissa Reitz.

2 MR. FALAHEE: I don't know if I want to
3 recognize Melissa.

4 MELISSA REITZ

5 MS. MELISSA REITZ: I couldn't not have a
6 public comment at your final meeting as chair.

7 Good afternoon. My name is Melissa Reitz. I'm
8 with McCall Hamilton. I promise to keep this under
9 three minutes.

10 I've had the pleasure of working with
11 Commissioner Falahee for over 25 years. I wanted
12 to take just a few minutes to give a special thank
13 you to you, Chip, for your many years of service to
14 the state of Michigan. During your tenure you have
15 helped usher through many meaningful changes in CON
16 policy, including high occupancy beds for
17 hospitals, primary and elective PCI in hospitals
18 without onsite open heart surgery, and numerous
19 other updates that have truly improved access to
20 high quality services across our state. You have
21 also been a tireless defender and advocate for CON
22 with the legislature. And I'd like to invite you
23 and everyone here to join us in celebrating you
24 with a little reception that we have planned out in
25 the vestibule immediately following the meeting.

1 Thank you so much for your service to our state.

2 (Applause.)

3 MR. FALAHEE: I was going to cut her off
4 early. Thank you. Melissa and I have worked
5 together on a lot of projects over the years.
6 Sometimes we disagree, but we disagree
7 professionally as recently as two days ago. So,
8 but, no, thank you for your kind words. I'll just
9 say it's been an honor and a privilege to do this.
10 I wouldn't do it if I didn't believe in CON because
11 it's a lot of work, but it's very valuable because
12 I think it provides the best care in Michigan. We
13 can talk about quality, access and cost, technical
14 changes, substantive changes, but what we're all
15 here for is what's best for the residents of the
16 state of Michigan. And that's what drives me and
17 still will drive me, because I may not be on the
18 Commission -- I've already had four people today
19 come up and say, "can I call you on Commission
20 issues" or "CON issues"? Sure. So happy to do
21 that.

22 But I want to thank Governors Granholm,
23 Snyder and Whitmer for appointing me to the
24 Commission going back to 2009. I did not throw my
25 hat in the ring. Tulika, you'll love this. And I

1 think -- I don't know if Walt's still here. Larry
2 Horvath got tired of me putting loopholes into his
3 way. He said, "you know, you'd be a great
4 Commission member."

5 So I thank you all for the opportunity to
6 serve. I thank you for putting up with me and my
7 questions and my cross-examination, but I do it all
8 for the best interest of the folks in Michigan.
9 Thanks to the commissioners, thanks to my friends
10 across the way in the Department. It's been a
11 great run. I really appreciate it. I'm leaving in
12 very -- with you in very good hands with
13 Commissioner Milewski and Commissioner Guido-Allen.
14 And I thank you very much for the opportunity. I
15 apologize for the interruptions today, but they
16 were a surprise to me, so thank you very much. I
17 appreciate it. And I'll be sure to get -- take
18 advantage of what's out there because I haven't
19 left this seat since 9:30 and I'm ready to do that.
20 But thank you all very, very much.

21 Let's go on to other exciting stuff like
22 the review of the Commission work plan.

23 MS. STANTON: No pressure. All right.
24 Keep it brief. Everything is the same as
25 previously pre- -- presented. As Marcus stated, we

1 started the NICU workgroup last month, starting CT
2 this month, and Nursing Home next month. So
3 everything's still on track so far. So there's no
4 changes as previously presented. But to continue
5 this, we would need a motion to accept as
6 presented.

7 MR. FALAHEE: So if you just heard
8 Tiffani, she -- subtle hint. We need a motion to
9 accept the Commission work plan. Is there a motion
10 to that effect?

11 DR. ENGELHARDT-KALBFLEISCH: Commissioner
12 Engelhardt-Kalbfleisch. Motion to accept the work
13 plan as presented.

14 MR. FALAHEE: Is there support?

15 DR. MILEWSKI: Support.

16 MR. FALAHEE: Any discussion? All in
17 favor please say "aye."

18 ALL: Aye.

19 MR. FALAHEE: Great.

20 (Whereupon motion passed at 12:56
21 p.m.)

22 MR. FALAHEE: Future meeting dates for
23 this year, September 18 and December 4. Anything
24 else to come before the Commission? I thank you
25 for sitting through substantive discussions. This

1 isn't the longest Commission meeting we've ever
2 had.

3 DR. MILEWSKI: Say, Chip, can I interrupt
4 you before you adjourn? Commissioner Milewski.
5 And I just wanted to express one last comment here.
6 I think I speak on behalf of all of the
7 commissioners in a hearty thank you. I have
8 learned so much from you from not even knowing how
9 to make a motion. I appreciate your confidence,
10 but it's not going to be the same around here
11 without you. You've entertained us and kept us
12 engaged, and I will do my best to fill your shoes,
13 but those are really big shoes. So thank you.

14 MR. FALAHEE: Thank you. Thank you very
15 much. With that, I entertain a motion to adjourn.

16 DR. ENGELHARDT-KALBFLEISCH: Engelhardt-K
17 albfleisch. Motion to adjourn.

18 MR. FALAHEE: Support?

19 DR. MILEWSKI: Support.

20 MR. FALAHEE: All in favor? ALL: Aye.

21 MR. FALAHEE: Thank you all very much.

22 (Proceedings adjourned at 12:57 p.m.)
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CERTIFICATE OF RECORDER

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

That this transcript, consisting of 173 pages, is a complete, true, and correct record of the meeting held on June 12, 2025.

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

IN WITNESS THEREOF, I have hereunto set my hand this 25th day of June 2025.

Marcy A. Klingshirn

Marcy Klingshirn, CER 6924
Notary Public, State of Michigan
County of Eaton
My Commission Expires: March 30, 2029