1 STATE OF MICHIGAN
2 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
3 CERTIFICATE OF NEED COMMISSION
4
COMMISSION MEETING
5
BEFORE SURESH MUKHERJI, M.D., VICE CHAIRPERSON
6
333 South Grand Townsend Street, Lansing, Michigan
7
Thursday, January 26, 2017, 9:30 a.m.
8
9 COMMITTEE MEMBERS: DENISE BROOKS-WILLIAMS
GAIL CLARKSON
10 JAMES FALAHEE, JR.
DEBRA GUIDO-ALLEN, R.N.
11 JESSICA KOCHIN
THOMAS MITTELBRUN III (via telephone)
12 JOSEPH POTCHEN
LUIS A. TOMATIS, M.D.
13
14 MICHIGAN DEPARTMENT OF
HEALTH AND HUMAN
15 SERVICES STAFF: TULIKA BHATTACHARYA
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1 Lansing, Michigan
2 Thursday, January 26, 2016 - 9:32 a.m.
3 DR. MUKHERJI: Welcome to the CON Commission
4 meeting. I'm filling in for Mark Keshishian. I'm not used
5 to people listening to me. I've got a wife and a teenage
6 daughter. So this is great. All right. I'm going to call
7 the meeting to order. Review of the agenda, I think this is
8 an action item, so everybody have any changes to the agenda?
9 MR. FALAHEE: This is Falahee. I'll move
10 acceptance of the agenda as we have in front of us.
11 MS. BROOKS-WILLIAMS: Brooks-William, second.
12 DR. MUKHERJI: We have a motion and a second. Any
13 discussions? No discussions. All in favor of the agenda?
14 Aye?
15 (All in favor)
16 DR. MUKHERJI: Anybody against? Okay. The agenda
17 passes. Next is declaration of conflict of interest. Any
18 relevant conflict of interest? Okay. Hearing none, we'll
19 go to the next is review of the minutes from the December
20 7th, 2016 meeting. We can just take a couple seconds to go
21 over the minutes.
22 MR. FALAHEE: This is Falahee again. I'll move
23 approval of the minutes.
24 MS. BROOKS-WILLIAMS: Brooks-Williams, second.
25 DR. MUKHERJI: We have a motion and a second. And

1 any discussion? No discussion. All in favor?
2 (All in favor)
3 DR. MUKHERJI: Anybody against? All right. The
4 minutes pass. Thank you very much. So the -- this is a --
5 if you will, we always refer to this as a special committee
6 meeting. We're going to take a look at various topics that
7 have surfaced over the next year and come up with a roadmap,
8 if you will, to determine whether these topics should be
9 handled directly by the Department or whether we feel they
10 should best be handled by a work group or potentially a SAC.
11 So the first topic is PET imaging, and I'll turn it over to
12 Elizabeth who's filling in for Brenda.
13 MS. NAGEL: Good morning. Number five on the
14 agenda is the Positron Emission Tomography Scanner Services.
15 As you know, every service by -- by law every service needs
16 to be reviewed every three years. This year there are six
17 on the docket for this agenda. Six standards were put out
18 for public comment, October 7th through October 21. The
19 Department collected those comments and summarized them for
20 you in your packet. Of the six organizations that provided
21 comments for PET Scanner Services, no issues were
22 identified. The Department didn't identify any issues
23 either. The Department recommends that PET Scanner Services
24 should continue to be regulated and there are no changes
25 this time. The next review would be in 2020.

1 DR. MUKHERJI: Okay. So what we're discussing
2 here is that the Department is -- no substantial public
3 comments and the Department is recommending no review
4 necessary and the next discussion will be in 2020.
5 Commission discussion on this or a motion to approve the
6 Department's recommendation?
7 MS. BROOKS-WILLIAMS: This is Commissioner
8 Brooks-Williams --
9 DR. MUKHERJI: Oh, is there a public -- I'm sorry.
10 Any public comment? I didn't get any cards. I'm sorry
11 about that.
12 MS. BROOKS-WILLIAMS: That's okay.
13 DR. MUKHERJI: Yeah, no public comment.
14 MS. BROOKS-WILLIAMS: Okay. Commissioner
15 Brooks-Williams. I move that we accept the Department's
16 recommendation.
17 MS. KOCHIN: Commissioner Kochin, second.
18 DR. MUKHERJI: So we have a motion and a second.
19 Any discussion? No discussion. All in favor?
20 (All in favor)
21 DR. MUKHERJI: Anybody against? Okay. Motion
22 passes. So the Department will handle that; correct?
23 MS. NAGEL: Uh-huh (affirmative).
24 DR. MUKHERJI: Okay. Great. The second one is
25 Surgical Services. Elizabeth?

1 MS. NAGEL: Surgical Services again held a public
2 comment period October 7th through October 21st of last
3 year. There were six organizations that provided comment.
4 Of those, two issues were identified. One -- the first
5 one -- and they're all summarized in your packet. The first
6 one was to review quality, cost and patient experience for
7 improvement as well as assign relative weights for each.
8 The Department is not recommending substantive review for
9 this item that was identified as there was a recent SAC that
10 did that in the last go-around two years ago and those were
11 included in the standards. The second issue was actually
12 identified by the Department. We are -- hang on. I'm on
13 the -- sorry, but I am a poor Brenda. I apologize. Brenda
14 would have caught that awhile ago. I was doing Open Heart
15 Surgery. I apologize.
16 There were four organizations that provided
17 feedback on Surgical Services. The Department is not
18 recommending substantive review of any of those three issues
19 that were identified. The first one is in Section 6,
20 Requirements for Expansion. The Department does not believe
21 that any substantive review is necessary. The second one
22 was a requirement for ambulatory surgical centers to
23 participate in a nationally recognized, nonprofit
24 organization. And again the Department does not recommend
25 any substantive review for that issue, and then we are not

1 aware of any -- we are aware of a typographical edit that
2 the Department will draft language and bring back to the
3 Commission at a later date. The Department is recommending
4 that Surgical Services should continue to be regulated by
5 Certificate of Need and that this standard should be
6 delegated to the Department to make a recommendation
7 regarding the typographical error we've identified.
8 DR. MUKHERJI: Okay. We do have public comment
9 for this. So the first person would be Steve Szelag from
10 University of Michigan.
11 STEVE SZELAG
12 MR. SZELAG: Good morning. My name is Steven
13 Szelag. I'm here to represent the leadership of the
14 University of Michigan Health System following up on the
15 interest to explore the potential modernization of the
16 standards regarding hospital-based and freestanding surgical
17 sites.
18 Health care delivery has evolved significantly
19 since Michigan CON was first enacted in 1972. Forty-five
20 years ago site-specific regulations were appropriate as most
21 acute care hospitals in the state were single site for all
22 surgical services, inpatient and ambulatory. However, there
23 has been a major shift in the structural model of health
24 care including location, a paradigm shift which now requires
25 new alignment between CON and health cares provided within

1 and across the system.
2 Over the years this shift has revealed that only a
3 few hospitals today remain independent. Health care
4 providers remain located -- health care providers located
5 only at one site. The vast majority have diversified their
6 portfolio by organic growth at a freestanding ambulatory
7 surgery center in local communities or via consolidation
8 with other providers.
9 We see three issues with the current standards.
10 First the standards and process to initiate a new site are
11 burdensome and don't reflect the routine advancement of
12 technology to enable quality effort of care and a lower cost
13 environment. The aim for integration across a continuum is
14 not reflected in the current standards which commingle
15 hospital services with qualification to initiate a new site.
16 We propose a system view to increase the flexibility and
17 deployment of operating rooms within prescribed criteria to
18 provide proper controls, but ease the process by which the
19 system expands. We propose relaxing the administrative
20 requirements that include obtaining pledges of activity
21 within a system to initiate a new, freestanding ambulatory
22 site for the system. Under the current CON standards, an
23 applicant who proposes to initiate a new freestanding
24 surgical site is required to demonstrate need by obtaining
25 over 1100 signed surgical case commitments per each OR

1 planned. Under the current structure when applications are
2 approved, preexisting, qualifying activity is deducted from
3 the hospital-based site which is already of record. We see
4 an opportunity to ease the administrative burden redundancy
5 in costs by relying upon the qualifying OR activity volume
6 already of record and eliminating the laborious surgical
7 commitment form process.
8 For example, the U of M qualifies for
9 approximately 11 incremental hospital-based OR's to expand
10 our service to other appropriate sites and to respond to
11 patient demand. The standards require us to go through a
12 pledging process even though the historical data already
13 indicates we have the volume by which to grow and meet
14 patient needs. If we sought to expand our existing hospital
15 site, there is no requirement for pledges but rather relying
16 upon activity of record. We think that within a proper
17 framework relying upon activity across the system as a basis
18 for future growth makes sense in alliance with today's
19 health care model.
20 A second issue or concern is uncontrolled
21 proliferation. Health care systems today are geographically
22 diverse throughout multi-county areas. The current
23 standards allow for some geographic planning flexibility for
24 providers under Section 5. This section permits the
25 relocation of an existing surgical services; all of ours are

1 within a ten-mile radius.

2 DR. MUKHERJI: Oh, okay. Go ahead. Sorry.

3 MR. SZELAG: Lastly, U of M recognizes the

4 concerns of how to define a system. Sites that operate

5 under the same provider number or formerly integrated under

6 a system consolidation, you know, could be an option for

7 defining what a system is. We don't suggest we have the

8 answer, but this might be something appropriate for a work

9 group or an advisory committee to study further. Thanks for

10 giving me the opportunity to make the comments.

11 DR. MUKHERJI: Thanks, Steve. Questions?

12 MR. FALAHEE: This is Falahee. Steve and I, other

13 representative of U of M, talked about the first issue which

14 is the commitments you need to get if you're going to put up

15 a new surgical candidate. And here's the example, i.e.,

16 we're in the middle of it now. If you want -- you have the

17 requisite volume in your hospital but you want to build an

18 ambulatory surgery facility, because many of the cases could

19 be done in an ambulatory setting and, if you want to build

20 it a block away, you have to get commitment letters from the

21 surgeons to justify or project the necessary volume. If,

22 however, you could build it and connect it via a tunnel or a

23 bridge, you don't need those commitment letters, because

24 there's a physical connection. And if I understood what

25 Steve was saying and others were saying, is it seems a

1 little bit burdensome to say to a hospital, "You've got the
2 requisite volume already. You want to build ORs somewhere
3 else close by, but now you need to do commitment letters."
4 Is that the gist of it, Steve?
5 MR. SZELAG: Yeah; yeah; yeah. So we're looking
6 for some planning flexibility, you know, for organizations,
7 you know, such as U of M or other larger system
8 organizations where it's easier to deploy assets. But like
9 the example you just gave, you qualify at your hospital to
10 expand, but you have to go through the commitment process to
11 place those ORs in a more appropriate location. So we're
12 looking for some modernization of the standards, you know,
13 that would allow for us to deploy these assets to a more
14 appropriate, lower cost environment to meet patient care
15 needs and to provide better access.
16 MR. FALAHEE: Steve, would you envision a mild
17 restriction on that? So, let's say, for example, University
18 of Michigan in Ann Arbor has -- if I've heard you
19 correctly -- enough volume for 11 additional operating
20 rooms.
21 MR. SZELAG: Yes.
22 MR. FALAHEE: You're not saying that you could
23 move those to Grand Rapids because you own a hospital in
24 Grand Rapids?
25 MR. SZELAG: No. I wouldn't suggest that. And I

1 think we would want to keep some type of mile radius in
2 place. What exactly that mile radius is, I'm not sure. But
3 I think -- as part of the controls for proliferation and to
4 moving, you know, into totally new, you know, market areas,
5 I think there needs to be some controls in place. But I
6 think allowing for some type or more flexibility in the
7 standards, you know, would be appropriate to study.
8 MR. POTCHEN: This is Joe. CONs are site-specific
9 and I think what you are asking for is a definition of what
10 the site entails, I mean, whether it entails exactly what
11 you're talking about. So that would be that kind of
12 analysis as to how broad or how narrow that site is defined.
13 DR. TOMATIS: Commissioner Tomatis. Didn't we
14 discuss that one or two years ago when Henry Ford asked for
15 the same thing just across the street?
16 MR. FALAHEE: We discussed that, and we added
17 language, if I recall correctly, that said, if you're
18 putting up a facility directly across the street, --
19 DR. TOMATIS: Yeah, that was the request at the
20 time.
21 MR. FALAHEE: -- (inaudible).
22 DR. MUKHERJI: So just a couple questions
23 regarding a system. So two questions, Steve. Given the
24 fact that systems now have equity ownerships of hospitals
25 all through the state as Joe was saying, I think, if we do

1 head in this direction, there has to be clear language. So
2 a system that owns a hospital in a different part of the
3 state as a footprint to try to gain more market share, they
4 just -- well, they can or can't. The language needs to be
5 determined whether it's appropriate for them to be able to
6 open a surgical center adjacent to a 20 percent ownership --
7 equity ownership of the facility. I think that's one of the
8 concerns I'm sure all systems have. So I don't know if
9 that's a comment or a question or if you have a response to
10 that?
11 MR. SZELAG: I'm not sure I have a response at
12 this time but, you know, we could --
13 DR. MUKHERJI: Discuss it in a different format?
14 Okay. The other question I have is, my understanding is how
15 this evolved was, if you're a non-hospital based surgeons,
16 there are some surgeons that have tried to open up
17 ambulatory care centers or some systems that are not
18 hospital-based and, if some type of proviso was created for
19 hospitals to be able to not ask for commitments from their
20 physicians to open an ambulatory care center within a given
21 radius, is there a potential unintended consequence of
22 disenfranchising those other non-hospital-based group
23 practices to open their own surgical center? Have we
24 shifted the balance?
25 MR. SZELAG: Well, I think we want to keep the

1 current language in place for the non-hospital-based
2 providers that you just used an example, but I think we want
3 to add language, you know, specific to systems, because I
4 think the initiation language is appropriate for certain
5 circumstances. But -- you know, but we would be looking,
6 you know, for the system language, you know, in addition to
7 what's currently in place.
8 MR. FALAHEE: This is Falahee. May I ask a
9 question of Beth, I guess? Beth, is this something the
10 Department would be willing to look at in terms of the
11 site-specific, the definition of site- -- I forget how it's
12 worded. Is this something the Department would be willing
13 to consider or don't have enough time for it right now?
14 MS. NAGEL: Well, that's never been proposed as an
15 option before. We would ask our Assistant Attorney General
16 Joe Potchen to look into that for us and to make a
17 recommendation.
18 MR. POTCHEN: Yeah. One of the things is that you
19 have the statutory restrictions and limitations in view of
20 the modern business and how hospitals do their jobs. So
21 it's a -- we would attempt to have it fit and comply. Again
22 we have those statutory requirements that we got to look
23 into. So, yes, we'd be able to assist the Department in
24 coming up with a response.
25 MR. FALAHEE: I think it would -- that would be

1 good to do, because this isn't an issue that just a
2 University of Michigan or a Bronson's going to have. As
3 more and more surgeries move to outpatient, you're going to
4 see an attempt, I think, for hospitals to try to put it in a
5 setting that's more accessible, cheaper and in and out
6 faster. And if you cannot over proliferate but at the same
7 time save commitment letters which are a pain to get when
8 you don't need them, I think that'd be a good solution to
9 look at.
10 DR. MUKHERJI: Other questions for Steve? All
11 right. Thanks, Steve.
12 MR. SZELAG: Thank you.
13 DR. MUKHERJI: The next public comment is from
14 David Walker from Spectrum Health.
15 MR. POTCHEN: Just so we get some closure here in
16 the next steps for this that, if you could submit something
17 to the Department and then they will submit it and then
18 they'll submit it to me for a response, but --
19 MR. FALAHEE: So that proposed language --
20 MS. NAGEL: The Commission would need to direct
21 the Department to ask -- as part of your action, you would
22 ask for it to come back at a future meeting.
23 MR. POTCHEN: So I guess, yeah, we need --
24 MR. FALAHEE: This is Falahee. I'm going to put
25 it in a parking lot until we hear the rest of the public

1 comments and then go from there.

2 MR. POTCHEN: Perfect.

3 DAVID WALKER

4 MR. WALKER: Good morning. I am David Walker with

5 Spectrum Health. Thank you very much for the opportunity to

6 provide comment on the Surgical Services CON Review

7 Standards.

8 Spectrum Health strongly supports continued

9 regulation of Surgical Services without any changes. We

10 specifically would be opposed to any changes related to

11 volume requirements and the relocation zones for OR

12 replacements. We agree with the Department here on their

13 recommendation to review this issue.

14 It is our belief that volume requirements in the

15 standards and the Department's interpretation of these

16 requirements accurately reflect the demonstration of need

17 required to initiate, expand or replace a surgical service.

18 If volume requirements were weakened, we would be concerned

19 that some services would initiate or expand and be unable to

20 meet maintenance volumes, which could result in expending

21 resources in health care that end up not being needed.

22 Using projection requirements, expansion

23 requirements as an example, there is a big difference

24 between a facility generating 1216 cases, which is required

25 for an expansion, and 2,084 cases, which would be expansion

1 plus maintenance, unlike in MRI where there is a relatively
2 small difference between the 11,000 expansion volume and the
3 12,000 minimum volume when you go from 1 MRI to 2. If you
4 just let every OR that reaches 1216 cases expand without
5 requiring them to show where the additional 868 cases will
6 come from, there is a much higher chance that they will not
7 succeed in meeting minimum volumes.
8 With regards to relocation zones for OR
9 replacements, the current 10-mile metropolitan and 20-mile
10 rural/micropolitan (sic) zones are effective in controlling
11 costs and preventing facilities from opening where no need
12 exists. Similar to reducing volume requirements, changing
13 relocation zones may result in expending resources in health
14 care that end up not being needed.
15 Thank you very much for your time for letting me
16 provide comments on these standards.
17 DR. MUKHERJI: Any questions? Thank you very
18 much.
19 MR. WALKER: Thank you.
20 DR. MUKHERJI: So I received those two public
21 comment cards. Is there anybody else that would like to
22 give public comment on this topic? Okay. Hearing none, I
23 think we have a Commission discussion.
24 MR. FALAHEE: This is Falahee. I guess I'll make
25 this in the form of a motion with a preamble ahead of it.

1 All right. Given the comments we heard from University of
2 Michigan, I think that we as a Commission would like -- I
3 propose that we, the Commission, ask the Department with the
4 necessary assistance of the Assistant Attorney General, if
5 needed, to look at the definition of a site as it's defined
6 in statute or in the standards to determine whether the
7 definition of site could be expanded to allow surgical
8 facilities to be constructed on a site without the necessity
9 for commitment letters when the hospital facility already
10 has the requisite volume to justify the operating rooms that
11 want to be constructed.
12 DR. TOMATIS: Commissioner Tomatis. Should we
13 then to clarify the definition or suggest would we want to
14 be the definition? Because if they come and said, "Well,
15 the definition is what it is," then will we go? Would we --
16 do we want to propose a mile, whatever it is or limited on a
17 need? What -- shouldn't we suggest what we want them to
18 study and answer us?
19 MR. FALAHEE: In my mind I'm not asking to look at
20 changing anything regarding volume requirements, not
21 changing anything regarding the relocation zone either,
22 whether it's 10 miles or 20 miles, metropolitan versus
23 rural. It's more enabling a facility to construct
24 additional ORs when the facility already has the requisite
25 volume for those ORs but just doesn't want to put them in

1 the actual hospital facility and wants to construct an
2 ambulatory facility -- actually I say "ambulatory," some say
3 freestanding surgical outpatient facility instead. I'm very
4 conscious of proliferation. I'm very conscious of, "Okay.
5 I've got the volume here and I'm going to move it 150 miles
6 away and put a surgery site there." That's why I'm not
7 going to talk about -- or I don't want to talk about
8 changing volume requirements or changing relocation zone or
9 trying not to limit it to that specific issue about what a
10 site should look like and, if there's any room to expand the
11 definition of site, keeping in mind the volume requirements
12 and the current relocation requirements.
13 MR. POTCHEN: This is Joe. One of the things that
14 I envision as we get further into the legal research here is
15 that we may need to go to you for clarity and clarification
16 of the question to make sure it's answering exactly what you
17 want, that you'd be okay with that.
18 MR. FALAHEE: Probably because I wasn't clear in
19 what I just said?
20 MR. POTCHEN: No; no. And actually you were very
21 clear, but I just envision and I see how things sometimes
22 when you start going into it -- like they might have a twist
23 or turn here that we don't anticipate that we would -- I
24 mean, if it's okay with the Board, we would contact
25 Commissioner Falahee to provide some clarification.

1 DR. TOMATIS: Commissioner Tomatis. I agree with
2 you, but I think that, if we keep the volume requirement,
3 we'll eliminate many of these other problem of
4 proliferation. We should just make the volume requirement
5 more strict than try what it will be in two or three years,
6 and that would control the --
7 MS. BROOKS-WILLIAMS: Do we have a second for the
8 mo- -- like are we in discussion yet or are we still
9 forming --
10 MR. FALAHEE: We don't have a second.
11 MS. BROOKS-WILLIAMS: -- Commissioner Falahee's
12 motion?
13 DR. MUKHERJI: I think -- was that a discussion?
14 I don't know if that was a motion or a discussion.
15 MR. FALAHEE: It was both.
16 DR. MUKHERJI: I don't know if we can do that.
17 Let's have a discussion first, and then you can make the
18 motion then.
19 MR. FALAHEE: Okay.
20 DR. MUKHERJI: Is that fair?
21 MR. FALAHEE: Okay. That's fine.
22 DR. MUKHERJI: All right.
23 MS. BROOKS-WILLIAMS: Okay. I think that the
24 question I was going to ask -- this is Commissioner
25 Brooks-Williams -- was, are we maybe broader than we need to

1 be? Is really distance is the issue? And I don't know,
2 Joe, how to frame it. I think we want to ask you to do
3 something, but --
4 MR. POTCHEN: Right.
5 MS. BROOKS-WILLIAMS: -- keep the scope very
6 narrow so that we're not making it broader than it needs to
7 be, if that makes sense?
8 MR. POTCHEN: What's very nice is that we have a
9 transcript of exactly what we're going to be -- what the
10 request is. And my ears heard that it was very clear and
11 narrow, but I want to verify that.
12 MR. FALAHEE: And when we look at it, we all go,
13 "You've got to be kidding." We can narrow it down.
14 MS. BHATTACHARYA: If I can ask a question? And
15 also to Steve if you want to jump in. So just trying to
16 understand the issue and the request. Is that issue so much
17 about those ORs at the ambulatory center to be considered
18 part of your hospital license and site, question number one,
19 or that issue is more you're okay with that being, you know,
20 an ambulatory center and freestanding surgical outpatient
21 facility, because it's a different type of license inpatient
22 hospital versus outpatient ORs. So is it okay for that
23 facility to have a distinct and separate license as it
24 should be, but you're just asking the Department to relax
25 the methodology or the process of commitment? Because then

1 throughout the years whenever we get into the discussion of
2 site, it gets very complicated and we don't achieve or
3 resolve the actual issue. So I just -- could you clarify
4 that, please?
5 MR. FALAHEE: I'll give you my opinion and then
6 Steve --
7 MS. BHATTACHARYA: Steve can --
8 MR. FALAHEE: -- it's number two.
9 MS. BHATTACHARYA: Okay.
10 MR. FALAHEE: Don't mind it at all being
11 considered outpatient, and that helps in terms of
12 construction costs, everything, because you're not building
13 it as a hospital. All right. But it's more the burden of
14 getting the commitment letters for that outpatient surgery
15 facility.
16 MR. POTCHEN: That does help. Did you agree,
17 Steve?
18 MS. BHATTACHARYA: Did Steve have a comment?
19 MR. SZELAG: Yeah. I would agree. I would think
20 this is, you know, akin to, like, an expand -- the ability
21 to expand and relocate, you know, to a new site, and we have
22 to determine what that distance is for the relocation.
23 MS. BHATTACHARYA: So the question is -- this is
24 Tulika -- can a hospital expand the number of ORs based on
25 their own utilization volume and construct those ORs at a

1 geographically different ambulatory center where the
2 licensees are the same? That's a much simpler question to
3 answer for the Department than getting to the issue of site.
4 MR. FALAHEE: Oh, okay. All right. Whatever
5 makes it easy for the Department.
6 MS. BHATTACHARYA: And that, I believe, can
7 achieve through some changes in the methodology and the
8 standards, yeah, without bugging Joe or -- not that we were
9 meant to do it, but --
10 DR. MUKHERJI: So this is Mukherji. I think -- I
11 think what we're sort of dancing around the issue is
12 something the Commission has always at some point will have
13 to tackle and what's the definition of quote, unquote, "a
14 system"? Because to me different sites are not part of the
15 system and when CON was first developed 35 years ago, there
16 was a hospital and then all these things were based on how,
17 what's a proximity? It's these various satellite health
18 care facilities could be built in proximity of a
19 freestanding hospital. Now we have larger hospitals and now
20 we have equity ownerships throughout the state. And I think
21 part of the guardrails that are in place of getting surgical
22 surgeons' commitments are to prevent a system that is now
23 purchased different equity ownerships and there's really no
24 definition of what a substantial equity ownership is in
25 different parts of the systems. If surgical commitments are

1 not obtained, then one could reasonably say, "Well, we have
2 an aggregate in our system, enough surgeons to demonstrate
3 volumes, and we're just going to put this in a satellite
4 area." That's the way I interpret this. And I may be wrong
5 on this, but I think at some point we have to grapple with
6 the issue of what's a site and what's a system and where
7 these health care facilities can be deployed.
8 MR. FALAHEE: Yeah. This is Falahee. I totally
9 agree, and that's why I asked Steve the hypothetical. If
10 you've got the volume in Ann Arbor but you own a facility in
11 Grand Rapids, can you move the 11 ORs to Grand Rapids?
12 DR. MUKHERJI: That's site consistent.
13 MR. FALAHEE: Right. And you know the answer is
14 no, and that's why I think the relocation zone is still an
15 issue.
16 And then, Tulika, I think a variation of what you
17 just said is, if a hospital is, say, qualified -- pick a
18 number that I can easily divide by -- 20 beds -- all
19 right -- but you want to take and put up an ambulatory
20 facility nearby of eight -- all right -- can you put the
21 eight there without commitment letters and keep 12 at the
22 hospital? So your overall number does not change. You
23 follow me? You leave 12 in the hospital, move eight to the
24 outpatient ambulatory facility. To do that now, you'd still
25 need commitment letters.

1 MS. BHATTACHARYA: Just one clarification. You
2 meant OR not beds.
3 MR. FALAHEE: Sorry. I made a mistake.
4 MS. BHATTACHARYA: So nothing in the methodology
5 would change because right now, if you are to collect
6 commitments from physicians, it has to be within a ten-mile
7 radius of the new --
8 MS. NAGEL: 20.
9 MS. BHATTACHARYA: -- 20? Okay. Thanks. So
10 20-mile radius of the new facility. So if it is 150 miles
11 away, one of the hospitals in your system, it cannot grab
12 that volume to initiate an ambulatory center here. It has
13 to remain within that 20 mile-radius, number one. We are
14 not changing that. Number two, CON is site-specific. CON
15 is also specific to that applicant and the licensee. Even
16 when we talk about a system, system is not defined and all
17 of the entities part of the system carries their own
18 corporate ID numbers, tax ID employer numbers, employer ID
19 employers and license numbers. They may have an umbrella
20 parent corporation. But for CON and licensing purposes,
21 they're all individually licensed. And that is also not
22 changing. What we -- what I believe you are proposing is
23 just to not have to collect individual physician commitment
24 to come up to that maybe 2,000 cases to initiate the service
25 here. So you will still be within 10-mile -- 20-mile radius

1 and has to be the same licensee who will run the ambulatory
2 center.
3 MR. FALAHEE: Right.
4 DR. MUKHERJI: Any other discussion? So I need to
5 ask Elizabeth, because the actual role of this agenda item
6 is to determine whether the Department handles it, whether
7 we have a work group or whether we have a SAC. So we have a
8 different suggestion on the table. So what are your
9 recommendations on a path forward?
10 MS. NAGEL: Thanks to the clarification in the
11 last couple minutes of discussion. We think the Department
12 can draft some language and bring it back to the Commission
13 to be able to fix the bill or, you know, what further
14 modifications need to be made.
15 MR. FALAHEE: And at that point, we can vote it up
16 or down.
17 DR. MUKHERJI: So we're okay with that's --
18 essentially are we saying the Department will then handle
19 the language?
20 MS. NAGEL: Yes. We can draft language and bring
21 it back to a subsequent meeting.
22 DR. MUKHERJI: So any other discussion, or should
23 we open for -- now I'm open for a motion.
24 MR. FALAHEE: Don't think we need one.
25 DR. MUKHERJI: We don't need what -- okay. We do

1 need it.
2 MR. FALAHEE: Well, I guess move to approve the
3 Depart- -- well, yeah. I'll make -- this is Falahee -- make
4 a motion to approve the Department recommendation as
5 presented, which is to make some technical edits that would
6 then be brought back to us, and then secondly that the
7 Department would bring back some proposed changes to the
8 language regarding the volume and the commitment letters and
9 bring that language back to us as well. And that would be
10 my motion.
11 DR. MUKHERJI: You okay with that?
12 MR. POTCHEN: Uh-huh (affirmative).
13 DR. MUKHERJI: Second?
14 MS. CLARKSON: Second, this is Commission
15 Clarkson.
16 DR. MUKHERJI: Okay. We have a motion and a
17 second. Any further discussion on this motion? All in
18 favor?
19 (All in favor)
20 DR. MUKHERJI: Anyone against? All right. Motion
21 passes. Thank you. The next agenda item is Open Heart
22 Surgery. Elizabeth?
23 MS. NAGEL: Okay. Open Heart Surgery, a public
24 comment period was held in October. The Department received
25 six pieces of testimony. They are summarized in your

1 packet. Two issues were identified. The first is actually
2 a -- you can reference input number four from the DMC Heart
3 Hospital and Cardiovascular Institute gave some lengthy
4 recommendations. The Department believes that these were
5 actually discussed and addressed at the most recent Standard
6 Advisory Committee that updated these standards last.
7 The second is to -- a requirement that -- or a
8 issue that was identified by the Department, and this is to
9 consider adding requirements for placing an existing open
10 heart service from one existing license site to another.
11 Currently that can only be done as part of a full hospital
12 replacement, but we have been going through the standards.
13 The Department has to add this language in to some of the
14 other services, and so we are recommending -- or the
15 Department can draft language and bring that back to the
16 Commission for their consideration at a subsequent meeting.
17 So with that, the Department's recommendation is
18 that the Department should draft language, bring it back to
19 the Commission, and the Commission should continue to
20 regulate Open Heart Surgery Services.
21 DR. MUKHERJI: Thank you. Public comment? We
22 have one card. David Walker.
23 MR. WALKER: Bad handwriting. I apologize.
24 DR. MUKHERJI: Man, you should be a physician.
25 He's from Spectrum, from Ohio State University. No, Open

1 Heart Surgery. Sorry.

2 DAVID WALKER

3 MR. WALKER: Hi. Good morning. David Walker
4 again, Spectrum Health to discuss Heart Surgery Services.
5 Thank you very much for the opportunity to provide comment.
6 Spectrum Health has some concerns with the
7 Department's recommendation to add the requirements for
8 replacing existing OHS service from one licensed hospital to
9 another existing hospital. Making this change of this
10 nature seems to me to be a little bit more than technical as
11 there's not actually a ready replacement section in these
12 standards. And I believe that it deserves more deliberation
13 and consideration than simply bringing back draft language.
14 In addition, there are a lot of concerns that should be made
15 in regards to the parameters around such a replacement. We
16 believe the implication and parameters should be carefully
17 determined and thoroughly considered before we decide if
18 this is a change we want to make. And we believe this would
19 be more appropriate for a work group or SAC.
20 Thank you very much for the opportunity to provide
21 comments.
22 DR. MUKHERJI: So what would be your
23 recommendations for a path forward on this?
24 MR. WALKER: Well, I would recommend that, you
25 know, we review this within a SAC or in a work group where

1 we can bring some medical experts together to determine if
2 this is the best path forward with replacement. You know,
3 I'm not a medical expert, so I would hate to get up here and
4 think -- you know, mislead you on what I think is medically
5 necessary and whatnot. So I think that's what -- we make a
6 SAC or advisory, a work group to bring the medical experts
7 to the table.
8 DR. MUKHERJI: Thank you.
9 MR. FALAHEE: Maybe a question directed to you,
10 David, and to -- or the Department. So what's the issue
11 here? We've got -- as I understand it, we have an existing
12 Open Heart Service in place that wants to be either -- that
13 wants to be replaced. So it's already in existence; it
14 wants to be replaced. Right now it's got to be a brand new
15 hospital project for that to happen. And at least the
16 Department is saying we need to look at that and perhaps
17 craft some language that would allow a replacement albeit
18 not in a brand new hospital; right?
19 MS. NAGEL: Right.
20 MR. FALAHEE: And, David, you've got issues with
21 that?
22 MR. WALKER: Yeah. I just think that again there
23 isn't already a replacement requirement. This seems to be a
24 policy change as opposed to a technical edit. So it's not
25 necessarily I'm opposed to putting in a replacement. I'm

1 more opposed to just drafting technical language to bring
2 back for consideration. Again I think that this should be
3 something that should be considered either in a work group
4 or a standard advisory committee.
5 MS. NAGEL: If I could clarify? We're not
6 proposing this as a technical edit, just that the Department
7 could draft the language. We were assuming that it would go
8 through the regular public hearing process with experts
9 weighing in along the way.
10 DR. MUKHERJI: Are you okay with that?
11 MR. WALKER: Again I think that the best approach
12 would be a standard advisory committee or a work group.
13 DR. MUKHERJI: Fair enough. Other comments for
14 David? All right. Thank you.
15 MR. WALKER: Thank you.
16 DR. MUKHERJI: The next is -- good writing --
17 Barbara Bressack from Henry Ford Health Care System. I can
18 read that.
19 BARBARA BRESSACK
20 MS. BRESSACK: Good morning. I'm Barbara Bressack
21 from Henry Ford Health System. Henry Ford submitted
22 comments in the fall regarding that we supported the
23 continued regulation of Open Heart Surgery standards and
24 didn't recommend any changes at that time.
25 In trying not to be too redundant as to the

1 previous public comment, Henry Ford also would like to make
2 a recommendation that the proposed change by the Department
3 first be vetted by a work group or a standard advisory
4 committee due to the substantive change for the same reasons
5 that was just shared.
6 DR. MUKHERJI: Questions? Thank you. Any other
7 public comments before we move on to Commission discussion?
8 All right. Commission discussion?
9 MR. FALAHEE: This is Falahee with a question.
10 Maybe I'm missing something. Does the Department feel that
11 this would be a substantive change?
12 MS. NAGEL: Yes. We do believe this would be a
13 substantive change. But just for your reference, we've made
14 similar changes in our Equipment Standards, MRT and Surgical
15 Services. So we're looking at it as more of a consistency,
16 that these provisions are in our other standards. This is
17 one that came up on your docket where those provisions are
18 not included, but it certainly is a substantive change. We
19 would be providing a mechanism that isn't there today.
20 MS. BROOKS-WILLIAMS: Commissioner
21 Brooks-Williams. So the request around a work group or a
22 SAC, does the Department object to that or --
23 MS. NAGEL: No. We don't object to that.
24 However, given that it's just this one issue, we felt that
25 the Commission has sufficient ability to hear public

1 testimony, to discuss and make decisions similar to that of
2 a work group.
3 DR. MUKHERJI: So this is Mukherji. My
4 interpretation of what you just said is you're almost making
5 it a little bit easier to put -- not easier but less
6 regulations. Could you maybe just explain to me what it is
7 again just so I have -- it's unambiguous for me?
8 MS. NAGEL: You know, I might turn that over to
9 Tulika. I think you may have more detail.
10 MS. BHATTACHARYA: About what we are proposing?
11 MS. NAGEL: Yes.
12 MS. BHATTACHARYA: Okay. So right now, as part of
13 the statute and the Open Heart Review standards, if a
14 hospital is proposing to replace the entire hospital with
15 all of its services including open heart surgery, cardiac
16 cath, OR beds, everything, they are allowed to do so as long
17 as they meet the requirements of a hospital replacement
18 under the hospital bed standards, the mile radius, occupancy
19 requirements, everything. If they don't meet the
20 requirement, they cannot replace their hospital to a new
21 site. So therefore the Open Heart also stays at the old
22 site, cannot move to a newly constructed site.
23 What the Department is proposing as part of this
24 language is, suppose there is an existing -- there are two
25 existing hospitals, one with open heart surgery currently

1 operational today and the second one does not have open
2 heart surgery. So for hospital A to be able to replace that
3 open heart surgery service into that existing hospital --
4 and obviously there would be requirements. It cannot be
5 anywhere in the state or, you know, other, like, common
6 ownership requirements maybe or the ability for that second
7 hospital to, you know, provide all of the space and separate
8 services and expertise. Those can be built into the
9 language. But it will allow the service to be replaced from
10 one existing hospital to another existing hospital if they
11 meet all of the requirements that the Commission will
12 approve. So that's the scope of this request, and that's
13 the difference compared to the current language in the
14 standard.
15 DR. MUKHERJI: So this is Mukherji. This
16 would still be re- -- go for public testimony and so on
17 and so forth?
18 MS. BHATTACHARYA: And it will require
19 Commission's approval before it goes to public hearing.
20 MS. BROOKS-WILLIAMS: This is Commissioner
21 Brooks-Williams again. So I'll kind of ask the question
22 maybe for dialogue amongst the Commissioners. So if we've
23 had testimony from two systems requesting work group for
24 whatever reason -- and I get always sometimes confused
25 between work group and SAC -- but wanting to have that

1 process to weigh in, is there a strong reason to not support
2 that?
3 I was hearing you say, Commissioner Falahee, that
4 maybe the scope being so narrow that that makes it better
5 for Department drafting the language than the work group.
6 So maybe I just need the education around why would it --
7 may we consider that request to do it in a work group versus
8 have the language drafted? Understanding that ultimately
9 you get to weigh in in either track but --
10 MR. FALAHEE: This is Falahee. Here's my personal
11 thought on it. Number one, this clearly does not merit a
12 SAC, because it's a one-issue issue. Number two, if it went
13 to a work group, a work group is only as good as or as poor
14 as the people that happen to show up that day or that
15 afternoon. And if you have people that are all for an issue
16 or all against an issue, you never know what's going to
17 happen until who shows up that day. To me -- and again this
18 is just my personal opinion -- I don't think this being a
19 one-issue matter requires a work group, because I think we
20 can entrust the Department to come up with the requisite
21 language which then goes through the entire vetting process
22 starting with us as a Commission, then goes out to public
23 comment. So that if anyone objects to the proposed
24 language, that's their opportunity to say, "No. It's wrong
25 and here's why." So it still gets a full airing, and it

1 still gets a full vote from us as a Commission.
2 MS. BROOKS-WILLIAMS: Commissioner Brooks-Williams
3 again. So I'm looking at the -- so the issue is coming up
4 based on the evaluation section, not necessarily the request
5 of --
6 MS. NAGEL: This is something that we've been
7 trying to do in all of the standards.
8 MS. BROOKS-WILLIAMS: Okay. So another option is
9 to just say you guys don't have to do it? Is that another
10 option?
11 MS. NAGEL: Sure.
12 MS. BROOKS-WILLIAMS: Okay. I guess I'm just
13 looking at the support of multiple organizations. I'm
14 assuming all of whom it would have some effect on saying
15 they don't want any changes, then they're saying they want a
16 work group, but we don't think a work group is appropriate.
17 So if we're doing the work -- I don't mean for the sake of
18 doing the work. I do understand you're trying to clean it
19 up. Is another option to say just don't move it forward?
20 MS. KOCHIN: This is Commissioner Kochin. I have
21 a question for clarification purposes. Is one of the
22 options to make a motion to accept the Department's
23 recommendation to craft language that's a little bit clearer
24 from what's being proposed right here, hear the public
25 comment, go through a process. Once it comes back to us

1 from a procedural standpoint to vote, if at that point in
2 time we feel as if a work group is appropriate, then start
3 one rather than, you know, putting the cart before the
4 horse?
5 DR. MUKHERJI: And I'll just chime in. This is
6 Mukherji. I think part of it is to make sure we can move
7 processes along, so I completely agree with what you're
8 saying. Having chaired lots of work groups, a lot of it
9 depends not only who shows up, but how many from each side
10 shows up. And then it's up to the chair of the work group
11 to figure out how to determine the consensus and the will of
12 that work group. And then you can have multiple sessions of
13 the work groups, so sometimes that can go on for three to
14 six months. So from a single issue like this from
15 expediency process, one could argue the Department can, if
16 you will, have a straw man. We can look at it, punch it
17 around, and then, if people don't like it, we can go to the
18 work group, but at least we've moved the ball forward.
19 MS. BROOKS-WILLIAMS: So I'm not going to make
20 that motion. No, I was going to make the one that said that
21 we don't move the language forward, because I think I'm just
22 asking for more clarity from the Department beyond --
23 right -- just the technical cleanup process is it something
24 that's required? And I'm not necessarily hearing that from
25 those that are being governed by it, that there's confusion

1 around the replacement or that they're resisting what's in
2 place now. And I think I'm just trying to be responsive to
3 does it have to be done? And I think I would ask that until
4 we can say it is a issue that you face, you know, regularly
5 or is it just the perfunctory cleaning up of the language.
6 MS. NAGEL: To answer your question, it is an
7 issue that comes up regularly. That's how it was identified
8 by the section that actually reviews the applications. It's
9 a lot like the issue that was just talked about Surgical
10 Services. Hospitals want to expand and they want to move --
11 have the freedom to move their services. So, yes, this is a
12 big change. It is different from how the standards look
13 today for sure, but it is -- and to answer your question
14 specifically, no, there's nothing telling us that this needs
15 to be done. It's just a policy decision that we've tried to
16 push forward and the Commission has agreed to in some of the
17 other services. So from our vantage, though, you could
18 argue, you know, that Open Heart Surgery is different for
19 many different reasons. To us, we thought this would, you
20 know, make sense to put language together.
21 DR. MUKHERJI: More discussion? Well, we're to
22 the point where we should ask for a motion.
23 MR. FALAHEE: This is Falahee. I'll make a motion
24 that we accept the Department's recommendation to make the
25 technical edits, number one, and to present to us language

1 regarding the requirements for replacing an existing Open
2 Heart Service from one existing licensed hospital to another
3 existing licensed hospital, that the Commission draft that
4 language -- that the Department draft the language and get
5 it to us and that the services continue to be regulated
6 under the standards.
7 DR. MUKHERJI: We have a motion on the table.
8 MS. KOCHIN: Commissioner Kochin, second.
9 DR. MUKHERJI: We have a motion and a second.
10 Further Commission discussion on the motion on the table?
11 MS. CLARKSON: And I just want to clarify that it
12 was under the same ownership? Is that part of the motion?
13 MS. NAGEL: Yes, that's something that we're --
14 it's in the other standards that we have added.
15 DR. MUKHERJI: Were there questions or discussion?
16 MS. BROOKS-WILLIAMS: I do. So here's my other
17 question. So we're saying it comes up frequently. But
18 again I'm looking at -- I don't know -- six, seven people
19 who have said no changes. Just -- help. I don't know.
20 Where is it coming up frequently from?
21 MS. NAGEL: I mean, it -- we get questions on this
22 and we tell --
23 MS. BROOKS-WILLIAMS: Specifically to Open Heart?
24 MS. NAGEL: Yeah. And we say, "No, you can't do
25 that in the standards." And so at this point, at the

1 special January meeting, this is when the Department makes
2 recommendations of things that we've seen through -- you
3 know, through over the course of time or that we think
4 should be changed. And that's where the genesis of this.
5 It wasn't from -- as you noted, it wasn't anything that came
6 in public testimony. This is -- it came from the
7 Department.
8 DR. MUKHERJI: Continued questions and discussion
9 on this? Should we call to question? Okay. We have a
10 motion on the table and a second. All in favor?
11 (In favor: Gail Clarkson, James Falahee, Debra
12 Guido-Allen, Jessica Kochin, Joseph Potchen, Luis
13 Tomatis)
14 DR. MUKHERJI: Anyone against?
15 (Against: Denise Brooks-Williams)
16 DR. MUKHERJI: Motion passes. The next one is
17 Hospital Beds. And, Elizabeth?
18 MS. NAGEL: Okay. The Hospital Bed standards were
19 part of the public comment period that was held in October
20 of 2016. The Commission received six pieces of input, and
21 the summary of those issues are listed in your packet.
22 There were numerous issues that the Department is
23 recommending substantive review for and believes that a work
24 group could potentially tackle these issues regarding the
25 Hospital Bed standards. If you'd like, I can go through

1 each of those issues at the -- at your direction.
2 DR. MUKHERJI: Why don't we give just a couple
3 minutes just so people can look at it. Or what would the
4 Commission like? Would you like Beth to go over it? Okay.
5 Beth, you're on.
6 MS. NAGEL: Okay. The first issue that was
7 identified was that currently in the standards a hospital is
8 required to send certified letters to hospitals within the
9 hospital service area when applying for high occupancy beds.
10 The goal there is to see if -- you know, just to make sure
11 the hospital has done their due diligence before applying
12 for these high occupancy beds. The recommendation is for
13 them to be removed, and the Department believes that we
14 should review this requirement.
15 The second was should outpatient observation beds
16 be regulated in a fashion similar to inpatient hospital
17 beds? The Department believes that this is an issue that
18 would need substantive review.
19 And the third one is regarding the requirement for
20 hospitals to participate in a nationally recognized
21 nonprofit organization with extensive experience in
22 collecting and reporting on data on a public web site. And
23 this is an issue that's come up and came up in several of
24 our most recent SACs and is a theme throughout these
25 standards that are on your plate today. And the Department

1 has looked at this in the past. We've relied on our
2 assistant attorney general and believe that this is outside
3 of the scope of Certificate of Need, and so we are not
4 recommending a substantive review to this issue.
5 The Department has identified an issue to evaluate
6 the comparative review criteria are still relevant and need
7 to be updated. This is something that we typically ask in
8 any of our bed standards. We want to make sure that the
9 comparative review requirements are still relevant, still
10 up-to-date. And so if there is going to be a work group or
11 a SAC, the Department wants that to be added as part of
12 their review. And the same for the project delivery
13 requirements. We have a technical edit there that we would
14 like to make as well that we can draft language on that.
15 And then a third issue is identified, and that is space and
16 lease renewal at hospitals again to determine if any updates
17 are needed. Again this was identified by the Department
18 and, if we have the opportunity to have experts in the room,
19 we want to make sure that these criteria are still relevant.
20 DR. MUKHERJI: Thank you. Public comment? So I
21 believe Steve Szelag from the University of Michigan.
22 STEVE SZELAG
23 MR. SZELAG: Good morning again.
24 DR. MUKHERJI: Steve, could you just -- I'm
25 getting old. I can't hear as well. I'm having a hard time

1 hearing you. Maybe you can just speak right in that
2 microphone?
3 MR. SZELAG: Yeah. Let me see if I can get a
4 little closer. Good morning again. The comments that I'm
5 providing to you today were not a part of your official
6 packet. This issue or opportunity came about after the
7 review period. So I just wanted to go through my comments.
8 UMHS is currently licensed for 1,000 med-surg
9 beds. And since 2007, occupancy has been in a constant
10 state of high occupancy as reflected in our inpatient growth
11 from 800 to 1,000 beds. Thirty-two of these 1,000 med-surg
12 beds are procmatically (sic) assigned as inpatient rehab
13 beds designated to a specific patient care unit within a
14 definition of an inpatient rehabilitation facility or IRF,
15 which means they have been approved to participate in
16 Medicare PPS. These beds also fall into the CON category of
17 excluded hospitals. This exclusion is specific to
18 occupancy, however we suggest that this is a reflection that
19 these beds are to be -- acknowledged to be separate and
20 distinct.
21 Patient flow processes are separate and distinct
22 for our rehab patients. Patients receiving care on this IRF
23 unit require a formal discharge from the acute service to
24 being admitted to the IRF, which is specifically designed
25 and staffed for rehabilitation patients. Similar to the

1 other 968 licensed beds at UMHS, these IRF beds are also
2 highly utilized and operate at a constant state of high
3 occupancy. However, due to physical capacity constraints
4 and land scarcity on our main medical campus, we are unable
5 to expand this clinical service in an efficient and cost
6 effective manner to meet the rising demand for inpatient
7 rehabilitation care, which is a part of our mission. As
8 there is an increasing patient demand at UMHS for various
9 tertiary and cautionary medical services, we are making
10 plans to grow inpatient capacity for acute medical, surgical
11 and rehab.
12 We propose a standards review which might lead to
13 the formal acknowledgment of the distinction between acute
14 medical, surgical and inpatient rehab beds within the
15 inpatient bed standards to acknowledge the different
16 episodes of care. A change would facilitate the
17 modernization of the current generic definition of a
18 hospital permitting a reasonable separation of a facility
19 type which aligns with patient movement from acute to
20 rehabilitation care.
21 Our East Ann Arbor campus, approximately
22 three-and-a-half miles from our main medical campus,
23 provides an opportunity for co-location of adult inpatient
24 rehab along with this corresponding ancillary clinical
25 services and outpatient clinics. If there is agreement with

1 the distinct levels of care, our future plan would be to
2 move rehab services to this existing ambulatory campus
3 within Ann Arbor to allow for better programmatic placement
4 of rehab services. We are seeking a change to the standards
5 which would apply to all providers who accommodate rehab
6 patients as to kind of a modernization based on patient flow
7 and continuing care. We are not seeking an exception to the
8 existing standards as a solution but for a reasonable change
9 to further define inpatient rehab care as a separate and
10 distinct patient care category for the purposes of placing
11 these qualified patients. On behalf of the U of M, I just
12 want to thank you for allowing me to make these comments
13 today.
14 DR. MUKHERJI: Thanks, Steve. Questions for
15 Steve?
16 MR. FALAHEE: Let me try to explain what I think
17 you just said. So U of M has inpatient rehab beds now of
18 30, 32?
19 MR. SZELAG: 32.
20 MR. FALAHEE: 32? All right. And they're full or
21 high occupancy?
22 MR. SZELAG: That is correct.
23 MR. FALAHEE: Okay. You would like to expand the
24 number of inpatient beds?
25 MR. SZELAG: Yes. We have a need to expand our

1 rehab complement, and we have also have a need to expand our
2 other acute care med-surg complement. Under high occupancy,
3 we have the ability to do that. We are working through a
4 master facility plan with the end result of being able to
5 build more physical plant. If we had the opportunity to
6 move these rehab beds off site, that would allow us to
7 expand our main hospital campus in a more thoughtful manner,
8 a more cost effective manner. We are landlocked, and there
9 is a lot of land scarcity. If we were able to decompress by
10 having our rehab services at a different site -- and this
11 site is three-and-a-half miles which is, you know, outside
12 of the replacement zone and it would, you know, it would not
13 be contiguous. So we're looking for a change in the
14 standards that would allow us to move this special category
15 of beds to a new location so that we can expand that service
16 in a more appropriate location while at the same time
17 expanding our acute care services on the hill so that we can
18 deal with them much more cost effective manner.
19 MR. FALAHEE: That helped. So following up on
20 that then, if I'm following this, you would take the 32
21 inpatient rehab beds and move them out -- what is it? --
22 near Earhart Road? That complex out there?
23 MR. SZELAG: Yes; yes.
24 MR. FALAHEE: Okay.
25 MR. SZELAG: Plymouth and Earhart.

1 MR. FALAHEE: To set up a new inpatient rehab
2 hospital there?
3 MR. SZELAG: Essentially, yes.
4 MR. FALAHEE: Okay. So what you're asking is what
5 the Department or a work group or a SAC or whatever, come up
6 with language to what a current inpatient rehab facility in
7 a hospital relocate to a different site and, in effect,
8 create a new inpatient rehab hospital?
9 MR. SZELAG: Yeah. You know, in a sense, you
10 know, these beds are defined under CMS, you know, as the
11 IRF, you know. So they are already viewed, you know,
12 differently under the federal rules as, you know, separate
13 and distinct. We just want or are looking toward the
14 Commission, you know, to modernize the standards so that we
15 may be able to take this one step further and, you know,
16 separate these physically to allow us for a more management
17 growth in our inpatient services.
18 MR. FALAHEE: Yeah. If my memory serves me
19 correctly, when you read the standards, these are listed
20 right there with critical access hospitals. They're carved
21 out in a section of the standards, and most of the carveouts
22 are separate facilities now.
23 MR. SZELAG: Yeah; yeah. And that specific
24 section is, it's specific to occupancy, you know, but we
25 suggest that, you know, the standards are already carving it

1 out, you know, let's -- you know, let's build upon that and,
2 you know, see what can be done, you know, within CON to help
3 us, you know, achieve the end result.
4 MR. FALAHEE: So, Steve, one last question from
5 me -- this is still Falahee. The Department has recommended
6 a work group to look at some of these other issues. Would U
7 of M be amenable to having what you discussed also be
8 considered by a work group?
9 MR. SZELAG: I think that we -- yeah, we would be
10 open to a work group or a SAC, whatever the Commission feels
11 is most appropriate.
12 MR. FALAHEE: Thank you.
13 DR. MUKHERJI: Any questions for Steve? Okay.
14 Thanks, Steve.
15 MR. SZELAG: Thank you.
16 DR. MUKHERJI: Okay. The next is David Walker
17 from Spectrum.
18 DAVID WALKER
19 MR. WALKER: Good morning. Again David Walker
20 with Spectrum Health. Thank you very much for the
21 opportunity to provide comment on the Hospital Bed Review
22 standards.
23 Spectrum Health strongly supports continued
24 regulation of hospital beds without any changes to the
25 standards. Allow me to touch on a few points related to the

1 possibility of regulating observation beds under CON and
2 quality reporting.
3 Spectrum Health has strong reservations about
4 regulating observation beds under CON. However, we would be
5 willing to participate in a work group to review the matter.
6 Hospitals currently operate in a structure where
7 observation beds are needed. It is not always medically
8 necessary for patients to be placed in inpatient care.
9 Having observation beds available to those who need
10 short-term treatment is imperative. Restricting the
11 accessibility of observation beds could negatively impact
12 the quality of care as some patients could be simply turned
13 away if there were no beds available.
14 Furthermore restricting the use of observation
15 beds could drive up costs. If hospitals are forced to
16 decide between sending a patient home or placing them in an
17 inpatient bed, it is likely due to liability reasons that
18 the patient will be admitted costing more money.
19 In addition to cost and access concerns, we
20 believe that CON is likely not the best tool to address
21 concerns with the use of observation beds. Many times, the
22 use of observation status is guided by payer rules that are
23 subject to change over time. Designating a given number of
24 beds as "observation" beforehand would not be able to
25 anticipate these changes and would cause a significant

1 hardship for hospitals. If, in fact, organizations are
2 using observation status outside of medical need or payer
3 rules, an appropriate regulatory authority already exists,
4 oftentimes with the payer, to curb this activity outside of
5 needing to resort to the CON process.
6 In response to the recommendation from EAM to
7 require participation in a nationally recognized nonprofit
8 to report hospital quality data on a public web site,
9 Spectrum Health vigorously supports transparency of quality
10 data. In doing so, we participate in over 60 national
11 registries and submit data to CMS, CDC, NHSN and others. We
12 are not inherently opposed to incorporating quality into the
13 standards in a more meaningful way. However, we would need
14 more information on the implementation of such a proposal
15 before we could take a position. New measures have not
16 often undergone scientific rigor, risk adjustment, or have
17 been given sufficient time to develop automated methods for
18 data abstraction. If additional quality reporting was
19 incorporated into the standards, perhaps there could be
20 incentives for high-quality facilities also added.
21 With that said, we would be opposed to anything
22 that increased these administrative burdens. Spectrum
23 Health, and presumably all hospitals, already spend a
24 tremendous amount on reporting to various oversight bodies
25 and organizations and would not want to see costs increased

1 even more by adding yet another layer of reporting. Any
2 additional reporting should involve CMS qualified specialty
3 registries, use EMR abstractable measures, and use
4 nationally validated standards vetted by NQF, CMS, and other
5 specialty organizations.
6 Thank you for the opportunity for me to share my
7 thoughts on these matters.
8 DR. MUKHERJI: Thank you very much. Questions for
9 David? Great. Thank you.
10 MR. WALKER: Thank you.
11 DR. MUKHERJI: Now I have one more card here, and
12 I want to make sure. It said U of M requests on
13 rehabilitation from Jeff Garber. Is this -- is Jeff here?
14 Is this where you wanted to speak?
15 MR. GARBER: Yes.
16 DR. MUKHERJI: Okay. All right.
17 JEFF GARBER
18 MR. GARBER: Thank you. This is my first time in
19 the CON Commission in the State of Michigan, and I'm proud
20 to be here and congratulate you on all your efforts of what
21 you guys have been doing here. I'm Jeff Garber. I'm vice
22 president for the system and network for the Mary Free Bed
23 Rehabilitation Hospital in Grand Rapids.
24 We have 125-year history of restoring hope and
25 freedom to people. And approximately five years ago we

1 expanded and developed a network and relationships to help
2 move people through the post acute continuum to highly
3 therapeutic environments.
4 I would like to be here today just to be in
5 support of opening up the consideration of the Commission
6 for modification of the CON standards as represented by the
7 letter written by the University of Michigan to provide the
8 flexibility. Specifically as it relates to inpatient
9 medical rehab beds, I have personally testified in many
10 related activities within Florida especially and other parts
11 of the United States on the expansion and the importance of
12 creating a very strong therapeutic milieu for patients that
13 are suffering from significant debility areas. And as it
14 relates to that, for strokes, spinal cord injuries, and all
15 the ones that exist in with our aging population, to be able
16 to have access to a facility easily. And if you visit the
17 University of Michigan -- if any of you've ever been here,
18 visited it, it's quite a challenge to even just get a
19 parking spot there and the opportunity for -- to allow them
20 to have decompression of that campus but more importantly to
21 provide adequate space for the development of something that
22 is first class for people to be able to move freely and
23 openly in that space, I think, would be valuable.
24 So on behalf of Mary Free Bed in Grand Rapids,
25 Michigan, I'd like to be supportive of your opening of the

1 consideration for modification. Thank you.
2 DR. MUKHERJI: Hold on for a second. You're not
3 done yet.
4 MR. FALAHEE: Nice try, Jeff.
5 DR. MUKHERJI: Good try.
6 MR. GARBER: Sorry.
7 DR. MUKHERJI: We have to give you a chance to get
8 grilled. Questions for Jeff.
9 MR. FALAHEE: Jeff, in other states, are there
10 separate inpatient rehab facilities outside of, let's call
11 it, typical acute care hospital?
12 MR. GARBER: Yes, very often. Oftentimes they're
13 freestanding rehab hospitals. You know, there are a lot of
14 those. I can tell you that within the State of Florida
15 anything that was like that we had certain considerations
16 where we paid very close focus to the amount of beds, that
17 it wasn't just a small amount of beds and that there was
18 consideration to economy, scale and what the needs were. In
19 just our review of what goes on, we've been reviewing across
20 the state. There is many locations inadequate access to
21 rehabilitation, in my opinion. And specifically on the
22 campus of the University of Michigan, it's a real access
23 problem to move to that next level of care. And the
24 opportunity for them to have some freedom to do that, I
25 think, will decompress. From a perspective of my sense when

1 you have this kind of hold up of the congestion, it costs
2 more money to keep those patients in a high cost, acute
3 setting, something like that. And to have a therapeutic
4 milieu and the focus is on restoring hope to them and being
5 able to get them home, the environment is very, very
6 important. And to not have to go on that big hospital
7 campus and have access and feel like you're going to another
8 level of care that still is acute is very important, I
9 believe, in that.
10 MR. FALAHEE: Thank you.
11 DR. MUKHERJI: Yes, Gail?
12 MS. CLARKSON: How is this different from what is
13 being provided and are still facilities that are
14 rehabilitation oriented at this point in time?
15 MR. GARBER: Very big difference between the two
16 different levels of care. I think there is a need for all
17 of those different levels of care. The patients that are
18 going today to comprehensive inpatient medical rehab
19 patients are very medically complex patients, more so than
20 ever before. As the shift in health care and value based
21 care is moving, the intensity of those patients -- so the
22 quantity of nursing care and intensity, the qualifications
23 of them as highly specialized rehab nurses is critical.
24 MS. CLARKSON: I still don't -- that's not
25 defining, because I work in long term care and our patients

1 are the same as what you're describing. So I'm trying to
2 understand what the different need is that you're saying
3 they would need an inpatient hospital. I mean, what is the
4 reason?
5 MR. GARBER: I think it has to do with the need
6 for medical supervision of the patient, attendance by a
7 physician on a daily basis due to medical complexity.
8 MS. CLARKSON: We have that.
9 MR. GARBER: Well, there are skilled facilities
10 that do offer high level of care today. I can't judge that
11 on that regard, but that's the --
12 MS. GUIDO-ALLEN: So Guido-Allen. A question for
13 you. Because of the medical complexity and there are
14 requirements that CMS has for inpatient rehab facilities
15 that there's very specific diagnoses that are -- qualify and
16 there's a whole -- yes, there's a whole criteria that
17 patients have to meet and then there's daily FIM scores and
18 you have to show improvement. So there are criteria that
19 are set forth by CMS that have to be maintained for IPR.
20 With the medical complexity that you stated, would we not be
21 driving up costs replicating physicians around the clock,
22 imaging around the clock, emergency responses around the
23 clock for this special patient population if it were offsite
24 from an acute care facility? Because we have a small IPR,
25 but the patients really are quite ill and do on occasion

1 have a requirement for the rapid response team to come and,
2 you know, bounce back to acute, which is, you know, a floor
3 or two over versus possibly an ambulance drive and EMS
4 transfer.
5 MR. GARBER: Well, I can only respond to some of
6 the freestanding rehab hospitals that exist, and they're all
7 different types. And depending on the types of patient
8 populations that you have, at U of M, for example, they have
9 a large population of spinal cord injuries, severe brain
10 injuries. Those patients in my opinion need to be in
11 comprehensive medical rehab with the intensity level of
12 nursing and therapeutic may be there. As it relates to
13 additional cost of things, you don't see MRIs or CT scanners
14 in most freestanding rehab hospitals. It's not like that.
15 You will see some good basic x-rays some places. And the
16 proximity to still utilizing the benefit of acute care
17 hospital when needed is still easily available. Some rehab
18 hospitals have ambulance support conveniently there, and
19 they can fast track it. Most freestanding rehab hospitals
20 have internal medicine physicians that are available to help
21 maintain them in that setting so they don't have to go up on
22 to, you know, the more expensive center, and the whole idea
23 is to do that. Normally in the high quality rehabilitation
24 hospital there's -- the need for readmission back into acute
25 care hospitals is well below ten percent on an annual basis.

1 In addition to that, high quality rehabilitation facilities
2 like us at Mary Free Bed, we have almost 90 percent of all
3 of our patients go home and don't need to go to other levels
4 of post acute care. And we're very proud of that. Did I go
5 over my three minutes? I thought there was --
6 DR. MUKHERJI: No. You were fine. Other
7 questions? Okay. Thank you very much.
8 MR. GARBER: Thank you very much.
9 DR. MUKHERJI: Those are the last three cards I
10 have for public comment for this issue. Is there anybody
11 that would like to speak? All right. Commission
12 discussion. So just to set things again, our charge here is
13 to -- the Department feels that these are substantial
14 changes, so they won't not handle this independently.
15 So, Elizabeth, correct me if I'm wrong, but our
16 charge is to determine whether the issues that have surfaced
17 through public comments and direct communications with the
18 Department are to either develop a work group or a SAC; is
19 that correct?
20 MS. NAGEL: You are correct. And if I could just
21 clarify the Department's recommendation?
22 DR. MUKHERJI: Uh-huh (affirmative).
23 MS. NAGEL: The issues listed in your summary grid
24 are issues that the Department believes can be handled by a
25 work group. However, the issue that has been discussed by

1 the first and third speakers is a substantive issue and a
2 significant issue that we would recommend a standard
3 advisory committee be formed to tackle that one -- well, to
4 tackle all of them then.
5 MR. FALAHEE: So if a SAC is needed for one, put
6 them all under the same SAC?
7 MS. NAGEL: Yes; yup.
8 MS. BROOKS-WILLIAMS: Commissioner
9 Brooks-Williams. Can I then ask a question of the other
10 Commissioners? We had a little bit of an update on
11 observation beds. I don't want to like have lengthy
12 conversation, but I'm not 100 percent sure of the value of
13 even talking about the concept of regulation around obs
14 beds. I don't know if it's better around an education
15 around how they function and they're utilized within the
16 organization. Because I would hate to offer it up for a
17 lengthy debate dialogue discussion and then we get something
18 back -- I guess we could just always reject it, right. But
19 in the spirit of not wanting to send something forward that
20 I disagree with, do we have the option to take things in or
21 out that will go forward? Okay. So I would be asking that
22 we do not move the observation conversation forward.
23 DR. MUKHERJI: Gail?
24 MS. CLARKSON: I'd like to keep it in. The reason
25 being that it affects Medicare patients being discharged.

1 If you're in an observation bed, you cannot qualify for
2 Medicare and come into skilled care. So there is a patient,
3 you know, part of that that's involved that should be
4 brought up in a conversation. A recipient, you know, they
5 would be denied their skilled benefits if they wanted to go
6 into rehabilitation.
7 MS. GUIDO-ALLEN: This is Guido-Allen.
8 Observation status is really determined very much by the
9 third party payer. Hate to say it. There's a two midnight
10 rule with CMS, there's been all different types of rec
11 audits done. There are times -- there are many occasions
12 where a physician will say, "I deem this patient an
13 inpatient because of my clinical assessment of this
14 patient," and that inpatient status will be overturned by
15 the third party payer and that patient would move back to
16 observation status. So, you know, while I would love to say
17 we would make everybody inpatient, we can't. And more and
18 more and more diagnoses, more and more clinical situations
19 are being moved to only observation status that you cannot
20 make that inpatient regardless of the patient's
21 presentation. So that's where I agree with Commissioner
22 Brooks-Williams. We have to expand our ability to manage
23 observation patients as they continue to grow year upon year
24 upon year.
25 MS. CLARKSON: Excuse me. I was only suggesting

1 that we keep it in to be discussed. That's all.
2 MS. KOCHIN: This is Commissioner Kochin.
3 Representing some of those paying entities, I would
4 absolutely recommend keeping this in. This would be a
5 substantive change, and I think would be valuable to be
6 discussed at the posed SAC.
7 MS. BROOKS-WILLIAMS: This is Commissioner
8 Brooks-Williams. So then just -- just in the spirit of
9 healthy debate and discussion, I just want to make sure that
10 whoever chooses to make the motion -- I don't know if we
11 want to go one by one? You know, I totally respect some
12 want it in and some want it out. And again I would want to
13 go on the record for why I say out. I'm not at all
14 suggesting that we don't need to have a discussion. I do
15 believe respectfully that there is confusion around if this
16 is a bed requirement category to be regulated by this
17 Commission or if it's a crisis and how we're being asked to
18 manage patients. That's my only reason for saying I don't
19 think that it belongs here, because it isn't a discreet,
20 separate category to be regulated. So I just don't want it
21 buried in a SAC to come out through opinions that says, "Oh,
22 manage it or not manage it" when it's something that you
23 would create, I think, a horrible conundrum to say that
24 you're going to manage something that practically from a
25 regional perspective we're submitting if there were a simple

1 answer or a number that someone will be able to create a
2 formula around. I don't think there's anyone who would
3 disagree with that. So having a discussion independent,
4 totally fine. But morphing it into the SAC is what I -- I
5 guess I disagree. Because I think there needs to be much
6 more education around at least how it functions, because I
7 think everyone is just coming from their own perspective.
8 And you have a risk, in my opinion, that, if you go in with
9 just opinions and not facts, that you may create an
10 unintended consequence.
11 DR. MUKHERJI: Jim?
12 MR. FALAHEE: This is Falahee. I agree with what
13 Commissioner Brooks-Williams just said. And I wonder, is
14 the question prompted by observation beds in an acute care
15 hospital? Because as I've -- I've had discussions with the
16 Department over the last couple years just explaining what
17 an observation bed is and how the number of observation
18 patients in an acute care hospital has just mushroomed over
19 the last three to four years where you could have -- correct
20 me if I'm wrong -- 25, 40 percent of your patients will be
21 observation patients and the nurse that's treating them has
22 no clue, because it doesn't matter. They're getting the
23 same level of care. Is that the kind of observation bed
24 we're looking at, or is this question prompted by entities
25 that want to set up, I call it, a 23-hour hospital? Is that

1 the kind of, quote, "observation bed," closed quote, that
2 prompted the question? Because that's different than what
3 you see within an acute care, over 24-hour hospital.
4 DR. MUKHERJI: So let me just jump in real quick.
5 So, Elizabeth, I see that this was prompted by the MDHHS CON
6 evaluation section. So can you explain to me how this
7 surfaced to what is the section and how this surfaced to the
8 team?
9 MS. NAGEL: I can explain that that appears to be
10 an error on your grid. This was brought about by the
11 Economic Alliance of Michigan, number five on your error --
12 or on your error -- on my error -- on your chart. My error.
13 That's the genesis of this recommendation.
14 DR. MUKHERJI: Dennis, since you were --
15 DENNIS MCCAFFERTY
16 MR. MCCAFFERTY: Dennis McCafferty, Economic
17 Alliance. Since I was the rascal who brought this to the
18 surface, I'll make some comments.
19 This originated not from the staff, not from
20 myself, but from our membership, the employers and the
21 unions that we represent. They are concerned that they have
22 seen a spike in their health care expenses, employee and
23 retiree health care expenses as it relates to observation
24 beds. And if we're trying to sift out the wheat from the
25 chaff here, it's more along the lines of what Commissioner

1 Falahee brought up. It's these not quite hospital facility,
2 the 23-hour place that was established but isn't able to get
3 licensed as a, quote, "hospital," that has this from our
4 members' perspective, this questionable use of observational
5 beds to change a facility that wasn't able to get licensed
6 into a hospital to be a de facto hospital where people are
7 being kept for much longer than the 23 hours, sometimes two
8 or three days. And also it then parlayed into this other
9 issue of, if they're an observational bed and then they need
10 to be moved to a rehab facility, the problem that creates
11 for the patient as to whether they're eligible for Medicare
12 reimbursement or not. So it's a combination of both of
13 those issues that our membership saw as something that
14 hadn't been anticipated by the current regulations but is a
15 current reality. Does that help?
16 DR. MUKHERJI: Questions for Dennis?
17 MR. FALAHEE: Yes. This is Falahee. Sometimes no
18 matter even if we want to, we can't control the reality.
19 So, if in the acute care hospitals as other Commissioners
20 have said, we don't know when someone is observation versus
21 an inpatient, and it can change weeks and months later based
22 on a payer. And we -- as the hospital, we don't have any
23 control over that.
24 MR. MCCAFFERTY: Nor does the patient.
25 MR. FALAHEE: And it's (inaudible) issue when the

1 patients go into a skilled nursing facility if they're
2 observation versus inpatient, I don't know what we can do to
3 control that or have any say in that. As to the issue of
4 the, I'll call it, 23-hour hospital, I don't know what
5 regulatory or statutory authority we as a Commission have
6 given the parameters under which we operate. I just don't
7 know the answer.
8 MS. BROOKS-WILLIAMS: This is Commissioner
9 Brooks-Williams. So not a question but just in response to
10 what you said. I think when I read it -- and I did get the
11 letter -- what I was struck by -- and I can only speak from
12 my perspective dealing with this every day. I can pull it
13 up on my iPad for you and tell you exactly how many obs
14 patients I have today. But what I do know is I always staff
15 and operate a certain number of beds. So it's still within
16 my licensed beds. And so when I read this, I said I
17 couldn't tell you what number to start to bifurcate off
18 because I think, to Commissioner Falahee's point, when that
19 patient enters the emergency department and needs care, the
20 dilemma we have every day is getting them the care that they
21 need. You then take them through a review process where a
22 payer tells us, "Are they categorized to be an inpatient?"
23 or do you keep them safe, keep them in the hospital, take a
24 third or less of what you would normally be reimbursed for
25 but expend the same amount of money? So I think I simply

1 read the issue as, if there's a perception that we're using
2 this as an economic boon or we're using it in a way -- and I
3 think we would agree with you that obviously there would be
4 no reason why we wouldn't want a patient who's staying for
5 four days, five days to be categorized and for us to be able
6 to receive the resources to properly care for them. So
7 that's the inpatient acute care hospital dilemma. I would
8 agree with Commissioner Falahee if this is seeking to be
9 restrictive around freestanding obs beds that have, you
10 know, some sort of a growth, because I talked to my
11 colleagues before I came. I don't know anyone who would be
12 coming here asking for more obs beds. Now, you may have two
13 to three that are in the standards of requirements around a
14 outpatient surgical facility. Again that's safety of the
15 patient. Some people go through a procedure and they are
16 not able to go home. They aren't staying there for three or
17 four days. The three, four day stays are in the acute
18 setting. So, you know, very passionate about the
19 perspective. This is not a boon business for facilities.
20 This is a area where we'd love to have dialogue and
21 discussion with your members around how we together go to
22 legislators and others to understand that this is a growth
23 that is an unintended consequence, I guess; right? But to
24 keep the patients safe, to keep them in the right place. So
25 the only language that would be appropriate to me is to say

1 that we're not operating above our current licensure. So
2 that I would understand, right. Because the way I read the
3 letter, it would say if my license gives me 401 beds, that
4 I'm going to 500 through observation. I assure you
5 economically that would be impossible. It would be
6 impossible. So I'm fine if you say within that licensure
7 that I have and the beds that I can properly staff and
8 operate, that I'm doing that; that's CON. Anything beyond
9 that is not CON. So I'm just saying I don't want the issue
10 to be taken up in a space that I don't think it's our
11 purview.
12 DR. MUKHERJI: Thanks. I'm sorry. Questions for
13 Dennis? Okay. So just, Elizabeth, a point of
14 clarification. It seems like based on your comments and the
15 University of Michigan initiative, if you will, we're sort
16 of heading towards a SAC; is that right? So the next step
17 is we're now having a conversation over what should be on
18 the agenda of the SAC. So what are the options? Because
19 the way I look at this, we've all sat on SACs or run a SAC.
20 You can have items that come in and you can say, yes, I
21 agree or no, I don't agree, so this could be -- this item
22 may not even pass muster of the SAC or it could be
23 eliminated from the agenda of the SAC. So can you give us
24 some guidance as to what the best path forward on this?
25 MS. NAGEL: Sure. Typically the Commission will

1 delegate the formation of the charge to the chair. That
2 said, the motion usually looks like the Commission delegates
3 creation of the charge based on the discussion at the
4 meeting, you know. So I think it is a helpful discussion
5 for the Commission to decide what should be in and what
6 should be out. But then at the end of the day, the charges
7 at the creation of the chair who seats the SAC and picks
8 the -- selects the chair.
9 DR. MUKHERJI: So the motion to move forward
10 theoretically to a SAC could be moved forward to the SAC but
11 specifically eliminate one of these charges and then that
12 could be a motion then?
13 MS. NAGEL: It could be a motion. I would add
14 include all of the issues identified or the recommendation
15 of the Department minus this particular issue.
16 DR. MUKHERJI: Thank you. All right. So we still
17 have this issue on the table. Further discussion? Jim?
18 MR. FALAHEE: This is Falahee. Just not talking
19 about obs beds, just a couple others just so you know. The
20 first item about the letters, I had the pleasure or the pain
21 of being the vice chair of the SAC that looked at the high
22 occupancy and actually wrote the high occupancy standards.
23 So I know from six months worth of tedium where this was
24 coming from. And it was -- I don't know -- at least ten
25 years ago when the requirements say, "Well, before you go

1 out and expand high occupancy, you need to send these
2 letters out." This day and age I don't think you need to
3 send the letters out. Part of it was driven by the fact of,
4 well, maybe if you sent the letters out, somebody would want
5 to sell their licensed beds to you, because that had
6 happened in the past. But again with the high occupancy
7 standards, you don't need to buy any beds, so why do you
8 need to send the letters out? And then the last one on the
9 page about the 75 percent occupancy and the project delivery
10 requirements, I hate it when the Department finds a loophole
11 that I've come up with ten years ago and tries to close it,
12 because that's what this is doing. Because what was going
13 on is, if you increased through high occupancy and you got
14 30 beds, one argument could be -- okay -- the high occupancy
15 test of 75 percent applies just to those 30 beds, not to the
16 entire denominator. So that was a loophole I was
17 successfully able to get through but not anymore if those
18 goes through. And I understand why. And that was the
19 discussion at that SAC driven by the Small Business
20 Association of Michigan. I totally get it. I understand
21 why. But that's the genesis of where this is coming from.
22 DR. MUKHERJI: Thank you. And thank you for
23 implicitly volunteering to participate in this process.
24 Other comments?
25 MR. FALAHEE: This is Falahee. I'll make a motion

1 that we create the SAC to look at the following issues:
2 Number one, the requirement that applicants send certified
3 letters as identified in the first box in our chart. I'll
4 leave it at that. That the SAC not look at observation
5 beds, that the SAC not look at as a charge the participate
6 in a nationally recognized organization given the
7 jurisdiction issues that Mr. Potchen talked about, that the
8 SAC do look at as a charge the comparative review criteria,
9 that the SAC do look at as a charge the project delivery
10 requirement, Section 9(4)(A), that the SAC do look at
11 reviewing space and lease renewal at hospitals to determine
12 if updates are needed, and lastly that the SAC look at the
13 issue that it was identified by University of Michigan about
14 moving inpatient rehab beds from inside an acute care
15 facility to another site and, if you will, establishing a
16 new hospital, an inpatient rehab hospital at that new site.
17 That's my motion.
18 DR. MUKHERJI: Thank you. We have a motion on the
19 table.
20 MS. BROOKS-WILLIAMS: Commissioner
21 Brooks-Williams, second.
22 DR. MUKHERJI: We have a second. We have a motion
23 with a second. Further discussion?
24 MS. CLARKSON: I'm going to go back to the
25 observation. Obviously with the discussion that we had

1 here, I feel that the observation stays should stay in. I
2 mean, we had more of a discussion about that than we did
3 about anything else, so I object to the fact that it's not
4 included.
5 DR. MUKHERJI: Okay. Other comments? Discussion?
6 DR. TOMATIS: Commissioner Tomatis. You mean that
7 the transfer bed outside, in essence, and CON for a new
8 hospital?
9 MR. FALAHEE: For the inpatient rehab beds.
10 DR. TOMATIS: Yeah; yeah. As in a new hospital?
11 MR. FALAHEE: Yes.
12 DR. TOMATIS: Is this our purview?
13 MR. FALAHEE: What I'm asking is that that be one
14 of the charges that's addressed within the SAC as to whether
15 that should be something that should be accomplished and
16 then the SAC would submit to us its recommendations up or
17 down as to that issue.
18 DR. TOMATIS: That was my question.
19 DR. MUKHERJI: Further discussion on the motion on
20 the table? I don't know if I'm allowed to call -- I can't
21 call to question, can I? Okay. I'm calling the question
22 then. Okay. All right. So we have a motion on the table.
23 All in favor of the motion say "aye."
24 (In favor: Denise Brooks-Williams, James Falahee,
25 Debra Guido-Allen, Joseph Potchen, Luis Tomatis)

1 (Against: Gail Clarkson, Jessica Kochin)
2 MS. NAGEL: Okay. So that's five -- six?
3 DR. MUKHERJI: All in favor?
4 MS. NAGEL: I see five. Yup. The motion fails.
5 You have to have six.
6 DR. MUKHERJI: Oh, you have to have six. Okay.
7 So the motion fails.
8 MR. FALAHEE: So this is Falahee. Take the same
9 motion that I just made but include as a charge a discussion
10 of observation beds. I'll stop there.
11 DR. MUKHERJI: Okay. So we have a new motion on
12 the table which includes a discussion of the observation
13 beds. So I'm looking for a second?
14 DR. TOMATIS: Second, Tomatis.
15 DR. MUKHERJI: We have a second. We have a new
16 with a second. Further discussion with the new mo- -- with
17 the motion on the table?
18 MR. FALAHEE: One of the seminal question for me
19 is whether there's even jurisdiction for us as a CON
20 Commission to look at this issue and, even if we have a
21 six-month everyday discussion about it, so what?
22 MS. BROOKS-WILLIAMS: This is Commissioner
23 Brooks-Williams, and I agree. I think the substantive
24 question is a lot -- and I agree that you would have a lot
25 of discussion as we did today. I do not know that it would

1 be value added, and I do not support taking the risk of
2 discussing something that we aren't sure that we have the
3 jurisdiction to change. So, I mean, I know Joe's not here,
4 so we can't technically ask that question, but --
5 DR. MUKHERJI: So we still have a motion on the
6 table with a second. Call to question. So how many are for
7 the motion?
8 (In favor: Denise Brooks-Williams, Gail Clarkson,
9 Jessica Kochin, Luis Tomatis)
10 (Against: James Falahee, Debra Guido-Allen)
11 DR. MUKHERJI: It looks like we have four. That
12 motion does not pass. And I know Patrick has just texted
13 me.
14 MS. NAGEL: I would have to ask the question as
15 whether or not a quorum is needed to take this kind of
16 action or action on standards, and I would need the
17 assistant attorney general to weigh in on that.
18 MR. FALAHEE: My understanding is that anything
19 that requires a Commission vote requires six positive votes
20 to move forward, because that's a majority of the
21 Commission.
22 MS. NAGEL: That's how I read the bylaws as well.
23 MS. BROOKS-WILLIAMS: So it's not a majority --
24 this is Brooks-Williams. Not a majority of who's present.
25 So we've established a quorum to have a meeting, but the

1 vote is always the six.
2 MR. FALAHEE: Right.
3 MS. BROOKS-WILLIAMS: Okay. So this is
4 Commissioner Brooks-Williams. Given that we've tried twice,
5 is it not possible to have this come back to the March
6 meeting when we have better guidance of our jurisdiction and
7 the Department give us some direction on --
8 DR. MUKHERJI: Is this a motion?
9 MS. BROOKS-WILLIAMS: If it needs to be, yes.
10 DR. MUKHERJI: Yeah, this needs --
11 MS. BROOKS-WILLIAMS: This is Commissioner
12 Brooks-Williams. I'm making a motion that we table the
13 action on the Hospital Bed standards until the March meeting
14 and request that the Department give us guidance prior to
15 that meeting on our ability to have jurisdiction over,
16 quote/unquote, "Observation beds."
17 MS. GUIDO-ALLEN: Guido-Allen, second.
18 DR. MUKHERJI: Okay. So we have a motion with a
19 second. Any further discussion on the motion on the table?
20 I'll call to question. Everyone for the motion, raise your
21 hand?
22 (All in favor)
23 DR. MUKHERJI: Motion passes. Thank you very
24 much. It was a great discussion. Now, based on the public
25 agenda, we're supposed to take a 10- to 15-minute break, so

1 I think it's probably -- I need to take a biological break,
2 so why don't we just take a 10 or 15 (sic) break, and then
3 we'll come back.
4 (Off the record)
5 DR. MUKHERJI: Okay. Elizabeth, I think we are
6 now going to talk about Cardiac Catheterization Services.
7 MS. NAGEL: We are. The Cardiac Catheterization
8 Services standards were part of the public comment period
9 held in October of 2016. There were eight pieces of
10 testimony received and several issues identified. The first
11 is a change that was made to Section 10 of the standards.
12 It was made at the most recent SAC that made changes to the
13 standards, and it was a requirement of quality requirement
14 that held all programs to demonstrate that they conformed to
15 specific national guidelines as part of their application.
16 Several -- I think there were two, perhaps even three
17 entities asked for clarification on this and perhaps its
18 removal. The Department does not recommend that it gets
19 removed. However, if you are going to remove it or have a
20 discussion, we do recommend a SAC to be formed.
21 The second was about whether or not certain types
22 of Cardiac Catheterization Services can be performed in
23 ambulatory surgical centers. Again the Department believes
24 that that should be reviewed by a Standard Advisory
25 Committee.

1 The third was the recommendation to relax the
2 definition of primary percutaneous coronary intervention,
3 and again we believe that that would require an expertise by
4 Standard Advisory Committee.
5 The fourth was to review the requirements for
6 door-to-balloon time and to exclude a specific type of
7 patient. Again we would like the expertise of a Standard
8 Advisory Committee for that.
9 Another recommendation was to review the
10 methodology, and again we would like a SAC to review that.
11 The second one on the second page of this was to review
12 volume, quality cost and patient experience. You can refer
13 to the comments provided by the DMC Heart Hospital. And the
14 Department recommends this is not given a substantive review
15 as it was part of the most recent Standard Advisory
16 Committee. The third one on the second page was -- speaks
17 to publically available reports from a third -- objective
18 third party. And again the Department as in other standards
19 believes that this is outside of the purview of Certificate
20 of Need. The fourth on the second page was identified by
21 the Department. We would like some clarification on an
22 initiation requirement. We'd like a Standard Advisory
23 Committee to do that. Next we would like a Standard
24 Advisory Committee to review whether or not the definition
25 for certain procedures that are allowed under Cardiac

1 Catheterization is still relevant. And again if we're going
2 to form a SAC, the Department would like some review on
3 whether or not Cardiac Catheterization Services can be
4 replaced from one existing hospital to another site. Again
5 this is similar to Open Heart Surgery. And any other
6 technical edits, we are not aware of any other technical
7 edits at this time but would like to leave the door open to
8 the Department making technical edits.
9 DR. MUKHERJI: Good. Public comment? I have a
10 couple. Melissa Cupp?
11 MELISSA CUPP
12 MS. CUPP: I don't have to sign in. There's no
13 page.
14 MS. NAGEL: Somebody must have taken it because
15 there was a page.
16 MS. CUPP: Oh, okay. Behind someone's notes.
17 Good morning. I am Melissa Cupp with Art of UC Advocacy.
18 This morning I'm here representing the Michigan Chapter of
19 the American College of Cardiology. They apologize for not
20 being able to send a representative directly but asked that
21 I read a quite brief letter, which I believe you all have
22 comments of as well, but I'll read into the record.
23 "Dear Commissioners: The Michigan Chapter of the
24 American College of Cardiology is committed to
25 supporting the development and delivery of

1 cardiovascular standards, with the ultimate goal of
2 transforming cardiovascular care and improving heart
3 health. We believe a robust discussion of the CON
4 standards is a necessary step to achieve this goal.
5 After reviewing the public comments pertaining to
6 the Cardiac Catheterization Standards, MCACC would like
7 to offer a clarification on the proposal to expand the
8 definition of primary PCI. We believe that primary PCI
9 is defined as, quote, 'emergent PCI of the
10 infarct-related artery without prior fibrinolysis for
11 ST-elevation MI (including posterior MI) within 12
12 hours of system onset.' While performing PCI for
13 patients with coronary ischemia in cardiogenic shock
14 emergently at PCI centers without surgical backup
15 merits a vigorous discussion, it should be considered
16 separately without changing the definition of primary
17 PCI.
18 MCACC members are best prepared to discuss the
19 merits of the balance of the suggestions provided in
20 public comment.
21 It is also important to note that the ACC, in
22 partnership with the American Heart Association now
23 offer accreditation services focused on all aspects of
24 cardiac care, including chest pain, cardiac
25 catheterization, atrial fibrillation, heart failure and

1 other cardiovascular conditions. This accreditation
2 will offer hospitals a single source of
3 state-of-the-art process improvement tools to bridge
4 gaps and integrate evidence-based science, quality
5 initiatives, clinical best-practices and the latest
6 ACC/AHA guidelines into their cardiovascular care
7 processes. The many hospitals that have chest pain
8 certification or Mission Lifeline accreditation are
9 likely to be rolled in to this new accreditation. We
10 anticipate that its accessibility will make it a
11 preferred product over ACE and so should be considered
12 as an option or replacement for ACE in the cath
13 standards.
14 Please contact me or our Executive Director, Alice
15 Betz if we can be of assistance."
16 And this is signed by Akshay Khandelwal, the President of
17 the Michigan Chapter of the ACC. Thank you.
18 DR. MUKHERJI: Questions for Melissa?
19 MS. GUIDO-ALLEN: Question, Guido-Allen. What do
20 you do in a patient who's post -- I'm a CICU nurse -- so
21 posterior MI who doesn't demonstrate ST-segment elevation?
22 Not considered primary PCI?
23 MS. CUPP: I apologize. I'm the least qualified
24 person in this room probably to answer that question, so I'm
25 very sorry. But I do think this was included in the

1 Department's recommendation for the SAC, so I assume that
2 that will be a part of that discussion and the ACC's
3 interest then in participating in that discussion as well.
4 MS. GUIDO-ALLEN: Thank you.
5 DR. MUKHERJI: Other questions? Okay. Thank
6 you, Melissa.
7 MS. CUPP: Thank you.
8 DR. MUKHERJI: The other public comment card I
9 have is from David Walker from Spectrum Health.
10 DAVID WALKER
11 MR. WALKER: Good morning again. David Walker
12 with Spectrum Health. Thank you very much for the
13 opportunity to provide comment on the Cardiac
14 Catheterization Services CON Review Standards. Spectrum
15 Health strongly supports continued regulation of Cardiac
16 Catheterization Services with the following
17 clarifications/changes.
18 Spectrum Health believes there needs to be
19 clarification with regards to Section 10(5)f of the project
20 delivery requirements. This section requires all cardiac
21 cath lab facilities to conform with the SCAI/ACC Guidelines
22 for PCI including the SCAI/ACC/AHA Expert Consensus
23 Document. It is our understanding that this document was
24 created specifically to address facilities without on-site
25 OHS and shouldn't be applied to programs without on-site

1 OHS. If the document does not apply to facilities with OHS
2 on-site but facilities with OHS on-site are claiming to meet
3 the guidelines, then it appears there is some confusion
4 about which guidelines should be followed. We believe this
5 section needs to be clarified to specifically address which
6 SCAI/AHA/ACC documents or metrics should be referenced when
7 complying with this section.
8 Spectrum Health also supports modifying the
9 definition of Primary PCI to mean a PCI performed on an
10 emergent basis for acute ST-segment elevation myocardial
11 infarction, posterior wall MI or cardiogenic shock secondary
12 to left ventricular or right ventricular failure from acute
13 myocardial ischemia. We believe this is a more accurate
14 definition. Spectrum Health also supports excluding
15 patients requiring cardiogenic shock from the 90-minute
16 door-to-balloon time requirements.
17 Given the additional recommendations from the
18 Department, we would support a more in-depth review of the
19 standards by a SAC.
20 Thank you very much for allowing me to speak to
21 these standards and provide some recommendations.
22 DR. MUKHERJI: Questions for David? Okay. Thank
23 you.
24 MR. WALKER: Thank you very much.
25 DR. MUKHERJI: Any other public comments on this

1 topic? I'll make an exception.

2 MARLENE HANSON

3 MS. HANSON: Thank you for allowing me to speak.
4 I'm Marlene Hanson. I'm the Director of Heart and Vascular
5 Services at Mercy Health-St. Mary's in Grand Rapids. We are
6 one of the organizations that did go through the primary
7 PCI, the elective PCI process this last cycle, and it's been
8 a wonderful experience, wonderful experience. But we did
9 have to go through the ACE accreditation. Though it was a
10 good learning experience, the cost total is going to come
11 out to about $70,000, cost prohibitive for a lot of
12 hospitals, and we did not really feel there was a benefit to
13 us. You know, you looked at dotting the I's and crossing
14 the T's. But when we look at why this was formed from an
15 economic viewpoint from patients, did it impact quality? We
16 already have our BMC2 and ECC/NCR reports excellent. That
17 has not changed. Patient experience definitely has improved
18 from elective PCI, but the ACE accreditation did not impact
19 that. So as you look at cost analysis and benefit for the
20 patient, it really comes out for our organization about $115
21 per patient that it increased the cost without additional
22 benefit. So as you have spoke, there are many other --
23 Spectrum Health addressed it earlier -- there are many
24 accreditations that we go through that already show benefit,
25 particularly the AHA and the ACC. So I'd really support

1 what Spectrum Health said going to those accreditations
2 versus ACE, which for one year spending $70,000 without
3 benefit really is prohibitive. Thank you for allowing me to
4 speak.
5 DR. MUKHERJI: Thank you. Questions? Thank you.
6 Any other people would like to make public comments before
7 the Commission discussion? Okay. So just to reiterate, our
8 charge on this is to determine whether or not the specific
9 topics should be brought to a SAC or a work group; is that
10 correct, Beth?
11 MS. NAGEL: (Nodding head in affirmative)
12 DR. MUKHERJI: So this topic is open for
13 discussion. Jim?
14 MR. FALAHEE: I'll try to cut this one short. I
15 would make a motion that we approve the recommendations of
16 the Department as listed on the pages in front of us and
17 that we form a SAC to look at the issues identified by the
18 Department and that that SAC's charges be identical to those
19 issues identified by the Department on the pages in front of
20 us.
21 DR. MUKHERJI: We have a motion on the table.
22 DR. TOMATIS: Wait. So this is a motion? You
23 made a motion? Yeah, second.
24 DR. MUKHERJI: We have a second. We have a motion
25 and a second. Commission discussion? Okay. I'll call to

1 question. All in favor of the motion, raise your hand.
2 (All in favor)
3 DR. MUKHERJI: Motion passes.
4 MR. FALAHEE: I'll make a second motion now that
5 that's passed to delegate to the chair and the vice chair
6 and the Department to work together to develop the final
7 official charges to the SAC and I'll make that motion.
8 DR. MUKHERJI: Thanks a lot.
9 MR. FALAHEE: You're welcome.
10 DR. MUKHERJI: We have a motion, hopefully there's
11 no second.
12 MS. CLARKSON: This is Commissioner Clarkson, I'll
13 second.
14 DR. MUKHERJI: Oh, dear, we have a second.
15 Further discussion? All in favor of this terrible motion?
16 (All in favor)
17 DR. MUKHERJI: Motion passes. So the next issue
18 is Megavoltage Radiation Therapy. Elizabeth?
19 MS. NAGEL: Megavoltage Radiation Therapy was the
20 sixth and final standard to be included in the October 2016
21 public comment period. The Department received comments
22 from seven organizations and the issues identified are in
23 the chart in your packet.
24 The first issue that was identified by one
25 facility asked that Section 11(2)(I) add that all

1 dosimetrists be Board Certified. The Department does not
2 believe that this requires substantive review. The second
3 issue identified -- the second and last issue identified
4 refers to Section 3(4) and asks for these to be updated or
5 removed -- that certain provisions be updated or removed.
6 This section is the HMRT or Proton Beam Therapy section, and
7 the Department does not recommend that this be reviewed at
8 this time. At this point there are two projects that have
9 not been implemented at this time, and we would ask that
10 those be implemented. We understand the outcome better of
11 those two projects before we make any changes to these
12 standards. However, if the Commission does decide that
13 these -- this specific section should be looked at, we do
14 strongly recommend that it be in the form of a Standard
15 Advisory Committee. And then we do not at this time have --
16 we have not at this time identified any other technical
17 edits that need to be made.
18 DR. MUKHERJI: Thank you. This is now open for
19 public comment. I know we did receive a letter from the
20 University of Michigan, so that's in your packet. I did not
21 receive a card from U of M regarding this.
22 MR. SZELAG: No public comments. No follow-up
23 comments.
24 DR. MUKHERJI: No follow-up comments. Okay. I
25 have not received any cards. One last chance.

1 MR. WALKER: I submitted one, but --
2 DR. MUKHERJI: You did?
3 MR. WALKER: Yeah.
4 DR. MUKHERJI: Oh, I'm sorry.
5 MR. WALKER: No. That's all right.
6 DR. MUKHERJI: David Walker. How can I forget?
7 Sorry about that, David.
8 MR. WALKER: Not a problem.
9 DR. MUKHERJI: I couldn't read your handwriting.
10 MR. WALKER: Yeah, that makes sense.
11 DR. MUKHERJI: Okay. All right. Apologies.
12 DAVID WALKER
13 MR. WALKER: Well, I'll be extremely brief, but
14 thank you for the opportunity to provide comment on the MRT
15 Review Standards.
16 Spectrum Health believes MRT should continue to be
17 regulated with one technical change as pointed out here.
18 Section 11(2)(iii) requires a dosimetrist, and we believe
19 the standards should be updated to indicate that this
20 dosimetrist be Board Certified.
21 Thank you very much.
22 DR. MUKHERJI: So I'll just -- is there -- I
23 believe there are certain accrediting bodies for
24 dosimetrists. Based on your suggestion, any accrediting
25 body would be -- provide certification? And I may be wrong

1 on this, but I thought there are different certifying bodies
2 for dosimetrists.
3 MR. WALKER: I'm actually not a expert in
4 dosimetrist certification. I would like to defer to medical
5 experts in that realm before making a public statement
6 confirming one way or the other. But I believe that
7 generally any Board Certification is a indicator of quality
8 which is what we're concerned with here and that, if that is
9 a nationally accredited organization and that would be an
10 indication of quality, then we would be satisfied with that.
11 DR. MUKHERJI: Any other comments? Okay. Thank
12 you.
13 MR. WALKER: Thank you.
14 DR. MUKHERJI: Is there anybody else who would
15 like to comment? Hopefully I didn't overlook anyone. I
16 apologize for that again. Okay. Commission discussion on
17 MRT? So from what I -- just to summarize everything, the
18 Department felt that there were no substantial changes, but
19 the Commission felt there was a substantial change. Not
20 saying they would recommend SAC but, from what I hear, we
21 also could go to work groups. So from my interpretation,
22 all three are on the table. So, Deb?
23 MS. GUIDO-ALLEN: Guido-Allen, just on the Board
24 Certification, to me, that's more of a job description of a
25 site that has dosimetrists versus this Commission or the

1 Department regulating minimum standards or competencies. My
2 two cents.
3 MR. FALAHEE: This is Falahee. I appreciate those
4 two cents. And I'd like to make a motion that we adopt the
5 recommendation of the Department as appear in front of us on
6 page 72 of 82. I make that motion.
7 MS. NAGEL: Can I clarify? Is that to form a SAC
8 or not to form a SAC?
9 MR. FALAHEE: No, just not to form a SAC. The
10 Department's recommendations were basically no and no, and
11 the motion I'm making is to approve that Department
12 recommendation.
13 MS. NAGEL: Thank you.
14 DR. MUKHERJI: We have a motion on the table.
15 DR. TOMATIS: Second.
16 DR. MUKHERJI: Dr. Tomatis seconds. So we have a
17 motion and a second. Further Commission discussion?
18 Hearing none, I'll call to question. All in favor of the
19 motion, raise your hand.
20 (All in favor)
21 DR. MUKHERJI: All right. The motion passes.
22 Based on the agenda, now we now have a opportunity for
23 anyone to comment on anything they wish to comment on
24 hopefully pertaining to CON. I haven't received any blue
25 cards, so I think the next thing is Review of the Commission

1 Work Plan.
2 So, Elizabeth?
3 MS. NAGEL: Sure. The Commission Work Plan will
4 be updated to show a Standard Advisory Committee for Cardiac
5 Catheterization Services for a discussion in March for
6 Hospital Beds, for Megavoltage Radiation Therapy to go on
7 its next schedule for review, for the Department to come
8 back with language on Open Heart Surgery, for Positron
9 Emission Tomography to come back to the Commission in three
10 years for its next review, and for the Department to come
11 back to the Commission with Surgical Services language. The
12 Work Plan will be updated to reflect these changes that
13 you've made at today's meeting.
14 DR. MUKHERJI: The way my interpretation of this
15 is an action item. So any Commission discussion on the Work
16 Plan? All right. So I'll entertain a motion.
17 MR. FALAHEE: So moved, Falahee.
18 DR. MUKHERJI: Motion to approve the work plan?
19 MR. FALAHEE: Approve the Work Plan.
20 DR. MUKHERJI: Okay. Just want to make sure. So
21 there was a motion to approve the Work Plan. Second?
22 MS. KOCHIN: Commissioner Kochin, second.
23 DR. MUKHERJI: Commissioner seconded. We have a
24 motion and a second. Any further discussion? Okay. All in
25 favor?

1 (All in favor)
2 DR. MUKHERJI: Any against? Motion passes. The
3 Work Plan is approved. Wow. So the next thing I have is --
4 is there any before I get to the future meeting dates?
5 MR. FALAHEE: I've got one other item before. I
6 don't see any legislative updates, which is good, but I'd
7 like to welcome former Representative Matt Lori to this
8 illustrious table. It was my pleasure to work with
9 Representative Lori when he was in the legislature for many
10 years. And I welcome you, Matt, as our legislative liaison,
11 look forward to whatever reports, hopefully few, you have
12 regarding the CON. But welcome. Thank you for joining us.
13 MR. LORI: Thank you.
14 DR. MUKHERJI: Thanks, Jim. Any other -- okay.
15 So the next item -- I'm starting to shed tears, because
16 we're about to leave -- future meeting dates: March 16th,
17 June 15th, September 21st and December 7th. And the last
18 thing is adjournment.
19 MS. NAGEL: Motion to adjourn.
20 DR. MUKHERJI: You can't make a motion to adjourn.
21 MR. FALAHEE: Motion to adjourn, Falahee.
22 DR. MUKHERJI: Falahee, we have motion to adjourn.
23 MS. KOCHIN: Second.
24 DR. MUKHERJI: Second. We have a second. All in
25 favor?

1 (All in favor)

2 DR. MUKHERJI: Anybody against? All right. Thank

3 you very much. We got a lot done. Thank you.

4 (Proceeding concluded at 11:47 a.m.)

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