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., CHAIRPERSON
6
333 South Grand Avenue, Lansing, Michigan
7
Thursday, December 7, 2017, 9:30 a.m.
8
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DENISE BROOKS-WILLIAMS
10 JAMES FALAHEE
TRESSA GARDNER, D.O.
11 DEBRA GUIDO-ALLEN, R.N.
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25

1 Lansing, Michigan
2 Thursday, December 7, 2017 - 9:32 a.m.
3 DR. MUKHERJI: Good morning, everyone. Welcome on
4 this snowy December morning. Just want to thank everyone
5 for coming to the CON Commission. So I'm going to call the
6 meeting to order. The next is the review of the agenda.
7 Does anybody have any comments on the agenda? If not, I'll
8 take a motion to approve the agenda.
9 DR. GARDNER: Motion.
10 DR. MUKHERJI: Okay. We have a motion to approve.
11 Second?
12 MS. BROOKS-WILLIAMS: Support.
13 DR. MUKHERJI: We have a second. We have a motion
14 and a second. Any point of discussion? Oh. Sorry.
15 MS. ROGERS: This is Brenda. Just as a friendly
16 reminder, would you please identify yourself each time
17 before you speak? So the maker of the motion was?
18 DR. GARDNER: Tressa Gardner.
19 MS. ROGERS: Thank you. And the second one?
20 MS. BROOKS-WILLIAMS: Denise Brooks-Williams.
21 MS. ROGERS: Thank you.
22 DR. MUKHERJI: You're slowing me down. Okay. So
23 we have a motion and a second. Any further discussion? All
24 in favor?
25 (All in favor)

1 DR. MUKHERJI: Any against? The agenda is
2 approved. The next is declaration of conflict of interest.
3 Anybody have any relevant conflict of interest? Hearing
4 none, I'll go to the review of the minutes. So the minutes
5 are included in the package, so we'll give people a couple
6 minutes to review the minutes. Once they've been reviewed,
7 I'll be happy to take a motion to accept the minutes.
8 MR. FALAHEE: This is Falahee. Make a motion to
9 approve.
10 DR. MUKHERJI: So we have a motion to approve.
11 Any second?
12 MR. MITTELBRUN: Mittelbrun, second.
13 DR. MUKHERJI: Mittelbrun, second. We have a
14 motion and a second. Any further discussion? Hearing no
15 discussion, all in favor?
16 (All in favor)
17 DR. MUKHERJI: Any against? Okay. The minutes
18 are approved. The next agenda item is Urinary
19 Extracorporeal Shock Wave Lithotripsy draft language. I
20 have one blue card for public comment. Brenda, do you want
21 to just tee this up for us before we get public comment?
22 MS. ROGERS: This is Brenda. Good morning. In
23 your packet of material you have the draft language. As
24 you'll recall at your September Commission meeting you asked
25 the Department to go back and possibly make some

1 modifications, taking a further look at the MRI conversion
2 language, which includes looking at it for a tax-exempt
3 not-for-profit hospital, operating a 24/7 ER, et cetera. So
4 the Department has done that. We've kind of done that in
5 conjunction with the requester of this addition to the
6 language. So you have that in front of you. So the major
7 changes from what you had in September -- okay? -- are we
8 have changed it from -- originally we were suggesting 1,000
9 procedures be done.
10 That's been changed to 500 procedures annually for
11 the past three years. But along with that, we have looked
12 at the ER visits, similar to what MRI does. In MRI, they
13 used 20,000 visits, but obviously that's a different
14 modality. In taking a look at the data for the -- I think
15 it was the 2016 data that we looked at, 80,000 visits kind
16 of seemed to be the mid point and seemed to be a reasonable
17 suggestion.
18 So that is an addition as well. I think the other
19 things we've done -- we've looked at removing the volume
20 requirement for replacement, same as what we've done in the
21 other CON review standards. And we've also -- under Section
22 4(3) there's language in there for a conversion from fixed
23 to mobile units. That was put in there years ago when there
24 were only fixed units in the state, and it was to be able to
25 allow them to convert to mobile. So we are leaving that in

1 there, but with a modification that if you want to
2 convert -- let's say as time goes by, if more facilities
3 convert their mobile units to fixed and at some point they
4 feel that they want to convert back, they may be allowed to
5 do that. However, you will have to be meeting the volume
6 requirement which isn't there right now. So we've left the
7 language in there for possibilities down the road, but you
8 do have to meet the volume requirement in order to do that.
9 I'm trying to think. The other major change,
10 you'll see some language in Section 7(4) of the draft
11 language which has been completely stricken. That is being
12 removed as to give mobile routes more flexibility to change,
13 to accommodate if there's changes caused by larger
14 facilities converting from mobile to fixed units. So
15 it's -- again, so trying to find a balancing act in all of
16 this. So that's really what that's doing.
17 So I believe those are the major changes in the
18 draft language. And if you have any questions, we will try
19 to answer those. Otherwise, we submit this language and do
20 support it for proposed action if the Commission chooses
21 today. Thank you.
22 DR. MUKHERJI: Any questions for Brenda?
23 DR. GARDNER: Tressa Gardner. Brenda, why was ER
24 even considered as this is not an emergent procedure, and
25 why was there an 80,000 visit?

1 MS. ROGERS: There was a discussion, as you'll
2 recall, at the last meeting to kind of take a look at that
3 and to add some additional parameters if we are going to
4 allow this in the state. So even though these seem to be
5 done in an outpatient setting, it still is done -- it's kind
6 of a demonstration of a facility that they are operating not
7 necessarily just lithotripsy, but they are a high-volume
8 facility that wants to do this.
9 So that was proposed and the Commission asked the
10 department to take a look at that. We looked at it and, you
11 know, we can support that if that's what the Commission
12 chooses. And I believe it was Commissioner Falahee that
13 made that suggestion, so I'll let him chime in if he's got
14 any additional comments.
15 MR. FALAHEE: No. I don't have any additional
16 comments. You're correct. When I mentioned that in
17 September, I said look at what we do for MRI as an example,
18 not to be zealously followed. But I think the department
19 did a good job of trying to thread the needle and I'm
20 comfortable with that language.
21 DR. GARDNER: Tressa Gardner. How many hospitals
22 would that include and is this a disadvantage to the
23 hospitals that do not have -- once again, ER volume is not
24 related to this procedure -- that do not have 80,000 ED
25 visits?

1 MS. ROGERS: I don't have the data with me, but I
2 believe it was the top ten percent of the hospitals in the
3 state.
4 DR. GARDNER: And does it cover a service area?
5 Appropriate coverage for the state?
6 MS. ROGERS: I personally did not look at where
7 the individual hospitals are, so that -- I can't answer the
8 question on that, but it was the top ten percent of the
9 hospitals in the state.
10 DR. GARDNER: I think those would be very
11 concentrated and my concern would be if you had 50,000-visit
12 ED's that could do the same procedure, it should be related
13 to the volume that they have if they're doing it from a
14 mobile unit as opposed to the ER volume overall.
15 DR. MUKHERJI: Any other questions?
16 MR. MITTELBRUN: I have one. Tom Mittelbrun.
17 Brenda, when you mentioned the change from the 1,000 to 500,
18 was that 500 annually or average?
19 MS. ROGERS: It's an average over the three years.
20 So let's say -- so it's the previous three years. And I had
21 to do this for myself because I keep getting those confused.
22 But it's -- so if you had 500 one year, 700 another, 600
23 over the other, a third year, and divide that by three, that
24 comes out to 600 so you meet the requirement.
25 MR. MITTELBRUN: Okay. Thank you.

1 DR. MUKHERJI: Other questions? Okay. Hearing
2 none, we have two cards. The first is from John Shaski at
3 Sparrow Health System. And just to remind all the speakers,
4 we're going to hold them to strict three minutes
5 presentation period. Right, Tania?
6 JOHN SHASKI
7 MR. JOHN SHASKI: Thank you. Good morning. I'm
8 John Shaski and I'm the government relations officer at
9 Sparrow Health System. Sparrow appreciates the Commission's
10 time and deliberation on the issue of UESWL standards,
11 specifically the conversion of a mobile to a fixed unit.
12 We've read the department's proposed standards and we
13 believe they provide for a good compromise to those who have
14 weighed in on this issue. The language allows hospital
15 providers with a demonstrated, consistent, high volume to
16 convert to a fixed unit at one location.
17 We believe the language is consistent with other
18 sets of standards and reflects the direction given by the
19 Commission to the department at the September meeting. As
20 you are aware, over the past several years Sparrow Hospital
21 has raised concerns about the cost of providing high-quality
22 high-volume lithotripsy services in a mobile environment.
23 Sparrow is very committed to our patients. In the past six
24 years our volume has maintained high levels. However, the
25 cost of the annual lease and service contract exceeds the

1 cost of a new machine, which creates a significant barrier.
2 We appreciate the work that is done by the department and
3 the Commission, and we look forward to working together to
4 advance this proposal.
5 DR. MUKHERJI: Thank you very much. Any questions
6 for Mr. Shaski? Thank you. The next card I have is from
7 Melissa Cupp from RWC Advocacy.
8 MELISSA CUPP
9 MS. MELISSA CUPP: Good morning. My name is
10 Melissa Cupp and I'm with RWC Advocacy. I am here this
11 morning representing Jorgen Madsen at Great Lakes
12 Lithotripsy. He actually did fly in for this meeting this
13 morning, stayed by the airport in Detroit and unfortunately
14 we didn't give him the warmest welcome. Someone broke into
15 his vehicle -- his rental vehicle -- and he is stuck dealing
16 with the police and the insurance and the rental company
17 this morning. So he did send me his comments and asked that
18 I deliver them on his behalf. So not quite the introduction
19 he was planning to make.
20 "Thank you for this opportunity to provide
21 additional comments regarding the CON standards for
22 lithotripsy services. We appreciate the additional
23 time and effort the department has put into finding a
24 compromised proposal to cautiously allow for the
25 conversion of higher volume lithotripsy host sites to

1 convert to fixed service and obtain their own units.
2 Although we continue to have concerns about the overall
3 impact these conversions will have on access to lower
4 volume sites throughout the state, we do support the
5 Department's proposal with just one exception. The
6 Department's proposal looks at a three-year average of
7 lithotripsy volumes at the host site proposing to
8 convert to fixed service. We do not feel this is the
9 most accurate way of projecting need for a service. If
10 a host site has had really high volume three years ago,
11 but since then experienced a decrease in volume, the
12 most recent 12 months would show a much more accurate
13 picture of what the facility should expect for volume
14 going forward. We do not believe a three-year average
15 is used in this way in any other standards and would
16 request this be changed to require 500 in the previous
17 12 months to qualify for this provision.
18 We do appreciate the inclusion of a couple of
19 provisions that will help remaining mobile routes to
20 adjust to significant changes in volume and schedules
21 which will hopefully allow them to maintain as much
22 geographic access as possible including assurance that
23 they will be allowed to replace aged equipment when
24 needed."
25 This was not in Jorgen's comments, but I'll add it

1 just regarding the 80,000 ED visits. Although we do
2 recognize that this is not an emergent procedure, as Sparrow
3 actually had pointed out in their comments last time, many
4 patients do arrive at the facility via the ED. And then in
5 looking at -- I did just a real quick review of the data
6 that I had on my laptop and there are facilities with 80,000
7 or higher ED visits that seem to be spread out pretty well.
8 I saw Grand Rapids, Jackson, Lansing, some in
9 Detroit. So I can't speak to everything, but there did seem
10 to be a reasonable distribution. "We hope that we found a
11 balance here that will allow the mobile routes to continue
12 to provide excellent access across the state and we support
13 the concept." Thank you.
14 DR. MUKHERJI: Thank you very much. Questions for
15 Ms. Cupp?
16 MS. BROOKS-WILLIAMS: Commissioner
17 Brooks-Williams. So talk a little bit more about the most
18 recent 12 months of the data versus the average of 3 years.
19 MS. MELISSA CUPP: The average 3 years? Yeah. So
20 I think the idea of being -- and I'll throw this out just as
21 a really absurd example. But I think sometimes the absurd
22 kind of demonstrates the concern that we have. So let's
23 say -- so we're looking at a 3-year average of 500. So if a
24 facility performed 1500 three years ago and nothing in the
25 most recent 12 months, their average would still be 500.

1 And so historically, at least from what I can remember --
2 and I admittedly did not look through every set of
3 standards, so if somebody knows otherwise, please jump in
4 and correct me -- but I don't believe we used a 3-year
5 average in this way in any other standards. So we used, I
6 think, like an average per year for, like, 3 consecutive
7 years out of high occupancy for hospital beds, and I think
8 we maybe used, like, a 2-year every, you know -- every two
9 years of high occupancy on psych. But for projecting, like,
10 a specific volume needed to do something in this area, we've
11 always just used the most recent 12 months.
12 MS. BROOKS-WILLIAMS: Okay. Thank you.
13 DR. MUKHERJI: Other questions?
14 MR. FALAHEE: This is Falahee. I can see the
15 other flip, though. You don't want to have a spike up or
16 down meaning that that's what you're going to have going
17 forward. So I understand why we do the average as we talked
18 about earlier. I'd like to know what the department's
19 position is on that. That will inform us.
20 MS. NAGEL: Sure. This is Beth. The average was
21 meant to recognize that today on the mobile routes, the
22 provider, the host site, is -- actually has less control
23 over their volume than in our other modalities. So if a
24 host site gets added to the route, the volume at that
25 facility will drop. And so the average was meant not to

1 capture the absurd, but to capture the very real thing
2 that's going on. The phenomenon we're seeing is that these
3 sites, unlike our other standards, have very little control
4 over the volume.
5 DR. MUKHERJI: I kind of agree with that, too.
6 I'm not a statistician -- I did stay in the Holiday Inn last
7 night.
8 MR. MITTELBRUN: You didn't have your car broken
9 into.
10 DR. MUKHERJI: Yeah. I didn't have my car broken
11 into. Sorry about that. But in general if you have the
12 flip side, if someone did have 1500 and they qualified and
13 the next year they have zero, this actually suffices for
14 that. So I think it does indicate a consistent need and
15 volume over time. Any other questions for Melissa? Okay.
16 Thanks.
17 MS. MELISSA CUPP: Thank you.
18 DR. MUKHERJI: So those are the only two blue
19 cards I have for lithotripsy. Would anybody else like to
20 comment? Okay. We'll move on to commission discussion. So
21 commission discussion on this proposed language?
22 MR. FALAHEE: Hearing none, I know there's some
23 questions about the 80,000 and where hospitals are located
24 that have 80,000 and whether if you draw a line north of
25 Grand Rapids no hospital is over 80,000. Given that, at

1 this stage of the game, because this now would go out to
2 public hearing if -- assuming we would approve it, what I
3 would do is make a motion to approve the revised standards
4 as we have in front of us right now; that's number one.
5 Number two, that they be sent to the JLC. Number three,
6 they be sent out for public hearing, and I would encourage
7 those at the public hearing or submitting written comments
8 if they so choose, to specifically comment on the 80,000
9 visits issue and the other items that were identified during
10 our discussion.
11 DR. MUKHERJI: And your name?
12 MR. FALAHEE: Mukherji. Falahee.
13 DR. MUKHERJI: That was Falahee before I get
14 reprimanded. So we do have a motion by Mr. Falahee to
15 approve and move this forward.
16 DR. KESHISHIAN: Commissioner Keshishian, second.
17 DR. MUKHERJI: We have a second. We have a motion
18 and a second. Further Commission discussion? Hearing none,
19 all in favor?
20 (All in favor)
21 DR. MUKHERJI: Any against? Motion carries
22 unanimously. The next is Surgical Services, Vascular Access
23 draft language. Brenda?
24 MS. ROGERS: Again, this is Brenda. You have
25 language in front of you. At the September Commission

1 meeting you did move forward surgical standards that just
2 became effective on November 17th. So the draft that you
3 have in front of you today -- which you asked us to take a
4 look at the vascular access issue, and in working with
5 Fresenius; we worked with them. And so the proposal we have
6 for you today is actually in the new set of surgical
7 standards, so that worked out good so we didn't have to mess
8 around with two different standards.
9 So what is being added, there are new definitions
10 being added to accommodate, we're defining CMS, we are
11 defining dedicated vascular access operating room, and ESRD
12 facility, vascular access surgical cases. So those are new
13 definitions to support this type of OR. And then we're
14 adding language under "Initiation" to allow for surgical
15 service of one or more operating rooms to be used
16 exclusively for vascular access surgery cases.
17 This will allow for sites to meet the CMS
18 regulations for ESRD facilities performing these types of
19 surgical cases, which I believe is the basis the Commission
20 asked the department to take a look at this. So in addition
21 to meeting the existing requirements in the surgical
22 standards, there are additional requirements that will have
23 to be met and they are outlined in the draft language. I
24 may miss one or two, but hopefully you've had a chance to
25 take a look at the language. They still have to meet the

1 same volume requirements as a regular OR, the 1128 in this
2 case. They will have to demonstrate that they currently
3 offer an ERSD facility. However, we've added language --
4 and if Tania pulls it up -- Tania, if we can, go to Section
5 4(1) -- or excuse me -- 4(4)(a) of the standards. It wasn't
6 in your packet yesterday, but it's on the -- you'll see it
7 up on the board here. We've added language in here to
8 accommodate for common control, common parent or consulting
9 agreement to -- because there could be different situations
10 as we put this language together.
11 We received some feedback earlier this week and so
12 we were just trying to cover all bases. And this is similar
13 language that we use in our other standards. All right. So
14 that's actually the only change that -- in this language
15 from what we sent out to you a week ago. Surgical cases
16 service shall be used only for vascular access surgical
17 cases.
18 "The applicant shall obtain accreditation from the
19 Joint Commission, the Accreditation for Ambulatory
20 Health Care or another accrediting body approved by CMS
21 for purposes of Medicare Certification," et cetera.
22 They have a certain time period that they have to
23 do this within. They shall participate in the Medicare
24 program and be certified as an ambulatory surgical center,
25 again, within a certain period of time. "The applicant

1 shall have a policy and procedure for assuring prompt access
2 for any ESRD patient in need of a vascular access surgical
3 case." And also, with one or more operating rooms being
4 used, they shall employ or contract with an interventional
5 radiologist, nephrologist, vascular surgeon, or other
6 physician trained to provide vascular access procedures for
7 clinical oversight of the surgical services. Additional
8 project delivery requirements have also been added for
9 anybody seeking approval under these standards.
10 And again, still meeting all the other project
11 requirements as applicable. So they will have to maintain
12 compliance with the accreditation. They will have to,
13 again, maintain the Medicare. They will have to -- the
14 rooms are only used for vascular access. So again, they're
15 agreeing to that up front, but they're also continuing to
16 agree with that project delivery requirements.
17 And again, policy and procedure for assuring
18 access. Again, something they agreed to up front, but again
19 reinforcing that in the project delivery requirements and
20 the same thing with the individual providing oversight;
21 agreeing to it up front, but again maintaining that
22 compliance and the project delivery requirements. And then
23 we also updated the "Documentation of Projection" section to
24 again accommodate for the vascular access surgical cases.
25 And then one carryover from the last approval of the

1 standards in September, where we made the revision regarding
2 the physician commitments, it was suggested that there was a
3 couple of other subsections that should also be exempt under
4 Section 11(2)(d) and so we've made those exclusions in this
5 draft per the Commission's request. And again, today, if
6 the Commission chooses to take proposed action, the
7 department can support the language that's being presented.
8 Thank you.
9 DR. MUKHERJI: So just to frame things from my
10 standpoint, my understanding is that we're not creating a
11 separate carve-out for this type of procedure, but what
12 we're doing is we're integrating this type of procedure into
13 a standard that's currently in place. It just doesn't count
14 for this type of procedure?
15 MS. ROGERS: This is Brenda. That is correct.
16 MS. BROOKS-WILLIAMS: Commissioner
17 Brooks-Williams. So to add to that clarification, as this
18 is stated, so if it's a renal dialysis facility that has a
19 room where they're doing vascular access, as long as they
20 have the volume threshold of an OR and get it certified by
21 an accrediting body and have a licensed appropriate
22 physician to deliver the care, they're then able to operate
23 under the ambulatory surgery standard. Are there no other
24 requirements beyond just a dedicated room that has the
25 volume and the certification and the physician?

1 MS. ROGERS: It can't just be for any OR
2 procedure. It's vascular access --
3 MS. BROOKS-WILLIAMS: So restricted to vascular
4 only. Okay.
5 MS. ROGERS: Yes; correct.
6 MS. BROOKS-WILLIAMS: It just seems broader
7 that it -- that word. I apologize. Yeah. Brooks-Williams.
8 But Falahee can say it.
9 MR. FALAHEE: No. Go ahead.
10 DR. TOMATIS: Commissioner Tomatis. For my own
11 education, how many procedures did the BCS service a year on
12 new access or revised access? Just to understand, what are
13 we regulating?
14 MS. NAGEL: Was your question how many of these
15 procedures are done now?
16 DR. TOMATIS: Just take the BCS service. How many
17 cases they do a year, new or revised accesses? Just -- I
18 want to know, what are we regulating?
19 MS. NAGEL: So we don't currently regulate these,
20 so we wouldn't have that data available.
21 DR. MUKHERJI: This is Mukherji. We will be
22 having public comment coming up by content experts, so maybe
23 that could be a question to ask in public testimony.
24 Commissioner Falahee?
25 MR. FALAHEE: Falahee. Following up on

1 Commissioner Brooks-Williams, I had some questions about the
2 language and maybe the commenters can comment. But when I
3 look at the definition of "vascular access surgical case," I
4 get worried when I see at the end, "Or any combination of
5 the foregoing or directly related procedures." I mean, can
6 you drive a truck through that or not? I'm not sure. Then
7 when -- I see in Section 10(5)(c),
8 "The surgical service shall be used only for
9 vascular access surgical cases unless the applicant has
10 obtained CON approval for any operating rooms that are
11 not dedicated exclusively to vascular access surgical
12 cases."
13 So again, this to me is potential OR creep and
14 this is a Certificate of Need, not a certificate of want, as
15 I've said many times before. So this commissioner at least
16 has several questions about the language, what it means, or
17 how it could be applied.
18 MS. NAGEL: I can comment on at least 10(5)(c).
19 That was meant to actually be a protection. So it's
20 interesting to hear your take on it because it was really
21 meant to be that they can only do these vascular access
22 cases unless they have a Certificate of Need to do other
23 services as well. How do you --
24 MR. FALAHEE: I'll take that argument any day of
25 the week. The way I read it is the exact opposite.

1 MS. NAGEL: That they can do what -- can you tell
2 me how you read it?
3 MR. FALAHEE: It said "only for vascular cases."
4 Okay? Now I've got one of those. Now it says "unless I've
5 obtained CON approval," so now I apply for CON approval for
6 another OR to do the volume that I'm generating for
7 combinations of the "foregoing or directly related
8 procedures." I think it creates some uncertainty as to what
9 can happen next.
10 MS. NAGEL: I'll tell you that was very meant --
11 not the intent. So I appreciate --
12 MR. FALAHEE: Oh. I'm sure. I'm sure. Right.
13 MS. NAGEL: So I certainly appreciate you bringing
14 that up. And you know, I think, would it satisfy your
15 concern if we put a period after "cases" and struck
16 "unless"?
17 MR. FALAHEE: It would satisfy this commissioner's
18 concerns.
19 DR. MUKHERJI: Which line number is that?
20 MR. FALAHEE: I don't know what line. I'm looking
21 at draft --
22 MS. NAGEL: It's 10(5)(c), but it's line 573.
23 MS. ROGERS: It's -- yeah -- up on the screen.
24 574 and -3.
25 MS. NAGEL: So this was meant -- how this thing --

1 this was -- I'll tell you the intent and you tell me what
2 you think of the words. The intent was that it would only
3 be used for vascular access cases, but if these -- this
4 wasn't meant to limit the -- if at some point of another
5 kind of FSOF or another kind of surgical service wanted to
6 add this, they could. So it wasn't meant to be --
7 MR. POTCHEN: So if I'm understanding the
8 problem/desire, if you put the word "previously obtained CON
9 approval" -- see, but what's unclear here is what comes
10 first.
11 MR. FALAHEE: Right.
12 MR. POTCHEN: And if that's the department's
13 intent, I could suggest that addition there if that's what
14 you're trying to do.
15 MS. GUIDO-ALLEN: Unless the applicant has
16 previously obtained CON approval --
17 MR. POTCHEN: Or "prior," or putting a period like
18 you suggested.
19 MS. NAGEL: Thank you. That's very helpful to
20 know.
21 DR. MUKHERJI: Chip?
22 MR. FALAHEE: I prefer just putting a period after
23 that and just leaving the rest of it out. That to me
24 eliminates any uncertainty or creative lawyering.
25 DR. MUKHERJI: You resemble that comment.

1 MR. FALAHEE: Thank you.
2 DR. MUKHERJI: So how would you propose it read
3 then?
4 MR. FALAHEE: Falahee. When I'm looking at line
5 573, that line would not be touched. But on line 574 where
6 the word "cases" is right now, put a period after the word
7 "cases" and strike the remainder of that sentence that goes
8 to the end of line 575. And I'll look to Mr. Potchen to see
9 if that's one of the options you were looking at.
10 MR. POTCHEN: I think that is one of the options
11 and I think that does make it very clear.
12 DR. MUKHERJI: Is the department okay with that?
13 MS. NAGEL: Yes.
14 MR. FALAHEE: And then the only other -- just a
15 general comment and maybe the witnesses can talk about it --
16 is what's the need for this? What happens now? Why the
17 request that we got in September and what's driving all
18 this? I understand we got a letter this morning, but,
19 again, I haven't had time to read that letter.
20 DR. MUKHERJI: Other comments by the Commission?
21 DR. KESHISHIAN: This is Commissioner Keshishian.
22 I second Commissioner Falahee's comments. I'd like the
23 witnesses to discuss why we need this policy change at all.
24 I know we discussed it in September, but I'd like a review
25 of the issues.

1 DR. MUKHERJI: Other comments by the commission?
2 We'll move on to the next sub item and I have two blue cards
3 for this. One is from David Walker from Spectrum Health.
4 DAVID WALKER
5 MR. DAVID WALKER: Good morning. Please excuse my
6 voice. My name is David Walker. I'm from Spectrum Health.
7 Thank you very much for the opportunity to provide comment
8 on the Surgical Services CON Review Standards. Spectrum
9 Health would like to thank the department for the hard work
10 on the draft Surgical Services Review Standards before the
11 Commission today.
12 Spectrum Health is specifically pleased to see
13 that the current draft addresses earlier concerns with the
14 physician volume exemption that was previously approved. By
15 exempting applicants from having to identify specific
16 physicians and cases to commit to a new facility, it relaxes
17 the administrative burden imposed on healthcare systems.
18 Spectrum Health supports the current draft and is glad a
19 solution could be found for our earlier concerns.
20 Again, thank you for the opportunity to provide
21 feedback on the proposed changes to the CON Review Standards
22 for surgical services. Spectrum Health appreciates the
23 department's and the Commission's work. I would be happy to
24 answer any questions the commissioners have.
25 DR. MUKHERJI: Thank you very much. Any questions

1 for David? All right. Thank you very much.
2 MR. DAVID WALKER: Thank you.
3 DR. MUKHERJI: The next blue card I have is from
4 Greg Miller from Fresenius. And just a reminder, anything
5 you say is three minutes.
6 GREG MILLER, M.D.
7 DR. GREG MILLER: And, yes, it is pronounced
8 Fresenius (pronouncing). So thank you to the Commission for
9 allowing me to come and give comment. My name is Dr. Greg
10 Miller. I've been focused on performing vascular access
11 procedures for the past 15 years. This is essentially all I
12 do these days. I'm a licensed physician in the state of
13 Michigan and I've actually personally cared for some ESRD
14 patients who require vascular access procedures here in the
15 Lansing area.
16 As I stated in the September meeting, this ESRD
17 population has very high co-morbidities. If they wind up
18 with a hemodialysis catheter as their main source of getting
19 their hemodialysis source of treatment, that has a very
20 significant risk of infection which really drives a very
21 significant increase of cost. Medicare has looked at these
22 patients and stratified them and understood that simply by
23 pushing patients from catheters to fistulas is a very
24 significant cost savings associated with doing that and a
25 significant improvement in morbidity and mortality. By

1 allowing these freestanding outpatient vascular access
2 centers to participate in CMS fistula first initiative and
3 ESCO and ESRD seamless care organizations, we anticipate
4 that there will be a significant cost savings. All of these
5 renal focused ASC's, as I like to call them, they exist for
6 the betterment of ESRD patients. They participate in
7 Medicare and Medicaid services. They're dedicated to
8 vascular access on advanced CKD, chronic kidney disease,
9 stage IV, V and ESRD patients.
10 They essentially maintain affiliation with
11 pathologists and local hemodialysis clinics. And these
12 types of centers focus on QAPI, quality assessment process
13 improvement programs, focused on catheter reduction
14 services. I have a letter of support here from
15 Lawrence Spergel. Lawrence Spergel is the educational
16 architect from the Fistula First Initiative. That may be
17 the letter that one of the commissioners referenced.
18 He wrote it from -- to the Commission on behalf of
19 what we're attempting to do with these renal focused ASC's.
20 The language in front of you today does not change your
21 current requirements for initiating or maintaining surgical
22 services. However, it allows physicians performing these
23 outpatient office-based surgical procedures to commit these
24 cases toward initiation of OR's dedicated to vascular access
25 and ESRD patients. I'll stop there.

1 DR. MUKHERJI: Thank you very much. Questions for
2 Dr. Miller?
3 DR. KESHISHIAN: This is Commissioner Keshishian.
4 I think you discussed this in September, but can you review
5 for us what has changed? There was something about CMS,
6 they had changed their regulations which precipitated you
7 coming to make a request to change the state of Michigan
8 CON. So what did CMS change and any ideas why they changed
9 it?
10 DR. GREG MILLER: Right. So what they did was
11 they actually shifted a very significant amount of
12 reimbursement from the office-based surgical services. I
13 mean, they cut the office-based surgical reimbursement by 30
14 percent and increased the ASC, ambulatory surgery center,
15 reimbursement by about 30 percent, so it was a 60 percent
16 delta.
17 Our centers are currently no longer viable and
18 we're actually going through Certificate of Need processes
19 across 15 different states to convert our centers. So, I
20 mean, we are clearly driven by a change in reimbursement.
21 But what they have done is they've basically said, "Well,
22 you guys have fragmented care, and we need to bring together
23 the fragmentation by combining the surgical access creation
24 as well as the interventions, angioplasties, thoracotomies,
25 catheter insertions/removals, all so that we can control

1 costs because this chronic disease patient population is
2 costing Medicare a tremendous amount of money."
3 DR. KESHISHIAN: This is Commissioner Keshishian.
4 To make sure I understand, so there still -- the sites
5 you're doing them now are considered office?
6 DR. GREG MILLER: Correct.
7 DR. KESHISHIAN: It'll be the same sites if we
8 pass this, they'll just be called ambulatory surgical
9 centers?
10 DR. GREG MILLER: Well, actually in order for us
11 to meet Medicare-deemed status, we will have to do some
12 retrofitting and some other facility modifications because
13 they weren't necessarily built to those specifications at
14 the time. However, they might certainly be in the same
15 location or they could be relocations. But certainly
16 without these types of facilities, you know, the patients
17 will definitely, you know, have access-to-care issues.
18 DR. KESHISHIAN: This is Commissioner Keshishian
19 again. I want to understand the access to care. You're
20 doing them right now in these facilities?
21 DR. GREG MILLER: Right.
22 DR. KESHISHIAN: You could still do these in these
23 facilities, it's just the reimbursement from the CMS would
24 be office versus a ambulatory surgical center?
25 DR. GREG MILLER: I mean, that is correct to the

1 extent that the center that we have here in Lansing will be
2 forced to close given the current state of reimbursement.
3 MS. BROOKS-WILLIAMS: Commissioner
4 Brooks-Williams. So to just piggyback on that, currently it
5 can be done in an ambulatory surgery center setting; right?
6 DR. GREG MILLER: Yes.
7 MS. BROOKS-WILLIAMS: Can you describe -- I think
8 the question was asked earlier just volume and impact. I
9 know you've spoken about the center here in Lansing. More
10 globally how much of the care right now would have been
11 delivered on what we're calling an outpatient basis, an
12 office-based versus an ASC or just other settings? Do you
13 have insight on that number?
14 DR. GREG MILLER: So nationally about 70 percent
15 of all vascular access interventions are performed
16 outpatient. I apologize. Your other question?
17 MS. BROOKS-WILLIAMS: No, that's fine. That was
18 the gist of it.
19 DR. KESHISHIAN: This is Commissioner Keshishian.
20 Follow-up on that question, 70 percent are done outpatient;
21 office outpatient or ambulatory surgical outpatient?
22 DR. GREG MILLER: Correct. Office-based surgery
23 outpatient is where the overwhelming majority of cases are
24 performed today.
25 DR. KESHISHIAN: Commissioner Keshishian. Can you

1 help me understand? If we improve this and you start
2 billing CMS ambulatory surgical units, costs for society
3 will go up because we've moved it from office-based over to
4 ambulatory surgical. So there will be a net increase cost
5 to society. Is that a correct understanding?
6 DR. GREG MILLER: So I would actually argue that
7 that is not a correct assertion.
8 DR. KESHISHIAN: Okay.
9 DR. GREG MILLER: The correct assertion is that by
10 decreasing fragmentation of care between both inpatient and
11 outpatient services we will actually significantly reduce
12 costs because we will now be able to combine both the
13 vascular surgical access creation piece with the
14 interventional radiology management piece. And by
15 coordinating that care, as we've demonstrated in other
16 Medicare programs specific to this population including the
17 ESCO's, we've actually been able to decrease the total cost
18 of care for these patients.
19 MS. BROOKS-WILLIAMS: Commissioner
20 Brooks-Williams. So what you're describing is that you're
21 really not suggesting that you will limit what you currently
22 do today in the outpatient setting. You're saying that this
23 allows you to have more comprehensive care by moving to the
24 ASC model. So we're not talking apples to apples. You're
25 not saying this allows you to continue to do what you're

1 doing, it actually allows you to change what you're doing?
2 DR. GREG MILLER: Yeah. It allows us to combine
3 the full spectrum of care that the patients need. So at the
4 moment these patients require a three-time-a-week
5 hemodialysis treatment. Okay? In order for them to get the
6 total spectrum of their services, the first event that
7 occurs is the surgical access creation by a vascular
8 surgeon. Okay? That happens.
9 Then they'll, you know, come for a follow-up
10 visit. Then maybe the fistula is not maturing. Then
11 they'll get an intervention. And if they're, you know -- so
12 they're bouncing back and forth between the dialysis unit,
13 the vascular surgeon's office, the interventional radiology
14 suite, however that's all occurring, and it's actually quite
15 complex.
16 And when you're already obligated to
17 three-time-a-week hemodialysis, what then happens is it
18 pushes out your entire length of time from the time the
19 access is created until your hemodialysis catheter can get
20 removed. So by us coordinating that care and having
21 surgeons and interventional radiologists and nephrologists
22 sort of all participating in the care of those patients, it
23 dramatically shortens those times. We have had pilot
24 studies within the Fresenius system. We know that currently
25 across the global United States it takes us 120 days to

1 remove a hemodialysis catheter. When I came in September I
2 presented that in several cases we've been able to shorten
3 that to either 90 days or even 45 days in the best case
4 scenario. And every day that you're able to decrease a
5 patient's catheter exposure, it's less bloodstream
6 infection, less sepsis, less ICU admission, and that's
7 really where the cost savings comes in.
8 DR. MUKHERJI: So I'm just going to ask a
9 question. So I think we all understand and say -- my mother
10 had end stage renal disease, so I get it. But this
11 interdisciplinary approach, what prevents that from being
12 done now in a facility that is not currently classified as
13 an ASC that's already serving the populace?
14 DR. GREG MILLER: So in the office-based surgery
15 you would not perform the actual surgical creation. There's
16 no reimbursement for it. There is a professional fee that
17 physicians can obtain, but there's no facility fee such that
18 the patient can come in, have an access created, facility
19 gets reimbursed for services, and then whatever follow-up
20 care they would need would essentially happen under the same
21 roof in a very timely fashion.
22 DR. MUKHERJI: So where are those procedures now
23 currently being done, the actual access of the fistula --
24 creation of the fistula, I should say?
25 DR. GREG MILLER: Those cases are at the moment

1 primarily performed in the hospital, but those cases are a
2 one-time event. And so the patient may have one surgical
3 creation today and not require another surgical creation for
4 many years until the access becomes dysfunctional or there
5 are some other issues with it.

6 DR. MUKHERJI: And the reason they're performed in
7 the hospital is because the physician offices don't have
8 enough oversight or what is going to change? If these
9 procedures are currently being performed in the hospital due
10 to quality and safety concerns, and what is going to change
11 by our reclassification to now provide the same quality and
12 safety guardrails to provide these in a different setting?

13 DR. GREG MILLER: It's an interesting journey
14 through history, and the history here is that up until 2015
15 there was zero reimbursement for access intervention,
16 surgical creation or any of these vascular-related
17 procedures for the ESRD patients, and only after 2015 or
18 2015 forward did they start to increase the reimbursement as
19 they came up with these initiatives.

20 So where there was essentially zero outpatient
21 access creation going on prior to 2015, we're now beginning
22 to essentially coordinate the care and, you know, attempt to
23 improve the timeline from which a patient can get a surgical
24 creation to a catheter removal.

25 MR. FALAHEE: So this is Falahee. I am not

1 following this. I'm trying to follow the money and I think
2 that's what I'm -- follow. Right now there's nothing to
3 preclude better care from happening but for the fact that
4 the reimbursement isn't there; right?
5 DR. GREG MILLER: So it suggests fragmentation;
6 right? The care is fragmented; right? So if 70 percent is
7 already being performed outside the walls of the hospital
8 for the access interventions, 100 percent is being performed
9 in the hospital. And so the patients wind up in this ping
10 pong between dialysis, outpatient centers, the hospital for
11 surgical creation, the vascular surgeon's office. It's
12 actually --
13 MR. FALAHEE: But I thought you said it could be
14 done in one location except that there isn't reimbursement
15 for it.
16 DR. GREG MILLER: Well, I mean, the office-based
17 surgical facilities today aren't really set up for it;
18 right? They don't have the same requirements for oxygen and
19 anesthesia and all those things, so they weren't built to
20 those standards and so it wouldn't make sense to do them in
21 that environment today. But by becoming a licensed ASC,
22 obtaining deem status, following, you know, Joint Commission
23 guidelines, you know, as we do in all of our centers, I
24 mean, I think that the opportunity is really there to get
25 those, you know -- to combine all of the surgical and

1 interventional procedures.

2 MR. FALAHEE: Let me ask Brenda. I'm sorry I

3 didn't go through all the PDR's here. Does Fresenius take

4 Medicaid patients?

5 DR. GREG MILLER: Absolutely.

6 MR. FALAHEE: Does Fresenius turn away any

7 patients for ability to pay?

8 DR. GREG MILLER: Absolutely not. So the one

9 point that I actually made in September was that if I were

10 to take my business model and go to a outpatient ambulatory

11 surgery center, that's not so easy because this patient

12 population is 70 percent Medicare, 15 percent Medicaid, you

13 know, 7 -- whatever the rest of the math is -- on

14 commercially insured, and that is not the model that the

15 overall majority of ambulatory surgery centers function.

16 So these centers do not cherry pick. By the

17 nature of our business we have to take care of

18 Medicare/Medicaid patients. It's the majority of our

19 business. And I feel very comfortable telling you that you

20 would not look back on this and say, "Oh, that wasn't a good

21 idea. These people aren't serving the patients that they

22 said that they would take care of."

23 MR. FALAHEE: One last and this is on a

24 definitional issue. The definition for "vascular access

25 surgical cases" -- still Falahee. I'm quizzical at the very

1 least when I see at the very end, "Combination of the
2 foregoing or directly related procedures." And that's line
3 123. Especially where it says "or directly related
4 procedures," my concern is what size truck can you drive
5 through that?
6 DR. GREG MILLER: I respectfully didn't draft the
7 language, so I don't know that I -- that I'd necessarily
8 know how to modify it. But, you know, if we look at the
9 language and we say that this is really limited to CKD,
10 chronic kidney disease stage IV, stage V, and ESRD patients,
11 that's our niche.
12 That's our sweet spot for patient care. I think
13 that, you know, when -- that there are some affiliated
14 procedures that they might need, they could need a drainage
15 procedure or something similar to that for one reason or
16 another; aneurism reduction of the hemodialysis access
17 itself. I mean, there's a lot of things. So I think when I
18 looked at the language it seemed appropriately broad to me,
19 but not overly so.
20 DR. MUKHERJI: Commissioner Mittelbrun?
21 MR. MITTELBRUN: Yes. Tom Mittelbrun. I hope I
22 can articulate this, but I'm listening to everything you're
23 saying and I'm trying to understand. CMS had a reason for
24 making their change in reimbursement. Everything you're
25 describing is going to affect other organizations besides

1 you. All right? And was it CMS' desire to have these
2 changes take place to what's being described today; to
3 what's being talked about so it's not so fragmented, so it's
4 more consolidated? So you believe it's overall cost
5 savings; right? So I'm trying to get my arms around the
6 whole change in your industry. Is it being driven by CMS to
7 try to get you to this spot or, you know, organizations like
8 yourself and organizations like this Commission to that
9 spot?
10 DR. GREG MILLER: So I will not pretend nor will I
11 be arrogant to say that I know exactly what's on Medicare's
12 mind, but they certainly have put their stake in the ground.
13 So for ten years we functioned in the office-based surgical
14 environment. And, you know, following the Affordable Care
15 Act -- right? -- there were a couple of changes; right?
16 These things went through CMMI at the highest
17 Medicare levels and they came up with models by which they
18 thought would control costs, one of which is the ESCO or the
19 ESRD seamless care organization. And in every market where
20 Fresenius has an ESCO -- and they're participating in 26
21 ESCO's across the United States -- we are scrambling to put
22 in a good vascular access center because these centers
23 can't -- these ESCO's can't control costs adequately without
24 being affiliated with a good vascular access center. So I
25 hope that sort of answers your question. Look, was it

1 related to straight-up utilization of CPT codes? Yeah;
2 sure. Right? It probably was related to straight-up
3 utilization. Was, you know -- you know, overuse of
4 angioplasty. Okay? At the same time I think that they've
5 made it very clear that they need to control costs within
6 this patient population, and coordination of care is the way
7 to go, and there's article after article that comes out in
8 the late press about coordination of care is the way to go
9 for patients with chronic disease.
10 MR. MITTELBRUN: Thank you.
11 DR. MUKHERJI: This is Commissioner Mukherji. Do
12 you perform purely regular routine dialysis in these
13 procedures, too? Because this was specifically for -- what
14 we discussed, it was specifically for vascular access.
15 DR. GREG MILLER: Correct.
16 DR. MUKHERJI: But, well, dialysis is now being
17 performed in various outpatient dialysis units. Will this
18 center now be -- performed routine dialysis and then receive
19 the additional payment for it?
20 DR. GREG MILLER: All right. One statement that
21 I'll comment on. Somebody had stated something to the
22 effect that, you know, dialysis will have a room and that's
23 where the vascular access center would be. So these are
24 completely separate entities. So dialysis centers only
25 perform the hemodialysis treatment, which is the cleansing

1 of the blood. The vascular access center is a totally
2 standalone, freestanding ambulatory surgical facility which
3 purely performs vascular access interventions and surgical
4 creations.
5 DR. MUKHERJI: And how does that facilitate
6 coordination of care?
7 DR. GREG MILLER: So, you know, one of the points
8 that we put in the language is that the facilities will
9 either have a consulting agreement with a nephrologist or --
10 staffed by nephrologists and radiologists. And so the
11 nephrologists are integral to the vascular access
12 surveillance, monitoring, and ultimately the interventions.
13 In the facility that we have here in Lansing it's a --
14 Dr. Edin Basic is an interventional nephrologist.
15 So he sees the patients. He rounds on them. He
16 takes care of them. He sees them in the office as needed.
17 And he also performs the actual interventions for the
18 hemodialysis accesses.
19 DR. KESHISHIAN: This is Commissioner Keshishian.
20 I'm a little confused. He could go to an ambulatory
21 surgical site there under CON regulations right now and do
22 any procedures that he needs to do right now. Has he had
23 any trouble getting a surgical time in order to do the
24 procedures? I mean, if we have a problem with access for
25 ambulatory surgical units, we probably should deal with that

1 versus separating it off. So does he have any problems that
2 you're aware of? Wait times, lead times? I mean, it's
3 easier if you -- I understand it's easier if you own the
4 center and you can -- it's next door or it's down the street
5 and you get to schedule it whenever you want to schedule it,
6 but that's the purpose of CON. So I'm just curious. Any
7 problems?
8 DR. GREG MILLER: So at the moment he has his own,
9 you know -- we have our center. He functions 100 percent
10 there exclusively. You know, we have been maintaining it as
11 best as possible. I don't have an answer for what it would
12 look like if he then needed to start finding ambulatory
13 surgery centers to take these patients to.
14 DR. KESHISHIAN: Thank you.
15 DR. MUKHERJI: Any other questions? All right.
16 Thank you very much. There's a bar across the street if you
17 want to go -- thank you very much. Are there any other
18 public comments for this topic? Okay. Let me go on. We'll
19 now have Commission discussion. Commissioner
20 Brooks-Williams?
21 MS. BROOKS-WILLIAMS: You can see my face.
22 Commissioner Brooks-Williams. I guess my question to the
23 department would be -- so it's proposed now as a language
24 change based on some of our discussion. And I'm going to
25 say to some degree my -- I don't want to say it's confusion.

1 I think I understand, but I'm not 100 percent sure I'm ready
2 to move forward with the language because I would like to
3 have a little bit more information about the setting, which
4 is kind of where I started with my questions. Are we saying
5 that this is within the four walls of the existing site? It
6 doesn't sound like that's necessarily always going to even
7 be possible to be done. So what are our options based on
8 what's in front of us?
9 MS. NAGEL: So this is proposed action. At this
10 point the Commission can -- you could take proposed action
11 on it and it would go to public hearing and it would go to
12 the JLC and then we come back at the March meeting for final
13 action, or you could take no action on it and defer it to
14 another meeting. You could, you know, request another
15 presentation. Really, at this point there's -- you have a
16 lot of flexibility is what I'm trying to say. There are a
17 lot of options. You're not tied to any timelines with this
18 language right now.
19 MS. BROOKS-WILLIAMS: Thank you.
20 DR. MUKHERJI: This is Commissioner Mukherji. So,
21 Beth, my understanding is that this was -- this language was
22 added to the surgical services. The surgical services
23 outside this has been -- it seems like it was approved or --
24 by the Commission. So this was an add-on plugged into this?
25 MS. NAGEL: Yeah. Brenda, when did they become

1 effective? The Commission made changes to surgical services
2 that became effective just recently.
3 MS. ROGERS: Right. November 17th.
4 DR. MUKHERJI: Okay. So they are effective.
5 Okay. Thank you.
6 MS. GUIDO-ALLEN: So this is Commissioner
7 Guido-Allen. Lines 120 and 121 were -- after "fistulagrams,
8 angioplasty, stent placement, percutaneous thrombectomy,
9 transluminal balloon angioplasty of extremities," that
10 category to me, if indeed we keep the language, is way too
11 broad because that opens it up to cardiac, peripheral --
12 just way too broad. I would rather have that language to be
13 very specific to the venous access that is particular to
14 dialysis.
15 But based on the comments that we just heard --
16 where I was very confused just like everybody else -- I just
17 don't feel that we as a group should proceed with something
18 that is really based on reimbursement from office-based
19 reimbursement to an ambulatory surgery center reimbursement
20 without seeing a true patient quality and safety advances or
21 improvements. That's just my opinion.
22 DR. MUKHERJI: Commissioner Mukherji. I wanted to
23 ask something, too, Beth. My understanding was -- when we
24 first discussed this my understanding was that these types
25 of procedures were not identified by CON to be credited

1 towards creating a ambulatory surgical center. That was my
2 understanding. Are we creating a specific ASC geared
3 towards vascular access for end stage renal disease or are
4 we creating credits that can be applied to creating a
5 general ambulatory surgery center?
6 MS. NAGEL: You are creating specific vascular
7 access surgery centers that only can be established by
8 demonstrating vascular access cases and then can only do
9 vascular access cases. So I'm not sure if that was one of
10 your choices.
11 DR. MUKHERJI: You answered my question.
12 MS. NAGEL: Okay.
13 MR. FALAHEE: This is Falahee. I share the same
14 concerns about the lines 120 and 121. I've still got
15 concerns about the need. There's a lot of open questions in
16 my mind. I think that assuming there's a need.
17 DR. MUKHERJI: Commissioner Keshishian?
18 DR. KESHISHIAN: I'd like to try to move this
19 forward and so I'm going to make a motion. We asked the
20 department to come up with this language based on the
21 testimony last week and so I want to -- and as part of my
22 motion I want to thank the department for doing an excellent
23 job in developing the language. And the second part of the
24 motion is we don't want to adopt this language. We don't
25 want to move it forward to any public hearing. We thank the

1 department. We understand the issue. And the next time
2 surgical -- ambulatory surgical centers come up, we can
3 discuss it again at that point. So it's a three-part
4 motion: Thank the department, no further action, and next
5 time there is an ambulatory surgical center they can be
6 discussed at that time.
7 DR. MUKHERJI: So the "no further action" means
8 that we're not going to include this language into the
9 current standard that's currently implemented?
10 DR. KESHISHIAN: That is correct.
11 DR. MUKHERJI: So we have a motion on the table.
12 MS. BROOKS-WILLIAMS: Support. Commissioner
13 Brooks-Williams.
14 DR. MUKHERJI: So we have a motion and we have a
15 second. Further Commission discussion?
16 MS. NAGEL: I'm sorry. Could you say who
17 seconded? I'm sorry.
18 DR. MUKHERJI: It was Brooks-Williams.
19 MS. NAGEL: Thank you.
20 DR. MUKHERJI: So all in favor of Commissioner
21 Keshishian's motion say "aye."
22 (All in favor)
23 DR. MUKHERJI: Any against? Okay. Commissioner
24 Keshishian's motion passes. The next is Nursing Home and
25 Long-Term-Acute Care. This was recalculating the bed need

1 numbers. There is a written report by Mr. Delamater that's
2 in our package. We have two blue cards. So Brenda, do you
3 want to take this?
4 MS. ROGERS: Yes. This is Brenda. Just a quick
5 update on this. It is that time to update the bed need
6 methodology according to the schedule of every two years.
7 We delayed it this summer knowing that standards were moving
8 through the process. And so in September -- I can't
9 remember the exact date of the standards becoming effective,
10 but at the September Commission meeting the Commission asked
11 the department to go ahead and run the bed need calculation
12 based on the new set of standards, which we've done -- or
13 Mr. Delamater has done. You have that report in front of
14 you. And so what the Commission needs to do is set the
15 effective date of the new bed need. Thank you.
16 DR. MUKHERJI: Any questions for Brenda or the
17 department? Commissioner Guido-Allen?
18 MS. GUIDO-ALLEN: Guido-Allen. What if we
19 question the increase? What if we question the number that
20 is being proposed as -- it just seems really high to me.
21 Sorry.
22 MS. ROGERS: Yeah. This is Brenda. The only
23 thing -- and I'll let Joe chime in if he's got additional
24 information. The only thing I can tell you, under the
25 standards we are required to run the bed need every two

1 years. We did postpone it based on that there were new
2 standards becoming effective with some changes that affected
3 the methodology, so it was held off. The standards for the
4 bed need has been re-run with the updated methodology and
5 numbers, and it's up to the Commission to set the effective
6 date. Whether or not you want to postpone that, I'm going
7 to let Joe respond to that. Thank you.
8 MR. POTCHEN: So this is Joe. The numbers being
9 high, based on what we have in Paul Delamater's report,
10 appear to be accurate. So just as a fact to the extent the
11 Commission disagrees or wants to change it at the
12 appropriate time, it'd be the next time these standards come
13 up. We have no evidence before us that we're aware of that
14 these numbers are wrong, it's just high.
15 DR. MUKHERJI: Other questions before we take
16 public comment?
17 MS. GUIDO-ALLEN: In Dr. Delamater's or in --
18 yeah. Table 4 is referenced under bed need, but I don't
19 have table 4. Does anybody have table 4?
20 MR. FALAHEE: Page 46 of our packet.
21 MS. NAGEL: It's the fourth page.
22 MS. GUIDO-ALLEN: Okay. Sorry. Got it.
23 MS. NAGEL: I will note these are the -- just so
24 you're aware, this is the first time we've run these numbers
25 with the standards and the changes to the methodology that

1 the Commission approved last. So yes, they are different.
2 The standards that you approved last did have changes to the
3 methodology and so now we're seeing the effect of those
4 changes.
5 MR. HUGHES: Commissioner Hughes. I remember a
6 few years ago when this came up a long time ago when -- and
7 I'm a little bit confused, but there was some census data
8 that was being used in this calculation and it appeared to
9 be older. Is the census data here? Because I know it
10 changes every once in awhile. I remember we were using old
11 census data and new census data was just about to come out.
12 MS. NAGEL: I remember the issue being about the
13 survey data. Do you think that that might be --
14 MR. HUGHES: No.
15 MS. NAGEL: Okay. So I'm just trying to look.
16 Paul usually says what year he uses the survey or the census
17 data for. I will say -- if I could address not your
18 question, but the survey data, that was something that we
19 worked on with the nursing home community. And we do have
20 higher confidence now in that survey data that we used to
21 calculate this. Did either of you see the census data that
22 Paul used?
23 MS. ROGERS: It says 2016.
24 MS. NAGEL: The 2016 census data. Oh. Yeah.
25 It's in the second line. The updates to the -- used the

1 2016 CON annual survey data and the 2016 U.S. Census
2 population data.
3 MS. ROGERS: And this is Brenda. Typically we've
4 always kind of project -- the standards say you can project
5 out I believe it's three to seven years, and so typically
6 we've always used five years. We did not use five years
7 this time. Based on Paul's suggestion we projected out
8 three years because that's what the data was available for.
9 Anything beyond the three years was simply an estimate, so
10 we did not want to use estimated projections. So this time
11 the projections are three years out versus five years out,
12 but based on actual data.
13 DR. MUKHERJI: Any other questions for the
14 department before we go to public comment? Okay. We'll
15 move forward with public comment. The first blue card I
16 have is from Pat Anderson from HCAM.
17 PAT ANDERSON
18 MS. PAT ANDERSON: Good morning. Thank you. I am
19 Pat Anderson from the Health Care Association of Michigan.
20 And you did receive our testimony I think late yesterday
21 afternoon. But I wanted to express on behalf of HCAM, we
22 represent about 320 nursing facilities across the state.
23 And I do agree with the Commissioner, that the bed need as
24 is recalculated seems extremely high. If you ask a number
25 of our members, we're not sure why. I've read

1 Mr. Delamater's report and he's claiming that the change in
2 the ADC factor is about 2300 of the beds, yet when you
3 compare the beds based on the bed need from the DHHS web
4 site, it's almost 7,000 beds more. There's 4,000 beds more
5 than that factor alone changing the item when the overall
6 occupancy across the state is currently only 82 percent. So
7 our members are concerned that this will make a flood.
8 We're not sure. Mr. Potchen is saying the numbers
9 are right. I haven't really seen the detail on that to
10 see -- to know that. And this does seem extreme high. From
11 the testimony I picked out five counties to see where they
12 landed. They were all getting quite a few beds. For
13 example, Oakland County was going to 400 more beds. They
14 only have 80 percent occupancy right now. That just doesn't
15 have a common sense logic to it. I don't know.
16 They could be fully right as Mr. Potchen said, but
17 it appears that this is way higher than it should be. So we
18 have concerns. What we would like the Commission to do is
19 to delay any action on setting the date until the March
20 meeting for the Commission and have a group of interested
21 parties sit down and look at the report and the data and
22 then act on it from that, and we would be interested in
23 doing it. Thank you for listening.
24 DR. MUKHERJI: Thank you. Questions?
25 Commissioner Falahee?

1 MR. FALAHEE: Yeah. This is Falahee. Okay.
2 Let's assume you're right or there's questions. To the
3 department or to Mr. Potchen, does it have to wait 'til
4 March? Couldn't we try to do something, if we have
5 questions, at the January meeting? Couldn't we try to
6 resolve those there? I know it's a, quote, "special
7 meeting," closed quote. But couldn't we do it there if we
8 had the time to get together between now and then?
9 MS. ROGERS: Yeah. This is Brenda. Yeah, if you
10 put it in a motion as part of, you know, the next meeting
11 agenda, that's truly up to the Commission to decide on that.
12 MR. FALAHEE: Okay. Thank you.
13 DR. MUKHERJI: Any other questions? Thank you
14 very much.
15 MR. POTCHEN: I just want to clarify. I'm stating
16 that the numbers that we have before us are based on Paul
17 Delamater's who has done it for the department for years.
18 So it's not that it's right or wrong. It's based on the
19 application of the standards as we have seen before us and
20 we haven't seen any evidence to the contrary that there's a
21 mistake here.
22 DR. MUKHERJI: Commissioner?
23 DR. KESHISHIAN: This is Commissioner Keshishian.
24 Could we ask him to take another look at these numbers and
25 to come back to make sure they are correct? Because if

1 there is -- they're so much different than they have been in
2 the past. A second look seems reasonable. Because I think
3 what you're saying is what are we going to know in January
4 that we don't know today? And the question is, "Please take
5 a second look. We're shocked at -- we're surprised at these
6 numbers."
7 MR. POTCHEN: And I think the Commission has the
8 authority to make such a request in a motion and can do
9 that.
10 DR. KESHISHIAN: Okay.
11 DR. MUKHERJI: Any other questions before we go on
12 to the next? It's Melissa Cupp from RWC Advocacy.
13 MELISSA CUPP
14 MS. MELISSA CUPP: Good morning. Again,
15 Melissa Cupp with RWC Advocacy. This time I am before you
16 representing Sienna Health Care. I just wanted to indicate
17 on their behalf that we support the comments that Pat
18 Anderson just made from HCAM. Thank you.
19 DR. MUKHERJI: Any questions for Melissa? Get
20 back there. Any questions? Okay. Now you can leave.
21 MS. MELISSA CUPP: Thank you.
22 DR. MUKHERJI: Any other blue cards, public
23 comments for this? Okay. You know, this really wasn't
24 Commission discussion, but I'll take prerogative of the
25 chair to have more discussion on this specific topic.

1 MR. MITTELBRUN: Commissioner Mittelbrun. I was
2 just curious. I think we all got an e-mail from fellow
3 commissioner Clarkson and I just was wondering your thoughts
4 on her opinion as she is an expert in that field.
5 DR. MUKHERJI: And I'll make a comment here. I,
6 you know -- I've listened to what everybody says and I'll
7 just revert to my previous life as a scientist. And we've
8 had the same methodology for years. And sometimes in
9 science we do experiments, we look at data, and we use a
10 scientific formula as statistical analysis, and so on and so
11 forth, and sometimes we like the results and sometimes we
12 don't like the results.
13 And if we like the results, we publish them and we
14 accept them. But if we don't like the results, we can go
15 back and make sure we did the right analysis. But if we
16 don't like the results and we've accepted a certain
17 methodology or analysis, I think we just have to accept it.
18 And I completely agree with Commissioner Keshishian that
19 because these are not what we expected, we should ensure
20 that the methodology and the analysis is correct.
21 But if it is correct, my own feeling is that we
22 should accept this and move forward because that's what
23 we've done in the past and that's probably what we're going
24 to do in the future to make our policy for the state.
25 MR. MITTELBRUN: Commissioner Mittelbrun. Is the

1 methodology exactly the same? It was my understanding the
2 methodology changed.
3 MS. NAGEL: Yes, there were major changes to the
4 methodology.
5 MR. MITTELBRUN: So if the methodology changed, I
6 mean, maybe, you know, to the scientific community,
7 sometimes you make changes in your analytical formula and
8 you say, "Well, maybe that wasn't the right mix or right
9 variable to use in the calculation." So I'm just curious if
10 there's -- I mean, it seems like there may be negative
11 effects to the changes in the methodology.
12 MR. HUGHES: Commissioner Hughes. This kind of
13 gets down to me what the core mission of CON is in terms of
14 quality, cost, and access. And you know, we've seen plenty
15 of data over the years; if you build it, they will come and
16 fill things. When I'm looking at the occupancy test, yeah,
17 we can have the methodology and we have computers do things,
18 but that's why we have humans here to look at things.
19 And when I'm seeing these occupancy rates and then
20 seeing these large increases in beds, it just doesn't add
21 up. And I don't know of anybody out there waiting and I
22 think that's -- we have to dig deeper into this because if
23 we just go ahead with things just because it says that's
24 what the procedure was, that's how we get too many
25 facilities out there and that's what costs more.

1 DR. MUKHERJI: This is Commissioner Mukherji. Are
2 we saying that we should have a target rate for occupancy
3 then?
4 MR. HUGHES: I'm saying that a 80 percent
5 occupancy rate in places where they're putting up massive
6 increases in the number of beds and I don't hear a problem
7 from other people, it just doesn't add up. It just doesn't
8 pass the eye test. Has there been massive population
9 growth?
10 DR. TOMATIS: Commissioner Tomatis. I don't think
11 that we are going to solve the problem limiting the number
12 of beds. The idea is just to find out exactly what are we
13 talking. And really, I don't trust the data that we got.
14 DR. MUKHERJI: Let me ask the department. Can
15 they re-run the bed needs using the old methodology and the
16 new methodology to see what the difference is?
17 MS. NAGEL: We certainly can, but I will say the
18 new methodology is the one that is in the statute currently
19 that the Commission passed and became effective in
20 September. So if you like the old standard, you're going to
21 have to change it.
22 DR. MUKHERJI: I think from an evidence-based
23 approach we can at least look at the delta, and then if we
24 did something that we probably shouldn't have done, we could
25 have the opportunity to change. That's part of the

1 iterative process of public policy.

2 DR. TOMATIS: Commissioner Tomatis. The idea is

3 not which methodology, it's which one is right. We are

4 making a decision of -- not using one methodology or the

5 other. Which are the fact?

6 DR. MUKHERJI: Other comments? So this really

7 wasn't -- I guess this is an action item; right?

8 MS. ROGERS: Yes.

9 DR. MUKHERJI: Okay. So we're open for an action

10 or a detail action.

11 MR. FALAHEE: All right.

12 DR. MUKHERJI: I can't make one because I'm the

13 chair.

14 MR. FALAHEE: Well, what he said five minutes ago.

15 This is Falahee. Motion would be, number one, that we ask

16 Mr. Professor Delamater to go back and relook at his numbers

17 using the current methodology. Number two, look at the

18 change in numbers using the old methodology to see what the

19 delta has been and, as Commissioner Keshishian said,

20 basically just relook, recheck, recalculate and bring us

21 those numbers back for the January meeting.

22 And then the last part of my motion would be to

23 work with HCAM and the others to see if there's any

24 difference in numbers and calculations. There may not be,

25 but at least to work with those that are raising the

1 questions.

2 DR. MUKHERJI: Okay. We have a motion on the

3 table.

4 MR. HUGHES: Could I just add? Could we also ask

5 for some feedback and interpretation of what's driving the

6 big increase that's changed?

7 MR. FALAHEE: I would approve.

8 MS. NAGEL: Could I ask for a clarification? Who

9 did you want that --

10 MR. HUGHES: I was just piling on to what --

11 MS. NAGEL: Just for clarification, did you want

12 that from the industry or from the department?

13 MR. HUGHES: The professor.

14 MS. NAGEL: For Dr. Delamater?

15 MR. HUGHES: Yes.

16 DR. MUKHERJI: Okay. So we have a very nice

17 motion on the table. Any second?

18 MR. MITTELBRUN: Mittelbrun. Second.

19 DR. MUKHERJI: Mittelbrun second. We have a

20 motion and a second. Any further discussion? Okay. All in

21 favor?

22 (All in favor)

23 DR. MUKHERJI: Any against? The motion passes.

24 The next is item number VIII, which is Cardiac

25 Catheterization Standard Advisory Committee, interim written

1 report only. It's in your agenda. I believe it's on page
2 number 47. Brenda, is that informational or an action item?
3 MS. ROGERS: This is Brenda. It's just
4 informational.
5 DR. MUKHERJI: Does anybody have any comments on
6 the report? All right. Hearing none, should we move on to
7 the next topic then? The next topic is Hospital Beds
8 Standard Advisory Committee. There's another interim report
9 that's in your packet and that is on page number 48. Again,
10 informational; correct?
11 MS. ROGERS: This is Brenda. That is correct.
12 DR. MUKHERJI: Any comments on the report? Let me
13 just -- also, we're going to get through now to the
14 legislative reports and our legal reports, so on and so
15 forth, but there is a public comment regarding proton beam
16 based on the agenda. And Brenda, tell me if this is
17 appropriate. That still is going to be under agenda item
18 XV; is that correct?
19 MS. ROGERS: This is Brenda. That is correct.
20 DR. MUKHERJI: Okay. So the next one is the
21 legislative report. Mr. Lori?
22 MR. LORI: I do not have anything to report from
23 the legislative side.
24 DR. MUKHERJI: Thank you. I appreciate that.
25 MR. FALAHEE: We all do.

1 DR. MUKHERJI: The next is the administrative
2 update, planning and access and care section update. Beth?
3 MS. NAGEL: This is Beth. I'd just update that we
4 are continuing our work with the two standard advisory
5 committees that are in play at the moment and are looking
6 forward to wrapping those up and reporting back to you in
7 March.
8 DR. MUKHERJI: Thank you. Any questions for Beth?
9 Next, the CON evaluation section update. Tulika?
10 MS. BHATTACHARYA: This is Tulika. So there are
11 the three regular reports for CON activity and compliance
12 monitoring in your packet, but you also have two special
13 reports on the statewide compliance review of Cardiac Cath
14 Services and Megavoltage Radiation Therapy Services. I'll
15 be happy to answer any questions.
16 DR. MUKHERJI: Questions? Tulika, the quarterly
17 performance measure? Or did you cover that as well?
18 MS. BHATTACHARYA: Yeah, so --
19 DR. MUKHERJI: All right. That was covered?
20 MS. BHATTACHARYA: Yes.
21 DR. MUKHERJI: I can only think of one thing at a
22 time. Legal activity report, Joe?
23 MR. POTCHEN: This is Joe. There is no current
24 active litigation and we continue to assist the department
25 in drafting of the rules and various other issues.

1 DR. MUKHERJI: I really appreciate that. Any
2 questions for Joe? The next is for the January meeting. We
3 always have a -- it was a special meeting in January that
4 got morphed into a regular meeting essentially. And it
5 turns out in January I'm not here, Tom's not here, Chip's
6 not here. So we have to figure out, number one, do we have
7 a quorum? And number two, if we have a quorum, is anybody
8 willing to run the meeting? So how many people, I guess,
9 are planning to be here for the January meeting on that
10 specific date, which is January 25th?
11 MS. GUIDO-ALLEN: Will be here?
12 DR. MUKHERJI: Yeah. Who will be here for that?
13 Otherwise, we'll have -- we may have to reschedule the
14 meeting. So how many people -- raise your right hand if you
15 plan on being here for that meeting. One, two, three, four,
16 five possibly. That's not a quorum. So what we probably
17 will have to do is reschedule that. So I don't know if
18 we're available the week before and the week after, so I
19 think just work offline. How much time do we need to give
20 for public notice if we change the meeting?
21 MS. ROGERS: I'm trying to remember what the --
22 MR. POTCHEN: I think it's 30 days.
23 MS. ROGERS: I'm thinking 30 days as well. We
24 might have to go into February. We'll try early February.
25 We just have to see what days we have available. That's

1 part of it.
2 MR. POTCHEN: I think it's 30 days, but we'll
3 verify that. But to be safe --
4 DR. MUKHERJI: So the bottom line is that we won't
5 have the January 25th meeting. I'll work with the
6 department to pick an alternate date. And we apologize for
7 any unintended convenience to the department.
8 MR. POTCHEN: And I'm just going to go back on the
9 record. We had an earlier motion to postpone it to the
10 January date. I'm believing that that motion would be to
11 the next --
12 MR. FALAHEE: To whenever we next meet.
13 MR. POTCHEN: -- next scheduled Commission
14 meeting.
15 DR. MUKHERJI: So we have a motion on the table.
16 MR. POTCHEN: I'm not motion.
17 MR. FALAHEE: This is Falahee. The motion that I
18 prior made to have this data come to the January meeting,
19 I'll amend it to be the next regularly scheduled meeting of
20 the Commission.
21 DR. KESHISHIAN: Commissioner Keshishian,
22 seconded.
23 MR. FALAHEE: "Scheduled." Take out "regularly."
24 DR. MUKHERJI: We have a motion and a second. All
25 in favor?

1 (All in favor)

2 DR. MUKHERJI: Thank you. So is everyone clear
3 about that? We'll change the date of the January meeting
4 and then we'll just iterate and figure out what works best.
5 The future meeting dates then, we won't have one on January
6 25th, but the meeting dates after that are in the package.
7 The next is public comment. We have one public comment card
8 from Dr. Theodore Lawrence from the University of Michigan
9 regarding CON for HMRT Proton Beam. Dr. Lawrence? And
10 please note three minutes.

11 THEODORE LAWRENCE, M.D.

12 DR. THEODORE LAWRENCE: Three minutes? Right. So
13 I'm Ted Lawrence. I'm chair of radiation oncology at the
14 University of Michigan. Thank you for taking the time to
15 listen to our request to reopen the regulations for Proton
16 Beam Therapy or HMRT. You have a handout in front of you.
17 I hope all the commissioners have that handout, so I'll
18 stick closely to the handout.

19 The original CON written years ago proposed a
20 collaboration to mitigate the cost of proton beam therapy.
21 So back then the cost of the facilities were -- the
22 regulations were written in a era of $150-million-plus
23 multi-room facilities that were going to treat 1200 or more
24 people per year. So this drove a logical argument that
25 there should be collaboration among multiple groups.

1 Collaboration was much easier 10 years ago compared to
2 today. Radiation therapy was provided by many more and
3 smaller facilities. So back then the regulation was that
4 there were only 5 providers who have more than 30,000 ETV's,
5 which is a unit of activity for radiation therapy, and at
6 that point only 2 of 5 were required, that is 40 percent, to
7 form a collaborative. So that was then and this is now.
8 So now the cost has decreased and consolidation of
9 health services in the state impedes collaboration. So now
10 the cost of a single-room proton beam facility -- is now --
11 it's not cheap, but it's down in the range of 25 to $30
12 million; very different from $150-million-plus. These can
13 treat up to 250 patients a year. And this then suggests to
14 us that a new normal now exists so we can return to an
15 appropriate standard CON metric based on activity and not
16 number of facilities, which is a unique thing as far as I
17 can tell in CON.
18 And then the collaboration requirement has become
19 much more difficult because, due to consolidation, there are
20 now 6 providers who deliver more than 30,000 ETV's. So the
21 impact of this is that to achieve the 40 percent rate we
22 need 3 partners. 2 of these 6 groups already have
23 facilities, one of which is functioning. So the 40 percent
24 rule we feel is an unreasonable barrier to providing access
25 to required cancer services. So CON, as you Commissioners

1 all very well know, are typically based on activity and not
2 on the number of facilities. Activity has always been a
3 reasonable basis for determining qualifications for covered
4 services under CON standards. For instance, the University
5 of Michigan Health System now has over 60,000 ETV's at our
6 own facility, so our facility alone would meet the activity
7 requirement that was originally described in the CON. The
8 40 percent rule prohibits advancement despite meeting an
9 activity requirement.
10 I'd like to make a couple notes about the
11 potential role of proton beam therapy. Children with cancer
12 are prime candidates for PBT. Children who are treated for
13 cure are the most likely to benefit from proton beam therapy
14 and the University of Michigan has the largest pediatric
15 program in the state. "The care of our children now is
16 being fragmented under the current standards by not being
17 able to provide timely and appropriate access."
18 And in particular, many treatments for children
19 require chemotherapy and radiation therapy and it's not
20 optimal, and in some cases it's even not safe to give
21 chemotherapy in one facility and then send the child to
22 another facility to receive radiation. Proton beam therapy
23 is likely to be effective in other diseases. Emerging data
24 suggests brain, head/neck cancer, liver cancers. In
25 addition, a new indication is that many -- some cancers, not

1 many, but some recur after treatment and proton beam therapy
2 is looking to be effective in this segment as well.
3 Thousands of people in the state of Michigan could
4 potentially benefit from proton beam therapy. So in
5 conclusion we feel it's time to review the CON regulations
6 and thresholds. The need for PBT cannot be met by one or
7 even two facilities, assuming the second one can become
8 functional in the state.
9 However, there have been no applicants for proton
10 centers since the current language was written, so this to
11 me is a sign that the current regulations are too
12 restrictive. It takes two or three years to build and
13 implement a proton facility. Given the decrease in cost and
14 the limitations in access, we propose that the Commission
15 charges a review of the existing HMRT standards to determine
16 reasonableness of the 40 percent rule and the collaboration
17 requirement.
18 DR. MUKHERJI: Thank you very much. Any questions
19 for Dr. Lawrence?
20 MR. FALAHEE: This is Falahee. I've been around
21 long enough that I remember all too well the initial
22 discussions and governor's actions and all that fun stuff
23 with proton beam. Help me understand what happens now if
24 there's a child at U of M that needs proton beam? What
25 happens now?

1 DR. THEODORE LAWRENCE: So that child will be sent
2 to a different facility. We're now referring patients out
3 on a regular basis. It depends on the expertise that the --
4 the problem that the child has and the expertise of the
5 institution. So we'll try to send that child to an
6 institution that's expert in giving that treatment, but the
7 rest of that child's care before and after that proton beam
8 will typically still occur at the University of Michigan.
9 MR. FALAHEE: So again, I'm trying to understand
10 what's going -- how many children do you send out on a
11 yearly basis?
12 DR. THEODORE LAWRENCE: So as more data develops,
13 it's becoming more and more. Right now it's in the range of
14 between, say, 60 and 80 children right now will ultimately
15 be sent out for other treatment.
16 MR. FALAHEE: So then a devil's advocate question
17 would be for 60 to 80 children we're looking at a request to
18 potentially to allow a proton beam unit to be built by the
19 University of Michigan or anybody else for millions of
20 dollars? That's the devil's advocate question.
21 DR. THEODORE LAWRENCE: Absolutely. And if that
22 were -- the only reason to use proton beam therapy were
23 treating children, I would agree with that. I think
24 children are the best example of who could benefit, but
25 there's a lot of emerging data now that there are other

1 diseases; head and neck cancer, potentially lung cancer,
2 brain cancers. So for instance, in the case of brain
3 cancer, we know that mild doses of radiation can affect
4 neurocognitive function. So even in an adult, a modest dose
5 of radiation can affect neurocognitive function. We've done
6 this research. We've published this. And so the difference
7 between proton beam therapy and x-ray therapy is that proton
8 beam therapy will not give those moderate doses to the rest
9 of the brain.
10 Now, proton beam therapy is -- I would say it's
11 early in its development. It's sort of moderate in its
12 development. So all these data are coming out now and being
13 developed now. But the data now are suggesting that there
14 are other diseases other than in kids where this is going to
15 be -- the kids are the best example, but there are other
16 diseases.
17 MR. FALAHEE: Okay.
18 DR. THEODORE LAWRENCE: Head and neck cancer,
19 brain cancers, liver cancer are an area that I publish in
20 extensively. There's a group at Massachusett (sic) General
21 Hospital that's now generating data that liver cancer
22 outcomes are better with proton beam therapy than x-ray
23 therapy. So our estimate is that there are about 25,000
24 people who will receive radiation therapy in state of
25 Michigan, at least 2015 data, the most recent data I have.

1 Somewhere between 10 and 20 percent of those patients would
2 likely benefit from proton beam therapy.
3 MR. FALAHEE: Thank you.
4 DR. THEODORE LAWRENCE: If it were just kids, I
5 agree with you.
6 DR. MUKHERJI: So Ted, you know, I remember very
7 well that we used to refer patients out to Mass General for
8 patients with skull-based tumors, especially adenoid cystic
9 carcinomas, because of the very focused beam. And when
10 proton beam did come out initially, it was really targeted
11 towards skull-based tumors with perineural spread or very --
12 adjacent to very sensitive structures. I think kids now --
13 it seems there is a potential dissemination of a very
14 potentially expensive technology that actually has excellent
15 curates by other commonly accepted treatment modalities.
16 So can you help us understand how CON cannot
17 prevent dissemination of this technology in the state, but
18 by the same times ensure that appropriate guardrails are in
19 place so that other tumors that have been treated by other
20 techniques -- and I'll specifically say prostate cancer --
21 all of a sudden are not sent to a proton beam therapy?
22 DR. THEODORE LAWRENCE: Right. So I think that's
23 very important. First of all, I think we all agree that an
24 activity requirement which -- still makes sense. You
25 wouldn't want to put a proton beam facility in, I guess,

1 Marquette. I don't know if anyone's here from Marquette.
2 But there may not be enough people in Marquette to generate
3 to justify that. So you still want an activity limitation.
4 I think that there are certain diseases where there really
5 isn't any evidence that proton beam therapy is better and I
6 would list prostate cancer as one of those. So I could
7 imagine regulations that would require generating radiation
8 plans that would show that you really get a benefit from
9 proton therapy as opposed to x-ray therapy -- proton beam
10 therapy.
11 And so one could have similar requirements. For
12 instance, in some situations we've -- modulated x-ray
13 therapy. We need to generate plans to show that we would
14 get benefit from that compared to standard 3D formal
15 radiation. So I think one could -- and I'd be delighted to
16 help. One could develop regulations that would only permit
17 treatment for patients who have a reasonable chance to
18 benefit.
19 DR. MUKHERJI: Other questions for Dr. Lawrence?
20 MR. HUGHES: I'm nervous to ask this question
21 because I might be wrong. But old school, like Commissioner
22 Microphone over here (indicating), I remember this
23 discussion a long time ago, and the impressions that I have
24 in my head were that we were going to have two in the state,
25 which was very unusual. It's unusual just to have one. And

1 if there was seven in North America -- and then an expert
2 had made the comment, "How many do we need from a volume --
3 and being able to service people?" We needed one in North
4 America and we had seven and potentially two in the state.
5 If I'm talking about the right thing, then I'm really
6 confused by this because, yeah, the price has come down from
7 160- to 25- or 50-, but I don't see the volume and -- am I
8 missing something here on we're not able to service the
9 people that we have with existing facilities and why we
10 would need more? Help. Is that a dumb question?
11 DR. THEODORE LAWRENCE: Can I answer that?
12 MR. FALAHEE: This is Falahee. First, you're
13 recalling exactly correctly the discussion we had around
14 this table and in the audience as well. I think what we're
15 hearing, and I think the doctor is going to expand, it's
16 now -- not only is it cheaper, but there are more potential
17 beneficiaries of that same therapy than there were when we
18 discussed this ten years ago, whenever it was, 2009.
19 MR. HUGHES: When our hair cells were different.
20 DR. THEODORE LAWRENCE: I think he answered your
21 question quite well. I mean, that's really it and you were
22 very succinct in your answer. I agree.
23 MR. HUGHES: But I guess the question I would have
24 is the existing facilities that we have, what kind of
25 utilization are they having?

1 DR. THEODORE LAWRENCE: Well, sir, the only
2 facility in the state that's functioning is at Beaumont and
3 it's coming up to speed. But again, if we go back to about
4 25,000 people in the state of Michigan are going to get
5 radiation therapy and we think that at a minimum 10 percent
6 based on the data we have now will benefit, we don't have
7 the facilities to treat patients who are likely to benefit
8 from treatment.
9 We're well below. Just to reiterate, in the past
10 they were $150 million facilities plus that were going to
11 treat 1200 to 1500 patients a year, and that was a
12 different, you know -- a different day back then. You know,
13 one other thing I didn't mention that is worth mentioning is
14 that the technology has improved proton beam therapy at the
15 same time during these last 10 years which has helped to
16 open up new applications.
17 MR. HUGHES: What is the status of the one that
18 got the governor exception for the second facility?
19 UNIDENTIFIED SPEAKER: It's Beaumont.
20 MR. HUGHES: So there's two?
21 DR. THEODORE LAWRENCE: Well, there's one at
22 McLaren which is not producing beam as best I know right
23 now.
24 MR. HUGHES: That's what I'm confused -- I thought
25 there was two approved.

1 DR. MUKHERJI: Yeah. So I think the challenge
2 is -- and I agree with everything that you said. Back when
3 I was -- when I had black hair instead of gray hair or
4 whatever, there was two centers in the country that we would
5 send patients to. It was the Mass General and University of
6 Washington; right, Ted? This was probably fifteen years ago
7 when I was a pup. And now the technology has gotten better,
8 but the elephant in the room regarding this is that
9 eventually when you make a multi-million dollar investment
10 you have to somehow justify that investment.
11 And the challenge is -- is there are specific
12 areas in which proton beam has been historically used and
13 clearly it's beneficial specifically in children and
14 small-based cancers and so on and so forth. But when you
15 make an investment like that, how do get that return? And I
16 think the challenge that we will face moving forward,
17 especially with insurance and payers and everyone around the
18 table, is to ensure that it's used appropriately, and when
19 you look at your pro forma and your P&L statement for this
20 that you're not doing other cancers -- treating other
21 cancers on that inappropriately just to get a return on the
22 investment. That's the challenge moving forward on it.
23 DR. THEODORE LAWRENCE: You know, the truth is
24 with the pro forma, we don't really -- I mean, the truth is
25 we don't expect -- this will not be a particularly

1 money-making venture for us. We just feel like we need to
2 deliver the top quality care to our kids and to the patients
3 where it's becoming clear that this is a better technology.
4 We don't anticipate this is going to be a money maker.
5 That's not the goal in this.
6 MS. GUIDO-ALLEN: This is Guido-Allen. According
7 to our docket it's up for review in 2020. Maybe we'll have
8 more data prior to that so that when it comes up for us to
9 review again we'll have more evidence to support what proton
10 delivers, more patient populations, that it may be
11 beneficial for survival rates, recurrent rates. I don't
12 know.
13 DR. MUKHERJI: Any other questions for Dr.
14 Lawrence?
15 DR. THEODORE LAWRENCE: May I just say, the
16 problem with waiting 'til 2020 is that means there won't be
17 another facility in the state before 2023 or 2024, which is
18 quite awhile from now, and the data are here already that
19 could benefit for other groups of patients. So we'll be
20 depriving our patients, people in the state of Michigan, for
21 at least another seven years if we wait 'til 2020 to look at
22 this again.
23 DR. MUKHERJI: Any other questions for Dr.
24 Lawrence? Thank you. We have about two more, both from the
25 University of Michigan. Don Tomford?

1 DON TOMFORD

2 MR. DON TOMFORD: Hi. I'm Don Tomford. I'm the
3 administrator for the Department of Radiation Oncology. I
4 would just like to address the one comment about -- that
5 there were 7 centers nationally. There are now 26 centers
6 nationally and 16 currently being planned. So within the
7 next couple years there will probably be 42 centers
8 operationally within the country. Florida has 5 or 6. So
9 there are more companies.

10 There are 2 or 3 companies now actually doing
11 proton centers. So there are a big push across the country
12 for proton centers. So I just wanted to address the change
13 in technology and in treating more cancers.

14 DR. MUKHERJI: Any questions for Mr. Tomford?

15 MR. HUGHES: Are people having an issue getting
16 into Beaumont currently?

17 MR. DON TOMFORD: Pardon me?

18 MR. HUGHES: Are people having an issue getting
19 into Beaumont currently?

20 MR. DON TOMFORD: I didn't hear you.

21 MR. HUGHES: Are people here in Michigan waiting
22 to use the existing facility?

23 MR. DON TOMFORD: I'm not sure if people are
24 waiting to use the existing facility. I don't really -- I
25 haven't talked with Beaumont, but we do send some kids to

1 Cincinnati Childrens. We have sent many kids out of state.
2 We will send kids to Beaumont if that's our choice, but we
3 have sent, just in the last -- Dr. Lawrence mentioned 60 to
4 80 in the last six months. We've sent 28 kids -- many of
5 those have been out of state because Beaumont was not
6 operational.
7 DR. MUKHERJI: Any other questions? Thank you.
8 MR. DON TOMFORD: Thank you.
9 TONY DENTON
10 MR. TONY DENTON: Thank you and good morning. I'm
11 the senior vice president operating officer for the
12 University of Michigan Health System. I just wanted to make
13 a couple of additional points of emphasis on Dr. Lawrence's
14 comments. The letter that I think is in your packet, both
15 he and I signed the communication. And actually my thought
16 about it was fairly narrow. We talked about what the
17 situation was ten years ago and how things have transpired
18 and there's not been any application.
19 But as we were preparing to try and meet the
20 Certificate of Need Standards, we actually do or thought we
21 did until there was a nuance. So the activity -- as Dr.
22 Lawrence mentioned, we actually doubled the activity
23 requirement in terms of the ETV's. In terms of the
24 collaboration we actually found a partner that would meet
25 the current standards the way that they are written. The

1 challenge came when we discovered this 40 percent rule,
2 which we did not understand, and I pursued clarification
3 with Certificate of Need staff, eventually the Attorney
4 General's office. And maybe Chip Falahee has good recall
5 being here 10 years ago, but no one seemed to understand why
6 40 percent.
7 For the last 10 years or so it's been 5 providers
8 that have exceeded 30,000 ETV's and so we thought we were
9 all set with the current standards, but then found out that
10 there was a sixth, which meant that we really had to meet 50
11 percent. And so it varies with the number even though we
12 meet the activity as has been prescribed to be the important
13 goal. So we demonstrated on volume that we are provider of
14 choice.
15 We're a comprehensive cancer center without the
16 ability to be as comprehensive as we would need to be, which
17 is why we're now sending patients away. So we're trying to
18 get to the intent with regard to Certificate of Need because
19 we thought we met the criteria only to find that there was
20 one nuance that could not be ignored called 40 percent. And
21 not having any explanation coming back to us, we would ask
22 the Commission to try to help clarify why that 40 percent
23 rule is actually in place since we meet all these other
24 criteria that will allow us for any other covered service to
25 go forward and be approved to put that capacity in place to

1 support the needs of our patient mission.
2 DR. MUKHERJI: Thank you. Questions for Mr.
3 Denton?
4 MR. FALAHEE: Not so much a question but others
5 may disagree. Let's just say I don't think there was a lot
6 of scientific analysis that went into coming up with 40
7 percent. One could stick one's finger in the air and see
8 what number came out. I don't recall any discussion, "Is it
9 35? Is it 45?" I don't recall specifically why we ended up
10 with 40.
11 DR. MUKHERJI: So just to clarify, are you saying
12 that you've met all the other requirements except for the 40
13 percent?
14 MR. TONY DENTON: Yes, based on the most recent
15 data available.
16 DR. MUKHERJI: Other questions for Mr. Denton?
17 Thank you.
18 MR. TONY DENTON: I would add one comment,
19 Commissioner. It's not in our interest to have to open up
20 the standards again, but if there's no real basis for the 40
21 percent, I don't know what the jurisdiction is for the
22 Commission to interpret the facts the way they are based for
23 the primary criteria, which would be the activity. Short of
24 that, we're asking that there be a review clarification to
25 make the 40 percent rule more valid or, as you say,

1 scientific. Thank you.

2 DR. MUKHERJI: Thank you.

3 DENNIS MCCAFFERTY

4 MR. DENNIS MCCAFFERTY: Dennis McCafferty,
5 Economic Alliance for Michigan. 10 years ago, when I was 28
6 years younger, I went through that process in the entire
7 year of 2009. And my recollection the 40 percent rule was
8 fundamentally to make sure that there were no more than two
9 in Michigan and it was as simple as that, 40/40, and there's
10 not enough for a third one. That was the thought process
11 back then. We didn't really think we needed one, but for
12 sure we didn't think we needed more than two.

13 DR. MUKHERJI: Any questions for Dennis? Thank
14 you. This was an add-on item. So where should we begin?
15 Brenda and Elizabeth, can you provide any historical
16 perspective for the Commission regarding alternatives?

17 MS. ROGERS: This is Brenda. I'm not sure what
18 you're asking, I guess, when you say "alternatives."

19 DR. MUKHERJI: Well, so are we saying that the
20 IMRT is not going to be reviewed until 2000? So is that set
21 in stone and nothing can be done -- or 2020 -- so -- or
22 nothing can be done or are there options for the Commission
23 to potentially address this issue?

24 MS. ROGERS: This is Brenda. Yes, it is -- at
25 this point it is scheduled for the next review in 2020, but

1 as has happened in the past, if the Commission deems that
2 there is an issue that needs to be looked at in a standard
3 out of sequence, that's certainly the Commission's
4 prerogative to do that.
5 DR. MUKHERJI: Thank you. I'm just going to open
6 this up for the Commission to just -- open discussion in
7 light of the testimony we just heard.
8 MR. HUGHES: I just still want to understand. I
9 understand that potentially there's a growing need here and
10 there's a lag time to build new facilities, but I also
11 understand health systems wanting to do everything for
12 everybody. We have an existing one out there. I'm trying
13 to understand if there is, from a volume and utilization --
14 if there's a wait for people that need it and what that
15 looks like currently and going forward. I don't hear that
16 there's a shortage of providers currently.
17 MR. MITTELBRUN: Commissioner Mittelbrun. Can the
18 department provide the data that Commissioner Hughes is
19 commenting on?
20 MS. NAGEL: Certainly.
21 DR. MUKHERJI: Commissioner Brooks-Williams?
22 MS. BROOKS-WILLIAMS: Commissioner
23 Brooks-Williams. I was going to ask similarly, did we hear
24 correctly that McLaren has the technology but does not
25 utilize it and it's only Beaumont that's active in the

1 state?

2 MR. HUGHES: Yeah. That's where it gets confusing

3 because we had one and we were going to get two, which

4 seemed crazy, and then I get confused on what happened with

5 the second one. Somebody here probably is more informed

6 than I am, but --

7 MS. BROOKS-WILLIAMS: So maybe just if we could

8 get that feedback? And then my second question is if we

9 don't have the science behind the 40 percent rule, would it

10 not be until 2020 that we would look at that or is the

11 request that we're looking at that now? I'm just trying to

12 make sure I understand what we're being asked to do. I

13 don't think it was change the standard, but is it to look at

14 the 40 percent rule?

15 DR. MUKHERJI: I'll give you my opinion on this.

16 In general if you look at all of our CON policy issues, they

17 tend to mirror volume and activity. And once we reach a

18 certain activity, then we can trigger something new. I

19 wasn't a member of the Commission back then, but I did hear

20 some of the rumblings and there was a sense of we wanted to

21 limit the number of proton beams, and we almost did it the

22 way we used to do it, was we'll ensure that only X number

23 are in the state. And that, from what I understand, is

24 that's how this was created. And then there was a special

25 option that was created through -- separate from the

1 Commission that allowed another institution to get a proton
2 beam. So I think the way that I look at it, is that how
3 this was created was not really consistent with the
4 processes and activity requirements of the Commission. I
5 think what we're seeing now is maybe an end result of the
6 initial process that really weren't consistent. So that's
7 where I think -- what I hear University of Michigan saying
8 is that they have done everything.
9 They actually thought they qualified. The initial
10 5, now with 6 because of the 40 percent rule -- and that was
11 just because of an increased activity with more cancers that
12 are now felt to be treated appropriately with radiation
13 therapy as opposed to previous they were treated with
14 surgery or some patients that couldn't get any treatment at
15 all. That's how I interpret from a clinical standpoint.
16 MS. GUIDO-ALLEN: Guido-Allen. Isn't this the
17 same argument we heard with bone marrow and our methodology
18 we used for bone marrow not being, you know -- being
19 arbitrary?
20 DR. MUKHERJI: I would assume so. It's really up
21 to opinion, but yeah.
22 MR. FALAHEE: This is Falahee. I think it makes
23 sense as a first step to hear from the department on if
24 there's any history on the 40 percent, and to get some data
25 as Commissioner Hughes talked about, you know, what happens

1 now; U of M, kids that go to Beaumont, kids that go to
2 Cincinnati, Mass General, wherever. I'd like to know that
3 so we know what's out there. Are the kids suffering? And
4 then I think that information can then help us as a
5 Commission inform whether we want then to look at the
6 standards early, and if so, do we want to have a potential
7 change in the 40 percent rule? I'm not saying we do yet.
8 I think we need some data first, then we can
9 discuss it, and then we can move forward. I'm not saying
10 wait 'til 2020 yet. I'm just saying, look, let's get the
11 data, figure out what it means to us, and then move forward
12 from there.
13 DR. MUKHERJI: Any other comments? Commissioner
14 Gardner?
15 DR. GARDNER: Tressa Gardner. And also include --
16 and you said the ten percent of the cancers may be treated.
17 If we can look at that and stratify it across the state
18 based on our current information and see how that will be,
19 how it would be serviced by adding another proton beam.
20 DR. MUKHERJI: Yeah, I think the one clarification
21 commented earlier is that there was -- you're right. It is
22 consistent with the bone marrow transplant, except there was
23 one institution that wouldn't have the special workaround.
24 So it wasn't really created through the initial bone marrow
25 because bone marrow actually, I think, was held to the

1 standards of CON, except for proton beam there was one
2 institution that came around. That's the difference.
3 MS. GUIDO-ALLEN: I wasn't part of you back then.
4 MR. FALAHEE: Right.
5 DR. MUKHERJI: So do we have a motion -- what do
6 we do? Do we have a motion on this or do we just ask the
7 Commission to come back with more information the next
8 meeting? What is the consensus of the group?
9 MR. POTCHEN: In January you have -- or whenever
10 that next meeting is going to be we are developing the
11 Commission plan to review certain standards. It would seem
12 appropriate at that time to get that information so you
13 can --
14 DR. MUKHERJI: Do you know the specifics of the
15 information that we need?
16 MS. NAGEL: I can just add one thing. Tulika just
17 brought up a great point, that the current proton beam
18 service just came online in July of this year. We may not
19 have annual -- the five months of that data until the
20 spring.
21 DR. MUKHERJI: So what's the information that the
22 Commission would ask and what's the information that the
23 department can provide? Chip? Denise?
24 MR. FALAHEE: Okay. Thanks.
25 MS. BROOKS-WILLIAMS: Commissioner

1 Brooks-Williams.

2 MR. FALAHEE: Short-term memory is the first to
3 go. Number one, let me try to summarize. How many cases
4 right now are being sent from the University of Michigan to
5 other facilities, whether it's Beaumont, Cincinnati, Mass
6 General, University of Washington, wherever. Number two, is
7 there a capacity issue or are the kids being -- is the
8 treatment being held up because of a lag somewhere else?

9 Number three, what other cancer modalities are out
10 there that are being or could be treated by proton beam?
11 How does that extrapolate to the entire state of Michigan?
12 I'm trying to look at the, quote, "need," closed quote,
13 here. Number four, what if any history is there on the 40
14 percent rule? And I don't disagree with what Mr. McCafferty
15 said, but if there's anything there, that would be helpful
16 so we as a Commission can get some data. And I may be
17 leaving something out, but that's where I'm at right now.

18 MR. HUGHES: Status of that second facility?

19 DR. GARDNER: McLaren is not functional at this
20 time.

21 MR. HUGHES: But does it have the ability to or
22 what --

23 MR. FALAHEE: So we can add that to the mix of
24 data we're asking for.

25 MR. HUGHES: And exact utilization of Beaumont.

1 DR. MUKHERJI: Elizabeth and Beth, do you have all
2 that info? Are you typing fast enough?
3 MS. ROGERS: I'm trying to, yeah. I think so.
4 DR. MUKHERJI: And so we'll get information on
5 that at the next -- whenever that next scheduled meeting is
6 in the winter. Is that --
7 MS. NAGEL: So if you were to put it on your
8 agenda for the special meeting, is that what you're asking?
9 Because at that time you would decide how you --
10 MR. FALAHEE: As soon as possible.
11 DR. MUKHERJI: What's that, Chip?
12 MR. FALAHEE: This is Falahee again. I'm not sure
13 if you're going to be able to gather all of that prior to
14 the January or whenever we have that next meeting.
15 MS. NAGEL: Correct.
16 MR. FALAHEE: I just say as soon as possible.
17 MR. THEODORE LAWRENCE: We can get all that
18 information. We're happy to help.
19 MR. FALAHEE: As soon as possible -- Falahee. If
20 you can get it to us as soon as possible, whether it's the
21 January-ish meeting or the March meeting, as soon as
22 possible.
23 MS. NAGEL: Okay.
24 DR. MUKHERJI: So if the data is already
25 available, can you work with the individuals that have the

1 data, so don't reinvent the wheel? Is that fair? Is that
2 okay?
3 MS. NAGEL: I was writing it down.
4 DR. MUKHERJI: That was a suggestion, not a
5 directive.
6 MS. NAGEL: Yes.
7 MS. BROOKS-WILLIAMS: Commissioner
8 Brooks-Williams. I don't know if this is added to the list,
9 but I just want to make sure I clarify. Was it the
10 University of Michigan's perspective, and does the
11 Department agree, that they meet all of the other criteria,
12 i.e., the demand criteria with the exception of a 40 percent
13 rule? I don't fully know what that is.
14 MS. NAGEL: It was just discussions. We didn't
15 receive an application. We really couldn't comment on that.
16 MS. BROOKS-WILLIAMS: Okay. So can we have a
17 strongman on that, though, when you come back, given that
18 the substance of this is that the 40 percent rule is the
19 barrier? So I'm not saying they have to complete an
20 application, but by whatever way you could objectively help
21 us to understand if that really is the --
22 MS. NAGEL: I think if I could -- is that you
23 could request that they come back with that information.
24 MS. BROOKS-WILLIAMS: Absolutely. That's my
25 request.

1 DR. MUKHERJI: Other comments? Okay. So we have
2 a request and we don't have to have a motion, but that's a
3 request. Is everybody comfortable with that around the
4 table moving forward? This kind of popped up over the
5 last -- and I just want to make sure that we have a
6 consensus of all the commissioners before moving forward on
7 this. Okay. Great. All right. I hate to ask this
8 question: Any more public comment? All right. No more
9 blue cards then. Next is review of the Commission's work
10 plan. Brenda?
11 MS. ROGERS: All right. This is Brenda. So you
12 do have the draft work plan in front of you. So a couple of
13 changes based on today's meeting. We will look at
14 rescheduling the January special meeting. And surgical
15 services, you received a report. Draft language was
16 presented, but the Commission decided to take no action and
17 put it out to the next scheduled review.
18 And then lithotripsy, you did take proposed
19 action, so public hearing will be scheduled with potential
20 of final action in March. And then just based on the
21 current discussion with the proton beam therapy or MRT
22 services, the department will be bringing back some data as
23 requested at a future meeting as soon as available. Thank
24 you.
25 DR. MUKHERJI: My understanding this is going to

1 be an action item, so thank you, Brenda. Commission
2 discussion? Open to a motion to approve the work plan?
3 MS. BROOKS-WILLIAMS: Commissioner
4 Brooks-Williams. I move to approve the work plan.
5 DR. MUKHERJI: And we have a motion.
6 MS. GUIDO-ALLEN: Guido-Allen. Second.
7 DR. MUKHERJI: Guido-Allen, second. Any
8 discussion? All in favor?
9 (All in favor)
10 DR. MUKHERJI: The last one is -- or I have a
11 separate item. I just want to wish everybody Happy
12 Holidays. That's my -- that's number XVI. Okay. Then the
13 next one is adjournment. Motion to adjourn?
14 UNIDENTIFIED SPEAKER: Motion to adjourn.
15 DR. MUKHERJI: Second?
16 UNIDENTIFIED SPEAKER: Support.
17 DR. MUKHERJI: Beth, is there anything else I need
18 to do before we adjourn for the holidays? Okay. All right.
19 All in favor?
20 (All in favor)
21 DR. MUKHERJI: We're adjourned.
22 (Proceeding concluded at 11:36 a.m.)
23
24 -0-0-0-
25