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

COMMISSION MEETING

BEFORE SURESH MUKHERJI, M.D., CHAIRPERSON

333 South Grand Avenue, Lansing, Michigan

Thursday, September 21, 2017, 9:30 a.m.

COMMITTEE MEMBERS:	THOMAS MITTELBRUN, III, VICE CHAIRPERSON DENISE BROOKS-WILLIAMS GAIL CLARKSON JAMES FALAHEE TRESSA GARDNER, D.O. DEBRA GUIDO-ALLEN, R.N. ROBERT HUGHES MARC D. KESHISHIAN, M.D. MELANIE LALONDE
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	JOSEPH E. POTCHEN (P49501) 525 West Ottawa Street, Floor 6 PO Box 30755 Lansing, Michigan 48909 (517) 373-1160
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES STAFF:	TULIKA BHATTACHARYA MATTHEW LORI AMBER MYERS BETH NAGEL TANIA RODRIGUEZ BRENDA ROGERS
RECORDED BY:	Marcy A. Klingshirn, CER 6924 Certified Electronic Recorder Network Reporting Corporation Firm Registration Number 8151 1-800-632-2720

TABLE OF CONTENTS

Lansing, Michigan

Thursday, September 21, 2017 - 9:31 a.m.

DR. MUKHERJI: All right. I just want to welcome everyone to the September Certificate of Need Commission. I just want to call the meeting to order. For introductions, I just want to introduce and welcome our two new members to the Certificate of Need Commission. One is Melanie -- I can't -- LaLonde. Sorry. It's almost as hard as Mukherji, but not quite. So I want to thank Mel. Can you just tell us a little bit about yourself and -- or -- speak into the microphone.

MS. LALONDE: Sure. Hi. As Suresh said, I'm Melanie LaLonde. I currently work at General Motors in the Global Benefits Department, specifically in the U.S. Healthcare Department. I have been in the profession of self-insured benefit programs for large employers since the day I walked out of college, which is about 20 years ago. So I am representing self-insured health --

DR. MUKHERJI: Thank you. Well, thank you very much for joining us. And the next one is Tressa Gardner. And they didn't misspell your first name; right? It's Tressa? Just tell us a little about you.

MS. GARDNER: I'm Tressa Gardner. I'm an ER physician that practices throughout the state of Michigan. I'm partners with a national group called American Physician

Partners. Primarily I work -- I live in Waterford and I work in Lansing and Saginaw and Pontiac and Lapeer -- well, wherever they need me, so --

DR. MUKHERJI: Thank you. We need you here and we're glad you're here, so thank you. Thank you very much. The next one is the review of the agenda. Anybody have comments to the agenda? We need a motion for approval.

DR. KESHISHIAN: Commissioner Keshishian, motion to approve the agenda.

MR. FALAHEE: Falahee, second.

DR. MUKHERJI: Any further discussion? All in favor of the agenda say "aye."

(All in favor)

DR. MUKHERJI: Any against? Okay. Thank you. The next is declaration of conflicts of interest. Do anybody have any relative conflicts of interest? All right. Hearing none, we'll go on to the review of the minutes. The review of the draft minutes are in your package. I assume everyone's read the minutes.

MR. FALAHEE: Falahee, make a motion to approve the minutes as presented.

DR. MUKHERJI: Okay. We have a motion to approve.

MR. MITTELBRUN: Mittelbrun, second.

DR. MUKHERJI: Any further discussion? All in favor?

(All in favor)

DR. MUKHERJI: Any against? Okay. The motion is approved. The next is going to be the discussion of urinary extracorporeal shock wave lithotripsy services, draft language and public hearing. Brenda?

MS. ROGERS: Good morning. This is Brenda. And just for -- just a couple housekeeping items for the new commissioners. We do have a court reporter here so we do record these meetings and so it's just important and a reminder for everybody else to please identify yourself each time before you speak. Thank you. All right. You do have in your packet today the lithotripsy standards draft language.

As you know, you took action or proposed action back in June changing the requirement for fixed from mobile from 500 procedures to 1,000 procedures, which is consistent with the maintenance and the other requirements throughout the standards. So it was sent out for another public hearing. We received testimony from five individuals representing three different organizations, which you do have that testimony and summary in your packet.

Overall support for the standards, however, there is some concern still regarding the 1,000 procedures versus 500 procedures for conversion from fixed to mobile -- or excuse me -- mobile to fixed. So you have the language in

front of you today. At this time there are no proposed amendments, so we are presenting it to you as you passed it back in June. Should you take final action today, then the language will be moved forward to the JLC and the governor for the 45-day review period.

DR. MUKHERJI: Any questions on -- for Brenda? Okay. The next is going to be the public comments. And the public comments -- I have several blue cards. We're going to limit this to three minutes because there are so many and we're going to strict three minutes. Sheriff Mukherji is watching this, so don't go over. So the first person is going to be Jorgen Madsen from Greater Lansing Lithotripsy.

JORGEN MADSEN

MR. JORGEN MADSEN: Thank you, Dr. Mukherji, and thanks to the commission for allowing us to add to the few more comments. We've sent various comments in and handed some out this morning, also. Greater Lakes Lithotripsy, GLL. I am Jorgen Madsen. I'm the CEO of United Medical Systems. We are the managing partner of GLL and we manage 7 mobile units in the state of Michigan. We service about 65 sites, hospitals and surgery centers alike.

We continue to support the Department's proposal of setting a 1,000 procedure -- annual procedure limit to convert a mobile to a fixed site. It's consistent with the other standards so we think that's the right decision. We

shared last time that Sparrow continues to cancel days of service when they don't have patients. They don't have patients for various reasons. It's not because the patients don't show up with pain, it's because the urologists don't schedule patients at Sparrow Hospital and may choose to take them to other sites. We schedule 12 days of service in Lansing monthly at 4 different sites: Sparrow, McLaren, Genesis Surgery Center and Michigan Surgical Center.

The longest the patient will have to wait in Lansing at any given time for treatment is 48 hours based on the current schedule. All the urologists in Lansing are credentialed at the 4 sites, so they have access to the service. We provided a letter from Lansing Institute of Urology and they indicate that there are many factors that go into the treatment of kidney stones with lithotripsy; patient preparedness, OR availability, urologist availability, et cetera.

Most importantly, the patient has to be ready. Lithotripsy is never an emergency procedure for kidney stone treatment. It is a terminal procedure at the end of a diagnostic complement of things that a urologist would do with a patient. A patient shows up in the ER, he sees a urologist on call that day, and the urologist will take immediate action if there's pain such as inserting a stent and administer the pain medicine, then effort. So first is

to stabilize the patient -- and there could be infection involved. The last thing you want to do is blast the stone with a patient where you don't know what the exact diagnosis is. It could cause significant trauma to the patient and possibly even death. So that's not the way to treat kidney stones. With lithotripsy, there are many other things that go into place, first factors that have to be established and things like that.

So having 24/7/365 access to a machine will not change the course of a patient's treatment at all. So if a unit is needed on specific dates, not scheduled somewhere else, we have available days. We average 6.2 cases per service day in Michigan on our routes. We can do as many as 12 in a day, so we're only at 50-percent capacity on any given day, so there's plenty of access. Not an issue at all. The service that we provide is cost effective.

We do fair market analysis across the country on a regular basis. Prices can vary from 25- to $2700 per case billed to a facility for the service. Sparrow has been kind enough to advertise their rates with us. They're $1300, so they're very competitive. So that's basically what I have to say. We support the 1,000 limit to convert from mobile to fixed again. Thank you very much. Happy to answer any questions.

DR. MUKHERJI: Thank you very much. Any questions

from the Commission for Mr. Madsen? Okay. Thank you very much.

MR. JORGEN MADSEN: Appreciate it. Thank you.

DR. MUKHERJI: The next card I have is from Dave Clark.

DAVE CLARK

MR. DAVE CLARK: Good morning. Thank you for allowing me to share my story. I have frequent kidney stones. I've gotten between three to seven kidney stones a year since I had esophageal cancer in 2007 that required an esophagectomy. My body is unable to process and break down food the way most people's body does because mine goes directly into my intestines. I have tried suggestions from doctors and dieticians.

None has worked and I never know what foods will agree with my body on a daily basis. There are many foods and supplements that I just cannot tolerate. I am sure I am not the only patient that has suffered through these painful wait times in order to access a litho machine. My experience demonstrates the availability of time on each facility is an issue statewide. Let me explain.

Of all the kidney stones that I've had, I have at least one a year that warrants lithotripsy, however, I have only been able to access lithotripsy twice because of wait times. Instead, I have been prescribed opioids that I don't

want to take and had to take time off of work that I could no longer stand the pain. I've had stents put in and surgeries. And let me provide a few examples. In Petoskey in 2012 I was told I could wait 6 weeks before there was a opening on the litho schedule. I was given Norco 5 milligrams for pain and told good luck. The doctor first tried to get the stone by going on a fishing expedition with a basket.

He was unable to catch it so he put in a stent and told me to come back in 2 weeks and he would try to laser blast it. The stent in the ether near the kidney is one of the most painful experiences that I've encountered. It is pain that is burned in my brain. And whenever somebody says the word "stent," I can feel the pain of every time I had to urinate.

In April of 2014 I went to Muskegon -- to a Muskegon-area neurologist while living and working in Niles during the work week, for an 8-millimeter stone that I was told I could get litho on January 28th. So this is from April to the end of June, first available date on the schedule in Michigan. I was given Norco 10 at that time and was told that all he could do for me is to wait. After 2 weeks I called back again to see if there were any cancellations on the schedule and told the doctor I was available if there was any kind of cancellations. I was

told the machine only comes around every 2 weeks and the schedule is full until the end of June. I asked if there was any other procedure that could be done to relieve the pain and was told to just take my medicine and wait. Another 2 weeks passed. I called again and requested an office visit. I met with a PA at the office and was told again that there was no way to get moved up on the schedule and I really just needed to wait my turn.

I was getting to the point that Norco was really not working for me and was told to take 20 milligrams a day to manage the pain. It's very difficult to continue to work, drive back and forth to Niles each way taking the meds only at night so that I could still teach school during the day.

DR. MUKHERJI: Mr. Clark, if you can wrap it up? We're at the three minutes.

MR. DAVE CLARK: Okay.

DR. MUKHERJI: I apologize. I'm just trying to be fair to all speakers.

MR. DAVE CLARK: I know. I understand. All right. I'll just read this last part about pain levels associated with waiting. In the middle of 2014 -- no. I just read that. Let me talk about something else. I'll talk about what happened this summer. In June of '17 I was in St. Ignace for wrestling camp with Fruitport team. On

the last night of camp I was in so much pain the other coach took me to the hospital in St. Ignace for a 7-millimeter stone and I was transported by ambulance to Petoskey, 54 miles away, where I met with a urologist and told that there was no machines available in Petoskey. I spent the next day calling around hospitals all over the state trying to get.

DR. MUKHERJI: Thank you very much.

MR. DAVE CLARK: You have my letter. It's all in there.

DR. MUKHERJI: Yeah; yeah. Does anyone have any questions for Mr. Clark? Thank you very much, sir. Okay. The next is Ric Hughes from Greater Michigan Lithotripsy.

RIC HUGHES

MR. RIC HUGHES: Good morning. Thank you for the chance to speak today. My name is Ric Hughes and I'm on the management team for Greater Michigan Lithotripsy and I'll use the term "GML" today. GML operates lithotriptors only in the state of Michigan. We have three lithotriptors; one on the east side of the state, one on the west side of the state, and we have one lithotriptor that is authorized to treat in both of those CON regions.

Importantly, we do not service any hospital in the Lansing area and do not service Sparrow. We, too, support the Department's recommendation to allow a mobile host site to convert to a fixed host site upon reaching 1,000

procedures a year. I wanted to talk about our volumes. Lithotripsy is not an expanding procedure. It's really going down in volume over the years. In the last 2 years we've seen a 10-percent decrease in volume. So we actually have more openings on the schedule now than we did in years past. In fact, 85 percent of our days scheduled this year we could have treated more patients.

We consider 7 to be a full day, and 85 percent of our scheduled days this year we could have treated more patients either earlier in the day or later if the facility and urologist wanted to add those cases. We have provided a couple letters from physicians who have talked about their ability to add on patients within 48 hours if they need a lithotriptor at their facility and it's not already scheduled there.

So we have that flexibility to do that in the 2 CON regions we work with. Importantly, Dr. Thompson's letter mentioned that really the operating room availability, the anesthesia availability, and the patient's meds that they might be on that needs to be altered in order to do the surgical procedure, those are really the impediments to litho. Machine availability is hardly ever an impediment to those doctors. We want to mention that if there is an increase in lithotriptors in the state and higher volume facilities can do that, it's going to leave

the lower volume facilities at a disadvantage because we're not going to be able to offer the service at the same price at the smaller rural hospitals, so we think 1,000 is a good number there. Just so -- in conclusion, we have plenty of time on our lithotriptors. I know we don't service the entire state, but we serve a lot of it and our patients and facilities and doctors have really good access to lithotripsy. So I'd be glad to take any questions.

DR. MUKHERJI: Thank you very much. Questions from the Commission? Mr. Falahee?

MR. FALAHEE: So if you've got availability -- the prior witness, Mr. Clark, talked about story after story after story that he's gone through. They don't jive. What's going on?

MR. RIC HUGHES: Yeah. We believe it's likely the urologist that was treating that patient. We know there are urologists around the country that make their patients wait for things, but it's rarely for -- in our view it's never because of the lithotriptor. It's because they've got block time at the OR and they want to do something else with patients or they've got vacations or, you know, maybe they are scheduled at other hospitals rather than the one where that patient's insurance wants to be treated. So really it's the urologist more than the machine.

MR. FALAHEE: I guess my reaction to that is if

everybody had ten hands, they'd be pointing ten different directions on this issue because everybody's blaming somebody else. Not you, I'm just -- it's the hospital's fault, it's the litho provider's fault, the urologist's fault. I'm just trying to get it straight in my mind what's going on.

MR. RIC HUGHES: Yeah. Well, I'm a numbers person and I just know we have tons of availability on a daily basis and we have open days where we don't have any patients scheduled. And if the hospital or doctor would call, we could bring a machine across the state and treat one or two patients.

MR. FALAHEE: Thank you.

DR. MUKHERJI: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: You indicated that your costs would go up. Can you talk a little bit more about that?

MR. RIC HUGHES: Well, sure. We have the three lithotriptors that I mentioned and, you know, we have trucks that take them around and we have full-time technicians that are licensed to use those lithotriptors. If we lost our big accounts and we were -- our only customers left were maybe some smaller rural hospitals, we would certainly have to charge more per case to take care of those maybe 50 patients a year at a smaller hospital.

MS. BROOKS-WILLIAMS: Thank you.

DR. MUKHERJI: Commissioner Mittelbrun?

MR. MITTELBRUN: I was writing my notes and I missed the area that you cover. I got the east side. What were the other areas that you cover?

MR. RIC HUGHES: We have the CON region on the west side of the state near Grand Rapids and the east side of the state in Detroit, and then we have one CON that allows us to take a lithotriptor to either of those two. So we only serve two CON regions.

MR. MITTELBRUN: You know, in all the years I've had to deal with health care I run into a lot of extreme circumstances and the previous speaker kind of described one of those, but that's not the normal case that I would consider for people who have kidney stones. I'm, you know -- but unfortunately those things happen. And in this whole discussion one of the things I worry about is access and I'm sure other people at this table worry about access.

I guess I'd like to talk a little more about that, and I'd like you to talk a little more about what damage there might be to access in the state if it was 500 as opposed to 1,000. I mean, you touched on it a little bit, but that's really a big concern for me. I think, you know, the mobile feature and the technology that's available is a plus for the citizens of Michigan and I don't want to see,

you know, us make a change that's going to harm that. If I'm making sense, what I'm trying --

MR. RIC HUGHES: Yeah; yeah. Well, there's two parts to that. One is that it's great to have a good machine, but you really need a good technologist because it's a technologist driven procedure. The doctor sometimes is more involved than others, but the tech is really important to getting that stone and we feel like if you're not treating enough stones, maybe if you're treating a couple hundred a year, you're not going to be very good at it.

So that's why we believe 1,000 is a safe bet for a hospital who may have two techs that would operate that lithotriptor because our techs do stones all day, every day. They treat about 800 a year each and so they're good at it. So that's one part of the access and the quality that we think is important. If every hospital can have a lithotriptor, it might make financial sense for the hospital, but they're not going to be very good at it.

MR. MITTELBRUN: Thank you.

DR. MUKHERJI: Any other questions? Thank you very much, sir.

MR. RIC HUGHES: Thank you.

DR. MUKHERJI: The next public comment card I have is from Theresa Perry from Greater Michigan Lithotripsy.

THERESA PERRY

MS. THERESA PERRY: Good morning. My name is Theresa Perry and I have been a registered nurse for working with lithotripsy patients and the urologist for over 30 years. During that time I've had the opportunity to be responsible for operations of an ambulatory surgery center where we did lithotripsy. I also have worked with mobile and local regional medical mobile routes. Currently I have clinical oversight for Greater Michigan Lithotripsy and I've been working with their physicians and their medical directors for many years now.

In my experience in the last 30 years I have found that doctors and urologists usually do not consider kidney stone treatment an emergency procedure and that's for many different reasons. Some of them, even if a lithotriptor like we had at the -- available all the time, the doctors might not be available, the tech. Even if we have it all ready to go, they don't always use that as their first line of treatment. That's not what they look for first.

A patient presents to the emergency room. The reason they go to the emergency room is because they're in pain. As you've seen in your letter from Dr. Thompson and as in my experience, patients are complaining of the pain not from the stone itself but from the obstruction that's caused from the kidney stone blocking off the ureter. So a

routine procedure is performed where they put up a stent; that relieves the pressure and then it also relieves the pain. After that is taken care of and the patient doesn't have the severe pain from the obstruction anymore, then they can be scheduled for an elective procedure such as lithotripsy at a later date, usually within a few days or a week or so of their original visit to the ER.

However, here in Michigan as Mr. Hughes just mentioned, we have three lithotriptors. We do have availability of time in Michigan that we can add cases on usually within 48 hours. If a patient needs treatment faster than their usual scheduled date for that area, we're able to add that on. We do advertise that and ask that the physicians or their offices call our managers and we're happy to accommodate that.

Even though we can add them on during the 48-hour period of time, it's often difficult for that patient to be scheduled for many reasons, some of which can be the medications that the patient is currently taking, such as anticoagulants like aspirin or something like that. Typically the physicians advise the patients to stop those medications up to seven days prior to their treatment. Also, another medical consideration would be if a patient has a cardiac device such as a pacemaker or a defibrillator and they need surgical cardiac clearance before the

lithotripsy occurs. In addition to the medical concerns, and as noted by both Dr. Anema and Dr. Thompson in the letters you have, there's other scheduling issues that come into play such as OR availability and as Mr. Hughes also mentioned about anesthesia availability. The availability of the lithotriptor is just one of the items that determines the availability of kidney stone treatment. Thank you. I will be glad to answer any questions you might have.

DR. MUKHERJI: Thank you very much. Any questions from the Commission? Thank you.

MS. THERESA PERRY: Thank you.

DR. MUKHERJI: The last card I have -- and we're happy to have more on this interesting topic -- is Paula Reichle from Sparrow Health System.

PAULA REICHLE

MS. PAULA REICHLE: Good morning. My name is Paula Reichle. I am the chief financial officer at Sparrow Health System based here in Lansing, Michigan. And I know the Commission has received my comments and this agenda item has been deliberated at length over many months. I would just like to highlight a few factors related to our request. Sparrow has and will continue to be committed to patients regardless of their ability to pay. Our interest in a fixed unit is not to increase volume or increase our revenue. It is just simply to have a machine available 365 and also to

lower our costs. Currently we have 3 days of service every other week. That's approximately 6 days a month. The volume in our service area has been relatively flat as others have commented on. The only thing that's happened recently in the last couple years is that the mobile providers have added a site at Michigan Surgical Center and Genesis Surgery Center. Basically those volumes were redistributed from McLaren Lansing and Sparrow Health System.

So we have the same volumes, they just -- the pie just got redistributed. In 2015 Sparrow accounted for 60 percent of the procedures performed at those 4 sites. Even at 60 percent we would never reach the 1,000 threshold procedure for a fixed unit, so that number does not seem realistic based on the total procedures being done in this region. The issue raised by UMS about our cancel days simply supports our position; that patients don't present on a set schedule, and when we don't have patients we cancel.

What they didn't mention is that we have to pay when we cancel. So we get 4 free cancellations a year. If we cancel more than 4 days, we pay $4,000 for them not to come. The increase in our cancellation rates has actually been directly related to the addition of the sites at Michigan Surgical Center and Genesis. It's not because Sparrow needs less, it's because they opened extra sites and

cases have been moved from Sparrow and McLaren to those other sites which has necessitated cancellation because there are no new cases. There has been some concerns raised about Sparrow's reimbursement for these cases and that we receive more money than the ambulatory surgery centers to get for these cases. So from a commercial perspective, Blue Cross and Blue Shield and BCN, we receive $2500 a case for a lithotripsy procedure.

We pay $1300 just for the machine and technicians. If you add anesthesia, OR time, drugs, and our nursing time, we lose money on every single case. This is not about increasing our profits on lithotripsy cases. We don't even make money on them. We provide service because it's a necessary service in our community. In 2016 we paid $700,000 for equipment rental. We could buy a machine, staff it and spend the other money necessary and recoup our investment in two years.

This is a really expensive place for us to be. And in summary, we would like to increase patient care and access and we ask the Commission to reduce the conversion to 500 cases.

DR. MUKHERJI: Any questions? Commission Hughes?

MR. HUGHES: I have two. The first one just to clarify about the charges. So are you saying that if you move this internally, that your billing rate for this

procedure is going to stay the exact same as going through the mobile?

MS. PAULA REICHLE: We get paid on a fixed fee based on contracted rates with Blue Cross. So the $2500 that we get for a case approximately would stay the same. What would reduce is that possibly we might break even on it versus losing money.

MR. HUGHES: Yeah, maybe I didn't ask my question clear enough. There's obviously charge masters at hospitals.

MS. PAULA REICHLE: Yes.

MR. HUGHES: And when you charge for procedures, they can be different from a hospital as opposed to an ambulatory clinic or something like that.

MS. PAULA REICHLE: Right.

MR. HUGHES: And I'm trying to understand if your billing rate's going to be the exact same.

MS. PAULA REICHLE: The charge has no impact on what we get paid. We can charge a million dollars for a case. Blue Cross is still going to pay us 2500.

MR. HUGHES: But you're going to have other providers other than Blue Cross?

MS. PAULA REICHLE: Blue Cross is the largest commercial payer. We actually get paid less money from other providers like Medicaid and --

MR. HUGHES: Well, everybody gets less from Medicaid, --

MS. PAULA REICHLE: Right; exactly.

MR. HUGHES: -- but that's not what we're talking about. Other commercial carriers, self-funded plans, et cetera?

MS. PAULA REICHLE: Self-funded plans usually come from Blue Cross. Usually TPA is Blue Cross and they access us at Blue Cross rates.

MR. HUGHES: What if they're using your own PHO?

MS. PAULA REICHLE: PHP or SPHN?

MR. HUGHES: Either one.

MS. PAULA REICHLE: SPHN rates are very similar to Blue Cross.

MR. HUGHES: But your rates are not going to change?

MS. PAULA REICHLE: Our payment rates will not change, no.

MR. HUGHES: Billing rates?

MS. PAULA REICHLE: We can charge whatever we want. What people pay us is what's contracted. So if we charge $10,000, they're going to pay us 2500 whether I charge 10-, 20-, 30-, $40,000. Doesn't matter. We get paid a fixed fee screen. It's not a percent of charge. It's not based on our charge.

MR. HUGHES: Second point is would you agree with the previous speaker that talked about there's definitely a correlation in health care the more somebody performs the procedure; you can have better outcomes and typically lower costs? Would you agree with that statement?

MS. PAULA REICHLE: I would not agree with that statement as it pertains to Sparrow. We operate da Vinci robots, cardiac cath labs, linear accelerators for cancer treatment. All of those staff are trained by us. Training and retaining and certifying staff to operate a lithotriptor does not pose a challenge for an organization like Sparrow Health System.

MR. HUGHES: So in general somebody doing a procedure more times than somebody that's not doing a lot, you don't think there's much value to that?

MS. PAULA REICHLE: I think there's value and I think at 500 or more cases we would meet that threshold easily.

MR. HUGHES: Thank you.

DR. MUKHERJI: Commissioner Mittelbrun?

MR. MITTELBRUN: Just on Commissioner Hughes' comments because there are a lot of people that don't use Blue Cross Blue Shield.

MS. PAULA REICHLE: Uh-huh (affirmative).

MR. MITTELBRUN: And so you have, you know,

Cofinity, HAP, et cetera. You have different reimbursement rates, so it's not just Blue Cross Blue Shield, but that's really -- it's really not the point, but he was looking for different reimbursement rates, which I'm sure you get. But I just wanted some clarification. You said other cases were moved to other facilities. You named those other facilities. Who moves the cases?

MS. PAULA REICHLE: The urologist.

MR. MITTELBRUN: So because the access was improved by these other facilities, the urologist chose to use them?

MS. PAULA REICHLE: I can't speculate on what the reason for moving --

MR. MITTELBRUN: Well, I, you know -- well, I'm just looking at -- so that's a benefit to the consumer or the patient because they may have not had to go and drive another hour or whatever because they had these other facilities available?

MS. PAULA REICHLE: All the facilities are located within about three-mile radius in Lansing.

MR. MITTELBRUN: Okay. Well, I'm not familiar with the geography, but --

MS. PAULA REICHLE: Yeah. So, you know, moving from Sparrow Health System to the Michigan Surgical Center is about a two-mile --

MR. MITTELBRUN: But the urologist must have had some rationale, I'm going to guess, for doing that?

MS. PAULA REICHLE: I am sure they did.

MR. MITTELBRUN: Okay. Thank you.

MS. PAULA REICHLE: I'd like to comment on the insurance. Just so every one is aware, in this region Blue Cross Blue Shield has 78 percent of the market share from a commercial insurer perspective so they are the major payer. There's not a lot of other payers that sell insurance in this marketplace.

MR. HUGHES: That's the same percentage throughout the state; a little bit heavier on the east side, actually.

MS. PAULA REICHLE: Yeah. So they are the payer after Medicare and Medicaid.

DR. MUKHERJI: Commissioner Falahee?

MR. FALAHEE: So I've got a devil's advocate question.

MS. PAULA REICHLE: Sure.

MR. FALAHEE: When I hear that there is other providers in Lansing -- all right? -- within three or four miles, and then I hear that you're -- according to your letter and what you said what you're paying for the mobile exceeds it looks like twice what you would be able to do it for if you bought your own, why are you still in this line of business?

MS. PAULA REICHLE: That is a question that's being evaluated and we have to evaluate that. We are being asked every day to reduce our costs as a health care provider. And when you look at the metrics on this, we are losing money on every commercial case. We lose money on Medicaid. We barely break even on Medicare. And so, you know -- and we're cancelling cases and paying -- are cancelling days and paying for those days.

I agree with you. We will be evaluating that because we can't continue to lose money on these cases although we lose money on a lot of cases, all different types. We're a level one trauma center. We have a regional neonatal intensive care unit. We do all kinds of things that don't make us money but that's who we are and so it's all just a big pie and everything gets put together. When you want to start pulling out and put a lot of scrutiny on one particular procedure, that's not how we do business.

We don't just do things because they make money. We do things because the community needs the care and we take care of anyone that shows up at our door regardless of their ability to pay or whether or not they have an insurance card in their hand.

MR. FALAHEE: Thank you.

DR. MUKHERJI: I've got a couple questions, if you don't mind.

MS. PAULA REICHLE: Sure.

DR. MUKHERJI: So I think what maybe Commissioner Hughes was asking, because as you know, as you well know, different insurers and different payers have different rates for the procedure done at the outpatient and then inpatient setting. So if you have your own system in house, would this payment that you receive be up-adjusted because it's an inpatient procedure versus if it's purely an outpatient procedure?

MS. PAULA REICHLE: We do almost all these procedures on an outpatient basis. So, you know, I don't think there were -- I mean, that's really a physician decision whether they do it as an out- or an inpatient. That's not something the facility dictates.

DR. MUKHERJI: All right. But would you get the facility component up-adjusted if it was done in -- you know about HOP's payments obviously.

MS. PAULA REICHLE: Yeah, this inclu- --

DR. MUKHERJI: So is there -- there's a 50-percent bump up --

MS. PAULA REICHLE: -- this in- --

DR. MUKHERJI: -- for a HOP's payment. So would that now qualify you for that?

MS. PAULA REICHLE: The numbers I quoted include our payment. That is what we get paid. It's the entire

payment. So yes, I agree that there sometimes is a differential, especially in the Medicare world, that we will get paid more for the same procedure in a hospital setting versus a non-hospital setting.

DR. MUKHERJI: Uh-huh (affirmative).

MS. PAULA REICHLE: But that number that I quoted you for Blue Cross and the number for Medicare -- I mean, overall, our entire outpatient business, including all commercial insurers, was a reimbursement of $3500. So there's not a huge amount of money in this arena and that includes all special payments. These are outpatient procedures only.

On the inpatient side we would not receive any additional payment for performing a lithotripsy if someone was in for another reason. That's just a procedure that would be done under the inpatient DRG, whatever classification we bill on.

DR. MUKHERJI: So the question -- some question asked is that Certificate of Need covers approximately 17 covered services with the state and every three years the role of the CON Commission, this Agency, is to review various standards. And in general when there is a concern, questions or a need to update standards, especially by health systems, usually there's a bit of a consortium of different systems asking for this change.

MS. PAULA REICHLE: Uh-huh (affirmative).

DR. MUKHERJI: And it seems in this particular case Sparrow seems to be the only system that has been pushing for this change. Why do you think that's the case?

MS. PAULA REICHLE: Well, I think that in some instances I believe one system is an owner in a mobile route, so obviously they may be receiving additional reimbursement from the profitability of that route to offset what they're paying for the cases.

And to be honest with you, there aren't that many health systems in the state that have this kind of volume, and some of those have multiple different hospitals; their volume is spread over three or four, if you're Beaumont or some other, you know, big health systems. So this 500-procedure limit really only would affect a handful of hospitals, so there's not that much to the coalition.

DR. MUKHERJI: So is that because they already own their own lithotriptor? So I assume what you're saying is that -- if I hear you correctly, you said there was one system that owns their system and we have about 10 major hospital systems in the state and some of these -- many of these are ranked in the top 50 just based on the scale.

MS. PAULA REICHLE: Uh-huh (affirmative).

DR. MUKHERJI: So if you take this one out, that leaves places like Beaumont, Ford, McLaren, University of

Michigan, Ascension, Trinity, but yet they seem to not have the same vigor that Sparrow does on this particular issue. Is that because you feel that these systems don't have the volume or they own their own lithotriptors? I'm just trying to figure out why Sparrow is --

MS. PAULA REICHLE: I think it could be both. I think it's dependent on the system. I think that in some cases they don't have the volume so they figure, "Why would we support Sparrow to go to the 500?" And I think in other cases they have other financial arrangements which might offset the cost that they're paying for the rental. And I can't, you know -- I'm not privy to those kinds of details, but that's my assumption. I mean, you know, I think that there's a couple things. This service is a low cost to entry.

It is not likely to increase volume and there's a low cost for ongoing initial investment. It differs from many of the other CON services and that's, you know, our perspective. And why we keep pushing on this particular issue is that we don't see this piece of equipment any different than we see digital mammography machine or a digital x-ray machine or an ultrasound machine, which all are in the same sort of cost as a lithotriptor. This service is not an MRI, PET or even a CT. It's a very different -- I mean, it has outlived its usefulness in terms

of trying to protect it from a cost and an access perspective, at least from my perspective.

DR. MUKHERJI: Okay. Other questions?

MS. GARDNER: How much revenue are you losing a month or a year and what do you anticipate if you were to get a machine you would offset?

MS. PAULA REICHLE: We did about 581 patients last year and our -- I would say we're probably overall in total about break even because our costs equal the reimbursement. So this would probably allow us to have a profit on every case of somewhere around $500 a case would be my estimate, because we will incur costs even if we have a machine. We have technicians, OR time, anesthesia time, all of those other things included.

MR. MITTELBRUN: Can I ask one follow-up?

DR. MUKHERJI: Commissioner Mittelbrun?

MR. MITTELBRUN: Mittelbrun. All of the items you just listed comparing them to other services, isn't it so much lower volume than the ultrasound and so on?

MS. PAULA REICHLE: Sure, it is; yeah.

MR. MITTELBRUN: Okay. Right.

MS. PAULA REICHLE: But that doesn't always, you know -- health systems don't always make individual decisions solely on a business case. They look at the overall need for a service. You know, we don't believe that

if we had a machine that urologists would form a barrier to access as was mentioned in one of the other comments. We actually pay our urologists to be on call 365, every day of the year, for our trauma service and other things that we ask them to be available for, so we don't believe that urologists are a barrier to scheduling a procedure if the patient condition dictates it.

DR. MUKHERJI: Commissioner Keshishian?

DR. KESHISHIAN: Yes. I do have a question and the first is to follow up on the urologist question.

MS. PAULA REICHLE: Uh-huh (affirmative).

DR. KESHISHIAN: Do you have any urologists on staff? Because what I heard earlier is that urologists have decided to move cases to freestanding. So if you get this, how are you going to convince urologists to do it at Sparrow unless they're employed by Sparrow or do you have --

MS. PAULA REICHLE: We do not have employed urologists.

DR. KESHISHIAN: So you'll have to convince the community urologists who are going to other community centers now to bring the cases back in to Sparrow?

MS. PAULA REICHLE: I don't think we need them to necessarily bring the cases in. We just want to lower our costs to have the machine available. So I, you know -- if we never got one more case than the trending that we have

now at this point, the economics still make sense for us.

DR. KESHISHIAN: And the other question is -- and this has been referenced somewhat in the conversation. Many of us think, you know, every time we hear about lithotripsy it's like why do we have this under CON regulation?

MS. PAULA REICHLE: Uh-huh (affirmative).

DR. KESHISHIAN: But every time we go through this it's like we are providing a service to rural communities because in fact in hos- -- and really I want your opinion on this. If hospitals were the basis of lithotripsy and everyone who has it, we'd have probably six or seven lithotripsy units in the state of Michigan based on hospitals and we wouldn't have the mobile routes.

MS. PAULA REICHLE: Right.

DR. KESHISHIAN: And so therefore we would be decreasing access for the residents of Michigan. So help me get over that hurdle because I, you know -- because, you know -- you think about why are we still having this under CON. It's low cost, low volume. It's like we should just get rid of this. And then we have -- getting to these discussions and we want people driving all over to six or seven -- and maybe -- and I -- maybe I should ask the other people who spoke. What happens in other states? Is it in fact just centralized in a few cities and people are traveling and, you know, mobile routes closed down? Because

access is one of the things that we are supposed to evaluate. Help me out with this, please.

MS. PAULA REICHLE: So I can speak for, you know, how Sparrow approaches these things. We actually own three hospitals in rural communities in mid-Michigan; in Ionia, St. John's and Carson City. We have a relationship with another hospital in Charlotte. As we look at those hospitals and services, we typically try to push service to those areas.

So it would probably not be out of the realm of possibility that we would actually possibly purchase a mobile and actually make it available to our own sites and potentially others so that, you know -- that that would not be the case. You know, we have a philosophy at Sparrow that we want to provide care as close to home as possible. And other than a hub and spoke where we're trying to push all services into Lansing, we are pushing services out to our local communities.

That's where cancer care should be delivered, that's where surgery should be performed if clinically effective, and that's where potentially litho services could be provided. So that would be our perspective from our health system and how we look at these issues.

DR. KESHISHIAN: Do any of your outlying sites now have --

MS. PAULA REICHLE: They do not.

DR. KESHISHIAN: Okay.

MS. PAULA REICHLE: They do not, no.

DR. KESHISHIAN: Thank you.

DR. MUKHERJI: Other questions from the Commission? Thank you very much.

MS. PAULA REICHLE: Thank you.

DR. MUKHERJI: And that's the last blue card I have on this topic. Would anybody else like to get up and give comment? Any blue cards? Speak now or forever hold your peace. All right. I don't have any blue cards and I don't see any racing up to the mic. So the next is we'll close public comment and transition to Commission discussion. So Brenda or Elizabeth, let me see if I frame this correctly just to get us back on track again.

So we have the lithotripsy standards in front of us. Approximately 3 to 6 months ago the initial entry, whether it's a mobile or a fixed, if someone wants to enter the market and get a lithotriptor, they still have to have 1,000 commitments. So the discussion here is can someone transition from a mobile to a fixed. And approximately 3 to 6 months ago we said if they have 500 cases that would allow the transition from a mobile to a fixed, and then at the last Commission meeting we said -- we bumped it up to 1,000. So that went to public comment and now we're back here. So

we're, if you will, on final action; is that right?

MS. NAGEL: No.

DR. MUKHERJI: Okay. So have I framed this correctly for our Commission members?

MS. NAGEL: This is Beth. And yes, you have framed it correctly. With your permission I'd like to just give a little bit more background.

DR. MUKHERJI: Please.

MS. NAGEL: Sure. So as Dr. Mukherji said, this language, you've seen it multiple times now. One time in June, I believe -- in March it came up through public comment this idea of transitioning from a mobile unit to a fixed unit and the public comment at that time recommended the 500 volume. The Commission asked the Department to put that in -- out for public comment. We did that and we brought back a recommendation to increase it to 1,000, and I wanted to give an explanation of our rationale behind that.

Where we decided to bring back the recommendation to you for 1,000 was based on consistency of the standards, based on consistency within the standard, and among Certificate of Need Standards. That said, within lithotripsy, this standard, in order to initiate you need to have 1,000 -- you need to be able to project 1,000 cases, and then the project delivery requirements require a maintenance volume of 1,000 as well. That said, the

language that is in the standard now as it is in front of you with 1,000 cannot be used by anyone in the state. There is no one in our volumes that we collect every year that's meeting 1,000. There are 4 that are close, but still within hundreds below 1,000. And so we've been asked multiple times, you know, can -- is our recommendation -- sometimes our recommendations are based on the fact that we can't administer a standard with anything other than what we're recommending and that is not the case here.

We could administer this language given the Commission's request of any such volume. Our concern was really just on consistency. It did not necessarily factor in some of the conversation that you've heard today. In the past the Commission or the Department has recommended deregulation of lithotripsy services and that's based on, again, what you've heard today is either a flat or a declining number of cases throughout the last ten years.

We see it as a relatively low-cost piece of technology that is low cost to enter, low cost to maintain and it's very well-established. And so for us on the Department side, that leads us to believe that regulation of this service may or may not be effective. However, that is always balanced by the discussion that you've heard here today with access issues and quality issues and cost issues as well. So I just wanted to explain our position and the

limitations of our position just based on what we see as kind of the front line of Certificate of Need administration. But certainly that does not include all of the, you know -- the expertise that you bring to the table as the front line of health care in the state. So that's my explanation.

DR. MUKHERJI: Nicely stated, Elizabeth. Thanks. Open for discussion for the Commission?

MR. MITTELBRUN: Well, I'll just make one comment. Commissioner Keshishian's questions and comments were the same ones I have when it comes to access and if we're going to take some action in the wrong direction where we're going to harm our citizens or our patients or cause them more difficulty.

MR. FALAHEE: This is Falahee. I don't know how many times we've addressed this now, and next time we probably address it it'll be to deregulate the whole thing. But until we get there, there's a lot of competing factors here and some of those I discussed with a state senator that -- he and I had an interesting chat yesterday. But when I look at quality, access, and cost, on the quality nobody's really talked about that, so let's say that's a given. Patients always assume they're going to get quality. And whether you're a hospital or a mobile litho, I think you get the quality. The access? Yeah, that's a tough issue.

We hear about Sparrow's request and I applaud them as an aside for working through the CON process, not trying to do a classic legislative end around. So I appreciate that. I'm sure it's frustrating to deal with the Commission; not the Department but the Commission. On access we hear 24/7 availability and that's what they want. Then we hear and we get letters today to talk about, "Well, do you really" -- it's not an emergency situation.

So I think you can go both ways on that. The biggest issue for me is the cost. When I see a provider that's paying -- if you believe what we've been presented and the testimony -- roughly twice every year what it would cost to buy a fixed and to operate it, that just bothers me. In this day and age when cost is so paramount -- and yes, Commissioner Hughes, as a hospital person I'm still talking about cost.

So I think it's important that we look at that. I do think there's some merit to the fact that this is a request by a hospital, tax exempt, takes patients regardless of ability to pay, Medicaid, charity care, wherever. Where I ended up in my mind at least -- and you may all disagree -- is I'm aware that in the MRI Standards there's sort of a middle ground that if a hospital wants to convert from a mobile MRI to a fixed, there are some lesser numbers that apply than the initiation numbers, and you've got a

hospital, a tax-exempt nonprofit that owns it, emergency room available, lithotriptor 24/7 also. I'm wondering if in the Department's perspective -- and Beth, you talked about the 500 or 1,000. I'm wondering if the Department ever has or would consider some sort of a middle ground here. And I don't have a number in mind, but given the fact that we've got cost issues, access issues going either way, quality is not the issue, is there something that's a middle ground to enable a litho to be fixed and to be available 24/7?

MS. NAGEL: This is Beth. And yeah. The answer to your question is "yes." We can administer this language similar to the MRI conversion that you discussed.

MR. FALAHEE: That would be my thought as we try to come up with a -- I don't ever like to come up with middle grounds, but in this one there's a lot of competing interest, at least in my mind, from the access to the cost to the availability.

DR. MUKHERJI: Yeah. I'll just make a comment because you keep looking at me.

MR. FALAHEE: No, it's because you're the chairman.

DR. MUKHERJI: I think, you know, when you look at covered services there, you know, there are 36 states that somehow have CON in their process, and I think one of the reasons Michigan has been consistently rated one of the

highest in administering CON is that we have an iterative process in which we review things every three years. And part of our process -- and we have to make a fundamental decision if we're going to change public policy for the state, do we put in new requirements that cannot be achieved, as Beth was saying, or do we really try to adjust to the current times and these standards were in place years ago.

I mean, when I was a resident, I was actually doing lithotripsy on rats doing research on it. So lithotripsy has been around since when I trained, which was in the last century, which I hate to admit. So this is not an evolving technology. It's been around there for awhile. And if you look at the technology curve, it's actually flattened out, if not declining. So I think we need to be able to be facile and adjusted, understand where this is in relation to other medical technologies.

The second issue is an access issue. And part of the reason I asked the question about why other systems don't have the vigor that Sparrow does, we have heard in prior testimony that part of the concern about causing a transition from hospitals to acquire the fixed units is that then the mobile providers will not have the ability to provide services in other parts of the state in rural areas. But for me -- then ask this question: Is it really the

charge of public policy and the charge of hospital systems to essentially cross-subsidize other carriers to provide services to other parts of the state? I don't have an answer to that, but that's what's going -- that's really what's going through my mind. So that's where I --

MR. HUGHES: I would just throw into that equation that with Medicaid and the number of people covered in the state with the expansion, we're subsidizing everybody for everything right now because Medicaid doesn't pay the providers anywhere near enough.

DR. MUKHERJI: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yes. Brooks-Williams. I have a -- I guess a thought right as we're trying to answer the question that's around what are the impacts. Right? So we kind of know Sparrow's business case around why it has put the, you know -- they market in their community and I think it was very compelling. But we maybe don't know -- right? -- what is the unintended consequence for other people that are on the mobile route. And I think I have consistently tried to ask the question -- right? -- what is the cost increase?

Because we're looking at their cost reduction. But is there a cost increase to those that remain on the mobile route and how -- I know we can't require it; right? But what are the access implications of any rate so if that

does become cost prohibitive for other people that are in those rural markets, so that we are at least maybe able to make a decision based on all the elements, you know, that we're responsible for. So I don't think I struggle as much with the business case that Sparrow presents. I struggle with not understanding what impact it has on everyone else that's affected by the service. And I don't know, you know, from a Department perspective or even as we discern how do we get those other answers.

DR. MUKHERJI: This is Mukherji. I agree with that. The challenge is if we assume it's a fixed pie and there's a certain amount of volume, then, yeah, in order to maintain you have to increase your costs. But the testimony that we heard earlier is that there's a lot of opportunity in different parts of the state that had never been tapped. So over time if you do have a cash cow that lithotripsy's become, you've become reliant on it.

But eventually in order to survive you have to be innovated, you have to see where the needs are, then adjust business models. That's the time that we live in. So I guess we're -- other discussion? I guess we're to the point where we have to make a recommendation or a motion or something like that.

MR. FALAHEE: For the sake of getting this started, what I'll do is make a motion to -- along the lines

of what I said earlier -- to request the Department to look at similar to what's going on now with MRI, to let a hospital that has a mobile MRI convert to a fixed, which is now lesser numbers that initiate. I don't remember what they are. But to request the Department to look at whether that makes sense and whether that could be done for a tax-exempt not for profit hospital operating a 24/7 emergency department.

And I don't want to tie it to level one or level two or level three trauma center, because if we're thinking of rural facilities you can't tie it down to that because there aren't that many level ones; to see if there's some other number that would be respectful of the volume requirements because the more you do, the better you're at for the most part; but to look at somewhat of a compromised number and see if you could come to the -- with that next time and that would be my motion. Not artfully worded, but that's the thought.

DR. KESHISHIAN: Commissioner Keshishian, second.

DR. MUKHERJI: So we have a motion on the table and we have a second. Brenda?

MS. ROGERS: Yeah. No, I just have a clarification. So are you asking the Department just to look at the MRI conversion language in regard to coming up with a volume requirement or also some of the other aspects

that are in that conversion language?

MR. FALAHEE: The other. That's why I mentioned hospital, tax exempt, emergency room. And don't use MRI necessarily as the "this is it," but use that as a springboard to say, "Okay. Here's what else we could come up with."

MS. ROGERS: Thank you.

DR. MUKHERJI: Is that what you were thinking, Commissioner Keshishian? You still second that?

DR. KESHISHIAN: I still second.

DR. MUKHERJI: Okay. So we have a motion and a second. This is open for discussion.

MR. HUGHES: I just have a question. Beth, just to help me understand because I get confused easily. You talked about a bunch of -- or a few places that are doing it that are not meeting the 1,000 standard; correct?

MS. NAGEL: There's no site in Michigan meeting the 1,000.

MR. HUGHES: And the reason we don't do anything about that even though that's the standard is --

MS. NAGEL: So this is exactly the reason why the Department has argued for deregulation of this service, because then we would have to take compliance action on every provider in the state. There isn't one that's passing the grade. And we have argued historically to deregulate,

and if not deregulate, then fix the standard.

MR. HUGHES: Thank you.

DR. MUKHERJI: Other questions? Comments? Okay. So we have a motion on the table. I think we're ready for a vote. All in favor, say "aye."

(All in favor)

DR. MUKHERJI: Any against? Okay. The motion passes. All right. Thank you very much. Thank you for all of you that took your time to come and be part of this process for public comment, et cetera. Thank you very much. All right. The next topic is on Surgical Services and this is in particular related to end stage renal disease and dialysis access. So Medicare has made a change in how freestanding dialysis centers are getting reimbursed and right now the standards does not affect this specific issue.

So we were approached -- the Department was approached by Fresenius Managed Vascular Centers. And because it was a new thing, we decided to allow them a maximum of ten minutes, not to be exceeded, just to present this to us so to educate us on the process and see if this is something that the Commission could assist with, given the changes in Medicare reimbursement. So go ahead, please.

PRESENTATION BY GREGG MILLER, M.D.

DR. GREGG MILLER: Okay. Thank you, Dr. Mukherji and the Commission for allowing us to present. My name is

Dr. Gregg Miller. I am a physician. My practice is based in New York. I over the past 15 years opened up about 25 outpatient vascular centers. In 2011, Fresenius, the nation's largest dialysis services provider, recruited me to help them with their difficulties with vascular access outcomes and we have been continuing to open centers. We now have 65 centers across the United States and we have one right here in Lansing, Michigan, which currently functions under OBS or the Office Based Surgery, which functions under the physician fee schedule.

The story that I'm going to tell you today is more about dialysis patients. In 2014 ERSD accounted for one percent of the Medicare population, however, they consumed 7.2 percent of the Medicare fee for service budget. So there's a very significant cost of care with this patient population. It's due to high co-morbidities. They're a sick patient population. They have socioeconomic difficulties.

The majority of beneficiaries are Medicare and Medicaid with about 14 percent of them falling under commercial insurances. So in order to contain costs, Medicare has come up with alternative payment models for the dialysis population. These are called ESCO's, which are essentially End State Renal Disease ESCO's. That's not what the "E" stands for. That actually stands for ESRD Seamless

Care Organizations. And, you know, the reason is because they're trying to get control of the excessive costs for caring for this population. And the most significant issue here is that the type of vascular access -- and that's our specialty is making sure the patients get the right type of vascular access -- is a major contributor to morbidity and mortality.

To the extent that if you just take all comers and sort dialysis patients just by access type, their total cost of care per year, if you have dialysis catheter, is 90,000; a graft, 79,000; if you have a fistula, 64,000. And the rationale for that is that if they have a catheter that leads to chronic bloodstream infections, ICU admissions, and dramatically drives up the cost of care of fistulas in need of vein, it's not synthetic, it actually is the best type of access you possibly can achieve.

So the biggest cost of care issue is in the first 6 months, and in those first 6 months the patients are -- generally start dialysis with a hemodialysis catheter and the goal is to get them off of the dialysis catheter as quickly as possible and get them to a fistula. Across the Fresenius dialysis system the average is 120 days to move a patient from a catheter to a fistula, and during that period of time they have an excessive mortality and it's almost entirely related to bloodstream infections. In places where

we have coordinated care, we have been able to achieve significant reductions to 45 days or 90 days in 2 different pilots of getting catheters out quicker, decreasing morbidity/mortality issues and helping patients. And the reason that it's so difficult for patients to actually start dialysis with the correct access, which is a fistula, is because there's so many places where the patient has to go, whether it's an independent office, an interventional suite, a hospital for access creation, back to the surgeon's office for additional followups and checks, and it actually takes time for these fistulas to grow and develop.

It's actually a pretty complex process. So the main issue's that, you know, Medicare has a policy change and they have essentially shifted from office-based -- they have made a policy change. We have shifted reimbursement from OBS, where we've been for the past 15 years, to ambulatory surgery center reimbursement, and their goal is to help us push forward ESCO's and fistula first initiative, all of these big Medicare initiatives, but it poses certain challenges.

And so when you try to think these -- well, why don't you just take these patients to a traditional ambulatory surgery center that's out there, you have to think about some of the barriers, some of which are the fact that the majority of these patients are Medicare and

Medicaid, and a lot of ambulatory surgery centers are not interested in that high proportion of Medicare/Medicaid patients. Vascular access issues are almost always urgent. I can't get my dialysis today, therefore, you know, if I miss my treatment I could wind up much sicker and I only have 48 hours from the time I get sick and miss a dialysis treatment until I'm at risk of death. All of the ESRD patients are category AS- -- American Society of Anesthesia category III, which means they're sicker, they have more co-morbidities.

We are interested in working in these kind of focused ambulatory surgery centers so that we can get concentration specialists and specialization within our services. We currently perform a sufficient number of procedures in our office-based surgical center to be able to support an ambulatory surgery facility. Considering that all of these patients are currently in office-based surgery today, a policy change should not materially change the hospital volume or impact the hospital significantly.

So we have offices in 25 states; 65 offices. In states without CON processes, we are moving as far and fast as we can to convert our offices from OBS to ambulatory surgery facilities. In CON states like Michigan, New York, a few other places, the CON requirement is actually a barrier to pushing forward those Medicare initiatives. For

example, in Michigan under the current surgical standards an applicant may only use surgical case volume from an approved Certificate of Need established operating room in order to take -- in order to apply those cases to an ASC. This essentially hampers CMS policy and makes it difficult for us to move those patients to an ambulatory surgery center. In short, we kind of sort of have a chicken and egg problem when it comes to establishing the volumes required to create the ASC.

In certain situations where we have been able -- this is data -- internal Fresenius data. We have been able to show that by combining all the services, getting specialization and essentially getting our arms around the one stop shop for these patients, we've been able to demonstrate 33 percent lower mortality, 12 percent lower hospital days rate, and fewer patients that actually had total access shutdown and failure where the access had to be abandoned and an entirely new one created.

So we are asking for an opportunity to work with the Department to develop a solution that would allow Michigan providers opportunities to follow the CMS guidelines. We would like to be able to perform these procedures in an ambulatory surgery center and apply our OBS volumes to the ambulatory surgery center such that we can establish that. We understand that we are a little bit late

to the table and not looking to delay any current plan changes to the surgical services, but we ask that we're able to come back in December and present to the Commission or the Department, you know, some plans to help us get through this process and establish these kind of renal ASC's. Thank you.

DR. MUKHERJI: Any questions from the Commission? So just to summarize when we discuss this, the CMS is changing payments to the outpatient centers that you had and they're moving it over to ambulatory surgical centers in order to try to reduce the amount of self referrals essentially as we discussed.

So the challenge is, it's my understanding, is that your hope is to potentially come up with a renal based ambulatory surgical center would certainly -- it's not necessarily the purview of the CON, but my understanding at that time was the dialysis, the vascular access that you provide to fistulas that you're creating is not currently a procedure that's recognized through the Michigan CON that could count for ambulatory surgical center procedures; is that correct?

DR. GREGG MILLER: Well, it's slightly different. So if you were performing these cases primarily in a hospital -- right? -- you could take that hospital-based volume, because it will be in a hospital or hospital

outpatient, and say -- and then apply that to the ambulatory surgery center. What I'm saying is we actually currently have an office-based surgical practice which actually would have sufficient volumes to transition over to an ASC, would just be -- given the way the surgical standards are written, we're not able to apply those current procedures to an ASC.

MR. FALAHEE: Falahee. It's the office-based nature of it that doesn't let you move it over to an ASC; is that right?

DR. GREGG MILLER: That's correct.

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

DR. GREGG MILLER: But we've been functioning for 15 years in the office-based surgical setting and Medicare now have a policy change, so we're attempting to adopt.

MR. FALAHEE: Yeah, Falahee again. I mean, I understand the issue. I'm sure the Department would love to work with you. As to whether it would be December? Who knows. It might take awhile. But, I mean, I think we're all -- as a group, we understand the issue. It was a very helpful presentation. I think when you're working with the Department you might want to really emphasize why is it that Medicare is changing the rules that puts us in this position. That would help and it would help us understand it as well as the reason why this is coming up now.

DR. GREGG MILLER: Right. I think to address

that, to me this is a very simple issue. Over the past 15 years Medicare has seen the CPT code for venous angioplasty skyrocket such that -- to, you know, extents they probably never imagined. And, you know, some of that is related to technology. It's been the growth of these office-based surgical centers all over the place and they're now trying to reign that in to some extent.

At the same time, they're also, you know -- the organizations that -- or the consultants that Medicare uses, everybody recognizes we need better coordinated care, hence the organization and creation of ESCO's. And part and parcel to the ESCO's is really getting vascular surgeons, interventionalists, all working together, a one stop shop, to decrease the fragmentation.

DR. MUKHERJI: Other comments? Questions? All right. Thank you very much. Appreciate it.

DR. GREGG MILLER: Thank you.

DR. MUKHERJI: The next item is Surgical Services draft language and public hearing report. Brenda?

MS. ROGERS: Okay. This is Brenda. You do have in front of you the language that you took proposed action on at your June Meeting. And as you just heard, during that public hearing that we held back in August we did receive testimony for an additional item. However, the language that you have in front of you today is the language as

presented at the June meeting, and if you take final action on that today, again, it'll move to JLC and the governor for the 45-day review period. If you decide you want to address this additional item in this set of language, then we would hold up on sending it out for final action, bring the language back, or we do it in a two-phase step as was suggested, move this language forward, final action today, and then take a -- so you'd -- essentially you'd have a separate motion on the other item under consideration. Thank you.

DR. MUKHERJI: Commission discussion?

MR. FALAHEE: No green cards?

DR. MUKHERJI: Any green cards for this? I don't have any.

MR. FALAHEE: Well, I am living this issue right today. As Tulika knows, as one of the Commissioners who actually fills out CON applications, my team is working on one now for an ambulatory surgery center and let me tell you what goes on now. Currently the language -- let's call it the current language, not the yellow -- says that you need commitment letters to move OR's or justify OR's in a new location.

So you need to get the commitment letters. We at Bronson want to open up a new ASC across the street from the hospital, connected to the hospital. We've been planning it

and we said we'll open with 10 OR's. This week we got the commitment letters back from our physicians. Several senior level physicians, meaning 60 years age and older, refused to sign the commitment letters because they said, correctly, the commitment letter say, "Thou shall do this number of cases in the hospital for three years." And they're saying to us, "I can't guarantee that I'll do that for three years. And if I don't, the Department I'm sure is going to come after me."

It doesn't do any good when I tell them the Department won't, but their point is, "I'm not signing a commitment letter." So what happens is, though we have the volume to justify an extra three OR's, because the commitment letters didn't come in in sufficient numbers, we would not be able to open with 10 OR's. We're down to 9, even though we have the volume to justify an extra 13.

I just wanted to point out what this means when it's tied to commitment letters, and that's why I'm very much in favor of -- for not just Bronson's case, but it would apply to others as well -- to say, "Look at the current volume that hospital A has." And what this says is if hospital A is going to build a ASC, also be the owner of the ASC, don't bother with commitment letters -- there's other reasons physicians don't sign them -- and just let the current volume as verified by the Department justify or

approve the OR. I wanted to give you a sense of why this has a practical application with the physicians when they are asked to sign these commitment letters. And I selfishly would like to, as Brenda said, do this as a two-step process so we can keep this moving forward, because there are active applications out there now and in the future, and I don't want to hold those up and have them tied to commitment letters when at least I think we know that's not the best way to determine volume.

DR. MUKHERJI: So Chip, if the volumes will then be calculated essentially independently, physicianless in the sense that no physician is being tied to a certain system, because part of the challenge is -- like, especially in Lansing where you have physicians that are not part of a faculty, they can operate at either system.

And if it's physician, if you will, independent or -- you know, I certainly don't want my commitments to be arbitrarily and without my knowledge be assigned to one hospital and then have the other hospital say, "Oh. Well, we can't use you," because they, unknown to me, committed me to this system. Does that alleviate that potential issue or not?

MR. FALAHEE: I don't think it alleviates it. I think it's a very valid issue because if I'm a physician and I go to three different locations, I don't want hospital A

to commit my procedures without me knowing it. And I don't know what form the Department is coming up with when it talks about a form in here, but I think -- I would think that we -- to get away from commitment letters, that doesn't mean you keep the physicians in the dark.

I think it's obligatory on the hospitals to work with their physicians to say, "Here's what we're planning to do, here's the volume we have, and here's how we're going to use the current volume to build that new ASC." But I think there must -- there needs to be a way where you can't get multiple commitments of the same physician around town.

DR. MUKHERJI: Okay. Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: Yes. I'm just making sure I clarify right what's in front of us before the second step. So the first step we're talking about same institution, the volume already exists. So if I'm hearing you correctly, Chip, there's an implied, I guess, agreement from those physicians because they are already delivering the volume to that facility, that facility within the footprint of its operation is just saying we want to go across the street, in your instance, or be adjacent?

MR. FALAHEE: Right.

MS. BROOKS-WILLIAMS: So it's relatively low entry; right?

MR. FALAHEE: Right.

MS. BROOKS-WILLIAMS: So I don't know what we're talking about in step two, but in step one it's same institution. So they are already your, you know, for whatever degree, committed, you know, physicians that would allow you to maintain that volume, and the way you would be held accountable for that, I guess, upon further review, if your volume dropped, --

MR. FALAHEE: Right.

MS. BROOKS-WILLIAMS: -- then you'd no longer be able to maintain, you know, those OR's that you opened?

MR. FALAHEE: Correct.

MS. BROOKS-WILLIAMS: Right?

MR. FALAHEE: Right.

DR. MUKHERJI: This is Commissioner Mukherji. Yeah. This works for a closed system if you have faculty or hospital employees; if you will, physicians that are employed by the hospital. It makes sense. I just want to make sure that if we go down this path, the unintended consequences -- what if you have those still independent practicing physicians or surgeons that toggle between hospitals and how are they accounted for?

And I just want to make sure that they still have a voice in the process and they're not without their knowledge assigned to one system versus the other.

MR. FALAHEE: And thinking about it, picking up what Commissioner Brooks-Williams just said, if you've got a surgeon that goes back and forth, really what you're looking at is current volume to justify an ambulatory surgery center. But then as Denise said, if three years or four years down the road that physician has moved volume from hospital A to hospital B, hospital A's numbers may drop assuming all others may stay the same, and at that point they're not going to have the requisite annual volume to justify the either number of cases or hours of use to justify the OR's, so they would inherently by themselves drop if the physicians by themselves started to move their business, move their cases.

DR. MUKHERJI: So it is physician independence purely based on hospital volumes?

MR. FALAHEE: If a physician group now that's independent does most of their work at hospital A -- all right? -- let's say they do a 1,000 cases a year at hospital A, if for whatever reason they move from A to B and hospital A thereby loses those 1,000 cases, when they fill out their annual survey every year for the Department, the Department will see that they're dropping below the requisite volume for their OR's and they could come back and either do an enforcement action, a compliance action, or you must drop one OR. So it takes care of itself with the physicians

moving. They're not beholden to hospital A. They don't have to stay there by any means. Tulika, did I just mess up every form you were thinking of?

MS. BHATTACHARYA: No.

DR. MUKHERJI: Did she say "yes"?

MR. POTCHEN: No, she said --

DR. MUKHERJI: Okay.

MR. FALAHEE: So Falahee again. Brenda, I guess I have a question. You talked about a two-step. The yellow language we have in front of us in our packets, is that -- the new subsection (e) and one option is that the first step would be to approve that today -- I'm not making the motion yet, I'm just trying to understand the process -- approve it today, final action, JLC 45 days, da, da, da, and then the second step would be what was it Henry Ford and Spectrum talked about? Is that -- or is there a different second step?

MS. ROGERS: No. The second step is the presentation brought to you by Fresenius today.

MR. FALAHEE: Okay. Fine. Got it.

MS. ROGERS: But having said that, yes, there was some public comment to making a slight modification to that language. But again, the Department -- we can administer whichever the Commission decides, but this is where it would have to come to -- if you decided to make an exemption on

those other two subsections, I believe it would have to go out for another public hearing if you wanted to do that, but we didn't see that making a big difference one way or the other.

MR. FALAHEE: I understand where -- this is Falahee. Sorry. I understand where -- think it was Spectrum and Henry Ford were coming from in terms of names of physicians and all that. I think we could get to that anyway as I talked about earlier, because if a facility's numbers drop, regardless of the physicians, if they drop too far they're going to lose those OR's. I think it takes care of itself and the physicians are free to move wherever they want.

DR. MUKHERJI: So is this a substantial change, Chip? Brenda?

MS. ROGERS: This is Brenda. So what came up during public hearing was within that same confines of the language subsection (2), it's subsections (a) and (b) underneath that.

DR. MUKHERJI: Which section?

MR. POTCHEN: 11.

MS. ROGERS: 11. Sorry. Section 11(2). So subsections (a) and (b), they were asking that they also be exempted from the physician, not just the physician requirements, but also the other two items.

MR. POTCHEN: I would say that's --

MS. ROGERS: Joe is saying yes, that is substantive change.

DR. MUKHERJI: Any other comments, questions?

MR. FALAHEE: Well, I'll go ahead -- if no other comments, Tom --

MR. MITTELBRUN: I was just going to ask if these -- the changes you just discussed with Henry Ford and Spectrum, can they be addressed when we go through step two so you don't have to delay what's already taking place? I'm sorry, Mittelbrun.

MS. ROGERS: Yeah. This is Brenda. I mean, again, that's up to the Commission's prerogative. If you feel that this is a change that should be made, I guess you could do it in that version of the language as well.

MR. FALAHEE: And when I look at (a) and (b), it's very easy for any hospital to give the names of the physicians that perform surgical cases. That's easy. And (b) is the number of cases each physician performed. That's easy as well. So I don't see either (a) or (b) as being difficult to gather. That's a simple Excel spreadsheet. It's probably two clicks on a mouse and you got it. So I don't see a big concern.

MS. BHATTACHARYA: This is Tulika. So this request was made by a couple health systems to the

Department, but thanks to them for bringing it to our attention. It is such an improvement and it reduces paperwork, but it keeps the methodology and the intent of the need methodology as is. So, I mean, we feel that this language should not be delayed and put it out -- to put it out there so that the providers can, you know, take advantage of this language.

Further refinement, I mean, what Henry Ford and Spectrum is asking, we can also administer it that way because we have the annual survey data and the physician volumes as part of that survey process. But this language is such an improvement in streamlining the processes we feel this should move forward without further delay.

DR. MUKHERJI: Commissioner Brooks-Williams?

MS. BROOKS-WILLIAMS: It's just a question because you said, you know, Henry Ford's all -- I will state that right before I recuse myself. But just to clarify, Tulika, so are you saying that it's simple to add now or you're saying that the way the language or the additional steps are being proposed, it's already there from the survey data, and if we visit it later it's easily accessible? I just want to make sure I understand what we're saying about the suggested addition.

MS. BHATTACHARYA: Yeah. So this is the new language. If we move this forward, it is approved and the

providers are using it. If you want to add additional exceptions, like they also don't need to keep track of the physician names and stuff as part of the application process, that's easy to administer because they're already keeping track of those things and reporting as part of the survey tool. And if you file an application, there's nothing stopping the Department from doing that additional check even though you did not submit it as part of the application.

MS. BROOKS-WILLIAMS: One more question. So just then, if Joe or Brenda can help me understand, what's substantive? Why are we suggesting that it --

MR. POTCHEN: Yeah. One of the things that we have as administrative is -- like, is it like an "an" or "a" or something like that. But with substantive, it's really how the Department treats its review of the particular CON. And this, if you're adding two exemptions, I would argue that it would modify how the Department reviews its CON.

DR. MUKHERJI: Any other discussion or questions? I guess we're open for a motion on this language.

MR. FALAHEE: So this is Falahee and since I always try to stay on Tulika's good side, I'll make the following motion, that the language up on the screen in yellow be approved for final action and that it then go to the JLC and the governor and the 45-day waiting period and

whatever else I forget that Brenda will remind me of later. I'll make that motion.

MS. ROGERS: This is Brenda. You have it, and basically it's the draft language you have in front of you today. It's the entire document.

MR. FALAHEE: That's correct.

DR. MUKHERJI: We have a motion on the table.

DR. KESHISHIAN: Commissioner Keshishian, second.

DR. MUKHERJI: Okay. We have a motion and a second. Any further discussion? Okay. All in favor of the motion say "aye."

(All in favor)

DR. MUKHERJI: Any against? Okay. The motion carries. All right. The next thing is -- really the next two things are interim reports, so Cardiac Catheterization Standard -- sorry.

MS. ROGERS: This is Brenda. Now -- yeah. And I think that's what Brooks-Williams is going to ask. What about the item, --

MS. BROOKS-WILLIAMS: The second part.

MS. ROGERS: -- the second part of this from --

DR. MUKHERJI: Oh. The second part.

MS. ROGERS: -- from the Fresenius group? Does the Commission want to do anything with that at this point in time?

DR. MUKHERJI: Well, what does the Commission say? I think the main thing is try to adjust the standards to account for this. I think, Chip, you've got a pretty good sense of that topic as well.

MR. FALAHEE: Yeah. I think from what I heard and what I understand, I think it makes sense for the folks from Fresenius to meet with the Department to go into more detail on why the changes are being, if you will, pushed by CMS by Medicare, and then what changes need to be made therefore within the CON Standards and then bring those to us. It doesn't have to be December. If it takes longer to do that to do it right, fine, then bring it back as soon as you can. But it makes sense to me based on the slides I saw and the presentation I heard.

DR. MUKHERJI: Do we need a motion for that, Brenda?

MS. ROGERS: Yes.

DR. MUKHERJI: Commissioner Williams?

MS. BROOKS-WILLIAMS: That wasn't my second part.

DR. MUKHERJI: Oh.

MR. FALAHEE: Oh. Okay. Sorry.

MS. BROOKS-WILLIAMS: That's a good part, but I also wanted to readdress the original conversation around what was substantive in the change to the language that we just approved. Do we want to have whatever the appropriate

next step is to consider that recommendation or two recommendations?

MS. ROGERS: Yeah. This is Brenda. I think that can actually go with this. I don't think you want to do three changes to the standards. I think if you're going to do -- consider the exemption of (a) and (b), that could be grouped in with whatever language. If we bring back language regarding the vascular access, could be incorporated into that document.

MS. BROOKS-WILLIAMS: And that does require a motion? No? It just --

MR. POTCHEN: Yeah.

MS. ROGERS: This is Brenda again. I think it can go either way, but it -- to be more official you may want to make -- just include it all in a motion. That way everybody's onboard.

DR. MUKHERJI: I'm delighted to entertain a motion with --

MR. FALAHEE: I'll let someone else make one for --

MS. BROOKS-WILLIAMS: So I move that we review the -- and I don't even know what the adjustments are, the two adjustments proposed by the two health systems as well as Fresenius's request to look at how we might include that fistula activity in the standards. You guys all make that

sound way more elegant than I did.

DR. MUKHERJI: Okay. We have a motion on the table?

MR. MITTELBRUN: Mittelbrun, second.

DR. MUKHERJI: Mittelbrun, second. Any further discussion or questions? All in favor?

(All in favor)

DR. MUKHERJI: Any against? The motion carries. Now, I think the next two are written reports only; is that correct, Brenda?

MS. ROGERS: This is Brenda. That is correct.

DR. MUKHERJI: Okay. So the first one is a Cardiac Catheterization Standard Advisory. The interim report is in your package for our review. What meeting are they on, Brenda?

MS. ROGERS: Yeah, this is Brenda. I believe it's the third.

DR. MUKHERJI: Third? Do you know how many they're expected to have?

MS. ROGERS: Right now they are scheduled either for six or seven, so --

DR. MUKHERJI: Okay. All right. So that's just in your package for your review. There's no -- we don't need to act on that; correct? Okay. And similarly, number nine is the Hospital Bed Standard Advisory Committee. They

have their ongoing SAC and that report is in your package for your review, too. Similar, do you know how many meetings they have had?

MS. ROGERS: Again, this is Brenda. They are in the same timeline. They both started up within a month of each other, so --

DR. MUKHERJI: Yeah. And they're planning about five or six or something?

MS. ROGERS: They also have six or seven scheduled as well. But again, if they wrap up before that time, then they will --

DR. MUKHERJI: Does the Commission have any questions or concerns about the interim reports? Next is a legislative report. Mr. Lori?

MS. NAGEL: He's currently unavailable.

DR. MUKHERJI: Okay. Mr. Potchen, care to --

MR. POTCHEN: You jumping to me?

DR. MUKHERJI: Can you do the legislative report or it's on Matt? Okay.

MR. POTCHEN: That's on Matt.

DR. MUKHERJI: All right. Okay. Let's go with the administrative update. Beth?

MS. NAGEL: I have one announcement and that is the public comment period for standards starting -- standards that the Commission will review in 2018 will take

place in October. The date just escapes me. I don't know if Brenda has it.

MS. ROGERS: Sorry.

MS. NAGEL: We will send out an announcement with the correct date, but that is --

MS. ROGERS: It's early October. This is Brenda.

MS. NAGEL: And that's all I have.

DR. MUKHERJI: Next is CON evaluation section update. Tulika?

MS. BHATTACHARYA: Yes. This is Tulika. So in your packet you have actually four reports this quarter. There are two regular reports on the program activity, timeliness and things of that nature, and also the regular compliance activity, how we are doing on following up approved projects, how many expiration, things like that. And then there are two special reports on the statewide compliance review on cardiac cath and megavoltage radiation therapy services.

As an update we made more progress on the cardiac cath service compliance monitoring versus the MRT simply because of staffing reasons. The person just had a new baby girl. She was out on maternity leave. She's back and we are starting back up where we left on the MRT compliance review. So the reports are in your packet. And if there are any questions or if you want me to cover any parts of

it, I'll be happy to do whichever.

DR. MUKHERJI: Any questions for Tulika? Okay. Commissioner Williams?

MS. BROOKS-WILLIAMS: Yes. I just had one more question on the standards compliance or lack thereof report. St. Mary's Health Care, where is -- which St. Mary's is this that was found not to be in compliance?

MS. BHATTACHARYA: Cath or MRT you're referring?

MS. BROOKS-WILLIAMS: Cath. I'm sorry.

MS. BHATTACHARYA: Is it in HSA1?

MR. POTCHEN: This says CT.

MS. BROOKS-WILLIAMS: Does it say -- oh.

MR. FALAHEE: It says CT.

MS. BROOKS-WILLIAMS: I'm sorry. It does say CT.

MR. FALAHEE: Fixed CT without approval.

MS. BROOKS-WILLIAMS: But I thought it's under the --

MR. FALAHEE: It's under compliance, yeah.

DR. MUKHERJI: Any other questions?

MS. BROOKS-WILLIAMS: So it's page 58 of 69. I was just curious. Since it just says "St. Mary's Health," I wasn't sure what city or what system it was. I'm sorry.

MS. BHATTACHARYA: I believe it's the Grand Rapids.

MS. BROOKS-WILLIAMS: Okay. Thank you.

DR. MUKHERJI: Any other questions or comments for Tulika? All right. Next is quality (sic) performance measures report, written report. Anybody want to tackle that one from the Department?

MS. BHATTACHARYA: Oh. They're all, like -- all four -- they're part of the four, so --

MS. NAGEL: It's a written report in the packet.

DR. MUKHERJI: Okay.

MS. BHATTACHARYA: Yup.

DR. MUKHERJI: For our review. Okay. All right. Legal activity, Mr. Potchen?

MR. POTCHEN: This is Joe. There is no active litigation right now so we continue to assist the Department in what they need and we're available to assist the Commission.

DR. MUKHERJI: Very grateful for that. Hope you'll visit me in jail if that happens -- future meeting dates is the next agenda item. December 7th, January 25th, 15th of March and -- let's see -- September 20th and December 6th of '18. The last agenda item -- second to last agenda item is public comment. Would anybody like to make any public comments on any issues that we have discussed today? Hearing none. Next is a review of the Commission work plan. Brenda?

MS. ROGERS: This is Brenda. You have the draft

work plan in front of you today. The only changes to this will be you did take final action on the Surgical Services language, but we will continue to work and bring a report back and/or draft language back to you at a future meeting date. And then on lithotripsy, you did not take final action so we will be going back and making -- taking a look and bringing back language to you.

I believe that one was at -- the December meeting is what we will try for, assuming that we can do that. So having said that, I would submit the work plan as presented with today's modifications. Thank you.

DR. MUKHERJI: This is an action item for the Commission. Is there any discussion or questions for Brenda or the Department?

MR. FALAHEE: You need a motion on that, Brenda?

MS. ROGERS: Yes.

MR. FALAHEE: Falahee, I move to support the amended work plan as described by Brenda.

MS. GARDNER: Gardner, second.

DR. MUKHERJI: Any discussion? All in favor?

(All in favor)

DR. MUKHERJI: Any against? The motion carries. And, unfortunately, item 16 is adjournment. So thank you for coming. I've got a motion to adjourn. Thank the new members for being here. Thanks everyone for the Department

and also for everyone for attending. So we'll take a motion to adjourn.

MR. MITTELBRUN: Motion to adjourn.

MS. BROOKS-WILLIAMS: Second.

DR. MUKHERJI: I assume there's no discussion on that, so all in favor?

(All in favor)

DR. MUKHERJI: Thank you very much. The meeting is adjourned.

(Proceeding concluded at 11:15 a.m.)

-0-0-0-