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, June 15, 2017, 9:30 a.m.

COMMITTEE MEMBERS:	THOMAS MITTELBRUN, III, VICE CHAIRPERSON
	DENISE BROOKS-WILLIAMS (via telephone)
	GAIL CLARKSON
	JAMES FALAHEE
	DEBRA GUIDO-ALLEN, R.N.
	ROBERT HUGHES
	MARC D. KESHISHIAN, M.D.
	LUIS A. TOMATIS, M.D.
MICHIGAN DEPARTMENT OF ATTORNEY GENERAL:	JOSEPH POTCHEN
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Thursday, June 15, 2017 - 9:33 a.m.

DR. MUKHERJI: Good morning. I was just trying to get back on the wireless to have my agenda, but we'll see if this works. Welcome to the Certificate of Needs meeting. First action, I believe the first item is review the agenda. The agenda has been passed out to all the Commissioners. Just take a second to review. If anybody has any changes --

MR. FALAHEE: This is Falahee. I'll recommend to make a motion to approve the agenda.

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

MS. GUIDO-ALLEN: Second. Guido-Allen, second.

DR. MUKHERJI: We have a first and a second. Do we have any discussion? Hearing no discussion, all in favor?

(All in favor)

DR. MUKHERJI: The agenda is approved. The next is declaration of conflicts of interest. Does anybody have any conflict of interest to declare? Okay. Hearing none. The next is the review of the minutes. I think the minutes were included in the agenda. Please take a second to review that and once you review it, we can take a motion to approve the minutes.

MR. MITTELBRUN: Motion to approve the minutes of

March 16, 2017, Mittelbrun.

DR. MUKHERJI: So we have a motion to approve the minutes from the last meeting. Do we have a second?

MR. FALAHEE: Second by Falahee.

DR. MUKHERJI: Okay. We have a second. Any discussion? No discussion. All in favor?

(All in favor)

DR. MUKHERJI: The meetings (sic) are approved. The next is Urinary Extracorporeal Shock Wave Lithotripsy, draft language and public hearing report. Brenda?

MS. ROGERS: Good morning. This is Brenda. You do have draft language in front of you this morning. The Commission took proposed action -- try this again. This is Brenda. The Commission took proposed action at its March 2017 meeting. The public hearing was held on May 2nd and written testimony was received by three organizations. There were two organizations that don't support the conversion language and one organization that does, and all three support the remaining language in the standard.

As you'll note in the information provided to the Commission and in the draft language, the Department is suggesting an amendment to the language and that amendment occurs under subsection (b) of the language indicating changing from 500 procedures to 1,000 procedures in the conversion language. The reason the Department is

suggesting this is that this is also the required initiation level for mobile and fixed services, as well as the maintenance level for mobile and fixed services, and it follows along with other standards that has conversion language. Having said that, the Department does support all remaining language along with the proposed amendment.

If the Commission decides to accept the amendment or any other amendments today that may be made, then a second public hearing would be scheduled and forwarded to the JLC. If the Commission decides to accept the original language with no amendments and takes final action today, then the language would be submitted to the JLC and the governor for the 45-day review period. Having said that, if there's any questions? Thank you.

DR. MUKHERJI: Brenda, could you just update us on how this topic was left after the last meeting? The Commission did -- I know there was testimony, et cetera.

MS. ROGERS: This is Brenda. I was not at the last meeting but my understanding was that the -- this language was proposed at the March meeting by an organization and the Commission asked that it be added to the language and sent out for public hearing and then along with a request for information for the cost, quality, access, et cetera, and that's been provided in the testimony that you've received today. So that was part of that

process, and I'll let Beth add to that if I missed something. Thank you.

MS. NAGEL: I would only add that the language was given to the Commission in March for proposed action. The Commission added language that was proposed by an organization and then it was sent to public hearing after that, so it was -- proposed action has been taken twice on this standard.

DR. MUKHERJI: Any questions for the Department? I think we have now public comments. The first note I have is from John Shaski, Sparrow Health System on lithotripsy. And just to remind all the people providing testimony, it's three minutes. If the buzzer goes off, please complete your thought. If you go over 30 seconds, we have a gong.

JOHN SHASKI

MR. JOHN SHASKI: Good morning. John Shaski from Sparrow Health System. We would like to thank the Commission for the time and deliberation on this issue. As you know, Sparrow has been providing testimony on this topic for a number of years now, dating back to when it was originally put forth for public hearing in October 2015. We have been willing to engage in conversations with the Department and have submitted both written and verbal testimony at every available opportunity. In March, the Commission approved draft language that would allow for a

conversion from mobile to fixed at a consistent volume level of at least 500 procedures annually over a 3-year period. The Department's recommendation raising that level to 1,000 procedures puts an unreasonably high burden on current mobile host sites. In other mobile modalities, numerous accommodations have been made to allow for a conversion from mobile to fixed.

For example, MRI, at one time there were 3 different thresholds for initiations allowing for hospitals in rural areas, hospitals with busy ED's, to convert from mobile to fixed at a lower number. Further, these volume requirements were not required for more than 12 months. In this case, we are not asking for a special provision, but rather a universally acceptable number for any host site that has consistently seen high volume or high number of patients and needs more access.

I can't speak for other host sites, but in Sparrow's case we have made attempts to obtain additional mobile time and time was not available at the level that we needed. Having said that, we fully expect to perform 1,000 cases annually based on our current volume. Sparrow handles over 550 cases annually with 6 to 7 days a month of service. More than tripling the availability of the service to patients would result in an excess of the volume that the Department had recommended. In closing, we have worked on

this issue for a number of years. We see the change -- we are disappointed and frustrated at the change in the volume put forth by the Department today to 1,000. We see this as delaying the process, opening this back up for public comment period again, and inching us closer to the 2018 standard review process for this service. I am certainly welcome or happy to entertain any questions.

DR. MUKHERJI: Thanks, John. Questions for Mr. Shaski? Mr. Mittelbrun?

MR. MITTELBRUN: Commissioner Mittelbrun. John, can you just tell everyone what your volume is now and what it's been for the past few years?

MR. JOHN SHASKI: I don't have that directly in front of me. The volume is over 550 cases. It has been for the last number of years, at least 5 years. I believe our last volume for 2016 was 583.

MR. MITTELBRUN: Okay. Thank you.

MR. FALAHEE: This is Commissioner Falahee. John, I understand you're not a fan of the recommended amendment, but the Department is coming at it from a position where this is consistent with other standards. So I'm trying to figure out why is it that lithotripsy should be different than other standards?

MR. JOHN SHASKI: Yeah. Thank you for the question. As I understand it, 1,000 cases for traditional

initiation contemplates commitments across a number of organizations. Our number is Sparrow only, so we're not pulling numbers from other organizations as other initiations are able to do to meet that 1,000 volume requirement.

MR. FALAHEE: But that begs the question if you've got X number of procedures you're actually doing now, let's say it's 580 or whatever you said, can't you go out and get -- I don't know if this is even doable under the standards. Can you get commitments to add to the 580 you're doing now to get potentially to the 1,000?

MR. JOHN SHASKI: I don't believe that's -- let me check with our CON guru Carrie Linderoth.

MR. FALAHEE: Okay.

MS. CARRIE LINDEROTH: Hi. I'm Carrie Linderoth from Kelly Hawthorne. I've been working with John and Sparrow on this issue. The 1,000 cases is based on MIDB data, so it's not actual lithotripsies performed; it's based on indications and projection. So essentially the difference is we're documenting 500 actual cases as opposed to projecting something that we aren't even certain of based on indications that have come through MIDB. Additionally, the MIDB data is locked up for a number of years, so even if that were an option, which it's not under the standards, a lot of that data has already been committed to existing

networks and wouldn't be available even though the volume has been consistently at a range that would allow for a fixed.

MR. FALAHEE: One more. The concern I've got is if the 500 went through within I believe it's 2 years, any program needs to be at 1,000 otherwise you're not meeting your project delivery requirements. And the concern I've got is that we know that once you've got a program here, it is very, very hard to lose it; to lose your ticket, if you will.

So one of the concerns I've got when we have to look at cost, quality and access is if we come in with a lower standard to get it but then we don't enforce the 1,000 later on, in effect you've got a program albeit with lower numbers and that's --

MS. CARRIE LINDEROTH: I'm not sure there really is a lower number to be honest with you, Chip, because what we've asked for is 3 years of consistent volume at 500 cases, and most standards allow for, you know, reaching that threshold in 12 months. So it's a consistently high demand by patients. And so if you equate that out to what that would be annually, it's actually much higher than 1,000.

MR. FALAHEE: Okay.

DR. MUKHERJI: A question I have is based on your testimony. You're saying that right now you're at 583 for

the year; right?

MR. JOHN SHASKI: Correct.

DR. MUKHERJI: Are you saying that you would be higher but you don't have enough access coming from the mobile provider?

MR. JOHN SHASKI: Yes. That's the assumption. At 580 cases with 6 to 7 days per month, I would imagine with a fixed lithotriptor and more access that we would be able to achieve a higher number.

DR. MUKHERJI: Okay. So in a way the ceiling that you're reaching is just based on the access that's provided by the mobile and there's no way to get more mobile at your site in order to increase your numbers?

MR. JOHN SHASKI: Correct.

DR. MUKHERJI: Okay.

MR. JOHN SHASKI: And with the data that we put forth in public comment, you can see that the cost associated with leasing the mobile site for a fraction of the time is much higher than the purchase cost of a fixed lithotriptor and that includes the service contract and staffing.

MR. FALAHEE: This is Falahee again. Do you have backup -- I mean, do you have backlog -- I'm sorry -- in terms of getting people through the current number of days you have per month on the mobile? Is there a backlog?

MR. JOHN SHASKI: Yes. There have been cases where people present themselves in the window that the lithotriptor is not available.

MR. FALAHEE: Okay. But are we talking two people a year? 200?

MR. JOHN SHASKI: I'm not familiar with the volume of the backlog. I would --

MR. FALAHEE: And if the backlog were high enough, I would think you would ask for an extra day or two.

MR. JOHN SHASKI: Correct.

MR. FALAHEE: Have you done that?

MR. JOHN SHASKI: Yes.

MR. FALAHEE: And the answer was "no, not available"?

MR. JOHN SHASKI: "Not available."

DR. MUKHERJI: Commissioner Hughes?

MR. HUGHES: Commissioner Hughes. Talking about the backlog and so forth, I don't know Dr. Zuckerman, but I'm sure he's a fine, outstanding urologist, and I think he works for one of the bigger urology places here in town and does 300 a year. And he is saying here in his letter that he has never, ever had a waiting list, people needing the procedure or had to schedule them. It's always been done quickly and efficiently. How would you respond to that?

MR. JOHN SHASKI: I'm not familiar with Dr.

Zuckerman, so I feel like it's not appropriate to comment on that. Don't know how to respond.

MR. HUGHES: I guess I'm just asking you to comment on the waiting of people to get in. If other people are saying they're not having an issue scheduling people and you're saying that you are, I'm just asking you to -- you're saying that there are waits and people are being delayed.

MR. JOHN SHASKI: Well, we have had waiting at Sparrow for lithotripsy services. So I don't know how to comment on Dr. Zuckerman's comment.

MR. HUGHES: Would somebody that does 300 procedures be somebody that is pretty familiar with things or --

MR. JOHN SHASKI: I would assume so, but I'm not familiar with his practice and I'm not -- I don't know the actual number of backlog that we experience at Sparrow nor do I know the time frame that he's speaking of. I'm just unfamiliar with him or his practice.

MR. HUGHES: Been doing it for 35 years.

MR. JOHN SHASKI: Performing lithotripsy for 35 years in --

MR. HUGHES: In the letter right here.

MR. JOHN SHASKI: Okay. I'm sorry. I haven't seen that letter.

MR. MITTELBRUN: John, this is Commissioner

Mittelbrun. I have a follow-up question to the chairman's question, but I lost track of the actual question when I was listening to the other ones. But you used a term to the chairman's question. You said, "That's the assumption." Are we dealing with assumptions or are we dealing with actual figures as to what's transpiring?

MR. JOHN SHASKI: My comment on the assumption, I was just doing simple math that at our current volume of a fraction of the month of time with mobile lithotriptor, it's my assumption that one more day would yield additional cases; that if we doubled our time we would perhaps double the amount of volume that we would have.

MR. MITTELBRUN: So I guess I'm -- you're making a comment that there's that many more people that need the services, so I'm not quite sure that that's the case. I mean, maybe it is, but that's why I'm kind of looking for the actual data. I mean, is there that many people that need the services at your facility?

MS. CARRIE LINDEROTH: Well, I would like to add just a little further distinction. Again, the 1,000 cases for the traditional initiation is again based on projection. The 500 we have suggested and the Commission approved in March is actual volume, and so we are showing to the Commission that we have consistently over the past -- in Sparrow's case it's over 5 years, but in the standards it

requires 3 years -- we've been at that level of volume of 500 cases. Traditional initiations project 1,000.

DR. MUKHERJI: Commissioner Mukherji. Which provider do you use?

MR. JOHN SHASKI: Great Lakes Lithotripsy.

DR. TOMATIS: Commissioner Tomatis. I have to put a lot of weight on this letter of Dr. Zuckerman that provide you two-thirds of your 400 patients. And he -- in conclusion,

"In my experience and perspective I truly believe that the current mobile lithotripsy system works very well and serves this state well. I hope the Commission will consider removing Sparrow's requested language from the standards and maintaining the current system."

DR. MUKHERJI: Are there any more questions for John? Okay. Thank you very much.

MR. JOHN SHASKI: Thank you.

DR. MUKHERJI: All right. The next card I have is from Robert Meeker from Greater Michigan Lithotripsy.

ROBERT MEEKER

MR. ROBERT MEEKER: Good morning. I'm Bob Meeker and I'm representing Greater Michigan Lithotripsy, which is one of the two mobile lithotripsy providers in the state of Michigan. GML's CEO, Alan Buergenthal, sends his regrets. He intended to be here today, but he was called to a meeting

out of state and so you're stuck with me. I'd like to just take a moment to refresh the Commission's memory on the history of lithotripsy regulation in this state. 15, 20 years ago there were 4 or 5 fixed lithotriptors in the state. There was one in Grand Rapids and there were 3 or 4 in the Detroit area and they were just chugging along.

Well, first of all, at that time the technology was such that it took up a whole room, it wasn't mobile, and urologists came from -- in the case of Grand Rapids, from the surrounding areas to treat their patients there. Volumes dropped. In all cases the fixed lithotriptors were at -- just at or below the 1,000 procedures annually required by the standards then and now to continue operating. It was at that time that the system of mobile lithotriptors came into being.

First of all, the technology changed. It became mobile. It can be wheeled right into operating rooms. And as a result, the fixed lithotriptors went away because they couldn't be kept busy enough at the centers, and they went mobile, going all over the state and providing access to everyone. At GML, we believe that the current system of mobile works really well in the state. It provides access to this relatively low volume procedure that patients can get close to their home. The existing system keeps costs low and maintains consistent quality. For example, a

patient being treated at the GML lithotriptor at West Shore Medical Center in Manistee receives treatment on the same machine by the same technologist as the patient who needs that case at Beaumont Royal Oak. Ideally we'd like to keep the system in place -- this system in place as it is and remove any language allowing conversion from mobile to fixed.

However, if the Commission feels that you must move forward in that direction, we would support the Department's recommendation. I'd like to just focus a little bit on the numbers. 500 cases per year is roughly 10 cases a week. That's one day of a busy lithotriptor. So if you were doing 500 cases in a fixed machine, that machine and its technologist would be idle the other 4 days. So that's just the math and I sort of wanted to add that to the end of my comments. But I would entertain your questions.

DR. MUKHERJI: Thanks, Bob. Questions from the Commission?

MR. HUGHES: You may or may not be able to answer this; may not be appropriate. But the organization that you represent or the other big provider, do you know, are they physician-owned?

MR. ROBERT MEEKER: In part, yes.

MR. HUGHES: Would somebody like Dr. Zuckerman be an owner of --

MR. ROBERT MEEKER: I don't know Dr. Zuckerman.

DR. MUKHERJI: Chip?

MR. FALAHEE: Commissioner Falahee. Mr. Meeker, I have a hunch you might have a little bit of knowledge about Spectrum and what Spectrum might have or might not have. It used to have a fixed litho. Does it still, Bob, or --

MR. ROBERT MEEKER: No.

MR. FALAHEE: No?

MR. ROBERT MEEKER: No. That was one of the conversions from fixed to mobile. You know, this technology has really turned on its -- upside down the trends that we've seen in all other technologies, like MRI and CT and so forth, that started as mobiles, and as places accumulated more volume they converted to fix. In this case there were fixed. Technology changed. The practice of medicine changed.

Actually, numbers of procedures went down. I'm not a physician nor am I provider, but my understanding is that there -- that the number of kidney stones that need to be treated statewide at least is relatively flat. There aren't a whole lot of people waiting to receive care and aren't able to. Mr. Madsen, who will be speaking from GLL, will probably be able to provide more information about that.

MR. FALAHEE: And one quick follow-up, Bob. Are

there any fixed units still functioning in Michigan, if you know? You may not know.

MR. ROBERT MEEKER: No, there are not. I've tried to find out if there are any fixed left in the United States and I've been unsuccessful. My guess is there may be a few for some major kidney centers, academic medical centers. But certainly a place like Spectrum Health, which was doing well over 1,000 in its, quote, "heyday," and actually right now is doing more -- according to the state website is doing more than Sparrow.

But I think that -- I think it's interesting to note that there's really only one of the 10 or so high-volume providers who's asking for this, and the others are relatively satisfied with their -- with the service they're getting from the mobiles.

MR. FALAHEE: Thanks, Bob.

DR. MUKHERJI: Just one question. Bob, as you know, when CON first created or conceived back in 1964 at Rochester, New York, the concept was --

MR. ROBERT MEEKER: I was there.

(Laughter in room)

MR. ROBERT MEEKER: No, I wasn't.

DR. MUKHERJI: But this was created back in the 1960's with the Kodak group, as you know. The whole concept was supposed to be state regulation for a -- expanding an

expensive health care environment. And what I hear you say -- I mean, given your expertise and experience, what I heard you say is that this segment of health care is actually declining; is that we used to have fixed units, and now a lot of hospitals got rid of them and they were converted to mobiles, and the number of stones that are actually treatable with lithotripsy is increasing. It may be at the very best flat.

And because hospitals have not seen appropriate business case to maintain fixed, they've transitioned to mobiles. Given the fact that we have one segment that's actually in decline or the very -- I think we can all agree is not expanding, given your experience why do we need to regulate this?

MR. ROBERT MEEKER: Well, I'd like to comment first of all on some of your assumptions. I'm not sure that kidney stones overall in the state are declining. I don't think they're expanding very rapidly, if at all. I think part of the problem was that, you know, a kidney stone patient in Traverse City, 3 or 4 hours -- well, 3 hours away from Grand Rapids probably wasn't getting lithotripsy, so they would have cystoscopy or a more invasive procedure. So there are probably more lithotripsies being done now than there were 20 years ago, but they're being done at the community hospitals where those patients are so those

patients aren't required to either travel a long distance or have an alternative procedure. So I didn't mean to say that there's no kidney stones left that need to be treated, but rather that the mobile system permits those treatments to happen more frequently as opposed to a more invasive procedure. Why it should still be regulated is a good question. It's a low volume procedure.

You know, if in fact there were -- if in fact there were more and more lithotriptors, for instance, if there were more fixed -- let's say that the 5 or 6 hospitals that qualify with the 500 got their lithotriptors, it would put a strain on the existing mobile routes to continue to provide service at least at the cost they're doing now to the rural sites now.

And as I think we talked about at the last meeting, they might have to contract or at least raise their prices because you would have such a huge chunk taken out of the overall volume of the mobile route. So, you know, there just aren't a lot of patients needing lithotripsy right now who aren't being treated. So you'd be spreading the same number of patients or maybe a few percentage more over a lot more machines and therefore the overall system costs would increase and in the worst case scenario, access could actually decrease.

DR. MUKHERJI: So based on your comment, again

taking out CON for a business case, are you suggesting that it's almost a cross-subsidization where the reason that the mobiles can charge the hospitals and therefore if they can get higher net profit margins, they now have the ability to go out into the -- so in a way this allows cross-subsidization?

MR. ROBERT MEEKER: I'm not an accountant and I'm not sure that an accountant would appreciate that characterization. It allows a route to be viable by having one or 2 or 3 large volume sites, and then they can also serve a place like West Shore in Manistee, which may only have, you know, 3 or 4 cases a day when they go out there, but then they go to Spectrum Health the next day and they might have 10 or 12 cases.

DR. MUKHERJI: Commissioner Tomatis?

DR. TOMATIS: Tomatis. Can you address the point that Sparrow says that they are losing money with this arrangement?

MR. ROBERT MEEKER: Well, as I said, I'm not an accountant and so I don't know all of the financial arrangements. I do know what they have said is that for what they are -- and I hope that I'm accurately characterizing this -- for what they are paying annually in fees to the mobile provider they could buy a machine. What they're not taking into account is the other benefits they

get from the mobile provider. They get the technologist. That technologist has a lot of experience because they're not just performing the 500 cases at Sparrow, they're performing 1,000 or more cases statewide, so their skills are up. That technologist also makes -- the mobile provider makes sure that they're up on their, you know, extended training so they're up to date.

They get preventive maintenance, they get insurance, they get upgrades on the machine. All of those are costs to the mobile provider which, if Sparrow had their own machine, they would have to pay, too. So to say that what we're paying a year would be -- buy us a machine may be true. I don't know. But let's assume that it is. It does not include all the other costs they would have operating that machine.

Plus, the fact if they had a technologist who was doing 500 cases a year, that's, you know, 10 -- 10 one day a week, that technologist is going to have to be doing something else the rest of the time, and it's going to be a part-time lithotripsy technologist and going to have to be doing -- I don't know -- other either OR procedures or other radiologic procedures.

DR. TOMATIS: Who established the rates that you charge the hospital?

MR. ROBERT MEEKER: Those are negotiated rates

between the provider and the hospitals.

DR. MUKHERJI: Other questions? Thanks, Bob. The next public comment card I have regarding lithotripsy is from -- I hope I don't mess your name -- Jorgen Madsen from Great Lake Lithotripsy. Okay. Try saying Mukherji.

MR. JORGEN MADSEN: Let's do that after the meeting.

JORGEN MADSEN

MR. JORGEN MADSEN: Thank you very much, Dr. Mukherji, Chairman. My name is Jorgen Madsen. I'm the general manager of GLL, Great Lakes Lithotripsy, and appreciate the opportunity to elaborate on these comments regarding the standards for lithotripsy and appreciate your time and interest. We've shared with you several times before that we support the current standards as they stand, and the ones that were up for final vote in March with the minor adjustments and changes, we agree with that.

We think the system in place today serves Michigan extremely well. Services are offered today at about 80 facilities throughout the state; small facilities, large facilities, all across the board. Every facility gets the same kind of service, quality of service. Typically the charge for procedure is identical whether you're a big facility or small facility. Those are some of the benefits to the system that's widespread like this. 10 units

operating in the state of Michigan. And so we continue to have, you know, concerns with the language that Sparrow put forward at the last meeting. The number of lithotripsy procedures in the state of Michigan and across the country are fairly stable as we've talked about this morning. We don't disagree with that. However, over time, you know, these procedures have sort of migrated away from hospitals into less expensive sites.

And so one of the -- some of the interest of CON of course is quality, access and cost. And so just as a point of interest, a lithotripsy procedure performed in a surgery center typically costs Medicare and/or commercial payers about half of what it costs in a hospital setting. So let's say Blue Cross may pay a surgery center 4 grand for a procedure facility fee where they may pay Sparrow $8,000.

So cases have migrated away from the hospital setting into less expensive sites of service thanks to physician preferences, thanks to patient preferences and access. So those are some of the things that actually have happened. So in terms of Sparrow's claim that they can't get access to a machine, we are the company that services Sparrow. Sparrow has actually cancelled about 15 percent of their service days starting March 1 this year because we've started tracking it because of this meeting among other things. But days cancelled since March 1 have about 15

percent of days scheduled. There are additional days available in the system. We've offered that to Sparrow particularly since these comments started coming out and they've vehemently denied that they needed any additional days of service, but certainly they're available if they want them and we're happy to provide that. As another case in point -- and we went back and looked at the actual cases performed at Sparrow Hospital since 2010.

So in 2010 850 procedures were done at Sparrow on 77 days of service; in 2016, 584 cases were done at Sparrow on 72 days of service. So the case volume has declined every year up until now. Currently in 2017 they're on track to do 480 cases. Sorry. Go ahead, Dr. Mukherji.

DR. MUKHERJI: You're at three minutes right now.

MR. JORGEN MADSEN: Okay. Fine.

DR. MUKHERJI: I have to be fair to everybody.

MR. JORGEN MADSEN: Okay. That's fine. Those are sort of the essential points that I wanted to mention. Okay. So, you know, I'm happy to take some questions.

DR. MUKHERJI: Thank you very much. I'm sorry. I didn't mean to be rude. I just --

MR. JORGEN MADSEN: It's not a problem.

DR. MUKHERJI: -- I give three to everybody to be fair to everybody.

MR. JORGEN MADSEN: It's fine. Yes.

DR. MUKHERJI: They're going to adhere to that.

MR. JORGEN MADSEN: Absolutely.

DR. MUKHERJI: Commission members, questions? Tom?

MR. MITTELBRUN: Commissioner Mittelbrun. Jorgen, I was just curious, you mentioned 15 percent of the service days were cancelled. I was just curious if there was a reason for that?

MR. JORGEN MADSEN: The reason that was communicated to us was because they didn't have patients to treat. Any other questions?

DR. MUKHERJI: So I just want to reiterate that -- so when we heard the prior testimony, we had heard that there was a cap essentially on the number of patients that could be done at a certain hospital because they have made the request to your specific organization. Are you saying that there hasn't been a request to your organization to provide more time or to provide more days of service?

MR. JORGEN MADSEN: Sparrow has not asked for additional days from us that we were not able to provide as far as we know it. Now, of course we're a big company, we've got people everywhere. And you know, has a call come in? I don't know. But specifically every time this conversation has come up at the meeting and comments from Sparrow have come out that access is an issue, we've gone

back and we've proactively contacted the hospital to suggest that they get some more days of service. And they've consistently said, "We don't need any more days of service." And this year, again, they've cancelled days of service which otherwise could have been used elsewhere. But regardless of all that, all the systems we have in our fleet have additional spare days available on them point blank.

MR. HUGHES: I don't know if you can address this or not, but I'd certainly like to ask your opinion. I'm looking at claims data for the Lansing area for basic shockwave treatment of a kidney stone breakup. And in that work the price ranges from $4,200 to $9,200.

MR. JORGEN MADSEN: Yes.

MR. HUGHES: And the two least expensive places in town are Genesis and Michigan Surgical Center, the two most expensive are McLaren and Sparrow.

MR. JORGEN MADSEN: Right.

MR. HUGHES: Can you comment on that?

MR. JORGEN MADSEN: Well, it's not different here in Michigan than it is elsewhere. Typical, you know, hospital rates are about twice as high as they are for ambulatory surgery centers for this particular procedure. This happens to be a procedure that is well done in an ambulatory surgery center. It's simple, easy, patient is in and out in a couple hours, so that makes a lot of sense.

Medicare pays a surgery center $1700 facility fee for lithotripsy. Medicare pays a hospital $3600 for lithotripsy facility fee. So that's the difference. It's almost a factor, too. That tends to play itself out in the various commercial rates also. So as far as we know it, Blue Cross has a Medicare-like reimbursement system in Michigan, meaning every facility sort of gets the same, and to our knowledge that's about 8 grand for lithotripsy facility fee.

We know that the surgery centers are in the range that you mentioned, about half. So as a result of that of course, who are the winners in that? The patients with large deductibles and co-pays, insurance carriers, et cetera, et cetera. So the migration we've seen specifically from Sparrow into these surgery centers is not unusual. We do service all over the country and so we see this procedure migrating into less expensive sites of service driven by patients, physicians and payers.

MR. HUGHES: And would you see the proposed changes here have any impact on that?

MR. JORGEN MADSEN: Well, I mean, I think what it will do is it'll certainly put a unit in a fixed site, there will be a tendency to try to justify its existence and of course try to drive cases there. I don't think that Sparrow is going to do any more cases just because they have a unit there all the time. I really don't think so. I think the

chance is that the volume is actually going to continue to drop as we've seen it over the last seven years and it'll become an unprofitable venture to own the machine there. The trend nationwide is not to go fixed. The trend is to be mobile and share the service.

DR. MUKHERJI: Commissioner Falahee?

MR. FALAHEE: Thank you. Jorgen, volume in Michigan, you touched a little bit on it, and then you, I think, mentioned it back in our March meeting. Remind me what you're seeing from your business for volume in Michigan overall.

MR. JORGEN MADSEN: I think the other presenters and Dr. Mukherji also are correct, that the volume for ESWL treatments is pretty much flat. That's a fact. I think across the country there may be one or two percentage movements up and down here and there, but generally speaking it's not a procedure that is growing. It's also not a procedure that is disappearing. It's a stable environment.

MR. FALAHEE: Thank you.

DR. MUKHERJI: I'll ask the same question I asked Bob. Can you give me your argument for why, given the flatness of the procedure, that this needs to be regulated in the state when the majority of states don't have regulation?

MR. JORGEN MADSEN: There are states that have CON

regulations for lithotripsy and states that don't. I think the system works extremely well in the state of Michigan. Rates that are charged to facilities for this service is highly competitive and I think it offers a high utilization rate. It also offers high specialization to the technologists. And so where you get -- tend to get a fragmented system, we don't have that in Michigan.

We have a very uniform, high quality system that works extremely well, so that's why I think the CON in this case works, certainly on the quality, on the access and the cost side. One can argue, you know, should everybody buy the lithotriptor, if you get into an arms race where every facility ends up buying, you know, half a million, 500-, $600,000 worth of equipment, staffing, service, et cetera, is that going to be good or bad for the system?

I think it's going to be an all around negative impact on a system that otherwise works extremely well. I mean, the system in our small facilities like we talked about, Upper Peninsula, small surgery centers, et cetera, that couldn't buy a unit to get access at a competitive price point and make it a, you know, very widely available, high quality service. So in that sense you could say that the CON accomplishes something that may not have been set out over in Rochester originally, but it seems to work in this particular setting in my opinion.

DR. MUKHERJI: Questions?

MS. GUIDO-ALLEN: Guido-Allen. You said you are in multiple states. Are you in states that are non-CON-regulated?

MR. JORGEN MADSEN: Sure we are, yeah, absolutely.

MS. GUIDO-ALLEN: And would you say then that your access quality are different in those states than they are in Michigan?

MR. JORGEN MADSEN: So we do service in Texas, for example. Price points for this service from a provider to a hospital is roughly twice what it is in Michigan, so that's certainly not a benefit to those hospital systems. I think Michigan has an extremely compelling situation right now.

DR. MUKHERJI: Can I follow up what you mean by "price point"? The price that you charge or the price you receive?

MR. JORGEN MADSEN: That service providers charge to a hospital, yes.

DR. MUKHERJI: What you charge, but is that -- but everything's on a contract basis.

MR. JORGEN MADSEN: Correct.

DR. MUKHERJI: So there's a difference between a charge and what you receive?

MR. JORGEN MADSEN: No; no. I mean, that's a business contract; right? We get paid what we agree on in a

contract. Not like, you know, hospital bills 20 grand for lithotripsy and gets paid 9-. That's not what I meant.

MR. HUGHES: Is your organization primarily physician-owned or --

MR. JORGEN MADSEN: We have physician investors, yes, which is the norm around the country.

DR. MUKHERJI: Any more questions? Okay. Thank you very much.

MR. JORGEN MADSEN: Thank you.

DR. MUKHERJI: So these are all the cards that I have for lithotripsy. Would anybody else like to make a public comment before we move on to Commission discussion? John?

JOHN SHASKI

MR. JOHN SHASKI: Commissioner Hughes, I wanted to follow up on the question about Dr. Zuckerman's comments about not seeing a backlog in his office. I recently asked one of my associates to call his office and check if he accepts new patients. He does. Unfortunately he does not accept Medicaid patients and those are referred to the local hospitals. I would assume that may be part of his not having a problem with backlog is that the less desirable payer patient is transferred to the local facilities.

MR. HUGHES: Might have something to do with that Medicaid doesn't pay the full cost, too.

MR. JOHN SHASKI: Could, but Sparrow being the nonprofit organization that we have been for 120-plus years located on Michigan Avenue, our doors are open to all people at all times regardless of their ability to pay or what insurance company they may or may not have.

MR. HUGHES: Yeah, just a comment on a bigger problem.

MR. JOHN SHASKI: Thank you.

DR. MUKHERJI: Thank you. I think we're now moving -- any more cards? John jumped in. Anybody else want to comment? Okay. All right. We'll close that portion up and we'll move on to Commission discussion. So maybe Brenda and Elizabeth, do you want to just set our deliverable for this session?

MS. ROGERS: This is Brenda. So as I stated earlier, you have a couple options today. You can either take -- accept the Department's recommended amendment and then send it out for another public hearing, as we have been advised that that would be substantive change, changing that number from 500 to 1,000, and then it would go out for public hearing and to the JLC; or you could take any other amendments, and then depending on if they're substantive, again, may or may not have to go out for another public hearing; or you can accept the language as without any amendment, so as was originally drafted, and take final

action today and it would move to the JLC and governor for the 45-day review period. And I do believe that if you would -- if you were to remove the entire conversion language -- and Joe can correct me if I'm wrong -- but because that's already been out for a public hearing the first time around, it would not have to go out to a second or to a third public hearing to do that. You could still take formal action on that today. So you have several options.

DR. MUKHERJI: So everybody clear on that one? So option one is we take the language which did not have the conversion language which has already gone to public hearing and that would be option one, which would be maintaining, if you will, the status quo. Option two is at the last Commission meeting there was a suggestion of having conversion from a mobile to a fixed at 500 procedures, and that's what the Commission approved at the last meeting and that went to public hearing.

And option number three is that the Department reviewed this and felt that the 500 was actually -- the conversion of 500 was actually less than the initiation at 1,000, so that was a bit -- they felt that there was a discrepancy, so they recommended moving the 500 to 1,000. Those are my -- in very lay terms, just being a dumb doctor, those are the three options that I see. Is that correct?

MS. ROGERS: This is Brenda. That's correct. And then, as I said, unless you have any other suggested changes there would actually be a fourth option.

MS. GUIDO-ALLEN: Guido-Allen. So the Department doesn't have any concerns about going -- allowing fixed, but would maintain the 1,000 threshold, whether it be mobile or fixed?

MS. NAGEL: I believe the answer to your question is "yes," but I'll just restate it. The Department has no objection to the language that was inserted at the last meeting. That's not our concern. We are recommending 1,000 for consistency, but we're not opposed to the language as drafted.

DR. MUKHERJI: So my understanding there was a concern, it was just at the 1,000 level as opposed to the 500 level, that's the way I understood it?

MS. NAGEL: Yes.

DR. MUKHERJI: Okay.

MR. MITTELBRUN: I just want a clarification. Mittelbrun. So on an ongoing basis when you have the unit, it's 1,000; right?

MS. NAGEL: Yes.

MR. MITTELBRUN: Okay. So irregardless of what the initial is, you've still got to do 1,000 every year?

MS. NAGEL: Yes. The maintenance volume and the

project delivery requirements is 1,000. And typically -- Tulika and Brenda can correct me when I'm wrong. But in other places in the standard you must meet 1,000 to do things like make a change in your service or upgrade your service and things like that, and that's why we added the 1,000, just to be consistent with whenever you're making a change you have to be meeting the project delivery requirements that are currently in place and that's the 1,000 volume.

MR. MITTELBRUN: And, Chip, was that the point you were trying to make earlier, is that once you're in you've got to, you know, make sure you maintain it and it's hard to --

MR. FALAHEE: Beth said it much better than I.

MR. HUGHES: Is there people that have been below 1,000 before and then yanked or below the 1,000 and not been yanked?

MS. NAGEL: Are you asking if we've taken compliance action on anyone who's not meeting the volume?

MR. HUGHES: (Nodding head in affirmative)

MS. NAGEL: No.

DR. KESHISHIAN: This is Commissioner Keshishian. Has anybody not met the volume proposed?

MS. NAGEL: Yes. There are providers that are not meeting the 1,000 volume.

DR. KESHISHIAN: As of the last couple years?

MS. NAGEL: Yes.

DR. KESHISHIAN: Thank you.

DR. MUKHERJI: We have our marching orders. Discussion?

MS. CLARKSON: This is Commissioner Clarkson. I just had a clarification. If I was applying and saying that I was 1,000, would I have to show a track record before or I just project that I'm going to be 1,000? So if I'm -- the hospital is saying they have 500, you know, how do you get to the fact that they're going to have 1,000 if you're going to grant someone a (inaudible) saying that they will be 1,000?

MS. NAGEL: That's a great question. I'm going to have Tulika explain the ins and outs of that.

MS. BHATTACHARYA: So we are talking about two different types of project. So the first thing that happens for a hospital or SC, if they want to initiate litho service, meaning they currently do not provide the service, they need to project the volume which will result in 1,000 lithotripsy procedures, and the method for doing that is to show that through their MIDB discharge data from the hospitals that they have treated patients with conditions, so on and so forth. And the ICD codes are listed in the standards. It's very specific. So the hospitals project

the volume. And they show that they have projected 1,000 for the future. When the service actually starts operating, then they're held to that volume. After 2 full years of operation they need to show 1,000 lithotripsy procedures. The second type of project, what we are discussing here, is an actual host site. So if they are currently performing 500 lithotripsy procedures, the language will allow them to convert to a fixed unit.

And when that fixed unit has been in operation for 2 full years, they need to show that they have done 1,000 lithotripsy procedures. So that's the assumption anyone or us or the providers are making, that in 2 years -- if the host site is doing 500 today, in 2 years they will come up to the 1,000 volume.

MS. CLARKSON: Understood. Thank you.

DR. MUKHERJI: Commissioner Mittelbrun?

MR. MITTELBRUN: Commissioner Mittelbrun. Can I ask what happens if they don't meet that after two years?

MS. BHATTACHARYA: Then they are not meeting the maintenance volume requirements and the project delivery requirements. If the Department is doing a statewide compliance review, the Department may take action against those facilities.

DR. MUKHERJI: Discussion? So I'll start off. I mean, the biggest challenge that I have with this is that we

have -- we've heard two different versions of events and I'm trying to figure out whether the inability to reach a certain threshold is due to lack of volume or due to access not being provided when requested. That's where I'm struggling with because we have two versions.

MR. FALAHEE: And this is Falahee. I agree with that. Let me get the ball rolling here. The chairman -- I think this is going to your alternative three. My initial reaction was we could always just stick with the status quo and take out the conversion language completely and then take final action, but -- though I am not sure if we'll learn anything more or hear anything more than we already don't know.

What I would do is propose that, number one, we accept the Department's recommendation to move to 1,000 as in our packets; number one. Number two, that that would then go out to public hearing and we could then hear maybe more of the same or more or new information about that and maybe information that we could figure out -- we've got competing stories here. Which one is accurate? And then so that would take the 1,000 language, send it out to public hearing. And then, Brenda, does it need to go to the JLC? Do I need to add that?

MS. ROGERS: This is Brenda. Yes.

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

thought. So that would be the third component, that that would then go out to the JLC as well. And that would be my motion.

DR. MUKHERJI: Okay. We have a motion on the table. Looking for a second.

MS. CLARKSON: This is Commissioner Clarkson. I'll second that motion.

DR. MUKHERJI: We have a motion and a second. This motion is now open for discussion. No discussion. Do we have a call to question?

MR. FALAHEE: Falahee. Call to question.

DR. MUKHERJI: Okay. We have a call to question. So all in favor of the motion on the table, say "aye."

(All in favor)

DR. MUKHERJI: Anyone against? The motion passes.

MR. FALAHEE: Mr. Chairman, do we have somebody on the phone? I thought I heard.

DR. MUKHERJI: Yeah, Denise is on, but I don't think she can --

MS. BROOKS-WILLIAMS: Yeah. I'm on the phone but I know I can't vote, so I just listen to the dialogue.

MR. FALAHEE: Right. I know you can't, but I just -- I heard a click in and click off and I wanted to see if somebody was there. Thank you, Denise.

DR. MUKHERJI: Yeah. Denise, if you want to say

anything, just chime in. Okay? She's allowed to --

MS. BROOKS-WILLIAMS: I tried, but I don't think you guys can hear me so -- like I didn't want to interrupt anyone, but no problem. Everything I was thinking was said, so it's fine.

DR. MUKHERJI: Okay. It's no interruption.

DR. TOMATIS: Mr. Chairman, the Urological Society has, the national one, any position about this?

DR. MUKHERJI: I'm not sure.

MS. NAGEL: We passed on all testimony that we received.

DR. TOMATIS: Have we asked them?

MS. NAGEL: No.

DR. TOMATIS: Shouldn't we?

DR. MUKHERJI: All right. Well, we can try to get that information. All right. So the next topic that we have is Nursing Home and Hospital Long-Term-Care Unit Beds. This is the draft language and public hearing report. Brenda?

MS. ROGERS: This is Brenda. You do have Nursing Home direct language in front of you today. You took proposed action back in March. Public hearing was also held on May 2nd and we received one testimony supporting the language and you do have that testimony in your packet. The recommendation today is to accept the draft language as

presented and move forward to the JLC and the governor for the 45-day review period. Thank you.

DR. MUKHERJI: Any questions for Brenda on this matter? All right. So I have two cards on this topic. The first is from David Stobb from Sienna Healthcare. Is that correct, Stobb, S-t-o-b-b?

AUDIENCE MEMBER: I'm sorry. He doesn't wish to make a comment. He just wanted it on the record that they support the changes that are proposed.

DR. MUKHERJI: No need to speak, but support the changes.

MR. POTCHEN: You can just put on the record.

DR. MUKHERJI: Okay. So just put that on the record. All right. Thank you. That was a new one. The second one is Pat Anderson from HCAM Nursing Home.

PAT ANDERSON

MS. PAT ANDERSON: Good morning. I'm Pat Anderson with the Health Care Association of Michigan. HCAM represents about 325 nursing facilities across the state out of the 440, and on behalf of them we would like to thank the Commission for their work on this, the work group and what they did, and we are in support of the changes that are put forward and are glad of some of those things. I think it's progressive for the industry to help us move and provide care. We would have one request if possible. There is a

change in how the bed need methodology is calculated; change in the average day census in formulary. That if there's a potential to re-run the bed need -- and I don't know if the 2016 data is available yet to do that -- but if that's possible, that will be great. The ongoing concern we have, which we understand we could not resolve at the work group level, was on release renewals between the same parties. The work group kind of determined it was more of a legal issue, you know. We'd have to go forward in looking at that.

And the concern there is that when you're renewing a lease, same parties and that, if you do it for multiple years you have a huge application fee through CON where it's just the same peoples that maybe have been running it for 10 and 15 years renewing. But we'll look at other avenues to try to address that. But thank you for your work on this. Questions?

DR. MUKHERJI: Any questions?

MR. FALAHEE: Yeah, this is Falahee. Pat, help me understand that last issue.

MS. PAT ANDERSON: The lease renewals?

MR. FALAHEE: Yeah.

MS. PAT ANDERSON: Yeah. The facilities are leasing basically from themselves. All right? And it's mostly for business purposes. After the lease is up they

have to renew it. It's all the same parties providing the care, providing the business, everything. But they'll come in and they'll typically -- if you have a multi-year lease, it can be $30 million over 10, 15 years. They have to pay that patient fee based on that.

What we would like is if they could pay an application fee based on an annual amount instead of the 30 million; maybe it's 5 million for one year or something, or 3 million in my case; so it would be a lower application fee, because it's quite extensive when it's really all of the same parties, nothing has really changed.

DR. MUKHERJI: Other questions? All right. Thank you very much.

MS. PAT ANDERSON: Thank you.

DR. MUKHERJI: So those are the only two cards I have for public comment on this topic. Is there anybody in the audience that would like to make a comment? Okay. Seeing none we'll close that segment and move on to Commission discussion. So, Brenda and Elizabeth, can you frame this for us?

MS. ROGERS: Again, this is Brenda. As stated earlier, pending no changes to these standards, then it would be your option or your to-do today would be to take final action and move it forward to the JLC and governor for the 45-day review period.

DR. MUKHERJI: Could you give us a little bit of context regarding the suggestion made by the prior speaker regarding redoing --

MS. ROGERS: The rerunning?

DR. MUKHERJI: Yeah.

MS. ROGERS: Yeah. This is Brenda. It is actually time for the Department to re-run the bed need methodology for nursing homes and we have talked to Joe about this. Instead of running it right now, it does seem to make sense to run it with the new changes, so we would not be able to run it 'til closer to the end of the year once these standards become effective. So just kind of keeping that in mind and if the Commission wish, you know -- would like us to do that, I believe the Department is supportive of that.

DR. MUKHERJI: Thank you very much. Any discussion? Motions?

MS. GUIDO-ALLEN: Guido-Allen. I think that based on the Medicare spent per beneficiary, which is the CMS looking at the utilization, I think that we should look at the numbers now. Is there a change in utilization of extended care facil- -- nursing home beds in the state based on what -- based on where the government is going with reimbursement and with -- I just think we may want to look at the utilization a little sooner than later.

MS. ROGERS: And this is Brenda. And, again, if that's what the Commission would like us to do, we can certainly run it based on the current standards and so you'd have to keep that in mind. It won't be run with the new changes.

DR. MUKHERJI: Thank you. Any comments?

MS. CLARKSON: This is Commissioner Clarkson. I don't know if everyone understands how a bed need is determined, but it's a census against, you know, today's census. And I think what you're suggesting is if the 200- -- using the 2016 numbers, which would make it a more valid situation which would answer your question, but you're suggesting to wait until the end of 2017 so that you have the valid numbers in; is that my understanding?

MS. ROGERS: Given where we're at in the timing of you taking final action, because of the summer recess that the legislature takes, the best case scenario of these standards becoming effective at the very earliest would be possibly late September, early October. And so it wouldn't necessarily be at the very end of the year, but it would be later this fall.

MS. CLARKSON: Which would make it more accurate?

MS. ROGERS: Yes, because it would make it in alignment with what the language is in the standards.

MS. CLARKSON: Thank you.

DR. TOMATIS: Could you clarify for me when we are writing all these, are we concerned that there are too many beds or not enough?

MS. NAGEL: Are you asking right now are there too many beds?

DR. TOMATIS: No. We are writing all these regulation assuming to be correct, is it because we are concerned there are not enough or there are too many?

MS. NAGEL: I think that we're concerned about both of those. Perhaps I'm not tracking and I apologize for that. But the purpose of the running the need methodology is to determine how many beds there are and in some areas they're over bedded, we call it, where there are more beds than what the utilization suggests, and in other areas we can see that there aren't enough beds.

And so what we're talking about running this methodology is being able to see that. And I did just want to add that it would make sense from my perspective to wait for the 2016 data because the Department made great improvement in the survey that went out to nursing home providers to be able to get accurate data. We included some prompts into the survey they made you triple-check what you were adding because we have had significant trouble with accuracy of the data in '14 and '15, I believe.

MR. HUGHES: And I'd just add that last time we

did look at it there was concern about over bedding particularly in some areas, and the new methodology -- the census that was being used was quite old and there was going to be a change in terms of having more current census data, would actually affect the population changes.

MS. NAGEL: Yes; yes. Every year we use the most recent census data available. And I don't recall what it was the last time we looked at it, but the major problem last time was inaccuracies in the data. For instance, some providers reported quarterly data instead of annual data and so we put safeguards in the survey to try to ferret some of that out on the front. So it's anticipated that the 2016 data will be a better picture of what was actually utilized.

DR. MUKHERJI: Any other questions? So we're open for a motion if there's no more discussion.

MS. CLARKSON: I'll move. I don't know if I'm going to get the whole thing right, though. I'll move to vote on this as proposed and then to go to the JLC. Is that what it is?

MR. FALAHEE: And the governor.

MS. CLARKSON: And the governor.

MR. FALAHEE: This is Falahee. I'll support that motion.

DR. MUKHERJI: So we have a motion and a second. Any discussion, further discussion? Hearing none, all in

favor? Anyone against?

(All in favor)

DR. MUKHERJI: Okay. Motion passes.

MR. FALAHEE: Mr. Chairman, may I ask the Department? Do you need some guidance on running the numbers?

MS. ROGERS: (Shaking head negatively)

MR. FALAHEE: Okay. Good. Thank you.

DR. MUKHERJI: The next agenda item is Surgical Services draft language. Brenda?

MS. ROGERS: Again, this is Brenda. At the January Commission meeting the Department was tasked with drafting language that included some technical edits as well as language regarding commitment letters for initiation utilizing the applicant's historical surgical cases. So that's what you have in front of you today, language that includes those technical components, and then language that will exempt facilities from having to submit physician requirements for initiation if they are utilizing their own surgical cases and they're under the same ownership.

The major -- majority of those changes occurs under Section 11(2)(e) and they are still subject to all other initiation requirements. So today what you would be doing is taking proposed action and then moving it forward to the JLC, and we would schedule a public hearing for that

and then we would bring any comments back to you in September for potential final action on the language.

DR. MUKHERJI: Any questions for the Department before we go forward? Okay. I have one card, Dave Walker from Spectrum Health.

DAVE WALKER

MR. DAVE WALKER: Good morning. My name is Dave Walker and I'm here on behalf of Spectrum Health. Thank you for the opportunity to provide public comment today. Spectrum Health appreciates the Department's proposed changes to the surgical services review standards. My understanding, that the intent behind these changes was to provide flexibility for health care systems to initiate new surgical services based on current system resources.

The language presented today does in fact seem to accomplish this goal by easing the administrative burden imposed on systems by eliminating the requirement to collect physician commitments to initiate a new surgical service. The proposed standards also maintain CON's goal of ensuring that only needed services are developed by keeping a 20-mile initiation zone.

Spectrum Health would be inclined to be supportive of this proposed language, but we are seeking clarification, which I think we just got, on how the Department plans to implement these changes. The reason it appears is because

the way the draft is written -- and I think that what was just clarified -- the applicants initiating a new service will still be required to provide physician names and numbers of cases per physician. My question is, will the form referenced on page 11, line 551, of the proposed draft still require physician names and number of cases? This is Section 11(2)(a)(b). And will the surgical case data currently required to accompany the physician commitment forms still be required?

In my mind, identifying specific physicians in cases in essence commits those specific physicians to moving their cases to the new site. Although I am certain a system would not propose a facility if they had no physicians lined up to move cases to, I'm not sure we would be comfortable making that commitment on behalf of the specific physician. Rather, the facility should simply demonstrate that it has required excess cases to initiate a new service and commit to ensuring that the requisite volume will move over there to meet CON volume requirements.

Again, Spectrum Health appreciates the Department's work on this proposal and is eager to work with the Department on this clarification. The underlying intent of this change is well received, but clarification is needed to ensure that this really does ease the administrative burdens placed on health care systems. Thank you very much

for your time. I would be happy to answer questions. I could also defer to my predecessor, Bob Meeker, since he's still here.

DR. MUKHERJI: Thank you very much. Any questions? Okay. Thank you.

MR. DAVE WALKER: Thank you.

DR. MUKHERJI: Would anybody else like to provide public comment on this issue? Okay. Hearing none, we'll move on to the next segment. Commission discussion?

MR. FALAHEE: This is Falahee. Mr. Walker raised a question about the Department form. I sure wouldn't want the form to be even worse than the commitment forms we have to submit now, because they're a pain in the you know what. Has the Department got any idea what this form might ask for? Sorry, Tulika.

MS. BHATTACHARYA: So I'll answer your question first and then I would like to answer -- I think there was a question in Dave's comment, also. So the form -- stepping back. This language does not change the core methodology for initiating new surgical services in the state. We have to establish that there is a met need in the community in terms of surgical volume at the existing facility and therefore if there is a need for new OR's, new FSOF in the community. And if we follow that core methodology, we have to know how many OR's are there at each hospital, what are

the surgical volume, therefore, do you have excess to commit to another facility or not. So that's why there will still be a form, which is institution specific. So if a hospital is committing their excess volume to a new FSOF, the hospital representative, whoever it is, will sign a commitment form acknowledging -- let's say they are transferring 1200 cases -- that those 1200 cases were actually performed at their hospital and those, you know -- they're committing that those cases will be transferred to the new facility for next 3 years after being operational.

So that will be the institution-specific form, kind of like a certification we have, I believe, for open heart surgery MIDB commitments which are institution-specific, and maybe also transplant methodology which are also institution-specific. But I do want to make a point. An important part of that methodology, as all the provider knows, when you submit your annual survey data you also submit the case volume for each physician.

So you give us a list of all of your surgeons and what are their total number of cases and hours for your facility. So when we are looking at the total volume that is being committed from your institution, the volumes came from those physicians. So there will still be a list of all the physician and their individual cases that are being committed towards the new application; not individual signed

commitment forms from hundreds of physicians, but a list of the physicians and their individual cases.

DR. MUKHERJI: Did that answer your question?

MR. FALAHEE: Sadly, yes.

DR. MUKHERJI: Duly noted. Any other questions or discussion? Accept a motion.

MR. FALAHEE: This is Falahee. My motion would be to take a proposed action to accept the language as presented which would then, if I'm right, call for a public hearing and that the proposed standards would be sent to the JLC for review as well.

DR. MUKHERJI: We have a motion. Any second?

MR. MITTELBRUN: Second, Mittelbrun.

DR. MUKHERJI: We have a motion and a second. Further discussion? Hearing none, all in favor? Anyone against?

(All in favor)

DR. MUKHERJI: Motion passes. All right. The next thing I have is Psychiatric Beds and Services --

(Emergency siren going off)

DR. MUKHERJI: -- oh, coming to get me -- recalculation of bed need numbers setting the effective date. I do have my immigration card.

(Laughter in room)

MS. ROGERS: All right. This is Brenda. Again,

you do have a report in your packet. It was time to re-run the psych bed need numbers and so that has been done by Mr. Delamater and you have that report. If you've looked at the report, as you can see there were increases in some HSA's for both pediatrics and adults, and then a lot of the stability remaining the same as well; so not significant changes. So what the Commission's responsibility is to do today is to set the effective date of these new bed need numbers.

And knowing that the Commission usually asks the Department if we have a recommendation, we would suggest July 3rd. That is the next posting of the bed inventories out on the web site, so we'd just like to make it coincide with that.

DR. MUKHERJI: So, Brenda, this is an action item; correct?

MS. ROGERS: That is correct. Thank you.

DR. MUKHERJI: Any discussion? I don't see any public comment. Is it --

MS. ROGERS: You don't need it.

DR. MUKHERJI: You don't need public comment? Okay. Any discussion at all? So we're looking for a motion.

MS. GUIDO-ALLEN: I have one question. When do we look at this again?

MS. ROGERS: Psych beds are run every two years.

MS. GUIDO-ALLEN: I have another question. In the community the psychiatric population are the ones who are identified as growing. We're basing our bed need on how many patients use the beds now; is that right? Do we have -- ever look at coded data to see how many patients have psychiatric needs that we can't get into beds? So working in a hospital setting I see how many psych holds we get that we can't get into beds, and then you end up with psych borders who then go to a facility to be put into beds, but if they're not -- it's just a vicious cycle.

My question is, is that I believe that methodology is we're looking at how many bed were used and all. I know I'm questioning the methodology, but based on what we're seeing as reality, it doesn't seem to match the numbers, both this pediatric and adult.

MS. ROGERS: This is Brenda. There is a projection component in that -- built into the methodology, so --

MS. GUIDO-ALLEN: Thanks.

MR. FALAHEE: And this is Falahee. Haven't we decided that we've increased the number of beds? So if we see that there's a need -- we've already said here a couple times, you know, the pool is X. If that pool is taken and we still have a need, we'll increase that pool. The trick

is to find the providers to take care of the patients.

MS. NAGEL: If I could just remind you that the psychiatric bed standards will be up for review this coming year.

MS. GUIDO-ALLEN: Okay. Thank you.

MR. FALAHEE: With that -- this is Falahee -- make a recommendation to set the effective date July 3, '17.

DR. MUKHERJI: We have a motion.

DR. KESHISHIAN: Commissioner Keshishian, support.

DR. MUKHERJI: So we have a motion and a second. Any further discussion? All in favor? Anyone against?

(All in favor)

DR. MUKHERJI: Thank you. The next thing that I have is legislative report. Matt Lori?

MS. NAGEL: Matt is unavailable.

DR. MUKHERJI: Matt is unavailable. And was somebody giving the legislative report?

MS. NAGEL: There is no legislative report.

DR. MUKHERJI: There is no legislative report. Okay. Administrative updated?

MS. NAGEL: I can do that.

DR. MUKHERJI: Okay.

MS. NAGEL: I wanted to update you on a couple of things that have happened since the last meeting. The first is that two standard advisory committees have been seated,

one for cardiac catheterization, the other one for hospital beds. Those will both start in July of this year. Chairs have been made, named, the schedule is online, so we're all set to go for July. The other issue I wanted to bring to your attention on the -- your work plan, we had planned to follow up with you at this meeting on open heart surgery.

In January the Commission designated the Department to come back with open heart surgery language that would allow an open heart surgery service to be replaced to a new facility independent of a full hospital replacement. And we in the Department sat down in earnest to write that language and then we became stuck because it's closely tied to the cardiac catheterization standards. If we made a change to the hospital bed standard, it wouldn't -- because they're so tied with cardiac cath, we would not be able to actually make that change.

And so what we decided is that it would make sense for the cardiac catheterization standard advisory committee, which already has this on their charge, to make some decisions around this before the Department attempts to update any regarding surgery services. And those are my two updates.

DR. MUKHERJI: Any questions for --

MR. FALAHEE: Just a commendation. I want to congratulate the Department and the chair and the vice chair

for getting these SAC's seated. As a former chair, it is not easy to do that, so thank you and congratulations on getting them seated and up and running so quickly.

DR. MUKHERJI: Thanks. And I'll just thank the partnership of Brenda and Elizabeth. I've only been doing this job for a couple months and they've been fantastic to work with, so thank you. And also for Tom for answering my e-mails at 2:00 in the morning, so appreciate that. CON Evaluation Section Update, Tulika?

MS. BHATTACHARYA: So there are two reports in your packet, the program activity reports and the compliance activity report. I mean, I'll be happy to answer if you have any questions. On the compliance activity, I just wanted to give a brief update on the statewide compliance review related to the cardiac cath and MRT services. So we need our statewide review and we have set up and we are nearly completed, nearly towards the end of the line in completing all of our compliance call with these providers. Just a few facilities are left.

Once we are done with all of our compliance calls and Q&A with the providers, we will bring back to the Commission the summary of the facilities that are not meeting volume and what are those delivery requirements statewide that we observed that are not being met.

DR. TOMATIS: Tomatis. I just wonder why we do

these compliance, because one of the problem with our committee is we have no authority to do anything to the non-compliant and every time you keep repeating. In the case of open heart, there are 16 institution in east Michigan that are not compliant, and as long as I've been in this committee I just heard that they're not compliant and not compliant. It's nice to hear the report, but there is nothing we can do about it.

MR. POTCHEN: This is Joe. There is statutory authority for the Department to take action in certain non-compliant situations. It does give the Department the discretion to take the action, though.

DR. TOMATIS: Yeah, but we have no authority.

MR. POTCHEN: You have authority under the statute.

DR. TOMATIS: Are we ever --

MR. POTCHEN: The Department does. I'm sorry.

DR. TOMATIS: The Department, not us. We can recommend --

MR. POTCHEN: No. The statute gives the authority to the Department.

DR. TOMATIS: Because has any of these services ever closed for being non-compliant?

MR. POTCHEN: The statutory authority given to the Department gives a wide variety of actions to take. One of

those could be shutting down the service, but they oftentimes take a -- there's a large scale of a lot of options that --

DR. TOMATIS: Joe, I heard you.

MR. POTCHEN: Yeah.

DR. TOMATIS: But you know as well as I that never happen. That's okay. I understand they have to make on these -- but it has never happened in the time that I've been a Commissioner.

MS. NAGEL: Dr. Tomatis, if I could? It's true that what Joe said, in the statute -- and the statute is listed at the top of the memo that Tulika gave you. There are five or six things listed that the Department can do, and then in the end, the last criteria said "take any other action as determined appropriate by the Department." We do give you several reports at every Commission meeting and oftentimes we do take enforcement action.

Many providers have received civil fines, many providers have received corrective action plans at the discretion of the Department. It's true we don't shut them down, but we do work with them to come to some resolution with the help of the Attorney General's office.

DR. TOMATIS: That's nice. I will keep listening to the compliance every year.

DR. MUKHERJI: I will jump in here. Like I said,

I've only been in this role for a couple months, but I know the Department's looking at specific covered services. And I can attest to the fact that I've received phone calls and e-mails from some of the services that are being looked at. So if it looks to tactics that the Department could undertake, yes, on the one end is complete shutting down of a service, which is at one end of the spectrum, but I think we also have to be aware of the Hawthorne effect.

And I can tell you the Hawthorne effect is working because I'm getting e-mails and phone calls right now about some of the scrutiny that some of these services are under. Any other --

MR. FALAHEE: Yes. Falahee. I'm also getting calls because -- I'm getting calls from Tulika because -- and I'll commend her for that in her department, for both the MRT and the cardiac cath. I mean, we should hold everyone to the standards. And if there's questions about survey data, you know, you're correct to pursue it and make sure that the standards and the project delivery requirements are being met. So I think that's a laudable goal and I'm glad you're doing it even though I get the phone calls.

DR. MUKHERJI: Other comments or questions for Tulika or the Department? I think the next thing I have is Quality (sic) Performance Measures written report.

MS. BHATTACHARYA: Oh. Yeah. So the next one, the second one is the program activity report, so just to show that in the statute and in our administrative rules we have various deadlines for processing applications, letters of intent, amendment request, FOIA requests. So this is just to give you the idea of -- that we are meeting our deadline 99 to 100 percent of the time.

DR. MUKHERJI: Any comments, questions for Tulika? We don't need a motion, this is just information; correct?

MS. ROGERS: (Nodding head in affirmative)

DR. MUKHERJI: All right. Next thing on the agenda is Legal Activity Report.

MR. POTCHEN: This is Joe. We continue to assist the Department in drafting the standards and there is no current active litigation.

DR. MUKHERJI: Thank you. We appreciate that. The next are future meeting dates. We have the '17. Do we have the '18 dates yet?

MS. ROGERS: This is Brenda. Yeah, we are actually working on the '18 dates, so you will see those when the September agenda comes out.

DR. MUKHERJI: Next on the agenda is Public Comments. Is there anyone that would like to make a comment on anything? Except the Tigers. All right. Hearing none, next is Review of Commission Work Plan. Brenda?

MS. ROGERS: This is Brenda. Again, you have the draft work plan in front of you. The only change that would be made to this today, based on your action taken today, is for lithotripsy. And instead of final action we will change that to proposed action and schedule public hearing and bring that back to you in September for final action. Thank you.

DR. MUKHERJI: Is there any discussion of the work plan? I think we have to -- we have to take --

MS. ROGERS: (Nodding head in affirmative)

DR. MUKHERJI: If there's no discussion, we'll take an action item -- or a motion, I should say, to approve the work plan.

DR. TOMATIS: So moved.

DR. MUKHERJI: So we have a motion approval.

DR. KESHISHIAN: Commissioner Keshishian, second.

DR. MUKHERJI: And we have a second. Any discussion? Hearing none, all in favor? Anyone against?

(All in favor)

DR. MUKHERJI: Motion passes. Oh. Wow. The next one is adjournment.

DR. TOMATIS: Motion to adjourn.

MR. FALAHEE: Second.

DR. MUKHERJI: Motion, second. All in favor?

(All in favor)

DR. MUKHERJI: We're adjourned.

(Proceeding concluded at 11:06 a.m.)

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