

1 STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
 2 R.I. DEPARTMENT OF HEALTH  
 3 \* \* \* \* \*  
 4 PUBLIC HEARING: R.I. HOSPITAL,  
 5 CON APPLICATION FOR HIGH  
 6 INTENSITY ONCOLOGY/BONE MARROW  
 7 TRANSPLANTATION PROGRAM  
 8 \* \* \* \* \*  
 9 VOLUME VI  
 10 R.I. DEPARTMENT OF HEALTH  
 11 3 CAPITOL HILL  
 12 PROVIDENCE, RI 02908  
 13 JULY 26, 2007  
 14 8:30 A.M.  
 15 BEFORE: BRUCE McINTYRE, HEARING OFFICER  
 16 PRESENT:  
 17 FOR R.I. HOSPITAL.... NIXON PEABODY, LLP  
 18 BY: LINN FREEDMAN, ESQUIRE  
 19 STEPHEN ZUBIAGO, ESQUIRE  
 20 FOR ROGER WILLIAMS  
 21 HOSPITAL..... ROGER WILLIAMS HOSPITAL  
 22 BY: KIMBERLY O'CONNELL, ESQUIRE  
 23 - and -  
 24 NORMAND LAW, LTD.  
 25 BY: CHARLES W. NORMAND, ESQUIRE  
 26 - and -  
 27 PANNONE, LOPES &  
 28 DEVEREAUX, LLC  
 29 BY: WILLIAM P. DEVEREAUX,  
 30 ESQUIRE  
 31 JOHN WALSH, ESQUIRE  
 32 FOR THE DEPARTMENT... LAW OFFICE OF JOSEPH MILLER  
 33 BY: JOSEPH MILLER, ESQUIRE  
 34 ALSO PRESENT: MICHAEL DEXTER  
 35 VALENTINA ADAMOVA  
 36 ANDREW KARLBERG  
 37 SAJEL SHAH  
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1 I N D E X  
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1 E X H I B I T S  
 2 NO. DESCRIPTION PAGE  
 3 (Department's)  
 4 18 ZIMMERMAN CV 782  
 5 19 ZIMMERMAN REPORT 782  
 6 20 ZIMMERMAN POWER POINT 782  
 7 (IP's)  
 8 10 DANA FARBER COLLABORATIONS 870  
 9 11 BOSTON CHILDREN'S HOSPITAL WEB  
 10 12 SITE 872  
 11 13 MASS. GENERAL HOSPITAL  
 12 14 COLLABORATIONS 875  
 13 15 BETH ISRAEL DEACONESS HEMATOLOGIC  
 14 16 MALIGNANCIES 878  
 15 17 COORDINATED HEALTH CARE PLANNING  
 16 18 IN RHODE ISLAND 879  
 17 21 ROGER WILLIAMS SUMMARY OF  
 18 22 ARGUMENTS 938  
 19 (Applicant's)  
 20 23 RESPONSE TO PURPORTED TABLE OF  
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1 (COMMENCED AT 8:45 A.M.)  
 2 MR. McINTYRE: Good morning,  
 3 ladies and gentlemen. We are here for the  
 4 last, and we hope, final day of the public  
 5 meeting regarding the application of Rhode  
 6 Island Hospital for a bone marrow transplant  
 7 program. It's been a very interesting and  
 8 informative public meeting thus far. We  
 9 hope to conclude today with Mr. Zimmerman's  
 10 report and Mr. Miller, followed by  
 11 questioning from Roger Williams Medical  
 12 Center and then any questions from Rhode  
 13 Island Hospital following that. And then we  
 14 hope to proceed to final argument.  
 15 I expect that we will be  
 16 finished no later than three o'clock, but  
 17 with any luck, before that. Mr. Miller, are  
 18 you ready to go forward?  
 19 MR. MILLER: Thank you. May I  
 20 ask that the witness, Mr. Zimmerman, be  
 21 sworn.  
 22 HARVEY ZIMMERMAN  
 23 Being duly sworn, testifies as follows:  
 24 COURT REPORTER: Please state  
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1 your full name for the record.  
2 THE WITNESS: Harvey  
3 Zimmerman.  
4 EXAMINATION BY MR. MILLER  
5 Q. You can be seated, if you would like,  
6 Mr. Zimmerman. Would you state your name,  
7 again, for the record, and spell your last  
8 name?  
9 A. Harvey Zimmerman, Z-I-M-M-E-R-M-A-N.  
10 Q. Do you do business under a corporate name?  
11 A. Yes, I do.  
12 Q. What is that name?  
13 A. Spectrum Services, Inc.  
14 Q. Where are they located?  
15 A. 2845 Post Road in Warwick.  
16 Q. In connection with your engagement in this  
17 case, have you provided to the Department of  
18 Health, which has been disseminated  
19 hopefully to all the parties, a report that  
20 was prepared by you entitled, The Need For  
21 Bone Marrow Transplantation Facilities in  
22 Rhode Island?  
23 A. Yes, I did.  
24 Q. Have you, also, supplied the Department and

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1 parties a copy of your curriculum vitae?  
2 A. Yes, I did.  
3 Q. And have you, also, in preparation for this  
4 morning's testimony, prepared a power point  
5 presentation, which hopefully will summarize  
6 the essence and at least the high points in  
7 your report?  
8 A. Yes, I did.  
9 MR. MILLER: May I approach,  
10 please.  
11 MR. McINTYRE: You may.  
12 MR. MILLER: I would like to  
13 have these introduced with counsels' consent  
14 as the Department's exhibit. I think we may  
15 have some Department exhibits in there in  
16 the beginning.  
17 MR. McINTYRE: Yes. I would  
18 like to mark these as Department exhibits.  
19 MS. ADAMOVA: We can continue  
20 on here --  
21 (MR. MCINTYRE PERUSING  
22 DOCUMENTS)  
23 MR. McINTYRE: Why don't we  
24 make this Exhibit 18, curriculum vitae,

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1 Exhibit 18, and is this the power point,  
2 Mr. Miller?  
3 MR. MILLER: No, that's the  
4 report itself. I'd like that to be a  
5 separate number.  
6 MR. McINTYRE: The CV will be  
7 Exhibit 18, the report Exhibit 19, and the  
8 power point Exhibit 20.  
9 (DEPARTMENT'S EXHIBIT 18, 19  
10 AND 20, ZIMMERMAN CV, ZIMMERMAN REPORT AND  
11 ZIMMERMAN POWER POINT, MARKED FOR  
12 IDENTIFICATION)  
13 MR. MILLER: Now, it's my  
14 understanding that everybody here has a copy  
15 of each of those documents?  
16 MR. DEVEREAUX: Correct.  
17 MR. MILLER: I don't know that  
18 there's any need -- I will ask counsel if  
19 they waive any further comment with respect  
20 to Mr. Zimmerman's background, his  
21 expertise, his preparation of numerous  
22 reports in numerous hearings on behalf of  
23 the Department?  
24 MR. McINTYRE: Does everyone

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1 agree that Mr. Zimmerman is an expert on the  
2 subject?  
3 MS. FREEDMAN: We will so  
4 stipulate.  
5 MR. DEVEREAUX: We have no  
6 objection.  
7 MR. McINTYRE: No objection  
8 from either side. Okay. No objections.  
9 MR. MILLER: Okay. That's  
10 going to cut back on a lot of time, so we  
11 can move forward. Having had that  
12 stipulation on the record and having had the  
13 reports themselves become exhibits in the  
14 case, I would ask Mr. Zimmerman to present  
15 his power point; but before we get into  
16 that, it has been called to my attention  
17 that he had a couple of corrections. I  
18 would ask him to just go forward so people  
19 would know where the corrections are going  
20 to appear and then go back to the power  
21 point.  
22 MR. McINTYRE: Are we talking  
23 about the report, Mr. Miller?  
24 MR. MILLER: Yes, I am.

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1 MR. McINTYRE: That's  
2 Exhibit 19.  
3 A. When I was preparing my notes for  
4 today, I noted that in Table 6 on Page 28 of  
5 the report that I had reported to you that  
6 there were 231 Non-Hodgkin's Lymphoma  
7 patients in the state on average over the  
8 period I was looking at, and that 2 percent  
9 of those were, that 2 percent of 231 was  
10 two, and of course, that's not good  
11 arithmetic; so, I went back and looked at my  
12 source material and found out that's a typo.  
13 That should have been a 20, and the  
14 corresponding percent should be 9 percent.

15 And then the discussion of that  
16 table of that section I noted that in  
17 looking at Non-Hodgkin's Lymphoma, I did not  
18 complete my analysis there; so, when I get  
19 to that point, I will complete that for you  
20 and tell you how I finally got to the 0.9  
21 that you will see in the power point  
22 presentation.

23 Q. So, for further clarification,  
24 Mr. Zimmerman, we are on Table 6 on

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1 I'd like you to do is go right across and  
2 tell us what numbers so we can write them  
3 in.

4 A. Page 28, the row in Table 6 is the row  
5 that says, Non-Hodgkin's Lymphoma. That is  
6 NHL. The annual incidents in Rhode Island  
7 was correct, 231. The prevalence and the  
8 percent associated with that reads 2, and it  
9 should read 20. The percentage is 2 percent  
10 and it should be 9 percent. The potential  
11 eligible patients is correct as written, and  
12 the associated change --

13 Q. Now, the 9 percent, is that in the fourth  
14 column on the bottom?

15 A. The 9 percent is in the third column.  
16 Where it says 2 percent, it should read 9  
17 percent.

18 Q. So, the 9 percent is in the parentheses next  
19 to the 20?

20 A. That's correct.

21 Q. That's what I wanted to be sure about. And  
22 the .9; is that correct?

23 A. And the .9 is correct.

24 Q. And the total 8.6; is that correct?

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1 Page 28?

2 A. Yes.

3 Q. And are we talking about the four columns  
4 there?

5 A. Yes.

6 Q. And are we talking about -- which one of the  
7 columns?

8 A. Look at the row that says, NHL. That's  
9 Non-Hodgkin's Lymphoma.

10 Q. So, the first column under annual incidents,  
11 is there any change in 231?

12 A. No, 231 is correct.

13 Q. Now, the second one, prevalence percentage,  
14 is there any change there?

15 A. Yes. Where it says, two, that should  
16 have said 20.

17 Q. And in the third column --

18 A. And the corresponding percent would be  
19 9 percent.

20 Q. Well, potential BMT eligible patients, what  
21 should that be; what number should appear  
22 there?

23 A. 20, not looking at my...

24 Q. Well, that's what I wanted to clarify. What

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1 A. That's correct.

2 Q. All right. Thank you. I'm sorry for  
3 laboring over this, but I wanted to be sure.  
4 A. Thank you.

5 Q. Would you then continue with your power  
6 point?

7 A. This morning I'm going to go over  
8 with you my analysis on the need for bone  
9 marrow transplantation in Rhode Island  
10 facilities in Rhode Island. In the way of  
11 establishing context here, I need to tell  
12 you that I do not get to tell you how many  
13 or whether Rhode Island Hospital needs to  
14 have a bone marrow transplant facility.  
15 That Dr. Gifford gets to make that decision.  
16 I don't get to make a recommendation to  
17 Dr. Gifford. That is for the Health  
18 Services Council to make.

19 What I do is to present the  
20 evidence that I think they need in order to  
21 arrive at correct decisions; so, in so  
22 doing, I'm going to be as transparent as I  
23 possibly can, and in cases where there might  
24 be a variance on what I have presented here,

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1 I'm going to try to present it in a way that  
2 you can make changes as simply as possible  
3 and that the Health Services Council cannot  
4 accept my whole report but use my report to  
5 make a correct decision.

6 Now, with that in mind, first,  
7 I need to establish the terminology that I'm  
8 using this morning. Since, if you read the  
9 news, you hear a lot about stem cells these  
10 days. Stem cells, by definition, are cells  
11 that, at a single level, separate into more  
12 stem cells and also give rise to different  
13 and other types of cells. The stem cells  
14 that we are accustomed to hearing about are  
15 embryonic stem cells that are what you call  
16 pluripotent stem cells that can turn into  
17 any type of human tissues. The particular  
18 type of stem cells that I'm going to be  
19 talking about are hematopoetic stem cells.  
20 That is stem cells that differentiate to  
21 form all elements of the blood. They result  
22 from cell division in the bone marrow and  
23 have four fates. They can either renew into  
24 more stem cells. They can differentiate

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1 reproduce better. The peripheral blood stem  
2 cells will graft and graft faster than the  
3 other sources. The cord blood stem cells  
4 have the advantage of being more permissive,  
5 if they are mismatched on the HLA level; so,  
6 different types of transplant may use  
7 different sources of stem cells here.

8 Since the bone marrow was the  
9 initial source of stem cells, we continue to  
10 call this process bone marrow  
11 transplantation even though the stem cells  
12 may come from one of the other sources.  
13 Another distinction we need to keep in mind  
14 is we may have autologous transplantation.  
15 That is cases in which a stem cell is taken  
16 from a person, frozen, and a patient  
17 receives radiation and chemotherapy and then  
18 the stem cells are thawed out and go back  
19 into the blood stream, taken into the blood  
20 marrow and repopulate and begin the stem  
21 cell production from there.

22 The other type of  
23 transplantation is allogeneic  
24 transplantation. That's the case in which

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1 into progenitor cells, which differentiate  
2 into, further into white blood cells and red  
3 blood cells, or they can immigrate into the  
4 blood stream or they can realize a fate of  
5 program cell death.

6 The types of transplantation  
7 that we are looking at, the bone marrow  
8 transplantation, actually can get stem cells  
9 from one of several sources. The stem cells  
10 can come from the bone marrow. That's the  
11 place where stem cells are most prevalent.  
12 About 1 percent of bone marrow is stem  
13 cells, or they can come from peripheral  
14 blood, in which stem cells are much less  
15 frequent, but with the use of some  
16 medications, can be encouraged to move from  
17 the bone marrow into the blood; or it can  
18 come from cord blood, which is taken from  
19 the placenta and the umbilical cord after  
20 the birth of a baby.

21 Each of those will have  
22 different types of reactions when they are  
23 used as a source of stem cells. For  
24 example, the bone marrow stem cells tend to

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1 the stem cells from one person are reinfused  
2 into a second person; and in that case, they  
3 may match the HLA characteristics of the  
4 second person or they may not, in which case  
5 we have mismatched and we have additional  
6 problems. There's a special case of  
7 allogeneic stem cells called syngeneic stem  
8 cells in which the source of the stem cells  
9 are from the identical twin. Actually,  
10 those are usually grouped with the  
11 autologous stem cells.

12 We are also going to be looking  
13 at a reaction that comes from bone marrow  
14 transplantation calls Graft Versus Host  
15 Disease, and we need to be clear when we  
16 talk about that whether we are talking about  
17 acute disease or chronic disease. Acute  
18 Graft Versus Host Disease is a reaction that  
19 usually occurs in the first 100 days after  
20 transplantation. And there's absolutely no  
21 advantage to having that, and we like to  
22 avoid it in all possible cases. The other  
23 type is Chronic Graft Versus Host Disease.  
24 That usually occurs after 100 days after

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1 transplantation; and in that case, the  
2 presence of Chronic GVHD is related to  
3 improved control of the cancers, that is an  
4 improved relapse rate of cancer. So,  
5 Chronic GVHD is not necessarily all bad. We  
6 like to control the symptoms.

7 And finally, when we are  
8 talking about transplantation, it can be  
9 done in adult or pediatric cases, and again,  
10 it makes a difference. The pediatric cases  
11 actually will accept transplantation more  
12 easily than the adult cases, but the cases  
13 that do require care typically require more  
14 care than do the adult cases.

15 Then in the next slide, when I  
16 looked at this same question 15 years ago, I  
17 reported back that this was pretty much an  
18 experimental procedure, and it was not clear  
19 exactly where we were going with all of it.  
20 There have been a lot of technical  
21 improvements in bone marrow transplantation  
22 in the last 15 years. Some of them are  
23 listed in this slide. The HLA matching is  
24 one area that's of grave importance. At

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1 closer and some minor matching probability  
2 problems that used to exist can now be  
3 identified early on.

4 A second area that's seen  
5 technical improvements is immunosuppressive  
6 drugs. At the time of the first  
7 presentation, there were only a couple of  
8 those, and there are several additional  
9 immunosuppressive drugs that can be used to  
10 help control not only the preparation for  
11 the bone marrow transplantation but also  
12 control the acute and Chronic Graft Versus  
13 Host Disease that may result.

14 The third area that's of great  
15 importance is reduced intensity  
16 conditioning. Early on, it was determined  
17 that in some cases patients who had minimal  
18 residual disease after treatment that after  
19 a period of several months after having  
20 received bone marrow transplantation, that  
21 disease completely disappeared. So, it was  
22 determined that there's, in some cases, a  
23 Graft Versus Leukemia effect in which the T  
24 cells and the graft are in the bone marrow

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1 that time, the matching was done on  
2 primarily four different HLA subgroups and  
3 now that's increased to six.

4 At the time I wrote the paper  
5 15 years ago, I reported to you that for  
6 each of these subgroups there were 40  
7 different variants. Now, there are several  
8 hundred in each of those subgroups that have  
9 been identified; and if you look at all the  
10 combinations and permutations of the HLA  
11 subgroups, it turns out there are 19 and a  
12 half million possible combinations and  
13 permutations of that. Fortunately, not all  
14 of those exist in nature; and if you look at  
15 the number of cases identified, you're, only  
16 one and a half percent of the possible  
17 combinations have been identified in people  
18 who have been typed, but with the HLA typing  
19 at the time that I reported before, most of  
20 it was done by blood serology, which was at  
21 what's called the two-digit level, a very  
22 crude match. Now, it's done by looking at  
23 the DNA. And by looking at the DNA at the  
24 four-digit level, the matches are much

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1 transplants, the stem cells actually attack  
2 the cancer and get rid of a minimal residual  
3 amounts of that. Reduced intensive  
4 conditioning means the conditioning regimen  
5 is much less harsh, and the result of that  
6 is to greatly expand the number of patients  
7 that are candidates for bone marrow  
8 transplantation. Now, older patients that  
9 originally were thought off-limits can now  
10 be treated. In particular, when I did the  
11 original presentation, people that were  
12 above 40 were thought to be too old to  
13 receive allogeneic transplantation and  
14 people above 60 were thought not to be able  
15 to receive autologous transplantation. Now,  
16 the people who receive transplantation from  
17 both sources can go up as high into their  
18 70's and get very good conditioning or  
19 pretty good results based on reduced  
20 intensity conditioning.

21 Then as I have noted earlier,  
22 there are alternative stem cell sources.  
23 The importance of this is for the use of  
24 peripheral blood as a stem source means that

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1 the engraftment is faster and that we get  
 2 more Graft Versus Leukemia effect, and it's  
 3 easier to collect these stem sources, which  
 4 means it easier to recruit donors for this.  
 5 Finally, infection prophylaxis is important.  
 6 It increases in ability to treat infections.  
 7 One of the major sources of  
 8 treatment-related mortality has been  
 9 considerably reduced as a result of these  
 10 improvements.

11 With that in mind, then the  
 12 next slide notes some of the complications  
 13 that grew out of bone marrow  
 14 transplantation. The most likely  
 15 complication that one gets soon after  
 16 transplantation is inflammation of the mucus  
 17 membrane, mucositis. It can be in the mouth  
 18 area or in the intestinal area and can  
 19 create problems.

20 A second problem that's very  
 21 problematic is a liver condition called  
 22 hepato venoocclusive disease. Another is  
 23 lung injury that can occur up to four months  
 24 after transplantation, and again, the

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1 reconstituting the bone marrow, it is  
 2 important to keep the patient well hydrated,  
 3 which may mean that IV fluids are needed to  
 4 support the patient.

5 Finally, there is blood  
 6 component support, which the preparation  
 7 regimen gets rid of the white blood cells  
 8 and platelets. It may be necessary to give  
 9 the patient white blood cell transfusions or  
 10 platelet or even red blood cell  
 11 transfusions. It can go on for a period of  
 12 time until engraftment, which is usually two  
 13 to three weeks after the bone marrow  
 14 transplant.

15 Finally, the patient is in need  
 16 of protection against drugs in the  
 17 community, so we put them in what's called  
 18 reverse isolation. That is isolation in  
 19 which the patient is isolated from the germs  
 20 in the world as opposed to the regular  
 21 isolation in which the world is protected  
 22 from an infected patient. And the protected  
 23 environment is what bone marrow transplant  
 24 beds are all about. That is to give them a

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1 patients can die from pneumonia that comes  
 2 from that. Finally, the neutropenia, that  
 3 is a decrease in the number of white blood  
 4 cells and the corresponding infection that  
 5 follows that creates one of the  
 6 complications. Graft Versus Host Disease,  
 7 both acute and chronic, are a complication  
 8 to be contended with, and finally, graft  
 9 failure, in which the graft, et cetera, may  
 10 not take; or if the graft does take, the  
 11 body may try to get rid of it later and  
 12 reject it and can also be problems that  
 13 occur with bone marrow transplantation.  
 14 With all of these, we need a certain amount  
 15 of supportive care.

16 The basic care is first  
 17 prophylaxis against infection. Doctors who  
 18 do this have found that if they prepare the  
 19 patient in advance by giving them a  
 20 background to treat pneumonia or if they  
 21 give them drugs to prevent fungal  
 22 infections, they get better outcomes.

23 Then while the patient is  
 24 receiving the bone marrow transplants and

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1 place that they can get the supportive care  
 2 services where the complications that grow  
 3 out of bone marrow transplantation can be  
 4 treated and the patient can be kept alive  
 5 until their own bone marrow begins to  
 6 reconstitute, and finally, there's need for  
 7 ICU in cases where there's additional  
 8 technical support that's needed, that organ  
 9 problems that may arise as a secondary  
 10 condition to all of the other complications.

11 Well, the first question to be  
 12 asked in case of bone marrow transplant is,  
 13 is it really worth it. And in looking at  
 14 some of the reports of long-term survival  
 15 and quality of life, I have given two of  
 16 them here that are typical of what one sees  
 17 in the literature. First, the Intentional  
 18 Bone Transplant Registry reported that the  
 19 survival rate at 10 years was 83 percent and  
 20 at 15 years was 76 percent for a group of  
 21 patients that they followed. So, this is a  
 22 life-saving intervention. This is the  
 23 result that, this is treatment for a  
 24 condition like an acute Leukemia that would

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1 result in 95 percent death of chance in  
 2 normally three or four months. And then  
 3 looking at the cause of death historically  
 4 in patients that have survived for more than  
 5 a year, they found, in the case of Leukemia,  
 6 cancer reoccurrence was the greatest cause  
 7 of death; and in the case of anemia, the  
 8 non-malignant condition that Graft Versus  
 9 Host Disease is the most likely cause of  
 10 death.

11 Another study that followed the  
 12 group of patients over a long period of time  
 13 is the Norwegian study which that found that  
 14 the relapse rate at one year was only 5  
 15 percent for allogeneic transplantation, 18  
 16 percent for autologous transplantation and 7  
 17 percent for high-dose chemotherapy. Among  
 18 the other things that the study reported is  
 19 that the patients who were working or  
 20 studying before the time of transplantation,  
 21 that 69 percent of those returned to work  
 22 within two years, if they had had bone  
 23 marrow transplants; and that compares  
 24 favorably to the 65 percent that returned to

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1 marrow transplantations. The general method  
 2 that I use in doing this was to first  
 3 estimate the average prevalence of bone  
 4 marrow transplantation in Rhode Island. For  
 5 that, I used a Department of Health  
 6 publication on the incidents by cancer in  
 7 Rhode Island over a period of 1997 to 2001.  
 8 Now, I used it, it's a five-year period.  
 9 The data have been out there, so there  
 10 should be no surprises to anyone that all  
 11 that cancer data is there. As a result of  
 12 having been used quite a bit, one has some  
 13 confidence of the percentages. That is not  
 14 in the report.

15 I requested additional data of  
 16 John Fulton from the Health Department.  
 17 Dr. Fulton could tell me the prevalence of  
 18 disease by age groups. I wrote this down  
 19 for the adults ages 20 to 69. I used the  
 20 group 20 to 69 because the cancer data are  
 21 given in five-year age groups, and this is a  
 22 simple one to relate to the literature; and  
 23 again, I'm trying to be as transparent as  
 24 possible in doing the analysis and making

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1 work after receiving intense chemotherapy.  
 2 In the next slide continues,  
 3 additional quality of life studies. You can  
 4 see the Austrian study that looks at a group  
 5 of syngeneic HLA, identical allogeneic and  
 6 other survival rate was 83 percent, 76 at 15  
 7 years ago. That some of the males and  
 8 females both parented children; and then a  
 9 Canadian study that looked at the  
 10 psychological effects of transplants  
 11 reported that the biggest long-term  
 12 psychological result was fatigue that  
 13 continues to occur up to five or ten years  
 14 post-transplantation.

15 And then, finally, a study at  
 16 St. Jude's in Memphis for children that had  
 17 had bone marrow transplantation found that  
 18 there was an elevated distress among the  
 19 children, but by the time they left the  
 20 hospital, most of those children had  
 21 returned to normal stress levels, so they  
 22 tolerated the procedure very well.

23 Now, this leads me into the report  
 24 on estimating the appropriateness of bone

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1 the presentation here. If you want to use a  
 2 different age group, you can modify this  
 3 quite easily, but this seems to make a lot  
 4 of sense.

5 If you look at the breakdown,  
 6 for example, Dana Farber reports that in  
 7 their bone marrow transplants unit with  
 8 Children's Hospital that they treat patients  
 9 up to age 23. And they report that in their  
 10 adult unit with Brigham & Women's they treat  
 11 patients down to age 17, so there's an  
 12 overlap here and sometimes the decision of  
 13 where to treat depends on whether the  
 14 disease is typically an adult disease that  
 15 can be treated in an adult place that's  
 16 accustomed to handling that disease or vice  
 17 versa. Then I looked at the selection of  
 18 treatment based on the literature and looked  
 19 at a great deal of literature here, some of  
 20 which I have included in the references to  
 21 my patients, but I looked at the literature  
 22 beyond that; and based on that, have  
 23 attempted to determine which of the patients  
 24 who have the particular type of cancer would

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1 be viewed as appropriate candidates for bone  
 2 marrow transplantation. And then for the  
 3 infrequent indications, what I have tried to  
 4 do there is since the numbers would be so  
 5 small in Rhode Island, that I have very  
 6 little confidence in them to try to link  
 7 those to existing registries and to give a  
 8 general order of magnitude for those numbers  
 9 based on what one would expect by looking at  
 10 much larger groups of patients. With that  
 11 in mind, then I have gone through this for  
 12 the potential adult patients for stem cell  
 13 transplantation here and broken it down into  
 14 the most likely reasons for having stem cell  
 15 transplant. And based on the literature and  
 16 the reported incidents and prevalence, I  
 17 come up with these numbers.

18 For AML, that's Acute  
 19 Myelogenous Leukemia, the average incidents  
 20 from 1997 to 2001 in Rhode Island is 42.6  
 21 cases. Of those 16 cases, 38 percent were  
 22 in the adult age group. That is age 20 to  
 23 69. Of those, when I look at the percentage  
 24 of patients that are likely to be a

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1 that are likely to be treated for the  
 2 adults, those are included there. And the  
 3 non-malignant conditions are linked to data  
 4 from the EBMT group that reports that about  
 5 5 percent of the adult bone marrow  
 6 transplantations in Europe are for  
 7 non-malignant conditions.

8 Then once I had an estimate of  
 9 the cases that might be appropriate, I know  
 10 that I need to adjust that. Now, I used the  
 11 year 2000 as a base year for a couple of  
 12 reasons. First, that's a census year, and  
 13 we have good census data. Second, that is  
 14 one of the mid years of the source that I  
 15 used for cancer incidents data. And the  
 16 third is a lot of the comparative studies  
 17 that you might want to look at can be most  
 18 easily reported based on the year 2000  
 19 patients, so my 88.2 appropriateness, case  
 20 appropriateness estimate is, for Rhode  
 21 Island patients, that is patients living in  
 22 the, within the state boundaries in the year  
 23 2000. Rhode Island Hospital reports a  
 24 secondary market area that includes adjacent

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1 candidate for transplant, three of those 16  
 2 patients would probably be a candidate.  
 3 Similarly, for the ALL, another 18.4 average  
 4 incidents. Four cases were in the adult age  
 5 group, and I expect only one of those would  
 6 be a candidate for transplant. For CML, 18  
 7 patients or 18.6 patients, were the average  
 8 incident, ten of which were in the adult age  
 9 group, and 1.5 and so forth for the others.

10 Now, in the case of solid  
 11 tumors, there's insufficient evidence in  
 12 Rhode Island to let me do that, so I linked  
 13 the solid tumors to data from the European  
 14 group for bone, blood and marrow  
 15 transplantation and based my estimate on  
 16 that and similarly for the non-malignant  
 17 conditions. Let me correct that. The solid  
 18 tumors I actually worked out a specific  
 19 study that was done by the European group  
 20 for blood and marrow transplantation that  
 21 looked at specific solid tumors that were  
 22 going to be transplanted. I subtracted out  
 23 those solid tumors. Frequently in the  
 24 pediatric cases and of the remaining ones

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1 cities and towns in Massachusetts, and that  
 2 is similar to one that they had used before  
 3 and I have looked at in regard to  
 4 cardiovascular services and found that a  
 5 reasonable secondary market area.

6 For the secondary market area,  
 7 I'm using 50 percent rate as a rate that I  
 8 suggest is appropriate that they will use  
 9 about half the rate of Rhode Island, and the  
 10 other half will perhaps go to Boston. Now,  
 11 I did not do a separate estimate for outflow  
 12 from Rhode Island to the Boston area.  
 13 That's actually captured in here, too. If  
 14 you believe that the secondary market area  
 15 should be greater than 50 percent, then it's  
 16 a simple matter here to simply increase the  
 17 1.22 to 1.44 until you use a hundred percent  
 18 or you can cut it in half. If you think  
 19 only 25 percent, you could make it 1.11, so  
 20 it's an easy adjustment if you believe that  
 21 this should be a different number. Again,  
 22 the purpose here is to be transparent and  
 23 give you a method for estimating what these  
 24 quantities are going to be.

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1 Then since population is  
 2 growing over time with this particular age  
 3 group, I looked at the population growth  
 4 from 2000 to 2010. I used the ten-year  
 5 period here, again, because that data are  
 6 available from the state-wide planning here  
 7 in Rhode Island, and I could report the data  
 8 to you simply, and it shows that there's an  
 9 increase in population that state-wide  
 10 planning expects to be 7 percent over this  
 11 ten-year period. If you want to look at  
 12 what it would be in 2007, then you can  
 13 reduce this number to, let's see my notes  
 14 here, reduce it to 5 percent that the  
 15 population is expected to grow, up between 5  
 16 percent between 2000 and 2007, again,  
 17 interpolating the numbers by state-wide  
 18 planning.

19 Not all cases of bone marrow  
 20 transplants are going to get transplanted.  
 21 Some of the patients will decide not to have  
 22 it. Some will have disease that relapses  
 23 before it's expected. In some cases, it  
 24 will not be possible to find appropriate

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1 types of cancer, it's been found that if a  
 2 patient receives a transplant, is given a  
 3 period of time to recover and then is  
 4 treated and receives a second transplant,  
 5 that they do better. That's particularly  
 6 true in cases of multiple myeloma. When I  
 7 looked at cases of that, I found that Roger  
 8 Williams Hospital reports that 12 percent of  
 9 their transplants are actually retransplants  
 10 or multiple transplants. That is a little  
 11 lower than I would expect based on the  
 12 literature. The number I have used here is  
 13 17 percent retransplant rate comes from the  
 14 European group on blood and marrow  
 15 transplantation. And I think that will  
 16 better reflect the recommendations in the  
 17 medical literature that multiple myeloma  
 18 patients in particular will do better with  
 19 more transplants.

20 So, when I make all of these  
 21 changes and adjustments, my potential  
 22 estimate for adult transplants in greater  
 23 Rhode Island, that is Rhode Island and  
 24 southeastern New England, in the year 2010

810

1 marrow sources or stem cell sources. In  
 2 looking at the propensity, that is the  
 3 number of appropriate patients that would  
 4 proceed to transplantation, I looked at  
 5 clinical trials that I had used for other  
 6 sections of the report. And for those  
 7 clinical trials, many of them simply compare  
 8 the results in patients that are selected as  
 9 appropriate for transplantation. Those that  
 10 have appropriate donor source receive  
 11 transplantation. Those that don't receive  
 12 the best alternative treatment. And based  
 13 on that, it's possible to look at the number  
 14 that are accepted for transplantation that  
 15 actually proceed to it.

16 And from a number of studies  
 17 here, you can see that both for adults and  
 18 children it seems like 70 percent is a  
 19 reasonable number there, and that seems to  
 20 be true whether you're dealing with  
 21 autologous or allogeneic transplants.  
 22 Finally, you have to take into account the  
 23 fact that there are retransplants and  
 24 multiple transplants. For some particular

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1 is 94.3 adult cases. For 2007, if you  
 2 adjust that, it becomes 92.5 cases. Then if  
 3 we know the number of cases, we can begin to  
 4 look at the need for adult bone marrow  
 5 transplants beds. Again, first, we need to  
 6 know the average length of study and the  
 7 HCUP Project, the Hospital Cost and  
 8 Utilization Project, that is done by the  
 9 agency for Health Care Research and Quality  
 10 is the source that I used here. They report  
 11 that for adults the average length of study  
 12 is 24.1 days. Actually, that's not very far  
 13 from the experience at Roger Williams  
 14 reports of 23.7 days in 2006. Then I looked  
 15 at the literature for evidence of  
 16 readmission for the patients that do not do  
 17 so well and have to be readmitted to the  
 18 hospital and the couple of articles that I  
 19 have found with five days or second article  
 20 with a little more for City of Hope, but I  
 21 used the more conservative number of five  
 22 days here giving me an estimate that 29.1  
 23 days is probably the average length of stay  
 24 for adult bone marrow transplant.

811

1 Multiplying that by the expected average  
2 number of patients gives me an estimate of  
3 total patient days of 2000, 744 patient days  
4 and that an 80 percent occupancy rate that  
5 would give us 9.4 beds, which I round out to  
6 ten beds.

7 Again, if you want to reduce  
8 that to 2007 numbers, the number is 9.2  
9 beds, which I would again round to ten beds.  
10 Now, these are the cases in which the, we  
11 are using the bone marrow transplantation  
12 for established uses, and I will talk about  
13 research uses later. Then I go through the  
14 same process for the pediatric cases, for  
15 the potential pediatric cases. You can see  
16 that the AML cases, out of the 42.6, only  
17 two of those patients were in the zero to 19  
18 age group based on Rhode Island data, and I  
19 expect very few cases of AML to be treated  
20 here. In this case, 0.3 cases or one case  
21 every three years.

22 For the ALL, again, there are  
23 13 cases, in which I expect about 3.7 cases  
24 to be treated per year. For Non-Hodgkin's

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1 the 15 percent of the patients that are  
2 expected not to have good outcomes based on  
3 the chemotherapy times the 30 percent for  
4 which we expect the patient to have an  
5 appropriate donor, then you get four and a  
6 half percent of those 20 patients that would  
7 be expected to be appropriate candidates for  
8 stem cell transplantation; and four and a  
9 half percent of 20, I think, is 0.9.

10 In the case of Hodgkin's  
11 Disease, I see I was a little abrupt in my  
12 explanation there, but the 20 percent number  
13 that I have used there is simply the same 20  
14 percent number that I used for adults  
15 because the literature reports that  
16 adolescents and young adults react to bone  
17 marrow transplantation in much the same, and  
18 other alternative means of cancer treatment,  
19 in much the same way that the adults do.  
20 There was only one Hodgkin's Disease case in  
21 the age group, and 20 percent of that is my  
22 estimate for 0.2. You can see that these  
23 numbers are all small. In the case of solid  
24 tumors, again, those are a heterogeneous

814

1 Lymphoma, I noted that I had put the wrong  
2 numbers in the tables. There's a typo in  
3 the table that should have read a total of  
4 20 potential pediatric patients, 9 percent  
5 of the 231 patients, and that 0.9 percent is  
6 the number there.

7 When I looked at my discussion  
8 in that table, I saw that I quit writing  
9 before I gave you all of my methodology, so  
10 I left you hanging there. My conclusions  
11 based on the literature and the discussion  
12 in that section, that's two pages earlier,  
13 what I concluded that it's, that for a  
14 Non-Hodgkin's Lymphoma patient, about 85  
15 percent will have long-term survival. That  
16 the other 15 percent would be, would  
17 potentially benefit from bone marrow  
18 transplantation.

19 In the case of pediatric  
20 patients, the use of unrelated donor is a  
21 controversial issue; so, I reduced that to  
22 30 percent of those patients. That is those  
23 patients that are expected to have a family,  
24 a matched family donor; so, if you multiply

813

1 group of different tumors, likely to be  
2 small numbers and hard to estimate based on  
3 Rhode Island numbers.

4 What I did in this case was to  
5 link that to a study that was done looking  
6 at HCUP data for pediatric cases for 1997  
7 and through 2001, and looked at the average  
8 number of solid cases that would be expected  
9 based on the relative number of leukemic  
10 cases at New England rates. If you look at  
11 these numbers, it's interesting to note that  
12 the coasts use more bone marrow  
13 transplantation than the interior sections  
14 of the country.

15 The East Coast and the West  
16 Coast report greater or higher utilization  
17 rates than do the Midwest and the South. In  
18 the case of non-malignant conditions, this  
19 is an important and drawing area. I have  
20 not put an number in there. I will tell you  
21 what my problem is. When I read the  
22 literature on this, the results are glowing,  
23 that you would get things like 100 percent  
24 survival at one year, 100 percent survival

815

1 at two years and very good results. Then  
 2 you look at the actual utilization data of  
 3 pediatrics for non-malignant conditions, and  
 4 those numbers are small, and I don't know  
 5 what that means. If the conditions can be  
 6 treated as readily as the literature would  
 7 suggest, then more doctors should be  
 8 recommending that their patients get bone  
 9 marrow transplantation. That's not the  
 10 case. So, I simply have left that area  
 11 blank and note that possibly the explanation  
 12 here is that these studies are sufficiently  
 13 new that the physicians are waiting to see  
 14 if additional studies will substantiate the  
 15 results, and maybe that's a result.

16 If you look at the trends page  
 17 on the National Marrow Donor Program web  
 18 site, you will see one of the things that  
 19 they say is a coming trend for bone marrow  
 20 transplantation are non-malignant conditions  
 21 for pediatric patients. So, this is maybe  
 22 an emerging area that needs to be put in  
 23 there later, although I'm not comfortable in  
 24 actually putting a number on that now.

816

1 year 2007, it would be 8.2 cases. Then  
 2 going through the same process, the estimate  
 3 bone marrow transplants bed need, the  
 4 average length of stay according to HCUP  
 5 data is 36.2 case. The readmission rate,  
 6 there's less data on this than there is for  
 7 adults, but again, it looks like five days  
 8 is a reasonable number for that giving an  
 9 expectation that a patient in the hospital  
 10 would stay on average 41.2 days. With an  
 11 annual incidence of 8.1 bone marrow  
 12 transplants patients, that would give us 334  
 13 patient days at 80 percent occupancy. That  
 14 would require 1.14 beds, which I rounded to  
 15 two. Now, I note in particular in pediatric  
 16 beds, when I looked at the data on length of  
 17 stay for bone marrow transplantation for  
 18 both adults and for pediatric cases, I see a  
 19 very wide range. In the case of adults, if  
 20 you look at a statistical measure, the  
 21 standard error of the mean, it's less than  
 22 one day. Meaning that even though there is  
 23 a wide range of different length of stay  
 24 that patients have, that most of the

818

1 Then the next slide shows you  
 2 that I go through the same process for  
 3 adjusting appropriate pediatric cases for  
 4 probably utilization. Again, the best case  
 5 for pediatric cases in the year 2000 is 8.6  
 6 cases. The secondary market area in Rhode  
 7 Island, the population is .24 at 50 percent  
 8 rather than .22 for adults. The population  
 9 is actually expected to decrease for this  
 10 population group in Rhode Island. By 2010,  
 11 it's expected to be at 97 percent of the  
 12 year 2000 census population. I used the  
 13 same propensity for transplantation of 70  
 14 percent because that seems to be reported  
 15 for both adults and pediatric studies. The  
 16 replant, multiple transplant rate is reduced  
 17 to 1.12 percent rather than the 1.17 percent  
 18 that I used before, because pediatric  
 19 patients do not have multiple myeloma and  
 20 those tandem transplants need to be taken  
 21 out of that. Given this, the potential  
 22 pediatric transplants for greater Rhode  
 23 Island in the year 2010 is 8.1 cases; or if  
 24 you want to interpolate an estimate for the

817

1 patients are clustered around the average.  
 2 But when you look at the pediatric patients  
 3 here, for the age one to 17 age group, the  
 4 standard error of the mean is 4.7 days.  
 5 That means that the patients are spread much  
 6 more thinly about the mean number of cases,  
 7 and it is much more likely that a hospital  
 8 is going to find itself with long-stay  
 9 patients and two or three at the same time  
 10 than would be the case for adult patients.  
 11 In this case of the zero to one patients,  
 12 the standard error of the mean is greater.  
 13 It's 20 days, which tells you that the mean  
 14 number is a volatile figure and one that you  
 15 need to plan for some excess capacity if you  
 16 want to be able to have the ability to admit  
 17 a patient when a patient needs to be  
 18 admitted to the bone marrow transplant unit.

19 So, in this case, this is one  
 20 of the reasons that I rounded this up by a  
 21 substantial amount. Now, I wondered if that  
 22 made sense, so, and this is not in the  
 23 report. I'm going outside for a moment. I  
 24 looked at Dana Farber, at Children's

819

1 Hospital to find out what their utilization  
 2 rate was. They reported that in the last  
 3 two years, for which I have data, which is a  
 4 later table you will see here, that they had  
 5 65 patients in one year and 75 the other  
 6 year. They also report that they have 15  
 7 beds. So, when I go through the same  
 8 process and estimate the bed need based on  
 9 my expected average length of stay, the Dana  
 10 Farber occupancy rate turns out to be right  
 11 around 50 percent. One year they have 65  
 12 patients. That gives an occupancy rate of  
 13 about 48 percent. One year they have 75  
 14 patients, which gives an occupancy rate of  
 15 55 or 56 percent; but in either case, they,  
 16 again, apparently, are reacting to the  
 17 highly erratic length of stay that you see  
 18 in the case of children.

19 Well, we know now about how  
 20 many beds we need, what's available to  
 21 satisfy this need. So, first, looking at  
 22 Roger Williams Medical Center, they were  
 23 approved for five bone marrow transplant  
 24 beds in 1992 and report that they began

820

1 A. Then to look at the availability of  
 2 other stem cell transplant facilities in the  
 3 New England area, first, I look at the  
 4 Boston stem cell centers. You can some  
 5 that, of the seven centers here, Beth Israel  
 6 does only adults, as does Boston Medical  
 7 Center. Dana Farber, Brigham and Women's,  
 8 Lahey Clinic and Tufts New England Medical  
 9 Center. That we have two pediatric  
 10 transplant centers, the Dana Farber  
 11 Children's Hospital and the Tufts New  
 12 England Medical Center treat children, and I  
 13 have indicated the ones that do both  
 14 autologous and allogeneic, and the two that  
 15 do only autologous with adults at Boston  
 16 Medical Center and Lahey Clinic. If you  
 17 look at the web sites and the various  
 18 advertising that hospitals do for their bone  
 19 marrow transplant centers, the one thing  
 20 they seem most proud of is FACT  
 21 accreditation. I will discuss that program  
 22 in more detail in a few minutes, but for the  
 23 moment, I note that all of these Boston  
 24 centers are FACT accredited.

822

1 operation in 1994. We surveyed the hospital  
 2 and found out some data here. That over the  
 3 five-year period, 2002 through 2006, they  
 4 treated an average of 23.6 patients per year  
 5 or 23.6 transplants per year. Some of those  
 6 were retransplants. That the average length  
 7 of stay is, in 2006, were 23.7 days. If you  
 8 look at the entire five-year period, the  
 9 average length of stay is 19.5 days. The  
 10 hospital reports that on average they have  
 11 eight investigational transplants per year.  
 12 That is a good thing. That indicates that  
 13 the hospital is doing research, which I  
 14 think is very important in the area of stem  
 15 cell transplantation. The hospital reports  
 16 that they have not done any cord blood stem  
 17 cell transplants, and also, that they became  
 18 a National Marrow Donor Center, Donor  
 19 Program Center in April of 1906 (sic).

20 Q. Excuse me, would you repeat that date? They  
 21 became when?

22 A. They became a National Marrow Donor  
 23 Program Center in April of 2006.

24 MR. MILLER: 2006. Thank you.

821

1 And then, finally, I have given  
 2 the 2005 cases, actually, there are some  
 3 reports of 2006, but there's a lot of blanks  
 4 in that, so I have used the latest year for  
 5 which there's pretty much complete data; and  
 6 you can see that Beth Israel did 47 cases in  
 7 2005. Boston Medical Center did 41  
 8 autologous cases. Dana Farber, Children's  
 9 did 65. Dana Farber, Brigham and Women's  
 10 did 363. This is a large number. Their  
 11 typical number are around 240 so cases a  
 12 year. I don't know if something unusual is  
 13 going on there or there is a typo or a  
 14 misreporting there. Lahey Clinic does only  
 15 about 13 per year, and Tufts New England  
 16 Medical Center did 50 in 2005. For the  
 17 other New England area stem cell transplant  
 18 centers, the U-Mass. Medical Center in  
 19 Worcester does only adult patients. They  
 20 are FACT approved and did 47 cases in 2005.  
 21 Yale-New Haven is, does only adult patients,  
 22 again, FACT accredited, and did 170.  
 23 Actually, the 170 number comes from their  
 24 web site since they did not report to the

823

1 source that I used for this table. There is  
 2 a small program at Stamford Hospital in  
 3 Connecticut that does only autologous cases  
 4 and are not FACT accredited and did four  
 5 cases in 2005. Maine Medical Center  
 6 similarly does only autologous patients, are  
 7 not FACT accredited and did 21 cases in  
 8 2005. Dartmouth Hitchcock does an adult  
 9 program for which part of it is approved,  
 10 the autologous part is approved, but not  
 11 FACT approved, but not the allogeneic. They  
 12 did not report the number of cases. They,  
 13 like Roger Williams, are a recent member of  
 14 the National Marrow Donor Program; and as a  
 15 result of being a recent member, have not  
 16 reported the historical data there.

17 Finally, the University of  
 18 Vermont does autologous cases, not FACT  
 19 approved and did ten cases in 2005. So,  
 20 these are the different sources.

21 Now, the question is, this is  
 22 an expensive proposition. Could we afford  
 23 to pay for it, so I went through in my paper  
 24 a number of different studies that looked at

824

1 the institutions based on what they say the  
 2 resources for providing these costs, and  
 3 then HCUP takes the Medicare ratio of cost  
 4 of charges and applies that to the cost to  
 5 estimate what the charge data will be. So  
 6 these charge data are a synthetic estimate  
 7 that may not be a measure of what anyone  
 8 actually pays.

9 If you read the literature on  
 10 this, the common feeling is that the average  
 11 cost of a bone marrow, typically, would be  
 12 about \$150,000 for an allogeneic transplant  
 13 and about \$80,000 for autologous transplant.  
 14 I have used the higher numbers that we have  
 15 here. Then I looked at what this would add  
 16 to the hospital costs in Rhode Island, if  
 17 the costs that are not being done at Roger  
 18 Williams or the patients, the cases that are  
 19 not being done at Roger Williams Hospital  
 20 were done somewhere else. The Rhode Island  
 21 cost at these rates for 70.7 additional  
 22 adult bone marrow transplants and 8.1  
 23 pediatric bone marrow transplants would be  
 24 \$50 million. The Rhode Island cost for 20.4

826

1 the cost of stem cell transplantation. The  
 2 problem with most of the studies is that  
 3 they like to report typical studies. As a  
 4 result of that they report medians instead  
 5 of averages and with medians, with the long  
 6 tail skewed to the right, you get an  
 7 underestimate of the total cost of the  
 8 program. So, I went back to the HCUP data  
 9 that I have used in the estimated stay and  
 10 looked at that data. While looking at it  
 11 for the latest year for which it is  
 12 reported, 2004, they report that the  
 13 expected cost of a bone marrow transplant is  
 14 61,755. Now, when I look at that in the  
 15 context of a historical trend, that is less  
 16 than I would expect. There is a definite,  
 17 significant trend in the cost data that  
 18 would led me to expect that data to be  
 19 70,300 in 2004. Similarly, they report  
 20 actual costs from their sample in 2004, or  
 21 actual charges of \$154,700; and I project,  
 22 based on trend, that that number is more  
 23 likely to be \$190,024. Now, the cost data  
 24 are data that HCUP actually collects from

825

1 transplants not now done, that is taking out  
 2 the number that Rhode Island Hospital says  
 3 is being performed in the Boston area  
 4 hospitals, and I project that we would need  
 5 some additional 20.4 to be my estimated  
 6 need, would be \$388 million additionally  
 7 that the health care system is not now  
 8 paying for.

9 Based on the reports to the  
 10 American Hospital Association, the 2006  
 11 hospital statistics reports that, based on  
 12 2004 hospital data, that the expenditure for  
 13 hospital services in Rhode Island now  
 14 exceeds \$2 billion per year. So, the  
 15 addition, regardless of how you look at it  
 16 here, to Rhode Island Hospital expenditure  
 17 from either doing the additional costs,  
 18 either doing the additional cases that are  
 19 not being done at Roger Williams or doing  
 20 just the cases not being done in any  
 21 hospital, would be less than 1 percent of  
 22 Rhode Island total hospital expenditures.  
 23 We are not talking about a major addition to  
 24 the total hospital cost of Rhode Island if

827

1 this program were to be approved.  
 2 Now, not included in my power  
 3 point presentation I should also note that  
 4 some of the studies actually looked at a  
 5 cost benefit analysis of bone marrow  
 6 transplantation. Something that economists  
 7 tend to care a lot about and not maybe other  
 8 people care too much about, but the analysis  
 9 shows that the, the pediatric cost per year  
 10 of lives saved is about \$12,000. And that  
 11 the cost per year of life saved for adults  
 12 with non-lymphocytic Leukemia is about  
 13 \$20,000. By way of comparison, economists  
 14 consider that any cost per year of life  
 15 saved of less than \$50,000 is usually a good  
 16 investment. So, the cost benefit data  
 17 support the, this particular treatment  
 18 method.

19 Then we seem to be talking a  
 20 lot these days about volume and quality; so,  
 21 I looked at the literature for indications  
 22 of how volume is related to quality. There  
 23 are several studies that have been done.  
 24 These studies go back over a long period of

828

1 time. The, to generalize the findings of  
 2 the studies, the basic finding is that the  
 3 volume outcome effect is, apparently, at  
 4 very low volume. That the Japanese study  
 5 found that there's significant worse results  
 6 for hospitals that do four to ten cases per  
 7 year and that hospitals that do more than  
 8 ten cases per year have superior results.  
 9 The IBMTR study shows that hospitals that do  
 10 more than six cases per year have better  
 11 outcomes. The only one of appreciable  
 12 volume here is the European group for bone,  
 13 or for blood and marrow transplantation  
 14 study that reported that 39 cases was the  
 15 threshold at which better results appeared;  
 16 and finally, a French study looking at ten  
 17 cases per year did not find any significant  
 18 relationship between the volume and the  
 19 outcome effects. Of these studies, the best  
 20 study is the Japanese study, and the  
 21 Japanese bone marrow transplant system is  
 22 organized in a way different from any other  
 23 country, I guess, in that any hospital can  
 24 offer a bone marrow transplant program that

829

1 does autologous transplants or does  
 2 allogeneic transplants from matched family  
 3 members. However, only specialized  
 4 hospitals that are accredited by the  
 5 government are allowed to do unrelated donor  
 6 transplants.

7 Now, when the Japanese looked  
 8 at their volume effect, they found that for  
 9 the unrelated donor transplants, that there  
 10 was no volume effect. That all the  
 11 hospitals had good results. When they  
 12 looked at the only family or the autologous  
 13 transplants, they found the volume effect  
 14 existed for all transplants. When they did  
 15 a subgroup analysis, they found the volume  
 16 effect also existed for Leukemia outcomes  
 17 but did not exist for some other things like  
 18 MBS -- I will give you the acronym. And  
 19 based on the results of the finding, the  
 20 recommendations by the authors of this study  
 21 were not that there be volume limits on  
 22 family-related donors but rather that all of  
 23 the hospitals in Japan be accredited like  
 24 the one for the unrelated donors. That is

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1 the direction that they chosen to recommend  
 2 based on their study.

3 Well, there are also other  
 4 indications of the relationship between the  
 5 quality of hospitals, one of which the  
 6 accreditation organizations that do bone  
 7 marrow transplant programs, the two of them  
 8 that I have looked at here are, one, first,  
 9 the National Donor Marrow Program that Roger  
 10 Williams now belongs to. My findings on  
 11 this vary from what some of the other people  
 12 have reported on the National Donor Marrow  
 13 Program. When I looked at their web site, I  
 14 found that a four-page description of the  
 15 qualifications of the program needs to  
 16 qualify for the NDMP program, and they say  
 17 that you need at least ten allogeneic  
 18 patients per year for 24 months or 20  
 19 allogeneic patients in 12 months in order to  
 20 apply for the program accreditation, and  
 21 that the program also needs appropriate  
 22 survival experience for the allogeneic  
 23 patients. I did not find any mention of  
 24 autologous transplants at all in that

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1 requirement program, but I did not look at  
2 this in depth.

3 The other one is the Cadillac  
4 of the accreditation programs here, the  
5 Foundation for Accreditation of Cellular  
6 Therapy. This program was founded in 1996  
7 by groups in Europe and the U.S. that were  
8 interested in accrediting bone marrow  
9 transplants programs. As a result, they  
10 have a very thorough program for  
11 accreditation, and the people who do receive  
12 their accreditations seem to be very proud  
13 of it. They require that there be at least  
14 ten new patients in the past twelve months  
15 in order to apply for the program for either  
16 the autologous transplant or the allogeneic  
17 transplant. Those can be approved  
18 separately, and we know before, in the  
19 Boston cases, that, indeed, that was the  
20 case. For the, or actually, it was  
21 Dartmouth. If you're going both autologous  
22 and allogeneic transplantations, then the  
23 program would need to have 20 new patients  
24 in the past twelve months with at least ten

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1 research going on are the programs that are  
2 doing a lot of bone marrow transplantation  
3 and the programs that are getting superior  
4 results. I think that any of these programs  
5 at Roger Williams, Rhode Island or Boston,  
6 need to participate in multi-center clinical  
7 trials, and we saw some indication that  
8 Roger Williams is, indeed, doing that. I  
9 think that, in particular, the programs need  
10 to pay attention to solid cancers. Again,  
11 the National Marrow Donor Program reports  
12 that solid cancers are one of the areas in  
13 which there's a trend to more  
14 transplantation being done.

15 And finally, I think that  
16 non-malignant applications deserve  
17 additional study. I have indicated that I  
18 had some problems with that for the  
19 pediatric cases, but that's also very  
20 important for the adult cases. More and  
21 more cases are being found in which  
22 autoimmune diseases can be treated by bone  
23 marrow transplantation. A recent article in  
24 the New England Journal reported that a

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1 of those patients allogeneic patients and at  
2 least four of those autologous patients.

3 And finally, if you're  
4 interested in doing a pediatric and an adult  
5 program, you need a minimum of four new  
6 patients for the pediatric group in addition  
7 to satisfying the above requirements. So,  
8 these are indications of the volume that  
9 accrediting organizations think that's it is  
10 important for various programs to have.

11 Well, based on my analysis,  
12 this is my results, summarized, that I think  
13 that in order to treat the needs of the  
14 greater Rhode Island patient population,  
15 that there needs to be ten adult bone marrow  
16 transplant beds and two pediatric bone  
17 marrow transplant beds.

18 I think that these programs,  
19 whether they be at Roger Williams, the  
20 Boston hospital or at Rhode Island Hospital,  
21 if that program is approved, needs to be  
22 contributing to the clinical bone marrow  
23 transplant research and looking at all of  
24 this. The programs that have a lot of

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1 Brazilian transplant program had done this  
2 effectively for Type I diabetes, and there  
3 are numerous studies being done now to treat  
4 things like Lupus and Multiple Sclerosis and  
5 systemic sclerosis and things like that.

6 Finally, I think that we need  
7 access to a cord blood bank in Rhode Island.  
8 I don't think this is something that can be  
9 taken lightly and simply added as a  
10 requirement to Rhode Island Hospital is  
11 something that needs to be done in a  
12 coordinated matter between all the bone  
13 marrow transplants units in the state,  
14 including Women and Infants Hospital, which  
15 would be the source of the blood, of Rhode  
16 Island Hospital, if that program is  
17 approved, and Roger Williams Medical Center.

18 Finally, I think that  
19 non-malignant diseases in children need  
20 additional study. Again, the results of the  
21 literature indicate that there's very  
22 promising results from using this; and as  
23 far as I can see, very little is being done  
24 in Rhode Island either by Rhode Island

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1 institutions or any other Boston institution  
2 to treat these conditions in children; so, I  
3 think it deserves some additional attention.  
4 So, based on my findings, my last slide here  
5 is my recommendations, and these are general  
6 recommendations.

7 The next slide, Val. I think  
8 that the bone marrow transplant unit serving  
9 the greater Rhode Island patients need to  
10 have a capacity to do 94.3 adult transplants  
11 per year, that would be about ten plants,  
12 ten bone marrow transplant beds in order to  
13 meet established uses. In addition, I think  
14 there should be one or two beds for research  
15 depending on the reserve projects that are  
16 being done. This is 70.7 transplants beyond  
17 what Roger Williams Medical Center is  
18 providing. I think there needs to be a  
19 capacity for 8.1 pediatric transplants for  
20 the greater Rhode Island population, which  
21 would be two bone marrow transplants beds,  
22 and I think this would provide for its own  
23 sufficient capacity to do some research on  
24 children's cases.

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1 timing-wise it would be a better use of time  
2 if Roger Williams went next, and I could  
3 just follow up with things that may need  
4 clarification.

5 MR. DEVEREAUX: I can  
6 understand why they would like me to go  
7 first, but frankly, I think the procedure is  
8 they are the Applicant. They have the right  
9 to ask the questions, then any other people  
10 from the public have the right to ask  
11 questions. I don't think it makes much  
12 difference whether, who has more questions,  
13 based on the history of the questions in the  
14 past so far.

15 MR. McINTYRE: I have to  
16 agree. I think the Applicant ought to go  
17 first; and if you don't have have a lot of  
18 questions, that's okay. If you have an  
19 opportunity or something comes up in the  
20 course of that, you would be allowed to go  
21 back and ask a few more questions, but I do  
22 want to keep this brief.

23 MS. FREEDMAN: I'm just saying  
24 I think it's a better use of time, because

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1 And finally, I point out that  
2 there are three options for satisfying these  
3 needs. That is you could expand the program  
4 at Roger Williams Medical Center. You could  
5 approve the Rhode Island Hospital program,  
6 or you could use Boston area hospitals to do  
7 this. Which of those are chosen is  
8 Dr. Gifford's call on recommendations that  
9 would be made by the Council. Thank you.

10 MR. McINTYRE: Why don't we  
11 take a five- or ten-minute break?  
12 Mr. Devereaux?

13 MR. DEVEREAUX: Just my  
14 understanding, I believe the Applicant has  
15 the right to question first, and then we  
16 question after that?

17 MR. McINTYRE: Does the  
18 Applicant have questions?

19 MS. FREEDMAN: I think that it  
20 would be more appropriate for Roger Williams  
21 to go next, and then I can just -- because I  
22 think they are going to have more questions  
23 than I am, and I don't think there's any  
24 procedural issue here; so, I think that

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1 depending on what the -- I assume they are  
2 going to have a lot more questions than I;  
3 and I think it's a much better use of time  
4 for them to go and me just to ask the  
5 questions that I believe need to be asked as  
6 opposed to perhaps asking things that don't  
7 need to be asked. I just really do believe  
8 it would be a better use of time.

9 MR. McINTYRE: I understand  
10 that. The Applicant is going to go first.  
11 The Health Services Council will be  
12 permitted, also, to ask questions, and Roger  
13 Williams Medical Center can go second and  
14 the Council last.

15 MS. FREEDMAN: I would like  
16 the opportunity to ask follow-up questions  
17 after Roger Williams.

18 MR. McINTYRE: As long as they  
19 are reasonable questions, that's what the  
20 rules apply for, and we are going to allow  
21 that, as I said, all along.

22 (SHORT RECESS)

23 MR. McINTYRE: All right. We  
24 are back on the record. I believe the

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1 Applicant, Rhode Island Hospital, is going  
2 to begin with questioning of Mr. Zimmerman.  
3 Miss Freedman?

4 MS. FREEDMAN: Thank you.

5 EXAMINATION BY MS. FREEDMAN

6 Q. Good morning, Mr. Zimmerman.

7 A. Good morning.

8 Q. Your bottom line recommendation to the  
9 Health Services Council is that there's  
10 several options available in order to meet  
11 the need for patients in Rhode Island and  
12 the surrounding area to obtain bone marrow  
13 transplants. The first is at Roger Williams  
14 Medical Center, correct?

15 A. That's correct.

16 Q. And you will agree with me that Roger  
17 Williams Medical Center has five approved  
18 beds from the Department at this time,  
19 correct?

20 A. That's correct.

21 Q. And you were not aware of any application or  
22 CON application by Roger Williams to  
23 increase their beds for this purpose,  
24 correct?

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1 Q. And you have assumed in their analysis that  
2 they will continue to perform what they have  
3 performed in the past, which is  
4 approximately 23.4 or 24 bone marrow  
5 transplants, correct?

6 A. Yes.

7 Q. So, despite the fact that they have only  
8 done six, your analysis indicates that  
9 you're assuming, for the purposes of your  
10 needs analysis, that they will continue to  
11 do 23 to 24 into the foreseeable future,  
12 correct?

13 A. That's correct.

14 Q. Roger Williams Medical Center or Roger  
15 Williams Hospital is not FACT accredited,  
16 correct?

17 A. That's correct.

18 Q. And Roger Williams Medical Center does not  
19 have a pediatric program, correct?

20 A. That's correct.

21 Q. And there's no pediatric program in the  
22 State of Rhode Island, true?

23 A. Yes.

24 Q. You will agree with me that Rhode Island

842

1 A. That's correct.

2 Q. So, as of right now, in Rhode Island, there  
3 are five beds that are approved to meet the  
4 demand for bone marrow transplants,  
5 correct?

6 A. That's correct.

7 Q. And the second option is to approve the  
8 program at Rhode Island Hospital, correct --

9 A. Yes.

10 Q. -- which we will get to in a second. And  
11 the third is for these additional 70  
12 patients, who are not being treated at Roger  
13 Williams today or in the last five years, on  
14 average, to continue to go to Boston and  
15 other areas for the treatment, correct?

16 A. Yes.

17 Q. Now, you will agree with me that Roger  
18 Williams Medical Center has performed six  
19 bone marrow transplants since October of  
20 '06?

21 A. Yes.

22 Q. You received that data just like the rest of  
23 us, correct?

24 A. Yes.

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1 Hospital has the capability or the support  
2 services in place for a tertiary care  
3 service such as bone marrow transplant,  
4 correct?

5 A. I have not looked at that specifically,  
6 but I think that's the case.

7 Q. Okay. So, with respect to the support  
8 services that you testified to on direct  
9 examination, you're not aware of any issues  
10 with Rhode Island Hospital being able to  
11 provide 24-7 support services to these very  
12 sick patients, correct?

13 A. That's correct.

14 Q. You indicate that you utilized data from  
15 2000 with respect to cancer incidents,  
16 correct?

17 A. Yes.

18 Q. And you will agree with me that cancer  
19 incidents have not gone down in Rhode Island  
20 since that time?

21 A. Well, that depends on the type of  
22 cancer; but for the cancer that's  
23 appropriate for bone marrow transplantation,  
24 that is correct.

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1 Q. In fact, it's gone up, true?  
 2 A. It has gone up for some types of cancer  
 3 such as Non-Hodgkin's Lymphoma.  
 4 Q. And so, would you agree with me that your  
 5 cancer incident figures in your testimony in  
 6 your report are conservative?  
 7 A. If present trend continues, yes, they  
 8 are.  
 9 Q. And particularly with respect to treatment  
 10 in the form of bone marrow transplant, so  
 11 the cancers that are relevant to the  
 12 treatment if the current trend continues  
 13 will increase, correct?  
 14 A. That's correct.  
 15 Q. You also indicated that, as of 2010, there  
 16 will be a need of 94.3 bone marrow  
 17 transplants, correct?  
 18 A. Correct.  
 19 Q. But in 2007 that number is 92.5?  
 20 A. Correct.  
 21 Q. Am I fair to say or will you agree with me  
 22 that the 92.5, today in 2007, means that  
 23 Rhode Island needs ten beds?  
 24 A. Yes.

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1 transplants.  
 2 Q. And in other words, to put it simply, you  
 3 did not increase your numbers in your needs  
 4 analysis to account for the fact that there  
 5 is a trend to utilize bone marrow  
 6 transplants for non-malignant diseases,  
 7 correct?  
 8 A. That's correct.  
 9 Q. So, is it fair that if physicians continue  
 10 to see the bone marrow transplantation get  
 11 the glowing reports, as you talked about,  
 12 into the future, that your numbers would  
 13 increase accordingly?  
 14 A. For those uses, yes.  
 15 Q. So, again, your numbers are conservative  
 16 because you didn't take that into effect,  
 17 correct?  
 18 A. In that sense, yes.  
 19 Q. And you would agree with me, that with  
 20 respect to the pediatric numbers, the same  
 21 is true?  
 22 A. Yes.  
 23 Q. That you're seeing in the literature glowing  
 24 reports about the conditions being treated

846

1 Q. Okay. BMT beds?  
 2 A. Yes.  
 3 Q. All right. You're aware, are you not, that  
 4 Rhode Island Hospital's application  
 5 indicates that they will not, if the program  
 6 is approved, they will not be able to treat  
 7 or perform bone marrow transplants until  
 8 2008?  
 9 A. I did not recall that, but I accept  
 10 that.  
 11 Q. Okay. And it's fair to say, is it not, that  
 12 in 2008, if the program is approved by the  
 13 Director, that ten beds will be needed at  
 14 that time?  
 15 A. Yes, it is.  
 16 Q. Okay. Would you agree with me that in your  
 17 analysis you did not take into consideration  
 18 the fact that non-malignant conditions are  
 19 starting to be treated with bone marrow  
 20 transplantation?  
 21 A. I considered the amount that's being  
 22 done right now. I did not make any  
 23 allowance for the observed trends, that that  
 24 is an area of increasing use for bone marrow

845

1 with bone marrow transplant being very  
 2 successful but there aren't a lot of bone  
 3 marrow transplants being done for those  
 4 particular purposes at this time, correct?  
 5 A. That's correct.  
 6 Q. Is it fair to say that if the trend  
 7 continues, that the pediatric cases will  
 8 also increase?  
 9 A. Yes, it is.  
 10 Q. You also indicated in your direct  
 11 examination that the secondary pediatric  
 12 market, your analysis was 50 percent,  
 13 correct?  
 14 A. Yes.  
 15 Q. Are you aware that Hasbro Children's  
 16 Hospital has a 92 percent market share of  
 17 Rhode Island residents?  
 18 A. No, I'm not aware of the specific  
 19 number.  
 20 Q. All right. And would it be fair then,  
 21 assuming that, that Hasbro has 92 percent  
 22 market share, your 50 percent is also a  
 23 conservative number?  
 24 A. It may well be.

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1 Q. In your analysis on the adult numbers, you  
2 did not take into consideration the impact  
3 of research with respect to needing  
4 additional beds, correct --

5 A. That's correct.

6 Q. -- in your actual number?

7 A. I did not. The estimate of bed need  
8 that I established was based on accepted  
9 conventional uses and did not include a  
10 research program.

11 Q. So, is it fair to say that the ten beds are,  
12 in your analysis, are just for conventional  
13 bone marrow transplant treatment?

14 A. That's what it's developed for, yes.

15 Q. And is it fair to say that if an  
16 institution, who has a history of performing  
17 research and has a goal of performing  
18 research, would need additional beds for the  
19 research performed?

20 A. It would need additional capacity for  
21 research, that's correct.

22 Q. And that's true for the entire state,  
23 correct?

24 A. Yes, it is.

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1 A. Yes.

2 Q. And you heard her testimony with respect to  
3 the fact that if the pediatric program was  
4 approved, that certainly research was very  
5 high on her priority list, correct?

6 A. Yes.

7 Q. And would you agree with me that the two  
8 beds that you have indicated are needed in  
9 Rhode Island presently are just for  
10 conventional treatment uses?

11 A. That two beds would have some  
12 additional capacity to accommodate some  
13 research.

14 Q. But would it be fair to say that if Hasbro  
15 Children's Hospital is able, if the program  
16 was approved, and they are able to implement  
17 the types of research that Dr. Schwartz  
18 testified to, that they would need more than  
19 two beds?

20 A. I don't think that's likely in the next  
21 few years. Maybe eventually.

22 Q. All right. And with respect to the  
23 potential increase of treatment with bone  
24 marrow transplants of non-malignant

850

1 Q. So, although you're saying we need ten beds  
2 just for treatment, you're also leaving the  
3 option open that if we do research, we need  
4 more beds, right?

5 A. That's correct.

6 Q. And how many beds would we need?

7 A. One or two.

8 Q. One or two additional beds. So, your  
9 analysis is really if, if we are going to do  
10 research in Rhode Island, which you highly  
11 recommend --

12 A. Yes.

13 Q. -- we really need twelve beds, right?

14 A. That's correct.

15 Q. And with respect to pediatrics, you were  
16 here for Dr. Schwartz's testimony, weren't  
17 you?

18 A. Yes, I was.

19 Q. And certainly, Dr. Schwartz is highly  
20 acclaimed and has a robust research  
21 experience, correct?

22 A. Yes.

23 Q. And is on national oncology committees and  
24 is very involved in research, correct?

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1 conditions, would that potentially increase  
2 the pediatric beds needed?

3 A. Yes, it would.

4 MR. DEVEREAUX: Was that, yes,  
5 it would, or I guess it would?

6 THE WITNESS: Yes, it would.

7 Q. You indicated with respect to accreditation  
8 that in order to be accredited by the  
9 National Donor Marrow Program, a facility  
10 needs to perform ten allogeneic patients per  
11 year for 24 months or two years or 20?

12 A. Yes.

13 Q. Or 20 allogeneic patients in the past twelve  
14 months, correct?

15 A. That's correct.

16 Q. You are aware, are you not, that Roger  
17 Williams Hospital has not performed that  
18 amount of allogeneic patients for bone  
19 marrow transplants, correct?

20 A. Yes, I am.

21 Q. You will agree with me that the survey  
22 received from Roger Williams indicates that  
23 they performed six allogeneic transplants in  
24 2004, nine in 2005 and seven in 2006?

851

1 A. Yes.  
 2 Q. So, they have not performed the standard for  
 3 the National Donor Marrow Program since  
 4 2003?  
 5 A. That's correct.  
 6 Q. Now, in your cost analysis, you did not take  
 7 into consideration the cost, the actual cost  
 8 that patients and their families have by  
 9 having to go out of state for this  
 10 treatment, correct?  
 11 A. That's correct. No travel costs are  
 12 included.  
 13 Q. They are included?  
 14 A. Are not.  
 15 Q. Okay. So, in your cost analysis, you were  
 16 talking about the actual costs of the  
 17 treatment as opposed to the costs that  
 18 patients and their families endure in having  
 19 to go out of state for the treatment,  
 20 correct?  
 21 A. That's correct.  
 22 Q. And you did not include the actual costs or  
 23 even any of the related costs such as child  
 24 care and hotels and other issues with

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1 employment and things like that, correct?  
 2 A. That's correct.  
 3 Q. You would agree with me, though, that those  
 4 are costs that are related to the fact that  
 5 patients have to seek this or may seek this  
 6 care out of state, correct?  
 7 A. Yes, they are an important cost.  
 8 Q. And in fact, every pediatric patient at this  
 9 point has to endure those costs, correct?  
 10 A. Pediatric and adult.  
 11 Q. And it was your conclusion that the costs  
 12 associated with the Rhode Island Hospital  
 13 application was minimal to the costs of  
 14 hospitals in the State of Rhode Island,  
 15 correct?  
 16 A. Less than 1 percent, yes.  
 17 Q. And yet, the cost of life is significant, is  
 18 it not?  
 19 A. Yes.  
 20 Q. It's fair, is it not, that the cost  
 21 associated with the actual procedure, the  
 22 cost is the same whether the patient has the  
 23 procedure in Rhode Island or Boston; in  
 24 other words, it costs?

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1 A. It's expensive either way.  
 2 Q. If someone is going to undergo a bone marrow  
 3 transplant, whether it's in Rhode Island or  
 4 in Boston, there is a cost associated with  
 5 that, correct?  
 6 A. Yes, there is.  
 7 Q. And would you agree with me that keeping  
 8 those costs and keeping that money in the  
 9 State of Rhode Island is significant for the  
 10 health care delivery system in Rhode  
 11 Island?  
 12 A. Yes, it is.  
 13 Q. Because if you keep the cost in Rhode Island  
 14 and the facilities are able to obtain those  
 15 monies, they can offer other services to  
 16 patients, correct?  
 17 A. Yes.  
 18 MR. DEVEREAUX: I'm going to  
 19 object at this point. We are speculating.  
 20 MR. McINTYRE: I'm going to  
 21 allow it.  
 22 Q. Your answer was?  
 23 A. Yes.  
 24 Q. So, your bottom line opinion is that the

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1 addition of, if approved, of a program at  
 2 Rhode Island Hospital is affordable to the  
 3 State of Rhode Island?  
 4 A. Yes, it is.  
 5 MS. FREEDMAN: No further  
 6 questions.  
 7 MR. McINTYRE: Thank you.  
 8 Mr. Devereaux?  
 9 MR. DEVEREAUX: Thank you.  
 10 EXAMINATION BY MR. DEVEREAUX  
 11 Q. Good morning, Mr. Zimmerman.  
 12 A. Good morning.  
 13 Q. I just have a few questions. As I  
 14 understand, I think it was slide -- the  
 15 slides that you had on -- I think I noted 22  
 16 was the capacity. This is it. You have  
 17 94.3 adult transplants. That's, you use the  
 18 term capacity, correct?  
 19 A. Yes.  
 20 Q. Okay. And you said that came out to I think  
 21 it was 9.4 specifically?  
 22 A. Beds per year.  
 23 Q. And you rounded that up to ten?  
 24 A. Yes.

855

1 Q. It could be either nine or ten then?  
 2 A. Well, if you have nine, there's .4  
 3 patients per year that may not have, may  
 4 need the services and may not be able to be  
 5 accommodated.  
 6 Q. So, that's why you rounded it up to ten?  
 7 A. Exactly.  
 8 Q. And according to your capacity for  
 9 pediatric, that was 8.1?  
 10 A. Yes.  
 11 Q. And that, you found, equated to two beds?  
 12 A. 1.14, which I rounded to two.  
 13 Q. In your options, you have Roger Williams  
 14 Medical Center, Rhode Island Hospital and  
 15 Boston area hospitals?  
 16 A. Yes.  
 17 Q. And you're aware -- I know this has gone  
 18 back and forth -- that Roger Williams has  
 19 approval for five beds but capacity for  
 20 seven; are you aware of that?  
 21 A. I'm aware of that.  
 22 Q. Let's assume that Roger Williams has the  
 23 capacity for seven beds, as I understand the  
 24 options, one option would be to increase the

856

1 Williams Hospital have the appropriate lab  
 2 support to support ten bone marrow  
 3 transplants beds or that they have all of  
 4 the other types of things.  
 5 Q. Okay. So, when you say you're not sure,  
 6 have you looked at the data or any other  
 7 evidence; is that why you're not sure?  
 8 A. Yes. I have not looked at specifically  
 9 the capacity of either hospital to support  
 10 the beds that would exist.  
 11 Q. I see. So, when you were asked on some  
 12 questions by Miss Freedman about support  
 13 services and sort of general questions about  
 14 whether you had any doubt, you do have  
 15 doubt, at least as to the ability for the  
 16 lab services, at this point?  
 17 A. The lab services and the specific  
 18 capability to treat the cancers that would  
 19 be treated with bone marrow transplants.  
 20 Q. Okay. So, one option, as I understand it,  
 21 in your recommendations is to increase the  
 22 number of beds at Roger Williams, if that  
 23 94.3 number is a correct number?  
 24 A. Yes.

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1 capacity at Roger Williams by three beds?  
 2 MS. FREEDMAN: I object to the  
 3 form of the question.  
 4 MR. McINTYRE: I'm going to  
 5 allow it.  
 6 A. Yes.  
 7 Q. Would you agree with me that Roger Williams  
 8 already has in place a bone marrow  
 9 transplant program that they have built up  
 10 over a series of years?  
 11 A. Yes, I would.  
 12 Q. So, the cost to the health care community in  
 13 Rhode Island would be less, wouldn't you  
 14 agree, to add three beds, based on the  
 15 numbers that you project, at Roger Williams  
 16 than to create a whole, new unit at Rhode  
 17 Island Hospital?  
 18 A. For that part of the program, the beds,  
 19 that would be true. For the supporting  
 20 services, that may not necessarily be  
 21 true.  
 22 Q. When you say it may not necessarily be true,  
 23 what --  
 24 A. I'm not sure that Rhode Island or Roger

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1 Q. And add perhaps two pediatric beds in a  
 2 stand-alone unit at Rhode Island Hospital?  
 3 A. That's a possibility.  
 4 Q. The other alternative, as I understand the  
 5 numbers that you have, that you project, is  
 6 that Rhode Island Hospital -- let me ask you  
 7 this, are you aware that they have put in an  
 8 application for eight bone marrow  
 9 transplants beds?  
 10 A. I was not aware of what the exact  
 11 number was.  
 12 Q. Okay. If I told you -- well, just assume,  
 13 for the purposes of some of my questions,  
 14 that they have applied for eight.  
 15 A. Yes.  
 16 Q. Okay. If they were to be approved for eight  
 17 beds and Roger Williams had seven for a  
 18 total of 15, that clearly would be over what  
 19 the demand would require based on 94.3?  
 20 A. Even with a robust research program,  
 21 that would be more beds than we need.  
 22 Q. Okay. And in that kind of a case, I assume  
 23 there would be a negative impact on the cost  
 24 structure, if you will, for the medical care

859

1 community in Rhode Island?  
2 A. In that case, you have surplus  
3 capacity. That capacity could be used for  
4 other things such as treating any  
5 immunosuppressed patient.

6 Q. Okay. And so, from what your  
7 recommendations are, based on the 94.3  
8 number, another alternative would be Roger  
9 Williams has seven beds and Rhode Island  
10 Hospital would be approved for three adult  
11 beds and two pediatric beds?

12 A. Yes.  
13 Q. And that would serve the ten-bed requirement  
14 that you have estimated in the slide?

15 A. For established uses, yes.

16 Q. Okay. And then the third option that you  
17 looked at was, you say, Boston area  
18 hospitals?

19 A. Yes.

20 Q. And was there any particular reason you  
21 selected Boston area hospitals?

22 A. Because that's where I think most bone  
23 marrow transplant patients would go if there  
24 is not sufficient capacity in this state.

860

1 on the second slide, and but, I just want to  
2 understand it, for the purposes of the core  
3 group of Boston hospitals that you say could  
4 address the bone marrow transplant demand,  
5 did you include Lahey Clinic and U-Mass.  
6 Worcester in that?

7 A. Yes, I did.

8 Q. Okay. Did you tally up how many bone marrow  
9 transplants were actually done all totaled  
10 based on those two slides?

11 A. No.

12 Q. If I told you that it was 841, would you  
13 accept that?

14 A. That's reasonable.

15 Q. Okay. And if I told you that of those 841,  
16 576 were done in hospitals in the immediate  
17 Boston area with the exclusion of Lahey  
18 Clinic and U-Mass. Worcester; does that  
19 sound --

20 A. That's reasonable.

21 Q. That would come out to approximately 68  
22 percent of all the BMT's that you show on  
23 that slide?

24 A. Yes.

862

1 Q. Okay. And is it fair to say that you base  
2 that on the past history of the number of  
3 bone marrow transplants that are done at the  
4 Boston area hospitals?

5 A. That entered into it.

6 Q. And the reason I ask you that is I think you  
7 had a slide -- I actually numbered it 16. I  
8 don't know if your assistant can get us back  
9 there, but it was on the different hospitals  
10 with the statistics that you put up. Yes,  
11 that's it. Thank you. And I, when you  
12 say -- 2005 statistic that you used?

13 A. Yes.

14 Q. Those are 2005 actual statistics?

15 A. Yes.

16 Q. And when you say Boston area hospitals, we  
17 are not talking about U-Mass. Worcester?

18 A. I did not include them on this slide  
19 because there was more on the other slide.  
20 Presentation convenience.

21 Q. Okay. There are actually two slides to this  
22 particular -- --

23 A. That's correct.

24 Q. -- point you're making? And we have U-Mass.

861

1 Q. And if you include Lahey Clinic and U-Mass.  
2 Medical Center, the number goes up to 636 of  
3 the 841 BMTs?

4 A. Yes.

5 Q. And that actually adds up, would you accept,  
6 to 76 percent in the year 2005 if all BMT's  
7 were done in those Massachusetts  
8 hospitals?

9 A. Yes, I would.

10 Q. Now, I take it that you also factor in the  
11 Boston hospitals because of their national,  
12 and in fact, international reputation?

13 A. That would be part of it.

14 Q. And I, from what I can gather from that  
15 slide, you basically included the bone  
16 marrow, the hospitals that offered bone  
17 marrow transplant, whether auto or allo, in  
18 New England?

19 A. That's what I tried to do, yes.

20 Q. Why did you try to do that?

21 A. I thought it was important to show the  
22 entire New England area, because Boston  
23 serves not only Massachusetts and Rhode  
24 Island but also Maine, Vermont, New

863

1 Hampshire as well as patients from out of  
2 the area.  
3 Q. Okay. Now, if we look -- I think you have  
4 the statistic here for Roger Williams. It  
5 might be on the second one.  
6 A. It's on the previous page.  
7 Q. Oh, it's on the previous page?  
8 A. Back one more page. There.  
9 Q. Roger Williams did 23.6 in a five-year  
10 period, 2002 to 2006?  
11 A. That's correct.  
12 Q. Can we round that off to 24?  
13 A. Sure.  
14 Q. Okay. And if you compare, for instance,  
15 that number of bone marrow transplants,  
16 accepting the 24, the Lahey Clinic did 13?  
17 A. Yes.  
18 Q. And the Maine Medical Center did 21?  
19 A. Yes.  
20 Q. So, and I think your statistics show UVM,  
21 for instance, did ten?  
22 A. Yes.  
23 Q. And Stamford Hospital, which is in southern  
24 Connecticut, did four?

864

1 when you examined this issue back in 1992,  
2 you mention there's sufficient estimated  
3 demand for bone marrow transplantation  
4 services to support one adult unit if that  
5 unit enjoys widespread support in the Rhode  
6 Island medical community; do you remember?  
7 A. I remember that.  
8 Q. And then you went on and said the success  
9 of a Rhode Island bone marrow  
10 transplantation program will depend  
11 critically on implementing a  
12 state-of-the-art program and on having  
13 widespread support from the state and  
14 medical community?  
15 A. I think it's still important.  
16 Q. Is it fair to say that what you're talking  
17 about there is collaboration and  
18 referrals?  
19 A. Yes, it is.  
20 Q. Now, I know that you didn't examine this. I  
21 think you might have said it was outside of  
22 the scope of your report as to why Roger  
23 Williams was getting an average of 24?  
24 A. That's correct.

866

1 A. Yes.  
2 Q. So, in comparison to the outside of the  
3 Boston core group of hospitals, Roger  
4 Williams compared fairly favorably, wouldn't  
5 you say?  
6 A. Actually, not only within New England  
7 but also if you compare it to the  
8 utilization in the European group. Of the  
9 European group in the hospitals, 50 percent  
10 of the hospitals in Europe that do bone  
11 marrow transplant do 25 or fewer  
12 transplants. 50 percent do more. So, Roger  
13 Williams would be very close to that  
14 average.  
15 Q. Is that right? Now, in your, and I know,  
16 this is what was it 15 years ago now?  
17 A. Yes.  
18 Q. In your report that you did back then, I  
19 noted that at the conclusion -- if you just  
20 give me a minute to find it -- I can show  
21 you this, but I assume that you probably  
22 remember it?  
23 A. I probably do.  
24 Q. But on Page 69 of your report that you did

865

1 Q. Okay. Did you look at any issues of  
2 collaboration as to how that might have  
3 affected --  
4 A. I didn't look at any issue at all.  
5 Q. At all. You did look, though, from what  
6 you're telling me, and correct me if I'm  
7 wrong, but I think you mentioned that you  
8 looked at Dana Farber and you looked at,  
9 might have been Dana Farber and Children's  
10 Hospital, for some information in compiling  
11 your report?  
12 A. Yes, I did.  
13 Q. Did you look to see at all what kind of  
14 collaboration they were doing in Boston  
15 among those hospitals?  
16 A. I did not specifically look for that  
17 information. I do know that they have a  
18 collaborative program through Harvard and  
19 with MIT for several research programs; so,  
20 I know there is a good deal of collaboration  
21 that's going on there.  
22 Q. And can you tell us a little bit more about  
23 what you know about that partnership, that  
24 collaboration?

867

1 A. Well, I know that many of the doctors  
2 have appointments at several institutions;  
3 and that when they do participation in  
4 clinical trials, they tend to draw from  
5 multiple institutions for patients to  
6 satisfy their needs for those drawings.

7 Q. Do you know which hospitals are a part of  
8 that collaborative consortium in Boston?

9 A. I would not be able to answer that off  
10 the top of my head.

11 MR. DEVEREAUX: Okay. Let me  
12 just -- I will show you -- if I could just  
13 mark these. Maybe I can mark these as the  
14 next in order.

15 MR. McINTYRE: Well, I  
16 believe, Mr. Devereaux, your Interested  
17 Party exhibits are up to the Pacheco CV, and  
18 that's Number 10, so this would be 10 and  
19 11, if my records are correct.

20 MS. FREEDMAN: Can I just see  
21 whatever -- is this a new document?

22 MR. DEVEREAUX: Yes.

23 MS. FREEDMAN: Do you have a  
24 copy for me?

868

1 founding members of Partners Health Care  
2 System, Brigham and Women's Hospital and  
3 Massachusetts General Hospital, consolidated  
4 their adult oncology programs and clinical  
5 research under Dana Farber Partners Cancer  
6 Care?

7 A. That's correct.

8 MR. McINTYRE: Mr. Devereaux,  
9 for the sake of everyone's ability to follow  
10 along, we are going to mark the Dana Farber  
11 Collaborations as Interested Party 10 so  
12 everybody knows what we are talking about  
13 here. Go ahead.

14 MS. FREEDMAN: May I, I just  
15 would like to place an objection on the  
16 record to the fact that Mr. Zimmerman is  
17 being asked questions about a document he  
18 says he's never seen nor has he ever looked  
19 at the web site.

20 MR. McINTYRE: So noted. Go  
21 ahead.

22 MR. DEVEREAUX: Thank you.

23 (INTEREST PARTY EXHIBIT 10,  
24 DANA FARBER COLLABORATIONS, MARKED IN FULL)

870

1 MR. DEVEREAUX: I think I do.  
2 I will give it to you at the break.

3 MS. ADAMOVA: Can we take a  
4 break, and I will get copies for everyone?

5 MR. McINTYRE: Sure.

6 (SHORT RECESS)

7 Q. Mr. Zimmerman, I'm going to show you a  
8 document that says Page 1 of 1 Dana Farber  
9 that I retrieved from their web site, and it  
10 says collaborations at the top of that  
11 document?

12 A. Yes.

13 Q. I don't know if you have ever perused this  
14 part of their web site?

15 A. No, I haven't.

16 Q. When we talked before, you know where it  
17 says, Dana Farber Brigham & Women's Cancer  
18 Center is a collaboration between Dana  
19 Farber Cancer Institute and Brigham and  
20 Women's Hospital to care for adults with  
21 cancer. Did I read that correctly?

22 A. That's correct.

23 Q. And in the next sentence, it says, in 1996,  
24 Dana Farber Cancer Institute and the

869

1 Q. Were you aware of that particular  
2 consortium?

3 A. Yes, I was.

4 Q. And on your slide that would include, let's  
5 see, Dana Farber is a member of it, Brigham  
6 and Women's Hospital, Boston Children's and  
7 Massachusetts General?

8 A. That's correct.

9 Q. Okay. Where you have Boston Medical Center,  
10 did you get those statistics from the Boston  
11 Medical Center?

12 A. These statistics came from a web site  
13 called BMT Info.

14 Q. Whatever that web site, BMT Info, they  
15 listed Boston Medical Center?

16 A. Yes, they did.

17 Q. The reason I ask is that I don't see a  
18 listing on there for Massachusetts General  
19 Hospital on either of the slides. I don't  
20 know if we missed it, but...

21 (PERUSING SLIDES)

22 A. It's my mistake. My Table 8 lists  
23 Massachusetts General Hospital as having  
24 done 60 transplants in 2005.

871

1 Q. Okay. So, on Table 8, on Page -- just so we  
2 are clear, for the record -- 30 of your  
3 report, that shows Massachusetts General  
4 Hospital is doing 60 BMT's in 2005?

5 A. That's correct.

6 Q. Is that both auto and allogeneic?

7 A. They have an adult program and a  
8 pediatric program, and both programs do  
9 autologous and allogeneic.

10 Q. Okay. Just so I can go through these  
11 exhibits, I'm showing you an exhibit that  
12 Mr. McIntyre is going to indicate for the  
13 record what number it is, but it's the  
14 Children's Hospital, Boston web site?

15 MR. McINTYRE: Mark as IP11.

16 Q. This is part their web site saying, Stem  
17 Cell Transplantation Program, why choose us.  
18 Did I read that correctly?

19 A. That's correct.

20 (INTERESTED PARTY EXHIBIT 11,  
21 BOSTON CHILDREN'S HOSPITAL WEB SITE, IN  
22 FULL)

23 Q. Here it says, in 2004, we performed more  
24 than 70 pediatric stem cell transplants

872

1 significant number of beds?

2 A. Yes, it is.

3 Q. And would that indicate to you that it is an  
4 internationally recognized program?

5 A. Yes, it is.

6 Q. Now, let me just move on. I have a  
7 Massachusetts General Hospital document that  
8 says, Collaborations, at the top, taken from  
9 their web site. Do you see this?

10 A. Yes.

11 MR. DEVEREAUX: Okay. And I'd  
12 ask that -- I don't know if Mr. McIntyre,  
13 there's two documents from Massachusetts  
14 General Hospital. One says, About Us, and  
15 the other says, Collaborations. I don't  
16 know if you want to mark those as the  
17 same?

18 MR. McINTYRE: I appear to  
19 have two things... I see, yup, okay.  
20 Collaborations?

21 MR. DEVEREAUX: Yes.

22 MR. McINTYRE: Mark that as  
23 IP12.

24 (INTERESTED PARTY EXHIBIT 12,

874

1 making us the most active program in New  
2 England?

3 A. Yes.

4 Q. And it refers also to their partnership with  
5 Dana Farber Cancer Institute, correct?

6 A. That's correct.

7 Q. Okay. Just for the record, because I don't  
8 know if it was included in the information  
9 you provided, but it says they have a  
10 state-of-the-art, 13-bed stem cell  
11 transplantation unit at Children's  
12 Hospital?

13 A. That's correct, and another place on  
14 the web site they report 15 beds. That may  
15 have been a different time period.

16 Q. And it says, 18-bed out-patient at Dana  
17 Farber?

18 A. Yes.

19 Q. Okay. So, you would agree that Boston  
20 Children's Hospital, apparently, has at  
21 least 13 beds for their pediatric transplant  
22 unit?

23 A. That's correct.

24 Q. Would you agree with me that is a

873

1 MASS. GENERAL HOSPITAL COLLABORATIONS,  
2 MARKED IN FULL)

3 Q. You would agree that it says both basic and  
4 clinical research at the clinical center  
5 within the Dana Farber Harvard Cancer Center  
6 it brings again the resources of the Harvard  
7 affiliated institutions and the adult and  
8 pediatric cancers?

9 A. Yes.

10 Q. Were you aware that Massachusetts General  
11 Hospital was part of this consortium in  
12 Boston?

13 A. Yes, I was.

14 Q. And you would agree with me, from what I  
15 have shown you, that both Dana Farber and  
16 Massachusetts General Hospital actually  
17 advertise collaboration on their web site?

18 A. Yes.

19 Q. And would you agree with me that is good for  
20 the health care community to see that kind  
21 of collaboration?

22 A. Yes, it is.

23 Q. Now, why do you think that that is?

24 A. It indicates that they are sharing

875

1 resources; so, if one has a special skill,  
2 the others have access to that skill; and  
3 when one needs additional backup support,  
4 they have access to that support.  
5 Generally, it's an efficient way of doing  
6 business and a way of doing quality  
7 business.

8 Q. Thank you. The last document I think I'm  
9 going to refer to here is the Beth Israel  
10 Deaconess Medical Center document. It says  
11 at the beginning --

12 MR. McINTYRE: Mr. Devereaux,  
13 excuse me, I'm a little confused here. I  
14 apologize.

15 MR. DEVEREAUX: That's okay.  
16 I caused the confusion, I think.

17 MR. McINTYRE: Collaborations,  
18 and About Us are going in together or About  
19 Us is not going in?

20 MR. DEVEREAUX: I'm not going  
21 to put About Us in at all. I don't think I  
22 need to do it.

23 MR. McINTYRE: I'm sorry for  
24 that. Go ahead.

876

1 Beth Israel Deaconess Hematologic  
2 Malignancies.

3 (INTERESTED PARTY EXHIBIT 13,  
4 BETH ISRAEL DEACONESS HEMATOLOGIC  
5 MALIGNANCIES, MARKED IN FULL)

6 Q. Let me ask you a number of questions about  
7 collaboration. Did you, either for the  
8 purposes of your investigation in this case  
9 or just based on your expertise, review a  
10 document entitled, Coordinated Health  
11 Planning in Rhode Island that was a report  
12 submitted to the Rhode Island General  
13 Assembly by the Department of Health?

14 A. No, I don't think I have seen that  
15 document.

16 Q. You have never seen that document?

17 A. I don't think so.

18 MR. DEVEREAUX: Okay. Since  
19 I'm going to refer to a couple of things in  
20 this document, I'd ask that this be marked  
21 as the next exhibit.

22 MS. FREEDMAN: I would just  
23 like to object to the questioning of the  
24 document that he's never seen.

878

1 Q. I'm going to refer to the Beth Israel  
2 Medical Center document from their web site  
3 where it says, hematologic malignant bone  
4 marrow transplants program?

5 A. Yes.

6 Q. On the second page of that document, which  
7 is from their web site, there is a bold  
8 heading, clinical excellence?

9 A. Yes.

10 Q. Beth Israel Deaconess is a founding a member  
11 of the world renowned Dana Farber-Harvard  
12 Cancer Center giving patients access to all  
13 clinical trials and bench to bedside  
14 break-throughs offered by any of the seven  
15 Harvard affiliated member institutions in  
16 Boston?

17 A. Yes.

18 Q. So, again, this is further evidence of the  
19 type of collaboration that's going on  
20 between these internationally recognized  
21 hospitals in Boston?

22 A. Yes.

23 Q. And I believe when you --

24 MR. McINTYRE: That's IP13,

877

1 MR. McINTYRE: Let me just  
2 take a look at this for a moment.

3 (PAUSE)

4 MR. McINTYRE: I'm going to  
5 mark this as IP14. It's called, Coordinated  
6 Health Care Planning in Rhode Island.

7 MS. FREEDMAN: May I just  
8 place an objection --

9 MR. McINTYRE: So noted.

10 MS. FREEDMAN: The substance  
11 of my objection is that this document hasn't  
12 been provided prior to today pursuant to the  
13 Order; and secondly, Mr. Zimmerman did not  
14 rely upon this document at all during his,  
15 in his analysis.

16 MR. McINTYRE: To the extent  
17 that it contains information that may or may  
18 not be helpful to the Council, we are going  
19 to allow questioning regarding it.  
20 Mr. Zimmerman is more than capable of making  
21 the determination of whether he's competent  
22 to answer the question or not.

23 (INTERESTED PARTY EXHIBIT 14,  
24 COORDINATED HEALTH CARE PLANNING IN RHODE

879

1 ISLAND, MARKED IN FULL)  
 2 Q. I have only one question based on this  
 3 document, Mr. Zimmerman. It ties in with  
 4 what you have telling us about  
 5 collaboration. It ties into what you said  
 6 in the 1992 report. On Page 3, do you see  
 7 where it says, findings?  
 8 A. Yes.  
 9 Q. And this was submitted by the Department of  
 10 Health in consultation with the Coordinated  
 11 Health Planning Advisory Committee?  
 12 A. Yes.  
 13 Q. And the findings section, the first bullet  
 14 says, the health care system has not and  
 15 will not transform optimally or effectively  
 16 without a robust health planning process  
 17 that features collaboration and coordination  
 18 across all public and private sector  
 19 participants?  
 20 A. Yes.  
 21 Q. And what that would seem to indicate, would  
 22 you agree, is what you said in 1992 about  
 23 collaboration is just as important and  
 24 relevant today in 2007?

880

1 A. I would agree with that.  
 2 Q. Now, when you were looking at the  
 3 Massachusetts data -- let me just ask you,  
 4 when you were hired to do this report, who  
 5 determined the scope of the report?  
 6 A. Basically, I prepared a proposal based  
 7 on the CON submitted by Rhode Island  
 8 Hospital suggesting what the scope of work  
 9 would be.  
 10 Q. Okay. So, you reviewed the Rhode Island CON  
 11 application?  
 12 A. Yes.  
 13 Q. I'm going to go back quickly to just one  
 14 other question on collaboration. Did you  
 15 see any answer or response in there about  
 16 any study concerning collaboration that was  
 17 in the materials that you viewed?  
 18 A. I don't recall seeing any.  
 19 Q. And you did not take into consideration, I  
 20 think you say, as a secondary market these  
 21 19, I think they say 19, you say 20, towns  
 22 in Massachusetts?  
 23 A. Yes.  
 24 Q. Just out -- do you know whether there is a

881

1 town that's added in your analysis that  
 2 isn't in theirs?  
 3 A. I think they include Acushnet with New  
 4 Bedford, and I separate them out.  
 5 Q. Okay. Because they are right next to one  
 6 another?  
 7 A. They are reported different populations  
 8 in the census, so I used the census in  
 9 arriving at my population numbers, so I used  
 10 the census designation.  
 11 Q. Now, the, would you agree with me that the,  
 12 what the Health Services Council has to  
 13 focus on is the public need definition  
 14 that's defined in the regulations?  
 15 A. Yes.  
 16 Q. And that is not the market demand for Rhode  
 17 Island Hospital?  
 18 A. That's correct.  
 19 Q. And in the 1992 report that you did, you  
 20 looked --  
 21 A. Yes.  
 22 Q. -- at, for lack of a better word, the effect  
 23 of an out-migration of the patients to  
 24 Boston hospitals?

882

1 A. Yes.  
 2 Q. And you came to a conclusion in 1992 that if  
 3 any patients came in-state from  
 4 Massachusetts, it would essentially be a  
 5 wash with the out-migration of Rhode Island  
 6 patients that would go to those Boston  
 7 hospitals that we have been talking about?  
 8 A. Yes, I did.  
 9 Q. In your analysis, as I have read it in the  
 10 2007 analysis --  
 11 A. Yes.  
 12 Q. -- you didn't go through that same procedure  
 13 of analyzing the out-migration versus the  
 14 in-migration?  
 15 A. That's correct.  
 16 Q. You would still agree with me, wouldn't you,  
 17 based on the statistics that you have here,  
 18 that a significant number of bone marrow  
 19 transplants in New England are still being  
 20 done historically at those institutions that  
 21 we talked about?  
 22 A. That's correct.  
 23 Q. And based on what you said, I think you said  
 24 there were, Roger Williams was doing pretty

883

1 well average-wise at 24?  
 2 A. Yes.  
 3 Q. I would have to assume that when I look at  
 4 those statistics, I will even put in  
 5 Yale-New Haven, but the Boston institutions  
 6 are doing phenomenally better than  
 7 average?  
 8 A. Yes, they are.  
 9 Q. Now, when you did your analysis in 1992, you  
 10 also looked at insurance as a factor as to  
 11 whether people could get bone marrow  
 12 transplant?  
 13 A. Yes.  
 14 Q. And did you do the same type of analysis in  
 15 this particular case?  
 16 A. No, I didn't.  
 17 Q. Was there any reason that you didn't?  
 18 A. Yes. It is because that bone marrow  
 19 transplant is now an established treatment  
 20 method; and at the time that I did it in  
 21 1992, was considered basically an  
 22 experimental treatment method; so, as a  
 23 result of it being an accepted treatment  
 24 method, then I think that whether, who the

884

1 call it centers of excellence, but that it  
 2 will only cover a certain, cover bone marrow  
 3 transplants at certain centers that do a  
 4 significant volume of bone marrow  
 5 transplants?  
 6 A. I have not looked into that at all.  
 7 Q. You didn't look at that at all?  
 8 A. No.  
 9 Q. Did you -- well, let me ask you this.  
 10 Assume, for the sake of this question, that  
 11 we have statistics that show approximately  
 12 20 percent of Rhode Islanders have United  
 13 Health Care.  
 14 A. Okay.  
 15 Q. And assume that they are, that if they need  
 16 a bone marrow transplant, they would have to  
 17 go to one of the hospitals in Boston, for  
 18 instance, Dana Farber?  
 19 A. Okay.  
 20 Q. And if that existed, that would, that would  
 21 reduce the number of demand that you have  
 22 calculated in your conclusions here?  
 23 A. Hypothetically, yes.  
 24 Q. Okay. You say hypothetically. You're

886

1 insurance companies are willing to pay for  
 2 it through negotiations between them and the  
 3 institution.  
 4 Q. In 1992, in your report, you reference the  
 5 Prudential Insurance company and how they  
 6 had this program called Centers of  
 7 Excellence; do you recall that?  
 8 A. Yes, I do.  
 9 Q. And you included that in your report?  
 10 A. Yes, I did.  
 11 Q. In '92?  
 12 A. Yes.  
 13 Q. And I take it the reason you included that  
 14 was because a certain number of eligible  
 15 patients that would be insured by Prudential  
 16 would have to go to these centers of  
 17 excellence to be covered for a BMT?  
 18 A. Yes, and again, because it was an  
 19 experimental program. It made a difference  
 20 about whether a particular hospital actually  
 21 would have the expertise to offer the care  
 22 that was really needed.  
 23 Q. Are you aware that United has a similar  
 24 program of -- I don't know if you want to

885

1 assuming that what I'm telling you is  
 2 correct?  
 3 A. Yes, I am.  
 4 Q. Were you here when Mr. Lubiner testified?  
 5 A. Yes, I was.  
 6 Q. And did you hear his testimony about United  
 7 Health Care?  
 8 A. Yes, I did.  
 9 Q. And did you review our submissions to the  
 10 Health Services Council in this case?  
 11 A. No, I did not.  
 12 Q. You didn't review our submissions?  
 13 A. No, I didn't.  
 14 Q. Okay. Did you review Rhode Island  
 15 Hospital's submissions other than their  
 16 application?  
 17 A. No, I didn't.  
 18 Q. Okay. So, the only -- let me try and  
 19 rephrase it. What you examined before you  
 20 gave your conclusions was the Rhode Island  
 21 Hospital CON application and the attachment  
 22 materials and then the materials that you  
 23 have referenced in your report?  
 24 A. That's correct.

887

1 Q. You didn't look at anything the hospital,  
2 Rhode Island Hospital submitted in support  
3 of that?

4 A. No.

5 Q. Or anything that Roger Williams has  
6 submitted?

7 A. No.

8 Q. And you didn't consider the United Health  
9 Care issue at all?

10 A. That's correct.

11 Q. Okay. In the Massachusetts analysis, you're  
12 just, for the sake of this presentation, you  
13 are assuming that those, that they have a  
14 market of some sort in those 19 or 20  
15 towns?

16 THE WITNESS: I'm not -- I  
17 don't follow your question.

18 Q. Okay. Let me rephrase it. For the purposes  
19 of your analysis here, you're accepting the  
20 Rhode Island Hospital's contention that  
21 their secondary market are these 19 or 20  
22 Massachusetts towns?

23 A. Yes, I am. The reason I am doing that  
24 is that once before, when I did a study of

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1 coming from.

2 Q. Okay. And did you assign any percentage to  
3 that like you did in this particular case?

4 A. I think it was about 25 percent of the  
5 volume from Rhode Island Hospital for  
6 cardiac patients, was from, 25 percent was  
7 from those cities and towns; and in my case,  
8 you saw 22 percent, so it's reasonably  
9 close.

10 Q. All right. So, the number, the percentage  
11 that was used in the cardiology model was 25  
12 percent?

13 A. Yes.

14 Q. And you used 22 percent?

15 A. Based on 50 percent market penetration,  
16 yes.

17 Q. Okay. And in the case of the, do you know  
18 what the -- well, let me rephrase the  
19 question. The predictions that were made on  
20 having more than one cardiology center, are  
21 you aware of what the true facts are now  
22 based on the market compared to what was  
23 projected at that time?

24 A. Actually, I feel vindicated. At that

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1 the need for cardiac invasive services at  
2 Landmark Hospital, I looked at the actual  
3 utilization from, patients from  
4 Massachusetts for cardiac services, and I  
5 found that the patients that were being  
6 drawn to Rhode Island and Miriam Hospital  
7 for open heart surgery and for angioplasty  
8 were primarily from the areas that were  
9 identified by Rhode Island Hospital. So, I  
10 found it a possible market for Rhode Island  
11 Hospital and accepted it as a 50 percent  
12 rate based on that prior research.

13 Q. Okay. In other words, in the cardiology --

14 A. Yes.

15 Q. -- application that you're referring to,  
16 that was actually an application by  
17 Landmark?

18 A. Landmark.

19 Q. And Rhode Island Hospital opposed that?

20 A. Yes.

21 Q. And you looked at the outlying 20 towns when  
22 you did an analysis?

23 A. I looked at where the patients being  
24 treated at Rhode Island and Miriam were

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1 time, I pointed out that we did not have  
2 sufficient volume of open heart surgery in  
3 the foreseeable future to support three  
4 programs, and I, I am learning now that that  
5 is, indeed, the case.

6 Q. Now, in this particular case, you assigned a  
7 50 percent number, as you said. You say it  
8 was kind of fluid but 50 percent to those 20  
9 towns?

10 A. 50 percent market penetration.

11 Q. 50 percent market penetration?

12 A. Yes.

13 Q. Okay. I'm just looking at Page 21 of your  
14 report. It says, on the end of the first  
15 paragraph, if the population in the  
16 secondary area uses services at one-half the  
17 rate of the population in the primary market  
18 area, then utilization would be increased by  
19 22 percent?

20 A. That's correct.

21 Q. Okay. So, what you're assuming, though, is  
22 that the population in the secondary area  
23 would use services at one-half the rate of  
24 the population?

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1 A. In other words, 50 percent market  
2 penetration for Rhode Island Hospital.  
3 Q. Okay. Did you look at any statistics or is  
4 there any statistical study that backs up 50  
5 percent or the half number that you used?  
6 A. No.  
7 Q. So, we could actually sit and work that  
8 number up, as you said, either 50 percent or  
9 25 percent?  
10 A. That's correct.  
11 Q. Okay. Because there really isn't any  
12 statistical hard evidence that backs up that  
13 50 percent number in Massachusetts?  
14 A. That's true. We have, we don't know  
15 about the treatment of tertiary cancer.  
16 Q. And in fact, if you look at the Health  
17 Services Council guidelines, their function  
18 is to look at what the public need is for  
19 Rhode Island?  
20 A. Yes.  
21 Q. Not the 20 towns in Massachusetts --  
22 A. That's correct.  
23 Q. -- that Rhode Island Hospital has focused  
24 on?

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1 number to be able to scale your estimate. I  
2 think the more important number there is the  
3 addition to the utilization at Rhode Island  
4 Hospital based on the population of that  
5 area. That amount is 22 percent.  
6 Now, the question to be asked  
7 is would Rhode Island Hospital draw 22  
8 percent of its utilization from that area.  
9 I am not aware of anything that is looked at  
10 tertiary cancer services that would help us  
11 answer that question. I told you what I  
12 found when I looked at the cardiac area, and  
13 I do see greater than, or I see just about  
14 that market penetration. I know from the  
15 studies I have done, looking at Women and  
16 Infants, that Women and Infants Hospital  
17 draws heavily from southeastern  
18 Massachusetts for its neonatal intensive  
19 care unit; so, there is a substantial amount  
20 of utilization going on with that. But I  
21 don't think you can argue from cardiac or  
22 the neonatal intensive care unit to the  
23 tertiary care and cancer units necessarily,  
24 so that's why I think it is important to be

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1 A. Yes.  
2 MR. DEVEREAUX: Could I just  
3 have one moment?  
4 (PAUSE)  
5 Q. This is just a follow-up question on the  
6 Massachusetts market. I have been looking  
7 and I'm trying to find, is there anywhere  
8 that there's support that Rhode Island  
9 Hospital gets 50 percent market penetration  
10 for tertiary care services in those 20  
11 towns?  
12 A. I'm not aware of any.  
13 Q. Are you aware of their Cyber Knife  
14 application, CON application?  
15 A. Yes, I am.  
16 Q. And are you aware that they assign a 15  
17 percent market penetration to those towns?  
18 A. I have not read the application.  
19 Q. Okay. So that would be news to you?  
20 A. That's correct.  
21 Q. Okay. So, fair to say that 50 percent  
22 number is a pretty fluid number?  
23 A. I think the 50 percent number, the  
24 market penetration is just a convenient

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1 able to modify one's estimate there based  
2 on -- the best information available was not  
3 very good.  
4 Q. Okay. Math wasn't my best subject in  
5 school; but if the percentage goes down,  
6 then the number of beds ultimately that  
7 would be needed in Rhode Island, according  
8 to the projections, would go down as well?  
9 A. Would go down, yes.  
10 Q. And did you hear, I knew you were here for  
11 part of the testimony. I don't know if you  
12 were here for all of the testimony of the  
13 witnesses, but Dr. Schwartz was referred to  
14 by Miss Freedman in questioning of you?  
15 A. I heard her, yes.  
16 Q. Do you recall her testifying that there were  
17 a number of factors that go into a patient's  
18 selection of a bone marrow transplant  
19 hospital?  
20 A. Yes.  
21 Q. And would you agree with me that those  
22 factors are unique to bone marrow transplant  
23 comparison to say cardiology or some other  
24 specialized field?

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1 A. Unique may be a little strong word, but  
2 they are different.  
3 Q. They are different. In other words, you  
4 would, because bone marrow transplants, it's  
5 really a last, almost a last resort  
6 medically for people that are pursuing this  
7 kind of care?  
8 A. In some cases, yes.  
9 Q. And when they, did you hear Dr. Schwartz say  
10 that, while location was a factor, it wasn't  
11 necessarily a primarily factor?  
12 A. I heard her say that.  
13 Q. Would you agree with that?  
14 A. Not necessarily.  
15 Q. You wouldn't agree with Dr. Schwartz on  
16 that?  
17 A. I think location is an important  
18 factor.  
19 Q. Okay. So, when she says it's secondary, you  
20 disagree with her?  
21 A. When she says it's secondary, I don't  
22 know what distinction she is making there.  
23 I think it's an important factor. I think  
24 there are other important factors, and I'm

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1 not sure that I'm the one to ask about how  
2 to prioritize that.  
3 Q. You're here to analysis the statistics,  
4 whereas the doctors are the ones that  
5 basically deal with the patients and have  
6 the experience of learning what it is that  
7 makes a person choose a particular  
8 facility?  
9 A. That's correct.  
10 Q. Okay. You mention that volume was not as  
11 important a factor, I think, in the slide  
12 presentation that you gave?  
13 A. That's correct.  
14 Q. Were you aware that -- and again, I don't  
15 want to -- well, let me rephrase it.  
16 Dr. Schwartz testified that having volume is  
17 very important?  
18 A. Yes.  
19 Q. You're saying you're looking at some studies  
20 that tell you something different?  
21 A. We may differ in what we consider  
22 volume. In the case of pediatric  
23 transplants, what she thinks of the volume  
24 may actually be a half a dozen cases. That

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1 would be high volume compared to the  
2 epidemiology or bone marrow transplant.  
3 When I think of volume, I'm thinking more  
4 along the lines of the volume used by the, a  
5 volume of ten bone marrow transplants.  
6 Q. Now, when you mentioned accreditation, you  
7 also testified about the National Marrow  
8 Donor Program and what is required to be a  
9 member of the National Marrow Donor  
10 Program?  
11 A. Yes.  
12 Q. I believe Miss Freedman asked you a number  
13 of questions about the number of bone marrow  
14 transplants that Roger Williams had done in  
15 certain years. Do you remember those  
16 questions?  
17 A. Yes, I do.  
18 Q. Are you aware -- in fact, I think you put  
19 this in your slide -- Roger Williams was not  
20 accredited as a member of the National  
21 Marrow Donor Program until 2006?  
22 A. That is correct.  
23 Q. Okay. And in order to maintain the  
24 membership in that organization, you have to

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1 have a certain number of bone marrow  
2 transplants done, allogeneic and autologous,  
3 each year?  
4 A. They evaluate, reevaluate your program  
5 periodically. I'm not sure if it's every  
6 year. It might be every two years or three  
7 years. I do know that from the literature  
8 they say after they reevaluate, they can  
9 either approve it, put the program on  
10 probation or they can suspend membership.  
11 Q. The numbers you testified to, I believe, in  
12 your presentation and then on questions from  
13 Miss Freedman, were they ten allogeneic and  
14 ten autologous per year?  
15 A. My finding for the National Marrow  
16 Donor Program is that they only looked at  
17 allogeneic and they required ten a year for  
18 a 24-month period or 20 for one twelve-month  
19 period.  
20 Q. Okay. And it is important for a successful  
21 bone marrow transplant unit to have a  
22 membership in that particular organization,  
23 would you agree?  
24 A. Having a membership in that

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1 organization gives the center access to  
2 unrelated donors that might provide matched  
3 unrelated donor marrow, and that's very  
4 important for patients that don't have a  
5 matched family member.

6 Q. Now, in this particular case, the Health  
7 Services Council would have to consider,  
8 wouldn't you agree, the effect of having two  
9 bone marrow transplant units in Rhode Island  
10 competing against one another that they  
11 would both be able to attain the levels to  
12 allow membership in the National Marrow  
13 Donor Program?

14 A. We should --

15 MS. FREEDMAN: I object.

16 MR. McINTYRE: Overruled.

17 A. They should consider that.

18 Q. Because if they are both under the limits  
19 that you talked about, we could have two  
20 programs that only could offer autologous  
21 transplants?

22 A. Well, autologous or family-related  
23 transplants.

24 Q. Right. They couldn't get allogeneic --

900

1 know what would happen in a case like that.  
2 I could see that the two hospitals could  
3 simply agree to divide up the market  
4 somewhat, so they have no competition  
5 head-to-head necessarily. I'm not sure if  
6 that satisfies your definition for  
7 fragmentation of the market; but if that's  
8 the case, then yes.

9 Q. Well, when you were asked questions about  
10 why -- were you aware that Roger Williams  
11 had only done a certain number of bone  
12 marrow transplants in 2005, excuse me, 2006  
13 and 2007; do you recall that?

14 A. Yes, I do.

15 Q. Were you aware that Rhode Island Hospital  
16 had recruited Dr. Peter Quesenberry from  
17 Roger Williams to Rhode Island Hospital?

18 MS. FREEDMAN: I object.

19 There's no testimony. There's no facts in  
20 evidence to substantiate that statement by  
21 Mr. Devereaux.

22 MR. DEVEREAUX: We have had  
23 ample testimony of that.

24 MR. McINTYRE: I thought there

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1 A. They couldn't get it through the  
2 National Marrow Donor Program.

3 Q. Which has this huge reservoir of potential  
4 matches?

5 A. Yes.

6 Q. Okay. And that, if that situation were to  
7 arrive where you had two competing -- when I  
8 say competing, in other words, if the  
9 hospitals are not collaborating, they are  
10 most likely competing; would you agree with  
11 that?

12 A. Well, they could be neutral, I guess,  
13 but competing is okay.

14 Q. Okay. If the situation developed that the  
15 hospitals both were trying to make a certain  
16 number to comply with the National Marrow  
17 Donor Program requirements, that would  
18 essentially fragment, could cause a  
19 fragmentation in the health care system as  
20 it related to bone marrow transplants in  
21 Rhode Island?

22 MS. FREEDMAN: Objection.

23 MR. McINTYRE: Overruled.

24 A. That's speculative. I really don't

901

1 had been, as a matter of fact.

2 MS. FREEDMAN: There has not  
3 been.

4 MR. McINTYRE: He woke up one  
5 morning and just went to work at the other  
6 place?

7 MS. FREEDMAN: The  
8 circumstances surrounding Dr. Quesenberry  
9 joining Rhode Island Hospital is not in this  
10 record. There have been allegations that  
11 have not been substantiated, and therefore,  
12 I object to the, to the characterization by  
13 Mr. Devereaux, as it is untrue.

14 MR. McINTYRE: You are making  
15 a representation to the Health Services  
16 Council today that he was not recruited?

17 MS. FREEDMAN: I am making the  
18 representation that he, that he applied for  
19 a position at Rhode Island Hospital, and to,  
20 and to characterize it as an active  
21 recruitment of the head of the bone marrow  
22 transplant program to come to Rhode Island  
23 Hospital to start a bone marrow transplant  
24 program is not true.

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1 MR. McINTYRE: Okay. So noted  
 2 for the record.  
 3 MR. DEVEREAUX: I will try and  
 4 rephrase it for you.  
 5 THE WITNESS: Thank you.  
 6 Q. Were you aware, when you were asked the  
 7 questions about 2006 and 2007 statistics on  
 8 bone marrow transplant, that Dr. Peter  
 9 Quesenberry had left, left Roger Williams  
 10 Hospital and gone across the street to Rhode  
 11 Island Hospital --  
 12 A. I was.  
 13 Q. -- to a non-existing bone marrow transplant  
 14 unit?  
 15 MS. FREEDMAN: Objection.  
 16 MR. McINTYRE: Overruled.  
 17 A. I was aware of that.  
 18 Q. Were you also aware that Dr. Colvin was also  
 19 previously at Roger Williams on the staff in  
 20 bone marrow transplant also went over to  
 21 Rhode Island Hospital?  
 22 A. I had heard that, too.  
 23 Q. And were you also aware, were you here when  
 24 Dr. Winer testified?

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1 A. Yes, I was.  
 2 Q. And so, you're aware that Dr. Winer, I  
 3 believe, testified he was recruited by  
 4 Dr. Quesenberry to go over to Rhode Island  
 5 Hospital?  
 6 A. I recall his saying he had moved.  
 7 Q. Okay. So, were you aware that essentially  
 8 three of the six bone marrow transplant  
 9 physicians at Roger Williams had now gone  
 10 over to Rhode Island Hospital during this  
 11 time period?  
 12 A. Yes.  
 13 Q. All right. And do you think that that might  
 14 have had an effect on the number of bone  
 15 marrow transplants that were done at Roger  
 16 Williams during that period of time,  
 17 statistically?  
 18 A. Yes, I would expect that.  
 19 Q. I'm just looking at the, again, going back  
 20 to the 1992 analysis that, and I know it was  
 21 a number of years ago; but in that  
 22 particular analysis, did you include any  
 23 population increase in the statistics in  
 24 that particular analysis as you did in the

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1 2007 analysis?  
 2 A. I probably didn't at that time.  
 3 Q. Okay. And the population increase that you  
 4 estimate here in this 2007 report was based  
 5 on which statistics?  
 6 A. Rhode Island State-wide Planning  
 7 population projections.  
 8 Q. And that's for the ages between 20 and 69?  
 9 A. That's correct.  
 10 Q. All right. And you increased the age  
 11 analysis, as I understand it, in comparison  
 12 from 1992 to 2007; you added ten years, 59  
 13 to 69?  
 14 A. I added from age 40 to age 70 for the  
 15 allogeneic transplants and from age 60 to  
 16 age 70 for the autologous transplants.  
 17 Q. Okay. In 1992, again, there was no analysis  
 18 of 20 Massachusetts towns?  
 19 A. That's correct.  
 20 Q. Okay. And the reasoning you did it in this  
 21 case is simply because Rhode Island Hospital  
 22 claimed that that was their secondary  
 23 market?  
 24 A. Two reasons. One is because bone

906

1 marrow transplant therapy has become an  
 2 established therapy, so I think it is  
 3 important to look at market as a basis for  
 4 estimating need rather than simply the  
 5 experimental cases that I specifically  
 6 focused on in 1992. The other is Rhode  
 7 Island Hospital claimed that geographic  
 8 area.  
 9 Q. If they had claimed 30 towns, would you have  
 10 done that analysis?  
 11 A. When I looked at the towns, I got my  
 12 map out and shaded those in and made sure  
 13 they were contiguous, and I went back and  
 14 looked at my cardiac data and saw that that  
 15 fairly well approximated what they drew for  
 16 the cardiac cases. On that basis, I did not  
 17 exclude cases. In other cases for other  
 18 projects I did exclude cases that the  
 19 hospital claimed because I didn't think it  
 20 reasonable.  
 21 Q. If I follow the reasoning as to the 50  
 22 percent, you're saying that of 50 percent of  
 23 the people in that area that have, that are  
 24 candidates for a bone marrow transplant,

907

1 they would consider 50 percent of them  
 2 coming to a Rhode Island hospital?  
 3 A. That's what I did.  
 4 Q. Okay. And when you say you believe, that's  
 5 not based on any hard statistics?  
 6 A. I think that's a reasonable number.  
 7 Q. Okay. But is there any statistical study at  
 8 all that supports that?  
 9 A. Not that I'm aware of.

10 MR. DEVEREAUX: May I have a  
 11 moment, please. I'm trying to see if we can  
 12 hone this in.

13 MR. McINTYRE: Please, do.

14 (PAUSE)

15 Q. On Page 22 of your study, Mr. Zimmerman, I'm  
 16 talking about the most recent one, you use a  
 17 Table III, I think it is. You list reasons  
 18 why people decide not to get bone marrow  
 19 transplants?

20 A. Yes.

21 Q. And if I, I just want to make sure I  
 22 summarize those. The reasons that you list  
 23 are, no donor match, no response to therapy,  
 24 the disease worsens, the patient decides

908

1 against a bone marrow transplant, there are  
 2 financial obstacles, health insurance  
 3 barriers and no opportunity for treatment.  
 4 Did I summarize those?

5 A. Yes.

6 Q. Did you assign any particular percentages to  
 7 those categories to come to the, I think it  
 8 was, it was 30 percent that would opt out?

9 A. Those reasons come from the literature.  
 10 Those are the reasons that the people  
 11 writing about this have either speculated or  
 12 reported that patients did not use the  
 13 transplant, and actually, arriving at the  
 14 number, what I did was to look at the number  
 15 of eligible patients in the clinical trial  
 16 who receive a bone marrow transplant and  
 17 compare that to the number of stem cell  
 18 transplant patients that actually receive  
 19 that transplant, on all the studies that I  
 20 had. I went through the ones that met the  
 21 criteria, and I included all of them in  
 22 there.

23 Q. Now, those are the studies that you referred  
 24 to in the report?

909

1 A. Those are the ones listed in Table III.  
 2 Q. Do any of those studies break down, by any  
 3 sort of percentage based on discharge data,  
 4 or any sort of data -- I guess it would be  
 5 discharge data, but any other sort of data,  
 6 how, what the percentages were of, for these  
 7 various reasons as to why people chose not  
 8 to get a bone marrow transplant?

9 A. They may have, but I don't recall it.

10 Q. And that was Table -- I think you referred  
 11 to in Table III to several studies?

12 A. Yes, I do.

13 Q. And if you could look at it, I think that's  
 14 Page 22?

15 A. Yes.

16 Q. The studies, if I have it correctly, were  
 17 essentially two multiple myeloma allogeneic  
 18 studies, one from Italy and one from the UK?

19 A. Yes.

20 Q. And then there were three AML studies?

21 A. Yes.

22 Q. Two that were allogeneic and autologous and  
 23 one that was just allogeneic; and as I look  
 24 at that, two of the studies were U.S. and

910

1 Europe, and one was the UK and a Dutch  
 2 study?

3 A. All of those were placed in my review  
 4 article, one of which included five trials,  
 5 and the second included nine trials, and the  
 6 third would include three trials; so, a  
 7 total of 17 trials together.

8 Q. In the United States, insurance coverage and  
 9 financial obstacles are factors in  
 10 determining whether you get a bone marrow  
 11 transplant?

12 A. Yes.

13 Q. Are you aware that Italy and the United  
 14 Kingdom have universal health care?

15 A. Yes, I am.

16 Q. And are you also aware that Holland has  
 17 universal health care?

18 A. Yes, I am.

19 Q. So that would seem under those, looking at  
 20 those studies, that the percentage of people  
 21 who didn't get bone marrow transplants from  
 22 those countries wouldn't have had insurance  
 23 or financial obstacles?

24 A. That's not necessarily true, because

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1 countries that have the national health  
2 insurance still put criteria on what  
3 patients are eligible for treatment; so,  
4 they may either put them in a line and  
5 ration the care, or they may say that for  
6 some particular patients with some  
7 particular disease characteristics that they  
8 don't believe the treatment is justified and  
9 won't pay for it.

10 Q. Okay. And, but that would be a bureaucratic  
11 decision made within the health care  
12 community for that country?

13 A. Yes, it would.

14 Q. Which would be different from the system  
15 here in the United States?

16 A. Well, you have a government insurance  
17 or you have private insurance; and if you  
18 want to make the distinction, you can make  
19 the distinction, but it is a natural  
20 parity.

21 Q. You also have no insurance in the United  
22 States?

23 A. In the United States; and if the  
24 national health insurance says they won't

912

1 A. Yes.

2 Q. So, those studies were limited to those  
3 cancers?

4 A. Yes.

5 Q. Were there, did you try to see if there are  
6 any statistics out of the Dana Farber  
7 consortium on the utilization on bone marrow  
8 transplant in comparisons to people that  
9 rejected that treatment?

10 A. No, I didn't.

11 MR. DEVEREAUX: May I have a  
12 moment, please.

13 (PAUSE)

14 MR. DEVEREAUX: I just have --  
15 hopefully, I just have a few more  
16 questions.

17 THE WITNESS: That's okay.

18 Q. When you were looking at the statistics on  
19 the stem cell transplant centers from New  
20 England --

21 A. Yes.

22 Q. -- you had statistics, I think, from Maine  
23 Medical Center, in 2005 they had 21?

24 A. Autologous.

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1 pay for it, you have no insurance in the  
2 country with the national health  
3 insurance.

4 Q. Did any of the studies that you looked at  
5 from Italy and the UK and Holland indicate  
6 the number of people that were  
7 bureaucratically excluded from bone marrow  
8 transplants as a percentage of the whole 30  
9 percent?

10 A. The thrust of the articles was the  
11 effectiveness of treatment, so that would  
12 not be something that would enter into the  
13 effectiveness of treatment.

14 Q. Because that wouldn't be -- that was not  
15 accounted for?

16 A. That would not be something that the  
17 reviewer would normally let you even put  
18 into an article.

19 Q. Now, the cancer studies that you looked at,  
20 based on this particular table, were limited  
21 to multiple myeloma, ALM and PH -- what was  
22 PH?

23 A. Philadelphia Chromosome Positive.

24 Q. ALL?

913

1 Q. Autologous transplants, correct?

2 A. Yes.

3 Q. Did you look at any of the population  
4 statistics from Maine, the State of Maine?

5 A. No, I didn't.

6 Q. Are you aware that the population in Maine  
7 is roughly about 20 percent higher than the  
8 population in Rhode Island?

9 A. Yes, I am.

10 Q. And assuming, would you just assume, for the  
11 sake of this question, age breakdown is the  
12 same as what you have analyzed for Rhode  
13 Island in 2007 and those 20 Massachusetts  
14 towns?

15 A. Yes.

16 Q. And you looked at Maine with their singular  
17 transplant unit?

18 A. Yes.

19 Q. It would appear that the demand or the  
20 capacity for bone marrow transplants would  
21 be similar in Maine as it is in Rhode  
22 Island?

23 MS. FREEDMAN: I object.

24 MR. McINTYRE: You know, I'm

915

1 going to let him continue the line of  
2 questioning to see where it goes.  
3 Overruled.

4 A. I'm not sure that you can draw that  
5 conclusion from the data that's reported  
6 here. The only thing that this tells us is  
7 that Maine has a very limited capacity to do  
8 any kind of bone marrow transplant, and that  
9 they did 21 cases in 2005. That does not,  
10 in any way, reflect on the market for bone  
11 marrow transplant, and indeed, is a reason  
12 that I didn't use this approach when I  
13 looked at the demand for bone marrow  
14 transplant or the need for bone marrow  
15 transplant facilities in Rhode Island. I  
16 rather looked at the epidemiology of disease  
17 and the usefulness of this particular  
18 therapy to treat the disease.

19 Q. Okay. So, I would assume the answer to the  
20 next question is that if Maine -- you never  
21 looked at any statistics in Maine concerning  
22 what the epidemiology was and the disease?

23 A. That's true.

24 Q. Okay. The number of potential bone marrow

916

1 transplant patients that you estimated in  
2 1992, I believe, was, was it 32?

3 A. I think that's a reasonable  
4 approximation of what I came to.

5 Q. Okay. The number that you're stating today,  
6 what, which you defined as capacity,  
7 correct?

8 A. Yes.

9 Q. Is 91.4? Did I get that right?

10 A. 94.1.

11 Q. 94.1. That's an increase of about 300  
12 percent from the 1992 analysis?

13 A. Yes.

14 Q. And the population increase in that age  
15 group in Rhode Island is 7 percent.

16 A. The population increase over ten  
17 years.

18 Q. Is going to be 7 percent?

19 A. Yes.

20 Q. Did, is there any -- are there any  
21 statistics that indicate that the incidence  
22 of cancer in Rhode Island increased by 300  
23 percent over that period of time?

24 A. The reason for the increase in the

917

1 demand is because, A, there's an increase in  
2 the age group that's being treated.

3 Q. Uh-huh?

4 A. That increase is in the older age  
5 groups. B, cancer increases in older age  
6 groups, so once you increase the age group  
7 range, that increases more than  
8 proportionately, much more than  
9 proportionately. And C, you have an  
10 increase in the number of indications for  
11 which bone marrow transplant is now  
12 considered appropriate. So, it is those  
13 factors and not the general population or  
14 the increase in cancer itself that is  
15 driving my increased need for bone marrow  
16 transplant facilities.

17 Q. You indicated that you reviewed the  
18 application that Rhode Island Hospital  
19 submitted?

20 A. Yes, I did.

21 Q. I don't know if you have a copy of that  
22 handy?

23 A. I don't.

24 MR. WALSH: May I approach.

918

1 Q. I'm going to refer to Page 23 of the 65  
2 pages of the Rhode Island Hospital CON  
3 application that's being submitted in the  
4 case.

(HANDED TO WITNESS)

5 Q. And if you look at the table at the top,  
6 that was submitted by Rhode Island  
7 Hospital?

8 A. Yes.

9 Q. It says, discharges from Rhode Island and  
10 Massachusetts hospitals?

11 A. Yes.

12 Q. This apparently purports to be -- it's  
13 submitted by Rhode Island Hospital, but it  
14 shows the discharge, actual discharge data  
15 from the Rhode Island residents and the 19  
16 Massachusetts towns for BMT's; and looking  
17 at where it says, adult, 1997, we had 62, 43  
18 Rhode Island, 19 Massachusetts, correct?

19 A. Yes.

20 Q. And if you follow along out to 2005, you've  
21 got 77?

22 A. Yes.

23 Q. I'm not sure what the average is between all

919

1 of those numbers, but it looks like it's  
2 somewhere in the mid seventies; would you  
3 agree with me?

4 A. Yes.

5 Q. And then the projected linear progression  
6 growth of Rhode Island Hospital is submitted  
7 from 2006 to 2015 would be 72 BMT patients  
8 to 78 BMT patients?

9 A. Correct.

10 Q. Which is certainly not a 300 percent  
11 increase; you would agree with that?

12 A. Oh, yes. Yes.

13 Q. And in the pediatric area, we have six in  
14 1997, four from Rhode Island and two from  
15 Massachusetts, and we have five in 2005.  
16 They are projecting eight in 2006, up to ten  
17 in 2015?

18 A. That's correct.

19 Q. Okay. And you were able to review this data  
20 before you formulated your numbers?

21 A. I read through this one time in order  
22 to put together my scope of work, and then  
23 everything else I did was independent of  
24 this study.

920

1 Q. Okay. Now, you mentioned that certain --  
2 and I'm going to try to stay within the  
3 scope of your report; but as you mentioned,  
4 you were, you had made certain  
5 recommendations, but obviously, that's up to  
6 the Health Services Council --

7 A. Yes.

8 Q. -- and Dr. Gifford? On affordability of  
9 this program, did you do any significant  
10 statistical analysis of the affordability of  
11 the program?

12 A. I looked at the cost of the program  
13 relative to the amount that we are spending  
14 on hospital services now and noted that it  
15 was less than 1 percent of that amount. The  
16 increase per year in hospital expenditure in  
17 this state runs around 8 or 9 percent most  
18 years, so 1 percent of that would not be a  
19 substantial obstacle.

20 Q. But the measurement you used was what the  
21 cost of a new bone marrow transplant unit  
22 would be at Rhode Island Hospital in  
23 comparison to the global expenditures for  
24 hospital care in the State of Rhode

921

1 Island?

2 A. I looked at the cost of operating the  
3 bone marrow transplant unit. I looked at  
4 that relative to the total expenditure on  
5 hospitals, the total expenditures on Life  
6 Span hospitals and the total expenditure on  
7 Rhode Island hospitals; and in all cases, it  
8 came to less than 1 percent.

9 Q. Now, is that an analysis that you have  
10 utilized in the past in terms of  
11 affordability?

12 A. I look at affordability, and I look at  
13 it in different ways.

14 Q. Right. What other different ways have you  
15 looked at affordability, in other analyses?

16 A. I also look at affordability -- I might  
17 have looked at the cost of alternative  
18 treatments and compared the affordability  
19 based on this, and I might have looked at  
20 the total cost, as I did in this case, in  
21 relation to the total expenditure on  
22 utilization, in this case, hospital  
23 utilization; and as I noted in my  
24 presentation, I often look at the cost per

922

1 year of lives saved.

2 Q. What was that, again, I'm sorry?

3 A. As I often look at in some of these, I  
4 look at the cost per year of lives saved for  
5 this particular area.

6 Q. Was part of your charge to look at  
7 affordability in this particular case?

8 A. My general charge is to look at  
9 affordability.

10 Q. Did you look at any of the actual costs at  
11 Roger Williams for their bone marrow  
12 transplant unit?

13 A. No, I didn't.

14 Q. And that, you would agree, is an existing  
15 bone marrow transplant unit?

16 A. Yes, it is.

17 Q. Okay. Did you look at any reimbursement  
18 data in Rhode Island?

19 A. No, I didn't.

20 Q. How about any percentage of free care or  
21 uncompensated care?

22 A. No, I didn't.

23 Q. There was some reference in Dr. Winer's  
24 testimony that a certain number of

923

1 Massachusetts patients were uninsured. Do  
 2 you remember him testifying to that?  
 3 A. No, I don't remember that.  
 4 Q. All right. Well, let me ask you this way.  
 5 There's a percentage of free care or  
 6 uncompensated care came from Massachusetts.  
 7 Was that factored in for the 50 percent  
 8 number in any way?  
 9 A. That would not have been considered.  
 10 Q. And I believe the Rhode Island Hospital cost  
 11 data you utilized says the cost per patient  
 12 is \$190,355?  
 13 A. That's based on national estimates.  
 14 Q. National estimates?  
 15 A. Yes.  
 16 Q. Do you know if that number, 190,355  
 17 number --  
 18 A. Yes.  
 19 Q. -- is greater than the reimbursement rate?  
 20 A. I would expect it to be. That's  
 21 charged at -- and I don't think any third  
 22 parties pay charges.  
 23 Q. So, the deficit, what happens to the  
 24 deficit?

924

1 A. It might be a deficit or it might be  
 2 profit that you don't make.  
 3 Q. Let me make sure I understand that  
 4 correctly, Mr. Zimmerman. If the cost per  
 5 BMT is 190,355 --  
 6 A. The charge could be -- I have a  
 7 different number for cost.  
 8 Q. Okay. What's the cost number that you  
 9 have?  
 10 A. 70,300.  
 11 Q. So, your number, 70,300, are you aware that  
 12 Rhode Island Hospital is 190,355, their  
 13 projected cost?  
 14 A. No, I was not aware of that.  
 15 Q. Referring to, I'd like to just refer for a  
 16 minute to your slide. Cost of stem cell  
 17 transplants.  
 18 A. Yes.  
 19 Q. And you have 2004 expected charge, 190,024;  
 20 do you see that?  
 21 A. Yes.  
 22 Q. I don't know if you have a copy.  
 23 A. Yes, I do.  
 24 Q. And then it says, Rhode Island cost for 70.7

925

1 adult and 8.1 pediatric transplants is 15  
 2 million plus 23.6 at Roger Williams Medical  
 3 Center?  
 4 A. That's correct.  
 5 Q. That 70.7 and the 8.1, looking at the 15  
 6 million, equates to 190,355, correct?  
 7 A. Correct.  
 8 Q. Now, if the reimbursement is less than  
 9 that?  
 10 A. Yes.  
 11 Q. Then you have a deficit?  
 12 MS. FREEDMAN: I object.  
 13 A. You're dealing with the hospital  
 14 accounting convention right here. What we  
 15 are calling costs is and sometimes it's  
 16 charges and sometimes it's the cost of the  
 17 resources used. And when you talk about  
 18 whether there's a profit or deficit, you're  
 19 looking at a different method. To be able  
 20 to say that the cost here is 190,000 and  
 21 include zero profit is not something that I  
 22 know to be true. This is a synthetic  
 23 estimate based on taking what the hospitals  
 24 reported their cost to be and by multiplying

926

1 by the Medicare cost to ratio for the  
 2 hospitals that provide the bone marrow  
 3 transplant unit that were included in the  
 4 sample of the HCUP Project, the agency for  
 5 health care, research and quality.  
 6 Now, there's, whether there's a  
 7 profit or a loss, that's not something that  
 8 you can deduce from these numbers. What  
 9 this does is give you an approximate measure  
 10 of what the cost is likely to do or to be.  
 11 I used the national numbers here rather than  
 12 using Rhode Island numbers, because these  
 13 are not subject to manipulation. These  
 14 hospitals are reporting what they did, and  
 15 the project is inflating those costs to show  
 16 what they think the market value is. Now,  
 17 that's what I used when I compared the cost  
 18 to the total cost of providing hospital  
 19 services and tried to deduce whether this is  
 20 unforwardable.  
 21 Q. Now, when you say you used other numbers  
 22 because Rhode Island -- I just want to get  
 23 that -- Rhode Island numbers couldn't be  
 24 manipulated?

927

1 A. I said the national numbers. They  
2 don't have any bone to pick. They don't  
3 have a dog in this fight. They don't care  
4 what the numbers are. Rhode Island Hospital  
5 may decide that they want to underinflate or  
6 overinflate their numbers. Roger Williams  
7 may decide to overstate or understate their  
8 numbers. They have reasons for doing that.  
9 But the number that I have chosen here is a  
10 number not related and no one has an  
11 incentive to provide a number to further  
12 their cause. That's why I used that.

13 Q. When you say that, you're talking about  
14 190,000?

15 A. \$190,000, that's the estimate of the  
16 average cost.

17 Q. Okay. So, as I understand it then, your  
18 number, 190,000 that you have estimated, is  
19 not related to the cost of the actual  
20 proposal made by Rhode Island Hospital?

21 A. No. That number comes from national  
22 reported representative hospital provision  
23 of bone marrow services.

24 Q. When you were looking at affordability, did

928

1 specific research.

2 MR. McINTYRE: We are not  
3 getting anywhere.

4 MR. DEVEREAUX: I just have a  
5 couple of specific questions, and then maybe  
6 we can wrap it up.

7 MR. McINTYRE: You are  
8 significantly over the time allotted.

9 MR. DEVEREAUX: I am?

10 MR. McINTYRE: Yes, so...

11 Q. Okay. I'm looking at the Non-Hodgkin's  
12 Lymphoma. I just want to focus on two parts  
13 of your report.

14 A. Okay.

15 Q. The Non-Hodgkin's Lymphoma, I think, this is  
16 around Page 15?

17 MR. McINTYRE: We are on his  
18 report?

19 MR. DEVEREAUX: Right.

20 Q. Have you got that? Let me know when you  
21 have that.

22 A. Yes, I do.

23 Q. Would you agree with me that Non-Hodgkin's  
24 Lymphoma is the second most common

930

1 you look or review any corresponding Boston  
2 cost data?

3 A. No, I didn't.

4 Q. The reason I ask that is because you have  
5 Boston listed as an option.

6 A. Yes.

7 Q. Do you know if there's any data that can be  
8 retrieved that would indicate cost of bone  
9 marrow transplants in those Boston  
10 metropolitan hospitals?

11 A. I know it is very difficult to get  
12 numbers that you can really trust, because  
13 hospitals tend to treat this as a  
14 proprietary market information.

15 Q. Did you attempt to get any of those  
16 numbers?

17 A. No, I did not.

18 MR. McINTYRE: Mr. Devereaux,  
19 if you have specific questions relating to  
20 your -- if you have done research and you  
21 want to ask about research you have done,  
22 fine, but we are going --

23 MR. DEVEREAUX: That was my  
24 last question was whether he did any

929

1 indication for transplant in the U.S.?

2 A. Yes.

3 Q. And of the 122, you have a 24.5 potential  
4 BMT candidates; is that accurate?

5 A. That's correct.

6 Q. And you say a 50 percent relapse, about 24  
7 to 25, would then be BMT eligible?

8 A. Yes.

9 Q. Now, we asked one of our doctors some  
10 questions about that, and I just want to  
11 follow up. Were you aware, when you came to  
12 that, the 50 percent analysis that you did,  
13 that that 50 percent applies only to  
14 patients with advanced stages of NHL?

15 A. No.

16 Q. Were you aware that the early stage, one and  
17 two A of Non-Hodgkin's Lymphoma, the relapse  
18 estimates are more like 25 to 30 percent?

19 MS. FREEDMAN: I object.

20 MR. McINTYRE: Overruled.

21 Q. Just assume for the sake of my question, if  
22 that was true, that it will be an adjustment  
23 downward, I take it, on the number of  
24 eligible BMT patients that you have

931

1 calculated?

2 A. I would have to recalculate.

3 Q. Okay. On multiple myeloma, which is

4 Page 15, beginning and then going over to

5 60 -- --

6 A. Yes.

7 Q. -- you have, I believe, of the 29 eligible,

8 you basically conclude that 29, on Page 20,

9 that of that number, 100 percent would be

10 potential BMT eligible patients?

11 A. Yes.

12 Q. Okay. It's true that multiple myeloma is

13 the most common indication for transplant in

14 the United States?

15 A. And the world.

16 Q. Okay. And I believe you reference a French

17 study, which was the Attal, A-T-T-A-L,

18 study?

19 A. That's in the Maine Journal of

20 Medicine.

21 Q. 85 to 88 percent of selected patients

22 actually underwent one transplant in that

23 study?

24 A. Then I have probably underestimated

932

1 A. Yes.

2 Q. And did you look at any actual discharge

3 data for the types of cancers that were used

4 in this particular study?

5 THE WITNESS: From where?

6 MR. DEVEREAUX: Anywhere.

7 A. No.

8 Q. So, the only information we have on the

9 solid, the capacity for, potential capacity

10 for solid tumor BMT's is based on this study

11 in Europe, the Grathwahl (phonetic) study in

12 2004?

13 A. Yes. This reports on actual

14 utilization for the 580 or so European bone

15 marrow transplant studies by country and

16 gives the number there. I linked it to that

17 because the numbers in Rhode Island are so

18 small that I wouldn't have very much

19 confidence in trying to look at the number

20 of lung cancers that might be transplanted

21 and so forth.

22 What I did here was take all of

23 the European numbers and subtracted out the

24 ones, the solid cancers that apply primarily

934

1 demand, because I reduced it to 70

2 percent.

3 Q. You reduced it to 70 percent?

4 A. Yes.

5 MR. DEVEREAUX: Can I have one

6 moment, please?

7 MR. McINTYRE: Yes.

8 MR. DEVEREAUX: I'm going to

9 wrap this up.

10 (PAUSE)

11 Q. Let me -- I'm coming right to the end. The

12 solid tumor section on Page 16 --

13 A. Yes.

14 Q. -- you indicate in here that the value of

15 autologous transplant is questionable, the

16 value of autologous stem cell

17 transplantations for solid tumors, in spite

18 of the large number that have been

19 performed, is questionable?

20 A. I gave you a quote from the literature

21 that said that. That's not my words.

22 Q. Okay. And you use a European study, as I

23 understand it, that extrapolates the 10.8

24 number?

933

1 to pediatric cases. That I took out the

2 Ewings sarcoma and neuroblastoma cases and

3 looked at the others. Now, that's where the

4 16.7 cases per million population comes

5 from.

6 Q. Uh-huh?

7 A. Now, in addition to that, I also looked

8 at a case that's not currently considered a

9 routine use for bone marrow transplant

10 patient that is renal cell carcinoma.

11 That's one of the cases that the National

12 March Donor Program lists as one of the

13 trends in bone marrow transplantation, and I

14 looked at the Rhode Island incidents of that

15 cancer and deduced that, based on that, that

16 probably 18 patients per year would satisfy

17 the criteria for appropriateness for bone

18 marrow transplantation in Rhode Island for

19 renal cell carcinoma alone.

20 So, the number that I'm looking

21 at here of 10.8 would be on the order of

22 half that.

23 Q. Now, when you looked at the solid tumor

24 aspect --

935

1 A. Yes.  
2 Q. -- were you able to review any U.S.  
3 insurance coverage data on BMT's for solid  
4 tumors?  
5 A. No, I did not.  
6 Q. All right. So, we don't know if Blue Cross  
7 or Medicare, Medicaid pays for that?  
8 A. We know that, in the past, Blue Cross  
9 has challenged paying that for breast  
10 cancer; but I would expect them to pay for  
11 childhood brain tumors and for neuroblastoma  
12 and cases that are conventionally treated  
13 with bone marrow transplantation.  
14 Q. Because if they don't, they are going to end  
15 up on the front page of the Providence  
16 Journal?  
17 A. They are going to end up in court.  
18 Q. But in any event, you used the figure of  
19 10.8 for adults in this?  
20 A. Yes, I did.  
21 MR. DEVEREAUX: No more  
22 questions.  
23 MR. McINTYRE: Thank you very  
24 much. Are there questions from the Health

936

1 a procedural issue. Mr. Normand and  
2 Mr. Devereaux gave me what appears to be a  
3 summary and informed me that Rhode Island  
4 Hospital has a copy of this.  
5 MS. FREEDMAN: I did receive a  
6 copy.  
7 MR. McINTYRE: Do you have one  
8 as well?  
9 MR. ZUBIAGO: Close enough.  
10 MS. FREEDMAN: I mean I have a  
11 copy of that. I don't have a similar  
12 document, if that's what you're -- yes, as  
13 we discussed before we left, I would like to  
14 submit a closing summary in writing.  
15 MR. McINTYRE: So, I will take  
16 this as IP21.  
17 MR. MILLER: Which is that,  
18 Mr. McIntyre?  
19 MR. McINTYRE: It's Roger  
20 Williams Hospital summary of their  
21 arguments.  
22 (INTERESTED PARTY EXHIBIT 21,  
23 ROGERS WILLIAMS HOSPITAL SUMMARY OF  
24 ARGUMENTS, MARKED IN FULL)

938

1 Services Council? No one here?  
2 (PAUSE)  
3 MR. McINTYRE: Do we have any  
4 questions on subject areas that have not  
5 been well tread?  
6 MS. FREEDMAN: I have  
7 questions in response to Mr. Devereaux's  
8 questioning, yes.  
9 MR. McINTYRE: In subject  
10 areas that are new, in other words?  
11 MS. FREEDMAN: I'm not  
12 bringing up any new things. I'm responding  
13 to Mr. Devereaux's questions.  
14 MR. McINTYRE: Okay. Go  
15 ahead, quickly.  
16 MS. FREEDMAN: He just took  
17 two hours.  
18 MR. McINTYRE: Yes, he did,  
19 and you will have plenty of time, too; so,  
20 we are going to take a quick break for a  
21 quick stretch.  
22 (LUNCH RECESS 12:35 TO 1:40  
23 P.M.)  
24 MR. McINTYRE: This is just as

937

1 MR. McINTYRE: This is summary  
2 of Roger Williams opposition to Rhode Island  
3 Hospital CON application for a duplicative  
4 program.  
5 MR. DEVEREAUX: Just so I, are  
6 we finishing everything today?  
7 MR. McINTYRE: Yes.  
8 MR. DEVEREAUX: So, there  
9 won't be any written submissions again after  
10 this?  
11 MS. FREEDMAN: No --  
12 MR. WALSH: I thought the  
13 e-mail you indicated the written submission  
14 today?  
15 MS. FREEDMAN: I'm sorry. I  
16 did not -- I did not read that it was due  
17 today. I'm sorry. That's probably my  
18 fault. Excuse me.  
19 MR. McINTYRE: Well, we will  
20 take this as 21. Let's see what we can get  
21 done today and --  
22 MR. MILLER: Is that the  
23 document summary of Roger Williams'  
24 opposition to RIH Life Span application?

939

1 MR. McINTYRE: That's the one.

2 Miss Freedman?

3 FURTHER EXAMINATION BY MS. FREEDMAN

4 Q. Good afternoon, Mr. Zimmerman.

5 A. Good afternoon.

6 Q. You indicated, on questioning from  
7 Mr. Devereaux, that you, you are unaware of  
8 the actual lab support or other support that  
9 either Rhode Island Hospital or Roger  
10 Williams Hospital have with respect to ten  
11 BMT beds, correct?

12 A. That's correct.

13 Q. But certainly, you will agree with me that  
14 Rhode Island Hospital has a history of  
15 investing in capital improvement, correct?

16 A. Yes.

17 Q. In fact, over the last five years, Rhode  
18 Island Hospital has invested over \$200  
19 million in capital improvements, correct?

20 A. I think so, yes.

21 Q. Are you familiar with the Cryan Report?

22 A. I have not read it.

23 Q. Okay. But you don't have any indication to  
24 believe that Rhode Island Hospital would not

940

1 by decreased capacity?

2 Q. Well, as of Dr. -- what's his name at Roger  
3 Williams -- Rathore, as of Dr. Rathore's  
4 testimony, no bone marrow transplants have  
5 been performed at Roger Williams in the  
6 months of June and July?

7 A. Yes.

8 Q. Are you aware of that?

9 A. I heard that.

10 Q. So, even though they are approved for five  
11 beds, those beds aren't being utilized at  
12 the present time, correct?

13 A. That's correct.

14 Q. So, patients are not seeking bone marrow  
15 transplants at Roger Williams Hospital at  
16 least in June and July, correct?

17 A. Correct.

18 MR. DEVEREAUX: Objection.

19 It's been asked and answered, and the  
20 witness is being asked to read the minds of  
21 patients.

22 MR. McINTYRE: Overruled. We  
23 are going to give her some time to get  
24 through this.

942

1 be able to support a bone marrow transplant  
2 program, including a laboratory, correct?

3 A. That's correct.

4 Q. All right. Now, you were asked some  
5 questions with respect to Roger Williams'  
6 program. Roger Williams is approved for  
7 five beds, correct?

8 A. That's my understanding.

9 Q. Roger Williams is not approved for seven  
10 beds, correct?

11 A. Correct.

12 Q. And you're not aware of any request by Roger  
13 Williams to increase their approval from the  
14 Department from five to seven beds,  
15 correct?

16 A. That's correct.

17 MR. DEVEREAUX: I will object  
18 only because it's been asked and answered.

19 MR. McINTYRE: I would  
20 agree.

21 Q. Would you agree with me that at the present  
22 time, even with five beds, Roger Williams is  
23 at a decreased capacity for BMT?

24 THE WITNESS: What do you mean

941

1 Q. And there's no indication at the present  
2 time that patients are all of a sudden going  
3 to seek this care at Roger Williams,  
4 correct?

5 A. That's correct.

6 Q. And you even indicated in your report that  
7 you were not sure as to why Roger Williams  
8 Hospital was under capacity, correct?

9 A. That's true.

10 Q. All right. And therefore, you gave them the  
11 benefit of the doubt that they would  
12 continue into the future to be able to  
13 perform 24 BMT's --

14 A. That's correct.

15 Q. -- with those five beds, correct?

16 A. Yes.

17 Q. Now, you're aware, are you not, that Dana  
18 Farber is an out-patient unit only?

19 A. Well, Dana Farber standing alone,  
20 without connection to Children's or Brigham  
21 & Women's, certainly only has out-patient.

22 Q. Dana Farber, standing alone, only treats  
23 out-patient patients, correct?

24 A. That's correct.

943

1 Q. Anytime where their out-patient patients  
2 need inpatient treatment or a bone marrow  
3 transplant, if it's a child, they refer it  
4 to Children's, correct?

5 A. Yes.

6 Q. And if it's an adult, they refer it to  
7 Brigham & Women's, correct?

8 A. Yes.

9 Q. And so, the collaboration there is with  
10 respect to admission referrals, correct?

11 A. Well, it includes admission referrals.  
12 I'm not sure it's limited to referrals.

13 Q. Isn't it fair to say that you're not sure  
14 what the collaboration is other than  
15 admissions?

16 A. Well, that's not quite right. I do  
17 know that the National Cancer Institute has  
18 commissioned the Boston area, the Harvard  
19 hospitals, as a comprehensive cancer center;  
20 and part of that has to do with their  
21 working collaboratively on programs; so, to  
22 that extent, I believe that they do more  
23 than just admit.

24 Q. Okay. But they -- all right. And I'm going

944

1 A. Yes, yes, I do.

2 Q. And in fact, isn't it true that Rhode Island  
3 Hospital receives 94 percent of the market  
4 share for kidney transplants?

5 A. Yes, I think that is true.

6 Q. And isn't it also true that for kidney  
7 transplants, Rhode Island Hospital receives  
8 46 percent of the market share from the 19  
9 Massachusetts cities and towns?

10 A. That may be true.

11 Q. And that's consistent with your analysis to  
12 utilize 50 percent, correct?

13 A. Yes, it would be.

14 Q. So, in fact, there's some history that Rhode  
15 Island Hospital has with respect to gaining  
16 the market share for a high-end service and  
17 that's kidney transplantation?

18 A. For a transplant service, yes.

19 Q. Okay. And Mr. Devereaux asked you some  
20 questions regarding United Health Care. Are  
21 you aware that with respect to kidney  
22 transplantation, Rhode Island Hospital was  
23 successful in negotiating a contract for  
24 reimbursement for that service?

946

1 to get into that. They also collaborate on  
2 research, correct?

3 A. Yes.

4 Q. And they use the same IRB; are you aware of  
5 that?

6 A. Yes.

7 Q. And they are all under the Harvard umbrella,  
8 correct?

9 A. That's correct.

10 Q. So, the collaboration is all under the  
11 Harvard umbrella, true?

12 A. Yes.

13 Q. And the list of the Boston entities that are  
14 performing bone marrow transplants, each one  
15 of those entities are major teaching  
16 hospitals, correct?

17 A. I think so, yes.

18 Q. Okay. With respect to market share, you  
19 were asked some questions regarding whether  
20 or not Rhode Island Hospital or you had any  
21 statistics to show that Rhode Island  
22 Hospital would obtain 50 percent of the  
23 Massachusetts market; do you recall those  
24 questions?

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1 A. No, I was not aware of that.

2 Q. And certainly, will you agree with me that  
3 if Rhode Island Hospital, Rhode Island  
4 Hospital's BMT program is approved, that  
5 certainly there's the possibility that  
6 United Health Care will pay for that service  
7 in Rhode Island for Rhode Island  
8 residents?

9 MR. DEVEREAUX: Note my  
10 objection to that question, because I think  
11 it's pure speculation, unless the witness  
12 has some foundation to base an answer to  
13 that. He's being asked is there a  
14 possibility. It's possible I could get hit  
15 by lightning walking out of the building  
16 tonight.

17 MR. McINTYRE: Well, I gave  
18 you some leeway, Mr. Devereaux, and I'm  
19 going to afford her the same. To the extent  
20 you can answer.

21 A. I think that United Health Care would  
22 look out for their own interest. If there  
23 was a good program at Rhode Island Hospital,  
24 I think they would certainly consider it,

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1 also.  
 2 Q. And certainly, just because a Rhode Island  
 3 or a patient in the 19 contiguous  
 4 Massachusetts towns has United Health Care  
 5 coverage does not mean that they have to go  
 6 to Boston, correct?  
 7 A. I don't know what their policies say,  
 8 so I really can't answer that question.  
 9 Q. You really don't know what United Health  
 10 Care's policy is, correct?  
 11 A. That's exactly true.  
 12 Q. And in fact, you have no idea about whether  
 13 or not a patient can request and obtain  
 14 preapproval for a bone marrow transplant  
 15 somewhere other than in Boston, correct?  
 16 A. That's true.  
 17 Q. You are aware, are you not, that Rhode  
 18 Island Hospital provides the highest  
 19 uncompensated care of patients in Rhode  
 20 Island?  
 21 A. Yes, I knew that.  
 22 Q. And you would -- well, let me leave it  
 23 there. Can I have one minute, please?  
 24 MR. McINTYRE: Absolutely.

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FURTHER EXAMINATION BY MR. DEVEREAUX  
 1 Mr. Zimmerman, you were asked some questions  
 2 about Dana Farber. I just want to follow up  
 3 quickly. You said you were aware they only  
 4 treat out-patients I think was the  
 5 question?  
 6 A. Yes. Dana Farber is not an inpatient  
 7 institution, as I understand it. They have  
 8 some beds, and they may keep you overnight,  
 9 but technically they are providing an  
 10 out-patient service.  
 11 Q. So, in other words, they treat a patient but  
 12 they treat the patient in collaboration with  
 13 one of the other facilities?  
 14 A. Yes, that's my understanding.  
 15 Q. Okay. And when you were asked, under the  
 16 Harvard umbrella, we are talking about all  
 17 of the hospitals that were in that  
 18 consortium that we spoke about this  
 19 morning?  
 20 A. That's the group, yes.  
 21 Q. And obviously, you don't know all the  
 22 clinical trials and what is going on between  
 23 one hospital and another, as you testified  
 24

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1 MS. FREEDMAN: Thanks.  
 2 (PAUSE)  
 3 Q. Mr. Zimmerman, you were asked some questions  
 4 about whether or not having two programs may  
 5 fragment the care provided. Certainly,  
 6 there's, any prediction of such  
 7 fragmentation would be speculative,  
 8 correct?  
 9 A. It does not have to be fragmented.  
 10 Q. It doesn't have to be fragmented and a  
 11 conclusion that it would be fragmented is  
 12 speculative; is it not?  
 13 A. Yes.  
 14 MS. FREEDMAN: Thank you. I'm  
 15 all set. I'm sorry.  
 16 MR. McINTYRE: I thought you  
 17 were pondering your next question.  
 18 MS. FREEDMAN: No, sorry.  
 19 MR. McINTYRE: Mr. Miller?  
 20 MR. MILLER: I have no  
 21 questions.  
 22 MR. McINTYRE: Mr. Devereaux?  
 23 MR. DEVEREAUX: Brief.  
 24

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1 today?  
 2 A. Right. I don't follow that.  
 3 Q. There was a question about 94 percent of the  
 4 kidney transplant market being captured by  
 5 Rhode Island Hospital?  
 6 A. Uh-huh.  
 7 Q. You're aware that there's a representation  
 8 by Rhode Island Hospital that that's what  
 9 they capture?  
 10 A. Yes, I am.  
 11 Q. Have you ever seen any data that underlies  
 12 that number?  
 13 A. No, I actually have not.  
 14 Q. And when you were asked about United, you  
 15 said you're not aware of what their policies  
 16 are; that wasn't part of your information in  
 17 your estimates?  
 18 A. That's true.  
 19 Q. Lastly, when you say the health, the system  
 20 doesn't need to be fragmented in this case?  
 21 A. Yes.  
 22 Q. It doesn't need to be fragmented, frankly,  
 23 if there was collaboration; would you  
 24 agree?

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1 A. That's true.  
 2 MR. DEVEREAUX: No further  
 3 questions.  
 4 MR. McINTYRE: Okay. All  
 5 right. Mr. Zimmerman, thank you very much  
 6 for your testimony today.  
 7 THE WITNESS: Thank you.  
 8 MR. McINTYRE: It was very  
 9 helpful and informative.  
 10 MS. FREEDMAN: I have one  
 11 piece of housekeeping.  
 12 MR. McINTYRE: Let's get to  
 13 that.  
 14 MS. FREEDMAN: Okay. I, at  
 15 our last meeting, indicated that I would be  
 16 sending in a response to the, to Roger  
 17 Williams Hospital' executive summary as well  
 18 as the chart table of purported inaccuracies  
 19 and omissions. I provided that to everybody  
 20 yesterday, and I'd like to provide the  
 21 original for the record; and I'd like to  
 22 request that it go into the record.  
 23 MR. McINTYRE: Yes, okay.  
 24 Mr. Devereaux?

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1 want to do that, because I know you need  
 2 some time to read and digest this.  
 3 Miss Freedman indicated that  
 4 she would like to submit written closing  
 5 arguments. Is that essentially prepared  
 6 already, Linn?  
 7 MS. FREEDMAN: Yes, it's  
 8 substantially prepared. I can get it to you  
 9 very quickly.  
 10 MR. McINTYRE: In other words,  
 11 if I kept the record open until the end of  
 12 the week --  
 13 MS. FREEDMAN: To the end of  
 14 if tomorrow?  
 15 MR. McINTYRE: Yes. Would  
 16 that do it for you, Mr. Devereaux?  
 17 MR. DEVEREAUX: Unfortunately,  
 18 I'm going to be defending an Indian Tribe  
 19 tomorrow morning.  
 20 MS. FREEDMAN: Well, I'm going  
 21 to be at Mental Health --  
 22 MR. DEVEREAUX: I probably  
 23 need until the close of business Monday.  
 24 MR. McINTYRE: And I'm

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1 MS. FREEDMAN: Both of them,  
 2 actually.  
 3 MR. DEVEREAUX: Could I have a  
 4 moment, please?  
 5 MR. McINTYRE: Absolutely.  
 6 (PAUSE)  
 7 MR. McINTYRE: Linn, when you  
 8 e-mailed something -- let's go off the  
 9 record for a moment.  
 10 (OFF THE RECORD)  
 11 MR. DEVEREAUX: The only issue  
 12 I have is I haven't even had a chance to  
 13 read that, because it came in yesterday.  
 14 You know, I mean if they are going to be  
 15 allowed, I would at least like some  
 16 reasonable latitude. If they deserve a  
 17 response, we can respond.  
 18 MR. McINTYRE: All right. Why  
 19 don't we do this then? I will take them  
 20 both in, and I think this relates to what we  
 21 are going to do with regard to closing  
 22 arguments as well. In other words, if we  
 23 were going to close the record today, that  
 24 would preclude anything else, but I don't

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1 circling the wagon, so...  
 2 MS. FREEDMAN: I don't have a  
 3 problem with the close of business Monday,  
 4 if that's what he needs.  
 5 MR. McINTYRE: Mr. Miller, any  
 6 objection?  
 7 MR. MILLER: No objection.  
 8 No.  
 9 MR. McINTYRE: You need it  
 10 over the weekend?  
 11 MR. DEVEREAUX: Yes.  
 12 MR. McINTYRE: Close of  
 13 business day Monday?  
 14 MR. WALSH: Yes.  
 15 MR. McINTYRE: Okay. Let's do  
 16 that then.  
 17 MR. WALSH: If we could close  
 18 at three today, I was promised.  
 19 MR. McINTYRE: There goes your  
 20 weekend. All right. Applicant Exhibit  
 21 Rhode Island Hospital 21 -- 22 rather.  
 22 MR. MILLER: 22 is which one?  
 23 MR. McINTYRE: 22 is going to  
 24 be, I forgot my glasses today, the Table.

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1 MS. FREEDMAN: 22.  
 2 MR. McINTYRE: Yes.  
 3 MR. McINTYRE: 22 is the  
 4 table, purported table of inaccuracies.  
 5 MS. FREEDMAN: The response to  
 6 purported table of inaccuracies.  
 7 MR. McINTYRE: Response to  
 8 purported table of inaccuracies.  
 9 (RHODE ISLAND HOSPITAL  
 10 EXHIBIT 22, RESPONSE TO PURPORTED TABLE OF  
 11 INACCURACIES, MARKED IN FULL)  
 12 MR. McINTYRE: God bless the  
 13 Council. And 23 will be Roger Williams --  
 14 Rhode Island Hospital's response to Roger  
 15 Williams Hospital's executive summary.  
 16 (RHODE ISLAND HOSPITAL  
 17 EXHIBIT 23, R.I. HOSPITAL'S RESPONSE TO  
 18 ROGER WILLIAMS HOSPITAL'S EXECUTIVE SUMMARY,  
 19 MARKED IN FULL)  
 20 MR. McINTYRE: Are we ready  
 21 for oral closing arguments? Are you going  
 22 to give it or differ?  
 23 MS. FREEDMAN: I was going to  
 24 differ, but I mean I can give a short one,

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1 Hospital was very conservative in its  
 2 analysis to state that it would capture 48  
 3 patients or 58 percent, I'm sorry, 57  
 4 percent of the market, that being 40 adults  
 5 and eight pediatric patients by FY11; and  
 6 certainly, with Mr. Zimmerman's testimony, I  
 7 think buttresses the fact that Rhode Island  
 8 Hospital was conservative in those numbers,  
 9 because Mr. Zimmerman indicated that the  
 10 numbers are 94 or 93.

11 So, with respect to the facts  
 12 set forth in the application as well as the  
 13 testimony of the witnesses, even with Roger  
 14 Williams Hospital continuing to perform 24  
 15 bone marrow transplants a year going  
 16 forward, which is clearly what the average  
 17 has been for the past ten years, there is  
 18 sufficient demand in the State of Rhode  
 19 Island to justify the need for a new program  
 20 at Rhode Island Hospital. Mr. Zimmerman and  
 21 Rhode Island Hospital, in the testimony and  
 22 the documents, have clearly demonstrated  
 23 that there's no pediatric program in Rhode  
 24 Island, and both entities, Mr. Zimmerman and

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1 if you want.  
 2 MR. McINTYRE: It's up to you.  
 3 If you feel like a written one is better off  
 4 for you, go ahead.  
 5 MS. FREEDMAN: I'm happy to  
 6 give a very short summation, subject to my  
 7 written summation.  
 8 MR. McINTYRE: Go ahead.  
 9 MS. FREEDMAN: Want me to  
 10 start?  
 11 MR. McINTYRE: Please.  
 12 MS. FREEDMAN: In this matter,  
 13 Rhode Island Hospital has met the criteria  
 14 set forth in the statute and the regulations  
 15 with respect to a certificate of need  
 16 application, particularly for the need for a  
 17 bone marrow transplant facility and program  
 18 at Rhode Island Hospital. The evidence is  
 19 clear and overwhelming, and even Rhode  
 20 Island Hospital's needs analysis was  
 21 conservative in indicating that the  
 22 estimated demand for the program or for bone  
 23 marrow transplant was 75 adults and nine  
 24 children as of FY11. And Rhode Island

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1 Rhode Island Hospital, have indicated that  
 2 there's a need for two beds here in Rhode  
 3 Island.

4 And I, I have to tell you that  
 5 Dr. Cindy Schwartz and her testimony was so  
 6 overwhelming and so clear about the need for  
 7 a pediatric program in Rhode Island, and it  
 8 was compelling testimony. The fact that we  
 9 have a nationally acclaimed  
 10 hematologist-oncologist, who has devoted her  
 11 career to the treatment of patients,  
 12 pediatric patients with blood and cancer  
 13 diagnoses and the fact that she is here in  
 14 Rhode Island is something that we should be  
 15 very, very proud of, and the fact that she  
 16 does not have a bone marrow transplant  
 17 program presently and she testified she's  
 18 already sent nine pediatric cases out of  
 19 state and has three more in the hopper,  
 20 right there twelve patients in this year  
 21 since last July. The fact that she is here.  
 22 The fact that she has the experience and the  
 23 research capabilities and has the priority  
 24 to really make a difference for cancer

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1 patients in Rhode Island is something that I  
2 think we cannot ignore.

3 These pediatric patients in  
4 Rhode Island are going to get the creme de  
5 la creme, the best of the best, and in fact,  
6 with this program at Hasbro Children's  
7 Hospital, we are going to see that  
8 nationally patients are going to come here  
9 because of the protocols and the research  
10 that she and her team will be able to do and  
11 implement; and to me, that's, that's very  
12 compelling, and what a great thing for Rhode  
13 Island to be able to offer that to our  
14 pediatric patients, and there's absolutely  
15 no evidence, none, that would, that would  
16 render that conclusion null and void.

17 So, I felt that her testimony  
18 was very compelling, that this is something  
19 we have to do in Rhode Island. That we have  
20 this talent here is incredible, in my  
21 estimation. The research capabilities at  
22 Rhode Island Hospital and Hasbro Children's  
23 Hospital certainly are widespread, are well  
24 known. We have every reason to believe that

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1 more uncompensated care can go on in the  
2 State of Rhode Island; and that money is not  
3 being sucked out to Boston or anywhere else.

4 Rhode Island Hospital, Hasbro  
5 has the support. There's not been any  
6 indication that Rhode Island Hospital and  
7 Hasbro do not have the proper support for  
8 this program in infrastructure, in support  
9 services and in human resources.

10 And lastly, I would like to say  
11 that the, there was compelling testimony by  
12 both Dr. Winer and Dr. Schwartz about the  
13 cost to families, and we can talk about  
14 hotel cost and we can talk about  
15 transportation cost, but the human cost to  
16 families of having to go elsewhere is  
17 substantial. And the Health Services  
18 Council should take that into account when  
19 you're talking about 90 families, you're  
20 talking about 90 patients, according to  
21 Mr. Zimmerman, but you're talking about 90  
22 families that that's going to affect, and  
23 you're talking about another eight to twelve  
24 pediatric families. The costs associated

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1 the research will continue and will grow and  
2 will make this a very robust program, and  
3 the affordability of the program, I think,  
4 is also unquestioned.

5 Mr. Zimmerman testified this  
6 morning that this was a very small cost in  
7 the grand scheme of things, and yet, the  
8 benefit to the lives, both adult and  
9 pediatric, are significant; and that's the  
10 right thing to do when you're talking about  
11 health care policy and you're talking about  
12 the needs of Rhode Islanders and meeting the  
13 needs of Rhode Islanders.

14 So, the other point I would  
15 like to make with respect to affordability  
16 is the record is clear about the impact that  
17 Life Span and Rhode Island Hospital has had  
18 on the economy in Rhode Island. If this  
19 program comes to Rhode Island Hospital, the  
20 facility fees, the professional fees, the  
21 costs associated with these, this treatment,  
22 will stay in Rhode Island; and as a result  
23 of keeping that, those resources in the  
24 State of Rhode Island, more services and

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1 with going out of state is tremendous; and  
2 as Dr. Schwartz said, you know, she referred  
3 one patient to Chicago because that's where  
4 they had family and that's where they had  
5 support.

6 So, the human cost to the  
7 people of Rhode Island is significant and  
8 should be, should be considered by the  
9 Health Services Council in part of their  
10 analysis of the affordability of this  
11 program.

12 So, I will supplement my  
13 closing remarks in writing, but I, I believe  
14 that the criteria of need and affordability  
15 and how good this would be for the people of  
16 Rhode Island is overwhelming in the record.  
17 Thank you.

18 MR. MCINTYRE: Thank you.  
19 Mr. Devereaux?

20 MR. DEVEREAUX: Thank you.  
21 I'm going to stand up, because I, I'm going  
22 to use this podium so I can get away from  
23 Charlie and Jack. Mr. McIntyre, Members of  
24 the Health Services Council, Members of the

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1 Department of Health, I certainly want to  
2 thank you for your attention for what's been  
3 a long and interesting and at times tedious  
4 process, but it's a very important process.

5 What I'd like to talk about  
6 first is what this case, frankly, is not  
7 about. What the case is not about, as I  
8 understand it, it's not about Rhode Island  
9 Hospital's need to expand. It's not about  
10 Rhode Island Hospital's need to capture more  
11 potential market share and competition with  
12 Boston hospitals. It's not about pushing  
13 other hospitals aside in their quest to  
14 compete with nationally recognized  
15 institutions, and it's not about 20 or 19 or  
16 however many towns in Massachusetts might  
17 come to Rhode Island, some residents that  
18 might come to Rhode Island for some tertiary  
19 service. That, as I understand the  
20 statutes, the law and the regulations, is  
21 not what this case is about.

22 What the case is about, it's  
23 about the Rhode Island health care community  
24 and what is good for the people of Rhode

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1 care equipment and for the scope thereof at  
2 the time and place and under the  
3 circumstances proposed, considering the  
4 availability of existing facilities,  
5 equipment and services, both state wide and  
6 on a local basis, which may serve as  
7 alternatives or substitutes for the whole or  
8 any part of the proposed new institution  
9 health service or new health care equipment;  
10 and then it lists pretty specifically what  
11 you have to do to demonstrate, at a minimum,  
12 that need.

13 And I would submit, when you  
14 go further and you look at Section 9.12, for  
15 the record, which also sets forth what the  
16 Health Services Council has to consider,  
17 again, the availability of alternative, less  
18 costly or more effective methods of  
19 providing such services or equipment,  
20 including economies or improvements in  
21 services that could be derived from feasible  
22 cooperative or shared services.

23 So that is the analysis that  
24 has to happen in this particular case. It's

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1 Island and what is affordable for the people  
2 of Rhode Island, because we are talking  
3 about health care. We are not talking about  
4 widgets or selling some type of commodity.  
5 We are talking about health care. That's  
6 why it's so heavily regulated, and it's why  
7 we have the process that we go through in  
8 this particular case.

9 So, what do the regulations in  
10 the statutes tell us, because I think you  
11 have to go back, after all is said and done,  
12 and we need to focus on what those statutes  
13 and regulations tell us. And you go right  
14 to the definition of public need, which is a  
15 substantial or obvious community need for  
16 the specific new health care equipment or  
17 new institutional health services proposed.  
18 An obvious and a substantial community need  
19 meaning the community of Rhode Island. And  
20 then you refer to Section 4.3, which talks  
21 about what has to be put before the Health  
22 Services Council. The demonstration of a  
23 public need for the proposed new  
24 institutional health service, a new health

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1 not a show and tell about what percentage of  
2 a potential market that's out there that we  
3 might be able to capture.

4 Frankly, I was impressed with  
5 Mr. Macri's presentation. It was a very  
6 good presentation by a CFO who's got a  
7 business that he has to run, and frankly, he  
8 made his points. But I, frankly, I went  
9 back and I looked at Mr. Macri's testimony,  
10 and it was refreshingly candid, because most  
11 of the terms he used, when he was describing  
12 what this was about, from Rhode Island  
13 Hospital's perspective, he was talking about  
14 how he was facing a very competitive  
15 environment that we function with all the  
16 Boston teaching hospitals. Talking about  
17 market share and what we see as the target  
18 market. What we continue to see -- we  
19 continue to see opportunities like this in  
20 order to grow and develop the institution.  
21 What happens in a business, he says, as we  
22 know, it gets perfected in the high-end  
23 centers. Over time it becomes almost  
24 commoditized and goes down to being offered

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1 in the community institutions.  
 2 We need to keep our investments  
 3 up so we can stay at the high end to enable  
 4 us to operate the kind of center we have, so  
 5 we stay ahead of the game, if you will.  
 6 Spoken like a good CFO, but that isn't the  
 7 analysis. The analysis is what is the  
 8 public need in Rhode Island and what is  
 9 affordable for the people of this state.

10 So, then you look at Rhode  
 11 Island Hospital's certificate of need  
 12 application; and as I understand what they  
 13 put forward, is essentially their case is,  
 14 trust us. We put a lot of money in the  
 15 economy. We are a big player. We are the  
 16 biggest player in Rhode Island. We are an  
 17 academic center. You might be a teaching  
 18 hospital but trust us. We are going to  
 19 capture the market, and what I would ask the  
 20 Health Services Council to focus on is when  
 21 Mr. Zimmerman put his numbers up, which we  
 22 very candidly admitted were estimates, he  
 23 said this is the capacity. Used the word  
 24 capacity in the slide, not the need, the

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1 factored in. Right now the status of the  
 2 evidence is Rhode Island Hospital says,  
 3 trust us. We can do this. The market is  
 4 there; and as I understood, Mr. Macri's  
 5 presentation, it was, Rhode Island Hospital  
 6 will get 40 or 50 BMT's but you folks over  
 7 there across the city at Roger Williams you  
 8 will still get your 20, and that's what I  
 9 understood his testimony to be, although  
 10 that wasn't the testimony of other witnesses  
 11 presented by Rhode Island Hospital.

12 I think, frankly, one of the  
 13 more candid things that was testified to was  
 14 Dr. Klein, certainly a very well-respected  
 15 and gifted physician. But when he was on  
 16 the other side of the coin, he sent a letter  
 17 on May 15 of this year in which he said to  
 18 Mr. Russin, at the DOH, as you know, data  
 19 analysis is complicated and can lead to  
 20 faulty conclusions even under the best  
 21 circumstances. What I found sort of ironic  
 22 is that what he was speaking about was the  
 23 cardiac program that Mr. Zimmerman testified  
 24 today, which he said he felt vindicated by

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1 public need. The capacity.  
 2 Where is the analysis in the  
 3 CON application that was submitted about  
 4 affordability? You know, it's one thing to  
 5 get a view from 50,000 feet and say, well,  
 6 it's less than 1 percent of the entire  
 7 hospital budget in Rhode Island; and I would  
 8 submit, with due difference to  
 9 Mr. Zimmerman, that is not a very detailed  
 10 analysis of the affordability of this  
 11 particular program in light of all the  
 12 circumstances. More has to be done, and the  
 13 fact is the evidence isn't there. The  
 14 evidence isn't there in the CON application.  
 15 The evidence, from what I heard from  
 16 Mr. Zimmerman, really isn't that detailed.

17 So, where, I would submit to  
 18 the Health Services Council we are left in a  
 19 position of surmising or guessing that it's  
 20 going to be affordable because we haven't  
 21 even looked at, you know, we are looking at  
 22 a best-case scenario. That's what we are  
 23 looking at. We are not looking at a  
 24 worst-case scenario, and that also has to be

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1 because everybody was projecting rosy  
 2 numbers at that time for cardiac, and it  
 3 didn't pan out. It didn't pan out. And I  
 4 think Dr. Klein was quite candid in saying  
 5 that data analysis, we can put a lot of  
 6 spins on it to make it look different ways.

7 In fact, one of the things that  
 8 Mr. Zimmerman said, which I found quite  
 9 candid, was when I said this 50 percent  
 10 number that he assigned to the 19 or 20  
 11 towns in Massachusetts were sort of a  
 12 sliding number, he felt comfortable with the  
 13 50, but the Health Services Council, you can  
 14 take it down to 25 or whatever number you  
 15 wanted. Well, if you slide that number  
 16 down, the number of projected beds certainly  
 17 comes down from ten. That number ten or  
 18 nine or whatever it is comes down. So, if  
 19 you take the numbers away from the, and  
 20 remember, the Massachusetts, I believe  
 21 Mr. Zimmerman said the reason he calculated  
 22 Massachusetts was because that was  
 23 essentially what was in the CON application  
 24 submitted by Rhode Island Hospital, and they

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1 had used it in the past.  
 2 Again, the standard is what is  
 3 needed and affordable in the State of Rhode  
 4 Island, not what potentially Rhode Island  
 5 Hospital might capture. But what I also  
 6 found striking in the case is what Rhode  
 7 Island Hospital specifically did not address  
 8 in their CON application. In  
 9 Section 4.3(d), they are asked about  
 10 collaboration. What other analyses did you  
 11 do in determining whether collaboration was  
 12 a viable alternative? The answer, as I  
 13 understand it, and I'm speaking candidly,  
 14 was pretty much what are you bothering us  
 15 with this question for because it's either,  
 16 A, you do nothing, or B, you give us a BMT  
 17 or you give us a pediatric BMT. That was  
 18 the answer to collaboration. There was  
 19 never any attempt to substantively examine  
 20 collaboration as an issue. It is not in the  
 21 application. You can look for it. You can  
 22 hold it up into the highest light. You're  
 23 not going to see it because it isn't there.  
 24 Because they don't want to collaborate,

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1 would invite the Health Services Council to  
 2 review that testimony, because, essentially,  
 3 what he said was, when I asked him about  
 4 collaboration and whether there had been any  
 5 collaboration or attempt to collaborate with  
 6 Roger Williams, which already has an  
 7 existing and very viable facility, his  
 8 answer was, on Page 290 of the transcript,  
 9 all I'm aware of is Dr. Amaral had two  
 10 conversations with Dr. Belcher and nothing  
 11 came from those conversations. I don't find  
 12 it unusual, because it's an atypical  
 13 arrangement for a collaboration with an  
 14 academic medical center that it would be in  
 15 this direction. Normally the academic  
 16 tertiary center would be providing the  
 17 highest-end services and the institution we  
 18 would collaborate with would provide either  
 19 primary or secondary care. So, I can  
 20 understand why it was difficult for the  
 21 parties to have a conversation relative to  
 22 collaboration. Question, well, just a  
 23 follow-up to that. You're basically saying  
 24 that in order for there to be collaboration,

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1 which is clear from the evidence.  
 2 Then we look at their  
 3 affordability analysis, and I would submit,  
 4 when the Health Services Council looks at  
 5 that, they should look at it and scrutinize  
 6 it, because there isn't any meat to it in  
 7 terms of what is in there to say, with any  
 8 confidence, that the people of Rhode Island  
 9 can afford to take this chance, which is  
 10 what the Health Services Council is being  
 11 asked to do in this case. They are being  
 12 asked to take a chance based on the  
 13 evidence, which I think brings us to the  
 14 crux issue in this particular case.

15 And the crux of the issue is  
 16 collaboration. Frankly, we are at a point  
 17 where we are either, as the Department of  
 18 Health and the Health Services Council, we  
 19 are going to say what we mean or what's been  
 20 written about collaboration really doesn't  
 21 mean anything. Because in this particular  
 22 case, and again, I commend Mr. Macri for his  
 23 candor in testimony, but I pressed him on  
 24 that point, if you will remember; and I

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1 the bone marrow transplant unit would have  
 2 to be at Rhode Island Hospital? Answer,  
 3 it's our view that a program needs to be an  
 4 it Rhode Island Hospital. The fact is, if  
 5 there's going to be any collaboration,  
 6 according to the testimony that I read, it's  
 7 going to be collaboration with a bone marrow  
 8 transplant unit at Rhode Island Hospital.  
 9 It's not going to be Rhode Island Hospital,  
 10 based on that testimony, collaborating with  
 11 Roger Williams. And that is a shame.  
 12 That's a shame for this system of ours that  
 13 that's the way we are going to conduct  
 14 business, and that's one of the reasons I  
 15 showed Mr. Zimmerman those web printouts  
 16 from the hospitals in Boston.

17 And I respect Rhode Island  
 18 Hospital, but frankly, you're talking about  
 19 premiere international institutions. Dana  
 20 Farber Cancer Center, Harvard Medical  
 21 School, all those schools, all of the  
 22 hospitals up there, and what do they do?  
 23 They collaborate. They collaborate with one  
 24 another. And the fact is that if the tone

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1 is essentially we are going to be the big  
2 guy on the block. We are going to do all  
3 the tertiary services and you guys aren't,  
4 and we are not collaborating with you, then  
5 that is one heck of a message to be sending  
6 out to the health care community.

7 The fact is, and I know that  
8 Mr. Zimmerman disagreed with this, but  
9 again, I thought Dr. Schwartz's testimony, I  
10 would agree with Miss Freedman, I thought  
11 she was a quite credible witness; and I  
12 thought she was very candid when she said,  
13 yes, volume is very important. That's her  
14 testimony. Volume is very important as a  
15 consideration in that bone marrow transplant  
16 world. And she indicated -- what I  
17 also found refreshing about her testimony  
18 was when she first talked about all of these  
19 considerations of people going to Boston and  
20 how it would impact families having to  
21 travel to Boston. Some of the direct  
22 examination was directed to the fact that  
23 Rhode Island Hospital felt that they could  
24 develop such a premiere pediatric unit that

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1 very impressive numbers that those  
2 Massachusetts institutions are doing for  
3 bone marrow transplant, very impressive  
4 numbers; and Roger Williams, he said, was  
5 actually doing as well as you would expect.  
6 Then he looked at some of the other  
7 statistics across the country and across, I  
8 believe, Europe and said those 24, that  
9 average is a pretty good average.

10 So, we have got, in Rhode  
11 Island right now, an opportunity and the  
12 opportunity is to stand up and say we are  
13 going to collaborate. That's what we are  
14 going to do. And I would ask the Health  
15 Services Council, when they review this, to  
16 look at -- give me just one minute.

17 (PAUSE)

18 MR. DEVEREAUX: Give me just  
19 one minute.

20 MR. McINTYRE: Sure.

21 (PAUSE)

22 MR. DEVEREAUX: The  
23 Coordinated Health Planning in Rhode Island  
24 document that was submitted by the

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1 people from Boston would come down to  
2 Providence. I guess they wouldn't have the  
3 same considerations then about traveling  
4 down to Providence. That, candidly, is a  
5 red herring; and as long as I have lived in  
6 this state, I have always found -- it's kind  
7 of what I called Rhode Islandese. Anything  
8 more than 20 minutes away is somehow a long  
9 expedition. The fact of the matter is you  
10 have a child who's in need of cancer -- a  
11 bone marrow transplant unit. If you can  
12 afford it, you're going to the best facility  
13 that you can find; and if there's a facility  
14 within 50 miles or 45 miles of your home,  
15 you're going to go there. That's just a  
16 fact of life; and to argue differently, is  
17 just defying logic. The point is that, when  
18 I hear that, yeah, my heart goes out to  
19 everybody that goes through that, that has  
20 to go to Boston. I have done it myself.  
21 But the fact is that people do travel on a  
22 regular basis, which is why Mr. Zimmerman  
23 listed all of those medical centers in his  
24 analysis, and candidly, said, yes, those are

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1 Department of Health in consultation with  
2 the Coordinated Health Planning Advisory  
3 Committee. And they came to certain  
4 findings, recommendations and conclusions.  
5 And I just want to, for the record, read a  
6 couple of those, because I think it  
7 addresses right square on what this case is  
8 all about.

9 The health care system and  
10 findings -- they say the health care system  
11 has not and will not transform optimally or  
12 effective without a robust health planning  
13 process that features collaboration and  
14 coordination across all public and private  
15 sector participants. And the conclusion  
16 section says, the report says, the U.S.  
17 health care system and Rhode Island's health  
18 care system are notoriously fragmented. One  
19 consequence of this is that the system costs  
20 more without better results in terms of  
21 population health. As the Coordinated  
22 Health Planning Act of 2006 stated in its  
23 legislative findings, a robust health  
24 planning process in Rhode Island should lead

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1 to improvements in the health care delivery  
2 system through the creation of a unified  
3 health care system planned and coordinated  
4 in public-private partnership. The health  
5 care system must transition from one based  
6 on competition to one that is rewarded for  
7 collaboration and coordination. And I just  
8 want, and one that is rewarded for  
9 collaboration and coordination. That's the  
10 conclusion.

11 Now, that, if that means  
12 anything, this is the case where we are  
13 either going to say it means something or it  
14 doesn't. Because the fact is the evidence  
15 here on collaboration is, to be charitable,  
16 it is just nonexistent. The fact is, and  
17 Mr. Zimmerman indicated in his report back  
18 in 1992, that in order for the bone marrow  
19 transplant unit to be successful, there had  
20 to be coordination; and here we are now in  
21 2007 and the Department of Health is saying  
22 the same thing. There should be  
23 collaboration. And why is that important in  
24 this case? Because even if you assume, for

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1 Williams wants to collaborate with Rhode  
2 Island Hospital, they've got to get in their  
3 cars and drive over to Rhode Island  
4 Hospital.

5 So, is that the best scenario  
6 for Rhode Islanders, cost effective scenario  
7 when you have already got a good bone marrow  
8 transplant unit; and you heard the people  
9 who came in here and testified. You heard  
10 from the doctors to the nurses, to the  
11 administrators. Dedicated people that are  
12 in there serving the health care community.  
13 And the bottom line is that we are at a  
14 point where if we are not going to  
15 collaborate, then we will just have  
16 straight-out competition, straight-out bare  
17 knuckles competition.

18 And I'm also going to ask the  
19 Health Services Council to look at the  
20 presentation that Rhode Island Hospital made  
21 in this case, because I don't believe the  
22 evidence shows it was a consistent  
23 presentation. Because if I look at  
24 Mr. Macri's testimony, essentially what he

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1 the sake of argument, that there's a demand  
2 or, or that there's -- I'm not saying a  
3 need, a capacity for 92 or 91 BMT's, if all  
4 of that data turns out to be correct, and  
5 that's what you're going to have to bet on  
6 is that all that data turns out to be  
7 correct, if half of the eligible  
8 Massachusetts people from the 20 towns say  
9 I'm not going up to Boston, I'm going to go  
10 to Rhode Island Hospital, the fact is that  
11 Mr. Zimmerman says there's only a need for  
12 ten beds. So, what are we going to do? Are  
13 we going to say, well, we are going to break  
14 up the system, basically? What we are going  
15 to do is we are going to have Roger Williams  
16 with five or seven beds, and I believe their  
17 application is for eight, but I guess if we  
18 are going to only have ten, if we follow  
19 Mr. Zimmerman's numbers, I guess we will  
20 have five beds over at Rhode Island Hospital  
21 and five or seven beds at Roger Williams and  
22 two pediatric beds, and there's no  
23 collaboration going on because they are  
24 competing with one another; because if Roger

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1 said was there is a, there is a market out  
2 there. And we are going to get it, and you  
3 will still get your 20. Don't worry.  
4 We will pat you guys on the head. You still  
5 get your 20, 24, whatever it is. That's not  
6 what Dr. Winer said when he was brought in  
7 here to testify. We didn't put him on the  
8 witness stand. They did. Now, did they  
9 bring Dr. Winer in to say that program at  
10 Roger Williams that I worked at 14 months,  
11 they have a good program and I had a tough  
12 time leaving that program, but you know, I  
13 thought I wanted to be with my mentor, Pete  
14 Quesenberry, and it was a professional  
15 decision, and I wish my colleagues well at  
16 Roger Williams? That was not the purpose  
17 that they brought him in to testify. He got  
18 up there, and his role, if you will, in this  
19 hearing was to basically come in and  
20 denigrate the Roger Williams program that he  
21 worked at for 14 months with his mentor,  
22 Dr. Pete Quesenberry. If there's any doubt  
23 that he came in here and said the reason he  
24 didn't refer people is that it's unsafe, I

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1 invite, I invite the Health Services Council  
 2 to look at Page 213 of his transcript  
 3 because that's exactly what he says.  
 4 Unsafe, but when he was there, it was safe  
 5 because he had confidence in his own  
 6 ability. That was his testimony. He was  
 7 recruited by Dr. Quesenberry to be the  
 8 director of a nonexistent BMT program at  
 9 Rhode Island Hospital. That's what the  
 10 facts show. And there's not one referral  
 11 that either Dr. Quesenberry or Dr. Winer has  
 12 provided to Roger Williams Hospital since  
 13 they left. People that they worked with  
 14 professionally, colleagues that they worked  
 15 with.

16 Now, why is that? Is it  
 17 because we should believe Dr. Winer that  
 18 it's an unsafe program while he's referring  
 19 patients to Boston but says that's okay?  
 20 Really troubles him to have a patient across  
 21 town three minutes away, but boy, he goes to  
 22 Boston, he can coordinate that care fine. I  
 23 submit his testimony, frankly, wasn't very  
 24 credible.

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1 is the goal in Rhode Island, it is to reward  
 2 collaboration. In this particular case, we,  
 3 we have a situation, and I contrast this and  
 4 I would ask the Health Services Council to  
 5 contrast this to Dr. Schwartz. Dr. Schwartz  
 6 came in from Baltimore. She was apparently  
 7 recruited for her excellent record in  
 8 pediatric cancer care. Dr. Quesenberry,  
 9 Dr. Colvin and Dr. Winer coincidentally all  
 10 happen to be on the staff at Roger Williams;  
 11 and what really galls me, personally, but I  
 12 would say it should gall anybody who reviews  
 13 the evidence in this case, is that Rhode  
 14 Island Hospital would then have the chutzpa  
 15 to come in and ask witnesses, well, how many  
 16 BMT's did Roger Williams do during 2005 and  
 17 2006. Oh, you only did six? Does it take a  
 18 bolt of lightning for somebody to recognize  
 19 that you took three out of the six doctors,  
 20 that same facility took three out of the six  
 21 doctors from the bone marrow transplant unit  
 22 and walked them across the street? You  
 23 don't think there's going to be an effect on  
 24 that? It is disingenuous to make that kind

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1 The fact is that what the  
 2 evidence shows is he was recruited over  
 3 there by Dr. Quesenberry, and what I submit,  
 4 and there's an empty chair where he could,  
 5 probably could have testified. He wasn't  
 6 brought in to testify, give us any  
 7 information on what he thought about the  
 8 program that he help build; but  
 9 Dr. Quesenberry, whether he was recruited or  
 10 a bird came over and landed on his  
 11 windowsill and told him to go to Rhode  
 12 Island, he's at Rhode Island Hospital.

13 We have testimony, un rebutted,  
 14 from one of our witnesses who said that  
 15 Dr. Quesenberry said the referrals stop  
 16 here. The referrals stop here. We have  
 17 testimony that Dr. Colvin, who also went  
 18 over coincidentally to Rhode Island  
 19 Hospital, said in front of a patient that  
 20 they were buying, Rhode Island Hospital was  
 21 buying the BMT unit at Roger Williams.

22 Why is that evidence important  
 23 in this case? Because if I read what the  
 24 Health -- what the Department of Health says

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1 of an argument that we are not addressing  
 2 the need after Rhode Island Hospital lured,  
 3 recruited or they just happened to end up on  
 4 the steps of Rhode Island Hospital and are  
 5 refusing to refer patients because,  
 6 according to Dr. Winer, he thinks the unit  
 7 is unsafe; so, they claim that after they  
 8 left, their colleagues that they left behind  
 9 are running an unsafe unit. It's a  
 10 duplicitous argument that's being made here,  
 11 and I hope the Health Services Council sees  
 12 it for what it is.

13 On the one hand, you can't say  
 14 there's plenty to go around. Don't worry.  
 15 You will get your 20; but on the other hand,  
 16 this unit here is in trouble. They lost  
 17 three of their doctors. They have an unsafe  
 18 unit, and they have carpets and this woman  
 19 left and that person left. They are in real  
 20 trouble. What I would ask the Health  
 21 Services Council to contrast is the  
 22 testimony of Dr. Winer as to why he left.  
 23 And I will give him this. He did do what's  
 24 the best case scenario and what's the worst

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1 case scenario analysis. He did that, and he  
2 said, very candidly, I was concerned that if  
3 I stayed here, that with Dr. Quesenberry  
4 going over to Rhode Island Hospital and  
5 others going to Rhode Island Hospital, that  
6 essentially I might not have a job. And  
7 that factored into why I went over to Rhode  
8 Island Hospital. And it's right there in  
9 the record for anybody to read in terms of  
10 what his testimony was. And I would submit  
11 that you can't come in on one hand and say  
12 there's a great demand, everybody is going  
13 to be fine, but on the other hand say this  
14 unit is essentially unsafe or inefficient or  
15 just can't make it. It just doesn't add up.

16 The fact is that you, the  
17 Health Services Council, can either reward  
18 the kind of behavior that took place in this  
19 case, which is the opposite of collaboration  
20 and is, as we sit here now, the opposite of  
21 collaboration and tell health care  
22 practitioners and tell health care  
23 administrators we are going in a different  
24 direction now. We are going to

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1 collaboration. We are willing to keep that  
2 door open; and if there's a necessity for  
3 seven beds or nine beds, put them at Roger  
4 Williams and collaborate with Rhode Island  
5 Hospital. And frankly, if the demand, the  
6 market is what everyone says it is, it will  
7 become readily apparent within the next  
8 couple of years. Isn't that the safest,  
9 smartest way to use your health care  
10 dollars, or do we want to have a system and  
11 take a roll of the dice, which is what we  
12 are being asked to do right now, take a roll  
13 of the dice, set up two competing bone  
14 marrow transplant units and hope they both  
15 survive. And by the way, hope they both hit  
16 the levels they have to hit for the National  
17 Marrow Donor Program, otherwise you are cut  
18 out of a lot of opportunity to help people  
19 who need allogeneic transplants. You are  
20 going to have to send those people to Boston  
21 because you won't have access to that  
22 program.

23 I would submit, there's no one  
24 that can argue against pediatric cancer

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1 collaboration. We are going to try and work  
2 together, because I have to believe that,  
3 despite maybe their business differences,  
4 that these doctors have an abiding desire to  
5 help people and that they would want to work  
6 together under whatever condition, under  
7 whatever circumstances exist to make people  
8 better; and I would submit, in fact, I  
9 believe it happens right at Dana Farber  
10 right now. Dana Farber doesn't even have  
11 inpatient beds.

12 By the way, they are a  
13 National Marrow Donor Program member, which,  
14 as an aside, I think shoots down that whole  
15 argument that it's essential for Rhode  
16 Island Hospital that they have a bone marrow  
17 inpatient transplant unit to be a member of  
18 that. The fact is that there's an  
19 opportunity now. We are at a fork. We are  
20 going in one direction, which is  
21 collaboration. Why does that make sense?  
22 Because, if Roger Williams, and I will tell  
23 you right now, the door is open as far as  
24 Roger Williams is concerned for

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1 care. That goes to the heart strings of  
2 anybody. But the fact is we do live in an  
3 area, and Mr. Zimmerman took note of that in  
4 his slide presentation, one of the other  
5 options is Boston hospitals. Why is that?  
6 Probably because Boston Children's Hospital  
7 is internationally renowned for treating  
8 pediatric cancer patients. And the fact is,  
9 I'd submit anyone could take judicial notice  
10 that families are going to go if they are  
11 within 50 miles to an institution like that.

12 And the fact is there isn't --  
13 I know there's been a lot of testimony,  
14 about, well, there's a tremendous cost  
15 involved here for families to go to Boston.  
16 But there's no statistical analysis to say  
17 what that cost even is. The fact is that  
18 every web site I looked at -- we put some of  
19 them into evidence here -- they have  
20 programs available for people to stay up at  
21 institutions when they have to do it. But  
22 for someone to, I mean to say, yeah, there  
23 is a tremendous cost and now we have to make  
24 a decision on affordability and cost without

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1 any data, we can't do that. I would submit  
2 we can't do it.

3 Mr. McIntyre, Members of the  
4 Health Services Council, I'd submit we are  
5 at a crossroads. We have a very good  
6 program at Roger Williams that can only get  
7 better. It's 13 years old. We have  
8 top-notch RN's. You heard from the chief of  
9 nurses. We have good doctors. We have good  
10 staff. We can follow the Boston model, and  
11 we can collaborate, and actually, if  
12 Mr. Zimmerman is right on what the capacity  
13 is, there's, it makes a lot more sense to do  
14 it at Roger Williams. But if his numbers  
15 end up being more optimistic, we are going  
16 to be in a pretty difficult situation; and I  
17 would suggest we would be in a much worse  
18 situation than exists with the cardiac  
19 numbers that were presented between Landmark  
20 and Rhode Island Hospital.

21 Because, frankly, we are  
22 talking about last resort kind of treatment,  
23 bone marrow transplant treatment; so, I'm  
24 asking the Health Services Council to

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1 consider what they have to consider, which  
2 is do we want fragmentation or do we want  
3 collaboration? And what is the best  
4 scenario, and I would submit that under any  
5 set of circumstances, the best-case  
6 scenario -- and it's a chance now for the  
7 Health Services Council to make a statement  
8 that we are interested in seeing  
9 collaboration between these health care  
10 providers. We are not going to endorse  
11 essentially fruit picking from another  
12 institution, and then saying that they are,  
13 their program isn't that good and give it to  
14 us, essentially, we'll do a better job.  
15 Trust us.

16 I submit, and the evidence is  
17 there for all to consider, but when you look  
18 at the issues of affordability, that hasn't  
19 been proven, to any reasonable satisfaction;  
20 and when you look at the need, the real  
21 need, the numbers are a lot more  
22 conservative. And frankly, I would submit  
23 there isn't any evidence anywhere of a Rhode  
24 Islander that's not getting a bone marrow

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1 transplant. No one ever put a single piece  
2 of evidence in that said there's a Rhode  
3 Islander that can't get a bone marrow  
4 transplant; and isn't that the real  
5 definition of public need? I mean if people  
6 are coming in saying I'm waiting for two  
7 months at Roger Williams, I can't get in  
8 there because I need a bone marrow  
9 transplant. That evidence isn't there.

10 So, I would submit, in  
11 closing, if you look at the issues that we  
12 need to look at, which are affordability,  
13 which are need and collaboration, all of  
14 those things weigh in favor of a denial of  
15 this application, and essentially a message  
16 going out that if you want to do this type  
17 of work, we stand for collaboration. We are  
18 telling you to start talking to one another  
19 and working together. And I would submit  
20 that is what is best for the people of Rhode  
21 Island. Thank you.

22 MR. McINTYRE: Thank you,  
23 Mr. Devereaux. Okay. We are going to keep  
24 the record open until the close of business

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1 day on Monday. I would like to thank  
2 Council for preparing an excellent record  
3 for the Health Services Council. You  
4 represented your clients very well. It's  
5 obvious that we have two very good  
6 institutions with a lot at stake here, and  
7 the Health Services Council has got their  
8 work cut out for them. Thank you, again.

9 MS. FREEDMAN: Thank you.  
10 (HEARING ADJOURNED AT 2:50  
11 P.M.)

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C-E-R-T-I-F-I-C-A-T-E

I, MARY ELLEN HALL, Notary Public, do hereby certify that I reported in shorthand the foregoing proceedings, and that the foregoing transcript contains a true, accurate, and complete record of the proceedings at the above-entitled hearing.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 13th day of August, 2007.

MARY ELLEN HALL, NOTARY PUBLIC/ CERTIFIED COURT REPORTER

IN RE: R.I. HOSPITAL BONE MARROW CON APPLICATION

DATE: July 26, 2007

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