From: <DoNotReply@michigan.gov>
To: moorean@michigan.gov
Date: Fri, Aug 1, 2008 2:42 PM
Subject: August 5, 2008 MRT Public Hearing Written Testimony (ContentID - 196938)

1. Name: John C. Ruckdeschel, M.D.
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3. Phone: 313-576-8123
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5. Testimony: August 1, 2008

Mr. Ed Goldman, Chairman
Certificate of Need Commission
University of Michigan
Health System Attorney
300 N. Ingalls, Box 0476
Ann Arbor, MI 48109-0476

Dear Mr. Goldman,

The Barbara Ann Karmanos Cancer Hospital d/b/a Karmanos Cancer Center (Karmanos) received a BMT Certificate of Need approval relating to the acquisition of a Bone Marrow Transplantation Service from Harper University Hospital, effective November 7, 2005.

Under the terms of the BMT Certificate of Need, Karmanos agreed to provide evidence, satisfactory to the Department of Community Health (Department), of approval as a Prospective Payment System (PPS)-exempt hospital within the time limits specified in Section 8(1)(g) of the Certificate of Need Standards relating to Bone Marrow Transplantation Services (the Standards).

At the June 11, 2008 Certificate of Need Commission meeting, the commission took action on language to technically amend the Standards to extend the 24-month deadline to no later than the last session day permitted by the United States Constitution for the NEXT United States Congress then in Session AFTER THE EFFECTIVE DATE OF THESE STANDARDS Karmanos Cancer Institute strongly supports this action and requests that the commission take final action on the BMT standards at the September 16, 2008 Commission meeting.

While Karmanos has not yet obtained the PPS exemption described in Section 2(1)(f) of the Standards, we continue to make significant progress toward that objective. On August 1, 2007, the House of Representatives adopted H.R. 3162, the ChildrenÆs Health and Medicare Protection Act of 2007. Section 505 of that bill provides for additional hospitals to be recognized as cancer hospitals for purposes of Section 1886(d)(1)(B)(v) of the Social Security Act, including Karmanos. Unfortunately the Senate passed version of the bill that ultimately become signed into law, did not include the provision for additional cancer hospitals.

In July, 2008 Congress passed a Medicare Bill that primarily focused on correcting a physician pay cut that was scheduled to take effect July 1, 2008. After lengthy discussion and compromise in the Senate, a House version of the bill ended up being the vehicle that moved through both chambers and withstood a Presidential veto to become law. Below this letter is an amendment that was introduced by Senator Harry Reid, along with Senators Levin and Stabenow, which was to be included in the Senate compromise bill. This amendment would have provided Karmanos with a PPS exemption.

Karmanos is currently working closely with Senator Debbie Stabenow and Representative Sander Levin to ensure that our PPS exemption request is approved. We have engaged them to include the exemption in any appropriate legislation being considered by Congress. We have met with Congresswoman Carolyn Cheeks Kilpatrick to gain access to House Appropriations Committee leadership. We continue to meet with majority and minority members of the Senate Finance Committee, including Chairman Grassley, and the House Ways and Means Committee to garner support for this initiative. Members of our board have been engaged in outreach to legislators and their staff to generate a comprehensive, grassroots approach to educating members about the tremendous positive impact a PPS exemption for Karmanos will have on access to quality cancer care in Michigan.

Thank you for your consideration of this request.

Sincerely,

John C. Ruckdeschel, MD

June 12, 2008 ù H. Reid, D-Nev., amendment introduced in the Senate: number 4981. (Ordered to lie on the table.) Congressional Record p. S5634, S5635

REID AMENDMENT SA 4981

TEXT OF AMENDMENT

SA 4981. Mr. REID (for himself, Mr. LEVIN, Mr. BROWN, Ms. STABENOW, Mr. LAUTENBERG, and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the bill S. 3101, to amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. TREATMENT OF CERTAIN CANCER HOSPITALS.

(a) In General. Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended

(1) in subparagraph (B)(v)ù

(A) by striking or at the end of subclause (II); and

(B) by adding at the end the following:

ô(IV) a hospital that is a nonprofit corporation, the sole member of which is affiliated with a university that has been the recipient of a cancer center support grant from the National Cancer Institute of the National Institutes of Health, and which sole member (or its predecessors or such university) was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, if the hospitalÆs articles of incorporation specify that at least 50 percent of its total discharges have a principal finding of neoplastic disease (as defined in subparagraph (E)) and if, of December 31, 2005, the hospital was licensed for less than 150 acute care beds, or

ô(V) a hospital (aa) that the Secretary has determined to be, at any time on or before December 31, 2011, a hospital involved extensively in treatment for, or research on, cancer, (bb) that is (as of the date of such determination) a free-standing facility, (cc)(aaa) for which the hospitalÆs predecessor provider entity was University Hospitals of Cleveland with medicare provider number 36-0137, or (bbb) received the designation on June 10, 2003, as the official cancer institute of its State;

(2) in subparagraph (B), by inserting after clause (v) the following new clause:

ô(vi) a hospital that

ô(I) is located in a State that as of December 31, 2006, had only one center under section 414 of the Public Health Service Act that has been designated by the National Cancer Institute as a comprehensive center currently serving all 21 counties in the most densely populated State in the nation (U.S. Census estimate for 2005: 8,717,925 persons; 1,134.5 persons per square mile), serving more than 70,000 patient visits annually;

ô(II) as of December 31, 2006, served as the teaching and clinical care, research and training hospital for the Center described in subclause (II), providing significant financial and operational support to such Center;

ô(III) as of December 31, 2006, served as a core and essential element in such Center which conducts more than 130 clinical trial activities, national cooperative group studies, investigator-initiated and peer review studies and has received as of 2005 at least $93,000,000 in research grant awards;

ô(IV) as of December 31, 2006, includes dedicated patient care units organized primarily for the treatment of and research on cancer with approximately 125 beds, 75 percent of which are dedicated to cancer patients, and contains a radiation oncology department as well as specialized emergency services for oncology patients; and

ô(V) as of December 31, 2004, is identified as the focus of the CenterÆs inpatient activities in the CenterÆs application as a NCI-designated comprehensive cancer center and shares the NCI comprehensive cancer designation with the Center; and

(3) in subparagraph (E)ù

(A) by striking subclauses (II) and (III)ö and inserting subclauses (II), (III), and (IV)ö; and

(B) by inserting and subparagraph (B)(vi)ö after subparagraph (B)(v)ö.

(b) Effective Dates; Payments.

(1) APPLICATION TO COST REPORTING PERIODS.

(A) Any classification by reason of section 1886(d)(1)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(vi)), as inserted by subsection (a), shall apply to cost reporting periods beginning on or after January 1, 2006.

(B) The provisions of section 1886(d)(1)(B)(v)(IV) of the Social Security Act, as added by subsection (a), shall take effect on January 1, 2008.

(2) BASE TARGET AMOUNT. Notwithstanding subsection (b)(3)(E) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), in the case of a hospital described in subsection (d)(1)(B)(vi) of such section, as inserted by subsection (a)ù

(A) the hospital shall be permitted to resubmit the 2006 Medicare 2552 cost report incorporating a cancer hospital sub-provider number and to apply the Medicare ratio-of-cost-to-charge settlement methodology for outpatient cancer services; and

(B) the hospitalÆs target amount under subsection (b)(3)(E)(i) of such section for the first cost reporting period beginning on or after January 1, 2006, shall be the allowable operating costs of inpatient hospital services (referred to in subclause (I) of such subsection) for such first cost reporting period.

(3) DEADLINE FOR PAYMENTS. Any payments owed to a hospital as a result of this subsection for periods occurring before the date of the enactment of this Act shall be made expeditiously, but in no event later than 1 year after such date of enactment.

(c) Application to Certain Hospitals.

(1) INAPPLICABILITY OF CERTAIN REQUIREMENTS. The provisions of section 412.22(e) of title 42, Code of Federal Regulations, shall not apply to a hospital described in section 1886(d)(1)(B)(v)(V) of the Social Security Act, as added by subsection (a).

(2) APPLICATION TO COST REPORTING PERIODS. If the Secretary makes a determination that a hospital is described in section 1886(d)(1)(B)(v)(V) of the Social Security Act, as added by subsection (a), such determination shall apply as of the first cost reporting period beginning on or after the date of such determination.

(3) BASE PERIOD. Notwithstanding the provisions of section 1886(b)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(E)) or any other provision of law, the base cost reporting period for purposes of determining the target amount for any hospital for which a determination described in paragraph (2) has been made shall be the first full 12-month cost reporting period beginning on or after the date of such determination.

(4) RULE. A hospital described in subclause (V) of section 1886(b)(1)(B)(v) of the Social Security Act, as added by subsection (a), shall not qualify as a hospital described in such subclause for any cost reporting period in which less than 50 percent of its total discharges have a principal finding of neoplastic disease. With respect to the first cost reporting period for which a determination described in paragraph (2) has been made, the Secretary shall accept a self-certification by the hospital, which shall be applicable to such first cost reporting period, that the hospital intends to have total discharges during such first cost reporting period of which 50 percent or more have a principal finding of neoplastic disease.

From: <DoNotReply@michigan.gov>
To: moorean@michigan.gov
Date: Mon, Jul 28, 2008 2:06 PM
Subject: July 30, 2008 Public Hearing Written Testimony (ContentID - 147062)

1. Name: James B. Falahee, Jr.
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5. Standards: MRI
6. Testimony: Bronson Methodist Hospital (Bronson) strongly supports the expansion of the current MRI standards to include Intra-Operative MRI Imaging (IMRI). There is clear proof that IMRI improves surgical outcomes and the quality of patient care. IMRI has already become the standard of care for some neurosurgery cases. Accordingly, Bronson believes IMRI should be made available to as many patients as possible.

Given the benefits of IMRI, Bronson is opposed to the draft IMRI standards because they unreasonably restrict the availability of the IMRI technology. The draft IMRI standards would make IMRI available to only a very few hospitals, and thus effectively deny this technology to the majority of Michigan's residents.

Bronson's specific objections to the draft IMRI standards are as follows:

1. The draft IMRI standards would make IMRI available only in a very limited number of hospitals until at least December 31, 2010. This limitation is not in the best interest of patient care. Those patients who live outside of the immediate vicinity of these few hospitals will be denied access to quality care.

Bronson proposes that the criteria in Section 3 of the draft IMRI standards be revised to enable more patients to be able to benefit from this technology. For example, the number of neurological surgeries should be reduced to 700. The number of pediatric discharges should also be reduced because there are only a handful of hospitals that would meet the 7,000 and 5,000 criteria.

2. There is no definition for "neurological surgeries." Does the term include spine procedures that are jointly performed by a neurosurgeon and an orthopedic surgeon? A definition is required.

3. The Department should consider adding a separate criteria to Section 3 for those hospitals that are designated as Level I trauma centers. These hospitals and their patients are most in need of IMRI to improve patient outcomes in trauma cases.

4. The pilot program needs to be shortened. The current wording allows the IMRI pilot program to run until December 31, 2010. The length of the pilot should be shortened by at least one year to enable this pilot project to be made permanent if it is working well.

Bronson fully understands the need of the CON Department to balance quality, access and cost. Nevertheless, Bronson believes the draft IMRI standards place an unreasonable restriction on access of the IMRI technology to Michigan's residents. In the interest of improving the quality of care for more of Michigan's residents, but still at a reasonable cost, Bronson recommends that the CON Department revise the draft IMRI standards to enable this important technology to be expanded to a wider population.

Thank you.

From: <DoNotReply@michigan.gov>
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Date: Tue, Aug 5, 2008 1:09 PM
Subject: July 30, 2008 Public Hearing Written Testimony (ContentID - 147062)

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5. Standards: MRI
6. Testimony: Spectrum Health supports the proposed changes to the MRI CON Review Standards that address the issue of intraoperative MRI (iMRI). Although a relatively small number of neurosurgery patients can benefit from having MRI imaging capability in the OR, for those patients, the impact can be significant. The surgical precision possible with MR imaging is crucial for many types of brain surgery.

Since an intraoperative MRI could never be expected to attain the utilization level of a purely diagnostic unit, the absence of a volume requirement for iMRI is appropriate. So, too, is the ability to use an iMRI unit for a limited array of diagnostic patients when the unit is not in use for intraoperative procedures. This provision will allow neurosurgery centers across the state to maximize the use of this very costly resource.

The proposed language effectively balances the issues of cost, quality and access. The proposed standards will permit a limited number of iMRI units located at major neurosurgery centers in the state, thus offering Michigan citizens access to the best available neurosurgery capabilities.