

From: DoNotReply@michigan.gov
To: [MDCH-ConWebTeam](#)
Subject: October 9, 2013 Public Hearing Written Testimony (ContentID - 147062)
Date: Monday, October 21, 2013 10:49:00 AM

1. Name: Dennis McCafferty
2. Organization: The Economic Alliance for Michigan
3. Phone: 248-596-1006
4. Email: DennisMccafferty@EAMOnline.org
5. Standards: MRT
6. Testimony: There was a workgroup last year that dealt with the issue of physician owned MRT services, how new cancers should be counted and other issues related to changes in this technology. We are not aware of any other issues that would require a SAC or workgroup in 2014.
7. Testimony:



CATHOLIC HEALTH EAST

October 22, 2013

James B. Falahee, Jr., J.D., Chairperson
Certificate of Need Commission
Capital View Building
201 Capital View Building
Michigan Department of Community Health
Lansing, MI 48913

RE: Megavoltage Radiation Therapy Services/Units

Dear Chairman Falahee:

CHE-Trinity Health Michigan would like to thank the Certificate of Need Commission for the opportunity to comment on what, if any, changes need to be made to the Certificate of Need Standards for Megavoltage Radiation Therapy Services/Units.

CHE-Trinity Health Michigan supports the continued regulation of MRT Services/Units under Certificate of Need. However, CHE-Trinity Health Michigan believes improvements should be made in the definition of a "special-purpose MRT unit" to address the new technologies now being offered by MRT equipment vendors. In the past, MRT vendors offered MRT units with single-function capabilities such as radiation therapy or radiosurgery. More recently, radiation therapy vendors have expanded their platform capabilities to create hybridized machines capable of a range of treatment options. This technological shift has essentially blurred the lines between the current CON definitions of "non-special MRT" and "special-purpose MRT."

CHE-Trinity Health Michigan supports revising the definition of a "special-purpose MRT unit" to reflect this changing technology. The new definition should continue to recognize that a special-purpose MRT is a highly specialized, singularly-focused technology used to serve unique patient populations, which as such, cannot meet the CON volume requirements of a more broadly capable machine. CHE-Trinity Health Michigan believes the existing definition could be revised to be: "A special-purpose MRT unit is any MRT that is not used for standard radiotherapy, but is dedicated to providing radiosurgery (1-5 fractions), total body irradiation, total skin irradiation, or IORT." We believe such a change in definition will not negatively impact any existing services approved for special-purpose MRT units. We continue to support the current requirement that all special-purpose MRT units must be part of an MRT service with non-special MRT units.

CHE-Trinity Health Michigan would be happy to support the CON Commission or the Department in addressing this important issue.

Respectfully,

A handwritten signature in blue ink, appearing to read "Garry C. Faja".

Garry C. Faja
President and CEO
Saint Joseph Mercy Health System
Southeast Michigan Region

A handwritten signature in blue ink, appearing to read "Roger W. Spoelman".

Roger W. Spoelman
Regional President and CEO
Mercy Health West Michigan



October 23, 2013

James B. Falahee, Jr, J.D.
CoN Commission Chairperson
Capital View Building
201 Townsend Street
Lansing, MI 48913

Corporate Planning

1 Ford Place, 3B
Detroit, MI 48202-3450
(313) 874-5000 Office
(313) 874-4030 Fax

Dear Commissioner Falahee:

Henry Ford Health System (HFHS) would like to offer comments on the proposed Certificate of Need (CoN) review Standards for Megavoltage Radiation Therapy (MRT).

HFHS strongly supports continued regulation of Megavoltage Radiation Therapy (MRT) and fully supports the most recent changes in the Standards effective May 24, 2013 specifically:

- The inclusion of a utilization based need methodology
- The inclusion of accreditation requirements from American College of Radiology/American Society for Radiation Oncology (ACR/ASTRO) or the American College of Radiation Oncology (ACRO)

HFHS does not support re-opening the Megavoltage Radiation Therapy (MRT) for review in 2014.

We appreciate the opportunity to comment on these Standards and commend the Department and the Workgroup chaired by CON Commissioner Dr. Marc Keshishian for their efforts.

Respectfully,

A handwritten signature in blue ink that reads "Karen E. Kippen".

Karen E. Kippen
Director, Planning & CON Strategy



Spectrum Health System
100 Michigan Street NE
Grand Rapids, MI 49503-2560

October 23, 2013

James B. Falahee, Jr, Chairperson
Certificate of Need Commission
C/o Michigan Department of Community Health
Certificate of Need Policy Section
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

RE: Megavoltage Radiation Therapy CON Standards

Dear Commissioner Falahee,

This letter is written as formal testimony about the CON Review Standards for Megavoltage Radiation Therapy (MRT). Spectrum Health appreciates the opportunity to comment on these Standards.

The MRT Standards have served the citizens and providers in the State of Michigan very well and therefore we believe that there is no need to open the MRT Standards at this point in time.

Spectrum Health appreciates the opportunity to comment on the CON Review Standards for this service.

Sincerely,

A handwritten signature in black ink that reads "Meg Tipton". The signature is written in a cursive, flowing style.

Meg Tipton
System Regulatory Consulting Specialist
Spectrum Health



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October 23, 2013

James B. Falahee, J.D. - CoN Commission Chairperson
Certificate of Need Policy
Capitol View Building
201 Townsend Street
Lansing, MI 48913

RE: Megavoltage Radiation Therapy - Certificate of Need Standards Review

Dear Commissioner Falahee:

This letter is written as formal testimony pertaining to the Certificate of Need (CoN) Review Standards for Megavoltage Radiation Therapy. The University of Michigan Health System (UMHS) supports the overall regulations for this service.

With substantive changes recently adopted by the CoN Commission, it is too early to objectively evaluate the effects these changes are having on cost, quality and access. UMHS recommends not reopening these standards until the next review cycle in 2017.

Thank you for allowing the University of Michigan Health System to provide these comments for consideration.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read 'S. Szelag', written in a cursive style.

Steven E. Szelag

From: DoNotReply@michigan.gov
To: [MDCH-ConWebTeam](#)
Subject: October 9, 2013 Public Hearing Written Testimony (ContentID - 147062)
Date: Thursday, October 24, 2013 4:13:29 PM

1. Name: Paul Chuba MD PhD
2. Organization: Michigan Radiological Society
3. Phone: 586 573-5186
4. Email: paul.chuba@stjohn.org
5. Standards: MRT
6. Testimony:

Mr. James Falahee JD
Chairman
Certificate of Need Commission
Michigan Department of Community Health
201 Townsend Street, 7th Floor
Lansing, MI 48913

I appreciate the opportunity to comment on the proposed revisions to the CON standards for megavoltage radiation therapy (MRT) services.

Please take into account the following:

1. In the new section 11 it is stated:

"Added requirements to be accredited by the American College of Surgeons Commission on Cancer or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and to be accredited by the American College of Radiology/American Society for Radiation Oncology (ACR/ASTRO) or the American College of Radiation Oncology (ACRO)" etc.

In fact I believe the intent is that all MRT services should have ACOS accreditation. This insures that they are true cancer programs. In addition to this, all free standing Radiation Oncology facilities need to be accredited by the ACR/ASTRO or ACRO mechanisms. Hospital based Radiation Oncology facilities can be accredited by JCAHO or through the HFAP.

2. It is important to keep the requirement for supervision.

a. This means that a board-certified or board eligible Radiation Oncologist physician should be physically present during hours of operation. So-called 'remote' supervision should not be allowed.

b. Supervision is particularly important for image guided radiation (IGRT) and intensity modulated radiation therapy (IMRT).

3. Only radiation treatments that are medically necessary should be reported for the purpose of counting ETVs.

4. Support the new methodology for projecting ETVs based on the physician MRT volume.

5. Requirements for relocation of existing MRT services should be adhered to more strictly. Recently large relocation projects have been approved for centers not meeting volume requirements.

Sincerely,

Paul J Chuba MD PhD

Medical Director for Radiation Oncology
St. John Macomb Oakland Hospital Webber Cancer Center

President
Michigan Radiological Society
7. Testimony:



*Advancing medicine.
Compassionate care.*

October 24, 2013

Mr. James B. Falahee, Jr., J.D.
Chairman
Certificate of Need Commission
Michigan department of Community Health
201 Townsend Street, 7th Floor
Lansing, Michigan 48913

Dear Chairman Falahee,

On behalf of Oaklawn Hospital in Marshall, Michigan, we appreciate this opportunity to provide comments on the MRT standards that became effective May 24, 2013. We'd like to take the occasion to expand upon our suggestions made last February, in anticipation of the Commission's upcoming review of the standards in 2014.

As you may recall, in 2012 a workgroup created a new methodology for determining need for a new MRT service. Although the workgroup accomplished a great deal over the course of a relatively short period of time, we shared concerns at the time that more work was needed on the planning areas and methodology due to potential unforeseen consequences of the new methodology.

Radiation therapy is a modality that requires multiple treatments, often on a daily basis and for weeks at a time. When a patient has access to an MRT service nearby, he or she is often able to continue a normal routine with little interruption, such as working, taking care of children, and participating in recreational activities. However, if the patient has to travel to receive treatment, even as seemingly little as 45 minutes or an hour, his or her ability to maintain routines and responsibilities significantly decreases. It is commonly held that patients who are able to continue to work and maintain routines have improved outcomes.

For this reason, it is important to encourage the initiation of new services in geographic areas that are most accessible to patients, which may not be the geographic areas where MRT services currently exist. We are concerned, however, that the recent revisions do the opposite. By only allowing initiations in areas where existing services have excess cases available to be committed, the methodology makes it extremely difficult, if not impossible, to initiate service in geographic areas that did not already have it. This is not in the best interests of the patients being served by this treatment modality.

The workgroup recognized this problem to an extent, and recommended an exception for the Upper Peninsula in attempt to alleviate the concerns specifically voiced by providers there. However, exceptions may not be the best way to address the concern. Instead, we would like to suggest two additional changes that we believe would resolve the problem for all patients in the State of Michigan, without utilizing exceptions.



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The first suggestion is to look at the residence location of the patients being treated rather than the facility location where they receive their treatment. If patients have to travel a significant distance to receive that treatment, the changes adopted last May do nothing to help initiate a service closer to those traveling patients. If patients in the UP currently have to travel to Traverse City for treatment, those patients could potentially count toward the initiation of a new service in the Traverse City planning area, but not in the UP planning area, even though that is where the service may be needed more. However, if we looked at where the patients live instead of where they are treated, the patients traveling from the UP would count toward the initiation of a new service in the UP.

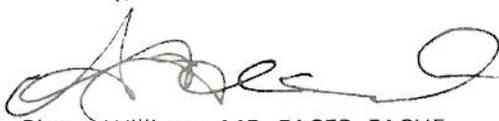
The second suggestion is to utilize a mileage radius planning area, instead of the Health Service Area (groupings of counties). As they relate to the description of a Planning Area, Health Service Areas (HSAs) are effectively just arbitrary lines on a map. If a proposed service is near an HSA boundary, it may be much farther from a patient on the opposite side of the HSA than it is to a patient just on the other side of HSA boundary.

In the alternative, a mileage radius is much more true to a provider's market area. There is considerable precedent for this approach as well. Most other covered clinical services use mileage radius for the planning area and set the radius at a mileage relative to the distance a patient would reasonably travel for the service. The larger the radius, the less restrictive as it relates to collecting data for initiating new service, allowing for greater flexibility in initiating new services in geographic areas that are not yet served.

Because MRT services are not nearly as prevalent as surgical services, CT, or MRI, a larger radius would be appropriate. The current standards already recognize that more than 60 miles is too far to travel for MRT services (a lower initiation threshold is allowed for a proposed service located more than 60 miles from the nearest existing service), therefore we would suggest a planning area of 60-mile radius around the proposed service location.

We believe these concerns are vitally important for the MRT standards to function effectively for cancer patients in the State of Michigan. Thank you again for your time in considering this matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ginger Williams', with a large, stylized flourish at the end.

Ginger Williams, MD, FACEP, FACHE
President and CEO