1. Name: Brian Klott
2. Organization: Chrysler Group LLC
3. Phone: 248 512 2204
4. Email: bak10@chrysler.com
5. Standards: MRI
6. Testimony: Additional capacity cannot be supported. The proposals create loopholes outside existing CON standards. These loopholes then could be utilized in the future, with the extra capacity yielding higher cost structures.

For example, MRI for MRT Simulation creates a scenario where a large hospital would eventually wish to use the machine for MRI imaging to increase its ROI, which would increase overall capacity, create overutilization and increase costs. Cancer centers should utilize their existing machines to provide for MRT simulation. In the interim, this topic should be sent back to the MRI workgroup for additional analysis and consideration.

Another example that is not supported is the lower standard (3,000 vs. current 6,000) MRI scans for the replacement of mobile MRI with fixed units in hospitals with high volume ERs. A small percentage of ER visits only require an MRI, and many installations don't run 24/7 due to the associated high personnel costs. The small volume and high costs would yield a similar situation where the ROI would want to be overcome, again leading to overcapacity and higher costs. The additional concern is that the mobile MRI utilization would be affected. They might have to lower their service levels to smaller hospitals or charge higher rates due to overcapacity. This proposal would also opens the door to significant loosening of the overall MRI CON standard.

I believe the exiting MRI CON standards should be upheld and the 2 proposal should not be approved. Thank you.
7. Testimony:

1. Name: David Kondas
2. Organization: Alliance Imaging
3. Phone: 330-327-6452
4. Email: dkondas@allianceimaging.com
5. Standards: MRI
6. Testimony: I have attached Alliance Imaging's public comments on the MRI standards proposal

Content-Length: 48721

Memo

To: CON Commissioners

From: David W Kondas, Director of Operations, Alliance Imaging

Date: 8/18/2009

Re: Proposed changes to the MRI Standards

This comment is in reference to the proposed MRI language that is being considered by the CON Commission and the Michigan Department of Community Health. There are 2 primary subjects in the proposed language that will be addressed: The use of MRI to support emergency department needs and the use of MRI in treatment planning. Alliance Imaging does not support the proposed language in Section 3(2)(b)(iii) which would allow for a hospital with 3,000 MRI adjusted procedures, 24-hour emergency care services, and at least 20,000 emergency room visits within a 12-month period, to convert from a mobile to a fixed MRI. Although Alliance Imaging supports the proposed language in Section 2 (1)(dd) for MRI Simulators, we are opposed to the timing of the review of these standards as there is no urgent need and the proposed changes should therefore be reviewed during the regular scheduled review period. We will expand on our reasoning below.

Regarding the language being proposed in Section 3(2)(b)(iii), our primary concern is that the proposed language is incomplete and not well supported by underlying data. The language is incomplete because it does not include the same base criteria as other exclusions to the 6000 adjusted procedure threshold that are in the current standard. The following should be added to be consistent with the current logic for exclusions:

> (A) IS LOCATED IN A COUNTY THAT HAS NO FIXED MRI MACHINES THAT ARE PENDING, APPROVED BY THE DEPARTMENT, OR OPERATIONAL AT THE TIME THE APPLICATION IS DEEMED SUBMITTED.
> (B) THE NEAREST FIXED MRI MACHINE IS LOCATED MORE THAN 15 RADIUS MILES FROM THE APPLICATION SITE.

The proposed language is not well supported because the appropriate volume of emergency room visits that would require 24/ 7 MRI coverage has not been established. Why should the threshold be set at 20,000 visits? No evidence has been submitted justifying this number. Since the appropriate number of emergency room visits has not been established, the CON Commission would be making an irrational and inappropriate policy decision if it simply pulled the number of 20,000 visits from out of thin air. How could the Commission later support this decision in the face of a future request by a facility with only 15,000 annual visits? A policy change of this nature should not be taken lightly. Additionally, the data specific to Oaklawn is not

compelling with regards to the need to have full time coverage and appropriate utilization. In data submitted to the MDCH in 2008, Oaklawn showed 2296 MRI visits with 182 inpatients, of these only a fraction were from the emergency department. The May 2009 adjusted procedures data showed Oaklawn has 2294 MRI visits or 3350 adjusted procedures utilizing 5 days of mobile MRI service per week. Oaklawn, which had less than 3,000 MRI visits last year and only 8 MRI patients per day, is now requesting that the CON Commission revise the CON Standards so that it can convert its less than fully utilized mobile MRI to a fixed MRI. Oaklawn's self-serving attempt to amend the CON MRI standards should be rejected by the CON Commission because there is no established need for such a fixed MRI and to allow it would result in an unneeded expenditure to treat a small number of patients. It should be of interest that Oaklawn is also presently exploring reducing their service to 4 days per week in order to get better utilization of the MRI. This type of utilization is not consistent with the CON Commission's goals for equipment utilization and justification of a mobile host site to fixed MRI conversion. Finally, it is not necessary for Oaklawn to operate an MRI on a 24/7 basis to cover its emergency department. We have contacted other fixed site MRI operators and have documented that many of these do not operate their MRI 24/7 in order to cover their emergency department. The fixed sites we contacted were: Bronson Methodist Hospital, Garden City Hospital, Owosso Memorial, and St. Mary Mercy in Livonia. It is our suggestion that better data be gathered to support the actual need for MRI as a supporting service for emergency departments.

On a final note, we are concerned that the CON Commission appears to be setting a new precedent regarding the timing of CON standards review in this case. Why are revisions to the MRI standards being considered out of sync with the Commission work plan? There is no urgent need to review the MRI Standards at this time. There may be a "want" by one facility, but that does not mean there is a true and urgent need.

Regarding the second proposal for the use of MRI for radiation treatment planning and the proposed language change in Section 2 (1)(dd), we support this concept. However, we are not in support of the timing of this change to the MRI Standards. Review of the MRI Standards is scheduled to occur on a regular cycle every other year. The exception to this would be an urgent need to review the standard and to modify the language therein. Given the fact that CT is still considered the gold standard for treatment planning and this request is directed toward facilities performing proton beam therapy, of which none will be operational prior to the next scheduled regular review, it appears that the CON commission is setting a new precedent regarding the timing of the review and revision of CON standards.

1. Name: Marsha Manning
2. Organization: General Motors
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5. Standards: MRI
6. Testimony:

Content-Length: 67061

GENERAL MOTORS COMPANY
PUBLIC COMMENTS – JULY 30, 2009
Marsha Manning, Manager, Health Care Initiatives and Public Policy

General Motors supports strong CON standards for Magnetic Resonance Imagine (MRI) in the state of Michigan. Previously shared data from General Motors Company, Ford Motor Company and Chrysler Group LLC demonstrated that the annual cost per covered life for MRI was 20% higher in states with significant auto membership that did not have CON for MRI compared with Michigan, which has strong CON standards for MRI. The cost difference was driven by higher utilization of MRI services in these states without strong CON standards for MRI. General Motors continues to support CON for MRI as a means to constrain excess capacity, with the result of lower costs due to more moderate utilization of this costly technology.

MRI for MRT simulation was reviewed by the MRI workgroup, which met one time. The workgroup concluded that MRI standards should be changed to allow an exemption for MRI units that are used only for MRT simulation. We do not support allowing this exemption, and urge the workgroup be allowed to continue its work to assess an alternative to the proposed changes. The proposed change in the CON standard would allow large cancer programs, which are the programs most likely able to justify the expense of an MRI machine solely for MRT simulation, to obtain an additional MRI unit, which would likely be underutilized if used for only this purpose. It is anticipated that there will be a desire to maximize this significant investment at some point in time, leading these centers to request the ability to use these MRI machines for diagnostic purposes. This increase in capacity will drive utilization of this costly diagnostic procedure. In addition, the facilities that might pursue this exemption would already have existing MRI units that could be used for simulation purposes, and these existing units should be explored as a viable source for MRT simulation, rather than adding costly units for a limited purpose. Even if the use of MRI for MRT simulation becomes the standard of care, opportunities to utilize existing infrastructure should be pursued before adding costly units to the health care delivery system.

An alternative has been proposed by the Economic Alliance for Michigan that would allow MRT programs to start using their current MRI units for MRT simulation (see EAM public comments dated 7/29/09). A higher MRI procedure adjustment value could be identified for this use, and future MRI expansion would be based on the volume of MRT simulation and MRI diagnostic volume combined. This would avoid the installation of MRI units solely for MRT simulation. This potential solution was not explored in the workgroup meeting that occurred, and General Motors would like to suggest that the workgroup explore this alternative fully and consider this as an alternative to adding costly, single purpose MRI units.

General Motors also has concerns with the proposed changes in the MRI standards to allow hospitals with ‘high volume’ ERs to replace a mobile MRI with a fixed MRI using lower minimal annual volumes than currently defined. The parameters used in these proposed standards are not based in clinical literature or other studies supporting their efficacy. It is not clear why a volume of 20,000 ER visits per year is the appropriate level at which to consider relaxing the standards for MRI. It is also not clear why 3000 adjusted MRI procedures per year is the appropriate volume to consider for a hospital ER to qualify for a fixed MRI. These proposed parameters appear to be based on the volumes currently being generated by a single hospital in Michigan that desires to replace its mobile MRI with a fixed unit, rather than being based on any sound criteria that would indicate a gap in MRI availability and be transferable to other similar situations.

In addition, it is unclear whether allowing a fixed MRI unit to replace mobile services will result in better outcomes from this ER setting. The number of emergency cases requiring MRI services is quite low, and one would assume that many of these cases are currently being well served by the mobile services available to the requesting hospital. In addition, there has been no evidence presented that transferring

cases to the nearest fixed MRI unit in the absence of Mobile MRI services has resulted in poor outcomes for these cases. The relatively small number of emergency cases, the availability of mobile MRI services for this ER, and the availability of fixed services within a reasonable distance does not warrant lowering the minimum annual volume of adjusted MRI scans needed to install a fixed MRI unit for ‘high volume’ ERs. Implementing this proposed relaxation of standards addresses the needs of a specific provider, which will open the door to other such requests. This weakens the CON process and does not result in good policy decisions.

1. Name: Dr. Benjamin Movsas
2. Organization: Henry Ford Health System
3. Phone: 313-916-5188
4. Email: bmovsas1@hfhs.org, kkippen1@hfhs.org
5. Standards: MRI
6. Testimony: Note: The following is a joint statement from Dr. Ted Lawrence (Chairman, Rad/Onc, University of Michigan and Dr. Benjamin Movsas, Chairman, Rad/Onc, HFHS)

"We support the exclusion of MRI simulators (used for radiation treatment planning purpose in conjunction with an MRT unit) from the CON standards for MRI units. MRI simulation is emerging as a useful tool for radiation treatment planning that has advantages over the more traditional method of CT simulation. First, compared to CT, MRI imaging provides more detailed and clearer images of the target and surrounding normal structures in certain anatomic locations, such as the brain, spine, prostate and soft tissues. As target delineation is essential for accurate radiation treatments, MRI simulation can help achieve more precise treatment planning for certain disease sites. Moreover, unlike CT simulation, MRI simulation does not involve additional radiation exposure to the cancer patient. The CON standards for CT units already contains an exception for CT simulators. We recommend that the same exclusion be created for MRI units to be used for MRT simulation. As radiation treatments become more precise, the ability to integrate the optimal imaging modalilty for treatment planning becomes more important."

7. Testimony:

1. Name: Ann Mazure
2. Organization: Oaklawn Hospital
3. Phone: (269) 789-7029
4. Email: amazure@oaklawnhospital.com
5. Standards: MRI
6. Testimony: Letter of Testimony, submitted on behalf of Rob Covert, Oaklawn Hospital.

Content-Length: 804779

OaklawnHospital

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July 30, 2009

Advancing medicine.
Compassionate care.

Mr. Edward B. Goldman, J.D.
Chairman
Certificate of Need Commission
Michigan Department of Community Health
201 Townsend Street, 7th Floor
Lansing, Michigan 48913

Dear Chairman Goldman,

On behalf of Oaklawn Hospital in Marshall, Michigan, we appreciate this opportunity to provide comments on the changes to the MRI standards sent to public comment at the June Commission meeting. First, I want to take the opportunity to thank you and the rest of the CON Commissioners for taking the time to thoughtfully discuss the recommendations of the MRI Workgroup and for moving most of the recommendations forward to public hearing. I also want to thank the Department staff and leadership, as well as Commissioner Sandler for the extra time they spent on these issues in the workgroup and in other meetings and discussions.

We are writing to express our support for the changes proposed to the MRI standards and urge you to give them final approval at the September Commission meeting. We support the Department's work to streamline and simplify the 22 pages of standards. In addition, we of course, still strongly support the changes to allow for the conversion of a mobile MRI host site to fixed service at a hospital site with at least 20,000 ER visits and 3,000 adjusted MRI procedures.

As our previous testimony and supporting materials have explained, MRI is becoming a standard of care for diagnosing many conditions that present in hospital emergency departments. The most suitable of these conditions currently include analysis of suspected stroke, hip fractures in the elderly, pediatric patients with abdominal pain and certain conditions in women of childbearing years. These last two populations benefit most by the reduction in radiation exposure and the associated risks. Prior to the June Commission meeting, we provided you with several journal articles discussing the use of MRI in emergency situations and its effectiveness in diagnosing many of these conditions.

Some argue that we do not perform enough MRI scans at Oaklawn to justify a fixed MRI unit. We reiterate that our concern is not in having more access to MRI so that we can perform more scans. Our concern is having access to MRI 24 hours per day, seven days per week, so that the MRI is available when urgent cases present at the hospital through the emergency department at all hours of the day and night. Let us also be clear that we will not staff the MRI unit 24/7. However, we will have access to it 24/7 through a call system where staff would be available to operate the MRI within 30 minutes of being notified. This is the same system we use with our CT scanner currently with much success and it is also the system used in many other hospitals large and small.

Oaklawn has worked with the MRI Workgroup and Commissioner Sandler to craft a proposal that seeks to ensure that MRI is accessible for emergency patients, while balancing that access with the likelihood that MRI is needed and that it will be utilized in a manner that effectuates actual improved outcomes for patients. By requiring a minimum of 20,000 ED visits, the proposed standard pinpoints Emergency Departments that are busy enough to be on the cusp of requiring more than one ED physician and therefore demonstrating that they have the patient throughput to justify the need for access to MRI 24/7. At the same time, the requirement that the facilities already utilize MRI services as a mobile host site and be utilizing that service at a volume of at least 3,000 adjusted MRI procedures per year, describes a facility that is likely to have sufficient radiology coverage to effectively utilize MRI to improve patient outcomes.

Clearly the CON standards for MRI already define the need for a fixed MRI based solely on volume. However, we have demonstrated through peer-reviewed research, that there is a need for MRI that is not just based on volume, but also based on patient care and patient access. Based on our experience at Oaklawn Hospital as well as the input from other members of the MRI workgroup, we believe that the parameters you approved in June reasonably define a facility that is in need of a fixed MRI unit. We appreciate your support for this proposal in June and look forward to your continued support at the September Commission meeting. If you have any questions or concerns, please do not hesitate to contact me directly at (269) 789-3924.

Sincerely,

Rob Covert

Rob Covert
President and CEO

1. Name: Robert Meeker
2. Organization: Spectrum Health
3. Phone: 616 391-2779
4. Email: robert.meeker@spectrum-health.org
5. Standards: MRI
6. Testimony: Spectrum Health supports the proposed changes to the CON Standards for MRI. Specifically, we endorse the proposed changes in proposed Sec. 3(2)(b)(iii) which permit a fixed MRI unit at a hospital with an emergency room having > 20,000 visits annually and with a mobile MRI service with >3,000 MRI adjusted procedures annually.
7. Testimony:

1. Name: Janelle R. Spann
2. Organization: Michigan Resonance Imaging
3. Phone: 248-299-8000
4. Email: mrirochesterhills@ameritech.net
5. Standards: MRI
6. Testimony:

Content-Length: 121363

Michigan Department of Community Health-MRI Standards Committee:

Michigan Resonance Imaging is a 501C-3 not for profit Michigan Corporation. It is a joint venture owned equally by Crittenton Hospital Medical Center, Mt Clemens Regional Medical Center and Pontiac Osteopathic Regional Medical Center. This company currently has two Mobile MRI Routes and three Fixed MRI units.

Michigan Resonance Imaging endorses the exclusion allowing for MRI simulations only, not for other billable scans. Patients undergoing cancer treatment require the most accurate scans to assure precise radiation therapy. This will also allow these patients reduced exposure to the radiation of Cat scans.

Michigan Resonance Imaging also endorses the exception to the criteria for conversion of a mobile to a fixed MRI in Section 3(2)(b)(iii) to allow for a hospital with 3,000 MRI adjusted procedures, 24 hour emergency care services and at least 20,000 emergency room visits within a 12- month period to convert from a mobile to a fixed. We additionally would ask the commission to consider review of data statewide and consider establishing the threshold of emergency room visits to 15,000 annual visits. Reasons for adopting this exception include the increased use of MRI in emergent situations in lieu of cat scan to reduce radiation exposure to patients, as well as increased use in stroke evaluation. It is our belief that this increased access to emergent MRI enhances the treatment of these emergency patients yielding better diagnoses and treatment outcomes.

Respectfully Submitted,

Janelle R. Spann
Executive Director
Michigan Resonance Imaging

Pancreas testimony is included.

>>> DoNotReply@michigan.gov <DoNotReply@michigan.gov> 7/28/2009 12:19 PM >>>
1. Name: Barbara Winston Jackson
2. Organization: BCBSM/BCN
3. Phone: 248.448.2710
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5. Standards: MRI
6. Testimony:

Content-Length: 74124

Blue Cross
Blue Shield
Of Michigan

600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

Testimony
Blue Cross Blue Shield of Michigan/Blue Care Network
Public Hearing
July 23, 2009

I appreciate the opportunity to provide testimony on behalf of Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN). BCBSM and BCN actively support the Certificate of Need (CON) program, designed to ensure the delivery of cost-effective, high quality health care to Michigan residents. This role has become even more significant due to the current turbulent economy.

Proposed Pancreas Transplant Standards

As indicated in prior testimony, over the past several months, BCBSM/BCN administrative and clinical staff members have met with many of the organizations interested in modifying the Pancreas Transplant CON review standards. BCBSM has also been an active participant in the MDCH Pancreas Transplant Work Group.

As a result of these meetings and work group discussions, where additional information was shared, BCBSM/BCN supports the proposed language, both independently and as member of the Economic Alliance for Michigan. BCBSM believes that the proposed language captures the comparability of these services. Specifically the proposed language links the ability to perform pancreas transplants to programs with high volume annual kidney transplant thresholds, generating quality-driven programs. In addition, these proposed standards help to retain the comprehensive role of Gift of Life as a Michigan-based organ procurement program. BCBSM supports the Commission taking proposed action and moving this language forward for final action.

Proposed MRI Standards

As stated in at the June Commission meeting, BCBSM continues to have concerns about how this language was developed. BCBSM/BCN clinical and administrative staff members actively participated in the MRI Work groups, and feel that these issues require additional clarification and discussion, particularly since many key groups were unable to attend the first meeting. The process needs to be transparent with as many engaged parties as possible to deliberate these issues.

BCBSM believes that this proposed language is premature and recommends additional work group meetings to complete these deliberations and develop consensus. Only following this process, would we consider supporting language brought forward for Commission action.

Again, BCBSM/BCN continues to support the review of CON standards in terms of cost, quality and/or access concerns. We applaud the CON Commission and MDCH staff as they continue to facilitate an objective review process, by eliciting in-depth clinical expertise as well as input from consumers, purchasers, and payors. BCBSM/BCN will continue to be an open-minded, active participant in these endeavors. As always, BCBSM/BCN commends the CON Commissioners and MDCH staff for their diligent efforts in maintaining CON as a strong, vibrant program to help ensure the delivery of high quality, safe and effective care to patients across the state.

1. Name: Dennis McCafferty
2. Organization: The Economic Alliance for Michigan
3. Phone: 248 596-1006
4. Email: Dennismccafferty@eamonline.org
5. Standards: Pancreas
6. Testimony:

Content-Length: 78346

Pancreas Transplants: EAM supports proposed changes that strengthen these standards:

- **Volume Requirement to secure and retain a Pancreas Transplant CON;** A hospital has to have done at least 80 Kidney/Pancreas transplants in the last two years. Previously, only needed to have done at least 80 Kidney transplants to qualify for a CON.
- **The minimum annual volume reduced from 12 to 2**; Evidence provided supports lower volumes of pancreas transplants, does not result in lesser quality when provided at facilities with higher kidney transplant volumes.

MRI: EAM members are convinced that the CON Standards for MRI results in constraining excess capacity and thereby controlling costs, improving efficiency and quality by preventing overutilization. Imaging, as cited by the AMA and President Obama, is now the fastest growing component in the cost of healthcare. Allowing additional capacity that is unjustified by community need only encourages additional excess utilization and higher costs. Our member, who are purchasers and consumers of health care services, do not support the proposed changes in the MRI Standards because of the following concerns:

MRI for MRT Simulation: EAM members have concerns regarding the proposed changes in these standards for exempting MRI units that are to be used only for MRT simulation. The major cancer programs that could justify the expense of an additional MRI that is used solely for MRT simulation already have multiple MRI units used for diagnostic purposes. This proposed change in the Standards would enable these major cancer programs to obtain an additional MRI unit. We would anticipate that many of these MRI units used solely for MRT simulation will be underutilized. We expect that many of these cancer programs will be coming back to the CON Commission in one or two years requesting that they be allowed to maximize their capital investment in this exempt MRI by allowing it to also be used for diagnostic purposes. This will results in further increasing their MRI diagnostic capacity and increasing the potential for overutilization and higher costs.

We believe that an alternative for addressing this desire for an MRI for MRT simulation already exists within the Standards. Major cancer centers could use one or more of their existing MRI units for MRT simulations, and the extra MRI time needed for the MRT simulation could be justified by allowing these services to have a higher MRI procedure adjustment value. This would allow every MRT program with MRI units currently available to immediately start using their current MRI units for MRT simulation. Additional MRI units would not need to be installed unless the volume of MRT simulation procedures, combined with the current MRI diagnostic volume, warranted an additional MRI unit. We could avoid installing expensive additional MRI units, approved for only MRT simulations, being underutilized.

The one MRI workgroup meeting did not address this potential alternative solution to this issue. We are requesting that the Commission not approve the proposed Standards at its September meeting until the above alternative has been considered by the workgroup.

Replacing Mobile MRI with Fixed MRI for hospitals with High-Volume ER: Lowering of the minimum annual volume of adjusted MRI scans needed to initiate a fixed MRI from 6,000 to 3,000, if a hospital with mobile MRI host sites has 20,000 or more annual emergency room visits, is a concern for our members for the following reasons:

1. Is there a need for 24/7 MRI services in every hospital emergency room?
    - Only a small percent of emergency room visits currently result in the need for an MRI scan and only a few of these emergency MRI scans might occur when the Mobile MRI unit is not in service.
    - Many of the existing hospital-based fixed MRI units don't operate on a 24/7 basis because of the staffing expense for so few off-hour patients.
    - Does such a small volume of scans (8-per day) warrant the cost of a fixed MRI that may or may not be available 24/7?
2. Will the financial viability of mobile MRI routs that serve small and mid-sized community hospitals be jeopardized by this proposed change?
    - The Mobile MRI Standards were established with lower annual volumes for smaller community providers to have access to MRI services. For a mobile MRI network to operate, a sufficient number of host sites with sufficient volume of scans are needed to make a mobile MRI networks viable.
    - By allowing a number of the higher volume, mid-sized hospitals to replace their mobile MRI host sites with fixed MRIs, will the mobile MRI network providers be able to continue to provide this service to the smaller community hospitals that do not have the volume to justify a fixed MRI?
3. Are 3000 adjusted procedures per year too low to justify a new, fixed MRI?
    - This works out to be only 8 scans per day for the usual 250 working days per year. (Given that the average adjusted scan is 1.5) The current CON Standard for initiating a new fixed MRI requires a minimum of 16 scans per day. This proposed exception to the MRI Standards allows for a fixed MRI unit that will operate at 50% of the minimum volume for all other fixed MRI units covered by these standards.
    - No information was provided that indicates that 3000 adjusted procedures per year is the appropriate minimum volume for a hospital emergency room to qualify for a fixed MRI. All we know for sure is that Oaklawn Hospital has just over 3000 adjusted procedures per year and wants a fixed MRI.
    - Doesn't this leave the Standards open to challenge by the next hospital that has a slightly lower number of adjusted procedures per year?
4. Why are 20,000 emergency room visits per year the appropriate minimum for a hospital to qualify for replacing its mobile MRI with a fixed MRI?
    - No information was provided that indicates that 20,000 ER visits per year is the appropriate minimum volume for a hospital emergency room to qualify for a fixed MRI. All we know for sure is that Oaklawn Hospital had 20,025 ER visits in 2008 and wants to qualify for a fixed MRI.
    - Doesn't this leave the Standards open to challenge by the next hospital that has slightly lower number of ER visits per year?

We believe that this proposed change in the standards was developed to address the perceived needs of a specific hospital. Revising the CON Standards for specific providers is detrimental to good public policy. This proposed change will result in undermining the bases for the MRI Standards and make it more difficult to defend against further requests to erode these standards.

Added comment regarding Open Heart Surgical:

The EAM members believe that the 2009 CON Work Plan is progressing well. MDCH staff and the Commission are to be commended on stepping-up to the challenges of a very full and ambitious agenda. The Commission should also be commended for resisting efforts to re-open the Open Heart Surgical Standards. We support the decision of the Commission's Chair that a case has not been made regarding a community need (Cost, Quality or Access) to re-open these Standards.

1. Name: Mark Mailloux
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5. Standards: Pancreas
6. Testimony:

Content-Length: 46597

University of Michigan Health System

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PANCREAS TRANSPLANTATION SERVICES
July 23, 2009

Good Morning. My name is Mark Mailloux, Sr. Health System Planner at the University of Michigan Health System (UMHS). I'd like to thank you for the opportunity to appear here today to offer our comments on the proposed Certificate of Need (CON) Review Standards for Pancreas Transplantation Services.

UMHS strongly supports the proposed revisions to these standards and believe that they should be adopted for several reasons:

- Because of the nature of the Pancreas organ itself, its fragility and its poor 'shelf life' as well as the current state-of-the-art for dealing with those factors, Pancreas Transplant is, and for the foreseeable future will continue to be, an extremely low volume service.
- At the same time, the technical knowledge and equipment required, such as the highly trained transplant physicians and other personnel required to perform such transplants, are difficult to attract and obtain as well as expensive to retain *solely* for an extremely low volume service such as this.
- From both a personnel as well as a technique standpoint, there is a close affinity between Pancreas and Kidney Transplants; a connection that would continue to exist informally, even if it were never formalized as is accomplished in these standards.

As a result, the establishment of a substantial volume standard for Kidney Transplants as a requirement for the establishment and on-going maintenance of a Pancreas Transplant program secures that link. Despite the fact that Kidney Transplant is not a CON-covered service, we believe that basing Pancreas Transplant standards on an underlying Kidney Transplant program will do more to secure a successful Pancreas Transplant program than any Pancreas volume requirement.

1. Name: Dennis McCafferty
2. Organization: The Economic Alliance for Michigan
3. Phone: 248-596-1006
4. Email: dennismccafferty@eamonline.org
5. Standards: Pancreas
6. Testimony:

THE ECONOMIC ALLIANCE FOR MICHIGAN
PUBLIC COMMENTS û JULY 23, 2009
Dennis McCafferty, EAM Health Policy Director
Pancreas Transplants: EAM supports proposed changes that strengthen these standards:

ò Volume Requirement to secure and retain a Pancreas Transplant CON; A hospital has to have done at least 80 Kidney/Pancreas transplants in the last two years. Previously, only needed to have done at least 80 Kidney transplants to qualify for a CON.
ò The minimum annual volume reduced from 12 to 2; Evidence provided supports lower volumes of pancreas transplants, does not result in lesser quality when provided at facilities with higher kidney transplant volumes.

19. Resume:

1. Name: Robert Meeker
2. Organization: Spectrum Health
3. Phone: 616 391-2779
4. Email: robert.meeker@spectrum-health.org
5. Standards: Pancreas
6. Testimony: Spectrum Health supports the proposed changes to the CON Standards for Pancreas Transplant. Specifically, we endorse the reduction in the annual number of transplants required to two (2), consistant with national standards, accompanied by the ongoing requirement to provide at least 80 kidney transplants every two years.
7. Testimony: