**Subject:** [Fwd: Cary]
**From:** "Carol G. Potter" <Carol.Potter@ncmail.net>
**Date:** Fri, 08 Aug 2008 16:11:12 -0400
**To:** Kelli Fisk <Kelli.Fisk@ncmail.net>

-------- Original Message --------
**Subject:**Cary
**Date:**Fri, 8 Aug 2008 16:08:00 -0400
**From:**Mark Liang <liang726@bellsouth.net>
**To:**<Carol.Potter@ncmail.net>

August 8, 2008

Ms. Carol G. Potter
NC Division of Health Service Regulation
Medical Facilities Planning Section
2714 Mail Service Center
Raleigh, NC 27699-2714 RE: Petition from Parkway Urology, P.A., d/b/a Cary Urology, P.A.

Dear Ms. Potter:

I am a radiation oncologist practicing in North Carolina. As a radiation oncologist specializing in the provision of cancer treatment, I feel that the preferential "carving out" of a single diseased organ by regulatory decision would be detrimental to the current multidisciplinary approach to cancer care now being practiced in North Carolina, which requires a critical mass of high technology and expert support staff in addition to the radiation oncologist, in order to provide appropriate and efficient treatment for not only prostate cancer, but a wide variety of both common and uncommon cancers.

If a more common cancer such as prostate were to receive designation for a 'special' treatment center through a revision to the carefully crafted methodology outlined in the *State Medical Facilities Plan (SMFP)*, our multidisciplinary and comprehensive community-wide approach to cancer care for other organs such as breast, brain, lung, and colorectal would be fragmented among multiple referring specialties, leading to potentially negative outcomes for our patients, some of whom are being treated for cancer at more than one site.

Organ-specific 'special' treatment centers could lead to a statewide proliferation of linear accelerators, as advocates for various disease sites argue that their own special disease of interest should receive equal consideration through the establishment of additional 'special' treatment centers - even though the 2008 *SMFP* (Table 9H) notes that North Carolina has an *excess* capacity of linear accelerators; ignoring the existing *SMFP*
methodology would only exacerbate the current excess capacity. It is important to note that there is no evidence that organ-specific radiation oncology centers provide better medical outcomes than comprehensive community or academic centers, so no medical advantage is to be gained from such an approach.

Wake County itself is already served by no less than four (4) radiation oncology centers, capable of IMRT/IGRT therapy for prostate cancer, which bracket the proposed Cary center. In fact, just two miles

from the petitioner, there already exists a radiation oncology center in Cary, which was among the first in North Carolina to offer IMRT services. In addition, linear accelerators are located in the two other Service Area 20 counties, Franklin and Harnett, while renowned multidisciplinary academic cancer centers at Duke University Medical Center (DUMC) and UNC-Chapel Hill are both within 30 miles of Cary. Finally, it should be noted that the July 25, 2008 "US News and World Report" ranked the DUMC urology program as the 6th
best in the country. It is also my understanding that existing radiation oncology departments in Wake county have grants to develop prostate centers of excellence. An additional radiation facility would be redundant.

The economic viability of existing cancer centers, which in many cases offer millions of dollars in uncompensated care to indigent and underinsured patients, could be jeopardized if care were to be offered under the single disease concept. Advertising campaigns purporting to offer a 'new improved' form of treatment would be at best disingenuous, sapping patients and resources from existing cancer treatment centers. In fact, patients in the Research Triangle region are already well-served by several multidisciplinary cancer centers which provide excellent care for prostate and other cancer patients. Clearly, there is ample evidence that abundant resources already exist for the treatment of prostate cancer patients in the Research Triangle area, so the issue of access is well addressed.

The Cary area is one of the most affluent in the country. In its report "Top 50 MSAs by Total Personal Income, 2006",
the U.S. Department of Commerce Bureau of Economic Analysis ranked Raleigh-Cary as the 50th richest Metropolitan Statistical Area (MSA). Similarly, for "Metro Areas by Median Household Income, 2007", Freddie Mac ranked Raleigh-Cary as the 42nd
richest MSA. Though the North Carolina Comprehensive Cancer Program has little available data indicating underserved areas at the diagnosis level, e.g.
prostate cancer, it seems reasonable that some of the North Carolina non-metropolitan, rural or poorer counties would be more deserving of and experience a greater benefit from additional excess linear accelerator capacity as has been proposed.

Radiation oncology facilities owned by referring physicians create a lucrative opportunity for self-referral, which has received special attention from the Centers for Medicare and Medicaid Services (CMS). In fact, CMS is reviewing whether to continue the current in office "ancillary service" exception enjoyed by such facilities; if this exception should be eliminated, the proposed prostate cancer center would then be illegal.

Thank you for allowing me to submit comments on this very important set of issues.

Sincerely,

Mark J. Liang MD