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In all three sections, we should state the principles as being those of the **State** and not of DHHS. While presumptuous on its face, DHHS is an instrument of state and should have no principles or guidelines that do not reflect the policy/goals/laws of the state.

2. "these times of high and increasing costs"…is not a meaningful qualifier. Indeed the current cost trends are less than in several years in the past and certainly no worse …so I think this is a bit misleading or loading. We may prefer to point to the increasing cost of care outstripping the growth in personal incomes or GDP etc and hence the need to constantly search for care that provides necessary care and better value (quality and outcomes) to more individuals in more cost effective ways .

3. Having said this I think to simply refer to "cost effective approaches to"care is a bit shallow and may even set up undesirable outcomes or false measures – at least from my perspective. Clinical based care, necessary care and cost effective CARE (not processes) should be the outcomes our State (not DHHS) strives for.

4. Under #1 I like the encouragement of organized systems of care or care collaboration, and prepaid plans etc, but think the encouragement of corporate structures and payment/payor forms are well outside of the jurisdiction of DHHS. If we want to go down this path (and I would welcome same) is to further define coat effective care as also including systems (or virtual systems, and/or provider collaboration) that put the PT in the center and provide coordinated care, care management, and shared clinical information that better assures both effective care outcomes and quality and safety (our third basic principle)! Giving preference in the development or allocation of future resources on regions that can corporately, virtually or collaboratively provide such PT care continuity would be a worthy principle indeed and in fact lead to the things (like systems of care) that the current construction of #1 says are desired.

5. The lead sentence in second paragraph of Principle #2 is revealing to say the least (in its replete references to local funding) which is at best redundant to the lead term "public funding". Perhaps a better way to express is to simple say that public expenditures (federal, state and local)

are replete throughout the health care systems and then site some of the examples cited. If we are trying to really portray the current world of subsidy and contribution to care, we are remiss in not also noting the considerable contribution to care for the underserved made by philanthropic entities in this state AND the considerable contribution of health care professionals who contribute mightily to the care of indigents by donating countless hours at free clinics, provide services in their offices or clinics to PTs referred by free clinics and others for which they knowingly will not get reimbursed and in recognizing that many professionals still support their community hospitals efforts to provide a full continuum of care for their communities by taking call without remuneration!

6. I am not sure that I could agree in this paragraphs suggestion that Medicare and Medicaid recipients are under-served. Indeed our society would do well to provide similar levels of care. If there is underservice for Medicare and Medicaid Enrollees, it is more likely to be the issue of ACCESS to providers and specialty services (which may result in the public policies that under pay for such services.. at least in the minds of the providers of such services).

7. 7. Finally the last sentence on page and principle #2 (a) seems falsely premised and t(b) suggests an accepted outcome that I am unwilling to support. CON was premised on the states adopting a policy that sought to assure reasonable access to care and a process that rationalized the acquiring and placement of services for the "greater good" rather than a competitive market which is premised more on survival of fittest and a tilt toward those who can acquire the capital the fastest or choose to serve only select portions of the market. To say that the market is becoming more competitive is perhaps fair (at least in more urban mid-sized town areas) though having just been to Englehard NC it would be a stretch to see ANY way completion is going to arrive there in my lifetime. To state this (increased competition) as if it is good per se….or that it should be what we promote is another matter and should be fully debated… competition on what basis….etc. I am not willing to suggest that a decrease in available services for the underserved is an acceptable policy alternative as implied in last line.

8. On principle #3 I think we need to explicitly speak to **safe** as well as quality care as Don Bradley suggested. And, I would advocate safe and necessary or effective care.

9. In the direction that #3 gives the department, I think broadly available and accessible care should be the first subprinciple (i.e. a); b) should read beneficial to the greatest number of citizens regardless of payment

prospects or payment source; and a new c) would refer to valued based care that is safe, high quality and evidence based.

10. Finally I think cost containment is a bit of an archaic term…and we probably need to find a way to use terms of: more effective; value based care and coordinated/collaborative care (i.e. that tries to get all providers viewing the PT in their entirety (not in a single process or service recipient).