Presentation of Petition
from
Affordable Health Care Facilities, LLC

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I am here today to discuss the petition prepared by Affordable Health Care Facilities, LLC ("AHCF") titled:

New CON Methodology Related to Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice

Last year the original petition was submitted to this body and the Single Specialty Ambulatory Surgery Work Group was ultimately created. Although significant work has progressed (creation of the pilot study for CON methodology in Mecklenburg County, etc.) since our prior petition was submitted, major tenets of the original petition have been ignored. The revised 2009 petition supplies more supporting data and research than last year. Some of the additional data and research are in response to the deliberations of the **Single Specialty Ambulatory Surgery Work Group**.

I am here today to present a physician's perspective on the issues raised by the petition and support the need for more facility competition as a basis to improve efficiency in care delivery; access to more affordable surgical care; safety and quality of care; and patient satisfaction.

As an orthopedic surgeon, I am beholden to the hospital where I perform my surgery. Scheduling patients is often difficult. There are no options. The excessive length of case turnover times illustrates the inefficiency in this setting and it is increasingly difficult to effect change or improvements in this system. Often the individuals (surgeons) most involved in the process have the least control over system management.

With the increasing number of under- and uninsured patients, I want to be able to offer my patients a more affordable facility alternative. For example, a recent 27 year-old uninsured laborer sustained an injury where surgery would be helpful but was not absolutely indicated. I could forgive my component of his charges but had no ability to affect a reduction by the hospital / facility, anesthesia care, etc. This patient chose a non-surgical, and in my opinion a less desirable, option purely for financial reasons. In a physician-controlled setting, I would have the option to write-off or significantly reduce these costs to make them reasonable for this patient. Under current CON regulation, such an alternative in the form of a physician owned ASC is not available. Additionally, hospitals often bill uninsured / under-insured patients a "full charge," and this is unconscionable to me. Most patients do not understand the dramatic disparity between actual charges ("full charges") and the Medicare reimbursed rate or negotiated private insurance rate. This disparity can reach a difference of 500%-800%, with the penalty being placed on those without adequate insurance coverage and knowledge. In fact, I encourage my uninsured and under-insured patients to negotiate a "Medicare rate" with the hospital after giving them this rate or an additional reduction for my own services.

Please let me address a major issue up-front. It is my understanding that some of the GI endoscopy centers approved for licensure beginning in 2005-2006 do not see their "fair share" of uncompensated care. Under our petition, such "skimming" of well paying patients will not occur. This premise is clearly delineated in the petition presented today.

For me, the greatest opportunity to benefit the welfare of my patients is to offer them an ASC alternative that is more affordable and easier to access. A physician owned and operated single specialty ASC can save the health care system many dollars both through efficiency of care and absolute lower pricing. Patient satisfaction improvements are expected in such a center, since we as physicians can respond much better to our patients' needs and expectations. Facility charges and reimbursement in my community are unacceptably high, which hurts private payers, government programs (Medicare, Medicaid, and Tricare), and patients.

Increasingly, hospitals are employing physicians or purchasing physician practices. I would like to be able to preserve the private practice of medicine for me and other physicians that join or follow me. The only way in which I can be assured of remaining independent in private practice is to own an ASC or a portion of one. Why do I say this? Because as more dollars get shifted to hospitals in the form of facility reimbursement by private payers, the more hospitals are looking to employ physicians or purchase physician practices. Despite STARK regulations, hospital employed or "'owned" physicians and physician practices virtually eliminate referrals outside the

hospital system. We have exceeding difficulty with physician recruitment and have lost well qualified physicians to surrounding states with less restrictive (or non-existent) CON laws.

Under the protection of CON regulation, hospitals and other licensed facilities that maintain strong market position have little or no incentive to become more efficient or to lower costs. Candidly, physicians do not always assist hospitals in lowering costs either. We work at our practice and treat patients. We do not get paid to participate in clinical management meetings to discuss operational improvements. Although this may seem petty, attendance at this meeting will cost the average surgeon (myself included) $2,000-$3,000 per day in lost revenues. I wonder if any members of the committee or work group members make this sacrifice on a regular basis in order to promote and improve costs and efficiency in healthcare delivery. If so, then we share a severe penalty / disincentive. Physician involvement is critical in this process and is promoted through physician-owned ASC's.

It seems that the vast majority of outpatient facility and diagnostic services performed at hospitals in North Carolina are reimbursed on a discount from the 'actual charge' by private payers (resulting in the penalty discussed previously). Many of you on the SHCC can confirm this assertion. Perhaps the private payers are given no other choice by hospitals due to CON protection and market position. This environment, however, is only promoting a tremendous reimbursement <u>imbalance</u> between facilities

and physicians. Hospital and facility-based services have gained an increasingly larger slice of the reimbursement pie over the last 15 years especially.

Our petition seeks to develop single specialty ASCs that will bring some balance back into the equation and offer additional choice to patients based on both price and service. Our petition provides a mechanism with measurable metrics related to safety and quality; access; and value in support of such choice.

The recommended pilot demonstration approach should not have geographic or number of applicant limitations as the **Single Specialty Ambulatory Surgery Work Group** seems to endorse to date. In limiting pilot demonstrations geographically or in number, the SHCC and the DHSR are in turn limiting potential innovation related to the Basic Principles of safety and quality; access; and value in the State Medical Facilities Plan. We all should want to see and learn from a number and diverse range of pilot demonstration ASC applicants as our petition proposes. I believe that New Bern, North Carolina (Craven County) represents an exceptional opportunity to show improvement in service and cost containment due to the complete lack of competition and elevated health care costs we experience in our region.

We also believe that the SHCC should adopt the provisions of the State Government Ethics Act. Currently any speaker presenting scientific data must disclose publicly any financial ties that could remotely affect or bias their research. Although extreme at times, this standard is critical to the delivery of health care information and

care itself. Drug reps and equipment reps no longer can bring even a ball point pen into my office due to potential influence and conflict of interest as of January 1, 2009. I wonder if any non-physician in this room is held to this same standard.

Those of you who work for or represent organizations that hold CONs should voluntarily recuse yourselves from voting on our petition. You possess undue conflicts of interest that run counter to the welfare of the citizens of North Carolina and the State Government Ethics Act. I hate to create an argument here. However, I think that deep down all of you would agree with this contention.

All we as physicians ask is for a level playing field on which to compete. Hospitals can always employ physicians and control where care is delivered as is done in many communities today and on an increasing basis. In our petition, we do not propose to duplicate facilities. We are providing a completely different service in terms of efficiency, affordability, and patient satisfaction. We do so under a pilot demonstration approach with measurable performance metrics in accordance with the new Basic Principles of the State Medical Facilities Plan.

Please give this petition a chance to succeed. There is limited downside and a huge upside. As we have argued in our petition, hospitals have done very well financially in recent years. The well managed ones continue to do so. Hospitals also have many other assets, not just CON regulation and dollars, to protect their revenue streams. They can simply employ physicians -- both surgeons and sub-specialists in

addition to primary care physicians -- and eliminate competition and the private practice of medicine altogether in a community.

My greatest concern is that the Single Specialty Ambulatory Surgery Work Group has severely limited the scope of our original presentation. I implore you to consider the 2009 petition; to allow geographic diversity; and to expand the numbers of pilot demonstration applicants that may be included, and to specifically include Craven County in this study. We look forward to your favorable consideration of our petition. Thank you for your time today.

Petition Title: New CON Methodology Related to Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice

Petitioner:

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Request: The request is to revise the CON methodology for single specialty ambulatory surgical operating rooms via a pilot demonstration approach with QAV Basic Principles metrics to achieve the objectives of:

1. Lower cost of outpatient surgical services;
2. Develop managed competition;
3. Increase disclosure and transparency of outpatient surgical costs for consumers (patients);
4. Increase (a) choice; (b) safety/quality; (c) access; and (d) value of outpatient surgical services for consumers;
5. Protect the fragile rural health care delivery system;
6. Support increased levels of operational efficiency in facilities that can be documented and measured; and
7. Encourage innovation in health service delivery.

Adverse Effects: Excessive costs for outpatient surgery for consumers will continue to result in the market place without implementation of this petition's premises/objectives. Hospital providers will encounter increased competition based on the QAV Basic Principles.

Duplication: The proposed methodology allows for pilot demonstration ASCs to be constructed in counties in which only more expensive and less safe HOPD facility settings are available to healthy consumers and provides for more affordable health services in all target non-rural counties. Pilot demonstration facilities cannot be approved for development without demonstrated and measurable improvements in QAV for consumers as shown in their applications to the DHSR.

QAV: The petition is based on the SMFP's QAV Basic Principles.

It is the request of AHCF that hospital representatives and board members, as well as physician practice representatives, whose organizations possess CONs and who serve on the SHCC, maintain fiduciary conflicts of interest in regard to this petition and should not be permitted to vote on this petition.

It is important to note that very few participants in the health care system maintain true incentives to lower costs as described in the table below:

	Participants	Incentive to Reduce Health Care Costs
1	Insurance industry	No. Insurance payers and representatives are generally compensated as a percentage of medical expenses on a "mark-up basis." One of the greatest health industry misunderstandings is the belief that insurance payers and commissioned agents and consultants are truly motivated to reduce health care costs. As health costs rise, insurance participants gain increased revenues and earnings.
2	Hospitals	No primarily. Limited Yes. Increased charges generally result in increased revenues and earnings, especially for outpatient services with private payers as this petition describes. Hospitals have an incentive to reduce inpatient health care costs when paid on a prospective payment basis.
3	Physicians	No primarily. Limited Yes. Physicians are generally paid on a fee-for-service basis. Yet, many physicians continue to be concerned about the continuing burden of health care costs on their patients. As the leading care givers to patients with nurses, many, but not all, physicians tend to feel a responsibility to reduce health care costs while increasing access and safety/quality of health care services for patients. The current fee-for-service reimbursement system creates many difficulties for physicians in the care of their patients.
4	Other health care providers	No. Most other health care providers are paid on a fee for service basis.
5	Pharmaceutical companies	No. Pharmaceutical companies are paid for each prescription ordered and purchased. There is an incentive to increase price and utilization of prescription drug use by consumers. However, it can be argued that prescription drugs used efficaciously can reduce hospitalization and other health care expenses.
6	Medical/DME suppliers	No. Suppliers are paid on a fee-for-service basis.
8	Consumers (Patients)	Yes with caveats. Consumers are often screened from the direct purchase costs of health care services, and if they are medially ill, there is limited incentive to seek less costly treatments. Medically ill patients seek to get well, often regardless of the cost to their health plan payer.
9	Government	Yes. Unequivocally the answer is "yes" unless lobbyists and conflicts of interests prevent elected representatives from voting on legislation that lowers health care costs.

AHCF by promoting the pilot demonstration approach as outlined in this petition can be a motivator for health care delivery system reform based on the QAV Basic Principles.

Petition
State Health Coordinating Council ("SHCC")

New CON Methodology Related to Single Specialty Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice

Proposed By:
Affordable Health Care Facilities, LLC
March 4, 2009

Preamble and Background

Last year at this time, Affordable Health Care Facilities, LLC ("AHCF") submitted a petition to change the CON methodology for ambulatory surgical operating rooms to provide more price competition and disclosure as to quality, access, and cost. In response to the petition and based on other discussion, the SHCC formed a ***Single Specialty Ambulatory Surgery Work Group***. In addition in 2008, the ***Quality, Access, and Value Work Group*** established a statement of Basic Principles which was approved by the SHCC and placed in the annual SMFP. The Basic Principles relate to the issues of:

1. **Safety and Quality;**
2. **Access; and**
3. **Value**

Together these Basic Principles are termed "QAV." AHCF believes that these efforts are significant and should not be diminished. However, the evolving focus of the ***Single Specialty Ambulatory Surgery Work Group*** does not address some of the core tenets of AHCF's petition from March 2008. These core tenets are:

1. **Price competition for area hospitals and other facility providers;**
2. **Price ceiling limits, disclosure, and transparency for CON applicant facilities; and**
3. **No limitation as to the number of CON applicant facilities.**

Therefore, AHCF is re-submitting a revised petition in March 2009 for the 2010 SMFP that addresses these and other issues. The petition proposes a pilot demonstration approach with consideration of the QAV Basic Principles approved by the SHCC. Additional focus is on increased disclosure to and choice for consumers, while supporting innovation and increased efficiency, in health care delivery. This 2009 petition has been supplemented with additional supporting health care research.

I. Petition Summary

It is proposed that the SHCC (i) develop a pilot demonstration program and (ii) change the CON methodology for ambulatory surgical operating rooms. Specifically, it is proposed that pilot demonstration facilities apply to the DHSR by submitting proposals that contain specific metrics that can be used to measure a facility's effectiveness in meeting the QAV Basic Principles of the SMFP in order to be granted under a CON under the proposed new need methodology. The premises of the proposed need methodology are outlined in section **IV. Framework for Need Methodology Change: Ten (10) Premises** of this petition.

There shall be no limitation as to the number or location of these pilot demonstration facilities that may be approved by the DHSR, other than that these pilot demonstration facilities should be located in:

- Counties with a population of at least 85,000 and one (1) hospital; or
- Counties with a population of at least 125,000 and two (2) or more hospitals. [1]

The prescription by the ***Single Specialty Ambulatory Surgery Work Group*** that such pilot demonstration facilities should be located in more populated counties potentially stifles (i) pilot demonstration development and (ii) innovation in health care delivery proposals. Such constraints also may run counter to the SMFP's QAV Basic Principles related to fostering innovation. This petition proposes no such constraints other than protection of our state's fragile rural health care delivery system by limiting county participation in accordance with population levels as described above. The pilot demonstration approach contained in this petition has evolved from consideration of discussion by the SHCC itself and work groups in 2008.

It is vitally important that pilot demonstration applicants address the QAV Basic Principles. It is recommended that the ***Single Specialty Ambulatory Surgery Work Group*** focus less on the prescription of where applicants should be located; what an applicant should propose in an application; etc. and more on a requirement of applicants to respond in innovative approaches to achieve the QAV Basic Principles and measurement of success in achieving QAV objectives as the basis of their applications. Through this more "open" approach, the DHSR and SHCC can be better exposed to (i) new health care delivery solutions and metrics and (ii) innovative ways in which they can be implemented.

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[1] Please refer to **Appendix A** for a list of eligible North Carolina counties.

In last year's petition, AHCF proposed to "change the need methodology for ambulatory surgical operating rooms to provide more price competition, increased patient access and choice, and transparency of actual service purchase costs through a managed approach allowing for increased levels of price competition, while accounting for such factors as care for indigent populations and the fragility of rural health care delivery." This year we have added an additional quality vector and related metrics. In final analysis, the strength of this petition is based on increased levels of consumer disclosure and choice.

II. Environmental Overview

The rising cost of health care services continues to alarm many constituencies in North Carolina. The fastest growing component of this health care inflation is outpatient facility-based services. CON regulation has not adequately controlled costs in the outpatient facility sector, which includes hospitals, ASCs, and diagnostic facilities. On the one hand, we want to encourage more outpatient care to save costs over inpatient settings. However, outpatient facility costs seem to bear little relationship to the underlying cost of providing these services due to a lack of price regulation and cost transparency among providers as a basis for consumers to negotiate lower service pricing.

Please read the excerpt from an article written in Health Affairs by Paul B. Ginsburg, President of Center for Studying Health System Change, (January/February 2008):

> **Hospital activity.** Hospitals have been expanding capacity, not predominantly by adding new beds but by expanding specialized facilities (such as operating rooms and imaging facilities) needed to serve patients with the latest technology. When hospitals do increase inpatient beds, the new construction typically occurs in rapidly growing suburbs, where well-insured patients live. Competing hospital systems also have expanded into some communities where hospital systems have already established dominance, raising concerns about overcapacity.
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> HSC researchers have documented the hospital "specialty-service line" strategy, and such strategies are continuing.[3] Hospitals have identified the types of services that are most profitable—under a mix of diagnosis-related group (DRG), per diem, and discounted charge reimbursement—and are expanding capacity to provide those services. Interviews with hospital executives suggest that the profitability of the services is the key to developing a service line, with cardiac procedures often topping the list. As one hospital chief executive officer (CEO) told me in response to a question about capital spending priorities: "We just list the specialty lines by profitability and go down the list." We found no hospitals developing a mental health service line; such admissions generally are considered money losers. It may have been too early, but we did not obtain indications of adjustments to these service-line strategies in response to the major revamping of the DRG system started in 2006. The changes appear to have reduced the variation in relative profitability of different DRGs but probably did not eliminate that variation.

In some larger North Carolina markets or communities, we have seen a duplication of services in a form of "medical arms race" among competing licensed health care facilities. There is also some evidence of "shadow pricing" of such services by facilities to non-government payers. We are also finding increased levels of consolidation in markets, such as Charlotte, where the hospitals are purchasing physician practices at an increasing rate. The result is a true integrated delivery system ("IDS"). Yet, it is unclear if the IDS's are producing more accessible and affordable health care services or just further preserving the dominant market positions of the existing licensed facilities. It may be argued that the IDS's have reduced competition and potentially consumer choice.

In February 2009 the Dartmouth Institute for Health Policy and Clinical Practice published a number of research papers with the Robert Wood Johnson Foundation ("RWJF") and in the New England Journal of Medicine ("NEJM"). This research is attached as **Appendices B**, **C**, and **D**. The article, "Slowing the Growth of Health Care Costs – Lessons from Regional Variation" (attached as **Appendix B**) was published last month on February 26, 2009 in the NEJM. The RWJF website (http://www.rwjf.org/qualityequality/product.jsp?id=38929) summarizes the findings of this research article in the excerpt below:

> This article by researchers at the Dartmouth Atlas examines the rapid growth in health care costs in the United States and suggests the use of information from regions with low growth in costs to find solutions to the problem.
>
> Key Findings:
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> - Health care markets around the country have widely varying rates of health care cost increases, which lead to a wide range of annual costs across regions.
> - The variation between regions is largely due to how physicians respond to the availability of technology and services. Physicians in higher-cost regions appear more likely to refer patients for more extensive care without strong supportive evidence.
> - To curb rising health care costs, high-growth, high-cost regions must emulate low-growth, low-cost areas of the country. Policies that encourage the growth of organized systems of care and payment reform can help create a system where health care costs are better contained.

This research more or less validates that tradtional CON regulation has been ineffective at slowing the growth of health care costs in North Carolina. Specifically, North Carolina's Hospital Referral Regions grew much faster in terms of per enrollee expenditures than the United States as a whole over the perriod 1992

to 2006 as observed in the following table excerpted from the Dartmouth research titled "The Policy Implicatons of Variations in Medicare Spending Growth" and attached as **Appendix C**:

Hospital Referral Region	Inflation-Adjusted Total Medicare Spending Per Enrollee, 1992	Inflaiton Adjusted Total Medicare Spending Per Enrollee 2006	Growth in Spending (Dollars Per Person),1992-2006	Annual Growth Rate 1992 to 2006
Asheville	4,040	6,359	2,319	3.29%
Charlotte	4,091	7,742	3,651	4.66%
Durham	4,094	7,202	3,108	4.12%
Greensboro	3,743	7,036	3,293	4.61%
Greenville	4,012	7,354	3,342	4.42%
Hickory	4,161	7,764	3,603	4.56%
Raleigh	4,368	8,051	3,683	4.46%
Wilmington	4,816	7,899	3,083	3.60%
Winston-Salem	4,195	7,702	3,507	4.44%
United States	5,110	8,304	3,193	3.53%

The Dartmouth research article attached as **Appendix D**, "Health Care Spending, Quality, and Outcomes," states important findings that directly link back to the SMFP's QAV Basic Principles:

> Perhaps the most counter-intuitive finding is that spending does not necessarily lead to better access to health care (see box),[2] or better quality of care. Patient outcomes can actually suffer, because more physicians involved increases the likelihood of mistakes (too many cooks spoil the soup), and because hospitals are dangerous places to be if you do not absolutely need to be there.

Table 1. Relationship Between Regional Differences in Spending and the Content, Quality, and Outcomes of Care

	Higher-Spending Regions Compared to Lower-Spending Ones*
Health care resources	• Per capita supply of hospital beds 32% higher. • Per capita supply of physicians 31% higher overall; 65% more medical specialists.
Technical quality	• Adherence to evidence-based care guidelines worse.
Health outcomes	• Mortality higher following acute myocardial infarction, hip fracture, and colorectal cancer diagnosis.
Physician perceptions of quality	• More likely to report poor communication among physicians and inadequate continuity with patients. • Greater difficulty obtaining inpatient admissions or high-quality specialist referrals.
Patient-reported quality of care	• Worse access to care and greater waiting times. • No differences in patient-reported satisfaction with ambulatory care. • Worse inpatient experiences..

* High- and low-spending regions were defined as the U.S. hospital referral regions in the highest and lowest quintiles of per capita Medicare spending as in Fisher (2003).

[2] Please refer to **Appendix D** to review the "box" referenced. A copy of the box without research references is copied in this section.

These findings have important implications for the reform of the U.S. health care delivery system. Three underlying causes are particularly important:

- ***Lack of accountability*** for the overall quality and costs of care – and for local capacity;
- ***Inadequate information*** on the risks and benefits of many common treatments and the related assumption (on the part of most patients and many physicians) that more medical care means better medical care.
- ***A flawed payment system*** that rewards more care, regardless of the value of that care.

Each suggests important principles that any successful effort to reform the U.S. health care delivery system will have to address.

It is quite well accepted that the outpatient or ambulatory setting is where the greatest increase in health care costs are occurring. The recently published McKinsey & Company's research on health care spending in the United States, "Why Americans pay more for health care," is attached as **Appendix E.** The research suggests that the United States overspends $436 billion on outpatient care annually and provides the following commentary:

Outpatient care
The high and fast-growing cost of outpatient care reflects a structural shift in the United States away from inpatient settings, such as overnight hospital stays. Today, the US system delivers 65 percent of all care in outpatient contexts, up from 43 percent in 1980, and well above the OECD average of 52 percent. In theory, this shift should help to save money, since fixed costs in outpatient settings tend to be lower than the cost of overnight hospital stays. In reality, however, the shift to outpatient care has added to—not taken away from—total system costs because of the higher utilization of outpatient care in the United States.

Further, it is the observation and contention of AHCF that hospitals in North Carolina are very supportive of CON regulation to protect their market share and negotiated pricing structure with private payers. Please refer to an October 2008 published interview in Health Leaders with a hospital executive in North Carolina that discusses CON law in relation to such protection. This published interview is attached as **Appendix F** and is quoted below:

HL: Why imaging when imaging seems oversupplied and under-reimbursed?
Executive: The decline in reimbursements for imaging isn't that much of a concern. In fact, it's probably what got the private equity folks even interested in selling. They were so leveraged. We stumbled on MedQuest. They had 90 sites—about 65 of which are in the Southeast—in those four or five states that are certificate-of-need states. When we approached them and wanted to buy North and South Carolina, they weren't interested in selling off those centers only. The only way we could buy it was to take the whole company. We did our due diligence and found that as a 13-

> year-old company, their base had been built off CON states, giving us some protection, and their culture was built on customer service and patient convenience. Our physicians who have used them told us that.

AHCF contends that due to the protection of CON regulation, hospitals and other licensed facilities in North Carolina are able to charge and gain excessive reimbursement for outpatient services. Equally important, many hospitals in North Carolina have chosen not to develop ASCs and retain only hospital outpatient department ("HOPD") delivery models. The result is higher reimbursement per outpatient service for all payers and consumers. In January 2003, the Office of the Inspector General ("OIG") of the Department of Health and Human Services published a study, "Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers." The research concluded that CMS could save billions of dollars if outpatient care were provided in ASC versus HOPD settings.

The pilot demonstration approach of developing increased numbers of single specialty ASCs that achieve the metrics proposed in this petition will provide increased levels of ASC competition in North Carolina. This petition argues that such managed competition is needed to provide more QAV-based competition with existing licensed facilities.

The Ambulatory Surgery Center Association ("ASCA") maintains an extensive on-line data base of ASC reimbursement by CPT procedure code for all procedures permitted to be performed in ASCs by Medicare. Any consumer or researcher may access this website http://ascassociation.org/medicare2009/. AHCF believes that Medicare reimbursement should be used in analyzing proposed charges and reimbursement for ASCs under the pilot demonstration application approach recommended in this petition. The ACSA on its website states the following:

> Under Medicare's payment system ASCs are paid a facility fee intended to cover the costs associated with providing surgical procedures. However, in general, ASCs are only paid a portion of what HOPDs receive for the exact same services. For 2008 ASCs were paid only 63% of what HOPDs received for providing the exact same services. For 2009, it is estimated that ASC reimbursement will only be 59% of HOPD reimbursement for the same services.
>
> http://ascassociation.org/medicare2009/

The ASCA discussion is 100% price based. The Dartmouth research addresses utilization and quality more than price considerations. These are factors that this petition will address in following sections.

The ASC setting is where we have the greatest opportunity to achieve cost savings for consumers. We should increase levels of pricing transparency to consumers in the ASC setting. The transparency will allow consumers to better evaluate services and their value before purchasing such services. It can be argued that such transparency will result in increased levels of price competition and more informed consumers, as well as lower health care costs and more efficient care delivery.

III. Financial Analysis: Facility Charges and Reimbursement in North Carolina

A. Hospital Reimbursement Analysis

Many hospitals state they must "cost shift" to make up for below cost reimbursement from government payers (e.g. Medicare, Medicaid, and TriCare) and uncompensated or charity care. AHCF, however, asserts the following:

1. Many hospitals are inefficiently managed. Due to this inefficiency, hospitals cannot easily break-even on Medicare reimbursement. Medicare reimbursement for hospitals was constructed to be set at a "break-even" level for the average hospital in the United States.

2. The protection of CON regulation permits hospitals to continue to operate in an inefficient manner and/or gain excessive charges and earnings by "cost-shifting" to private payers and federal and state employee health plans.

3. A combination of enhanced market and newly designed regulatory mechanisms needs to be enacted to bring positive pressure on hospitals to correct points 1 and 2 above.

This petition is not designed to prove the above assertions. The petition, however, does attempt to outline compelling evidence and arguments in support of the assertions that the SHCC and the DHSR should consider carefully and perhaps research.

Below in **Table III. A: Sample North Carolina Hospital Financial Performance**, AHCF has presented a mathematical model that represents payer mix and reimbursement by payer type for a sample hospital in North Carolina:

Table III. A: Sample North Carolina Hospital Financial Performance

Assumptions/Explanation:

1. Cost is equal to 100 for all health services at a sample hospital.

2. Target total reimbursement is equal to 105 or 5% above operations cost. A 5% percent earnings margin from operations is fair for a not-for-profit hospital.

3. The patient payer mix is 42% Medicare; 3% TriCare; 6% Medicaid; 8% FEHP and SEHP (government employee health plans); 33% Commercial; 3% Private Pay; and 5% Charity Care.

4. The cost to reimbursement ratio column assumes that Medicare reimbursement is 80, or 80% of cost (100). Medicare reimbursement for hospitals, however, is supposed to be set at cost for efficient hospitals on a national basis. Therefore, this pro forma can be considered conservative. Medicaid reimbursement is set at 80% of Medicare or 64. FEHP/SEHP reimbursement is set at 50% above Medicare or 120. Private Pay reimbursement is set at 30. Charity Care has no reimbursement or 0.

5. The Commercial payer "Cost to Reimbursement Ratio" is set (backed into) at the level that results in target reimbursement being equal to 105. In the table below, this Commercial reimbursement is $165.64 or $207.05% of Medicare.

	Payer Mix	Cost to Reimb. Ratio	Weighted Average	% of Medicare
Medicare	42.00%	80	33.6	100.00%
TriCare	3.00%	80	2.4	100.00%
Medicaid	6.00%	64	3.84	80.00%
FEHP and SEHP	8.00%	120	9.6	150.00%
Commercial	33.00%	165.64	54.6612	207.05%
Private Pay	3.00%	30	0.9	37.50%
Charity Care	5.00%	0	0	0.00%
	100.00%		105	
Target Reimbursement			105	

Given the above model, it should be assumed that reimbursement for hospitals should not be in excess of 207.05% of Medicare in order to gain a fair earnings margin from operations equal to 5%. Unfortunately, hospitals in North Carolina tend to charge and be reimbursed far more than 207.05% of Medicare by private or commercial payers. In addition, it is likely that FEHP and SEHP payers reimburse hospitals far more than the target level of 150% of Medicare shown in the above pricing model.

In addition, hospitals establish the cost of charity care in their financial reports to be charges foregone, which overstates the true cost of charity care. Charity care should be set at actual cost, but few hospitals have cost accounting systems that can calculate actual cost. Yet paradoxically, all hospitals can produce itemized bills for patients upon request.[3] In addition, hospitals (unlike physicians) receive federal matching funds for disproportionate share and charity care payments each year, which are not reasonably disclosed by hospitals when discussing charity care losses in financial presentation.

B. Explanation of Benefit ("EOB") Analysis

Now let us review an actual hospital claim for an outpatient surgery in North Carolina. The surgery occurred in December 2008. The explanation of benefits ("EOB") from United Healthcare, a list of itemized hospital charges, and other information are attached in **Appendix G.** In **Table III B: Achilles Tendon Repair Outpatient Surgery Analysis** below, we present hospital charges and reimbursement; physician charges and reimbursement; and other statistics for this actual three (3) hour outpatient surgery in an HOPD setting in North Carolina:

Table III B: Achilles Tendon Repair Outpatient Surgery Analysis

	HOPD Setting	Payer Discount
Hospital Charge (facility only)	$22,207.92	
Payer Discount	($7,484.07)	33.70%
Allowable Reimbursement by Payer (UHC)	$14,723.85	

Patient Amount Due: None due to annual OOP maximum of $4,000 having been met.

Estimated Medicare Cost: ASC	$1,104.34
Estimated Medicare Cost: HOPD	$1,871.76
Reimbursed Amount as % of Medicare: ASC	1333.27%
Reimbursed Amount as % of Medicare: HOPD	786.63%

Physician Charge	$2,820.00	
Payer Discount	($1,726.04)	61.21%
Allowable Reimbursement by Payer (UHC)	$1,093.96	
Estimated Medicare Reimbursement	$591.15	
Reimbursed Amount as % of Medicare	185.06%	

[3] A sample of itemized hospital charges are contained in **Appendix G.**

It is the contention of AHCF that North Carolina hospitals have long been over-charging and being reimbursed excessively by private payers in North Carolina for health services. In the case of the Achilles tendon surgery analyzed above, reimbursement was 786% of the Medicare allowable level. If an ASC setting was available in the community for the patient, the reimbursement would have been a 1333% multiple of Medicare. The 33.70% discount off of charges negotiated and accepted by United Heathcare is insufficient and results in excessive reimbursement for the hospital given the analysis of **Table III. A: Sample North Carolina Hospital Financial Performance.**

In contrast, the surgeon billed $2,820 for the 3 hour surgery and was reimbursed $1,093.96, or approximately 39% of the billed charge. The reimbursed amount was approximately 185% of the Medicare professional allowable amount, which seems to be more in line with acceptable reimbursement levels for health care providers.

C. Facility Pricing and Potential Benefits of Managed Competition

Through this petition, AHCF seeks to bring competition to the outpatient facility segment of the market place for hospitals. An alternative would be increased levels of price regulation by the DHSR. It appears to be unreasonable and impractical for DHSR to regulate charges and hospital rate setting as is done in West Virginia and Maryland. In addition, the ***Single Specialty Ambulatory Work Group*** has struggled in discussion of the facility pricing subject for a variety of reasons.

One of the unresolved discussion issues for the ***Single Specialty Ambulatory Work Group*** has been the source as to where to gain access to important pricing data for outpatient facilities. The ASCA provides a ready source for Medicare reimbursement of ASCs. AHCF contends that Medicare reimbursement is a sound foundation upon which to base pricing analysis and price ceiling limits for ASC pilot demonstration facilities. The Medicare reimbursement data is readily available, and Medicare represents the largest payer for health services in the United States.

A source for private payer pricing data is Milliman Consultants and Actuaries ("Milliman"). Milliman is a nationally recognized firm that maintains a database of negotiated pricing for all Blue Cross Blue Shield ("BCBS") health plans in the United States for purposes of re-pricing. When a potential BCBS customer seeks to determine the financial benefit of BCBS negotiated pricing or discounts over that of another payer(s), Milliman provides this re-pricing analysis. Essentially Milliman re-processes or re-prices a customer's health plan claims as if BCBS was the payer. AHCF through its principals has access to some of this Milliman re-pricing data.

The table below is an example of Milliman's re-pricing analysis. The re-pricing analysis compares an actual company's current negotiated discounts to that of BCBS. The company being analyzed has approximately 1,000 employees and is based in Illinois with operations in many states.

Table III C: Milliman - Aggregate Re-Pricing Results ($ Millions)
All Claims*

BCBS Network	Major Category of Service	Historical Billed Charges	Historical Allowed Charges*	BCBS Allowed Charges*	Historical Discount	BCBS Discount
In	Inpatient Hospital	$0.94	$0.69	$0.33	26.90%	64.50%
	Outpatient Hospital	$0.96	$0.79	$0.47	17.60%	51.40%
	Physician	$1.01	$0.95	$0.53	5.60%	47.30%
	Ancillary	$0.04	$0.04	$0.03	5.00%	30.00%
Out	All OON	$0.16	$0.16	$0.10	4.50%	38.80%
All	Total	$3.11	$2.62	$1.46	15.70%	53.10%

* Before any benefits are applied.

The multi-state company referenced in **Table III C: Milliman - Aggregate Re-Pricing Results ($ Millions)** used a combination of PPO networks similar to MedCost in North Carolina. The BCBS forecasted discount of 53.10% has proved out to be accurate in 2008. In discussions with a Medical Director of BCBS of Illinois related to this company, it was confirmed that the majority of hospital outpatient services continue to be reimbursed on a "discount off of charge" basis. It is likely that the Medical Director of BCBS of North Carolina can confirm that the majority of hospital outpatient services are also reimbursed on a "discount off of charge" basis in North Carolina, unlike physician fees and newly licensed GI endoscopy centers.

Therefore, AHCF further contends that CON regulation has afforded North Carolina hospitals so much market place protection that they are able to continue to be reimbursed on a "discount off of charge" basis for outpatient services, unlike other segments of the provider market place. The observed result is a continuous rise in billed charges year to year by North Carolina hospitals with limited incentives to (i) increase operational efficiencies and (ii) maintain or lower internal cost structures through innovation. The higher the hospital charge is; the higher the ultimate reimbursement that results.

This pricing environment has allowed North Carolina hospitals to make excessive earnings, which is evidenced by their continued expansion and building construction. An example is Novant Health's purchase of MedQuest diagnostic facilities and a 27% ownership position in the for-profit HMA hospitals in North Carolina and South Carolina. Few non-profit health systems have this purchasing power and financial strength without the protection of CON regulation.

For purposes of repetition, the EOB and analysis related to **Table III B: Achilles Tendon Repair Outpatient Surgery Analysis** are not isolated examples in North Carolina. As expected, the Milliman analysis confirms that PPO network pricing is near that of United Healthcare (26.9% versus 33.7% in negotiated discounts). It is further concluded that (i) with the protection of CON regulation and (ii) without some level of QAV competition as proposed by this petition, such excessive charging and reimbursement by North Carolina hospitals will continue unabated. Reasonable reimbursement for hospitals was modeled in **Table III. A: Sample North Carolina Hospital Financial Performance**. A charge level above q Medicare multiple of 350% certainly could be considered excessive given this model.

It has already been discussed that North Carolina hospitals seek the protection of CON regulation. The AHCF petition seeks to expose excessive charging and reimbursement by North Carolina hospitals and create some level of managed competition for hospitals in the outpatient setting, specifically from physician owned and managed ASCs and in accordance with the SMFP's QAV Basic Principles.

D. Financial Condition of Select North Carolina Hospitals

North Carolina hospitals often argue that they are in financial distress. Yet in recent years, North Carolina hospitals have undertaken an unprecedented increase in new construction. Hospital financial performance also has been excellent in recent years. Please refer to **Appendix H** for an analysis of hospital financial returns prepared by AHCF from recently filed annual reports with the Medical Care Commission. Most all of the analyzed hospitals have achieved cash flow earnings (earnings before depreciation and amortization) in excess of 10%. Some of the hospitals have reported net assets well in excess of $1 billion.

The vast majority of North Carolina hospitals, especially the large health systems, appear to have made excessive profits over the years that some politicians, such as Senator Grassley of Iowa and others, are challenging. Senator Grassley wants not-for-profit hospitals in the United States to be more accountable to consumers in terms of charges, reimbursement, and earnings or risk losing their not-for-profit status.

E. Reinforced Call for Managed Competition and Pricing Disclosure

The recent economic downturn is causing North Carolina hospitals to re-evaluate proposed new construction and to cut costs. However, there is no efficient market place or other mechanism in place to check such hospital expansion and growth other than a financial downturn. If we wait for the market place to "efficiently" manage itself, significant social destruction can take place in the interim, as we have learned all too well with the recent investment Ponzi schemes (e.g. Madoff).

This AHCF petition is one meaningful and small step toward increased price competition and disclosure to consumers that supports continued CON regulation of health care facilities in North Carolina. Slowing this growth in licensed health care facility charges is also important for the health of our state's economy. If the petition is rejected, it will show the continued bias and conflicts of interests maintained by many of the SHCC members in their voting.

Simply stated, this petition seeks to support full disclosure of outpatient charges and reimbursement for outpatient procedures and surgery so that consumers (patients) can be better informed and can protect themselves form excessive costs in advance of receiving care. Equally as important, this petition provides consumers with increased choice in the selection of outpatient facility providers.

IV. Framework for Need Methodology Change: Ten (10) Premises

The SHCC has the capability to change need methodology for a CON without the requirement of new legislation. Shown below are AHCF's proposed ten (10) key premises. These premises form the basis of a revised CON need methodology that would allow pilot demonstration applicants to develop single specialty ASCs under new CON requirements.

The proposed revision in need methodology does not result in a wholesale change to current CON need methodology. Rather, the proposed premises are based in large part on the QAV Basic Principles of the SMFP. The premises foster innovation and improvements in the safety/quality, access, and value of health services delivered to the citizens of North Carolina.

1. Capital Cost

- Each ASC pilot demonstration facility must have a total capital cost of less than $1.25 million per operating room in order to be eligible to apply for a pilot demonstration.

- Complete architectural and engineering plans with construction cost estimates must be developed to confirm cost-effectiveness and compliance with the $1.25 million threshold.

- The ASCs must agree through affidavit to meet all state licensure, accreditation, and Medicare certification requirements in the pilot demonstration application.

Objective: ***Build and operate the most cost-effective, efficient, and high quality facilities that meet all state licensure, accreditation, and Medicare certification requirements.***

2. Indigent Care and Community Safety Net

- Facilities must agree to have at least 5% of their total patient load being charity or indigent care (less than $200 per service in reimbursement).[4]

- Upon annual facility licensure renewal, if the 5% charity/indigent care threshold has not been met, the facility must pay into a DHSR managed state facility fund up to 5% of the facility's average reimbursement to reach the threshold.

- Under this pilot demonstration approach, the approved CON facilities are integral participants in the community "safety net" for care.

Objective: ***The major opposition to changes in CON need methodology will come from opponents who believe that the proposed pilot demonstration facilities will not provide their "fair share" of charity/indigent care and undermine the hospital position of being a community's health "safety net." Physicians now provide the professional services portion of charity/indigent care in the hospital setting. Each year hospitals are reimbursed under a federal/state program for charity/indigent care, which is an often overlooked fact. AHCF analyzed all of the hospital 2007 Licensure Renew Applications and found that the average percent of Charity Care and Self-Pay and Private-Pay Patients was approximately 4% for the ambulatory surgery category. Lastly, in the proposed pilot demonstration facilities, the ASCs will provide 100% of both professional and facility services for charity/indigent care at a required minimum level or be forced to pay the difference to a state facility fund managed by DHSR for such care. This premise supports the SMFP's Access Basic Principle.***

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[4] Please refer to **Appendix I: Analysis of 2007 Licensure Renewal Applications.** It is estimated that hospital Charity Care plus Self-Pay and Private-Pay patient totals for ambulatory surgical cases are approximately 4% in FY 2007.

3. Rural Counties and Service Areas

- Facility construction is limited to North Carolina counties with the following demographics:

  - Counties with a population of at least 85,000 and one (1) hospital; or

  - Counties with a population of at least 125,000 and two (2) or more hospitals. [5]

Objective: ***Another strong opposition argument will come from rural county based hospitals and political leaders that believe the proposed change in need methodology will threaten the financial health of rural hospitals and the county's health "safety net" now being provided by the hospital(s). By limiting need methodology change to non-rural counties, this opposition argument is neutralized in large part. This premise supports the SMFP's Access Basic Principle.***

4. Excessive Cost Counties and Service Areas

- Pilot demonstration applicant facilities must prove through the collection of patient EOB statements and other data sources, including hospital financial reports, that facility charges to private payers in the target counties are excessive and consistently exceed 350% of prevailing Medicare reimbursement for the services that the applicant facility will provide before receiving a CON. This requirement places the burden on pilot demonstration applicants to prove to the DHSR that increased price competition is required in the target county among health care facilities.

- Actuarial sources such as Milliman can also be used to demonstrate excessive charging by hospitals.

- The ***Single Specialty Ambulatory Surgery Work Group*** and the SHCC should not have to struggle with the discussion of what constitutes excessive charges. The level of 350% of Medicare is ample to account for "cost shift" and charity care requirements.

- The pilot demonstration facility applicants have the responsibility to present evidence that is sufficiently detailed to (i) prove excessive charges over the 350% of Medicare threshold and (ii) bring an enhanced level of transparency and public disclosure as to the need for increased price competition in the applicant's county.

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[5] Please refer to **Appendix A** for a list of eligible North Carolina counties.

Objective: ***The primary objective of the proposed approach is to provide necessary price competition for facilities that are not providing affordable health services to their communities and citizens. Therefore, only counties with excessive cost and reimbursement structures for facility services will be approved as pilot demonstration ASCs. It is important to provide such price competition in combination with regulatory reporting and monitoring associated with price ceiling limits, disclosure, and transparency for any new ASC facilities. This premise supports the SMFP's Value Basic Principle and is innovative in approach, while supporting value metrics that can be measured by a standard in relation to Medicare.***

5. Price Ceiling Limits, Disclosure, and Transparency for New Facilities

- ASC pilot demonstration applicant facilities agree not to charge more than 300% of prevailing Medicare reimbursement by CPT code for ASCs to all payers and consumers for the first two (2) years of operation.[6]

- Medicare has developed a new ASC reimbursement methodology based on CPT codes that can be accessed over the Internet if DHSR or another organization is willing to host such a web site. Or, the ACSA website can be used.

- Pilot demonstration facilities agree to publish a list of their charges by CPT code, procedure, or service and file a report each year with the DHSR with these charges upon licensure renewal.

- Pilot demonstration facilities agree to provide each consumer with an individual financial review of his/her expected out of pocket cost for the respective payer prior to performing any procedure or service.

Objective: ***The provision of price ceiling limits in combination with full disclosure and transparency of pricing will be a strong force for price competition in the target counties that have excessive facility costs. Pilot demonstration facilities will not readily support price ceiling limits and reporting requirements, but this approach is the foundation for increased price competition given regulatory oversight to support increased levels of consumer affordability with full disclosure and transparency. The approach also distinguishes pilot demonstration facilities from hospital and other licensed facilities that do not want such charge disclosure and transparency. The approach clearly***

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[6] To date the ***Single Specialty Ambulatory Surgery Work Group*** has rejected price ceiling limits in its meetings. AHCF believes that price ceiling limits are integral to achieving specific cost saving objectives for outpatient Facilities and meeting the SMFP's Value Basic Principle. The proposed Medicare multiple of 300% for pilot demonstration ASCs as a ceiling limit also should be carefully reviewed if Medicare increases or decreases ASC reimbursement in coming years. This is why the two (2) year trial period has been proposed for an initial target.

separates pilot demonstration facilities from the current market position of non-disclosure, which is quite anti-consumer and non-patient centric. Objections to price or reimbursement ceilings is simply another obstacle to lowering costs for consumers. Simply stated, pilot demonstration applicant facilities must operate at lower charge and cost levels than existing licensed facilities in order to bring needed change to the market place. This premise supports the SMFP's Value Basic Principle and is based on a series of metrics that can be evaluated and measured.

6. Single Specialty Facilities

- It is well documented that single specialty ASC facilities can operate at much lower costs and higher levels of operations efficiency than other types of health care facilities, such as larger hospitals and health systems.[7]

- Only single specialty ASC facilities are eligible as pilot demonstrations for a CON under this petition and proposed need methodology.

- The recent licensure of numerous GI endoscopy facilities in North Carolina provides significant evidence that such facilities are more efficient than hospitals for the same services. Single specialty GI endoscopy facilities can routinely perform more than two (2) procedures per hour. Many hospitals on their Licensure Renewal Applications indicate that the average procedure time for a GI endoscopy case is 45 minutes. By gaining such efficiency, the pilot demonstration applicants can document better value.

<u>Objective:</u> Document why single specialty and majority physician owned and operated facilities are more efficient and cost-effective than hospital based and other types of facilities.[8] This premise supports the SMFP's Value Basic Principle.

7. Demonstrated Volume and Efficiency

- ASC pilot demonstration applicant facilities must demonstrate that that they will perform a minimum target level of procedures per year. If forecasted volume targets are not reached by year two (2) of operation, the facility will lose its CON and state license.

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[7] Newly licensed ASCs for GI endoscopy in North Carolina have shown the ability to perform 2 or more procedures per hour versus hospitals that struggle to support the performance of 1.25 to 1.50 procedures per hour as reported in Licensure Renewal Applications.

[8] Single specialty hospitals and ASCs can provide documented evidence of lower operations costs and increased levels of operations efficiency for outpatient services.

- The target procedure volume for an applicant ASC is 1,000 procedures per operating room.

- Each ASC pilot demonstration facility applicant should be for at least two (2) operating rooms to ensure sufficient efficiency. ASCs with fewer than two (2) operating rooms cannot amortize fixed costs in an efficient manner.

- Each pilot demonstration facility applicant should describe specific and unique operational efficiencies that can be gained through the development of the proposed licensed facility.

Objective: ***Document that the new facilities will have sufficient procedure and service volume to support operations. Letters of support from referring physicians can be used to support volume and the need for the new facilities. If procedure and service volume targets are not achieved, the penalty will be loss of the facility's CON and state license. The penalty is significant so as to deter low volume provider entry. Documentation of specific and unique operational efficiencies will support the SMFP's QAV Basic Principles, especially in regard to documentation of value propositions.***

8. Physician Commitment to "Call" Coverage

- Physician groups who develop and operate the new facilities must commit to continued "call" coverage at area hospitals in order to maintain licensure for the facilities that they may develop.

- "Call" coverage is maintained in accordance with each individual hospital's medical staff by-laws, not by state mandate as to specific requirements.

Objective: ***Hospitals fear that once physicians develop and operate their own ASCs that they will no longer be willing to provide "call" coverage at the hospitals. Maintaining licensure of the facilities will require "call" coverage commitment. This premise supports the SMFP's Access Basic Principle.***

9. Safety and Quality Considerations

- There is significant research and evidence that patient health safety related to outpatient procedures is higher in free standing ASCs. In such free standing centers, exogenous infection rates are much lower. The Dartmouth Institute for Health Policy and Clinical Practice has published research on this topic as documented in the article, "Health Care Spending, Quality, and Outcomes," attached in **Appendix C**. Hospitals are not safe places for people to be treated if they are infection free and without life threatening

conditions. Additional support research on increased safety in free standing ASCs is attached in **Appendix J**.

- It can be argued that quality of patient care is equal or higher in free standing ASC settings managed by physicians. Physicians are more familiar with their own patients and can hire dedicated staff that is experienced in the procedures being performed.

- It is proposed that each ASC facility develop a series of safety and quality metrics as part of its pilot demonstration application. These metrics will vary by medical specialty. It will be important to compare the clinical safety and quality performance of multiple facilities in regard to proposed metrics. Therefore, it is important to have more than a few pilot demonstration facilities in operation to satisfy these clinical safety and quality measurement requirements.

- All pilot demonstration applicants will work with the DHSR and other organizations to develop a standardized patient satisfaction survey and reporting mechanism.

- All pilot demonstration facility applicants also must detail how clinical safety and quality performance and patient satisfaction will be reported. Accreditation agencies such as AAAHC, Joint Commission, and AAASF can support these initiatives and provide valuable insight.

***Objective:* The pilot demonstration approach will foster innovation in the development of reporting in regard to clinical and quality performance and patient satisfaction among outpatient facility providers. This premise strongly supports the SMFP's Safety and Quality Basic Principle.**

10. Expansion of Single Specialty Ambulatory Surgery Work Group

- Although the ***Single Specialty Ambulatory Surgery Work Group*** conducts open meetings, the work group's member composition is limited. It is proposed to expand the work group beyond the current membership or at least formally request input from nationally recognized industry leaders and researchers. The issues being discussed are too important to be minimized.

- Increased levels of input and discussion with consumers needs to occur with the work group. It is recommended that the leadership of the State Employees of North Carolina Association ("SEANC") specifically be invited to take part in the ***Single Specialty Ambulatory Surgery Work Group*** meetings and to provide input.

- AHCF has never been formally asked to present to the ***Single Specialty Ambulatory Surgery Work Group*** and discuss its 2008 petition.

- AHCF requests that its revised 2009 petition and analysis related to pricing disclosure and price ceiling limits be discussed in more depth by the work group, given the additional information provided herein.

- The mission and objectives of the ***Single Specialty Ambulatory Surgery Work Group*** should be expanded to work with other SHCC members and support staff to develop quality and clinical performance and patient satisfaction reporting requirements in conjunction with anticipated pilot demonstration applicants.

- AHCF volunteers to work with the DHSR, the North Carolina Medical Society ("NCMS"), and the North Carolina Hospital Association ("NCHA") to develop a CON need methodology based on the ten (10) premises contained herein and other premises proposed that the ***Single Specialty Ambulatory Surgery Work Group*** can evaluate.

- Data resources such as the ASCA and Milliman can and should be used to a greater degree to support work group analysis.

- Perhaps the greatest opportunity for input to the ***Single Specialty Ambulatory Surgery Work Group*** can come from potential pilot demonstration applicants that can provide proposals to the ***Single Specialty Ambulatory Surgery Work Group*** and SHCC for considerations in findings over the course of 2010 SMFP planning process.

Objective: ***Expansion of the Single Specialty Ambulatory Surgery Work Group will provide a broader dialogue and the opportunity to discuss the full range of issues related to changing CON need methodology for ambulatory surgical operating rooms. The expansion will also better achieve the QAV Basic Principles of the SMFP. More transparency and consumer involvement will begin to counter the conflicts of interests inherent in the SHCC's current membership. Involving potential pilot demonstration facility applicants in proposal development may be a very important untapped resource for innovation and creative thought related to the SMFP's QAV Basic Principles.***

V. Supporting Analysis

No change in CON methodology for the development and licensing of ambulatory surgical operating rooms should occur without a fact-based analysis. The SHCC may not have the resources to undertake the data collection and some of this analysis. Therefore, it is proposed that potential pilot demonstration applicants undertake the analysis and make proposals that meet the requirements and metrics of section **IV. Framework for Need Methodology Change: Ten (10) Premises** described above. These proposals and analysis then can be presented to the ***Single Specialty Ambulatory Surgery Work Group*** and the SHCC for review and public discussion.

VI. Potential Opposition to Petition and Related Discussion

Opposition to this petition for a revision in CON need methodology related to the development of pilot demonstration ASCs will continue to come from existing licensed facility providers. The SHCC has taken a positive step in the development of the ***Single Specialty Ambulatory Surgery Work Group***. This work group, however, has not followed many of the key tenets of this petition and its 2008 predecessor, including price disclosure; facility charge limitations; and no limitation on the number of pilot demonstration facility sites. It can be argued that the ***Single Specialty Ambulatory Surgery Work Group*** needs to pay greater attention to the QAV basic Principles of the SMFP, upon which this revised 2009 petition attempts to focus. This petition seeks to be innovative and bring more accountability and disclosure in the achievement of the SMFP's QAV Basic Principles.

If the existing licensed providers and their affiliated organizations (e.g. associations) choose to oppose this proposal, they are being anti-competitive and anti-consumer. An alternative would be to implement a price reporting and control system, such as in West Virginia and Maryland, in addition to consumer disclosure and transparency provisions for all licensed health care facilities in North Carolina. The current CON regulatory approach is not effective at controlling health care costs and ensuring access to affordable health services for consumers in North Carolina. Therefore, it can be argued that CON regulation has failed in its primary mission to control costs.

West Virginia, a state with far less health care resources than North Carolina, found it necessary to create the West Virginia Health Care Authority ("WVHCA"). The WVHCA has significant control over hospital rate setting, which North Carolina hospitals would likely oppose. The rate setting legislative mechanism is described in the following excerpt from WVHCA's website:

> Pursuant to W. Va. Code § 16-29B-1 et seq., the West Virginia Health Care Authority (hereinafter referred to as the "Authority") was created in March, 1983, in order "to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective, high quality health care services." West Virginia Code § 16-29B-1. The statute created the Authority as a three-member board with the power "to approve or disapprove hospital rates and budgets taking into consideration the criteria set forth in section twenty" of the statute. West Virginia Code § 16-29B-19(a)(4). http://www.hcawv.org/RateRev/rateHome.htm

Again, this petition does not propose rate setting for licensed health care facilities. This petition is one small, but meaningful step, toward increasing competition among licensed ASC health care facilities where it can be proven that such managed competition based upon the SMFP's QAV Basic Principles is warranted.

The argument that hospitals treat many millions of dollars in uncompensated care and cannot afford increased levels of competition, managed or not, from ASCs must be carefully analyzed by the DHSR given the following considerations:

1. Charity care in North Carolina is reported by hospitals as billed charges foregone in their audited financials. This method of calculating charity care simply overstates the amount of charity care provided in a community.

2. The analysis conducted by the AHCF related to Charity Care, Self-Pay, and Private-Pay cases in **Appendix I** can be analyzed further and updated with 2008 Licensure Renewal Application data. The 2007 Licensure Renewal Applications provided by hospitals show that approximately 4% of cases were for Charity care, Self-Pay, and Private Pay patients.

3. It would be beneficial if hospitals reported the Charity Care category properly on their Licensure Renewal Applications and acknowledged the amount of disproportionate share and charity care payments received from the federal government each year.[9]

[9] Many hospitals do not complete the Charity Care category on their Licensure Renewal Applications and/or group Charity Care in with Self-Pay and Private-Pay totals. This non-disclosure needs to be corrected for purposes of accuracy and full-disclosure.

This petition makes great effort to protect the fragility of North Carolina's rural health care delivery system. So increased levels of managed competition and implementation of the premises of this petition are not recommended in rural counties.

The recent research published by the Dartmouth Institute for Health Policy and Clinical Practice confirms one of the most interesting aspects of health care and facility use. The more health care facilities we build, the greater the use in most every case. We must begin to manage facility pricing through:

1. increased competition;
2. Some level of price regulation; and/or
3. Disclosure transparency to purchasers.

First, the current CON methodology and regulation are ineffective at controlling health care expenditures in North Carolina. The Dartmouth research has proven this point. Second, the current CON methodology and regulations do not permit new forms of efficient and value-based health care delivery, competition, and innovation. Third, this petition's proposed revision in CON methodology will only be effective and implemented in non-competitive markets, which have documented high pricing to consumers. Fourth, the proposed revision in CON methodology is balanced against a pre-determined set of metrics which are consistent with the SMFP's QAV Basic Principles and Governor Perdue's call for more transparency and disclosure in government. Fifth, this petition strongly supports increased levels of consumer choice.

Abolishing CON regulation altogether in North Carolina would prove to be detrimental given the recent Dartmouth research. Perhaps the DHSR and SHCC can undertake a searching review of their primary mission to control health care costs, ensure access, and increase quality of care. The current approaches are not working for North Carolina's citizens. The QAV Basic Principles can be well supported through implementation of this petition, which should result in important disclosure of unfair and excessive pricing practices by licensed health care facilities in North Carolina. Lastly, as the lack of disclosure related to licensed facility pricing continues to persist, there is an increasing likelihood that increased levels of regulation, perhaps similar to that of West Virginia and Maryland, will be brought to bear on licensed facilities in coming months and years.

Hospitals in North Carolina have already begun to protect their facility franchise by employing physicians. By employing large numbers of primary care physicians, hospitals can direct patient referrals. By employing surgeons and sub-specialists, hospitals can directly control in what facility setting care is provided. As a result, CON regulation is almost not required in some markets to limit competition from physician owned and operated facilities. There are no unaffiliated physicians to provide this level of competition. Hospitals also can negotiate with private payers to effectively restrict entry of physician owned and operated licensed facilities by offering different levels of discount depending on the number of competitors contracted with a given payer. Hospitals have sufficient financial protection beyond CON regulation.

Therefore, it can be concluded that the SHCC, the DHSR and Governor Perdue should not pay significant attention to objections from hospitals and their representatives in their evaluation of this petition. Evaluation should be focused on benefiting consumers through managed competition, increased choice, and enhanced levels of transparency and disclosure related to licensed outpatient facility costs, which the market place has been unable to manage or control.

AHCF believes that physician owned and operated licensed outpatient facilities are necessary to preserve value- and quality-based competition in North Carolina for these health care services. This petition supports the development of the SMFP's QAV Basic Principle metrics and full-disclosure of pricing by all facility-based providers, beginning with the pilot demonstration facility applicants. It is beyond the purview of this petition to consider increased levels of charge and reimbursement reporting by licensed facilities in North Carolina. However, the time may have come for such reporting because licensed facility-based health care costs to consumers have become unconscionably high as demonstrated by the EOB analysis contained in this petition.

VII. North Carolina State Government Ethics Act and Conflicts of Interest

Like the NCMS, AHCF is interested in the application of North Carolina's State Government Ethics Act to the SHCC. The majority of SHCC members maintain conflicts of interest. It is somewhat a travesty of justice that the State Government Ethics Act has not been applied to the SHCC and its members.

Governor Perdue's new administration is very concerned about increasing ethical behavior, transparency, and disclosure in state government. The current process to develop the SMFP involves conflicts of interest on behalf of the SHCC's members. Hospitals have gained financially, perhaps excessively over the past 15 years, through the protection of CON regulation. Hospital representatives who are SHCC members may have exerted undue influence or control over decision-making by

the SHCC for the benefit of the hospital industry, given their leadership of the Acute Care Services Committee. In turn, the welfare of North Carolina's citizens may have been harmed.

AHCF has attempted to document this environment in this revised 2009 petition (i) with factual data and (ii) without the call for increased regulation. This petition is a "win" for the consumer, transparency, and disclosure. The petition truly seeks to drive more accountability and improvements in the performance of ambulatory surgical facilities based upon measurable metrics related to safety/quality, access, and value. In closing, it is the request of AHCF that hospital representatives and board members, as well as physician practice representatives, whose organizations possess CONs and who serve on the SHCC, maintain fiduciary conflicts of interest in regard to this petition and should not be permitted to vote on this petition.

It is important to note that very few participants in the health care system maintain true incentives to lower costs as described in the table below:

	Participants	**Incentive to Reduce Health Care Costs**
1	Insurance industry	No. Insurance payers and representatives are generally compensated as a percentage of medical expenses on a "mark-up basis." One of the greatest health industry misunderstandings is the belief that insurance payers and commissioned agents and consultants are truly motivated to reduce health care costs. As health costs rise, insurance participants gain increased revenues and earnings.
2	Hospitals	No primarily. Limited Yes. Increased charges generally result in increased revenues and earnings, especially for outpatient services with private payers as this petition describes. Hospitals have an incentive to reduce inpatient health care costs when paid on a prospective payment basis.
3	Physicians	No primarily. Limited Yes. Physicians are generally paid on a fee-for-service basis. Yet, many physicians continue to be concerned about the continuing burden of health care costs on their patients. As the leading care givers to patients with nurses, many, but not all, physicians tend to feel a responsibility to reduce health care costs while increasing access and safety/quality of health care services for patients. The current fee-for-service reimbursement system creates many difficulties for physicians in the care of their patients.
4	Other health care providers	No. Most other health care providers are paid on a fee for service basis.

5	Pharmaceutical companies	No. Pharmaceutical companies are paid for each prescription ordered and purchased. There is an incentive to increase price and utilization of prescription drug use by consumers. However, it can be argued that prescription drugs used efficaciously can reduce hospitalization and other health care expenses.
6	Medical/DME suppliers	No. Suppliers are paid on a fee-for-service basis.
8	Consumers (Patients)	Yes with caveats. Consumers are often screened from the direct purchase costs of health care services, and if they are medially ill, there is limited incentive to seek less costly treatments. Medically ill patients seek to get well, often regardless of the cost to their health plan payer.
9	Government	Yes. Unequivocally the answer is "yes" unless lobbyists and conflicts of interests prevent elected representatives from voting on legislation that lowers health care costs.

AHCF by promoting the pilot demonstration approach as outlined in this petition can be a motivator for health care delivery system reform based on the QAV Basic Principles.

Appendix A

Appendix A

Eligible North Carolina Counties Under AHF Petition Requirements

COUNTY	J06Pop	A00Pop	Growth	% Grow
ALAMANCE	139,786	130,794	8,992	6.9
ALEXANDER	36,296	33,609	2,687	8.0
ALLEGHANY	11,012	10,680	332	3.1
ANSON	25,371	25,275	96	0.4
ASHE	25,774	24,384	1,390	5.7
AVERY	18,174	17,167	1,007	5.9
BEAUFORT	46,346	44,958	1,388	3.1
BERTIE	19,355	19,757	-402	-2.0
BLADEN	32,870	32,279	591	1.8
BRUNSWICK	94,964	73,141	21,823	29.8
BUNCOMBE	221,320	206,299	15,021	7.3
BURKE	88,663	89,145	-482	-0.5
CABARRUS	157,179	131,030	26,149	20.0
CALDWELL	79,298	77,710	1,588	2.0
CAMDEN	9,284	6,885	2,399	34.8
CARTERET	63,558	59,383	4,175	7.0
CASWELL	23,523	23,501	22	0.1
CATAWBA	151,128	141,677	9,451	6.7
CHATHAM	57,707	49,334	8,373	17.0
CHEROKEE	26,816	24,298	2,518	10.4
CHOWAN	14,664	14,150	514	3.6
CLAY	10,144	8,775	1,369	15.6
CLEVELAND	96,714	96,284	430	0.4
COLUMBUS	54,656	54,749	-93	-0.2
CRAVEN	95,558	91,523	4,035	4.4
CUMBERLAND	306,545	302,962	3,583	1.2
CURRITUCK	23,518	18,190	5,328	29.3
DARE	34,674	29,967	4,707	15.7
DAVIDSON	155,348	147,269	8,079	5.5
DAVIE	39,836	34,835	5,001	14.4
DUPLIN	52,710	49,063	3,647	7.4
DURHAM	246,824	223,306	23,518	10.5
EDGECOMBE	52,644	55,606	-2,962	-5.3
FORSYTH	331,859	306,044	25,815	8.4
FRANKLIN	55,315	47,260	8,055	17.0
GASTON	197,232	190,310	6,922	3.6
GATES	11,602	10,516	1,086	10.3
GRAHAM	8,109	7,993	116	1.5

Appendix A (continued)

Eligible North Carolina Counties Under AHF Petition Requirements

GRANVILLE	53,840	48,498	5,342	11.0
GREENE	20,833	18,974	1,859	9.8
GUILFORD	449,078	421,048	28,030	6.7
HALIFAX	55,606	57,370	-1,764	-3.1
HARNETT	103,714	91,062	12,652	13.9
HAYWOOD	56,662	54,034	2,628	4.9
HENDERSON	100,107	89,204	10,903	12.2
HERTFORD	23,878	22,977	901	3.9
HOKE	42,202	33,646	8,556	25.4
HYDE	5,511	5,826	-315	-5.4
IREDELL	145,234	122,664	22,570	18.4
JACKSON	36,312	33,120	3,192	9.6
JOHNSTON	151,589	121,900	29,689	24.4
JONES	10,318	10,398	-80	-0.8
LEE	55,282	49,172	6,110	12.4
LENOIR	58,172	59,619	-1,447	-2.4
LINCOLN	71,302	63,780	7,522	11.8
MCDOWELL	43,632	42,151	1,481	3.5
MACON	33,076	29,806	3,270	11.0
MADISON	20,454	19,635	819	4.2
MARTIN	24,396	25,546	-1,150	-4.5
MECKLENBURG	826,893	695,427	131,466	18.9
MITCHELL	15,906	15,687	219	1.4
MONTGOMERY	27,506	26,836	670	2.5
MOORE	82,292	74,770	7,522	10.1
NASH	92,220	87,385	4,835	5.5
NEW HANOVER	184,120	160,327	23,793	14.8
NORTHAMPTON	21,524	22,086	-562	-2.5
ONSLOW	161,212	150,355	10,857	7.2
ORANGE	123,766	115,537	8,229	7.1
PAMLICO	13,097	12,934	163	1.3
PASQUOTANK	39,956	34,897	5,059	14.5
PENDER	48,724	41,082	7,642	18.6
PERQUIMANS	12,442	11,368	1,074	9.4
PERSON	37,448	35,623	1,825	5.1
PITT	146,403	133,719	12,684	9.5
POLK	19,080	18,324	756	4.1
RANDOLPH	138,586	130,470	8,116	6.2
RICHMOND	46,700	46,551	149	0.3

Appendix A (continued)

Eligible North Carolina Counties Under AHF Petition Requirements

ROBESON	129,048	123,241	5,807	4.7
ROCKINGHAM	91,830	91,928	-98	-0.1
ROWAN	134,540	130,348	4,192	3.2
RUTHERFORD	63,178	62,901	277	0.4
SAMPSON	64,057	60,160	3,897	6.5
SCOTLAND	36,994	35,998	996	2.8
STANLY	59,128	58,100	1,028	1.8
STOKES	46,335	44,707	1,628	3.6
SURRY	72,990	71,227	1,763	2.5
SWAIN	13,938	12,973	965	7.4
TRANSYLVANIA	30,360	29,334	1,026	3.5
TYRRELL	4,240	4,149	91	2.2
UNION	172,087	123,738	48,349	39.1
VANCE	43,920	42,954	966	2.2
WAKE	790,007	627,865	162,142	25.8
WARREN	19,969	19,972	-3	-0.02
WASHINGTON	13,360	13,723	-363	-2.6
WATAUGA	43,410	42,693	717	1.7
WAYNE	114,930	113,329	1,601	1.4
WILKES	66,925	65,624	1,301	2.0
WILSON	77,468	73,811	3,657	5.0
YADKIN	37,810	36,348	1,462	4.0
YANCEY	18,368	17,774	594	3.3
STATE OF	**J06Pop**	**A00Pop**	**Growth**	**% Grow**
NORTH CAROLINA	8,860,341	8,046,813	813,528	10.11

Appendix F

The Year of the Deal

Two unusual acquisitions mark a period of transformation at nonprofit Novant Health.

Is the management team of Novant Health crazy, or crazy like a fox? That's the question many are trying to answer after a year that saw two major deals for the Winston-Salem, NC-based nonprofit healthcare company. If you're wondering what a nonprofit hospital operator is doing taking on nearly three-quarters of a billion dollars in liability to purchase a for-profit imaging center company and a 27% stake in several hospitals owned and managed by a rival for-profit hospital chain, you're not alone (see "Novant's Buying Binge").

In August 2007, Novant, an owner of seven hospitals, agreed to purchase MedQuest Inc., which owned 91 diagnostic imaging centers, many of which were in far-flung markets in which Novant had no presence, for $45 million and an assumption of $372.8 million of MedQuest's debt, according to Standard & Poor's. In the wake of recent cuts in imaging reimbursements by both Medicare and commercial insurers that theoretically make investing in imaging less attractive, the transaction was curious, to say the least.

Then in March, Novant paid $300 million to Health Management Associates Inc. for a 27% minority interest in seven hospitals in the Carolinas. This purchase was closer to Novant's preferred market, but many questioned the aggressive move. HMA will continue to manage the hospitals in the joint venture, but the true gem of the purchase might be 119 physicians and mid-level practitioners who came along with the hospitals—and whom Novant will employ going forward.

For a nonprofit hospital system that has made two substantial purchases in short succession, it helps to have clearly identifiable synergies to promote. In the case of Novant, which identifies the Carolinas and parts of Georgia, Virginia, and Tennessee as core markets, that's a problem. But if so, it's largely a problem of perception, says Novant chief financial officer Dean Swindle, who sat down with HealthLeaders senior finance editor Philip Betbeze for a conversation about the deals and whether they will help Novant better position itself for the future.

HealthLeaders: Were you surprised by the skepticism many voiced about these deals?
Dean Swindle: I was surprised there wasn't more. The rating agencies, for

instance, were critical of the 1997 merger between [Winston-Salem's] Carolina Medicorp Inc. and [Charlotte's] Presbyterian Health Services Corp. that created Novant. It was an equal merger, but back in those days there were never any two-market hospital mergers. But it was by far the best strategic move we've ever made. It laid the foundation for us to go forward.

HL: How do these deals support your mission?
Swindle: Large systems are rightly doing more around the consumer. Here's why: Novant does 100,000 inpatient discharges a year but more than 4 million ambulatory encounters. So we aren't any different from a consumer business. We could have gone out and bought hospitals to grow into areas we want to enter. But we're moving more toward an ambulatory world.

HL: Why imaging when imaging seems oversupplied and under-reimbursed?
Swindle: The decline in reimbursements for imaging isn't that much of a concern. In fact, it's probably what got the private equity folks even interested in selling. They were so leveraged. We stumbled on MedQuest. They had 90 sites—about 65 of which are in the Southeast—in those four or five states that are certificate-of-need states. When we approached them and wanted to buy North and South Carolina, they weren't interested in selling off those centers only. The only way we could buy it was to take the whole company. We did our due diligence and found that as a 13-year-old company, their base had been built off CON states, giving us some protection, and their culture was built on customer service and patient convenience. Our physicians who have used them told us that.

HL: Do you envision keeping all the centers from the deal?
Swindle: No other company in the ambulatory market had this level of concentration in just a few states. We're rationalizing the footprint, because some centers out west and in the Midwest won't fit with Novant long-term.

HL: How do these two deals fit your shift toward outpatient care?
Swindle: As we dug into it, we figured out really how bad we do [ambulatory] from a service and access perspective. We needed to grow to achieve the scale we wanted in a 250-mile radius surrounding our core in Winston-Salem. We looked at five states: the Carolinas, Georgia, Virginia, and some of Tennessee.

HL: So you buy the whole consumer revolution theory in healthcare?
Swindle: Whether we like it or not, people are comparing us to the experience they've had at Starbucks or stores at the mall. The healthcare business is one of intense cycles. We recently went through a positive cycle that went longer than

we were used to. What's likely ahead? In the past we've been less sensitive to government action than the economy as a whole, but that's changing. You see large systems doing more around the consumer.

HL: At first glance, is the HMA deal even more strange? **Swindle:** There isn't any parallel to this deal. The concept was tough to articulate because of the myths and legends among for-profits and nonprofits. We became comfortable with the concept, but the magnitude of it—not necessarily the money, but how it would be perceived—was concerning. Paul [Wiles, Novant's president and CEO] called around to others in the industry and posed hypotheticals during the due diligence. Are we going be viewed negatively? The message he got is that as quickly as the healthcare business is changing, many thought it was very forward-looking. HMA's managing the hospitals we took an interest in, but they have to earn their management fee. Eighty percent of their fee is at risk—most of it on quality indicators.

HL: But you didn't gain outright ownership of any of the hospitals?
Swindle: True, but for instance, we now have a minority interest in an ambulatory hospital that will be built right on the border of the Research Triangle. So in a short time frame we have a sizable scope of operations in the Triangle and in other submarkets where we have no presence. From that perspective, as other opportunities present themselves there, we will already have a presence. If you have no operations in a given location, you have very little chance of expanding there. Besides, in our model, in a particular market, having access to physicians is key. We're a little contrarian on that.

Philip Betbeze is finance editor with **HealthLeaders** magazine. *He can be reached at*

Appendix G

Your claim history (continued)

Your claim history from: 12/17/08 - 01/19/09

	Originally Billed by Provider	Health Plan Discount	Paid by Health Plan	You Owe the Provider	Applied to Your Deductible
Date of Service: 12/17/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$195.00	-$84.17	$110.83	$0.00	
- THIS CLAIM WAS PROCESSED ON 12/19/08. - THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS. **For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.**					
Date of Service: 12/18/08 **Member:** [redacted] **Provider:** Suppressed for member's privacy **Claim Number:** [redacted] **Type of Service:** PHARMACY	$34.40	...	-$18.73	$0.00	...
- THIS CLAIM WAS PROCESSED ON 12/18/08. **For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.**					
Date of Service: [redacted] **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$374.50	-$222.63	-$151.87	$0.00	
- THIS CLAIM WAS PROCESSED ON 12/23/08. - THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS. **For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.**					
Date of Service: 12/19/08 **Member:** [redacted] **Provider:** Suppressed for member's privacy **Claim Number:** [redacted] **Type of Service:** PHARMACY	$238.64	...	-$201.95	$0.00	...
- THIS CLAIM WAS PROCESSED ON 12/19/08. **For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.**					
Date of Service: 12/19/08 **Member:** [redacted] **Provider:** Suppressed for member's privacy **Claim Number:** [redacted] **Type of Service:** PHARMACY	$24.75	...	-$17.34	$0.00	...
- THIS CLAIM WAS PROCESSED ON 12/19/08. **For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.**					
Subtotal for this page	$867.29	-$306.80	-$500.72	$0.00	$0.00

Additional claims are listed on the next page

Please see the next page for more information

[redacted] [redacted]

Your claim history (continued)

Your claim history from: 12/17/08 - 01/19/09

	Originally Billed by Provider	Health Plan Discount	Paid by Health Plan	You Owe the Provider	Applied to Your Deductible
Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$820.00	-$516.30	-$303.70	$0.00	...

- THIS CLAIM WAS PROCESSED ON 12/24/08.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL Physician Surgeon	$2,820.00	-$1,726.04	-$1,093.96	$0.00	...

- THIS CLAIM WAS PROCESSED ON 12/24/08.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.
- WE HAVE APPLIED THE MAXIMUM ALLOWED EXPENSE FOR THE PRIMARY PROCEDURE. STANDARD PAYMENT ADJUSTMENT (OR REDUCTION) RULES FOR MULTIPLE PROCEDURES HAVE BEEN APPLIED FOR THIS PROCEDURE.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$2,820.00	-$2,743.67	-$76.33	$0.00	...

- THIS CLAIM WAS PROCESSED ON 12/24/08. 4
- THIS PROCEDURE CODE IS NOT ELIGIBLE FOR AN ASSISTANT SURGEON. THEREFORE BENEFITS ARE NOT PAYABLE.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL HOSPITAL	$27,207.92	-$7,484.07	-$14,723.85	$0.00	...

- THIS CLAIM WAS PROCESSED ON 01/01/09.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Subtotal for this page	$28,667.92	-$12,470.08	-$16,197.84	$0.00	$0.00

Additional claims are listed on the next page

Please see the next page for more information

[redacted]

Your claim history (continued)

Your claim history from: 12/17/08 - 01/19/09

	Originally Billed by Provider	Health Plan Discount	Paid by Health Plan	You Owe the Provider	Applied to Your Deductible
Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL Anesthesiologist	$1,577.00	...	-$1,577.00	$0.00	...

- THIS CLAIM WAS PROCESSED ON 01/08/09.
- FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE ADDITIONAL ANESTHESIA MINUTES AND THE AMOUNT CHARGED FOR THE QUALIFYING CIRCUMSTANCE(S) SUBMITTED.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/19/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$24.00	-$8.12	-$15.88	$0.00	...

- THIS CLAIM WAS PROCESSED ON 01/03/09.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/21/08 **Member:** [redacted] **Provider:** Suppressed for member's privacy **Claim Number:** [redacted] **Type of Service:** PHARMACY	$55.63	...	-$48.23	$0.00	...

- THIS CLAIM WAS PROCESSED ON 12/21/08.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/21/08 **Member:** [redacted] **Provider:** Suppressed for member's privacy **Claim Number:** [redacted] **Type of Service:** PHARMACY	$77.01	...	-$66.19	$0.00	...

- THIS CLAIM WAS PROCESSED ON 12/21/08.

For more detail on this claim, the Member can visit their claims & accounts, medical summary page at www.myuhc.com.

Date of Service: 12/21/08 **Member:** [redacted] **Provider:** [redacted] **Claim Number:** [redacted] **Type of Service:** MEDICAL	$30.00	...	...	$30.00	$26.09

For more details on this claim, please see additional information listed further in this document or you can view it online at www.myuhc.com.

Subtotal for this page	$1,763.64	-$8.12	-$1,707.30	$30.00	$26.09

Additional claims are listed on the next page

Please see the next page for more information

[redacted]

[redacted]

UNITED HEALTHCARE INSURANCE COMPANY

[redacted]

UnitedHealthcare
A UnitedHealth Group Company

DATE: 01/13/09
ID #: [redacted]
EMPLOYEE: [redacted]
CONTRACT: [redacted]
BENEFIT PLAN: [redacted]
CHECK NUMBER: [redacted]
CHECK AMOUNT: $1,577.00

[redacted]

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELATIONSHIP/CLAIM NUMBER	PROVIDER/SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
[redacted]	ANESTHESIA	12/19/08	1577.00		1577.00	100%	1577.00		KQ
	TOTAL		1577.00		1577.00		1577.00		QN
						PLAN PAYS	1577.00		
						** PATIENT PAYS	0.00		

* DEFINITION: "PATIENT PAYS" IS THE AMOUNT, IF ANY, OWED YOUR PROVIDER. THIS MAY INCLUDE AMOUNTS ALREADY PAID TO YOUR PROVIDER AT TIME OF SERVICE.

EMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(KQ) FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE ADDITIONAL ANESTHESIA MINUTES AND THE AMOUNT CHARGED FOR THE QUALIFYING CIRCUMSTANCE(S) SUBMITTED.
(QN) YOUR CLAIM MAY HAVE BEEN SEPARATED FOR PROCESSING PURPOSES. ANY ADDITIONAL CHARGES WILL BE PROCESSED AS SOON AS POSSIBLE.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION	
[redacted]	$1577.00

SATISFIED 2008 TO DATE	DEDUCTIBLE MEDICAL/RX COMBINED	OUT OF POCKET MEDICAL/RX COMBINED
FAMILY	$4000.00	$4000.00
PLAN YEAR 2008	FAMILY: $4000.00	FAMILY: $4000.00

REVIEW OF THIS BENEFIT DETERMINATION MAY BE REQUESTED BY SUBMITTING YOUR APPEAL TO US IN WRITING AT THE FOLLOWING ADDRESS: UNITEDHEALTHCARE APPEALS, P.O. BOX 30573, SALT LAKE CITY, UT 84130-0573. THE REQUEST FOR YOUR REVIEW MUST BE MADE WITHIN 180 DAYS FROM THE DATE YOU RECEIVE THIS STATEMENT. IF YOU REQUEST A REVIEW OF YOUR CLAIM DENIAL, WE WILL COMPLETE OUR REVIEW NOT LATER THAN 30 DAYS AFTER WE RECEIVE YOUR REQUEST FOR REVIEW.

YOU MAY HAVE THE RIGHT TO FILE A CIVIL ACTION UNDER ERISA IF ALL REQUIRED REVIEWS OF YOUR CLAIM HAVE BEEN COMPLETED.

* * * * * * *

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HOW TO REGISTER?
YOU CAN REGISTER AND BEGIN USING MYUHC IN THE SAME SESSION. ACCESS WWW.MYUHC.COM TO REGISTER. THE INFORMATION REQUIRED IS ON YOUR INSURANCE ID CARD (FIRST NAME, LAST NAME, MEMBER ID, GROUP NUMBER AND DATE OF BIRTH).

* * * * * * *

MAINTAINING THE PRIVACY AND SECURITY OF INDIVIDUALS' PERSONAL INFORMATION IS VERY IMPORTANT TO US AT UNITEDHEALTHCARE. TO PROTECT YOUR PRIVACY, WE HAVE IMPLEMENTED STRICT CONFIDENTIALITY PRACTICES. THESE PRACTICES INCLUDE THE ABILITY TO USE A UNIQUE INDIVIDUAL IDENTIFIER. YOU MAY SEE THE UNIQUE INDIVIDUAL IDENTIFIER ON UNITEDHEALTHCARE CORRESPONDENCE, INCLUDING MEDICAL ID CARDS (IF APPLICABLE), LETTERS, EXPLANATION OF BENEFITS (EOBS) AND PROVIDER REMITTANCE ADVICES (PRAS). IF YOU HAVE ANY QUESTIONS ABOUT THE UNIQUE INDIVIDUAL IDENTIFIER OR ITS USE, PLEASE CONTACT YOUR CUSTOMER CARE PROFESSIONAL AT THE NUMBER SHOWN AT THE TOP OF THIS STATEMENT.

FURTHER EXPLANATION OF BENEFITS INFORMATION IS ON CONTINUATION PAGE(S)

THIS IS NOT A BILL

[redacted]

UNITED HEALTHCARE INSURANCE COMPANY

[redacted]

UnitedHealthcare®
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 01/13/09
ID #[redacted]
EMPLOYEE[redacted]
CONTRACT:[redacted]
BENEFIT PLAN:[redacted]
CHECK NUMBER[redacted]
CHECK AMOUNT: $1,577.00

[redacted]

SUMMARY EXPLANATION OF BENEFITS

PLAN PAYS:

[redacted]					TOTAL:
$1,577.00					$1,577.00

PLAN PAYS:	$1,577.00
PAYMENT SENT TO PROVIDER(S):	$0.00
YOUR CHECK AMOUNT:	$1,577.00

YOUR EXPLANATION OF BENEFITS ACCOMPANIES THIS SUMMARY. FOR INFORMATION CALL: 1-800-357-0978.
PLEASE CONTACT US IF YOU HAVE ANY QUESTIONS.

Detach Check

Detach Check

UNITED HEALTHCARE INSURANCE COMPANY

[redacted]

Fleet National Bank
150 Windsor Street
Hartford, CT 06120

51-44
119

[redacted]

DATE: 01/13/09

PLEASE PRESENT PROMPTLY FOR PAYMENT

PAY:$******1,577.00**

CONTRACT: [redacted]

BENEFIT PLAN OF: [redacted]

ONE THOUSAND FIVE HUNDRED SEVENTY SEVEN & 00/100 DOLLARS ********

PAY TO THE ORDER OF [redacted]

Robert W Alexander

AUTHORIZED SIGNATURE

[redacted]

Itemized Hospital Charges

ADM/SER:	12/19/08	UR CHG:	0 UHCATL	17766.34	12/19/08
DISCHARGE:		AR CHG:	22207.92 SP	4441.58	12/19/08
LST STMT:		BALANCE:	22207.92		

BCH DATE	BCH SER	DATE	USER	PROCEDURE	BL#	DESCRIPTION	AMOUNT	TOTAL
12/22/08	172	12/19/08	[redacted]	039F		SUCTION LINER SM	9.50	9.50
12/22/08	172	12/19/08	[redacted]	046C		COVER MAYO STAND	0.00	9.50
12/22/08	172	12/19/08	[redacted]	103K		ESMARK - |FROM ORPK27	0.00	9.50
12/22/08	172	12/19/08	[redacted]	115F		NEEDLE INJECTION (2X)	0.00	9.50
12/22/08	172	12/19/08	[redacted]	115F		NEEDLE INJECTION (2X)	0.00	9.50
12/22/08	172	12/19/08	[redacted]	126F		SYRINGE, 1-3-5-10-20-30	0.00	9.50
12/22/08	172	12/19/08	[redacted]	130M		INCISOR SCALPEL 15C (5X)	0.00	9.50
12/22/08	148	12/19/08	[redacted]	1794		HISTO., DECALCIFICATION PROC.	35.76	45.26
CPT 4	88311							
12/22/08	148	12/19/08	[redacted]	1814		SURG PATH LEVEL 111	193.02	238.28
CPT 4	88304							
12/22/08	172	12/19/08	[redacted]	5320		POST-OP RECOVERY/FIRST 30 MINS	806.29	1044.57
12/22/08	172	12/19/08	[redacted]	5330		POST-OP RECOVERY/EA ADDL 15 M (3X)	1062.81	2107.38
12/22/08	169	12/19/08	[redacted]	5490		MONITOR NIBP ANESTHESIA	94.40	2201.78
12/22/08	169	12/19/08	[redacted]	5492		MONITOR EKG ANESTHESIA	118.44	2320.22
12/22/08	169	12/19/08	[redacted]	5494		ANALYZER OXYGEN ANESTHESIA	124.30	2444.52
12/22/08	169	12/19/08	[redacted]	5495		PROBE TEMPERATURE ANESTHESIA	83.18	2527.70
12/22/08	169	12/19/08	[redacted]	5496		VOLUME MONITOR 5400/VENTILATOR	70.10	2597.80
12/22/08	169	12/19/08	[redacted]	5537		MONITOR CO2 END-TIDAL	118.44	2716.24
12/22/08	169	12/19/08	[redacted]	5541		PULSE OXIMETRY ANESTHESIA	87.14	2803.38
12/22/08	169	12/19/08	[redacted]	5568		STETHOSCOPE ESOPHAGEAL/TEMP PR	97.36	2900.74
12/22/08	169	12/19/08	[redacted]	5600		PROBE B.I.S. AWARENESS	179.61	3080.35
12/22/08	169	12/19/08	[redacted]	5613		ANESTHESIA GASES	503.65	3584.00
12/22/08	172	12/19/08	[redacted]	71019		ANESTHESIA FIRST 30 MIN ($849.28 P/C)	849.28	4433.28
12/22/08	172	12/19/08	[redacted]	71020		ANESTHESIA EA ADD 15MIN (10X) ($2745.80 P/C)	2745.80	7179.08
12/22/08	172	12/19/08	[redacted]	95284		COBAN 2 INCH	0.00	7179.08
12/22/08	172	12/19/08	[redacted]	95548		CAUTERY PAD	20.48	7199.56
12/22/08	172	12/19/08	[redacted]	95555		GLOVE TRIFLEX	0.00	7199.56
12/22/08	172	12/19/08	[redacted]	95583		CAUTERY PENCIL HAND CONTROL - |FROM ORPK27	22.40	7221.96
12/22/08	172	12/19/08	[redacted]	95598		NEEDLE CAUTERY E1552	9.50	7231.46
12/22/08	172	12/19/08	[redacted]	95799		CAST PADDING STR 4IN30321 (2X)	0.00	7231.46
12/22/08	172	12/19/08	[redacted]	95879		DRAPE TOWELS 4PK 2104 (3X)	0.00	7231.46

12/22/08	172	12/19/08	[redacted]	TOURNIQUET CUFF 18 INCH DISP	0.00	7231.46
12/22/08	172	12/19/08	[redacted]	STOCKINETTE IMPERVIOUS LG - FROM ORPK27	0.00	7231.46
12/19/08	152	12/19/08	[redacted]	RT. OS CALCIS 2 VIEWS	311.59	7543.05
CPT 4		73650RT				
12/19/08	155	12/19/08	[redacted]	CEFAZOLIN SODIUM 1GM VIAL - ANCEF (CEFAZOLIN) 1 GM VIAL	82.98	7626.03
12/19/08	155	12/19/08	[redacted]	ZEMURON 10MG/ML 5 ML - ZEMURON (ROCURONIUM) 10 MG/ML, 5 ML	153.15	7779.18
12/19/08	155	12/19/08	[redacted]	HYDROMORPHONE HCL 2MG - DILAUDID (hydromorPHONE) 2 MG/ML IN	50.40	7829.58
12/19/08	155	12/19/08	[redacted]	REGLAN 10MG/2ML AMPULE - REGLAN (METOCLOPRAMIDE) 10 MG/2 ML	49.00	7878.58
12/19/08	155	12/19/08	[redacted]	DECADRON 10MG INJECTION - DECADRON (DEXAMETHASONE) 10 MG/1 ML	14.36	7892.94
12/19/08	155	12/19/08	[redacted]	ROBINUL 0.4 MG/2ML VIAL - ROBINUL (GLYCOPYRROLATE) 0.2 MG/ML,	10.43	7903.37
12/19/08	155	12/19/08	[redacted]	GENTAMICIN 40MG/ML 20ML VIAL - GENTAMICIN 800 MG/20 ML VIAL	51.91	7955.28
12/19/08	155	12/19/08	[redacted]	DIPRIVAN 200MG AMP - DIPRIVAN (PROPOFOL) 200MG/20ML VIAL	73.00	8028.28
12/19/08	155	12/19/08	[redacted]	DECADRON 4MG INJECTION (2X) - DECADRON (DEXAMETHASONE) 4 MG/ML VI	23.76	8052.04
12/20/08	13	12/19/08	[redacted]	DECADRON 4MG INJECTION (-2X) - DECADRON (DEXAMETHASONE) 4 MG/ML VI	-23.76	8028.28
12/19/08	155	12/19/08	[redacted]	VERSED 2 MG/2ML VIAL - VERSED (MIDAZOLAM) 2 MG/2ML VIAL	12.22	8040.50
12/19/08	155	12/19/08	[redacted]	VERSED 2 MG/2ML VIAL - VERSED (MIDAZOLAM) 2 MG/2ML VIAL	12.22	8052.72
12/19/08	155	12/19/08	[redacted]	XYLOCAINE MPF 2% 10ML - XYLOCAINE-MPF (LIDOCAINE) 2% 10 ML	27.78	8080.50
12/19/08	155	12/19/08	[redacted]	NEOSTIGMINE PER VIAL - PROSTIGMIN (NEOSTIGMINE)1:1000 10 M	30.20	8110.70
12/19/08	155	12/19/08	[redacted]	ZOFRAN 4MG INJECT (2X) - ZOFRAN (ONDANSETRON) 4 MG/2ML VIAL	146.04	8256.74
12/19/08	155	12/19/08	[redacted]	MARCAINE 0.5% 30ML - MARCAINE (BUPIVACAINE) 0.5% P-F *30	25.17	8281.91
12/19/08	155	12/19/08	[redacted]	MARCAINE 0.5% 30ML - MARCAINE (BUPIVACAINE) 0.5% P-F *30	25.17	8307.08
12/19/08	155	12/19/08	[redacted]	SUFENTANIL CITRATE 50MCG - SUfenta (SUfentanil) 50 MCG/ML AMP	26.80	8333.88

12/22/08	172	12/19/08	[redacted]	96518
12/22/08	172	12/19/08	[redacted]	96573
12/19/08	152	12/19/08	[redacted]	300343
12/19/08	155	12/19/08	[redacted]	A78P
12/19/08	155	12/19/08	[redacted]	B10C
12/19/08	155	12/19/08	[redacted]	D25B
12/19/08	155	12/19/08	[redacted]	E16B
12/19/08	155	12/19/08	[redacted]	E75T
12/19/08	155	12/19/08	[redacted]	E99B
12/19/08	155	12/19/08	[redacted]	F61C
12/19/08	155	12/19/08	[redacted]	F72C
12/19/08	155	12/19/08	[redacted]	G29T
12/20/08	13	12/19/08	[redacted]	G29T
12/19/08	155	12/19/08	[redacted]	G85B
12/19/08	155	12/19/08	[redacted]	G85B
12/19/08	155	12/19/08	[redacted]	I61E
12/19/08	155	12/19/08	[redacted]	I93B
12/19/08	155	12/19/08	[redacted]	J03T
12/19/08	155	12/19/08	[redacted]	K98E
12/19/08	155	12/19/08	[redacted]	K98E
12/19/08	155	12/19/08	[redacted]	M14B

12/22/08	172	12/19/08	[redacted]	M63F	SURGICEL 4X8 - |FROM ORPK27	105.94	8439.82
12/19/08	155	12/19/08	[redacted]	M82T	TORADOL 30MG INJECTION - TORADOL (KETOROLAC) 30 MG/ML VIAL	31.98	8471.80
12/19/08	155	12/19/08	[redacted]	N88I	NONFORMULARY INJECTION - XYLOCAINE (LIDOCAINE) 2%, 5 ML VIAL	13.98	8485.78
12/22/08	172	12/19/08	[redacted]	OR1180	CORKSCREW FT W/NEEDLE (2X)	3060.00	11545.78
12/22/08	172	12/19/08	[redacted]	OR1311	INCISIOR 2108-105 WIDE MED	32.16	11577.94
12/22/08	172	12/19/08	[redacted]	OR1345	OPER ROOM FIRST 30 MINUTES	2240.36	13818.30
12/22/08	172	12/19/08	[redacted]	OR1346	OPERATING ROOM EA ADD 15 MIN (10X)	7306.00	21124.30
12/22/08	172	12/19/08	[redacted]	OR1372	CHLORAPREP ORANGE	0.00	21124.30
12/22/08	172	12/19/08	[redacted]	OR1475	BLADE SAW SAGITAL TRITON	210.00	21334.30
12/22/08	172	12/19/08	[redacted]	OR1701	SUTURE SUPPLY	50.00	21384.30
12/22/08	172	12/19/08	[redacted]	OR1701	SUTURE SUPPLY	50.00	21434.30
12/22/08	172	12/19/08	[redacted]	OR1701	SUTURE SUPPLY	50.00	21484.30
12/19/08	155	12/19/08	[redacted]	Q18D	LOVENOX 40MG INJECTION - LOVENOX (ENOXAPARIN) 40 MG/0.4 ML S	96.37	21580.67
12/22/08	169	12/19/08	[redacted]	R22A	IV VENOSET SECONDARY PIGGYBACK	32.60	21613.27
12/22/08	169	12/19/08	[redacted]	R24A	IV SET, SURGICAL PRIMARY	14.75	21628.02
12/19/08	155	12/19/08	[redacted]	R28G	LACTATED RINGERS IRRIGATION - LACTATED RINGER'S IRRIGATION 1000 M	74.30	21702.32
12/22/08	169	12/19/08	[redacted]	R30F	EXTENSION SET 42 INCH	48.60	21750.92
12/22/08	169	12/19/08	[redacted]	S12B	TEGADUM 5X7.5 CM	9.50	21760.42
12/22/08	169	12/19/08	[redacted]	U85A	IV STOPCOCK 3-WAY	9.50	21769.92
12/19/08	155	12/19/08	[redacted]	V28C	LACTATED RINGERS 1000ML - LACTATED RINGERS 1000 ML BAG	170.00	21939.92
12/22/08	169	12/19/08	[redacted]	V28C	LACTATED RINGERS 1000ML	170.00	22109.92
12/19/08	155	12/19/08	[redacted]	V85C	D5W MINIBAG 50ML - DEXTROSE 5%-WATER 50 ML BAG	60.00	22169.92
12/22/08	172	12/19/08	[redacted]	W91A	XEROFORM GAUZE 1X8 - |FROM ORPK27	9.50	22179.42
12/22/08	172	12/19/08	[redacted]	Y01A	ADAPTIC GAUZE 3X3	9.50	22188.92
12/22/08	172	12/19/08	[redacted]	Y39A	KLING 2 INCH	9.50	22198.42
12/22/08	172	12/19/08	[redacted]	Y49A	SPONGE 4X4 10 PACK	9.50	22207.92

[redacted]

[redacted]

Appendix H

University Health Systems of Eastern North Carolina, Inc. (in '000s)

	2008	2007	2006
Total Revenues	$1,032,758	$956,988	$881,315
Salaries and Wages	$406,182	$373,789	$341,355
Income From Operation	$59,500	$56,912	$31,035
Excess of Revenues Over Expenses	$22,720	$63,046	$22,643
Depreciation and Amortization	$55,730	$52,907	$49,303
EBDA (Free Cash Flow)	$78,450	$115,953	$71,946
EBDA/Net Revenue	7.60%	12.12%	8.16%
Increase in Net Assets	($11,184)	$77,333	$27,109
Net Assets - End of Year	$583,495	$594,679	$517,346

The Moses H. Cone Memorial Hospital and Affiliates (in '000s)

	2008	2007	2006
Total Revenue	$828,567	$784,931	$767,623
Salaries and Wages	$329,408	$312,443	$303,713
Fringe Benefits	$105,953	$102,662	$108,213
Operating Income	$36,671	$33,117	$29,335
Excess of Revenues over Expenses	$63,533	$63,070	$67,683
Depreciation and Amortization	$45,913	$44,274	$41,042
EBDA (Free Cash Flow)	$109,446	$107,344	$108,725
EBDA/Net Revenue	13.21%	13.68%	14.16%
Increase in Net Assets	($100,472)	$64,306	$112,254
Net Assets	$915,370	$1,015,842	$951,321

Mission Health, Inc and Affiliates (in '000s)

	2008	2007	2006
Total Revenues		$797,603	$773,039
Salaries and Wages		$308,963	$285,397
Employee Benefits		$71,613	$68,811
Operating Income		$32,837	$51,561
Excess of Revenues over Expenses		$70,734	$86,683
Depreciation and Amortization		$48,165	$42,145
EBDA (Free Cash Flow)		$118,899	$128,828
EBDA/Net Revenue		14.91%	16.67%
Change in Net Assets		$114,285	$101,661
Net Assets		$878,147	$763,974

Cumberland County Hospital System, Inc
dba Cape Fear Valley Health System (in '000s)

	2008	2007	2006
Total Revenue		$505,675	$493,497
Salaries		$234,102	$219,329
Fringe Benefits		$55,147	$50,625
Operating Income		$2,464	$22,518
Excess of Revenues over Expenses		$23,275	$29,850
Depreciation and Amortization		$23,780	$23,646
EBDA (Free Cash Flow)		$47,055	$53,496
EBDA/Net Revenue		9.31%	10.84%
Change in Assets		$23,722	$29,956
End of Year		$315,445	$291,723

Rex Healthcare, Inc and Subsidiaries (in '000s)

	2008	2007	2006
Total Revenue	$469,461	$426,690	$394,626
Salaries	$188,888	$172,823	$158,266
Employee Benefits	$49,236	$42,000	$38,974
Operating Income	$14,058	$13,449	$12,870
Excess of Revenues over Expenses	$18,659	$18,804	$18,869
Depreciation and Amortization	$22,976	$21,170	$20,712
EBDA (Free Cash Flow)	$41,635	$39,974	$39,581
EBDA/Net Revenue	8.87%	9.37%	10.03%
Change in Assets	$6,917	$31,338	$20,863
Net Assets - End of Year	$307,998	$301,081	$269,743

Novant Health, Inc. and Affiliates (in '000s)

	2008	2007	2006	2005
Total Revenue		$2,250,505	$1,956,730	$1,728,329
Salaries		$1,162,603	$988,093	$856,678
Operating Income		$87,162	$111,766	$68,168
Excess of Revenues Over Expenses		$212,041	$201,428	$115,400
Depreciation and Amortization		$129,689	$123,078	$117,359
EBDA (Free Cash Flow)		$341,730	$324,506	$232,759
EBDA/Net Revenue		15.18%	16.58%	13.47%
Increase in Net Assets		$180,133	$200,630	$117,001
End of Year		$1,655,127	$1,471,168	$1,268,873

WakeMed (in '000s)

	2008	2007	2006
Total Revenue		$780,575	$771,789
Salaries		$420,127	$385,118
Operating Income		$14,959	$55,216
Excess of Revenues Over Expenses		$48,179	$77,271
Depreciation and Amortization		$56,148	$52,835
EBDA (Free Cash Flow)		$104,327	$130,106
EBDA/Net Revenue		13.37%	16.86%
Change in Assets		$49,301	$77,902
Net Assets - End of Year		$684,204	$634,903

Lenoir Memorial Hospital, Inc. and Affiliates

	2008	2007	2006
Total Revenue	$107,419,176	$101,338,931	$106,236,395
Salaries and Benefits	$57,551,488	$52,447,190	$51,373,742
Operating Income	($831,879)	$1,890,561	$10,695,992
Excess of Revenues Over Expenses	$3,452,401	$6,297,315	$14,322,226
Depreciation and Amortization	$8,000,660	$7,939,391	$7,820,881
EBDA (Free Cash Flow)	$11,453,061	$14,236,706	$22,143,107
EBDA/Net Revenue	10.66%	14.05%	20.84%
Change in Net Assets	($3,433,824)	$9,155,932	$16,361,569
Net Assets - End of Year	$122,361,979	$125,795,803	$116,639,871

Catawba Valley Medical Center

	2008	2007	2006
Total Revenue		$168,182,243	$151,433,520
Nursing Services		$48,379,131	$42,894,718
Other Professional Services		$48,460,022	$45,538,330
General Services		$12,244,503	$11,496,699
Administrative Services		$39,665,416	$37,395,124
Income From Operations		$6,812,622	$1,798,876
Excess of Revenues Over Expenses		$9,778,121	$4,382,022
Depreciation		$12,116,687	$11,758,674
Amortization		$55,671	$77,052
EBDA (Free Cash Flow)		$21,950,479	$16,217,748
EBDA/Net Revenue		13.05%	10.71%
Change in Net Assets		$9,904,328	$4,520,338
Net Assets - End of Year		$100,183,731	$90,279,403

Alamance Regional Medical Center and Affiliates

	2008	2007	2006
Total Revenue		$207,734,175	$188,203,109
Salaries		$69,914,174	$65,427,017
Employee Benefits		$16,839,220	$15,459,509
Operating Income		$10,126,717	$4,933,503
Excess of Revenues over Expenses		$16,578,798	$11,087,457
Depreciation and Amortization		$12,255,617	$11,949,947
EBDA (Free Cash Flow)		$28,834,415	$23,037,404
EBDA/Net Revenue		13.88%	12.24%
Change in Assets		$13,359,105	$12,157,365
Net Assets - End of Year		$138,616,183	$125,265,406

First Health of the Carolinas, Inc. (in '000s)

	2008	2007	2006
Total Revenue	$439,218	$414,679	$390,945
Salaries	$167,747	$164,037	$157,119
Employee Benefits	$40,163	$40,748	$37,122
Operating Income	$11,232	$9,217	$10,407
Excess of Revenues over Expenses	$36,924	$60,343	$22,029
Depreciation and Amortization	$28,962	$29,117	$27,823
EBDA (Free Cash Flow)	$65,886	$89,460	$49,852
EBDA/Net Revenue	15.00%	21.57%	12.75%
Change in Assets	($46,120)	$41,634	$42,737
Net Assets - End of Year	$462,711	$508,563	$459,378

Appendix I

Hospital Name	Charity	CC+PP+SP	Charity	Comm	Medicaid	Medicare	PP/SP	Other Gov't	All Other	Total
Alamance Regional Medical Center	3.89%	5.64%	280	3,549	868	2,200	126	43	133	7,199
Albemarle Hospital	0.00%	2.13%	0	2,598	552	2,935	144	523	0	6,752
Alleghany Memorial Hospital	4.78%	8.37%	12	95	28	105	9	2		251
Angel Medical Center, Inc	NC	8.94%		440	128	696	127	14	15	1,420
Annie Penn Hospital	4.09%	4.09%	64	754	195	527	0	6	18	1,564
Anson Community Hospital	0.87%	2.77%	5	186	80	295	11			577
Ashe Memorial Hospital, Inc	NC	3.59%		149	31	240	16	10		446
Beaufort County Hospital	0.00%	3.30%	0	944	189	1,159	81	10	68	2,451
Bertie Memorial Hospital	W-PP/SP	2.09%		204	72	608	19	5	0	908
Betsy Johnson Regional Hospital	NC	3.42%		1,038	398	1,162	97	125	19	2,839
Bladen County Hospital	NC	4.96%		231	123	259	32			645
Blue Ridge Regional Hospital (Spruce Pine)	NC	6.73%		496	178	518	86			1,278
Brunswick Community Hospital	1.49%	3.65%	31	765	273	894	45	50	22	2,080
Caldwell Memorial Hospital, Inc	1.04%	4.36%	42	1,704	543	1,580	134	38	0	4,041
Cape Fear Valley Medical Center	NC	4.64%		2,373	1,050	2,158	334	922	362	7,199
Carolinas Medical Center/Center for Mental Health	W-PP/SP	4.63%		7,781	1,574	1,552	569	79	745	12,300
Carteret General Hospital	NC	9.24%		729	219	505	167	187		1,807
Catawba Valley Medical Center	2.27%	4.30%	172	3,933	704	2,477	153	62	64	7,565
Central Carolina Hospital	0.70%	2.02%	19	1,301	394	906	36	45	18	2,719
Charles A. Cannon, Jr. Memorial Hospital, Incorporated	0.12%	2.74%	1	285	61	432	21	3	0	803
Chatham Hospital	0.67%	4.70%	1	87	5	50	6			149
Chowan Hospital	NC	1.73%		464	132	533	20		6	1,155
Cleveland Regional Medical Center	0.51%	4.84%	18	1,343	429	1,547	152	26	0	3,515
CMC - Lincoln Medical Center	NC	4.94%		827	443	372	87	19	14	1,762
Carolinas Medical Center Mercy/Pineville	W-PP/SP	3.04%	0	6,935	608	1,930	318	0	669	10,460
CMC - Northeast, Inc	2.34%	8.20%	176	4,303	590	1,731	440	33	236	7,509
Carolinas Medical Center - Union	NC	3.50%		2,845	785	1,818	206	17	213	5,884
Carolinas Medical Center - University	W-PP/SP	3.55%	0	5,175	332	681	247	0	515	6,950
Columbus Regional Healthcare System	NC	3.41%		557	854	2,307	190	85	1,575	5,568
Craven Regional Medical Center	NC	1.56%		2,673	967	3,576	131	866	188	8,401
Davie County Hospital	0.00%	16.33%	0	25	7	9	8	0	0	49
Davis Regional Medical Center	NC	7.01%		1,134	257	599	150			2,140
Duke Health Raleigh Hospital	1.37%	2.68%	125	5,903	210	2,028	120		748	9,134
Duke University Hospital	W-PP/SP	2.55%		10,111	1,810	5,456	477		840	18,694
Duplin General Hospital, Inc	0.09%	1.21%	1	289	369	396	13	9	77	1,154
Durham Regional Hospital	W-PP/SP	3.87%	0	2,239	169	769	133	0	124	3,434

Hospital Name	Charity	CC+PP+SP	Charity	Comm	Medicaid	Medicare	PP/SP	Other Gov't	All Other	Total
FirstHealth Montgomery Memorial Hospital	0.00%	9.98%	0	308	79	203	66	5	0	661
FirstHealth Moore Reg Hosp/Pinehurst Treatment	NC	3.77%		2,290	419	1,663	181	252		4,805
FirstHealth Richmond Memorial Hospital	6.45%	14.20%	65	181	292	352	78	39		1,007
Forsyth Memorial Hospital	W-PP/SP	2.40%	0	4,153	403	1,355	151	236	0	6,298
Franklin Regional Medical Center	0.24%	3.58%	4	564	422	573	56	12	45	1,676
Frye Regional Medical Center	0.17%	1.77%	14	4,716	1,156	1,825	132	56	351	8,250
Gaston Memorial Hospital	NC	2.26%		5,940	1,543	2,252	234	385		10,354
Grace Hospital, Inc	NC	3.47%		2,009	446	1,626	149	29	32	4,291
Granville Medical Center	NC	2.23%		980	301	763	48	20	44	2,156
Harris Regional Hospital	1.28%	4.62%	54	1,768	827	1,212	141	216	0	4,218
Haywood Regional Medical Center	0.06%	3.10%	4	2,742	604	3,528	220	74	63	7,235
Heritage Hospital	W-PP/SP	2.90%		686	337	309	43	27	79	1,481
High Point Regional Health System	1.47%	4.47%	80	2,742	444	1,925	163	37	45	5,436
Highlands-Cashiers Hospital, Inc	0.00%	21.43%	0	77	2	108	51			238
Higsmith-Rainey Memorial Hospital	0.03%	1.49%	1	754	628	1,181	44	256	149	3,013
Hoots Memorial Hospital, Inc	2.78%	28.17%	7	48	66	36	64		31	252
Hugh Chatham Memorial Hospital, Inc	NC	3.77%		1,105	286	709	97	379		2,576
Iredell Memorial Hospital, Incorporated	0.39%	3.06%	14	1,674	438	1,287	97	44	70	3,624
J. Arthur Dosher Memorial Hospital	NC	3.00%		799	64	687	48			1,598
Kings Mountain Hospital	NC	1.50%		252	384	326	15		22	999
Lake Norman Regional Medical Center	NC	4.12%		1,569	91	877	109			2,646
Lenoir Memorial Hospital, Inc	0.00%	3.97%	0	1,315	548	982	128	193	56	3,222
Margaret R. Pardee Memorial Hospital	0.40%	3.20%	19	1,730	375	2,290	134	94	144	4,786
Maria Parham Medical Center	0.31%	3.96%	7	866	416	837	83	57	8	2,274
Memorial Mission Hospital/Asheville Surgery Center	0.76%	3.54%	151	10,744	2,540	5,620	555	60	277	19,947
Morehead Memorial Hospital	0.49%	1.08%	11	1,266	230	673	13	10	22	2,225
Moses Cone Health System	2.71%	2.71%	484	11,171	1,281	3,872		102	962	17,872
Murphy Medical Center, Inc	NC	9.01%		692	315	902	189			2,098
Nash General Hospital	0.44%	2.10%	31	3,160	1,006	2,510	116	42	148	7,013
New Hanover Regional Medical Center	1.50%	3.51%	282	7,308	1,885	5,915	377	2,410	605	18,782
North Carolina Baptist Hospital	W-PP/SP	4.83%		7,814	2,893	4,507	808	270	425	16,717
North Carolina Specialty Hospital	0.15%	1.21%	6	2,433	327	890	43	171	173	4,043
Northern Hospital of Surry County	1.32%	3.91%	27	860	190	858	53	14	45	2,047
Onslow Memorial Hospital, Inc	0.00%	16.14%	0	132	200	409	213	122	244	1,320
Park Ridge Hospital	NC	4.70%		1,842	400	1,940	209	58		4,449
Pender Memorial Hospital, Inc	1.44%	9.63%	9	171	67	315	51	9	1	623
Person Memorial Hospital	0.92%	1.83%	25	1,246	287	1,077	25	69		2,729
Pitt County Memorial Hospital	NC	4.88%		4,349	1,245	2,640	454	334	280	9,302
Presbyterian Hospital	W-PP/SP	3.47%		7,727	1,647	4,115	500	372	44	14,405
Presbyterian Hospital Huntersville	W-PP/SP	2.84%		2,847	216	673	112	83	9	3,940
Presbyterian Hospital Matthews	W-PP/SP	8.42%		3,410	254	720	416	131	8	4,939
Presbyterian Orthopaedic Hospital	W-PP/SP	3.77%		3,010	161	720	157	93	22	4,163

Hospital Name	Charity	CC+PP+SP	Charity	Comm	Medicaid	Medicare	PP/SP	Other Gov't	All Other	Total
Randolph Hospital, Inc	NC	3.56%		1,713	620	711	115	7	68	3,234
Rex Hospital	2.51%	3.13%	446	12,529	801	2,136	111	1,116	629	17,768
Roanoke-Chowan Hospital	NC	4.06%		688	462	528	74	22	49	1,823
Rowan Regional Medical Center	1.31%	5.77%	85	3,506	706	1,525	290	392		6,504
Rutherford Hospital, Inc	NC	4.02%		753	280	798	79	9	48	1,967
Sampson Resional Medical Center	NC	6.95%		697	229	655	118			1,699
Sandhills Regional Medical Center	NC	2.71%		321	209	640	33	16		1,219
Scotland Memorial Hospital and Edwin Morgan Center	2.05%	2.43%	114	2,100	987	2,250	21	46	44	5,562
Souteastern Regional Medical Center	1.68%	6.17%	70	1,719	873	1,299	187	17		4,165
St. Luke's Hospital	NC	4.90%		484	88	1,055	112	3	546	2,288
Stanly Regional Medical Center	NC	1.69%		1,599	511	1,275	60	45	51	3,541
Stokes-Reynolds Memorial Hospital, Inc	0.00%	2.62%	0	340	22	367	20	4	9	762
Swain County Hospital	0.34%	1.37%	1	105	19	161	3	2		291
The McDowell Hospital	NC	4.56%		650	192	559	67			1,468
The Outer Banks Hospital, Inc	NC	6.37%		468	75	164	51	24	19	801
Thomasville Medical Center	W-PP/SP	3.15%		1,166	368	571	71	76		2,252
Transylvania Community Hospital, Inc and Bridgeway	3.49%	4.87%	109	877	247	1,799	43	25	19	3,119
University of North Carolina Hospitals	5.61%	7.85%	759	5,961	2,573	2,533	303	969	427	13,525
Valdese General Hospital, Inc	NC	5.71%		500	398	659	104	22	138	1,821
WakeMed	6.67%	6.67%	894	7,462	2,060	2,433		558		13,407
WakeMed Cary Hospital	1.73%	1.73%	124	5,087	279	1,555		114		7,159
Washington County Hospital	NC	4.78%		2	38	169	15	35	55	314
Watauga Medical Center, Inc	0.26%	3.22%	8	1,222	327	1,375	91	35	13	3,071
Wayne Memorial Hospital, Inc	NC	11.20%		2,394	1,044	2,335	835	701	149	7,458
Wilkes Regional Medical Center	1.01%	3.02%	25	1,166	273	868	50	25	74	2,481
Wilson Medical Center	4.13%	6.21%	143	1,752	510	947	72	30	10	3,464
			5,020				14,653			481,675
Total Charity Care + Private-Pay + Self-Pay	**19,673**	**4.08%**	1.04%				3.04%			

Notes

NC = Not Completed

NA = Not Applicable

W-PP/SP = Charity Care included With Private Pay/ Self Pay

These barriers to efficiency result in lower patient, physician, and staff satisfaction, as well as increased operating expenses. However, by relocating four endoscopy rooms to an outpatient setting, scheduling, patient flow, and daily operations can be managed more efficiently.

5. *Enhance Patient Safety*: In recent years, increasing public attention has been given to the need to create a safer healthcare environment. While patient safety has always been a prime interest of health professionals, it has recently received increased emphasis as a result of two studies by the federal Institute of Medicine and also through professional initiatives such as the National One Hundred Thousand Lives Campaign, in which PCMH participates.

   This public attention includes the safety of endoscopy services. In a 2004 article that is attached in Appendix S, the Wall Street Journal notes that infectious outbreaks among endoscopy patients at other facilities and doctor's offices are now reported on a regular basis. While such incidents are rare in comparison to the enormous number of endoscopies that are performed, each incident can potentially affect hundreds of patients. This problem has been extensively discussed in medical and health industry literature, and has received much attention from the Centers for Disease Control and the Food and Drug Administration.

   One method for controlling infection among endoscopy patients is to significantly reduce the risk of exogenous (patient-to-patient) infections. Attached in Appendix S is a 2003 article from the journal Gastrointestinal Endoscopy that discusses some of the challenges of preventing exogenous infections. The most effective method of preventing or eliminating these types of infections is to perform routine outpatient endoscopies and other procedures for relatively asymptomatic patients in areas that are not used for more acute patients. The best way to accomplish this is to provide outpatient endoscopy services in a dedicated environment rather than in a setting where an asymptomatic patient will inevitably encounter an acutely or chronically ill patient. PCMH's proposal to create a dedicated area that will be used only for screening endoscopies and other outpatient procedures will separate most endoscopy patients from an environment that is unavoidably populated by acutely or chronically ill patients.