Acute Care Services Committee

Recommendations to the North Carolina State Health Coordinating Council

May 27, 2009

The Acute Care Services (ACS) Committee has met twice since the March Council meeting, first on April 8th and again on May 6th.

At the April 8th meeting the Committee:
- Reviewed the current Acute Care policies and methodologies;
- Was provided an overview of the February 23 Acute Care Bed Need Methodology work group meeting;
- Discussed a new method for counting excluded trauma cases when determining need for additional Operating Rooms;
- Considered operating room petitions from Affordable Health Care Facilities and the Southern Surgical Center requesting approval of ambulatory surgery demonstration projects;
- Reviewed and discussed the recommendations from the Single Specialty Ambulatory Surgery Work Group; and
- Considered the Affordable Health Care Facilities License Renewal Application Petition.

At the May 6th meeting, the Committee
- Reviewed preliminary drafts of need projections generated by the standard methodologies; and
- Reviewed and discussed revised recommendations from the Single Specialty Ambulatory Surgery Work Group.

Following is an overview of the Committee's recommendations for the Acute Care Services chapters of the Proposed 2010 SMFP. The report is organized by Chapter of the SMFP.

5 Acute Care Beds

Acute Care Hospital Policies:
- The Committee recommends no changes to the Acute Care Hospital Policies for the Proposed 2010 Plan.

Acute Care Bed Need Methodology:
- The Committee recommends no changes to the Acute Care Bed Need Methodology for the Proposed 2010 Plan. The Committee concurs with the Acute Care Bed Need Methodology Work Group's recommendation for the work group to reconvene in the fall to review additional data and to consider changing the Acute Care Bed Need methodology in the spring of 2010.

- The Acute Care Bed Need Methodology Work Group, which met on February 23 of this year, was convened in response to acute care bed adjusted need determination petitions filed last summer and is charged:

  1. To evaluate the present bed methodology with respect to the impact that uneven growth in days in acute care hospitals throughout the state has on the methodology.

  2. To develop recommendations which can effectively and fairly address the growth disparities and which will be consistent with the present methodologies in the 2009 SMFP.

  At the February 23 meeting, the work group reviewed acute care bed need projections generated by using HSA and county based growth rates and considered changing from using a statewide growth rate to an HSA or county based growth rate. The work group also considered changing the acute care bed need methodology occupancy factors and number of years over which the growth rate is averaged, and using growth rates based on groups of counties. The work group consensus was that an HSA based growth rate was not appropriate and that a county based growth rate had potential, but that more work was required before a recommendation to change the methodology could be made. The work group also agreed that given the current economic climate, now is not a good time to change the acute care bed need methodology such that need for a large number of acute care beds is generated.

Draft Table 5A:
- The Committee recommends approval of the draft Table 5A, which applied the standard Acute Care Bed Need Methodology to updated inventories and to the FY 2008 Thomson acute care days. The three year average Growth Factor used in projecting need for additional acute care beds was .02% and application of the standard methodology indicated need for 36 additional acute care beds for Orange county.

- However, whereas the Committee noted overall improvement in the Acute Care utilization data compared to past years, there are still some hospitals showing discrepancies of five percent or greater between their Licensure data and their Thomson data. The Committee authorized staff to work with the Sheps Center and the hospitals during the summer to improve discrepant data and to recalculate the need projections based on the improved data.

(See ACS Attachment A.)

6 Operating Rooms

Operating Room Need Methodology:
- The Committee recommends no changes to the Operating Room Need Methodology for the Proposed 2010 Plan. However, the Committee discussed “chronically underutilized facilities” whose OR inventory and utilization data are excluded from need determinations. Such facilities are defined in the OR methodology as: “licensed facilities operating at less than 40% utilization for the past two fiscal years, which have been licensed long enough to

submit at least two License Renewal Applications to the Division of Health Service Regulation." The Committee asked staff to model increasing the number of License Renewal Applications required from two to three, or to model an increased period based on another suitable factor, and to report results to the Committee.

Trauma/Burn Center OR Exclusion:

- The current Operating Room Need Methodology excludes one operating room for each Level I and II Trauma Center and one additional operating room for each designated Burn Intensive Care Unit. The methodology also excludes the cases associated with the excluded operating rooms.

- After being informed that the North Carolina Office of Emergency Medical Services (NC OEMS) is developing a reporting system which can be queried for trauma cases by hospital, the Committee recommends:
    1. For the Proposed 2010 SMFP, using the current method for excluding trauma cases from the OR methodology, i.e., collecting excluded case data from trauma/burn centers when need is determined in an OR service area with a Trauma/Burn Center;
    2. Adding a note to the Proposed 2010 SMFP describing the NC OEMS reporting system and requesting comments on querying the system for trauma case numbers to be excluded from the OR methodology; and
    3. After NC OEMS implements the trauma case reporting system, comparing data from the NC OEMS system to data submitted by the trauma centers.

Operating Room Petitions:

- The Committee considered two operating room petitions, one from Affordable Health Care Facilities and one from Southern Surgical Center. Both petitioners requested approval of a pilot demonstration project for ambulatory surgery centers. The specific requests are shown below:

  Affordable Health Care Facilities: *"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."*
  (See ACS Attachment B.)

  Southern Surgical Center: *"A Freestanding Ambulatory Surgery Center Demonstration Project should be included in the 2010 State Medical Facilities Plan. The demonstration project should include 6 different sites owned and operated separately in 6 different geographic areas of the state - Mecklenburg, Forsyth, Guilford, Wake, Pitt, and New Hanover Counties. Each site will be awarded two operating room and two procedure rooms."*
  (See ACS Attachment C.)

- The Committee recommends denial of both petitions. The Committee agreed with the Agency's rationale for recommending denial of the petitions, which was that a work group

was developing a single Specialty Ambulatory Surgery Demonstration Project and it would be imprudent at this time to recommend approval of any additional ambulatory surgery demonstration projects.

(See ACS Attachment D – Agency Report.)

Single Specialty Ambulatory Surgery Work Group Recommendations:

- The Committee reviewed and discussed the recommendations from the Single Specialty Ambulatory Surgery Work Group. The work group charge is shown below:

  "Upon the recommendation of the Acute Care Services Committee and as approved by the vote of the State Health Coordinating Council, a single specialty ambulatory surgery workgroup has been appointed by the Chairman. The workgroup consists of members of the Acute Care Services Committee, the SHCC, and staff. The committee is charged to do the following:
  - *Develop a plan to evaluate and test the concept of single special ambulatory surgery centers in North Carolina*
  - *Formulate recommendations regarding the number of sites and potential geographic locations for pilot projects*
  - *Identify measures that can be used to evaluate the success of the pilot projects, to include measures of value, access to the uninsured, and quality and safety of care*
  - *Recommend how the test sites will be held accountable and responsible in the event they are unsuccessful in meeting target guidelines*

  The workgroup will present its recommendations to the Acute Care Services Committee by April 30, 2009 for consideration and referral to the SHCC for inclusion in the Draft 2010 State Medical Facilities Plan."

- The Single Specialty Ambulatory Surgery Work Group recommendations are shown in the table beginning on the next page:

Project Description:

Three new separately licensed single specialty ambulatory surgical facilities with two operating rooms each.

CRITERIA	CRITERIA BASIC PRINCIPLE AND THE RATIONALE
Establish a special need determination for three new separately licensed single specialty ambulatory surgical facilities with two operating rooms each, such that there is a need identified for one new ambulatory surgical facility in each of the three following service areas: • Mecklenburg, Cabarrus, Union counties (Charlotte Area) • Guilford, Forsyth counties (Triad) • Wake, Durham, Orange counties (Triangle)	*Value* At least one county in each of the groups of counties has a current population greater than or equal to 200,000 and more than 50 total ambulatory/shared operating rooms and at least 1 separately licensed Ambulatory Surgery Center. Locating facilities in high population areas with a large number of operating rooms and existing ambulatory surgery providers prevents the facilities from harming hospitals in rural areas, which need revenue from surgical services to offset losses from other necessary services such as emergency department services.
In choosing among competing demonstration project facilities, priority will be given to facilities which are owned wholly or in part by physicians.	*Value* Giving priority to demonstration project facilities owned wholly or in part by physicians is an innovative idea with the potential to improve safety, quality, access and value. Implementing this innovation through a demonstration project enables the State Health Coordinating Council to monitor and evaluate the innovation's impact.
Each demonstration project facility shall provide care to the indigent population, as described below: The percentage of the facility's total revenue that is attributed to self-pay and Medicaid revenue shall be at least seven percent, which shall be calculated as follows: The Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid cases divided by the total revenues for all surgical cases performed in the facility. Following are examples of the calculation of self pay and Medicaid revenue: If Medicare allows \$300 for a surgical procedure and a self-pay patient pays the facility \$0, \$300 is considered self-pay revenue. If Medicare allows \$300 for a surgical procedure and a self-pay patient pays the facility \$50, \$250 is considered self-pay revenue. If Medicare allows \$300 for a surgical procedure and Medicaid pays the facility \$225, then \$75 is considered Medicaid revenue. Demonstration project facilities shall report utilization and payment data to the	*Access* Requiring service to indigent patients promotes equitable access to the services provided by the demonstration project facilities.

CRITERIA	CRITERIA BASIC PRINCIPLE AND THE RATIONALE
statewide data processor as required by G.S. 131E-214.2. The Agency will monitor compliance with indigent care requirements by analyzing payment data submitted by the facilities.	
Demonstration project facilities shall complete a "Surgical Safety Checklist (adapted for use in the US)" before each surgery is performed. Note: "Surgical Safety Checklist is based on the WHO Surgical Safety Checklist developed by: World Health Organization" Each demonstration project facility shall develop a system to measure and report patient outcomes to the Agency for the purpose of monitoring the quality of care provided in the facility. If patient outcome measures are available for a facility's particular surgical specialty, the facility shall identify those measures and may use them for reporting patient outcomes. If patient outcome measures are not available, the facility shall develop its own patient outcome measures that will be reported to the Agency. Demonstration project facilities shall submit annual reports to the Agency regarding the results of patient outcome measures. Examples of patient outcome measures include: wound infection rate, post-operative infections, post-procedure complications, readmission, and medication errors.	*Safety and Quality* Implementing a system for measuring and reporting quality promotes identification and correction of quality of care issues and overall improvement in the quality of care provided.
Demonstration project facilities are encouraged to develop systems which will enhance communication and ease data collection, for example, electronic medical records that support interoperability with other providers.	*Safety and Quality, Access, Value* Electronic medical records improve the collection of quality and access to care data and collecting data is the first step in monitoring and improving quality of care and access. Interoperability facilitates communication among providers, enhancing care coordination.
Demonstration project facilities are encouraged to provide open access to physicians.	*Access* Services will be accessible to a greater number of surgical patients if the facility has an open access policy for physicians.
Physicians affiliated with the demonstration project facilities are required to establish or maintain hospital staff privileges with at least one hospital and to begin or continue meeting Emergency Department coverage responsibilities with at least one hospital, with the following caveat: This requirement has to be available to the physicians and not denied based upon charges that physicians are engaging in competitive behavior by providing services at a facility that is perceived to be in competition with the hospital if it is so happens that the CON is issued to an organization other than the hospital. Additionally, physicians affiliated with the demonstration project facilities are	*Safety and Quality* Encouraging physicians to establish or maintain hospital staff privileges and to begin or continue meeting Emergency Department coverage responsibilities helps prevent a decrease in the quality of the overall healthcare system resulting from lack of resources.

CRITERIA	CRITERIA BASIC PRINCIPLE AND THE RATIONALE
required to provide annually to the Agency data related to meeting their hospital staff privilege and Emergency Department coverage responsibilities. Specific data to be reported, such as number of nights on call, will be determined by the Agency.	
Facilities shall obtain a license no later than two years from the date of issuance of the certificate of need, unless this requirement is changed in a subsequent State Medical Facilities Plan.	*Access and Value* Timely project completion increases access to services and enhances project value.
The Single Specialty Ambulatory Surgery Work Group values the collective wisdom of the North Carolina Hospital Association and the North Carolina Medical Society and requests that the two organizations work together to assist the demonstration project facilities in developing quality measures and increasing access to the underserved.	*Safety and Quality, Access and Value* Collaboration between the North Carolina Hospital Association and the North Carolina Medical Society in an effort to develop quality measures and increase access to the underserved promotes all three Basic Principles.
Facilities will provide annual reports to the Agency showing the facility's compliance with the demonstration project criteria in the State Medical Facilities Plan. The Agency may specify the reporting requirements and reporting format. The Agency will perform an evaluation of each facility at the end of the first calendar year the facility is in operation and will perform an annual evaluation of each facility thereafter. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress towards meeting the demonstration project criteria. The Agency will evaluate each facility after each facility has been in operation for five years. If the Agency determines that the facilities are meeting or exceeding **all** criteria, the work group encourages the State Health Coordinating Council to consider allowing expansion of single specialty ambulatory surgical facilities beyond the original three demonstration sites. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress towards meeting the demonstration project criteria. If the Agency determines that a facility is not in compliance with any one of the demonstration project criteria, the Department, in accordance with G.S. 131E-190, "may bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b)."	*Safety and Quality, Access, Value* Timely monitoring enables the Agency to determine if facilities are meeting criteria and to take corrective action if facilities fail to meet criteria. This ensures that all three Basic Principles are met by the demonstration project facilities.

- The Committee recommends including in the Proposed 2010 SMFP a Single Specialty Ambulatory Surgery demonstration project which complies with all the criteria listed in the above table. Additionally, the Committee recommends adding a note to the 2010 Proposed SMFP requesting comments on the demonstration project.

Draft Table 6B
- The Committee recommends approval of the draft Table 6B, which applied the standard Operating Room Need Methodology to updated inventory and utilization data. Application of the standard methodology indicated need for four additional operating rooms: three in the Wake County OR service area and one in the Watauga County OR service area.

(See ACS Attachment E.)

7 Other Acute Care Services

Other Acute care Services Policy/Need Methodologies:
- No petitions or comments were received related to any of the Other Acute Care Services. The Committee recommends no changes to Policy AC-6 (Heart-Lung Bypass Machines for Emergency Coverage) or to the methodologies.

Open Heart Surgery Services and Heart-Lung Bypass Machines Need
- The Committee recommends no need for additional Open Heart Surgery Services and no need for additional Heart-Lung Bypass Machines for review in 2010.

(See ACS Attachment F.)

Burn Intensive Care Services Need
- The Committee recommends no need for additional burn intensive care services for the Proposed 2010 Plan.

(See ACS Attachment G.)

Bone Marrow Transplantation Services and Solid Organ Transplantation Services Need
- The Committee recommends no need for additional bone marrow transplantation services and no need for additional solid organ transplantation services for the Proposed 2010 Plan.

(See ACS Attachment H)

8 Inpatient Rehabilitation Services

Inpatient Rehabilitation Services Need Methodology:
- No petitions or comments were received related to Inpatient Rehabilitation Services. The Committee recommends carrying forward the current methodology for the Proposed 2010 Plan.

Draft Table 8A:

- The Committee recommends approval of the draft Table 8A, which applied the standard methodology to 2008 inventory and utilization data, indicating no need for additional Inpatient Rehabilitation Beds anywhere in the State.

(See ACS Attachment I.)

All Chapters Acute Care Services

Affordable Health Care Facilities License Renewal Application Petition:

- The Committee considered a petition from Affordable Health Care Facilities. The petitioner requested that the SHCC, North Carolina DHHS and DHSR require that prior to submission to DHSR, License Renewal Applications be reviewed and approved by Licensed Certified Public Accountants or be certified in the same way as Medicare Cost Reports are certified.

(See ACS Attachment J.)

- The Committee recommends denial of the petition. The Committee agreed with the Agency's rationale for recommending denial of the petition, which was that the content, structure and signature requirements for the License Renewal Applications are within the purview of the Division of Health Service Regulation and not within the purview of the State Health Coordinating Council.

(See ACS Attachment K – Agency Report.)

Additionally, the Acute Care Services Committee has authorized staff to make changes in Acute Care Services data and narratives as additional information is received.

Table 5A: Acute Care Bed Need Projections

(2008 Utilization Data from Thomson as compiled by the Cecil B. Sheps Center for Health Services Research)

Counties with one hospital shown first, followed by counties with more than one hospital.													
A	B	C	D	E	F	G	H	I	J	K			
License Number	Facility Name	County	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson 2008 Acute Care Days	6 Years Growth Using .02% Growth Rate	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus ("-")	2014 Need Determination	2008 Licensure Days	2008 Licensure Days Minus 2008 Thomson Days	Percent Difference Thomson/ Licensure
H0272	Alamance Regional Medical Center	Alamance	182	0	45,843	45,898	126	176	-6	0	46,346	503	1.1%
H0274	Alexander Hospital	Alexander	25	0	0	0	0	0	-25	0	0	0	0.0%
H0108	Alleghany Memorial Hospital	Alleghany	41	0	2,785	2,788	8	11	-30	0	2,824	39	1.4%
H0082	Anson Community Hospital	Anson	52	0	4,152	4,157	11	17	-35	0	4,947	795	**19.1%**
H0099	Ashe Memorial Hospital	Ashe	76	0	5,182	5,188	14	21	-55	0	5,193	11	0.2%
H0037	Charles A. Cannon, Jr. Memorial Hospital	Avery	30	0	6,433	6,441	18	26	-4	0	5,713	-720	**-11.2%**
H0268	Bertie Memorial Hospital	Bertie	6	0	1,578	1,580	4	6	0	0	1,570	-8	-0.5%
H0154	Cape Fear Valley - Bladen County Hospital	Bladen	48	0	3,794	3,799	10	16	-32	0	3,809	15	0.4%
H0036	Mission Hospitals	Buncombe	673	0	186,888	187,112	513	682	9	0	186,795	-93	0.0%
H0031	Carolinas Medical Center - NorthEast	Cabarrus	447	0	105,542	105,669	290	385	-62	0	105,103	-439	-0.4%
H0061	Caldwell Memorial Hospital	Caldwell	110	0	17,505	17,526	48	72	-38	0	19,712	2,207	**12.6%**
H0222	Carteret General Hospital	Carteret	135	0	27,483	27,516	75	113	-22	0	27,761	278	1.0%
H0007	Chatham Hospital	Chatham	25	0	3,341	3,345	9	14	-11	0	3,280	-61	-1.8%
H0239	Murphy Medical Center	Cherokee	57	0	8,473	8,483	23	35	-22	0	8,673	200	2.4%
H0063	Chowan Hospital	Chowan	49	0	6,988	6,996	19	29	-20	0	7,003	15	0.2%
H0045	Columbus County Hospital	Columbus	154	0	18,581	18,603	51	76	-78	0	24,319	5,738	**30.9%**
H0201	CarolinaEast Medical Canter	Craven	270	37	77,706	77,799	213	283	-24	0	77,163	-543	-0.7%
H0213	Cape Fear Valley Medical Center	Cumberland	487	44	145,017	145,191	398	529	-2	0	144,554	-463	-0.3%
H0273	The Outer Banks Hospital	Dare	21	0	3,634	3,638	10	15	-6	0	3,663	29	0.8%
H0171	Davie County Hospital	Davie	81	0	1,420	1,422	4	6	-75	0	1,422	2	0.1%
H0166	Duplin General Hospital	Duplin	61	0	11,401	11,415	31	47	-14	0	10,794	-607	**-5.3%**
H0258	Heritage Hospital	Edgecombe	101	0	15,631	15,650	43	64	-37	0	15,629	-2	0.0%
H0261	Franklin Regional Medical Center	Franklin	70	0	11,342	11,356	31	47	-23	0	11,232	-110	-1.0%
H0105	Gaston Memorial Hospital	Gaston	372	0	81,162	81,259	223	296	-76	0	81,280	118	0.1%
H0098	Granville Medical Center	Granville	62	0	8,077	8,087	22	33	-29	0	8,192	115	1.4%
H0025	Haywood Regional Medical Center	Haywood	153	0	14,217	14,234	39	58	-95	0	15,774	1,557	**11.0%**
H0001	Roanoke-Chowan Hospital	Hertford	86	0	14,323	14,340	39	59	-27	0	14,288	-35	-0.2%
H0087	Harris Regional Hospital	Jackson	86	0	18,293	18,315	50	75	-11	0	18,295	2	0.0%
H0151	Johnston Memorial Hospital	Johnston	157	22	37,952	37,998	104	146	-33	0	38,141	189	0.5%
H0243	Central Carolina Hospital	Lee	127	0	19,687	19,711	54	81	-46	0	20,332	645	3.3%
H0043	Lenoir Memorial Hospital	Lenoir	218	0	46,226	46,281	127	178	-40	0	47,588	1,362	2.9%
H0225	Carolinas Medical Center - Lincoln	Lincoln	101	0	15,253	15,271	42	63	-38	0	15,500	247	1.6%
H0078	Martin General Hospital	Martin	49	0	7,965	7,975	22	33	-16	0	8,346	381	4.8%
H0097	The McDowell Hospital	McDowell	65	0	6,525	6,533	18	27	-38	0	6,696	171	2.6%

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

Table 5A: Acute Care Bed Need Projections

(2008 Utilization Data from Thomson as compiled by the Cecil B. Sheps Center for Health Services Research)

Counties with one hospital shown first, followed by counties with more than one hospital.

A	B	C	D	E	F	G	H	I	J	K			
License Number	Facility Name	County	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson 2008 Acute Care Days	6 Years Growth Using .02% Growth Rate	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus ("-")	2014 Need Determination	2008 Licensure Days	2008 Licensure Days Minus 2008 Thomson Days	Percent Difference Thomson/ Licensure
H0169	Blue Ridge Regional Hospital	Mitchell	46	0	6,568	6,576	18	27	-19	0	6,594	26	0.4%
H0003	FirstHealth Montgomery Memorial Hospital	Montgomery	37	0	1,835	1,837	5	8	-29	0	1,850	15	0.8%
H0100	FirstHealth Moore Regional Hospital	Moore	297	23	73,264	73,352	201	267	-53	0	76,079	2,815	3.8%
H0228	Nash General Hospital	Nash	270	0	56,687	56,755	155	218	-52	0	56,671	-16	0.0%
H0221	New Hanover Regional Medical Center	New Hanover	647	0	139,307	139,474	382	508	-139	0	139,437	130	0.1%
H0048	Onslow Memorial Hospital	Onslow	162	0	33,350	33,390	91	137	-25	0	32,714	-636	-1.9%
H0157	University of North Carolina Hospitals	Orange	621	72	199,848	200,088	548	729	36	36	194,948	-4,900	-2.5%
H0054	Albemarle Hospital	Pasquotank	182	0	27,437	27,470	75	113	-69	0	27,472	35	0.1%
H0115	Pender Memorial Hospital	Pender	43	0	5,647	5,654	15	23	-20	0	3,155	-2,492	**-44.1%**
H0066	Person Memorial Hospital	Person	50	0	9,717	9,729	27	40	-10	0	10,914	1,197	**12.3%**
H0104	Pitt County Memorial Hospital	Pitt	667	67	197,218	197,455	541	719	-15	0	198,558	1,340	0.7%
H0079	St. Luke's Hospital	Polk	45	0	3,521	3,525	10	14	-31	0	3,540	19	0.5%
H0013	Randolph Hospital	Randolph	145	0	27,782	27,815	76	114	-31	0	26,136	-1,646	**-5.9%**
H0064	Southeastern Regional Medical Center	Robeson	292	0	60,085	60,157	165	231	-61	0	57,809	-2,276	-3.8%
H0040	Rowan Regional Medical Center	Rowan	223	0	34,559	34,600	95	142	-81	0	35,071	512	1.5%
H0039	Rutherford Hospital	Rutherford	129	0	17,359	17,380	48	71	-58	0	19,161	1,802	**10.4%**
H0067	Sampson Regional Medical Center	Sampson	116	0	12,653	12,668	35	52	-64	0	11,695	-958	**-7.6%**
H0107	Scotland Memorial Hospital	Scotland	97	21	24,706	24,736	68	102	-16	0	24,714	8	0.0%
H0008	Stanly Regional Medical Center	Stanly	97	0	14,101	14,118	39	58	-39	0	14,279	178	1.3%
H0165	Stokes-Reynolds Memorial Hospital	Stokes	53	0	842	843	2	3	-50	0	822	-20	-2.4%
H0069	Swain County Hospital	Swain	48	0	1,607	1,609	4	7	-41	0	1,606	-1	-0.1%
H0111	Transylvania Community Hospital	Transylvania	42	0	5,829	5,836	16	24	-18	0	5,874	45	0.8%
H0050	Carolinas Medical Center - Union	Union	157	0	40,362	40,410	111	155	-2	0	39,616	-746	-1.8%
H0267	Maria Parham Hospital	Vance	91	0	19,892	19,916	55	82	-9	0	19,844	-48	-0.2%
H0006	Washington County Hospital	Washington	49	-37	1,849	1,851	5	8	-4	0	1,853	4	0.2%
H0257	Wayne Memorial Hospital	Wayne	255	0	60,022	60,094	165	230	-25	0	61,403	1,381	2.3%
H0153	Wilkes Regional Medical Center	Wilkes	120	0	16,184	16,203	44	67	-53	0	16,318	134	0.8%
H0210	Wilson Medical Center	Wilson	294	-96	34,631	34,673	95	142	-56	0	34,948	317	0.9%
H0155	Hoots Memorial Hospital	Yadkin	22	0	1,069	1,070	3	4	-18	0	834	-235	**-22.0%**

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

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License Number	***Facility Name***	***County***	***Licensed Acute Care Beds***	***Adjustments for CONs/ Previous Need***	***Thomson 2008 Acute Care Days***	***6 Years Growth Using .02% Growth Rate***	***2014 Projected Average Daily Census (ADC)***	***2014 Beds Adjusted for Target Occupancy***	***Projected 2014 Deficit or Surplus ("-")***	***2014 Need Determination***	***2008 Licensure Days***	***2008 Licensure Days Minus 2008 Thomson Days***	***Percent Difference Thomson/ Licensure***
H0188	Beaufort County Hospital	Beaufort	120	0	7,987	7,997	22	33	-87		11,509	3,522	**44.1%**
H0002	Pungo District Hospital Corporation	Beaufort	39	0	2,259	2,262	6	9	-30		2,283	24	1.1%
		Beaufort Total	159	0						0			
H0250	Brunswick Community Hospital	Brunswick	60	14	11,513	11,527	32	47	-27		11,545	32	0.3%
H0150	J. Arthur Dosher Memorial Hospital	Brunswick	36	0	4,630	4,636	13	19	-17		4,617	-13	-0.3%
		Brunswick Total	96	14						0			
H0062	Grace Hospital	Burke	162	0	20,541	20,566	56	85	-77		20,708	167	0.8%
H0091	Valdese General Hospital	Burke	131	0	11,794	11,808	32	49	-82	0	11,954	160	1.4%
		Burke Total	293	0									
H0223	Catawba Valley Medical Center	Catawba	200	0	39,713	39,761	109	153	-47		41,508	1,795	4.5%
H0053	Frye Regional Medical Center	Catawba	209	0	47,695	47,752	131	183	-26		49,065	1,370	2.9%
		Catawba Total	409	0						0			
H0024	Cleveland Regional Medical Center	Cleveland	241	0	37,156	37,201	102	143	-98		36,061	-1,095	-2.9%
H0236	Crawley Memorial Hospital (CON to convert 41 AC beds to LTCH beds and 10 AC beds to nursing beds issued 7.14.08.)	Cleveland	50	-50	1	1	0	0	0		0	-1	**-100.0%**
H0113	Kings Mountain Hospital	Cleveland	72	0	7,025	7,033	19	29	-43		6,920	-105	-1.5%
		Cleveland Total	363	-50						0			
H0027	Lexington Memorial Hospital	Davidson	94	0	11,231	11,244	31	46	-48		11,307	76	0.7%
H0112	Thomasville Medical Center	Davidson	123	0	12,900	12,915	35	53	-70		13,186	286	2.2%
		Davidson Total	217	0						0			
H0015	Duke University Hospital	Durham	924	0	242,051	242,342	664	883	-41		239,920	-2,131	-0.9%
(Duke University Hospital has a CON for 14 additional acute care beds under Policy AC-3. These 14 beds are not counted when determining acute care bed need.)													
H0233	Durham Regional Hospital	Durham	316	0	64,752	64,830	178	249	-67		64,886	134	0.2%
	Duke/Durham Regional Hospital Totals		1,240	0	306,803	307,171	842	1,132	-108				
H0075	North Carolina Specialty Hospital	Durham	18	0	3,248	3,252	9	13	-5		3,278	30	0.9%
		Durham Total	1,258	0						0			

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

Table 5A: Acute Care Bed Need Projections

(2008 Utilization Data from Thomson as compiled by the Cecil B. Sheps Center for Health Services Research)

Counties with one hospital shown first, followed by counties with more than one hospital.													
A	B	C	D	E	F	G	H	I	J	K			
License Number	Facility Name	County	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson 2008 Acute Care Days	6 Years Growth Using .02% Growth Rate	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus ("-")	2014 Need Determination	2008 Licensure Days	2008 Licensure Days Minus 2008 Thomson Days	Percent Difference Thomson/ Licensure
H0209	Forsyth Medical Center	Forsyth	751	39	210,295	210,547	577	767	-23		212,302	2,007	1.0%
H0229	Medical Park Hospital	Forsyth	22	0	4,906	4,912	13	20	-2		4,909	3	0.1%
		Forsyth/Medical Park Hospital Totals	773	39	215,201	215,459	590	787	-25				
H0011	North Carolina Baptist Hospitals	Forsyth	789	0	218,898	219,161	600	799	10		212,843	-6,055	-2.8%
	2007 Forsyth SMFP Need Determination	Forsyth		26	0	0	0	0					
		Forsyth Total	1,562	65						0			
H0052	High Point Regional Health System	Guilford	291	16	67,906	67,988	186	261	-46		68,234	328	0.5%
H0159	Moses Cone Health System	Guilford	818	-41	192,429	192,660	528	702	-75		196,507	4,078	2.1%
		Guilford Total	1,109	-25						0			
H0230	Halifax Regional Medical Center	Halifax	186	0	33,056	33,096	91	136	-50		32,858	-198	-0.6%
H0004	Our Community Hospital	Halifax	20	0	52	52	0	0	-20		53	1	1.9%
		Halifax Total	206	0						0			
H0224	Betsy Johnson Regional Hospital	Harnett	101	0	27,358	27,391	75	113	12		26,453	-905	-3.3%
	Harnett Health System Central Campus	Harnett	0	50	0	0	0	0	-50				
		Betsy Johnson/Harnett Health System Totals	101	50	27,358	27,391	75	113	-38				
H0080	Good Hope Hospital (closed effective 4/11/06)	Harnett	0	34	0	0	0	0	-34				
		Harnett Total	101	84						0			
H0161	Margaret R. Pardee Memorial Hospital	Henderson	193	0	23,211	23,239	64	96	-97		25,344	2,133	**9.2%**
H0019	Park Ridge Hospital	Henderson	62	0	14,135	14,152	39	58	-4		13,683	-452	-3.2%
		Henderson Total	255	0						0			
H0248	Davis Regional Medical Center	Iredell	120	-18	16,476	16,496	45	68	-34		16,520	44	0.3%
H0259	Lake Norman Regional Medical Center	Iredell	105	18	27,321	27,354	75	112	-11		27,573	252	0.9%
		Davis Regional/Lake Norman Regional Medical Center Totals	225	0	43,797	43,850	120	180	-45				
H0164	Iredell Memorial Hospital	Iredell	199	0	40,708	40,757	112	156	-43		41,198	490	1.2%
		Iredell Total	424	0						0			
H0034	Angel Medical Center	Macon	59	0	5,607	5,614	15	23	-36		5,677	70	1.2%
H0193	Highlands-Cashiers Hospital	Macon	24	0	919	920	3	4	-20		920	1	0.1%
		Macon Total	83	0						0			

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

Table 5A: Acute Care Bed Need Projections

(2008 Utilization Data from Thomson as compiled by the Cecil B. Sheps Center for Health Services Research)

Counties with one hospital shown first, followed by counties with more than one hospital.													
A	B	C	D	E	F	G	H	I	J	K			
License Number	Facility Name	County	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson 2008 Acute Care Days	6 Years Growth Using .02% Growth Rate	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus ("-")	2014 Need Determination	2008 Licensure Days	2008 Licensure Days Minus 2008 Thomson Days	Percent Difference Thomson/ Licensure
H0042	Carolinas Medical Center - Mercy & Pineville	Mecklenburg	294	36	61,844	61,918	170	237	-93		62,595	751	1.2%
H0255	Carolinas Medical Center - University	Mecklenburg	130	-36	21,979	22,005	60	90	-4		22,746	767	3.5%
H0071	Carolinas Medical Center / Center for Mental Health	Mecklenburg	795	0	233,864	234,145	641	853	58		234,134	270	0.1%
		Carolinas Medical Center Totals	1,219	0	317,687	318,068	871	1,181	-38				
H0010	Presbyterian Hospital	Mecklenburg	463	76	154,618	154,804	424	564	25		154,182	-436	-0.3%
H0282	Presbyterian Hospital Huntersville	Mecklenburg	60	15	17,081	17,102	47	70	-5		17,842	761	4.5%
H0270	Presbyterian Hospital Matthews	Mecklenburg	102	12	30,779	30,816	84	127	13		31,418	639	2.1%
	Presbyterian Hospital Mint Hill	Mecklenburg	0	50	Utiization for reporting period shown below with H0251.				-50			0	0.0%
H0251	Presbyterian Orthopaedic Hospital	Mecklenburg	140	-126	12,803	12,818	35	53	39		12,803	0	0.0%
		Presbyterian Hospital Totals	765	27	215,281	215,539	591	814	22				
	2009 Mecklenburg SMFP Need Determination	Mecklenburg		20	0	0							
		Mecklenburg Total	1,984	47						0			
H0158	FirstHealth Richmond Memorial Hospital	Richmond	99	0	12,731	12,746	35	52	-47	0	12,794	63	0.5%
H0265	Sandhills Regional Medical Center	Richmond	54	6	11,962	11,976	33	49	-11		10,470	-1,492	**-12.5%**
		Richmond Total	153	6						0			
H0023	Annie Penn Hospital	Rockingham	110	0	13,555	13,571	37	56	-54		14,050	495	3.7%
H0072	Morehead Memorial Hospital	Rockingham	108	0	21,894	21,920	60	90	-18		25,299	3,405	**15.6%**
		Rockingham Total	218	0						0			
H0049	Hugh Chatham Memorial Hospital	Surry	81	0	18,817	18,840	52	77	-4		19,018	201	1.1%
H0184	Northern Hospital of Surry County	Surry	100	0	15,719	15,738	43	65	-35		15,826	107	0.7%
		Surry Total	181	0						0			

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

ACS Attachment A
5.27.09 SHCC Meeting

Table 5A: Acute Care Bed Need Projections

(2008 Utilization Data from Thomson as compiled by the Cecil B. Sheps Center for Health Services Research)

Counties with one hospital shown first, followed by counties with more than one hospital.													
A	B	C	D	E	F	G	H	I	J	K			
License Number	Facility Name	County	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson 2008 Acute Care Days	6 Years Growth Using .02% Growth Rate	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus ("-")	2014 Need Determination	2008 Licensure Days	2008 Licensure Days Minus 2008 Thomson Days	Percent Difference Thomson/ Licensure
H0238	Duke Health Raleigh Hospital	Wake	186	0	23,215	23,243	64	96	-90		24,625	1,410	**6.1%**
H0065	Rex Hospital	Wake	421	12	106,947	107,075	293	390	-43		105,270	-1,677	-1.6%
H0276	WakeMed Cary Hospital	Wake	156	0	38,542	38,588	106	148	-8		38,496	-46	-0.1%
H0199	WakeMed Raleigh Campus	Wake	515	60	177,318	177,531	486	647	72		177,004	-314	-0.2%
		WakeMed Totals	671	60	215,860	216,119	592	795	64				
	2008 Wake SMFP Need Determination	Wake		41	0	0							
	2009 SMFP Wake Need Determination (neonatal beds only)	Wake		18	0	0							
		Wake Total	1,278	131						0			
H0160	Blowing Rock Hospital	Watauga	28	0	585	586	2	2	-26		654	69	**11.8%**
H0077	Watauga Medical Center	Watauga	117	0	21,199	21,224	58	87	-30		20,844	-355	-1.7%
		Watauga Total	145										
Grand Total All Hospitals			**20,468**	**425**						**36**			

Projections bsed on Growth Factor at .02% per year for the next 6 years.
Target Occupancy Factors: ADC<100=150%, ADC 100-200=140%, ADC>200=133%.
(ADC=Average Daily Census)

ACS Attachment A
5.27.09 SHCC Meeting

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

Petitioner:

Affordable Health Care Facilities, LLC
944 19th Avenue NW
Hickory, North Carolina 28601
(828) 310-9333
bob@medcapllc.com

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.
>
> 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:
>
> - 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.***

[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***

[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.

***Objective:** 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.

<u>Objective:</u>* 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 <u>not</u> 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.

<u>Objective:</u>* 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.

<u>Objective:</u> 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.

Petition to the State Health Coordinating Council

Regarding _

For the 2010 State Medical Facilities Plan

March 4th, 2009

Petitioner:

Name	Southern Surgical Center, LLC
Address	3410 Executive Drive, Raleigh, NC 27609
Phone	919-872-5296

Contact:

Name	Paul L. Burroughs III, MD,
Address	3410 Executive Drive, Raleigh, NC 27609
Phone	919-673-7171

PETITION

STATEMENT OF REQUESTED CHANGE

The Southern Surgical Center, LLC requests the following policy change to the 2010 State Medical Facilities Plan (SMFP). The Southern Surgical Center requests that a demonstration project be added to the 2010 plan to study freestanding ambulatory surgery centers.

Chapter 6: Operating Rooms should be changed as follows:

A Freestanding Ambulatory Surgery Center Demonstration Project should be included in the 2010 State Medical Facilities Plan. The demonstration project should include 6 different sites owned an operated separately in 6 different geographic areas of the state - Mecklenberg, Forsyth, Guilford, Wake, Pitt, and New Hanover Counties. Each site will be awarded two operating room and two procedure rooms.

To clarify the intent of the demonstration, the following criteria need to be added to this Demonstration Project.

1. Sites must bill as a freestanding Ambulatory Surgery Center, which is not licensed as part of a hospital or other Medicare Part A provider.

2. Conditions must be applied to the CON, including

   - The ASC cannot be sold to a hospital corporation, unless the ASC billing rates can be maintained, or unless laws are passed that make an owner ineligible for continued ownership.
   - Groups that own, run, or utilize the ASCs must be prohibited from signing exclusive provider contracts with third party payors for any of the services they provide.
   - Each year an applicant must document that seven percent of its facility's cash receipts are from self-pay, charity/indigent, and Medicaid patients.

3. Letters of hospital support must be excluded from the application. Applicants may state their case as to why they will be beneficial to a hospital system, but letters from a hospital system will benefit only specific types of groups, and will unfairly disadvantage most applicants.

4. Need for the facility must be supported with documentation of existing historical surgical case volumes of at least 2,000 cases and letters of support from surgeons who have completed these cases.

5. Applicants may propose single or multi-specialty facilities, and neither should be favored over the other.

6. The state should provide a specific outline of what data is to be reported. Each site should follow the same research protocol and follow the same data points mandated by the state.

REASONS FOR THE PROPOSED CHANGES

1. Sites must bill as a freestanding Ambulatory Surgery Center, which is not licensed as part of a hospital or other Medicare Part A provider.

The CON law governs both Operating Rooms and ambulatory surgery centers and all new operating rooms must be awarded by the state following the lengthy CON process. Currently we find that the overwhelming majority of operating rooms are under control of hospitals. Only 10 percent are not hospital-owned. While the CON mandates do not spell this out as a goal, it is the result that we see today in Wake County and the State as a whole. Most of the ambulatory surgery operating rooms are located inside hospital inpatient facilities. Multiple studies show that procedures performed in an Ambulatory Surgery Center provide a better value to the patient. When those procedures occur in a freestanding non-hospital facility, the patient gains in cost savings as well as in efficiency of healthcare delivery.

This demonstration study also needs to address the topic of Joint ventures. We have found that the state will give deference to proposals that partner with hospitals. We are convinced that any demonstration project for Ambulatory Surgery Centers should specifically state that they be run by entities that bill ASC rates to ensure cost savings.

Hospital charge structures are higher and hospital layers of management are heavier. Both of these impede innovation and cost savings. CON measures of revenue per visit yield themselves to extensive manipulation through contractual write-offs and payor mix. Charge is a true measure of impact on the consumer and should be weighted more heavily in the evaluation. Hospitals are as free to apply as non-hospital applicants, but must find a way to bill at ASC rates to be competitive for this demonstration study.

2. Conditions must be applied to the CON, including

- The Center cannot be sold to a hospital corporation, unless the ASC billing rates can be maintained, or unless laws are passed that make an owner ineligible for continued ownership.

Outpatient surgery performed in a facility billing as an ASC is reimbursed at lower rates than hospitals and at lower rates than outpatient surgery centers billing as hospital departments. It is conceivable that a site could apply for a site with the intention of later converting it to a hospital department and thus increase reimbursements. This should be prevented in order to solidify the cost savings to the community.

- Groups that own, run, or utilize these ASCs must be prohibited from signing exclusive provider for any health care service.

Competition for patients is very fierce in many areas of the state. Physician reimbursements have been negotiated downwards at significant rates. Groups that own or utilize and ASC will be able to combine both surgical and nonsurgical provider contracts and provide a great cost savings to third party payors/ insurance companies. The cost savings for surgical services will be so substantial that these physicians might be able to convince insurance companies to sign exclusive agreements them and corner their respective markets. This should not be allowed to happen.

- Each year an applicant must document that seven percent of its facility's cash receipts are from self-pay, charity/indigent, and Medicaid.

We have been reviewing many of the previously submitted petitions concerning ambulatory surgery centers, and we particularly are interested in the findings of the recent Ambulatory Surgery Center (ASC) workgroup. We agree with the recommendations made by the

Ambulatory Surgery Center workgroup, specifically with points involving the reimbursement ceilings. However we feel that this point will be automatically satisfied with the current reimbursement schedules in existence. We do agree that each applicant should document 7 % of cash receipts should be from self-pay, charity/indigent care, and Medicaid. The other points in that document petition are very valid and agree with those points included in the recommendations we have made in this petition.

3. Special rules for this project should deemphasize letters of hospital support in the decision making process. Applicants may state their case as to why they will be beneficial to a hospital system, but letters from a hospital system will benefit only specific types of groups, and will unfairly disadvantage most applicants.

Proof of admitting privileges at a hospital should be sufficient documentation of an applicant's capacity to handle emergency situations requiring hospital admission. Hospital commitments to serve Medicaid and uninsured patients who come to the emergency room and are covered by EMTALA rules and the same rules apply to any patients who may have had surgery at an ASC. However these commitments have been given undeserved deference in the CON process. In the current economic climate, even the most liberal of studies repeatedly note that working people who have insurance that has high copayment and deductibles are more adversely affected by a high medical charge structure. They are not eligible for charity deductions, or for social supplements to their family budgets. Their insurance rates go up if they have a medical condition that causes them to use the health care delivery system. The incremental approach of CON Policy GEN-3 has insufficient definition and clout to benefit them. Removing the requirement or deference of hospital support is necessary.

Hospitals are reimbursed at much higher levels, so this alone should make them less appropriate recipients of this type of CON. If they can find a way to bill as an ASC, as with partnering with a physician group, they could do so. This way the state will have to weigh the merits of each application, not which applicant is most supportive of hospitals. The system

currently has too many back door ways for hospitals to outweigh physician-led proposals for surgery programs.

4. Need for the facility must be supported with documentation of existing historical surgical case volumes of at least 2,000 cases and letters of support from surgeons who have completed these cases. Forecast utilization based only on population growth and estimated surgical use rates should be considered insufficient documentation. Letters of support from actual surgeons using the center need to be included in the application.

In deference to community physicians, these sites should be awarded to applicants with an existing case volume. Population growth and estimated use rates should be considered less valid. One benefit of making this a requirement is that it will prevent outside corporations with no ties to the community from coming in and getting involved in the process.

5. Applicants may propose single or multi-specialty facilities, and neither should be favored over the other.

We believe that the type of facility should not be limited. One possible option would be to have three single specialty and three multispecialty sites as part of the demonstration study. The state could derive more information from such a design.

6. The state should provide a specific outline of what data are to be reported. Each site should follow the same research protocol and follow the same data points.

Standardizing the research protocols will improve the quality of the demonstration project. An effort should also be made to document "total dollars received per procedure" for cases done at each site, and compare to "total dollars received per procedure" for the closest hospital providers. If this information is difficult to come by, a multiple of Medicare reimbursements can be used for some cases and extrapolated across the fee schedules used by each center. We have found that patients are very willing to share their EOBs, which detail

dollars reimbursed to the hospital for cases done there. We are currently using this technique on an MRI demonstration project currently.

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

Patients are hurt by the status quo because freestanding ambulatory surgery centers are more cost effective, and the more ambulatory surgery that can be performed outside of a hospital and out from under the expensive hospital bureaucracy, the better. Many of these points have already been listed in previous petitions, (see attachments). Only ten percent of operating rooms in North Carolina are not hospital owned. The freestanding ASC cost structure needs more support.

More than 70 percent of surgical procedures involve outpatient procedures. Very few of them involve specialized equipment that must be shared with inpatients. Many procedures can be done in a procedure room, which is less expensive to build than an operating room. Many of these procedures would be appropriate for an ASC setting.

If North Carolina is to have the flexibility to respond to the national call for cost management in health care, we must have policies that permit willing providers to develop innovative facilities. All of the reform agendas involve increased participation and ownership of physicians in care management, care evaluation and care direction. In the face of a documented growing national shortage of specialty physicians, we must think about efficient use of their time. This requires thinking about deployment of resources in a very different way. Measuring only the total productivity of existing multi-specialty operating rooms will force replication of the status quo.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

The obvious alternative is to develop an ambulatory surgery center using the existing CON process. The current model for forecasting ambulatory surgery center need is an accretive methodology that tends to favor adding rooms to existing structures. It contains no provisions for change thinking. The lengthy debate about two operating rooms in Randolph County in order to permit a hospital-physician joint venture is evidence of the heavy status quo thinking implicit in the existing methodology. We did attempt this and were denied.

EVIDENCE OF NON-DUPLICATION OF SERVICES

This requested change would cause no duplication of services.

There are currently no CONs for free standing Ambulatory Surgery Center operating rooms in Wake County. While a CON for four Operating Rooms has recently been awarded, it is possible that one or more of the three of the three hospital applicants will end up with the rooms, and thus leave the county without any additional ASCs. The current surgical volumes and projected growth of the listed six counties indicate more operating rooms are needed, especially when considering that the last CON for operating rooms in Wake County took seven years to be built after the award of the CON.

EVIDENCE THAT THE REQUESTED CHANGE PROMOTES SAFETY, QUALITY, ACCESS AND VALUE

The arguments made in the previous petitions and outlined in the preceding paragraphs supports the promotion of quality, access, and value. Safety concerns are of the highest priority, and the existing state, Medicare, and licensing requirements will be in effect for these demonstration ASCs as they are for existing ones, as well as hospital based operating rooms. This will ensure safety protocols and designs are met.

CONCLUSION

We have reviewed many of the previous petitions and also the findings of the Ambulatory Surgery Center Workgroup. We also applied for Operating Rooms under the existing CON framework and despite having a fully conforming application, we were denied and the need remains. Therefore, we are petitioning the state for an Ambulatory Surgery Center Demonstration Project for six Ambulatory Surgery Centers in different regions of the state (two rooms each) and are making the following recommendations.

1. Sites must bill as a freestanding Ambulatory Surgery Center, which is not licensed as part of a hospital or other Medicare Part A provider.
2. Conditions must be applied to the CON, including
   - The Center cannot be sold to a hospital corporation, unless the ASC billing rates can be maintained, or unless laws are passed that make an owner ineligible for continued ownership.
   - Groups that own, run, or utilize these ASCs must be prohibited from signing exclusive provider for any health care service.
   - Each year an applicant must document that seven percent of its facility's cash receipts are from self-pay, charity/indigent, and Medicaid.
3. Letters of hospital support must be excluded from the application. Applicants may state their case as to why they will be beneficial to a hospital system, but letters from a hospital system will benefit only specific types of groups, and will unfairly disadvantage most applicants.
4. Need for the facility must be supported with documentation of existing historical surgical case volumes of at least 2,000 cases and letters of support from surgeons who have completed these cases.
5. Applicants may propose single or multi-specialty facilities, and neither should be favored over the other.

6. The state should provide a specific outline of what data is to be reported. Each site should follow the same research protocol and follow the same data points mandated by the state.

We agree with many of the general points put forward by other similar petitions, but feel our points are the ones that will result in a successful demonstration study.

Sincerely,

Paul L. Burroughs III MD

ATTACHMENTS

Acute Care Services Committee
April 8, 2009

Agency Report

OR Petition 1: Affordable Health Care Facilities, LLC
OR Petition 2: Southern Surgical Center, LLC
2010 Proposed State Medical Facilities Plan

Petitioners:
OR Petition 1:
Affordable Health Care Facilities, LLC
944 19th Avenue NW
Hickory, North Carolina 28601
(828) 310-9333
bob@medcapllc.com

OR Petition 2:
Paul L. Burroughs III, MD
Southern Surgical Center, LLC
3410 Executive Drive
Raleigh, NC 27609
919-872-5296

Requests:
Both petitioners request approval of a pilot demonstration project for ambulatory surgery centers. A table summarizing each of the projects is provided on pages three and four of this report.

Background Information:
Chapter 2 of the Plan allows petitioners early each calendar year to recommend changes that may have a statewide effect. According to the Plan, "Changes with the potential for a statewide effect are the addition, deletion, and revision of policies and revision of the projection methodologies." The change recommended by these petitioners is a methodology revision that would have a statewide effect.

The current operating room need projection methodology was first used in the 2004 North Carolina State Medical Facilities Plan. Since that time, much interest has been shown in the methodology and the consequences of its application, as evidenced by the operating room petitions filed annually since 2004 and the continued discussions of the methodology during Acute Care Services Committee and State Health Coordinating Council (SHCC) meetings. The most recent response by the SHCC to this interest was the convening of a Single Specialty Ambulatory Surgery Work Group, which has met three times during 2008 and 2009. The Single Specialty Ambulatory Surgery Work Group's charge is shown below:

"Upon the recommendation of the Acute Care Services Committee and as approved by the vote of the State Health Coordinating Council, a single specialty ambulatory surgery workgroup has

been appointed by the Chairman. The workgroup consists of members of the Acute Care Services Committee, the SHCC, and staff. The committee is charged to do the following:

- Develop a plan to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina
- Formulate recommendations regarding the number of sites and potential geographic locations for pilot projects
- Identify measures that can be used to evaluate the success of the pilot projects, to include measures of value, access to the uninsured, and quality and safety of care
- Recommend how the test sites will be held accountable and responsible in the event they are unsuccessful in meeting target guidelines

The workgroup will present its recommendations to the Acute Care Services Committee by April 30, 2009 for consideration and referral to the SHCC for inclusion in the Proposed 2010 State Medical Facilities Plan."

Analysis/Implications:
The table on the following pages summarizes each of the petitions.

Petitioner: Southern Surgical Center	***Petitioner: Affordable Health Care Facilities***
Facility Characteristics	
Six sites proposed in the following counties: Mecklenburg, Forsyth, Guilford, Wake, Pitt, and New Hanover	No limit on number or location of sites, as long as the following criteria are met: • Counties with a population of at least 85,000 and one hospital; or • Counties with a population of at least 125,000 and two or more hospitals.
Two ORs and two procedure rooms per site.	At least 2 operating rooms per site.
Single specialty or multispecialty ORs.	Single specialty ORs only.
Case/Procedure Volume	
• Documentation of existing historical surgical case volumes of at least 2,000 cases • Letters of support from surgeons who have completed these cases. • Exclude hospital letters of support	Must project at least 1,000 procedures per operating room.
Indigent Care	
Seven percent of facility's cash receipts are from self-pay, charity/indigent, and Medicaid patients.	• At least 5% of total patient load charity or indigent care (less than $200 per service in reimbursement). • 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.
Quality and Safety, Access, Value	
State provide a specific outline of what data are to be reported. Each site should follow the same research protocol and follow the same data points.	• Each facility shall develop a series of safety and quality metrics as part of application. These metrics will vary by medical specialty. • All facilities will work with the DHSR and other organizations to develop a standardized patient satisfaction survey and reporting mechanism. • All facilities also must detail how clinical safety and quality performance and patient satisfaction will be reported. • The ASCs must agree through affidavit to meet all state licensure, accreditation, and Medicare certification requirements in the pilot demonstration application.
Not addressed	• 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.

Petitioner: Southern Surgical Center	***Petitioner: Affordable Health Care Facilities***
	• Facilities agree not to charge more than 300% of prevailing Medicare reimbursement for the first two (2) years of operation. • 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 • 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
Miscellaneous	
The ASC cannot be sold to a hospital corporation, unless the ASC billing rates can be maintained, or unless laws are passed that make an owner ineligible for continued ownership.	Not addressed.
No exclusive provider contracts with third party payers for any of the services provided.	Not addressed.
Sites must bill as free standing Ambulatory Surgery Centers	Not addressed.
Award CONs to existing community providers	Not addressed.
Not addressed.	ASC physicians must commit to continued "call" coverage at area hospitals.
Not addressed.	• Expand the work group beyond the current membership or at least formally request input from nationally recognized industry leaders and researchers. • Invite 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.
Not addressed.	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

The Agency appreciates submission of innovative ideas, such as the ideas included in the petitions that are the subject of this report. However, given that a Single Specialty Ambulatory Surgery Work Group is currently in the process of developing a demonstration project, the Agency believes that it would be imprudent at this time to recommend approval of any additional ambulatory surgery demonstration projects. Based on the progress and the preliminary recommendations made by the work group to date, the Agency is confident that the demonstration project, as developed by the work group, will be carefully constructed and consistent with the revised Basic Principles governing the development of the State Medical Facilities Plan.

Agency Recommendation:
In consideration of the above, the Agency recommends denial of both the petitions. The Agency also recommends development of the Singe Specialty Ambulatory Surgery Work Group demonstration project.

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	B	C	D	E	F	G	H	I	J	K	L
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	2008 Inpatient Cases (without exclusions)	Inpatient Case Time Standard (3 Hours)	Estimated Inpatient Hours	2008 Ambulatory Cases	Ambulatory Case Time Standard (1.5 Hours)	Estimated Ambulatory Hours	Total Estimated Hours (D+G)	Growth Factor 2008-2012 (Population Change Rate)	Projected Surgical Hours: 2012	Standard Hours per OR per Year (9/260/80%)	Projected ORs Needed in 2012
Alamance	1,958	3.0	5,874	7,196	1.5	10,794	16,668	9.23%	18,206.56	1872	9.73
Caswell	0	3.0	0	0	1.5	0	0	-1.31%	0.00	1872	0.00
Alamance Caswell Total	1,958	3.0	5,874	7,196	1.5	10,794	16,668	7.78%	17,964.39	1872	9.60
Beaufort	745	3.0	2,235	2,261	1.5	3,392	5,627	1.55%	5,713.80	1872	3.05
Hyde	0	3.0	0	0	1.5	0	0	-2.58%	0.00	1872	0.00
Beaufort Hyde Total	745	3.0	2,235	2,261	1.5	3,392	5,627	1.11%	5,689.23	1872	3.04
Buncombe	13,146	3.0	39,438	28,185	1.5	42,278	81,716	5.34%	86,081.04	1872	45.98
Madison	0	3.0	0	0	1.5	0	0	-1.49%	0.00	1872	0.00
Yancey	0	3.0	0	0	1.5	0	0	3.37%	0.00	1872	0.00
Buncombe Madison Yancey Total	13,146	3.0	39,438	28,185	1.5	42,278	81,716	4.60%	85,477.25	1872	45.66
Cherokee	469	3.0	1,407	2,348	1.5	3,522	4,929	5.27%	5,188.76	1872	2.77
Clay	0	3.0	0	0	1.5	0	0	8.10%	0.00	1872	0.00
Cherokee Clay Total	469	3.0	1,407	2,348	1.5	3,522	4,929	6.05%	5,227.43	1872	2.79
Chowan	579	3.0	1,737	1,217	1.5	1,826	3,563	1.08%	3,600.82	1872	1.92
Tyrrell	0	3.0	0	0	1.5	0	0	0.77%	0.00	1872	0.00
Chowan Tyrell Total	579	3.0	1,737	1,217	1.5	1,826	3,563	1.01%	3,598.37	1872	1.92
Craven	3,809	3.0	11,427	8,352	1.5	12,528	23,955	2.95%	24,662.38	1872	13.17
Jones	0	3.0	0	0	1.5	0	0	0.26%	0.00	1872	0.00
Pamlico	0	3.0	0	0	1.5	0	0	-0.36%	0.00	1872	0.00
Craven Jones Pamlico Total	3,809	3.0	11,427	8,352	1.5	12,528	23,955	2.37%	24,523.00	1872	13.10
Halifax	1,510	3.0	4,530	2,683	1.5	4,025	8,555	-0.60%	8,503.38	1872	4.54
Northampton	0	3.0	0	0	1.5	0	0	-0.74%	0.00	1872	0.00
Halifax Northampton Total	1,510	3.0	4,530	2,683	1.5	4,025	8,555	-0.64%	8,500.05	1872	4.54
Jackson	1,222	3.0	3,666	4,399	1.5	6,599	10,265	5.98%	10,878.46	1872	5.81
Graham	0	3.0	0	0	1.5	0	0	2.29%	0.00	1872	0.00
Swain	0	3.0	0	0	1.5	0	0	4.64%	0.00	1872	0.00
Jackson Graham Swain Total	1,222	3.0	3,666	4,399	1.5	6,599	10,265	5.16%	10,794.00	1872	5.77
Moore	5,616	3.0	16,848	18,730	1.5	28,095	44,943	7.47%	48,301.62	1872	25.80
Hoke	0	3.0	0	0	1.5	0	0	10.44%	0.00	1872	0.00
Moore Hoke Total	5,616	3.0	16,848	18,730	1.5	28,095	44,943	8.49%	48,758.49	1872	26.05
Pasquotank	1,323	3.0	3,969	4,501	1.5	6,752	10,721	1.31%	10,860.83	1872	5.80
Camden	0	3.0	0	0	1.5	0	0	4.63%	0.00	1872	0.00
Currituck	0	3.0	0	0	1.5	0	0	-2.63%	0.00	1872	0.00
Gates	0	3.0	0	0	1.5	0	0	4.22%	0.00	1872	0.00
Perquimans	0	3.0	0	0	1.5	0	0	8.32%	0.00	1872	0.00
Pasquotank Camden Currituck Gates Perquimans Total	1,323	3.0	3,969	4,501	1.5	6,752	10,721	1.96%	10,930.18	1872	5.84
Pitt	10,705	3.0	32,115	20,387	1.5	30,581	62,696	9.63%	68,735.92	1872	36.72
Greene	0	3.0	0	0	1.5	0	0	2.82%	0.00	1872	0.00
Pitt Greene Total	10,705	3.0	32,115	20,387	1.5	30,581	62,696	8.82%	68,223.38	1872	36.44
Vance	702	3.0	2,106	1,878	1.5	2,817	4,923	0.29%	4,937.26	1872	2.64
Warren	0	3.0	0	0	1.5	0	0	-0.34%	0.00	1872	0.00
Vance Warren Total	702	3.0	2,106	1,878	1.5	2817	4,923	0.09%	4927.50	1872	2.63

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	*Number of Inpatient Operating Rooms*	*Number of Ambulatory Operating Rooms*	*Number of Shared Operating Rooms*	*Excluded Dedicated C-Section Rooms*	*Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit*	*Adjustments: CONs Issued, Settlement Agreements, Previous Need*	*Adjusted Planning Inventory*	*Projected Operating Room Deficit or Surplus (Surplus shows as a "-")*	*Projected Need for New Operating Rooms*
Alamance	2	3	9	-2	0	-2	10	-0.27	
Caswell	0	0	0	0	0	0	0	0.00	
Alamance Caswell Total	2	3	9	-2	0	-2	10	-0.40	0
Beaufort	1	0	5	-1	0	0	5	-1.95	
Hyde	0	0	0	0	0	0	0	0.00	
Beaufort Hyde Total	1	0	5	-1	0	0	5	-1.96	0
Buncombe	21	19	9	-2	-1	4	50	-4.02	
Madison	0	0	0	0	0	0	0	0.00	
Yancey	0	0	0	0	0	0	0	0.00	
Buncombe Madison Yancey Total	21	19	9	-2	-1	4	50	-4.34	0
Cherokee	0	0	4	0	0	0	4	-1.23	
Clay	0	0	0	0	0	0	0	0.00	
Cherokee Clay Total	0	0	4	0	0	0	4	-1.21	0
Chowan	0	0	3	0	0	0	3	-1.08	
Tyrrell	0	0	0	0	0	0	0	0.00	
Chowan Tyrell Total	0	0	3	0	0	0	3	-1.08	0
Craven	3	6	9	-1	0	0	17	-3.83	
Jones	0	0	0	0	0	0	0	0.00	
Pamlico	0	0	0	0	0	0	0	0.00	
Craven Jones Pamlico Total	3	6	9	-1	0	0	17	-3.90	0
Halifax	0	0	6	0	0	0	6	-1.46	
Northampton	0	0	0	0	0	0	0	0.00	
Halifax Northampton Total	0	0	6	0	0	0	6	-1.46	0
Jackson	0	0	6	0	0	0	6	-0.19	
Graham	0	0	0	0	0	0	0	0.00	
Swain	0	0	0	0	0	0	0	0.00	
Jackson Graham Swain Total	0	0	6	0	0	0	6	-0.23	0
Moore	2	13	10	0	0	2	27	-1.20	
Hoke	0	0	0	0	0	0	0	0.00	
Moore Hoke Total	2	13	10	0	0	2	27	-0.95	0
Pasquotank	2	0	8	-2	0	0	8	-2.20	
Camden	0	0	0	0	0	0	0	0.00	
Currituck	0	0	0	0	0	0	0	0.00	
Gates	0	0	0	0	0	0	0	0.00	
Perquimans	0	0	0	0	0	0	0	0.00	
Pasquotank Camden Currituck Gates Perquimans Total	2	0	8	-2	0	0	8	-2.16	0
Pitt	7	8	22	-4	-1	6	38	-1.28	
Greene	0	0	0	0	0	0	0	0.00	
Pitt Greene Total	7	8	22	-4	-1	6	38	-1.56	0
Vance	0	0	5	0	0	0	5	-2.36	
Warren	0	0	0	0	0	0	0	0.00	
Vance Warren Total	0	0	5	0	0	0	5	-2.37	0

ACS Attachment E
5.27.09 SHCC Meeting

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	B	C	D	E	F	G	H	I	J	K	L
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	2008 Inpatient Cases (without exclusions)	Inpatient Case Time Standard (3 Hours)	Estimated Inpatient Hours	2008 Ambulatory Cases	Ambulatory Case Time Standard (1.5 Hours)	Estimated Ambulatory Hours	Total Estimated Hours (D+G)	Growth Factor 2008-2012 (Population Change Rate)	Projected Surgical Hours: 2012	Standard Hours per OR per Year (9/260/80%)	Projected ORs Needed in 2012
Alexander	0	3.0	0	0	1.5	0	0	3.31%	0.00	1872	0.00
Alleghany	27	3.0	81	239	1.5	359	440	3.02%	452.75	1872	0.24
Anson	65	3.0	195	636	1.5	954	1,149	-0.52%	1,142.98	1872	0.61
Ashe	275	3.0	825	425	1.5	638	1,463	3.09%	1,507.67	1872	0.81
Avery	143	3.0	429	290	1.5	435	864	-0.05%	863.58	1872	0.46
Bertie	17	3.0	51	846	1.5	1,269	1,320	0.65%	1,328.55	1872	0.71
Bladen	274	3.0	822	436	1.5	654	1,476	0.25%	1,479.62	1872	0.79
Brunswick	1,078	3.0	3,234	3,993	1.5	5,990	9,224	14.42%	10,553.09	1872	5.64
Burke	1,552	3.0	4,656	6,915	1.5	10,373	15,029	4.76%	15,744.46	1872	8.41
Cabarrus	5,713	3.0	17,139	14,664	1.5	21,996	39,135	15.39%	45,158.81	1872	24.12
Caldwell	1,292	3.0	3,876	3,041	1.5	4,562	8,438	3.71%	8,750.17	1872	4.67
Carteret	1,865	3.0	5,595	3,653	1.5	5,480	11,075	1.71%	11,263.80	1872	6.02
Catawba	6,295	3.0	18,885	19,219	1.5	28,829	47,714	5.42%	50,300.35	1872	26.87
Chatham	66	3.0	198	221	1.5	332	530	10.35%	584.32	1872	0.31
Cleveland	2,533	3.0	7,599	6,050	1.5	9,075	16,674	3.46%	17,250.55	1872	9.22
Columbus	1,453	3.0	4,359	3,418	1.5	5,127	9,486	2.52%	9,724.89	1872	5.19
Cumberland	6,654	3.0	19,962	23,601	1.5	35,402	55,364	4.01%	57,583.32	1872	30.76
Dare	348	3.0	1,044	1,661	1.5	2,492	3,536	-4.37%	3,380.85	1872	1.81
Davidson	1,509	3.0	4,527	4,931	1.5	7,397	11,924	6.22%	12,664.89	1872	6.77
Davie	6	3.0	18	48	1.5	72	90	6.89%	96.20	1872	0.05
Duplin	740	3.0	2,220	1,236	1.5	1,854	4,074	3.97%	4,235.69	1872	2.26
Durham	21,718	3.0	65,154	33,192	1.5	49,788	114,942	10.79%	127,339.47	1872	68.02
Edgecombe	736	3.0	2,208	1,295	1.5	1,943	4,151	-0.65%	4,123.42	1872	2.20
Forsyth	24,697	3.0	74,091	41,206	1.5	61,809	135,900	6.73%	145,043.78	1872	77.48
Franklin	923	3.0	2,769	1,422	1.5	2,133	4,902	7.50%	5,269.62	1872	2.81
Gaston	4,055	3.0	12,165	14,233	1.5	21,350	33,515	8.82%	36,470.60	1872	19.48
Granville	545	3.0	1,635	1,951	1.5	2,927	4,562	4.06%	4,746.62	1872	2.54
Guilford	18,273	3.0	54,819	49,400	1.5	74,100	128,919	7.17%	138,156.14	1872	73.80
Harnett	1,236	3.0	3,708	2,928	1.5	4,392	8,100	12.19%	9,087.28	1872	4.85
Haywood	1,325	3.0	3,975	2,027	1.5	3,041	7,016	1.98%	7,154.16	1872	3.82
Henderson	3,199	3.0	9,597	10,109	1.5	15,164	24,761	6.82%	26,450.38	1872	14.13
Hertford	809	3.0	2,427	1,696	1.5	2,544	4,971	-0.23%	4,959.67	1872	2.65
Iredell	5,117	3.0	15,351	11,847	1.5	17,771	33,122	10.96%	36,751.63	1872	19.63
Johnston	2,191	3.0	6,573	3,885	1.5	5,828	12,401	14.87%	14,244.09	1872	7.61
Lee	891	3.0	2,673	2,577	1.5	3,866	6,539	8.33%	7,083.19	1872	3.78
Lenoir	1,933	3.0	5,799	3,077	1.5	4,616	10,415	-0.40%	10,373.05	1872	5.54
Lincoln	699	3.0	2,097	1,788	1.5	2,682	4,779	10.85%	5,297.72	1872	2.83
Macon	203	3.0	609	1,445	1.5	2,168	2,777	4.93%	2,913.50	1872	1.56
Martin	293	3.0	879	813	1.5	1,220	2,099	5.27%	2,209.10	1872	1.18
McDowell	522	3.0	1,566	1,558	1.5	2,337	3,903	7.17%	4,182.74	1872	2.23
Mecklenburg	31,949	3.0	95,847	85,914	1.5	128,871	224,718	7.77%	242,175.17	1872	129.37
Mitchell	389	3.0	1,167	790	1.5	1,185	2,352	0.62%	2,366.52	1872	1.26
Montgomery	138	3.0	414	408	1.5	612	1,026	1.75%	1,043.92	1872	0.56
Nash	2,318	3.0	6,954	7,275	1.5	10,913	17,867	5.29%	18,811.34	1872	10.05
New Hanover	9,800	3.0	29,400	29,450	1.5	44,175	73,575	5.48%	77,607.34	1872	41.46
Onslow	1,309	3.0	3,927	3,177	1.5	4,766	8,693	6.84%	9,287.35	1872	4.96
Orange	11,006	3.0	33,018	13,970	1.5	20,955	53,973	5.68%	57,040.62	1872	30.47
Pender	63	3.0	189	293	1.5	440	629	12.78%	708.79	1872	0.38
Person	699	3.0	2,097	1,744	1.5	2,616	4,713	1.09%	4,764.39	1872	2.55
Polk	282	3.0	846	1,066	1.5	1,599	2,445	0.82%	2,464.96	1872	1.32
Randolph	1,288	3.0	3,864	3,471	1.5	5,207	9,071	5.41%	9,560.94	1872	5.11
Richmond	1,128	3.0	3,384	2,092	1.5	3,138	6,522	0.86%	6,578.38	1872	3.51
Robeson	2,148	3.0	6,444	4,520	1.5	6,780	13,224	3.90%	13,739.10	1872	7.34
Rockingham	1,645	3.0	4,935	3,817	1.5	5,726	10,661	0.74%	10,739.32	1872	5.74
Rowan	2,215	3.0	6,645	6,243	1.5	9,365	16,010	6.77%	17,093.63	1872	9.13
Rutherford	1,414	3.0	4,242	2,047	1.5	3,071	7,313	4.58%	7,647.51	1872	4.09

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	Number of Inpatient Operating Rooms	Number of Ambulatory Operating Rooms	Number of Shared Operating Rooms	Excluded Dedicated C-Section Rooms	Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit	Adjustments: CONs Issued, Settlement Agreements, Previous Need	Adjusted Planning Inventory	Projected Operating Room Deficit or Surplus (Surplus shows as a "-")	Projected Need for New Operating Rooms
Alexander	0	0	2	0	0	0	2	-2.00	0
Alleghany	0	0	2	0	0	0	2	-1.76	0
Anson	0	0	2	0	0	0	2	-1.39	0
Ashe	0	0	2	0	0	0	2	-1.19	0
Avery	0	0	2	0	0	0	2	-1.54	0
Bertie	0	0	2	0	0	0	2	-1.29	0
Bladen	0	0	2	0	0	0	2	-1.21	0
Brunswick	1	0	5	-1	0	1	6	-0.36	0
Burke	1	2	9	-1	0	0	11	-2.59	0
Cabarrus	4	6	17	-2	0	0	25	-0.88	0
Caldwell	1	3	4	-1	0	0	7	-2.33	0
Carteret	1	2	5	-1	0	0	7	-0.98	0
Catawba	3	8	27	-1	0	0	37	-10.13	0
Chatham	0	0	2	0	0	0	2	-1.69	0
Cleveland	1	2	8	-1	0	0	10	-0.78	0
Columbus	1	0	4	-1	0	1	5	0.19	0
Cumberland	5	11	17	-3	0	1	31	-0.24	0
Dare	1	2	2	-1	0	0	4	-2.19	0
Davidson	1	0	9	-1	0	0	9	-2.23	0
Davie	0	0	2	0	0	0	2	-1.95	0
Duplin	0	0	3	0	0	0	3	-0.74	0
Durham	7	16	49	-2	-1	4	73	-4.98	0
Edgecombe	1	0	5	-1	0	0	5	-2.80	0
Forsyth	9	6	68	-2	-2	4	83	-5.52	0
Franklin	0	0	3	0	0	1	4	-1.19	0
Gaston	5	14	9	-4	0	0	24	-4.52	0
Granville	0	0	3	0	0	0	3	-0.46	0
Guilford	7	42	47	-1	-1	1	95	-21.20	0
Harnett	0	0	4	0	0	6	10	-5.15	0
Haywood	0	0	7	0	0	0	7	-3.18	0
Henderson	0	0	16	0	0	0	16	-1.87	0
Hertford	1	0	5	-1	0	0	5	-2.35	0
Iredell	3	3	22	-3	0	0	25	-5.37	0
Johnston	1	1	4	-1	0	3	8	-0.39	0
Lee	1	0	5	-1	0	2	7	-3.22	0
Lenoir	1	0	9	-1	0	0	9	-3.46	0
Lincoln	0	0	4	0	0	0	4	-1.17	0
Macon	1	0	4	-1	0	0	4	-2.44	0
Martin	0	0	2	0	0	0	2	-0.82	0
McDowell	1	0	3	-1	0	0	3	-0.77	0
Mecklenburg	22	41	99	-12	-1	-1	148	-18.63	0
Mitchell	0	0	3	0	0	0	3	-1.74	0
Montgomery	0	0	2	0	0	0	2	-1.44	0
Nash	1	0	13	-1	0	0	13	-2.95	0
New Hanover	5	16	20	-3	-1	4	41	0.46	0
Onslow	1	4	5	-1	0	0	9	-4.04	0
Orange	6	4	29	-3	-2	4	38	-7.53	0
Pender	0	0	2	0	0	0	2	-1.62	0
Person	1	0	4	-1	0	0	4	-1.45	0
Polk	0	0	3	0	0	0	3	-1.68	0
Randolph	1	0	5	-1	0	2	7	-1.89	0
Richmond	1	0	6	-1	0	0	6	-2.49	0
Robeson	1	0	9	0	0	0	10	-2.66	0
Rockingham	1	0	9	-1	0	0	9	-3.26	0
Rowan	2	3	8	-2	0	0	11	-1.87	0
Rutherford	0	0	5	0	0	0	5	-0.91	0

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	B	C	D	E	F	G	H	I	J	K	L
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	*2008 Inpatient Cases (without exclusions)*	*Inpatient Case Time Standard (3 Hours)*	*Estimated Inpatient Hours*	*2008 Ambulatory Cases*	*Ambulatory Case Time Standard (1.5 Hours)*	*Estimated Ambulatory Hours*	*Total Estimated Hours (D+G)*	*Growth Factor 2008-2012 (Population Change Rate)*	*Projected Surgical Hours: 2012*	*Standard Hours per OR per Year (9/260/80%)*	*Projected ORs Needed in 2012*
Sampson	780	3.0	2,340	1,684	1.5	2,526	4,866	6.24%	5,169.83	1872	2.76
Scotland	1,077	3.0	3,231	2,842	1.5	4,263	7,494	3.84%	7,781.45	1872	4.16
Stanly	629	3.0	1,887	2,349	1.5	3,524	5,411	3.68%	5,609.79	1872	3.00
Stokes	4	3.0	12	573	1.5	860	872	2.87%	896.53	1872	0.48
Surry	2,330	3.0	6,990	4,706	1.5	7,059	14,049	2.27%	14,368.10	1872	7.68
Transylvania	395	3.0	1,185	1,934	1.5	2,901	4,086	3.93%	4,246.55	1872	2.27
Union	1,514	3.0	4,542	5,796	1.5	8,694	13,236	19.80%	15,856.93	1872	8.47
Wake	21,840	3.0	65,520	60,499	1.5	90,749	156,269	16.49%	182,030.20	1872	97.24
Washington	15	3.0	45	376	1.5	564	609	-1.16%	601.93	1872	0.32
Watauga	1,420	3.0	4,260	4,165	1.5	6,248	10,508	5.11%	11,044.18	1872	5.90
Wayne	3,510	3.0	10,530	8,269	1.5	12,404	22,934	1.41%	23,256.72	1872	12.42
Wilkes	1,005	3.0	3,015	2,375	1.5	3,563	6,578	1.86%	6,699.65	1872	3.58
Wilson	1,759	3.0	5,277	3,184	1.5	4,776	10,053	5.61%	10,617.33	1872	5.67
Yadkin	1	3.0	3	297	1.5	446	449	4.10%	466.90	1872	0.25
Grand Totals	267,124		801,372	649,435		974,153	1,775,525	7.48%	1,910,312		1,020

Updated 5.4.09 - Table 6B: Projected Operating Room Need for 2012

A	M	N	O	P	Q	R	S	T	U
Operating Room Service Areas (Multi-County Groupings and Single Counties. Multi-County Groupings First, Followed by Single Counties.)	*Number of Inpatient Operating Rooms*	*Number of Ambulatory Operating Rooms*	*Number of Shared Operating Rooms*	*Excluded Dedicated C-Section Rooms*	*Exclusion of One Operating Room for each Level I and II Trauma Center and Burn Unit*	*Adjustments: CONs Issued, Settlement Agreements, Previous Need*	*Adjusted Planning Inventory*	*Projected Operating Room Deficit or Surplus (Surplus shows as a "-")*	*Projected Need for New Operating Rooms*
Sampson	0	0	8	0	0	0	8	-5.24	0
Scotland	1	0	5	-1	0	0	5	-0.84	0
Stanly	1	0	5	-1	0	0	5	-2.00	0
Stokes	0	2	2	0	0	0	4	-3.52	0
Surry	1	0	9	-1	0	0	9	-1.32	0
Transylvania	0	0	4	0	0	0	4	-1.73	0
Union	0	1	7	0	0	1	9	-0.53	0
Wake	9	16	67	-5	-1	8	94	3.24	3
Washington	0	0	2	0	0	0	2	-1.68	0
Watauga	1	0	5	-1	0	0	5	0.90	1
Wayne	1	2	10	-1	0	1	13	-0.58	0
Wilkes	1	1	4	-1	0	0	5	-1.42	0
Wilson	1	0	9	-1	0	0	9	-3.33	0
Yadkin	0	0	2	0	0	0	2	-1.75	0
Grand Totals	154	257	854	-83	-11	53	1224	-204	4

Table 7A: Open-Heart Surgery Procedures

(Procedures Utilizing Heart-Lung Bypass Machines)

Adults

Facility	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*
Cape Fear Valley Medical Center	225	243	283	317	326	327	387	388	356	448	458	432	352	301	299
Carolinas Medical Center Mercy/Pineville	357	396	388	425	283	290	272	246	231	199	134	150	104	92	62
Carolinas Medical Center/ Center for Mental Health	1068	1118	1281	1242	1280	1143	997	941	875	719	710	631	615	640	457
CMC-NorthEast	178	292	318	271	193	248	297	340	307	361	375	286	296	257	227
Craven Regional Medical Center	102	140	126	139	244	184	193	215	240	222	238	255	255	219	209
Duke University Hospital	1318	1367	1477	1490	1578	1494	1555	1565	1428	1229	995	914	947	852	829
Durham Regional Hospital	179	179	170	170	175	198	204	173	178	170	168	166	142	119	87
FirstHealth Moore Regional Hospital	233	282	269	291	294	366	340	393	355	429	316	387	319	369	406
Forsyth Memorial Hospital	661	722	769	836	763	703	792	675	688	717	609	747	598	657	634
Frye Regional Medical Center	470	621	614	598	557	359	408	315	271	281	388	374	344	224	206
Gaston Memorial Hospital					30	217	316	313	309	309	248	202	246	183	190
High Point Regional Health System	375	342	309	301	295	315	302	339	273	293	295	313	281	194	208
Memorial Mission Hospital and Asheville Surgery Center	822	983	1077	1200	1185	1186	1161	1193	1053	1064	1084	1025	1105	1067	992
Moses Cone Health System	690	852	1016	1030	1029	1005	935	894	889	829	883	849	860	578	596
New Hanover Regional Medical Center	501	587	643	694	646	709	684	689	709	794	691	476	497	529	522
North Carolina Baptist Hospital	682	637	767	726	674	677	660	564	666	625	563	521	534	511	496
Pitt County Memorial Hospital	969	1012	1069	1091	1098	1102	1208	1147	1111	1096	933	938	1042	805	865
Presbyterian Hospital	783	865	845	848	753	760	633	609	564	551	412	401	306	301	321
Rex Hospital	399	454	431	479	550	516	526	448	416	419	369	357	359	334	313
Southeastern Regional Medical Center													15	58	71
University of North Carolina Hospitals	264	276	284	291	289	304	297	282	268	246	283	361	311	265	238
WakeMed	892	974	1025	1059	1123	1048	1043	1141	1072	1040	976	1032	931	894	908
Total Procedures	11168	12342	13161	13498	13365	13151	13210	12870	12259	12041	11128	10817	10459	9449	9136

ACS Attachment F
5.27.09 SHCC Meeting

ACS Attachment F
5.27.09 SHCC Meeting

Table 7B: Heart-Lung Bypass Machine Capacity and Volume

License #	Hospital	Current Inventory	CON Issued / Pending Development	Total Planning Inventory	Backup Machines	2008 Procedures (Weighted)	Hospital Procedure Capacity (Number of Machines X 400)	Percent Utilization of Capacity	Equipment Deficit	Pending Review or Appeal	Need
H0213	Cape Fear Valley Medical Center	2	0	2	1	299	800	37.4%	0	0	0
H0042	Carolinas Medical Center Mercy/Pineville (One of the two machines in the Total Planning Inventory is to be used for backup only following completion of CON project F-7979-07.)	3	-1	2	0	62	800	7.8%	0	0	0
H0071	Carolinas Medical Center/Center for Mental Health	6	0	6	0	853	2400	35.5%	0	0	0
H0031	Carolinas Medical Center - NorthEast	2	0	2	1	227	800	28.4%	0	0	0
H0201	Craven Regional Medical Center	2	0	2	0	209	800	26.1%	0	0	0
H0015	Duke University Hospital	7	0	7	0	1061	2800	37.9%	0	0	0
H0233	Durham Regional Hospital	2	0	2	0	87	800	10.9%	0	0	0
H0100	FirstHealth Moore Regional	2	0	2	1	406	800	50.8%	0	0	0
H0209	Forsyth Memorial Hospital	3	0	3	0	634	1200	52.8%	0	0	0
H0053	Frye Regional Medical Center	2	0	2	1	206	800	25.8%	0	0	0
H0105	Gaston Memorial	2	0	2	1	190	800	23.8%	0	0	0
H0052	High Point Regional Hospital	2	0	2	0	208	800	26.0%	0	0	0
H0036	Memorial Mission Hospital	6	0	6	0	992	2400	41.3%	0	0	0
H0159	Moses Cone Hospital	4	0	4	0	596	1600	37.3%	0	0	0
H0221	New Hanover Regional Medical Center	3	0	3	0	522	1200	43.5%	0	0	0
H0011	North Carolina Baptist Hospital	4	0	4	0	634	1600	39.6%	0	0	0
H0104	Pitt County Memorial Hospital	5	0	5	0	935	2000	46.8%	0	0	0
H0010	Presbyterian Hospital	3	0	3	1	321	1200	26.8%	0	0	0
H0065	Rex Hospital	3	0	3	0	313	1200	26.1%	0	0	0
H0064	Southeastern Regional	1	0	1	1	71	400	17.8%	0	0	0
H0157	University of North Carolina Hospitals	4	0	4	0	462	1600	28.9%	0	0	0
H0199	WakeMed	5	0	5	0	908	2000	45.4%	0	0	0
	T O T A L	73	-1	72	7	10196	28800	35.4%	0	0	0

2008 procedures (weighted) equal adult procedures plus pediatric procedures X 2 for: Carolinas Medical Center/Center for Mental Health, Duke, North Carolina Baptist, Pitt County, and UNC Hospitals.

35.4% utilization based on 72 machines.

Table 7C: Burn Intensive Care Services

Days of care utilized by severely burned patients (DRGs 504-511) in the designated burn intensive care units.

Facility	Beds	2003-2004 Total Days	2004-2005 Total Days	2005-2006 Total Days	2006-2007 Total Days	2007-2008 Total Days
University of North Carolina Hospitals	21	3594	3030	4089	5074	6273
North Carolina Baptist Hospital	8	2185	2255	2358	2268	2142
TOTAL	29	5779	5285	6447	7342	8415

Facility	Beds	2003-2004 Percent Utilization	2004-2005 Percent Utilization	2005-2006 Percent Utilization	2006-2007 Percent Utilization	2007-2008 Percent Utilization
University of North Carolina Hospitals	21	46.8%	39.5%	53.3%	66.2%	81.6%
North Carolina Baptist Hospital	8	74.6%	77.2%	80.8%	77.7%	73.2%
TOTAL	29	54.4%	49.9%	60.9%	69.4%	79.5%

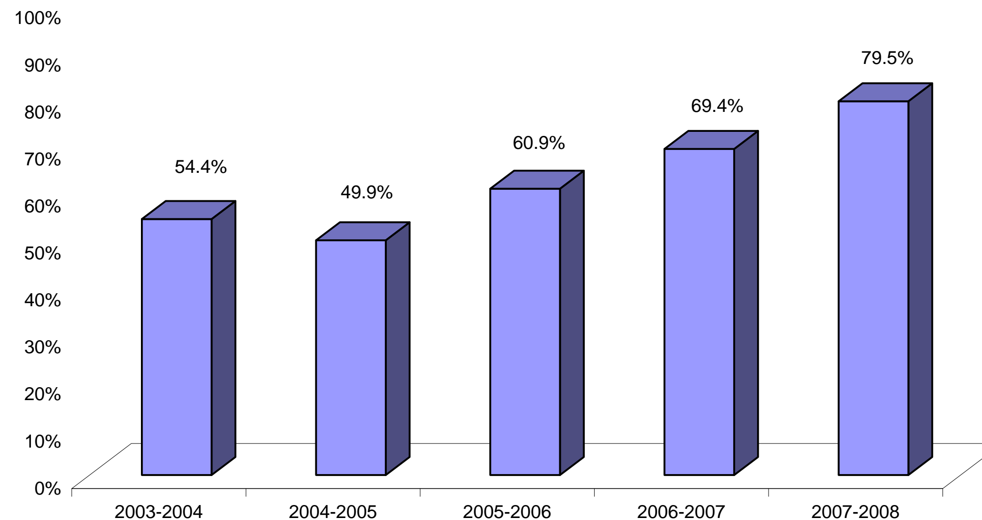


Table 7D: Bone Marrow Transplants

Allogeneic Bone Marrow Transplants	*2004-2005*	*2005-2006*	*2006-2007*	*2007-2008*
Carolinas Medical Center/Center for Mental Health	0	0	0	0
Duke University Hospital	129	167	115	139
North Carolina Baptist Hospital	24	12	11	51
Pitt County Memorial Hospital	1	0	0	0
University of North Carolina Hospitals	34	36	37	35
TOTAL	188	215	163	225

Autologous Bone Marrow Transplants	*2004-2005*	*2005-2006*	*2006-2007*	*2007-2008*
Carolinas Medical Center/Center for Mental Health	8	11	5	8
Duke University Hospital	116	98	149	104
North Carolina Baptist Hospital	52	37	35	24
Pitt County Memorial Hospital	6	0	0	0
University of North Carolina Hospitals	56	59	69	83
TOTAL	238	205	258	219

Total Bone Marrow Transplants	*2004-2005*	*2005-2006*	*2006-2007*	*2007-2008*
Carolinas Medical Center/Center for Mental Health	8	11	5	8
Duke University Hospital	245	265	264	243
North Carolina Baptist Hospital	76	49	46	75
Pitt County Memorial Hospital	7	0	0	0
University of North Carolina Hospitals	90	95	106	118
TOTAL	426	420	421	444

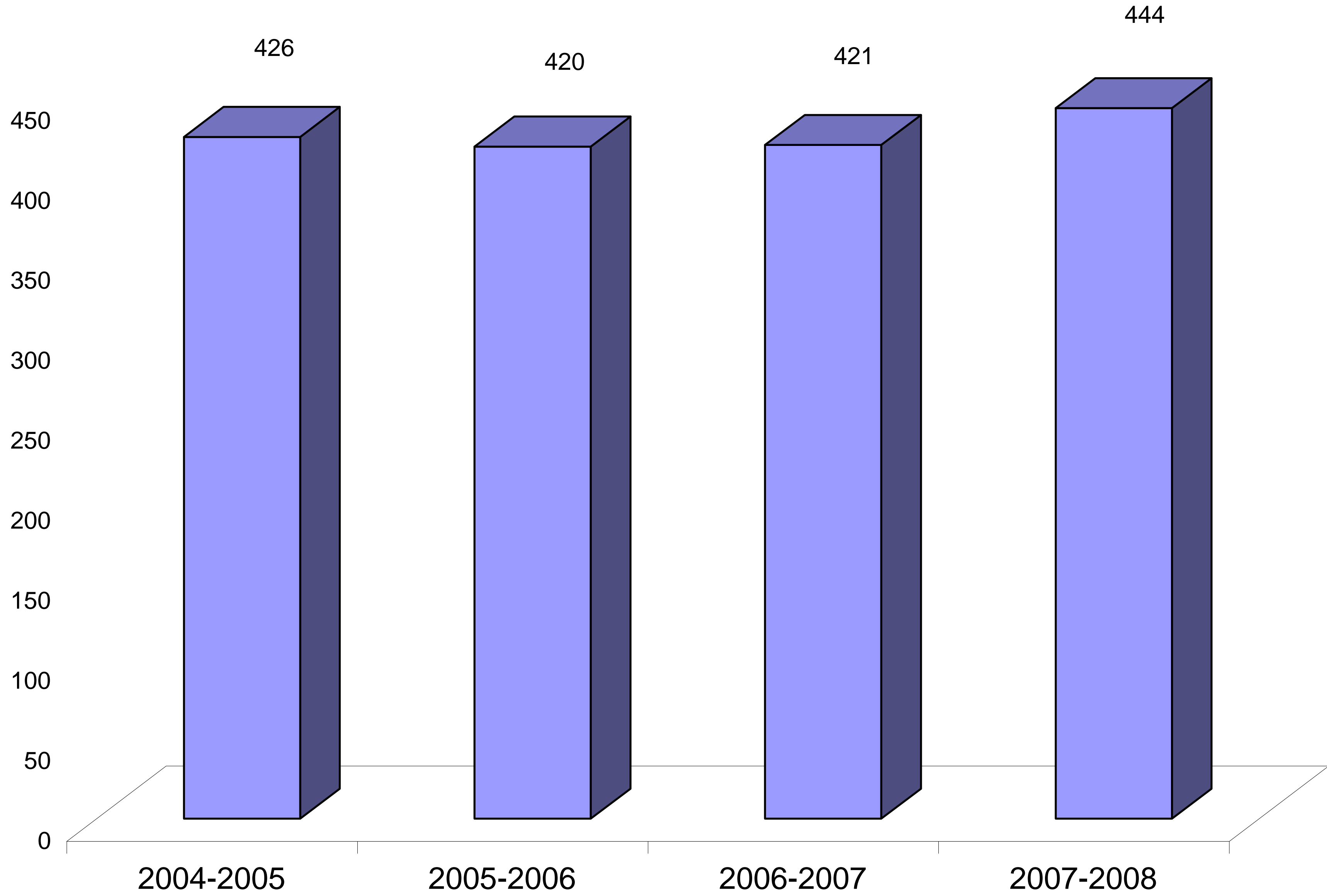
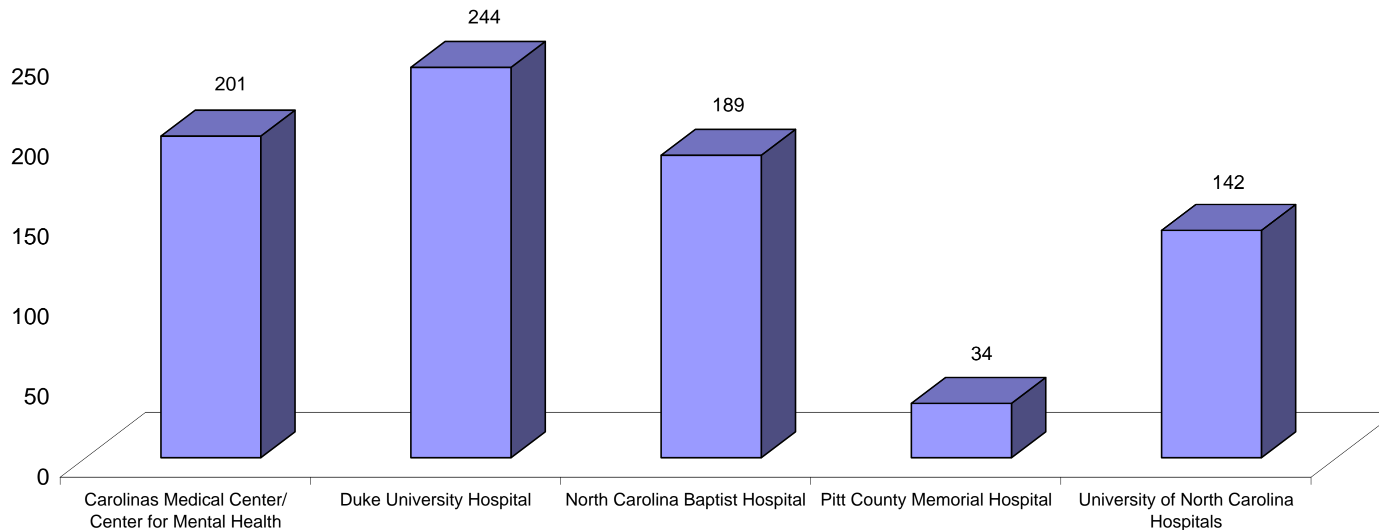

Total Bone Marrow Transplants: 2004 - 2007
426
420
421
444
450
400
350
300
250
200
150
100
50
0
2004-2005
2005-2006
2006-2007
2007-2008

Table 7E: Solid Organ Transplantation Services

	Carolinas Medical Center/ Center for Mental Health	Duke University Hospital	North Carolina Baptist Hospital	Pitt County Memorial Hospital	University of North Carolina Hospitals	Total
Heart Transplants	22	43	0	0	11	76
Heart/Lung Transplants	0	0	0	0	0	0
Kidney/Liver Transplants	3	0	0	0	0	3
Liver Transplants	55	28	0	0	41	124
Heart/Liver Transplants	0	0	0	0	0	0
Kidney Transplants	114	86	175	34	72	481
Heart/Kidney Transplants	1	1	0	0	1	3
Lung Transplants	0	67	0	0	13	80
Pancreas Transplants	6	1	3	0	1	11
Pancreas/Kidney Transplants	0	17	11	0	3	31
Pancreas/Liver Transplants	0	0	0	0	0	0
Liver/Lung	0	1	0	0	0	1
Totals	201	244	189	34	142	810



ACS Attachment H
5.27.09 SHCC Meeting

Table 8A: Inventory and Utilization of Inpatient Rehabilitation Beds

ACS Attachment I
5.27.09 SHCC Meeting

		Inventory				Days of Care		Average Annual Utilization Rate		
HSA	Facility	Current	CON Issued / Pending Development	Pending Review or Appeal	Total Planning Inventory	2006-2007	2007-2008	2007	2008	Beds Needed
I	Catawba Valley Medical Center	20	0	0	20	1,526	1,644	20.9%	22.5%	
I	Care Partners Rehabilitation Hospital	80	0	0	80	16,980	17,001	58.2%	58.1%	
I	Frye Regional Medical Center	29	0	0	29	2,769	2,276	26.2%	21.4%	
I Total		**129**	**0**	**0**	**129**	**21,275**	**20,921**	**45.2%**	**44.3%**	**0**
II	High Point Regional	16	0	0	16	4,005	4,481	68.6%	76.5%	
II	Hugh Chatham Memorial Hospital	12	0	0	12	2,154	1,987	49.2%	45.2%	
II	North Carolina Baptist Hospital	39	0	0	39	6,724	6,038	47.2%	42.3%	
II	Whitaker Rehabilitation Center	68	0	0	68	13,408	12,652	54.0%	50.8%	
II	Moses Cone Memorial Hospital	49	0	0	49	8,333	8,300	46.6%	46.3%	
II Total		**184**	**0**	**0**	**184**	**34,624**	**33,458**	**51.6%**	**49.7%**	**0**
III	Rowan Regional Medical Center	10	0	0	10	2,665	2,058	73.0%	56.2%	
III	Stanly Regional Medical Center	10	0	0	10	743	778	20.4%	21.3%	
III	Carolinas Rehabilitation Hospital	119	0	0	119	40,315	32,113	64.2%*	73.7%	
III	CMC-Levine Children's Hospital	13	0	0	13	0	2,127	0.0%	44.7%	
III	Carolinas Rehabilitation Hospital Mount Holly	40	0	0	40	0	8,489	0.0%	58.0%	
III	2009 Adjusted Need Determination (see row below for note from 2009 SMFP)	0	10	0	10	0	0	0.0%	0.0%	
Ten inpatient rehabilitation beds to be awarded to an existing acute care hospital in Rowan County, as a result of the removal of the inpatient rehabilitation facility beds from a unit at a Rowan County hospital in 2008. To avoid any confusion over the status of inpatient rehabilitation facility beds in Rowan County, I have concluded that any successful applicant for a CON to develop these ten beds shall be required as a condition of its approval to withdraw any other pending application or litigation concerning the right to develop or offer such beds in Rowan County.										
III Total		**192**	**10**	**0**	**202**	**43,723**	**45,565**	**62.4%**	**61.6%**	**0**
IV	Durham Regional Hospital	30	0	0	30	6,758	6,382	61.7%	58.1%	
IV	University of North Carolina Hospitals	30	0	0	30	9,084	9,046	83.0%	82.4%	
IV	WakeMed	78	6	0	84	24,006	27,728	78.3%	90.2%	
IV	Maria Parham Hospital	11	0	0	11	2,588	2,612	64.5%	64.9%	
IV Total		**149**	**6**	**0**	**155**	**42,436**	**45,768**	**75.0%**	**80.7%**	**0**
V	FirstHealth Moore Regional Hospital	25	0	0	25	5,929	5,870	65.0%	64.2%	
V	New Hanover Regional Medical Center	60	0	0	60	10,904	10,557	49.8%	48.1%	
V	Scotland Memorial Hospital	7	0	0	7	1,322	1,323	51.7%	51.6%	
V	Southeastern Regional Rehabilitation Center	78	0	0	78	18,813	19,696	66.1%	69.0%	
V Total		**170**	**0**	**0**	**170**	**36,968**	**37,446**	**59.6%**	**60.2%**	**0**
VI	Nash General Hospital	23	0	0	23	7,140	6,915	85.1%	82.1%	
VI	Lenoir Memorial Hospital	17	0	0	17	2,554	2,187	41.2%	35.1%	
VI	Heritage Hospital	16	0	0	16	3,112	3,276	53.3%	55.9%	
VI	Pitt Hospital Regional Rehabilitation Center	75	0	0	75	16,657	17,560	60.8%	64.0%	
VI	Craven Regional Medical Center	20	0	0	20	3,393	3,342	46.5%	45.7%	
VI Total		**151**	**0**	**0**	**151**	**32,856**	**33,280**	**59.6%**	**60.2%**	**0**
Grand Total		**975**	**16**	**0**	**991**	**211,882**	**216,438**	**59.2%**	**59.7%**	**0**

* Utilization rate based on 172 beds in service at Hospital for reporting period. Hospital transferred 30 beds 10.17.07 and 10 beds 1.8.08 to Carolinas Rehabilitation Hospital Mount Holly and 13 beds 1.27.07 to Levine Children's Hospital.

Petition Title: Requirement for Licensure Renewal Applications for Health Care Facilities to be Reviewed and Approved by Licensed Certified Public Accountants or Certified Prior to Submission to the Division of Health Service Regulation

Petitioner: Affordable Health Care Facilities, LLC
944 19th Avenue NW
Hickory, North Carolina 28601
(828) 310-9333
bob@medcapllc.com

Request: The request is to have CPAs review and approve all Licensure Renewal Applications ("LRAs")submitted by licensed facilities.

Adverse Effects: None.

Duplication: Not applicable.

QAV: The petition improves the accuracy of LRA data upon which the SMFP and CON analysis are based.

Petition
State Health Coordinating Council ("SHCC")

Requirement for Licensure Renewal Applications for Health Care Facilities to be Reviewed and Approved by Licensed Certified Public Accountants or Certified Prior to Submission to the Division of Health Service Regulation

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

Premise

Each year every licensed health care facility in North Carolina is required to complete a Licensure Renewal Application ("LRA"). The LRA process is one of voluntary reporting. The completed LRAs and then are used as basis to (i) develop the State Medical Facilities Plan ("SMFP") and (ii) determine need for additional facilities or health care services. Affordable Health Care Facilities, LLC ("AHCF") has observed that many LRAs are completed inadequately or incorrectly, which causes AHCF to question the accurateness of the SMFP and the facility need assumptions and methodology contained in the SMFP.

Petition

AHCF petitions the SHCC, DHHS, and DHSR to require LRAs to be reviewed and approved by Licensed Certified Public Accountants ("CPAs") or certified in the same manner as Medicare Cost Reports prior to submission to the DHSR each year.

Examples of inaccurate LRAs can be provided upon request.

Acute Care Services Committee
April 8, 2009

Agency Report

Petition: Affordable Health Care Facilities, LLC
2010 Proposed State Medical Facilities Plan

Petitioner:

Affordable Health Care Facilities, LLC
944 19th Avenue NW
Hickory, North Carolina 28601
(828) 310-9333
bob@medcapllc.com

Request:

The petitioner requests that the State Health Coordinating Council (SHCC), North Carolina Department of Health and Human Services and the North Carolina Division of Health Service Regulation (DHSR) require that prior to submission to DHSR, License Renewal Applications be reviewed and approved by Licensed Certified Public Accountants or be certified in the same way as Medicare Cost Reports are certified.

Background Information:

Chapter 2 of the Plan allows petitioners early each calendar year to recommend changes that may have a statewide effect. According to the Plan, "Changes with the potential for a statewide effect are the addition, deletion, and revision of policies and revision of the projection methodologies." The petitioner is not requesting changing a State Medical Facilities Plan policy nor is the petitioner requesting changing a methodology.

Analysis/Implications:

It is the Agency's view that the content, structure and signature requirements for the License Renewal Applications are within the purview of the Division of Health Service Regulation and not within the purview of the State Health Coordinating Council.

Agency Recommendation:

In consideration of the above, the Agency recommends denial of the petition by the SHCC, and forwarding the suggestion to the Division of Health Service Regulation Director.