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MFPB

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Chairman, North Carolina State Health Coordinating Council
c/o Medical Facilities Planning Branch
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

August 15, 2014

Re: Comments Opposing the Petition Submitted by Blue Ridge Bone & Joint Clinic for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility Demonstration Project in the Buncombe-Madison-Yancey Operating Room Service Area in the *2015 State Medical Facilities Plan*

Dear Dr. Ullrich:

Mission Health System (Mission) appreciates an opportunity to comment on the Petition submitted by Blue Ridge Bone & Joint Clinic (BRBJ) for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility Demonstration Project in the Buncombe-Madison-Yancey Operating Room Service Area in the *2015 State Medical Facilities Plan* (*2015 SMFP*) (BRBJ 2014 Petition).

Mission does not support the changes proposed by BRBJ. The reasons for our position are enumerated below.

A. SMFP Single Specialty Ambulatory Surgery Demonstration Project

Beginning in the fall of 2008, the SHCC's Single Specialty Ambulatory Surgery work group met and drafted recommendations for a Demonstration Project "to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina."

The SHCC approved plans for the Demonstration Project on May 27, 2009, which included three ambulatory specialty sites. The *2010 SMFP* outlined criteria for the three Demonstration Project facilities. On page 85 of the 2010 SMFP, the following Criterion was defined for the Demonstration Project facilities, with emphasis added:

> "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 SHCC to consider allowing

expansion of the single specialty ambulatory surgical facilities beyond the three demonstration sites."

Consistent with the terms of the criteria outlined in the *2010 SMFP*, three certificates of need were awarded. All three Single Specialty Ambulatory Surgery Center Demonstration Projects are now licensed and operational. They are:

1. Piedmont Outpatient Surgery Center, LLC, which has been operational for two years;
2. Triangle Orthopaedics Surgery Center, which has been operational for one year; and
3. University Surgery Center, LLC, which has been operational less than six months.

To date, none of the three projects have been operational for the five years; therefore, none have met the five year Criterion. Only one Single Specialty Ambulatory Surgery Center Demonstration Project has been found to be in substantial compliance with the Demonstration Project criteria outlined in the *SMFP* and the Certificate of Need for its first year of operation.

B. All Petitions Submitted by BRBJ have been Denied by the SHCC based on Sound Reasoning

In 2009, BRBJ petitioned the SHCC to add Buncombe County as a site to the Single Specialty Ambulatory Surgery Facility Demonstration Project. In 2010, 2011, 2012, and 2013, respectively, BRJB submitted a petition to approve a demonstration project for a single specialty, two operating room ambulatory surgery facility in the Buncombe-Madison-Yancey Operating Room Service Area.

The SHCC denied all five petitions from BRJB, basing its denial upon the following principles:

1. Limit the Demonstration Project to three sites initially
2. Evaluate each facility after each facility has been in operation for five years
3. Consider expanding the number of facilities beyond the original three demonstration sites only if the Agency determines that the facilities are meeting or exceeding all criteria.

It is clear that the SHCC must wait until all three Demonstration Project facilities are operational for five years, and each found to have demonstrated substantial compliance with the Demonstration Project criteria outlined in the *SMFP* and the Certificate of Need before it considers expansion of the number of facilities beyond the original three.

Further, in the Agency Recommendation to deny BRBJ's 2011 Petition, the Agency wisely stated that:

> [...] no conclusions have been drawn, 'positive' or 'negative,' about the impact of [the three demonstration project] facilities. Indeed, the purpose of the demonstration project is to test that hypothesis. The Agency also wishes to

> clarify that the three demonstration project sites were authorized in the *2010 SMFP* and **no additional** demonstration sites were authorized in the *2011 SMFP*. As noted above, the underlying concept of the demonstration project was to '...evaluate each facility **after each facility has been in operation for five years** [...].' [**Emphasis** in the original].

The Agency added:

> [...] 'the opportunity for competition' by itself is not a goal of the *SMFP* and that the anticipated '**positive impact** on quality, cost and access' [of the three demonstration project facilities], **has not yet been affirmed**. [**Emphasis** added.]

Accordingly, Mission respectfully requests that the SHCC act consistently with the Agency's well-reasoned precedent to deny the BRBJ 2014 Petition.

C. Physician Ownership of an Existing Orthopaedic Ambulatory Surgery Center in Buncombe County

Peter G. Mangone, MD presented the 2014 BRBJ Petition at the Asheville public hearing for the *Proposed 2015 SMFP* conducted on July 15, 2014. Dr. Mangone is an orthopedic surgeon in practice with BRBJ. In his presentation, **Dr. Mangone verbally disclosed that he is a part owner of the Orthopaedic Surgery Center of Asheville, LP**, a fact not heretofore disclosed in any of the BRBJ Petitions filed annually since 2009, a fact not disclosed in the 2014 BRBJ Petition, and a fact not disclosed in the written comments submitted by Dr. Mangone in support of the 2014 BRBJ Petition.

It also is noteworthy that Dr. Mangone did not disclose his ownership in Orthopaedic Surgery Center of Asheville, LP during his presentation on January 21, 2014 to the General Assembly Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health. In that presentation, Dr. Mangone stated that:

> [...] the current CON laws are inherently unfair, restrict competition[,] and in doing so, decrease patient choice and increase health care costs. **In light of this fundamental unfairness, I request that you recommend to your colleagues [to] revise the existing laws to level the playing field and allow for physician ownership of ambulatory surgery centers. [Emphasis added.]**[1]

Dr. Mangone made the same statement in his written comments submitted in support of the 2014 BRBJ Petition. The 2014 BRBJ Petition also contains that statement.

[1] A copy of Dr. Mangone's January 21, 2014 presentation is attached as Exhibit 1.

According to a letter dated June 27, 2014 from Waller Landsden Dortch & Davis, LLP to the DHSR Certificate of Need Section, 46% of the Orthopaedic Surgery Center of Asheville, LP is owned by individual physicians.[2] Dr. Mangone is one of the individual physicians who own 46% of Orthopaedic Surgery Center of Asheville, LP. Efforts to determine the identities of each individual physician owner and percentage ownership using publicly available sources have been unsuccessful.

According to its 2014 Ambulatory Surgery Center License Renewal Application, the Orthopaedic Surgery Center of Asheville has a medical staff of 31 with three licensed operating rooms in Asheville. In FY 2013, the Orthopaedic Surgery Center of Asheville performed 3,160 ambulatory surgical cases, 2,904 of which were orthopedic cases and 256 were podiatry cases, in its three licensed operating rooms.

The following table calculates the available capacity at the Orthopaedic Surgery Center of Asheville based on *SMFP* planning threshold of 1,872 hours per operating room per year which represents 80% of total capacity: 2,340 total hours per operating room per year. With three operating rooms, surgically capacity of the Orthopaedic Surgery Center of Asheville equals 7,020 hours using *SMFP* definitions.

Orthopaedic Surgery Center of Asheville
Operating Room Capacity: FY 2013

October-September	FY 2013
Total Ambulatory Surgical Cases	3,601
Total Estimated Hours per Ambulatory Surgical Case	1.5
Total Estimated Hours	5,402
SMFP Operating Room Capacity: Hours per Operating Room per Year	2,340
OSCA Total Capacity – Hours per Room x 3 ORs	7,020
Utilization of Total Capacity	**77%**
SMFP Planning Threshold: Hours per Operating Room per Year	1,872
Operating Rooms Needed per Year	2.89

Source: SMFP; LRAs

As reflected in the previous table, current utilization of the three existing orthopedic specialty operating rooms in Buncombe County is less than 80%.

It would appear from the previous table that concerns of Dr. Mangone and BRBJ about "fundamental unfairness," an "[un]level playing field," and need for revision of the CON Law "to

[2] A copy of the June 27, 2014 Waller Landsden Dortch & Davis, LLP letter is attached as Exhibit 2.

allow for physician ownership of ambulatory surgery centers" are unwarranted. The existing orthopedic surgical center in Asheville, partially owned by Dr. Mangone, is not fully utilized.

Mission respectfully requests that the SHCC fully appreciate the existence of a robust physician-owned orthopedic ambulatory surgery center with available surgical capacity in the Buncombe-Madison-Yancey Operating Room Service Area and deny the BRBJ 2014 Petition.

D. Operating Room Surplus in Buncombe-Madison-Yancey Service Area

The Instructions for Writing Petitions for Adjustments to Need Determination states:

> [a]t minimum, each written petition requesting an adjustment to a need determination in the [*Proposed 2015 SMFP*] should contain:
>
> [...]
>
> 4. Evidence that health service development permitted by the proposed adjustment would not result in unnecessary duplication of health resources in the area.

In the Agency Recommendation to deny the BRBJ 2013 Petition, the Agency stated:

> The Agency urges caution in allowing additional operating rooms for a service area with a projected surplus before demonstration project data regarding impact of the model can be received and evaluated.

At the time of the September 2013 Agency Recommendation, Table 6B of the *Proposed 2014 SMFP* projected a **surplus of 3.16** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2015.

Table 6B of the *Proposed 2015 SMFP* projects a **surplus of 3.72** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2016.

The **projected surplus** of operating rooms has **increased 118%** (3.72/3.16) in one year.

The existence of a surplus of operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area is evidence that the development of the proposed demonstration project for a single specialty, two operating room, ambulatory surgical facility would be an unnecessary duplication of services in the Buncombe-Madison-Yancey Operating Room Service Area.

The **documented existing and projected operating room surplus** in the Buncombe-Madison-Yancey Operating Room Service Area also supports BRBJ's conclusion that there is a "projected oversupply of operating rooms."

Mission respectfully requests that the SHCC heed the Agency's caution with respect to surplus operating rooms in its September 2013 Agency Recommendation to deny the BRBJ 2013 Petition, and deny the BRBJ 2014 Petition.

E. Existing Operating Room Inventory in Buncombe-Madison-Yancey Service Area is Adequate and Proportional

BRBJ claims that there is an "inordinately large percentage of [inpatient operating rooms] and shared [operating rooms]" in Buncombe County. The following table shows a comparison of operating room inventory by type as a percentage of total licensed and approved operating rooms in Buncombe, Mecklenburg, and Wake counties, respectively.

Comparison of Inventory by Type
as Percentage of Total Licensed and Approved Operating Rooms: FY 2013

County	Inpatient Operating Rooms as % of Total Operating Rooms	Ambulatory Operating Rooms as % of Total Operating Rooms	Shared Operating Rooms as % of Total Operating Rooms
Buncombe	15.1%	28.3%	56.6%
Mecklenburg	14.6%	24.6%	60.8%
Wake	14.3%	26.8%	58.9%
Three County Combined	14.6%	25.9%	59.5%

Source: Exhibit 3
Note: Total Inventory as per *Proposed 2015 SMFP*, Table 6A (includes CON Adjustments, Demonstration Project ORs) with no exclusions

The previous table documents that the Buncombe percentage of licensed and approved ambulatory operating rooms as a percentage of total operating rooms exceeds both the percentage in Mecklenburg and Wake Counties. Buncombe also has a lower percentage of licensed and approved shared operating rooms as a percentage of total operating rooms than the other two counties.

The Petition submitted by Blue Ridge Bone and Joint also implies that few ambulatory surgical procedures are performed in shared operating rooms. Mission has 47 licensed operating rooms as reflected on its 2014 Licensure Renewal Application; 30 of the 47 operating rooms are shared operating rooms providing both inpatient and outpatient surgical procedures and 9 of the 47 are dedicated ambulatory operating rooms. Over 35% of total surgical time utilized in 28 of the 30 shared operating rooms[3], or the equivalent of around 10 operating rooms, is utilized for ambulatory patients. Mission takes issue with BRBJ's characterization because it is factually incorrect, incomplete, and misleading.

[3] 30 total shared ORs – 2 Vascular OR. Percentage calculation included in Exhibit 3

Utilization of surgical services, both ambulatory operating rooms and shared operating rooms at Mission show additional capacity available as reflected in the following table.

Mission Hospital – Utilization of Licensed Operating Rooms

	Number of Operating Rooms	Utilization
Total All Operating Rooms	47	64.7%
Total Operating Rooms Less Dedicated Open Heart (6), C-Section (2) and Vascular (2) Operating Rooms	37	70.3%
Dedicated Ambulatory Only	9	64.8%
Shared ORs Only (30 Shared – 2 Vascular ORs)	28	72.0%

Source: 2014 Mission LRA; Exhibit 3

Note: Vascular ORs are shared ORs dedicated for vascular procedures both inpatient and outpatient

As shown in the previous table, utilization of the 37 operating rooms available for outpatient surgical patients is only 70.3%. The available surgical hours in the nine dedicated ambulatory surgical operating rooms are utilized at only 64.8%. Additional capacity is available in both the dedicated and shared operating rooms at Mission as illustrated in the above table. Since January 2014 Mission physician leadership has been working with local surgeons to encourage practices to examine all facets of the surgical process to increase OR availability in an effort to make even more time available to local patients and surgeons.

In its Petition, BRBJ referenced a letter from Mission physician leadership, as support for its Petition. However, the references utilized by BRBJ are taken completely out of context and specifically do not reference a lack of capacity. Instead, that letter focused on support to improve OR efficiency. As illustrated above, Mission has additional capacity to meet the needs of the Service Area, both in our shared and dedicated ambulatory operating rooms.

BRBJ "would redirect the SHCC to the assertions made by the local hospital [...] regarding delays [of scheduled elective cases] in the January 2014 communication we received."

> It is generally agreed that (the hospital) lacks sufficient OR availability for urgent, emergent and first come / first served (FCFS) cases, and OR schedules routinely run into the evening.

BRBJ chose not to share the entirety of the "January 2014 communication [it] received."

This correspondence was not from "the hospital", rather it was a request for assistance and better stewardship to all surgeons by the Executive Procedural Administrative Committee, a physician-led and staffed committee, which includes seven key leaders of the medical staff. This communication was intended to encourage surgeons to examine all facets of the operative process in order to increase OR efficiency including, "patient assessment, scheduling, transport, anesthesia and surgeon utilization of block time".

Since the initiation of this physician-led effort, overall utilization in the ORs has increased from 57% in the month of January 2014 to an average of approximately 59% from February through July 2014 thereby modestly improving overall operating room utilization but also highlighting the ongoing need for increased efficiencies.

It should also be noted, that the Mission Ambulatory Surgery Center currently operates at 64.8% of capacity as reflected above and has ample time available for additional orthopedic ambulatory surgery cases

Mission respectfully requests that the SHCC look closely at all of the facts and analysis, and deny the BRBJ 2014 Petition.

F. Comparison of Ambulatory Surgical Payor Mix: Orthopaedic Surgery Center of Asheville and Mission Hospital

In its evaluation of the performance of each Demonstration Project facility, each facility is to provide to the Agency the number of and payor source of the patients it served. Using that data, the Agency must verify that the facility's total revenue attributed to self-pay and Medicaid was at least 7%.

Mission believes that it is valuable for the SHCC to review the ambulatory surgical payor mix of the existing physician-owned orthopedic ambulatory surgery center in Buncombe County with the ambulatory surgical payor mix of Mission.

The following table shows the FY 2013 payor mix for patients of the Orthopaedic Surgery Center of Asheville, based on information reported by the facility in its 2014 Ambulatory Surgery Center License Renewal Application.

Orthopaedic Surgery Center of Asheville
Ambulatory Surgical Case Payor Mix: FY 2013

Primary Payor Source	Number of Cases	Percentage of Cases
Self Pay/Indigent/Charity	**7**	**0.2%**
Medicare & Medicare Managed Care	1,203	37.0%
Medicaid	**198**	**6.1%**
Commercial Insurance	1075	33.1%
Managed Care	433	13.3%
Other – Workers Comp/Federal	334	10.3%
Total	3,250	100.0%

Source: 2014 ASC LRA, page 7 (Reimbursement Source)
Note: The number of cases reported by payor is less than the number of cases reported on page 6. No explanation is provided for the difference.

The previous table documents that **only 6.3%** of the total ambulatory surgical **cases** performed at the Orthopaedic Surgery Center of Asheville are performed on patients whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid.** It is not possible to verify facility's **total revenue** attributed to self-pay and Medicaid was at least 7%.

For comparison purposes, the following table shows the FY 2013 payor mix for ambulatory surgical patients of Mission Hospital, based on information reported by the facility in its 2014 Hospital License Renewal Application.

Mission Hospital
Ambulatory Surgical Case Payor Mix: FY 2013

Primary Payor Source	Number of Cases	Percentage of Cases
Self Pay/Indigent/Charity	**515**	**2.5%**
Medicare & Medicare Managed Care	7,585	36.6%
Medicaid	**2,835**	**13.7%**
Commercial Insurance	201	1.0%
Managed Care	8,865	42.7%
Other (Worker's Comp, Champus, other governmental agencies)	748	3.6%
Total	20,749	100.0%

Source: 2014 Hospital LRA, page 7 (Reimbursement Source)
Note: Asheville Surgery Center (9 dedicated ambulatory surgery operating rooms) is included by Mission Hospital in its cumulative ambulatory surgery volume, patient origin, and payor mix reported on its 2014 Hospital LRA

The previous table documents that **16.1%** of the total ambulatory surgical **cases** performed at Mission are on persons whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid**. Therefore, Mission's Self Pay/Indigent/Charity and Medicaid payor mix **exceeds** that of the Orthopaedic Surgery Center of Asheville by **256%** (16.1%/6.3%).

The most recent payor mix data substantiates that the ambulatory surgical needs of **Self Pay/Indigent/Charity and Medicaid** patients in the Buncombe-Madison-Yancey Operating Room Service Area are better met by Mission than the physician-owned orthopedic ambulatory surgical center in Buncombe County.

Further, the BRBJ Petition does not discuss how a "demonstration specialty ambulatory surgery" in Buncombe County would impact payor mix at the existing specialty Orthopaedic Surgery Center of Asheville. As discussed above, 46% of Orthopaedic Surgery Center of Asheville is owned by physicians, including physicians at BRBJ, the presenter of this Petition. Dr. Mangone also discussed his commitment to serving all patients at the summer public hearings. However, no discussion or commitment was made that Medicaid and non-paying patient levels at the existing specialty orthopedic surgery center would not decrease as a result

of the proposed "demonstration" project to meet the payor mix, nor was there any explanation whatsoever as to why those needs were not being met by the existing physician-owned ambulatory surgery center .

It is also worth noting that in its Petition, BRBJ asserts that the demonstration project will promote access to surgical services for economically disadvantaged patients based upon the BRBJ's physicians' past history of treating government payor or charity care patients. BRBJ touts that nearly 55% of the patients at its physician practice have been government payor or charity care patients in the past. This statistic about the patients served by the physician practice does not establish that the development of the desired demonstration project will actually increase access to surgical services for economically disadvantaged patients.

The composition of patients served by a physician practice is, by its nature, different from the composition of patients who would be seen by an ambulatory surgical facility. The payor mix of a physician practice includes all patients seen by the practice. In comparison, the BRBJ physicians cannot perform procedures on every patient they treat at an ambulatory surgical facility due to the nature and limitations of any ambulatory surgical facility. Some patients have comorbidities and other medical conditions which require that any surgery performed on them be done in a hospital setting. Additionally, ambulatory surgical facilities do not have emergency departments and are not required to meet the same obligations with respect to treating patients presenting with emergency medical conditions that apply to hospitals. Accordingly, the physicians of a practice may be referred and may treat patients in a hospital setting whom they would not see in an ambulatory surgical setting.

Further, even if a statistic about the patients served by the physician practice could be equated with the payor mix of an ambulatory surgical facility, BRBJ does not provide what percentage of those patients are Medicare, Medicaid, and charity care patients but instead lumps the three together. Because of the nature of the Medicare program and of orthopedic issues, it is not unusual for Medicare to be the payor for a large percentage of an orthopedic physician practice's patients. Moreover, as the SHCC well knows, patients covered by Medicare can have a broad spectrum of economic resources and are not, as a group, economically disadvantaged patients.

In addition, BRBJ refers to the number of hospital Medicaid cases in the Buncombe County service area to support its argument but does not provide any data on the number of cases of charity care or uninsured patients or even the number of charity care or uninsured patients BRBJ treats. Medicaid patients, charity care patients, and uninsured patients are all different types of patients. Along with failing to provide the number of charity care patients it has treated or reasonably expects to treat at the desired demonstration project, BRBJ also has provided no information about how patients qualify for its charity care program, the level of discounts provided to such patients, and the actual number in real dollars of charity care it provides or proposes to provide. BRBJ has likewise provided no quantitative data with respect to uninsured patients, who may or may not fall within the category of charity care patients.

G. Physician Ownership of Asheville Surgery Center

Asheville Surgery Center (ASC) is a hospital based surgery center, located separately from the Mission campus. ASC has 9 dedicated ambulatory surgery operating rooms and 2 procedure rooms. In FY 2013, Asheville Surgery Center operated at less than 65% of its capacity; a total of 9,103 ambulatory surgical cases were performed in nine operating rooms[4]. That surgical volume is reported on Mission's 2014 Hospital LRA.

However, ASC has a unique design and is a joint venture between Mission Hospital and Asheville Surgeons. While licensed as part of Mission, the facility is separately located on the Mission campus in a building owned by local surgeons. Surgeons – including members of BRBJ and partners of Dr. Mangone – own the building, utilize the surgical facility and are actively involved in the governance of the surgery center. Using a performance-based management model, improvements made in the last year alone include.

- New Surgery and Block Scheduling Policies which became effective February 1, 2014
- Monitoring of utilization criteria which became effective February 1, 2014
- Blocks less than 4 hours or greater than 12 hours were reviewed and reallocated, adjusted or continued, based on discussion with the holding physician or group
- Blocks below a utilization of 40% were reviewed and reallocated, adjusted or continued, based on discussion with the holding physician or group
- Blocks below a utilization of 60% were reviewed and discussed with the holding physician or group
- Blocks below a utilization of 60% at the end of July, 2014 are being adjusted, based on discussion with the holding physician or group
- Staggered start times for morning blocks and first case criteria for first come-first serve will became effective February 1, 2014
- Advance and Automatic Release Times and Criteria became effective February 1, 2014
- The policy Physician Collaboration and Adherence to Policy became effective April 1, 2014
- Urgent Classifications became effective April 1, 2014
- City Call Room and Urgent Room(s) are being addressed when first come-first serve availability on the Mission Campus is evaluated and documented to be appropriate, with a target of July 1, 2014

Again, it would appear that concerns of Dr. Mangone and BRBJ about "fundamental unfairness," an "[un]level playing field," and the need for revision of the CON Law "to allow for physician ownership of ambulatory surgery centers" are unwarranted.

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[4] ASC capacity = 2,340 surgical hours per OR = 9 x 2340 =21,060 surgical hours. Total ASC outpatient surgical cases = 9,103 x 1.5 hrs per case = 13,655 total surgical hours in FFY2013. Utilization = 13,655 / 21,060 = 64.8% of total capacity at ASC.

H. Theoretical Cost Savings to Medicaid from Single Specialty Ambulatory Surgery Center Demonstration Projects are Simplistic and Overstated

Much is made in the BRBJ 2014 Petition about the potential cost savings to Medicaid. Specifically, BRBJ contends that adding ambulatory surgery centers will result in saving 70 to 150 million dollars. The data provided on pages 9 and 10 of the BRBJ 2014 Petition are simplistic and fail to address several key issues.

First, BRBJ does not provide any data, details, or information regarding potential savings associated solely to orthopedic cases, ENT cases, or any specialty cases, just total outpatient cases.

Second, Medicaid has a process which defines outpatient surgery by category:

- those which are appropriate to be performed in an ambulatory surgery center; and
- those which are not appropriate to be performed in an ambulatory surgery center, that must be performed in a hospital outpatient setting.

The BRBJ 2014 Petition does not subset the outpatient surgical data (presented on page 10) to compare only cases which by definition can be performed in an ambulatory surgery center, but includes all Medicaid patients, including those with co-morbidities at higher risk and higher costs. If it wishes to, North Carolina Division of Medicaid Services can expand the list of surgical procedures approved for ambulatory surgery centers; such change can occur independently of and does not necessitate the SHHC's approval of additional single specialty ambulatory surgery center demonstration projects.

Third, the data (presented on page 10) does not address the fact that many Medicaid patients have co-morbidities and disabilities, and does not remove from the data those higher risk patients receiving ambulatory surgical services at hospitals. Health disparities for many diseases are large and long-standing in North Carolina and throughout the nation. For example, a study published in the July/August 2010 issue of the North Carolina Medical Journal examined medical care costs for diabetes and documented that the diabetes prevalence among adult Medicaid enrollees was 15.7% compared with 9.1% for all North Carolina adults.[5]

The development of additional specialty ambulatory surgery centers in North Carolina will not address the needs of the population at highest risk and with high costs.

[5] http://www.ncmedicaljournal.com/archives/?medical-care-costs-for-diabetes-associated-with-health-disparities-among-adult-medicaid-enrollees-in-north-carolina

I. Theoretical Cost Savings from Single Specialty Ambulatory Surgery Center Demonstration Projects will be Irrelevant as Payors Move to Site-neutral Payments

Much is made in the BRBJ 2014 Petition about cost-effectiveness of ambulatory surgery centers. The BRBJ 2014 Petition outlines "three scenarios for projected cumulative costs for Medicaid and the State Health Plan related to ambulatory surgery." Each scenario is based on a shift of cases to "lower cost" ambulatory surgery centers. However, the Petitioner does not provide any information regarding trends by both government and private payors toward site-neutral payments.

- **BRBJ fails to mention in its 2014 Petition that expanding cuts to hospitals' outpatient services is among the leading Medicare cost-reduction proposals gaining interest from Congress.** [6]

The Medicare Payment Advisory Commission (MedPAC) recommended in March 2012 that Medicare should equalize evaluation and management office visit payment rates, regardless of whether they occur in a hospital outpatient setting or a physician's office, which would save up to $1 billion a year. Congress' board of Medicare experts issued a report on June 14, 2013 offering 66 other ambulatory payment areas where such a "site-neutral" policy could be used to derive $900 million in additional annual savings.

MedPAC advisers introduced the following three main proposals in its June 14, 2013 report:

1. The "site-neutral" policy — in which hospital outpatient departments (HOPDs) and ambulatory care settings receive similar Medicare payments — would expand to 66 additional ambulatory payment classifications, which would reduce hospital Medicare payments by $900 million.

2. HOPDs and physician offices would receive the same payment for three high-volume cardiac imaging ambulatory payment classifications, which would reduce hospital Medicare payments by $500 million.

3. HOPDs and ambulatory surgery centers would receive equal pay for 12 surgical ambulatory payment classifications, reducing hospital Medicare payments by $590 million.[7]

MedPAC voted at its January 16-17, 2014 meeting to recommend that Congress decrease the reimbursement differential between services provided in an outpatient hospital setting and

[6] Information contained in this Section is derived from: http://kevinbrady.house.gov/kevin-brady-in-the-news/medpac-sees-hefty-savings-in-siteneutral-payment-policy/

[7] http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/medpac-suggests-equalizing-payments-between-hospitals-ambulatory-clinics.html

services provided in a physician's office for select ambulatory payment classifications. Those recommendations were published in MedPAC's March 2014 report to Congress.[8]

On April 16, 2014, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) released Report A-05-12-00020 entitled "Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center-Approved Procedures To Ambulatory Surgical Center Payment Rates." In that study commissioned by Congress, OIG assessed the impact on total Medicare expenditures of providing surgical services in an ambulatory surgical center as compared with a hospital outpatient department paid under the outpatient prospective payment system (OPPS). Because Medicare ambulatory surgery center payment rates are generally lower than hospital OPPS payment rates for the same procedures, Medicare saves when surgical procedures that do not pose significant risk to patients are performed in an ambulatory surgery center instead of in a hospital. The Report quantifies those savings, and OIG found:

1. During CY 2007 through 2011, Medicare saved $7 billion for surgical procedures performed in ambulatory surgery centers instead of in other outpatient settings. It stands to save $12 billion for CY 2012 through 2017.

2. Medicare could potentially save up to an additional $15 billion for CY 2012 through 2017, if CMS reduces hospital outpatient department payment rates to ambulatory surgery center payment levels for ambulatory surgery center-approved procedures performed in outpatient departments on no-risk to low-risk beneficiaries. OIG consulted with the Agency for Healthcare Research and Quality to obtain patient risk statistics and used the risk profiles to estimate the potential additional savings possible if payment rates for ambulatory surgery center procedures performed in outpatient departments are lowered to ambulatory surgery center rates.

3. Beneficiaries have saved and should continue to save billions of dollars attributable to reduced cost-sharing amounts.

OIG made the following recommendations to CMS:

1. CMS should draft and submit for review a legislative proposal that would exempt the reduced expenditures attributable to reduced OPPS payment rates from budget neutrality adjustments. This would be necessary because both the OPPS and the ambulatory surgery center fee schedules are required by statute to be budget neutral to insulate both payment systems from Medicare payment fluctuations.

2. If a budget neutrality exemption for the reduced expenditures is secured, CMS should reduce OPPS payment rates to ambulatory surgery center fee schedule rates for ASC-

[8] A copy of the March 2014 MEDPAC Report to Congress can be found here: http://www.medpac.gov/documents/Mar14_EntireReport.pdf

approved procedures performed in outpatient departments on beneficiaries with no-risk or low-risk clinical needs.

3. CMS should "develop and implement a payment strategy" providing for the continued standard OPPS payment rate for beneficiaries whose clinical needs require their ambulatory surgery center -approved procedures to be performed in an outpatient department for safety and quality reasons.

CMS had an opportunity to review a pre-publication draft report and did not concur with OIG's recommendations, noting, first, that such a legislative initiative to change the payment system is not included in the President's budget. Further, CMS was concerned that the recommended changes introduced a "circularity" problem insofar as most ambulatory surgery center payment rates are based on the OPPS payment rates that OIG is recommending that CMS reduce. Finally, CMS was concerned that OIG did not provide specific clinical criteria to distinguish patient risk levels.

OIG countered that CMS could propose budget neutrality legislation for future legislative initiatives and that, historically, it has done so based on OIG recommendations. As to CMS's concerns on circularity and the absence of specific patient risk criteria, OIG effectively responded that CMS should "take the necessary steps" to implement OIG's recommendations, regardless.[9]

- **Commercial insurers have instituted payment policies limiting hospital outpatient payment to the freestanding ambulatory surgery center payment rate**

Some commercial insurers have instituted payment policies limiting hospital outpatient payment to the freestanding ambulatory surgery center payment rate even if a former ambulatory surgery center was acquired by a hospital and, after the acquisition, the ambulatory surgery center met the Medicare provider-based rule permitting higher hospital OPPS payment. Commercial payors are not bound to follow Medicare payment rules.[10] Mission reasonably believes that the theoretical savings from single specialty ambulatory surgery center demonstration projects will be determined to be irrelevant as Medicare and other payors move to site-neutral payments. Further, there is no evidence that the "costs" that are "avoided" are actually changed in any way. The primary driver of hospital-based costs are related to other services that are critical for the communities they serve and are unrelated to the specifics of any ambulatory surgery center (e.g., ED, Trauma, Pediatrics, and other cost drivers) and would be unchanged based upon any physician-owned center. Said another way, those costs would remain, and no cost "savings" would actually occur.

[9] A copy of the Report can be found here: https://oig.hhs.gov/oas/reports/region5/51200020.pdf

[10] http://blogs.hallrender.com/blog/oig-releases-report-recommending-reduction-of-opps-payment-rates-to-asc-rates/

Mission respectfully requests that the SHCC consider the ever-changing environment for health care, and the importance and effects of the cost-reduction proposals, specifically site-neutral payments, on the health care marketplace, and deny the BRBJ 2014 Petition.

J. Trend Toward Ambulatory Surgery Center to Hospital Outpatient Department Conversions: A Reverse Migration

Only 40 years ago, virtually all surgeries and diagnostic procedures were performed in hospitals. Today, as a result of medical advancements and new technologies, a whole new range of procedures can be performed on an outpatient basis.

There are several facts that BRBJ fails to mention in its Petition.

First, although the number and types of procedures that are performed in an ambulatory surgical center setting continue to expand, **studies and reports indicate a slower growth in the number of ambulatory surgical centers and volume of services performed at ambulatory surgical centers compared to previous years.**[11]

Second, according to the data from an Ambulatory Surgery Center Association, **one-third of the 179 ambulatory surgery center that have closed since 2009 did so after being purchased by hospitals and converted to hospital outpatient departments.**[12]
In North Carolina, the following freestanding ambulatory surgery centers, three of which were specialty ambulatory surgery centers, have converted to hospital based outpatient surgery centers in the last five years.

- SameDay Surgery Center New Hanover, LLC to NHRMC - 2013
- Chapel Hill Surgical Center to UNC Hospitals - 2013
- Southern Eye Center to WakeMed in Wake County - 2012
- Wayne ASC to Wayne Memorial - 2011
- Raleigh Women's Center to DukeRaleigh in Wake County - 2010

Conversion to hospital outpatient departments are appealing to hospitals and physicians for a number of reasons, to include less risk for physicians and co-management arrangements, which align and reward physicians for their assistance and often include incentive compensation to improve quality and efficiency. Asheville Surgery Center is a prime example of a hospital outpatient department with physician ownership and co-management.

It is quite possible that that three existing Demonstration Projects may undergo an ownership conversion at the end of each Project's required five-year operational term. That possibility is

[11] Report to Congress: Medicare Payment Policy, Chpt. 5 Ambulatory Surgical Center Services, p. 115, Medicare Payment Advisory Commission (2012)
[12] http://www.ascassociation.org/AdvancingSurgicalCare/ascpolicyfocus/asctohopd

made more likely as payors move to site-neutral payments, if facility payments dilute ownership incentives, and other reforms such as accountable care organizations that control utilization gain a stronger foothold.

Mission respectfully requests that the SHCC consider the ever-changing environment for health care, particularly in view of the reverse migration and conversion from physician-owned ambulatory surgery centers to hospital outpatient departments, and deny the BRBJ 2014 Petition.

K. Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries

Much of the past research has focused on "physician-owners' skimming their most lucrative patients away from full-service hospitals."[13] Jon Gabel and colleagues showed that "providers at physician-owned surgery centers tended to route well-insured patients to their own facilities."[14] Ariel Winter demonstrated differences in case-mix between surgery centers and hospital outpatient departments, and found that patients who were more medically complex tended to receive treatment at the latter.[15]

Mission calls the SHCC's attention to important research published in the April 2010 issue of Health Affairs[16].

Using the Healthcare Cost and Utilization Project's State Ambulatory Surgery Databases, researchers analyzed data from Florida over the years 2003–2005, which capture 100 percent of ambulatory procedures. Florida data was chosen because they allow for the tracking of individual surgeons, regardless of the site of care delivery. Researchers measured the association between surgery center ownership and surgery use among five common ambulatory procedures. Further, to see whether the establishment of an investment interest altered surgery use, researchers compared the practice patterns of physician-owners of surgery centers, before and after they acquired ownership, to those of physician-non-owners over the same time period.

Researchers' analysis of Florida data for five common procedures "revealed a significant association between physician-ownership and higher surgical volume."[17] Specifically,

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[13] Gabel JR, Fahlman C, Kang R, Wozniak G, Kletke P, Hay JW. Where do I send thee? Does physician-ownership affect referral patterns to ambulatory surgery centers? Health Aff (Millwood). 2008;27:w165.

[14] Id.

[15] Winter A. Comparing the mix of patients in various outpatient surgery settings. Health Aff (Millwood). 2003;22(6):68–75.

[16] Hollingsworth JM, Ye Z, Strope SA, Krein SL, Hollenback AT, Hollenbeck BK. Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume Of Surgeries. Health Aff April 2010 vol. 29 no. 4 683-689. Article can be found here: http://content.healthaffairs.org/content/29/4/683.full

[17] Id.

> [d]uring the study period, **the mean annual caseloads for physician owners, on average, were at least twofold greater than those for non-owners** (Formula for each comparison; again, unlikely to be due to chance). Although non-owners' annual caseloads remained relatively stable, owners' caseloads increased during the study period. **Even after differences between patients and health care markets were adjusted for, physicians with ownership in a surgicenter were found to perform more of all five procedures examined, compared with non-owners. For a physician-owner** who performed carpal tunnel surgery, cataract surgery, gastrointestinal endoscopy, knee surgery, or ear surgery, **that association would translate into an additional 16 carpal tunnel releases, 204 cataract excisions, 366 colonoscopies, 53 knee arthroscopies, or 15 myringotomies annually (Formula for each procedure, again, unlikely to be due to chance). That association held true regardless of the threshold used to constitute ownership status. [Emphasis added.]**

The independent researchers continued:

> [t]he association between surgicenter ownership and increased surgery use may be explained, in part, by physician specialization. In particular, eventual owners might carry the high caseloads necessary to justify the initial financial outlay of surgicenter investment and, thus, choose to buy into one. Indeed, we found that for three procedures (cataract excision, colonoscopy, and knee arthroscopy) the surgical volumes of eventual owners were greater during the pre-ownership period than those of their nonowner counterparts. However, **after accounting for this baseline difference, our multiple time series analysis revealed that the acquisition of ownership status kicked owners' already high volumes up even higher.** This would suggest that what underlies the association between ownership and surgery use is more than just a "high-volume surgeon" phenomenon alone. In other words, it isn't just that the surgeons who own surgicenters tend to be high-volume ones; **it's that surgeons become high-volume surgeons once they become owners of surgicenters. [Emphasis added.]**

The study filled an important knowledge gap in the literature on physicians' investment in surgery centers and was consistent with other studies showing overutilization of imaging, laboratory, and other services when physicians directly benefit financially from "clinical decisions" that only they control and only they benefit financially from. The data quantified the relationship between surgery center ownership and surgical volume. Further, the analysis was the first to suggest increased surgery use subsequent to a physician's acquisition of ownership status in a surgery center.

Mission respectfully requests that the SHCC use the study, data, and analysis of physician-induced demand to inform its debate, decline to expand the number of Demonstration Projects

until there can be further examination of ownership status and its relationship to patients' outcomes and the cost of care, and deny the BRBJ 2014 Petition.

L. BRBJ's Desired Demonstration Project Would Not Improve Geographic Access to Surgical Services.

Promoting the effective distribution and use of health care services, facilities, and equipment is a fundamental purpose of North Carolina's Certificate of Need health planning scheme. *See* N.C. Gen. Stat. § 131E-175(7). The General Assembly, when enacting the Certificate of Need Act, N.C. Gen. Stat. §§ 131E-175, *et seq.*, made multiple findings regarding the purpose of and need for the CON regulation. *See* N.C. Gen. Stat. § 131E-175. These findings make the legislative purpose of ensuring appropriate geographic access to health service facilities and services and avoiding the "geographical maldistribution" of those facilities and services clear. *See id.*

In its petition, BRBJ has requested that the SHCC add a demonstration project for a single specialty, two OR ambulatory surgical facility in the Buncombe County multicounty operating room service area. The Buncombe County multicounty operating room service area includes not only Buncombe County but also Madison and Yancey Counties. However, all of the operating rooms currently located in the multicounty service area are located in Buncombe County and in Asheville specifically. There are no operating rooms located anywhere in the three counties other than in Asheville. Depending upon the location in Madison County, Asheville is 15 miles or more away. Likewise, depending upon the location in Yancey County, Asheville is at least 30 miles away.

BRBJ's Petition requests the addition of the demonstration project in Buncombe County. If the SHCC adds the requested demonstration project to the State Medical Facilities Plan, Mission understands and believes that BRBJ would apply to develop that project in Asheville. Adding two additional operating rooms in Asheville would not promote greater geographic access to health services and facilities, especially when the existing operating rooms in Buncombe County are not fully utilized as outlined above.

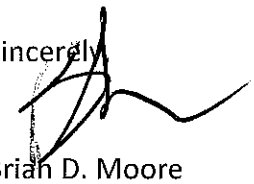
Rather, if BRBJ truly wished to improve the access to healthcare facilities and services for the residents of the Buncombe County multicounty service area, it would request for the demonstration project to be designated for Madison or Yancey Counties. As it is, BRBJ's Petition would do nothing to improve geographic access to healthcare facilities and services. Instead, BRBJ's desired demonstration project would merely add additional operating room capacity where the existing operating rooms already have capacity and would not bring surgery services closer to where patients live in more rural areas.

Conclusion

For all of the reasons set forth above, Mission respectfully requests that the SHCC deny the BRBJ 2014 Petition, and take no further action with respect to single specialty ambulatory surgical centers.

Please do not hesitate to contact me at 828.213.3059 if you have questions or if there is any additional information that I can provide. Many thanks in advance for your consideration.

Sincerely,



Brian D. Moore
Executive Director, Public Policy and Regulatory Affairs
Mission Health

Exhibit 1

Comments by Dr. Pete Mangone
Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health
Date: January 21, 2013

Members of the committee, thank you for the opportunity to speak to you today.

My name is Peter Mangone and I am an orthopaedic surgeon practicing for the last 15 years with Blue Ridge Bone and Joint Clinic in Asheville and Hendersonville, North Carolina. Blue Ridge Bone and Joint Clinic is comprised of 21 physicians who deliver comprehensive orthopedic and musculoskeletal care to western North Carolina through our affiliations with Mission Hospital and Pardee Hospital as well as our professional relationship with multiple urgent care centers throughout the region. Since 1985 BRBJ physicians have provided comprehensive orthopaedic and musculoskeletal care through office based professional services, inpatient and outpatient surgery, and emergency call coverage. We serve all categories of patients including patients who are indigent. Our physicians have participated in Project Access for many years as well as the Pardee Indigent Clinic system.

As a physician, patient, and citizen of Western North Carolina, I am here today to testify that ***the current CON regulations limit patient choice and increase healthcare cost.*** This ultimately results in decreased healthcare efficiency for the patient, the doctor, and society. Nowhere is this situation more evident than in the realm of ambulatory surgery in Western North Carolina.

The existing CON law limits patient choice

Currently patients in Western North Carolina have very limited choice as to where they can receive ambulatory surgery services. The 26 counties that comprise Health Service Area 1 in western North Carolina have a combined total population of 1.68 million people. Those patients have access to only 20 ambulatory operating rooms. The limited patient choice is further amplified when we examine other regions in the state.
The residents of Mecklenburg County (population of 986,502) have access to 38 licensed ambulatory operating rooms. Wake County residents (population of 965,833) have access to 24 licensed ambulatory operating rooms.

If we look at a county comparison of hours of inpatient vs outpatient surgery, the lack of choice for my patients becomes even more evident.*

Hours of surgery	Type of ORs present	Projected oversupply of ORs	**Comparison**
Buncombe • 36,000 inpt	21 inpatient 19 ambulatory	3 ORs	• **16% more outpatient than**

• 43,000 outpt	13 shared Total = 53 ORs		**inpatient hrs. yet** • **10% less ambulatory ORs than inpatient ORs**
Mecklenburg • 99,000 inpt • 123,000 outpt	22 inpatient 38 ambulatory 106 shared Total = 166 ORs	18.8 ORs	• **23% more outpatient than inpatient hrs. and** • **40% more ambulatory ORs than inpatient ORs**
Wake • 60,000 inpt • 89,000 outpt	12 inpatient 24 ambulatory 66 shared Total = 102 ORs	10.5 ORs	• **33% more outpatient than inpatient hrs. and** • **50% more ambulatory ORs than inpatient ORs**

*Information obtained from State Health Coordinating Council 2014 North Carolina Proposed State Medical Facilities Plan.

To summarize, currently the citizens of both Mecklenburg and Wake Counties have significantly greater access to ambulatory surgical services but yet their individual respective populations are each approximately 40 percent smaller than the 26 counties of western North Carolina.

For the past five years our group, Blue Ridge Bone and Joint, has submitted petitions to the North Carolina State Health Coordinating Council requesting the opportunity to submit a CON application to develop an orthopedic ambulatory surgery center. Our petitions explain that the proposed new surgery center would improve patient choice in a region of the state that lacks adequate competition The petition also verifies that the proposed surgery center would provide service to all categories of patients, including charity care and Medicaid patients. Each year our petition requests have been denied. We would request that the legislature re-examine the CON laws that currently restrict patient options in our region compared to those in other areas of the state.

The existing CON law increases healthcare cost

Although many with opposing views will try to explain how the healthcare marketplace is different than other business marketplaces, the basic concepts of supply and demand remain unchanged even in healthcare. The fewer number of

operating rooms, the fewer number of patient options, and the less competition – all of these forces combine to result in higher overall costs.

Unfortunately, the reality is that the current CON law hits the middle class harder than any other group. The indigent often are able to obtain free or reduced healthcare costs through local, state, and federal aid programs. The wealthy can afford to pay higher prices. However, it is the teacher, policeman, fireman, administrative aide, and local small business owner who is most affected by these restrictive laws. ***Currently outpatient surgical procedures performed in a freestanding ambulatory surgery center cost approximately 40 percent less than the same cases performed in hospitals.*** For a $5000 bill, this results in a cost savings of $2000. For the average middle class individual/family still trying to recover from the Great Recession, I do not know anyone who would turn down the opportunity to reduce their healthcare costs by 40% .

The fact is that while there are many complicated and different financial reasons put forth as to why North Carolina should continue the current restrictive CON environment, there is one main financial reason to make it less restrictive – simply put, the cost of surgical services and healthcare will not decrease until more choices and greater supply is introduced into the marketplace so that competition among providers can occur.

As a medical provider and small businessman, I can certainly empathize with the difficulties hospitals face in today's healthcare environment. ***I face those same issues on a daily basis*** – these include increased overhead, increased regulations, decreased reimbursement, treating patients who don't pay their bills and/or writing off bills for indigent patients, and most recently, the challenges of the Affordable Care Act (both as a doctor and an employer). Unlike the hospital, private practice healthcare providers do not get federal subsidies to help pay for the indigent care and we do not have the benefits of tax-exempt status.

In conclusion, while hospitals do provide a valuable community service, I believe physicians who provide care in those hospitals also provide a unique and valuable service as well. On behalf of my colleagues, I submit to you that the current CON laws are inherently unfair, restrict competition and in doing so, decrease patient choice and increase healthcare costs. In light of this fundamental unfairness, I request that you recommend to your colleagues revise the existing laws to level the playing field and allow for physician ownership of ambulatory surgery centers.

Exhibit 2

waller

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615.244.6804 fax
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John Arnold
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June 27, 2014

North Carolina Department of Health
Attention: CON Program
2704 Mail Service Center
Raleigh, NC 27600-2704

Re: Orthopaedic Surgery Center of Asheville, LP
Notice of Proposed Transaction

Dear Sir or Madam:

We are writing on behalf of Orthopaedic Surgery Center of Asheville, LP (the "Center"), which owns and operates an ambulatory surgery center known as "Orthopaedic Surgery Center of Asheville," located at 34 Granby Street, Asheville, North Carolina 28801 (the "Facility"). The purpose of this letter is to notify you of a proposed transaction that will result in a change to the indirect owners of the Center through a stock transaction. As a result of the transaction, a new indirect owner, Surgery Center Holdings, Inc. (the "Buyer"), will be added to the ownership structure. The parties intend to make the proposed transaction effective as soon as possible. For your convenience, we have attached organizational charts showing a "before" and "after" view of the Center's ownership structure in connection with the transaction.

The Center will remain the owner and operator of the Facility and the Center's Federal Employment Identification Number (EIN) (i.e., Tax ID) will not change as a result of the transaction. There are also no planned changes to the legal name, location or clinical operations of the Facility as a result of the transaction. Similarly, there are no planned changes in the staffing or day-to-day operations of the Facility as a result of the transaction. It is our understanding that the proposed addition of an indirect owner as a result of a stock transfer does not constitute a change of ownership that would require Certificate of Need review. I would greatly appreciate if you would let me know at your earliest possible convenience if you need any additional information or documentation regarding this transaction. If so, please send any forms or applications that are required to be completed by the Facility in connection with the transaction to my attention at 511 Union Street, Suite 2700, Nashville, Tennessee 37219 or via e-mail at john.arnold@wallerlaw.com.

I thank you in advance for your assistance. Please do not hesitate to contact me at 615-850-8018, if you have questions or need additional information.

Best regards,

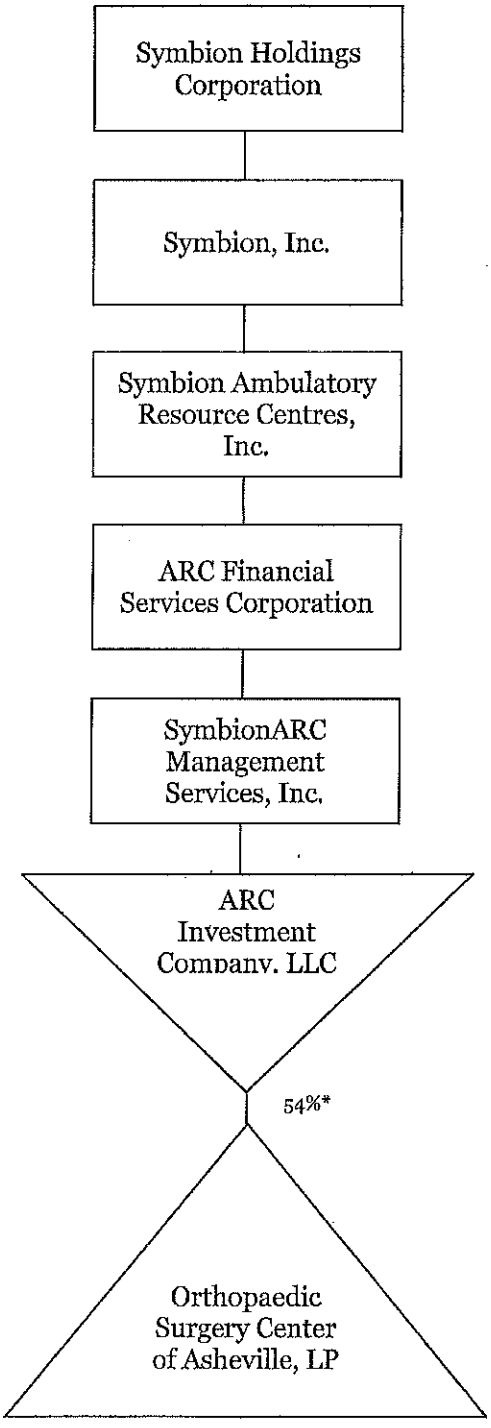
John V. Arnold

JVA:bab

Exhibit 2

waller

OWNERSHIP STRUCTURE
(CURRENT - BEFORE)

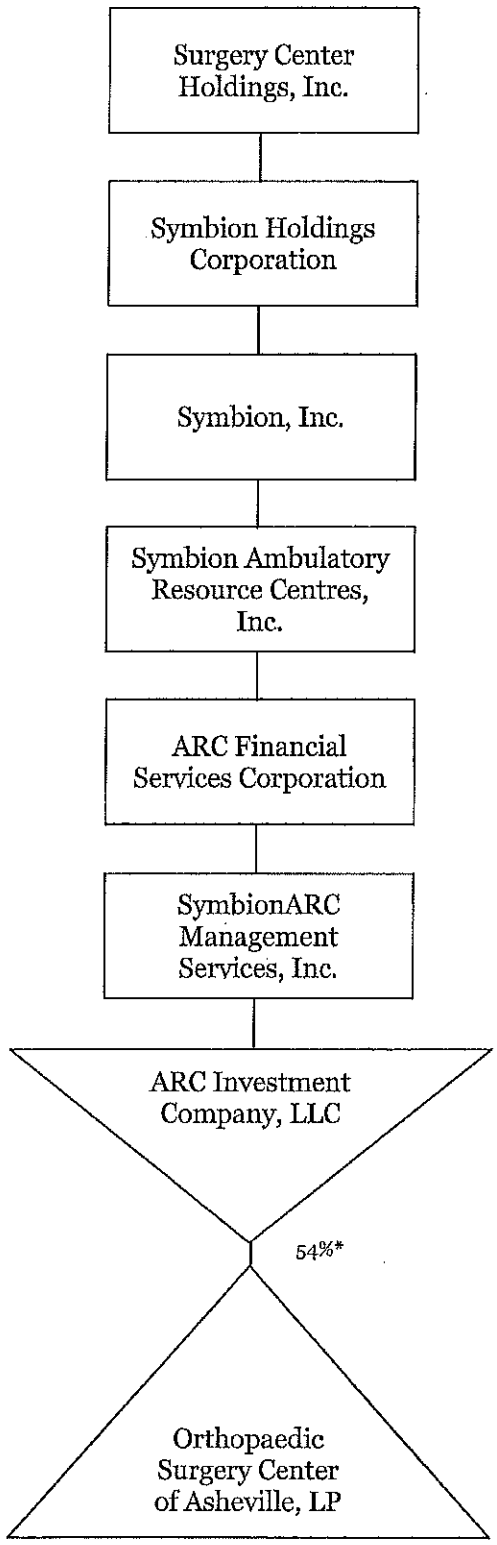


*Remaining 46% held by individual physician investors (not changing).

Exhibit 2

waller

OWNERSHIP STRUCTURE
(ANTICIPATED - AFTER)



*Remaining 46% held by individual physician investors (not changing).

EXHIBIT 3

Table 1. Operating Room Inventory, Utilization, Planning Inventory, and Projected Surplus/Deficit

County	Inpt ORs	Amb ORs	Shared ORs	Excluded C-Sec ORs	Excluded Trauma/ Burn ORs	CON Adjustments	Underutilized Exclusions	Demonstration Project Exclusions	Total Licensed and Approved ORs (no Exclusions)	Inpt Cases (C-Sec OR Cases Excluded)	Inpt Hrs (C-Sec Case Hrs Excluded)	Outpt Cases	Outpt Hrs	Total Cases	Total Hrs	Total Planning ORs (w Exclusions)
Buncombe	8	15	30	-2	-1	0	-2	0	53	12,100	36,300	28,743	43,115	40,843	79,414	48
Mecklenburg (Note 3)	22	42	104	-13	-1	3	-2	-2	171	34,040	102,120	85,700	128,550	119,740	230,670	153
Wake (Note 4)	12	30	66	-8	-1	4	-1	-2	112	20,057	60,171	60,307	90,461	80,364	150,632	100
Three County Combined	42	87	200						336							301

Source: *Proposed 2015 SMFP*, Tables 6A & 6B

Note 1: Underutilized Facilities excluded from Need Determination calculation (Table 6B)
FEMCARE (2 ORs)
NH Ballantyne (2 ORs)
Raleigh Plastic Surgery Center (1 OR)

Note 2: Demonstration Project ORs and Underutilized OR are included in Inventory (Table 6A = Column J), but excluded from Need Determintion calculation (Table 6B = Column Q)

Note 3: Mecklenburg County adjusted to include OrthoCarolina Demonstration - University Surgery Center

Note 4: Wake County adjusted to reflect shift in ownership from Southern Eye AmSurg ORs to hospital shared ORs at Wake Med

Table 2. Operating Room Inventory by Type as Percentage of Total Licensed and Approved ORs (no exclusions)

County	Inpt ORs as % of Total ORs	Amb ORs as % of Total ORs	Shared ORs as % of Total ORs	Total
Buncombe	15.1%	28.3%	56.6%	100.0%
Mecklenburg	14.6%	24.6%	60.8%	100.0%
Wake	14.3%	26.8%	58.9%	100.0%
Three County Combined	14.6%	25.9%	59.5%	100.0%

Source: Table 1

Note: Total Inventory as per Table 6A (includes CON Adjustments, Demonstration Project ORs) with no exclusions

Table 3. Utilization of Mission Operating Rooms

	Number of Operating Rooms	Inpatient Cases	Inpatient Surgical Hours	Outpatient Cases	Outpatient Surgical Hours	Total Surgical Hours	Capacity = 2,340 Hrs/OR	Utilization
Total All Operating Rooms	47	13,354	40,062	20,749	31,124	71,186	109,980	64.7%
Open Heart ORs	6	1,196		20				
Csection ORs	2	1,254		0				
Vascular ORs	2	735		516				
Total Operating Rooms Less Dedicated Open Heart, C-Section and Vascular Operating Rooms	37	10,169	30,507	20,213	30,320	60,827	86,580	70.3%
Dedicated Ambulatory Only	9	0	0	9,103	13,655	13,655	21,060	64.8%
Shared ORs Only	28	10,169	30,507	11,110	16,665	47,172	65,520	72.0%
Percent Outpatient Surgical Hours/OR	10				35.3%			

Source: Mission 2014 LRA