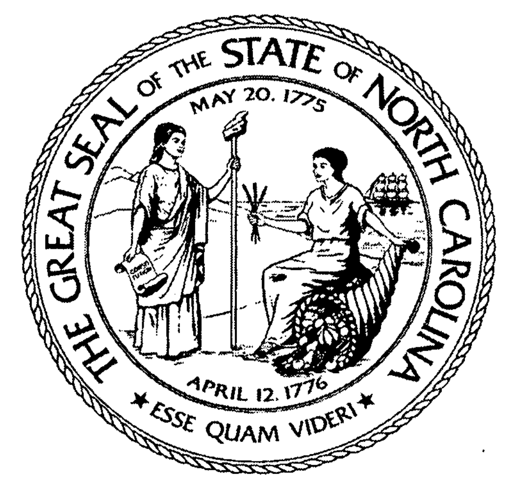
2011-2012

CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES HOUSE SELECT COMMITTEE

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY



HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

REPORT TO THE
2012 SESSION
of the
2011 GENERAL ASSEMBLY

APRIL 2012

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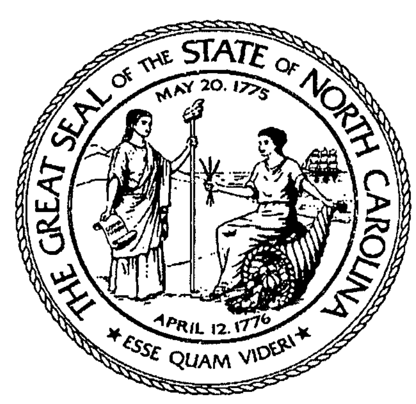
TRANSMITTAL LETTER

STATE OF NORTH CAROLINA

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES



April 19, 2012

TO THE MEMBERS OF THE 2012 HOUSE OF REPRESENTATIVES:

Attached for your consideration is the interim report of the House Select Committee on the Certificate of Need Process and Related Hospital Issues established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Respectfully submitted,

Representative Fred Steen
Co-Chair

Representative John Torbett
Co-Chair

COMMITTEE AUTHORIZATION

Office of Speaker Thom Tillis
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TO THE HONORABLE MEMBERS OF THE
NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on the Certificate of Need Process and Related Hospital Issues (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Section 2. The Committee consists of the 11 members listed below, appointed by the Speaker of the House of Representatives. Members serve at the pleasure of the Speaker of the House of Representatives. The Speaker of the House of Representatives may dissolve the Committee at any time.

Representative Fred Steen, Co-Chair
Representative John Torbett, Co-Chair
Representative Jamie Boles
Representative Mark Hollo
Representative Bill Current
Representative Marilyn Avila
Representative Jeff Collins
Representative Shirley Randleman
Representative Rick Glazier
Representative Martha Alexander
Representative Marcus Brandon

Section 3. The Committee may study all of the following:

(1) The provisions of House Bill 743, First Edition, 2011 Regular Session and House Bill 812, First Edition, 2011 Regular Session.

(2) The legal requirements and process governing Department of Health and Human Services determinations on applications for CON, including an analysis

of exceptions granted under policy AC-3 of the State Medical Facilities Plan as implemented by the Department of Health and Human Services.

(3) Issues relating to publicly owned hospitals, including determining the appropriate role of State-owned hospitals and the appropriate manner for public hospital authorities created under G.S. 131E-17 to operate beyond the boundaries of the local government that created the authority.

(4) Whether a hospital operating under a Certificate of Public Advantage should be required to comply with the same rules, policies, and limitations to each county in which it operates.

(5) The extent to which a publicly owned hospital should engage in business with an entity having a Certificate of Public Advantage or operating under an exemption under the CON laws of the State.

(6) Any other matter reasonably related to subdivisions (1) through (4) of this section, in the discretion of the Committee.

Section 4. The Committee shall meet upon the call of its Co-Chairs. A quorum of the Committee shall be a majority of its members.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1.

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2012, by filing a copy of the report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives prior to the convening of the 2013 General Assembly by filing the final report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee terminates upon the convening of the 2013 General Assembly or upon the filing of its final report, whichever occurs first.

Effective this the 24th day of August, 2011

Thom Tillis
Speaker

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PREFACE

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. This health care planning process seeks to ensure that rural areas and underserved populations have adequate access to health care, to encourage safety and high quality in the health care services provided, and to reduce health care costs through the elimination of unnecessarily duplicative expensive facilities, equipment and services. To accomplish these goals, the statutes require the development of annual projections of need for various types of health care facilities and services.[1] The resulting document is known as the State Medical Facilities Plan (SMFP). To implement the SMFP, the General Assembly enacted the Certificate of Need Law,[2] which provides the process by which persons may apply for a license to construct or expand health care facilities or to provide services in accordance with the determined need.

In addition to the SMFP and the CON law, the State has also taken steps to enhance the availability of quality health care services by allowing hospitals and other persons to enter into cooperative agreements for the provision of health care that would otherwise be subject to State antitrust scrutiny.[3] Such agreements are subject to the issuance by the State of a Certificate of Public Advantage (COPA). The COPA spells out conditions of operation on the parties to the agreement that, in theory, should counterbalance any competitive advantage gained in the health care marketplace under the cooperative agreement. Only one COPA has issued since the enactment of the statute in 1993.

Although the Certificate of Need law has been amended several times since enacted, it has been a number of years since the General Assembly undertook a serious review of the program.[4] Further, there is concern that our certificate of public advantage law has not adequately offset the competitive advantage gained under the cooperative agreement and it is unclear if Article 9A provides a definitive process to initiate the termination of an agreement.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues was created and charged with the review of the State health planning process, including the State's CON program and the implementation of the COPA law, to determine whether these programs are adequately serving their intended purpose of ensuring the availability of quality, cost effective health care services to North Carolina citizens. The Committee began its work in September of 2011 and after soliciting input from citizens in all regions of the State has determined, based on the depth and complexity of the information received, further examination is warranted prior to any action.

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[1]. G.S. 131E-177
[2] Article 9, Chapter 131E of the General Statutes
[3] Article 9A, Chapter 131E of the General Statutes.
[4] 1991, Legislative Research Commission: Committee on Care Provided by Rest Homes, Intermediate Care Facilities, and Skilled Nursing Homes; Necessity for Certificates of Need; and Continuing Care Issues.

COMMITTEE PROCEEDINGS

Below is a brief summary of the Committee's proceedings. A more detailed record of the Committee's work can be found in the Committee's notebook, located in the Legislative Library.

September 14, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Wednesday, September 14, 2011, in Room 544 of the Legislative Office Building at 10:00 am. Shawn Parker, Committee Counsel, was called upon to give a review of the Committee Charge. Committee Counsel, Barbara Riley, Amy Jo Johnson, and Jan Paul, gave an overview of North Carolina Certificate of Need Law. This presentation included a review of the North Carolina State Coordinating Council, the State Medical Facilities Plan, and the State Health Planning Process. Also discussed were facilities, services, and equipment subject to the Certificate of Need laws, the application process, and the process by which to appeal a decision regarding Certificate of Need. Following the presentation on Certificate of Need, Shawn Parker gave an overview regarding Certificate of Public Advantage, including its purpose, the legislative history, and the application process. At this time, there is only one Certificate of Public Advantage in the State and Mr. Parker reviewed the details of Mission Health System's Certificate of Public Advantage. The Committee engaged in discussion and requested additional information be provided at the next meeting.

October 6, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, October 6, 2011, in Room 544 of the Legislative Office Building at 10:00 am. The Chair recognized Shawn Parker, Committee Counsel, to go over the Committee charge and address questions remaining from the previous meeting. Drexel Pratt, Director, Division of Health Service Regulation, Department of Health and Human Services spoke briefly on Policy Acute Care 3 (AC3), which allows Academic Medical Center Teaching Hospitals to request additional capacity and equipment to address educational and academic research needs, even if the State Medical Facilities Plan indicates "no need determination" based on the projected need for the general population. Mr. Pratt indicated that the upcoming 2012 State Facilities Medical Plan would include compromise language surrounding AC3 due to the Hospital Associations work with stakeholders and explained the compromise language. Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, Department of Health and Human Services, gave an overview and inventory of facilities regulated by the Certificate of Need Process, as well as a review of the Certificate of Need application and appeal process. Mr. Horton also provided various statistics surrounding Certificate of Need in North Carolina.

Following the presentations by the Division of Health Services Regulation, the Committee heard from Hugh Tilson, Senior Vice President, North Carolina Hospital Association. Mr. Tilson explained the economics of health care and challenges facing hospitals in the State. The final

presentation was given by Noah Huffstetler III, Attorney and Partner at the firm Nelson Mullins. Mr. Huffstetler discussed Certificate of Need regulation from a legal practioner's point of view, including areas in which the Certificate of Need law presents opportunities for improvement.

October 20, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, October 20, 2011, in the Boone Building at the WNC Agricultural Center in Fletcher, North Carolina, at 6:00 pm. Shawn Parker, Committee Counsel, gave a brief overview of the Committee's charge. The Committee heard two presentations regarding Certificate of Public Advantage. The first presentation was made by the following individuals: Dr. Ron Paulus, Chief Executive Officer, Mission Health System, Richard Vinroot, Legal Counsel, Mission Health System, Dr. Tom McCarthy, Economist, and Brandon Sutherland, Senior Manager, Dixon Hughes Goodman LLP. This presentation entailed a description of Mission's experience with its Certificate of Public Advantage, the effectiveness of the Certificate of Public Advantage on the hospital's performance, and a request that Mission be released from the Certificate of Public Advantage in the future.

The second presentation was made by the following individuals: Jim Bunch, President and Chief Executive Officer, Park Ridge Hospital, Graham Fields, Assistant to the Presented for External Relations, Park Ridge Hospital, Dr. Brian Quaranta, Physician, 21st Century Oncology, Gail Cummings, Regional Administrator, 21st Center Oncology, and Dr. Nathan Williams, Physician and Coalition Member, Western North Carolina Community Heathcare Initiative. This presentation detailed areas in which the individuals felt the Certificate of Public Advantage would benefit from changes and requested further oversight of the Certificate of Public Advantage program. Following the presentations, the Chair recognized individuals from the public to address the Committee on issues related to Certificate of Need and Certificate of Public Advantage.

November 1, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, November 1, 2011, in the Council Chamber of the Citizens Center in Mount Holly, North Carolina at 6:00 pm. Shawn Parker, Committee Counsel, gave a brief overview of the Committee's charge. Darise D. Caldwell, President of Rowan Regional Medical Center presented information regarding the AC3 policy in the State Medical Facilities Plan and suggestions for further changes to that policy. Carol Lovin, President, Management Company, Carolina HealthCare System, then addressed the Committee. Ms. Lovin explained why the Certificate of Need process is beneficial and discussed the challenges facing the Certificate of Need regulations, which in her opinion involve the application and appeals process, as well as the AC3 policy. The final presentation was made by Doug Luckett, Acting Chief Executive Officer, CaroMont Health and Maria Long, Executive Vice President and Chief Legal Officer, CaroMont Health. Mr. Luckett and Ms. Long detailed the positive aspects of the Certificate of Need regulations and discussed areas for improvement within the application and appeals process. Following the presentations, the Chair

recognized individuals from the public to address the Committee on issues related to Certificate of Need and Certificate of Public Advantage.

November 17, 2011

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Tuesday, November 17, 2011, at Cape Fear Community College in Wilmington, North Carolina at 6:00 pm. The first presentation was made to the Committee by Denise Mihal, President, Brunswick Novant Medical Center regarding the benefits of Certificate of Need regulations to Novant Health's facilities. The Committee then heard from Dennis Coffey, Chief Financial Officer, Dosher Memorial Hospital, who spoke in support of Certificate of Need regulation and offered suggestions for improving the regulations, particularly with regards to smaller hospitals. The third presentation was made by the following individuals: Sue Collier, Vice President, University Health Systems of Eastern Carolina, Dr. Herbert Garrison, Vice President, Medical Affairs, Pitt County Memorial Hospital and Professor of Medicine, Department of Emergency Medicine, the Brody School of Medicine, and Dr. Brian Kuszyk, Chief of Staff, Department of Radiology, Pitt County Memorial Hospital. This presentation discussed the virtues of the AC3 policy and the benefits this policy provides to the State. The final presentation was made by John Gizdic, Vice President of Strategic Services and Business Development, New Hanover Regional Medical Center, who spoke in support of the process. He detailed the benefits that the Certificate of Need Regulations have had on New Hanover Regional Medical Center's facilities. Following the presentations, the Chair recognized individuals from the public to address the Committee on issues related to Certificate of Need and Certificate of Public Advantage.

January 19, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, January 19, 2012, in Room 544 of the Legislative Office Building at 10:00 am. Representative Torbett presided and gave a brief recap of the previous meetings held across the State. The Chair then recognized Amy Jo Johnson, Committee Counsel, to present topics for discussion regarding the Certificate of Need. The presentation included a chart containing issues and possible solutions that Research staff complied from presentations heard by the Committee and comments from public (see minutes). The Chair opened the floor for discussion and Committee members made various changes and additions to the recommendations. Staff was directed to follow-up on several questions raised by the Committee.

February 15, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Wednesday, February 15, 2012, in Room 421 of the Legislative Office Building at 9:00 am. Shawn Parker, Committee Counsel, began with a review of the items pertaining to the Certificate of Public Advantage. The presentation was followed by extensive Committee discussion.

March 15, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, March 15, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The first presentation of the day was made by Jonathan Christenbury, MD regarding amending the Certificate of Need Law to allow ophthalmic procedure rooms in licensed health services facilities in order to improve patients' access and choice. Next the Committee continued discussions on possible recommendations regarding the Certificate of Need law. After lunch citizens from Harnett County spoke on how the Certificate of Need law impacts health care, the economy, and overall well-being of their county. The speakers present from Harnett County were: Pat Cameron, Good Hope Hospital; Jim Burgin, Harnett County Commissioner; Dr. Linda Robinson, Family Practitioner; and Patsy Carson, Mayor of Erwin. The Chair then opened the floor for discussion. At the end of the meeting, the Chair directed staff to start assembling a draft interim report for the Committee's consideration at a future meeting.

April 19, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, April 19, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The Committee discussed a draft of the interim report.

Having clear and open processes enables the stakeholders, as well as the public, to fully participate in the programs and encourages more thorough oversight of the Certificate or Need and Certificate of Public Advantage programs. The Committee believes that maintaining the utmost integrity of these programs is vital. The Division of Health Service Regulation should continue to expand upon its procedures to create more expeditious and transparent processes within the Certificate of Need and Certificate of Public Advantage programs.

The Committee finds that in order to effectuate the purpose of a certificate of public advantage, which is to foster improvements in the quality health care services, moderate health care costs, and improve access to health services in underserved areas, regulatory and judicial oversight of such agreements are necessary to ensure that the benefits of cooperative agreements outweigh the disadvantages and reduction in competition resulting from such agreements.

The Committee concludes there is a need for more transparency and accountability by the State Health Coordinating Council for decisions it makes in the development of the State Medical Facilities Plan. The Committee finds, while it is necessary for the State Health Coordinating Council members to have certain experience and expertise in the health care industry, there is concern of public perception of impropriety based on potential conflicts of interest and the potential of undue influence by a single individual based on the current appointing process. While exemptions to the provisions of need determinations of the North Carolina State Medical Facilities Plan may be necessary, fairness dictates exemptions should be limited to the greatest extent possible so that all applicants of a particular type of health services are subject to the same requirements.

The Committee heard concerns that the specified capital expenditure amounts for certain projects and activities needed to be adjusted based on inflation or necessity and that Certificate of Need review and regulation is no longer needed for specified equipment acquisitions and services. Further the length and volume of appeals cause delays in the provision of needed facilities and/or services. It is in the best interest of the State that the Certificate of Need process be as expeditious as possible and that unnecessary delays be deterred and there should be an expedited process for appellate review in order to shorten the overall Certificate of Need determination process.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues shall continue its in depth review of health care service regulation in North Carolina and shall, after prudent deliberation, recommend changes that are equitable and effective.

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

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ATTENDANCE

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

DATES	09/14/11	10/06/11	10/20/11	11/01/11	11/17/11	01/19/12	02/15/12	03/15/12	04/19/12	09/13/12	09/27/12	10/11/12	10/25/12	11/15/12	12/06/12
Representative Fred Steen, Co-chair	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Representative John Torbett, Co-chair	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Representative Martha Alexander	X			X		X		X	X		X				
Representative Marilyn Avila	X		X	X	X	X	X		X	X		X	X	X	X
Representative Jamie Boles	X	X		X		X	X	X	X		X			X	X
Representative Marcus Brandon		X			X		X				X	X			X
Representative Jeff Collins	X	X	X				X	X	X	X	X			X	X
Representative Bill Current	X	X				X	X	X	X	X	X			X	X
Representative Rick Glazier						X		X	X	X					
Representative Mark Hollo	X	X				X	X	X	X		X		X	X	X
Representative Shirley Randleman	X	X		X		X	X	X	X		X	X		X	X
Chris Hayes, Speaker's Office	X	X				X	X		X						
Amy Hobbs, Speaker's Office	X	X						X	X						
Shawn Parker, Staff Attorney	X	X	X	X	X	X	X	X	X						
Barbara Riley, Staff Attorney	X	X	X		X	X		X		X				X	X
Amy Jo Johnson, Staff Attorney	X	X	X	X	X	X		X	X	X	X	X	X	X	X
Jan Paul, Staff Attorney	X	X	X	X	X	X		X	X	X		X	X	X	X
Susan Barham, Research Assistant	X		X		X	X	X	X	X	X	X	X	X	X	X
Lisa Hollowell, Fiscal Research	X														
Viddia Torbett, Committee Assistant	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Joyce Jones, Staff Attorney		X				X		X	X					X	X

Office of Speaker Thom Tillis
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TO THE HONORABLE MEMBERS OF THE NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on the Certificate of Need Process and Related Hospital Issues (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

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Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1.

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2012, by filing a copy of the report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives prior to the convening of the 2013 General Assembly by filing the final report with the Office

of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee terminates upon the convening of the 2013 General Assembly or upon the filing of its final report, whichever occurs first.

Effective this the 24th day of August, 2011.

Thom Tillis

Thom Tillis
Speaker

Everett J. Bowman
Charlotte Office
704.377.8329 Direct Phone
704.373.3929 Direct Fax
ebowman@rbh.com

rbh.com

March 23, 2012

Email and First Class Mail

Representative Fred F. Steen, II (fred.steen@ncleg.net)
House Select Committee on the Certificate of Need Process and Related Hospital Issues
300 N. Salisbury Street, Room 305
Raleigh, NC 27603-5925

Representative John A. Torbett (john.torbett@ncleg.net)
House Select Committee on the Certificate of Need Process and Related Hospital Issues
300 N. Salisbury Street, Room 537
Raleigh, NC 27603-5925

Ms. Viddia Torbet, Committee Clerk (torbettla@ncleg.net)
House Select Committee on the Certificate of Need Process and Related Hospital Issues
300 N. Salisbury Street, Room 537
Raleigh, NC 27603-5925

Mr. Shawn Parker (shawn.parker@ncleg.net)
Senior Legislative Analyst and Staff Attorney
300 N. Salisbury Street, Room 545-LOB
Raleigh, NC 27603-5925

Re: Request for Public Records relating to Certificate of Public Advantage

Dear Messrs. Steen, Torbett and Parker and Ms. Torbett:

Pursuant to Section 132-6 of the General Statutes of North Carolina, I write to request copies of all public records relating in any way to any Certificate of Public Advantage or Article 9A of Section 131E of the North Carolina General Statutes. Please provide them at your earliest convenience; we will remit the cost of producing these records. Note that this request does not seek any communications, emails or materials submitted to the Select Committee by Robinson, Bradshaw & Hinson, P.A. or by Mission Health System, Inc. and related entities.

Please let me know if any of you have questions regarding this request. Thank you for your assistance.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Everett J. Bowman

EJB:rhk
cc: Ann Y. Young, Mission Health System, Inc.

Viddia Torbett (Rep. Torbett)

From: NCGA Committee Notices <noreply@ncleg.net>
Sent: Tuesday, August 30, 2011 10:10 AM
Subject: <NCGA> House House Select Committee on Certificate of Need Process and Related Hospital Issues Committee Meeting Notice for Wed, 09-14-2011 at 10:00am

NORTH CAROLINA HOUSE OF REPRESENTATIVES

COMMITTEE MEETING NOTICE

AND

BILL SPONSOR NOTIFICATION

2011-2012 SESSION

You are hereby notified that the Committee on **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Wednesday, September 14, 2011

TIME: 10:00am

LOCATION: 544 LOB

COMMENTS: 10:00am - 12:00pm Introduction, Health Care Facilities, CON

12:00pm - 1:00pm Lunch Break

1:00pm - 3:00pm CON, COPA

Respectfully,

Representative Steen, Chair

Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at

9 AM o'clock on **August 30, 2011**.

Principal Clerk

Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

This message was sent to you by Viddia Torbett (Rep. Torbett) (torbettla@ncleg.net) because you signed up to receive NC General Assembly Committee Notices by email. To unsubscribe, visit http://www.ncleg.net/gascripts/Committees/Committees.asp?sAction=ViewDLForm&sActionDetails=House%20Standing

General Assembly of North Carolina

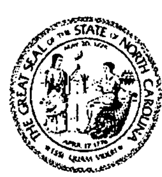
REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

State Legislative Building
Raleigh, North Carolina



AGENDA

10:00 a.m. Wednesday, September 14, 2011
Room 544 Legislative Office Building

I. Call to Order and Introductory Remarks
Representative Fred Steen
Representative John Torbett

II. Committee Charge
Shawn Parker, Research Division, NCGA

III. State Health Services Planning and Certificate of Need
Barbara Riley, Research Division, NCGA
Amy Jo Johnson, Research Division, NCGA
Jan Paul, Research Division, NCGA

IV. Certificate of Public Advantage
Shawn Parker, Research Division, NCGA

V. Committee Discussion

VI. Adjourn

Next meeting:
10:00 a.m., October 6, 2011,
544 Legislative Office Building

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

Wednesday, September 14, 2011

1:45 p.m.

Room 544, Legislative Office Building

The House Select Committee on Certificate of Need and Related Hospital Issues met on Wednesday, September 14, 2011, at 1:45 p.m. in Room 544 of the Legislative Office Building. Representatives Alexander, Boles, Collins, Current, Hollo, Randleman, Steen, and Torbett attended.

Representative Steen presided. He welcomed the Committee members.

PRESENTATIONS

Shawn Parker, Research Division, NCGA, gave a presentation on the Committee Charge (see attached). A

Barbara Riley, Research Division, NCGA, Amy Jo Johnson, Research Division, NCGA, and Jan Paul, Research Division, NCGA, gave a presentation on State Health Services Planning and Certificate of Need (see attached). B B

Representative Steen gave overview of Constitutional changes and asked for questions.

Representative Torbett: If you could expand on the last slide on page 39 where it references 1993-7, the term any person?

Amy Jo Johnson: What happened in 93, prior to that it really was just health service facilities that were needing to apply for a certificate of need for their institutional health services, and in 93 it opened it up to any person, that would also involve physicians and providers and not just the facilities themselves, so it really broadened that category of people that would be going through the certificate of need process.

Representative Current: The appointment of the SHCC members, is that by the governor, you mentioned the chair and so forth?

Janice Paul: Yes, the governor appoints all 29 members of the SHCC as well as designates which member is going to be chair and co-chair and then they are divided up into different committees, they'll have an acute care committee, they have various committees that report to

the council, then the council makes recommendations and decisions that regulate the form of the plan.

Representative Current: Are they required to fill out conflict documents and so forth?

Janice Paul: Based on my understanding, from prior discussion with the department, they would be subject to the same ethics and conflict requirements as the general assembly.

Representative Current: Can the governor override any decision the committee makes?

Janice Paul: The governor has to approve the plan. If the governor does not approve the plan, then it goes back to the committee for re-keying of the plan to meet with the governor's specifications.

Representative Current: If there is a decision made by the committee for or against issuing a certificate of need, can the governor override that?

Barbara Riley: No, the governor would not be able to override. If somebody wants to object, it goes up through the legal process, that is not to say, many of these cases are settled to the extent that there are settlement agreements between the department and provider involved. I would assume that decisions are made at that level. The decision itself is appealed through the office of administrative hearings, then the court of appeals. It cannot be unilaterally changed by the governor.

Shawn Parker, Research Division gave presentation on COPA (see attached)Ⓒ.

Representative Steen asked for questions.

Representative Steen: Is the COPA review process mostly done through the attorney general's office or through the department?

Shawn Parker: What is prescribed is that either of those offices can initiate a review. I believe that the biennial report is where the review takes place and that would require public comment and notice that the report has been provided.

Representative Steen: The general assembly changed some things this year and was COPA reviewed by the general assembly since its conception back in the 90's?

Shawn Parker: As far as the action from this body beyond initial enacting of the statute, there was an adjustment in 1998. There was an additional adjustment which as more technical, in 2005, related to the department of health and human resources changed to the department of

health and human services, but as far as what this body controls, they do not take part of it, they do have the authority to change the statute, which would then govern the review process but beyond being members of the public or having influence within the other two bodies, this body did not review the COPA or take any official action towards it.

Representative Steen: The physician employment cap was changed this year, is that right?

Shawn Parker: Yes, the third amendment amended it from 20 to 30% and may have had a few other adjustments as well.

Representative Collins: My question is this, back on page 2, if we are going to have an institution operating under a COPA, from which I understand that we have one operating in the state, the federal government will allow us to basically bypass their antitrust laws as long as we meet a two prong test, one of which is to provide active supervision and is our reading a review every two years considered sufficient to provide that supervision or are we doing other supervisory activities that we didn't bring out in this rather brief review?

Shawn Parker: I don't believe the active supervision prong has not been challenged, again, as the statute reads, it has the requirement of every two years, and it has the ability to review at any time. There has not been any federal antitrust challenge to the one in operation yet.

Representative Boles: How many employees oversee COPA?

*Shawn Parker: Defer to department to answer.

Representative Alexander: Has any other hospital tried for COPA?

*Shawn Parker: Verify with Mr. Stewart, Mission Hospital is the only application.

*Representative Current: 1. what is the cost and percent of increase in cost of healthcare in the states that have CON versus the states that do not?

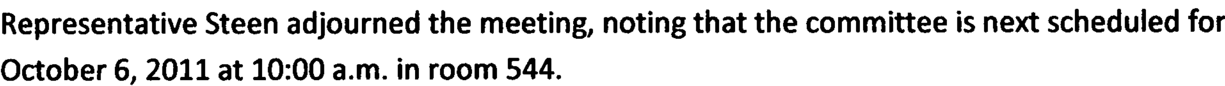
*2. What is the future projection of CON & COPA if the affordable healthcare act becomes law?

3. If someone is granted a CON can they give some beds to someone else or work out a deal?

Barbara Riley: No.

Representative Current: In other words CON would have to approve whole deal?

Barbara Riley: Yes.



Representative Steen adjourned the meeting, noting that the committee is next scheduled for October 6, 2011 at 10:00 a.m. in room 544.

*Answers to above questions attached.

Representative Fred Steen, Co-Chair Presiding

Viddia Torbett, Clerk

Representative John Torbett, Co-Chair

I. Committee Authorization, Powers , and Duties

1. Appointed by letter- requires a Q of 6 members be established prior to taking official action
2. Authorized to meet in the interim or between sessions
3. Meet in Raleigh or with approval elsewhere (public hearing)
4. Deemed a committee of the House
    a. Permanent House rules apply
    b. Limitation to matters contained in the authorization
5. Powers under Articles 5 and 5A
    a. Compel state agencies to provide all information and data in their possession or attainable from their records
    b. Call witnesses and compel testimony (under oath)
        i. Process for the committee to subpoena a witness if warranted

II. Matters properly before the committee:

1. Review concepts and provisions as provided in House Bill 743 and 812
    a. H743- Requires all rules, policies, and need determinations in the State Medical Facilities Plan apply equally to particular types of health services.
    b. H812 requires any hospital authority engaging in activities outside its territorial boundary obtain a Certificate of Public Advantage
2. Study the provisions of law relating to Certificate of Need
3. Roles of state-owned and publically owned hospitals and public hospital authorities to operate beyond the boundaries
4. Issues related inconsistencies in rules, policies, and limitations within each county that a hospital with a COPA operates
5. Business relationships among and between publically owned hospitals and entities that are operating under a CON or COPA.
6. Other matters reasonably related.

III. Reports required

1. Interim report is authorized to be submitted on or before May 1, 2012
2. Final report required by the convening of the 2013 General Assembly- Committee terminates upon filing.

Appendix A: North Carolina Health Service Areas

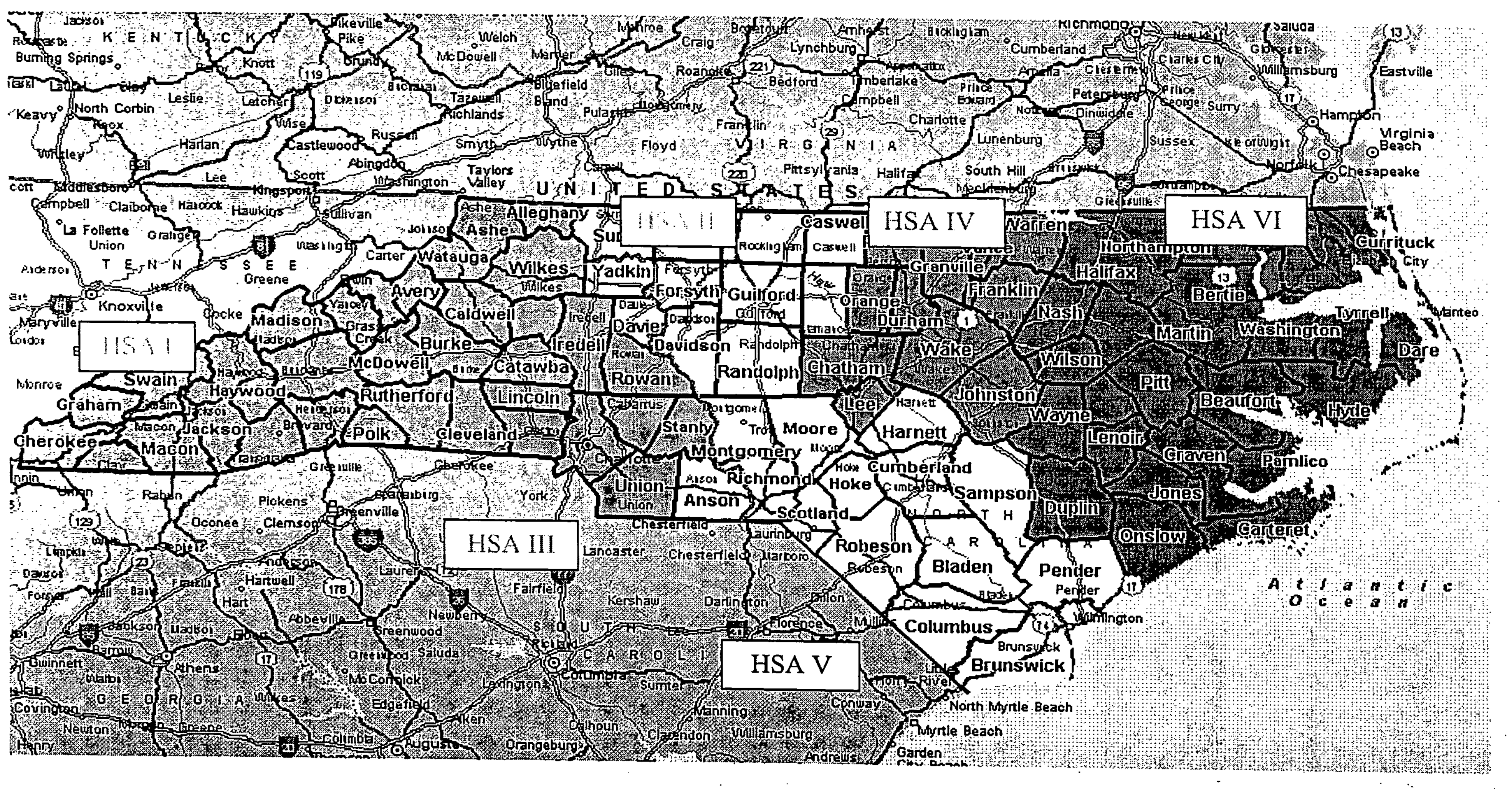


Table 3A: 2012 Proposed Certificate of Need Review Schedule

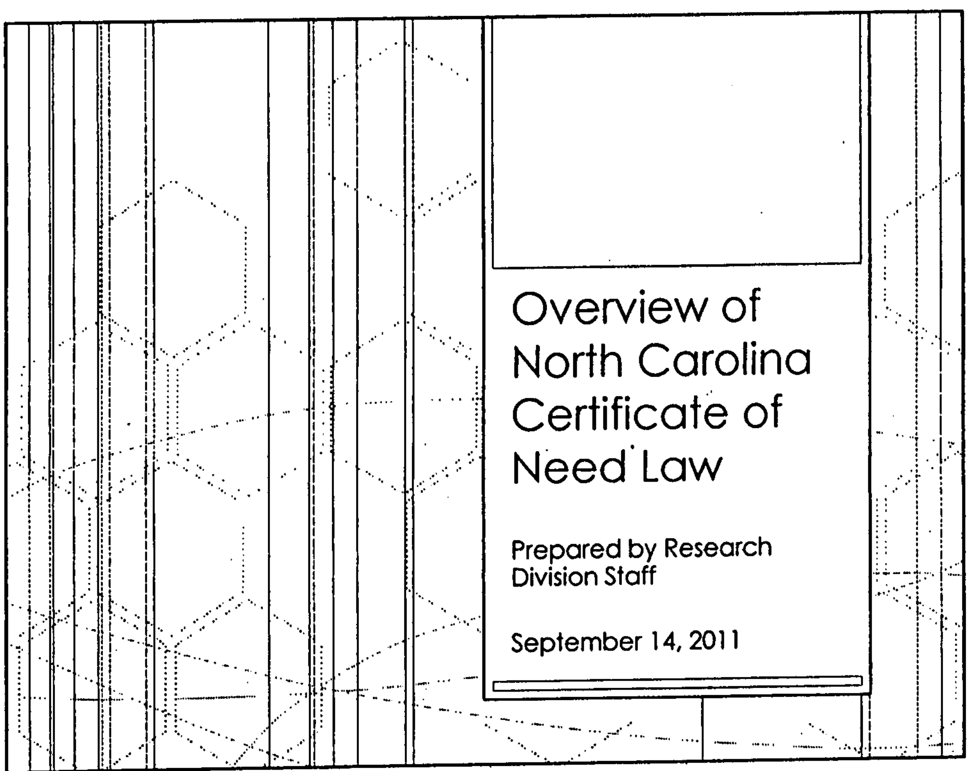
CON Beginning Review Date	Health Service Area I, II, III	Health Service Area IV, V, VI
January 1, 2012	--	--
February 1, 2012	A, B, C, G, H, I	--
March 1, 2012	--	A, B, C, E, G, H, I
April 1, 2012	C, D, E, F, H, I, K(1), M(1)	D
May 1, 2012		C, F, H, I, K(4), M(4)
June 1, 2012	A, B, C, F, H, I	
July 1, 2012	J	A, B, C, E, H, I, J, K(5), M(5)
August 1, 2012	B, C, E, F, H, I, K(2), M(2)	--
September 1, 2012	--	B, C, E, F, H, I
October 1, 2012	A, C, D, F, H, I	D
November 1, 2012	B, C, E, H, I, L, K(3), M(3)	--
December 1, 2012	--	A, B, C, E, F, H, I, L, K(6), M(6)

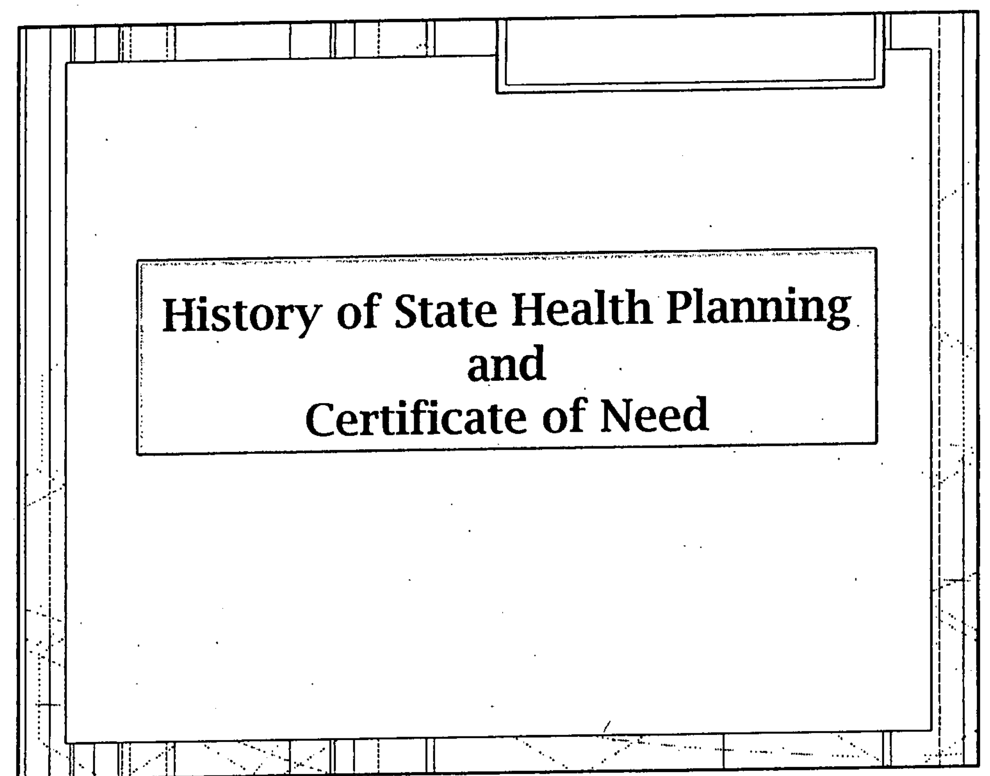
(1) HSA I only.
(2) HSA II only.
(3) HSA III only.
(4) HSA IV only.
(5) HSA V only.
(6) HSA VI only.

For further information about specific schedules, timetables, and certificate of need application forms, contact:

North Carolina Division of Health Service Regulation
Certificate of Need Section
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

Phone: (919) 855-3873


Overview of
North Carolina
Certificate of
Need Law
Prepared by Research
Division Staff
September 14, 2011


History of State Health Planning
and
Certificate of Need

History of State Health Planning and Certificate of Need

- General Purposes of State Health Planning and Certificate of Need:
  - Define need for health care facilities and services.
  - Control costs by preventing the unnecessary duplication of facilities and services.
  - Improve access to health care facilities and services in rural areas and by medically underserved populations

History of State Health Planning and Certificate of Need

- Federal Health Planning efforts began with passage by Congress of the Hospital Survey and Construction Act. P.L. 79-725. (Hill-Burton Act).
- Hill- Burton was designed to provide Federal grants to modernize hospitals that had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II (1929 to 1945).
- 6,800 health care facilities in more than 4,000 U.S. communities received grants and loans for construction and modernization.

History of State Health Planning and Certificate of Need

- Hill-Burton facilities must provide free or low cost health care services to all persons residing in the facility's area who cannot afford to pay for the services.
- Hill-Burton obligated facilities in North Carolina are:
  - Piedmont Health Service, Chapel Hill
  - Cumberland County Health Department
  - Snow Hill Medical Center
  - New Hanover Community Health Clinic

History of State Health Planning and Certificate of Need

- Hill-Burton is considered the catalyst for State health planning efforts.
- In addition to providing funding for modification and construction of hospital facilities, the act provided federal funds for local health planning councils which were charged with determining the need for hospital facilities.
- Sought to assure an adequate distribution of health care facilities.
- Hospitals were required to submit plans to the State for approval prior to the start of construction.
- Plans submitted had to be consistent with the State's health plan.

History of State Health Planning and Certificate of Need

- First State CON program was enacted by New York in 1964. Metcalf-McCloskey Act of 1964. Ch. 730 (1964) NY Laws 1883.
- New York law mandated a determination of need for a new hospital or new nursing home facility prior to approval for construction.
- Maryland, Rhode Island, California, and Connecticut adopted CON programs during the next 5 years.
- The certificate of need approach to controlling health care costs was endorsed by the American Hospital Association and by 1975, twenty States had adopted Certificate of Need programs.

History of State Health Planning and Certificate of Need

- Meanwhile, at the federal level, Congress continued to expand and encourage State health planning efforts.
- The Comprehensive Health Planning Act of 1966 provided funding for State and local health planning councils.
- Planning efforts were expanded to include health manpower and services.
- Health planning councils were to assess the health needs of each area and plan for the coordination and development of new services.
- Councils had no authority to enforce their plans.

History of State Health Planning and Certificate of Need

- Section 1122 of the Social Security Act Amendments of 1972 required States to review all proposed health care capital expenditures in excess of $100,000 to determine if they fit in with the State health plan.
- Also required review of changes in bed capacity and substantial changes in services offered.
- States that did not comply risked losing Medicare/Medicaid funding.

History of State Health Planning and Certificate of Need

- In 1974, Congress enacted the National Health Planning and Resource Development Act which established the first CON program requirements.
- The legislation required the states to create local health service agencies, designate a State Health Planning and Development agency, and create a State Health Coordinating Council to carry out the planning function consistent with federal requirements.

History of State Health Planning and Certificate of Need

- Proposed projects had to be consistent with the State's health plan to be approved for construction or implementation.
- Intent was to assure a proper distribution of health care facilities and services throughout the State and to control health care costs by eliminating the unnecessary duplication of such facilities and services.

History of State Health Planning and Certificate of Need

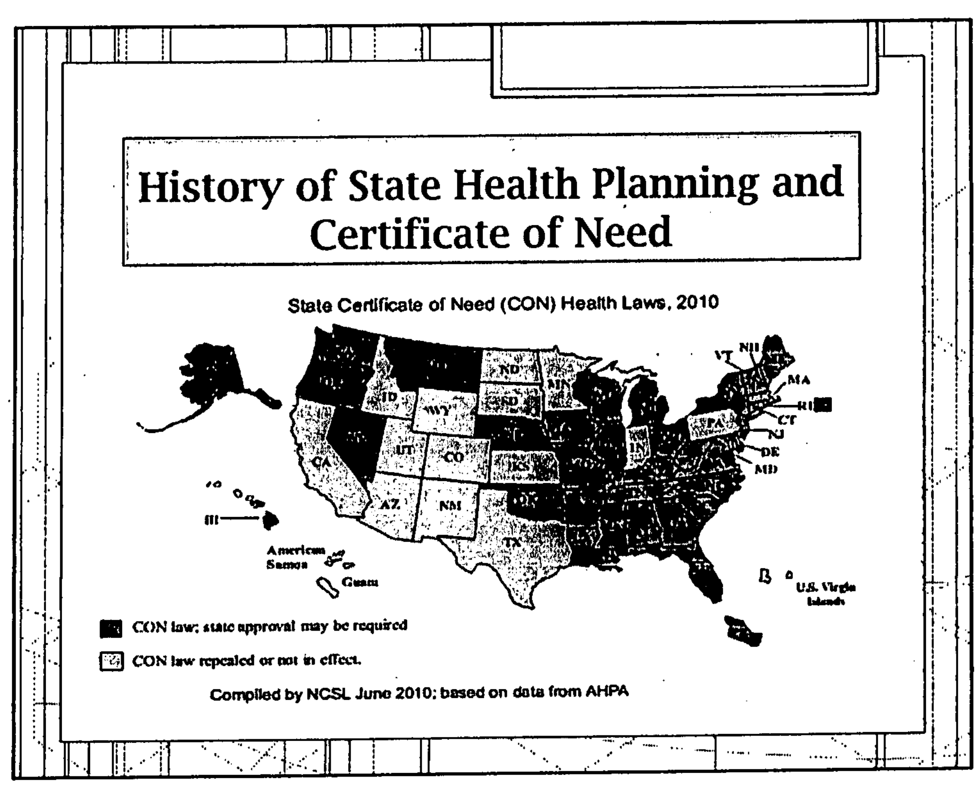
- NHPRDA was amended in 1979 to require CON programs to consider "Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness".
- By 1980, all States had either established CON programs or were operating under Section 1122 agreements.

History of State Health Planning and Certificate of Need

- A Congressional Budget Office study of federal health planning programs was undertaken in 1982. The effectiveness of the federal programs in cost containment and the effects on competition were brought into question.
- NHPRDA repealed effective January 1, 1987. States were allowed to continue their health planning and certificate of need programs, but federal funding would no longer be provided.

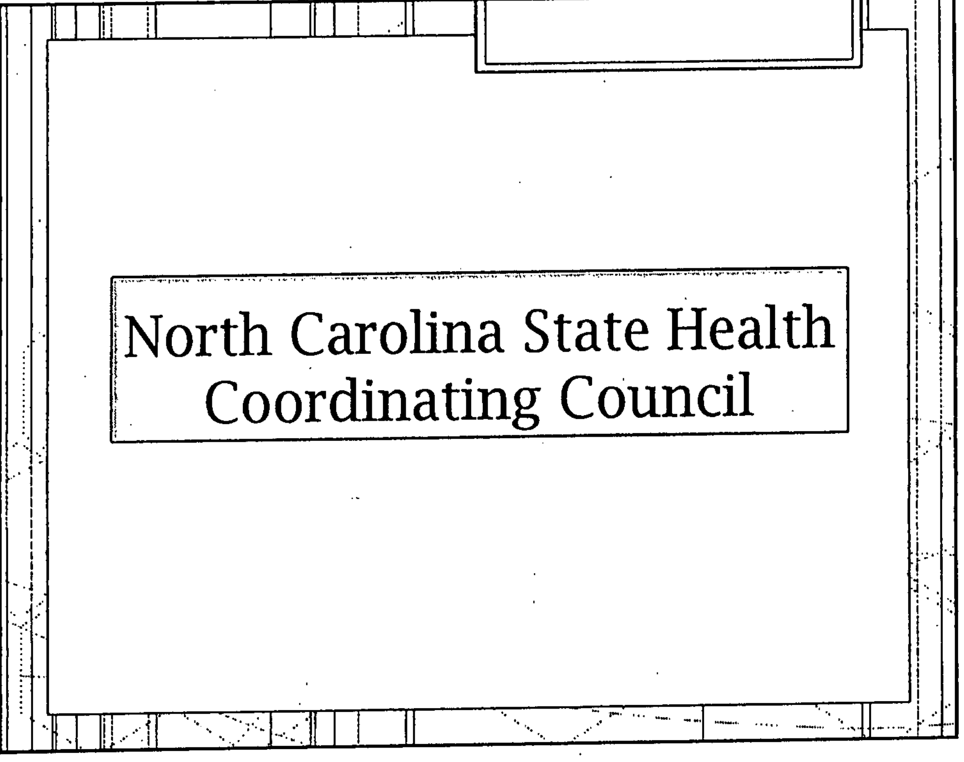
History of State Health Planning and Certificate of Need

- 14 States repealed their CON programs in the decade after the repeal of NHPRDA. 36 States and the District of Columbia still maintain CON programs.
- Many States that repealed CON, however, still maintain some cost control regulation.
- Efficacy of CON to meet health planning goals continues to be reviewed by the States, including Georgia (2006), Illinois (2007) and Georgia (2008).



History of State Health Planning and Certificate of Need

- A final note regarding a recent constitutional challenge to Certificate of Need laws.
- August 19, 2011 Ninth Circuit Court of Appeals decided Yakima Valley Memorial Hospital v. Washington State Department of Health, 2100 WL 3629895 (2011).
- Court held CON applicant had standing to raise a dormant commerce clause claim regarding whether a certificate of need regulation constituted an undue burden on interstate commerce. The case was remanded to the District Court for further proceedings.



North Carolina State Health
Coordinating Council

- **Establishment and Membership:**
  - Originally established by Executive Order No. XIX signed by Gov. Holshouser on June 1, 1976.
  - Directs the development of the annual State Medical Facilities Plan, which prescribes the policies and methodologies used in determining need for new health care facilities and services in North Carolina. G.S. 131E-177.

Establishment and Membership continued:

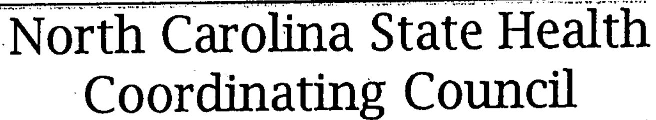
Current Council created by Executive Order No. 139 by Gov. Mike Easley on March 3, 2008. Provides for 29 members appointed by the Governor:

- 1 member from the academic medical centers
- 1 member from the area health education centers
- 2 members from business and industry (at least one individual representing small business and one representing large business)
- 1 member from the health insurance industry
- 1 member from the N.C. Association of County Commissioners
- 1 member from the N.C. Health Care Facilities Association
- 1 member from the N.C. Hospital Association
- 1 member from the N.C. Association for Home Care
- 1 member from the N.C. Association of Long-Term Care Facilities
- 1 member from the N.C. Association of Local Health Directors
- 1 member from the N.C. Medical Society
- 1 member from the N.C. House of Representatives
- 1 member from the N.C. Senate
- 1 member from the U.S. Department of Veterans Affairs (non-voting)
- 14 at-large members to represent other health professional associations and to ensure regional representation

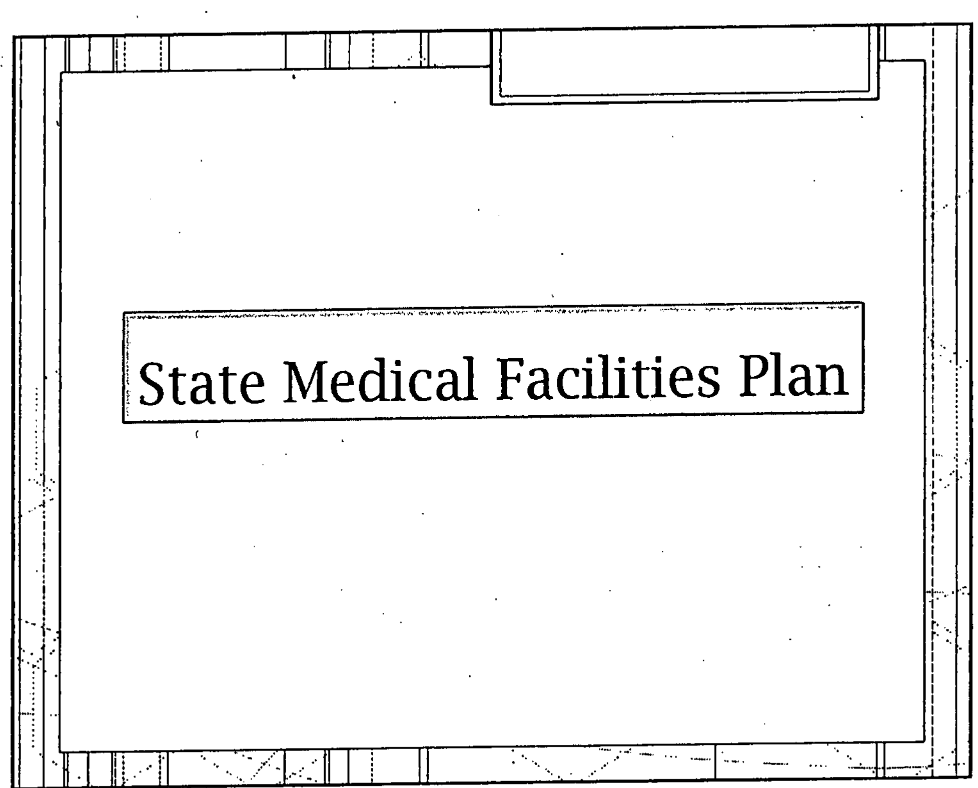
Current SHCC Members

Member	Representing	From
William Wainwright, Chairman	N.C. House of Representative	Havelock
Donald Beaver	Health Care Facilities Association	Hickory
Bill Bedsole	At-Large	Washington
Greg Beier	At-Large	Winston-Salem
Don Bradley, MD	Health Insurance Industry	Durham
Richard Bruch, MD	N.C. Medical Society	Durham
Vacant	At-Large	
Dennis Clements, III, MD	Academic Medical Centers	Durham
Johnnie Farmer	County Commissioners Association	Aulander
Anthony Forlest	N.C. Senate	Graham
Sandra Greene, DrPH	At-Large	Chapel Hill
Ted Griffin	Business and Industry	Durham
Harold Hart	Business and Industry	Siler City
Laurence Hinsdale	At-Large	Concord
Daniel Hoffman	Department of Veterans Affairs	Durham
John Holt, Jr., MD	At-Large	Raleigh
Eric Janis, MD	At-Large	Smithfield
Brenda Latham-Sadler, MD	At-Large	Winston-Salem
Leslie Marshall, MD	At-Large	Raleigh
Frances Mauney	At-Large	Durham
Zach Miller	Long-Term Care Facilities Association	Wilmington
Jerry Parks	Association of Local Health Directors	Edenton
Prashant Patel, MD	At-Large	Cary
Thomas Pulliam, MD	At-Large	Winston-Salem
Pam Tidwell	Home Care Association	Asheville
Deborah Teasley, PhD	Area Health Education Centers	Fayetteville
Christopher Ullrich, MD	At-Large	Charlotte
Zane Walsh, MD	At-Large	Fayetteville
John Young	N.C. Hospital Association	Kings Mountain

- Next meeting September 28, 2011, on the Dorothea Dix Campus at the Brown Building, Conference Room 104, beginning at 10:00 a.m.



- Members serve 3-year staggered terms so that the terms of approximately 1/3 of the members expire in a single calendar year.
- Chair and Vice-Chair appointed by Governor for 2-year terms.



State Medical Facilities Plan

- **What is it?**
  - An annual document containing policies and methodologies used in determining need for new health care facilities and services in North Carolina.
  - Developed by the North Carolina Department of Health and Human Services, Division of Health Services Regulation, under the direction of the North Carolina State Health Coordinating Council.
  - Must be approved by the Governor.
  - Each Plan takes effect on January 1st and expires on December 31st.

State Medical Facilities Plan

- The purpose of the Plan is to make an overall needs assessment.
- Major objective is to provide individuals, institutions, state and local government agencies, and community leadership with policies and projections of need to guide local planning for specific health care facilities and services.

State Medical Facilities Plan

- **What's in it?**

10A NCAC 14C .0103 STATE MEDICAL FACILITIES PLAN

(a) The North Carolina State Medical Facilities Plan contains the following information:

(1) inventory of certain categories of inpatient and outpatient health care facilities, including number of beds and utilization of beds;

(2) type of services provided by each category of health care facility;

(3) projections of need for acute care hospitals (including rehabilitation services), long-term care facilities (including nursing homes, home health agencies, and hospice inpatient facilities), mental health facilities and end stage renal dialysis services for various geographical areas of the state;

(4) statement of policies related to acute care facilities, rehabilitation services, long-term care, psychiatric facilities, chemical dependency facilities, and facilities for intermediate care for the mentally retarded, which are used with other criteria contained in this Subchapter and in G.S. 131E-183 and need projections to determine whether applications proposing additional beds and services of these types may be approved under the certificate of need program; and

(5) the certificate of need review schedule and description of review categories.

State Medical Facilities Plan

- Determination of need is based primarily on population growth and demographics.
- The projections of need for the various facilities and services are used in conjunction with other statutes and rules in reviewing certificate of need applications for establishment, expansion, or conversion of health care facilities and services.

State Medical Facilities Plan

- Projections of need are provided for the following types of facilities:
  - acute care hospitals
  - operating rooms
  - inpatient rehabilitation facilities
  - technology services
  - nursing care facilities
  - adult care home beds
  - Medicare-certified home health agencies
  - end-stage renal disease dialysis facilities
  - hospice home care and hospice inpatient beds
  - psychiatric hospital units and specialty hospitals
  - substance abuse hospital units, specialty hospitals, and residential facilities
  - intermediate care facilities for mentally retarded persons

State Medical Facilities Plan

- **Basic Principles Governing Plan Development**
  - The Department of Health and Human Services is designated under G.S. 131E-177 as the State Health Planning and Development Agency for the State of North Carolina.

State Medical Facilities Plan

- ***Approved 2011 Plan***
  - Promote cost-effective approaches
  - Expand health care services to the medically underserved
  - Encourage quality health care services
- ***Proposed 2012 Plan***
  - Safety and Quality Basic Principle
  - Access Basic Principle
  - Value Basic Principle

State Medical Facilities Plan

- Methodologies are driven by utilization and demographics.
- As utilization changes, and as the population grows and ages, methodologies may change.
- Consideration is given to county needs as well as the prevention of unnecessary duplication of health resources in an area.

State Medical Facilities Plan

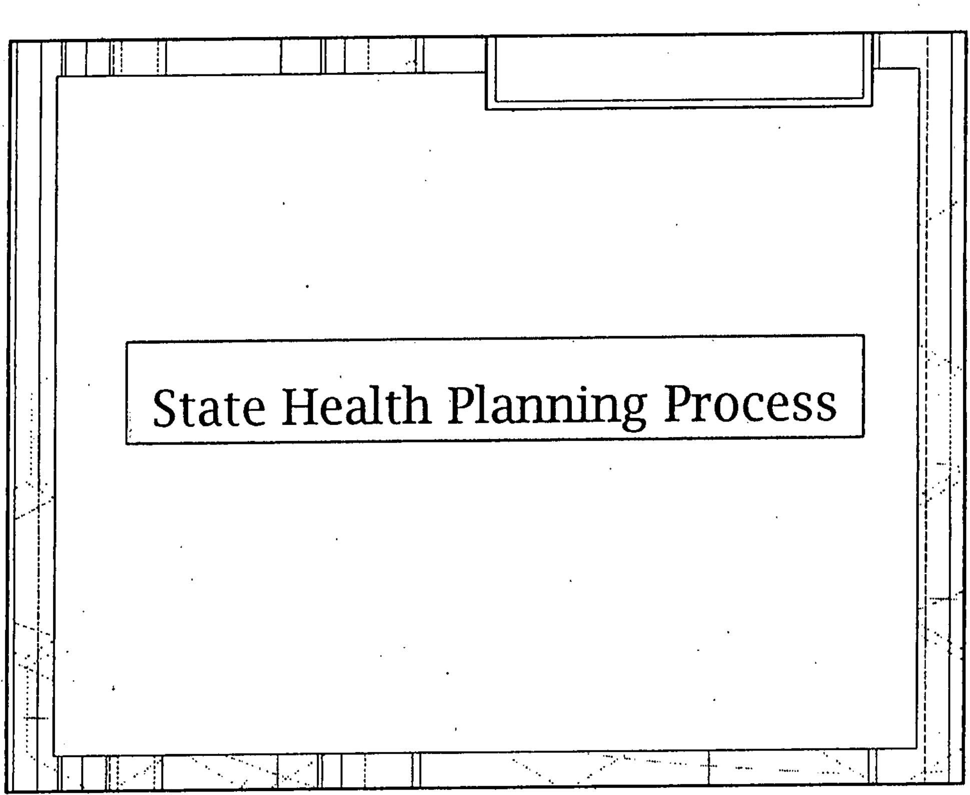
It should be noted that the State Plan does not necessarily cover all services and equipment regulated under Certificate of Need.

State Medical Facilities Plan

Although DHHS is involved in making determinations of need for services and facilities in the Plan, DHHS does not necessarily participate in the reimbursement of the cost of care of patients using services and facilities developed in response to this need.

State Medical Facilities Plan

- "Need Determinations" and, where appropriate, "Certificate of Need Application Due Dates" are listed in each service area chapter.
- Includes background information on the North Carolina State Health Coordinating Council and on the annual planning cycle, and contains general policies related to implementing the planning cycle.
- Chapters dealing with specific facility/service categories contain summaries of the supply and the utilization of each type of facility or service, a description of changes in the projection method and policies from the previous planning year, a description of the projection method, and other data relevant to the projections of need.



State Health Planning Process

State Health Planning Process

- Throughout the development of the North Carolina State Medical Facilities Plan there are opportunities for public review and comment.
- The process starts in the spring. A general public hearing is held to discuss methodologies as to how to project need determinations.

State Health Planning Process

- A public hearing is held in the winter to receive comments and petitions for changes in basic policies and methodologies for projecting need.
- Sections of the plan, including the policies and methods for projecting need, are developed with the assistance of committees of the North Carolina State Health Coordinating Council. The committees submit their recommendations to the Council for approval.

State Health Planning Process

- A proposed plan is assembled and made available to the public.
- Public hearings on the proposed plan are held throughout the state in early summer.
- Comments and petitions received during this public hearing period are considered by the council and, upon incorporation of all changes approved by the Council, a recommended proposed plan is presented to the Governor for review and approval.
- With the Governor's approval, the State Medical Facilities Plan becomes the official document for health facility and health service planning in North Carolina for the specified calendar year.

State Health Planning Process

- After the Plan has been signed by the Governor, it will be amended only as necessary to correct errors or to respond to statutory changes, amounts of legislative appropriations, or judicial decisions.
- Public hearings will be conducted on proposed amendments and the Council will recommend any changes deemed necessary and appropriate for the Governor's approval.
- Thereafter, petitions may be submitted to revise the next State Medical Facilities Plan, to change basic policies and methodologies, or to make adjustments to need determinations.

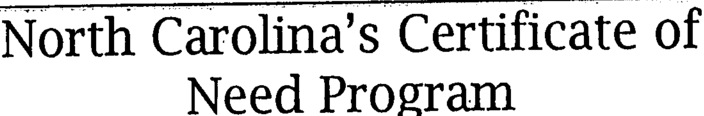
Helpful Resources

- The 2012 Proposed State Medical Facilities Plan is online at: http://www.ncdhhs.gov/dhsr/ncsmfp/2012/prop2012snfp.pdf
- Information on civil rights under Hill-Burton can be found at: http://www.hhs.gov/ocr/civilrights/understanding/Hill-Burton/index.html
- Publications relating to the North Carolina Medical Facilities Plan can be found online at: http://www.ncdhhs.gov/dhsr/mfp/publications.html
- Information on the purposes of the N. C. Division of Health Service Regulation, including links to information Certificate of Need, legislative actions, declaratory rulings, and rules and regulations, can be found at: http://www.ncdhhs.gov/dhsr/

North Carolina's Certificate of Need Program

Overview

- Certificate of need (CON) is the regulatory system through which the State determined need for certain medical facilities, services, and equipment is allocated among providers and throughout the state.
- NCGS 131E-176(3): A Certificate of Need is a written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of such project.



North Carolina's Certificate of Need Program

- CON law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services. Prior approval is also required for the initiation of certain medical services.
- A CON is valid only for the defined scope, physical location, and person named in the application and cannot be assigned except as provided by law. G.S. 131E-181.

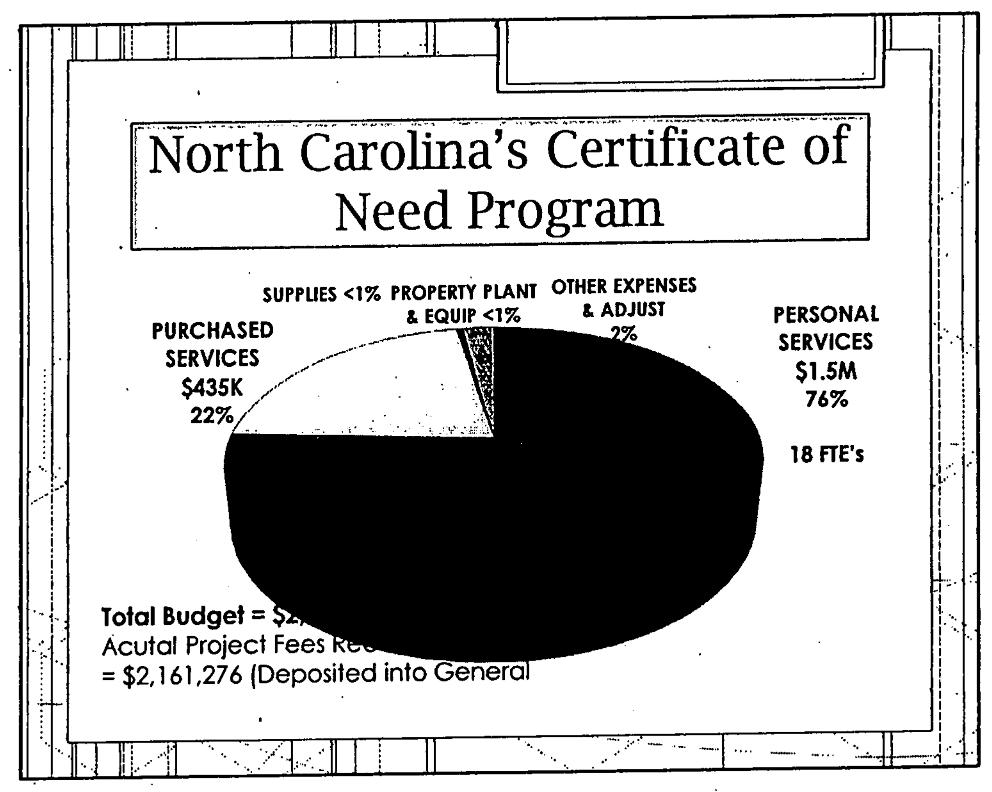
North Carolina's Certificate of Need Program

- CON Regulations are found in Article 9 of Chapter 131E of the NC General Statutes. G.S. 131E-175 – G.S. 131E-191.1.
- Certificate of Need Regulations are found in Subchapter 14C of Chapter 10A of the NC Administrative Code. (10A NCAC 14C.0101 through 10A NCAC 14C.4006)

North Carolina's Certificate of Need Program

- The CON Section (the "agency") is located in the Division of Health Services Regulation within Department of Health and Human Services.
- Data from the Department shows that the Certificate of Need Section receives an average of 217 applications for review each year.
- The CON program is primarily receipts funded.

North Carolina's Certificate of Need Program



North Carolina's Certificate of Need Program

History

- North Carolina first adopted a CON law in 1971.
- The 1971 law was found unconstitutional by the NC Supreme Court. In re Certificate of Need for Aston Park Hospital, Inc. 282 NC 542 (1973).
- The basis for the decision was that the statutory program deprived individuals of the right to use private property without due process of law.
- Legislature repealed the act shortly thereafter.

North Carolina's Certificate of Need Program

Current CON Law

- Enacted in 1977.
- Included extensive findings of fact including:
- "(7) That the general welfare and protection of lives, health, and property of the people of the State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria..."
- The NC Supreme Court has upheld the constitutionality of the current CON law.

Hope – A Women's Center, P.A. v. State, _ N.C. App. _ (2010).

Certificate of Need in NC

- **Requirement of Certificate of Need**

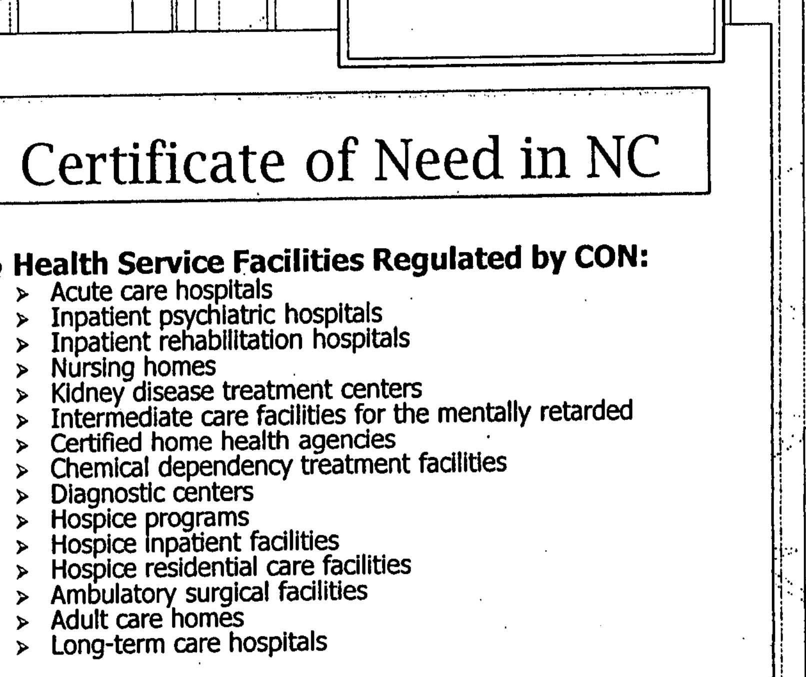
A CON must be obtained before:

- Developing or offering a "new institutional health service."
- Acquiring a health service or facility if the acquisition would have been a "new institutional health service if purchased."
- Capital expenditure of $2 million or more

Certificate of Need in NC

Developing or offering a "new institutional health service"

- Construction, development, or other establishment of a new health service facility



Certificate of Need in NC

Acute Care Hospitals*

- Hospital: A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of the injured, disabled, or sick persons, except long-term care hospitals. NCGS 131E-176(13)
- As of Spring 2011, there are 114 licensed acute care hospitals for a total of 20,699 licensed acute care beds.

Certificate of Need in NC

Long-term Care Hospitals*

- Long-term care hospital: A hospital that has been classified as a long-term care hospital by the Centers for Medicare and Medicaid Services, pursuant to 42 C.F.R. § 412. NCGS 131E-176(14k)
  - Meets Medicare's conditions of participation for acute care hospitals
  - Average stay of more than 25 days
- 2010 data indicates there are 9 licensed long-term care hospitals with a total of 424 beds.

Certificate of Need in NC

Adult Care Homes*

- Adult care home: a licensed facility with seven or more beds that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental. NCGS 1313E-176(1)
- Services are founds in adult care homes, nursing homes, and hospitals.

Adult Care Homes (continued)

- 41,809 licensed beds
- 996 licensing pending beds
- 530 beds with previous need determinations for which a CON has not been issued

Certificate of Need in NC

Hospice Programs*

- Hospice: Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. A hospice program of care provides palliative and supportive medical to meet needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement. NCGS 131E-176(13a)

- 257 hospice facilities
  - 35 hospice inpatient facilities with 323 beds
  - 26 hospice residential facilities with 177 beds

End-stage Renal Disease (ESRD) Facilities*

- Kidney disease treatment center: A facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, pursuant to 42 C.F.R. § 405. NCGS 131E-176(14e)
  - Renal transplantation center
  - Renal dialysis center
  - Renal dialysis facility
  - Self dialysis unit
  - Special purpose renal dialysis facility

- 168 ESRD centers that are certified and operational
- 214 CONs are issued for more centers but they are not yet certified

Certificate of Need in NC

Substance Abuse Inpatient and Residential Services*
(Chemical Dependency Treatment Beds)

- Chemical dependency treatment facility: A facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. NCGS 131E-176(5a)

- 3 state-owned Alcohol and Drug Abuse Treatment Centers (ADATCs) have 240 beds
  - Julian F. Keith ADATC – Black Mountain, NC
  - R. J. Blackley ADATC – Butner, NC
  - Walter B. Jones ADATC – Greenville, NC

- 17 non-state owned in specialty and acute care hospitals
- 15 residential treatment facilities
- 658 beds

- Beds specifically for detoxification are not included.

Intermediate Care Facilities for Mentally Retarded*(ICF/MR)

- Intermediate care facility for the mentally retarded: Licensed facilities providing health and habilitative services for persons with mental retardation, autism, cerebral palsy, epilepsy or related conditions.
  NCGS 131E-176(13a)
  - ICF/MR is a category of group home under the federal-state Medicaid program.
  - 5,084 certified beds

Certificate of Need in NC

Also regulated by CON as a "new institutional health service"

- Operating Rooms
- Gastrointestinal Endoscopy Rooms

Certificate of Need in NC

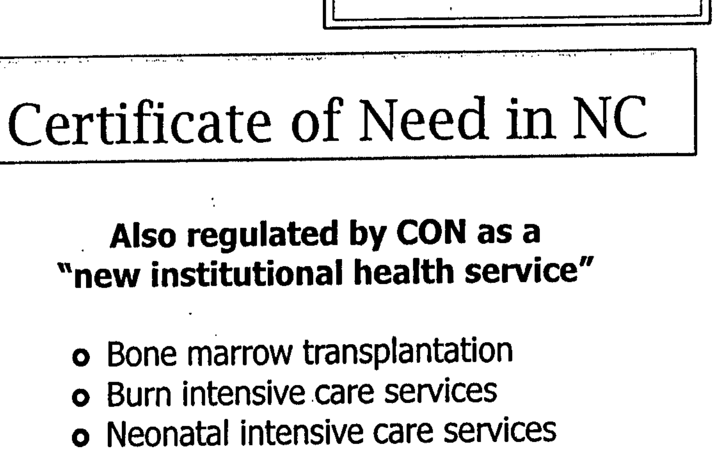
Operating Rooms*

- Operating room: A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room. NCGS 131E-176(18c)
- Ambulatory surgical facility: A facility designed for the provision of a specialty or multispecialty ambulatory surgical program.. An ambulatory surgical facility may only admit patients for a period of less than 24 hours. NCGS 131E-176(1b)
  - 161 dedicated inpatient surgery rooms
  - 292 dedicated ambulatory surgical facility rooms
  - 869 shared operating rooms.

Certificate of Need in NC

Gastrointestinal Endoscopy Rooms*

- Session Law 2005-36 removed GI endoscopy rooms from the definition of operating room.
- Gastrointestinal endoscopy room: A room used for procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes. NCGS 131E-176(7d)
- 444 GI Endoscopy rooms



Certificate of Need in NC

Bone Marrow Transplantation Services*

- Bone marrow transplantation: The process of infusing bone marrow into persons with diseases to stimulate the production of blood cells. NCGS 131E-176(2a)
- Two Types:
  - Allogeneic (donor)
  - Autologous (self)

> 593 transplants were performed in FY 2009-2010. Allogeneic bone marrow transplants are limited to the 5 Academic Medical Center Teaching Hospitals.

Certificate of Need in NC

Burn Intensive Care Services*

- Burn intensive care services: Services provided in a unit designed to care for patients who have been severely burned. NCGS 131E-176(2b)
- Currently there are 2 burn intensive care service centers:
  - WFU Baptist Hospital
  - UNC Hospital
- Total of 29 burn unit beds

Certificate of Need in NC

Cardiac Catheterization Services*

- Cardiac catheterization services: Procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart. NCGS 131E-176(2g)
  - 51 hospitals
  - 3 cardiac diagnostic centers (outpatient facilities)
  - 12 mobile cardiac units

Certificate of Need in NC

Open-heart Surgery Services*

- Open-heart surgery services: The provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects. NCGS 131E-176(18b)

> 22 hospitals provide open-heart surgery services
> 72 heart-lung bypass machines

Certificate of Need in NC

Solid Organ Transplantation Services*

- Solid organ transplantation services: Surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor. NCGS 131E-176(24d)

- Performed only at the 5 Academic Medical Center Teaching Hospitals.

Certificate of Need in NC

Equipment regulated by CON as a "new institutional health service"

- Air ambulance
- Cardiac catheterization equipment
- Gamma knife
- Heart-lung bypass machine
- Linear accelerator
- Lithotripter
- MRI
- PET scanner
- Simulator
- Mobile medical equipment not in use prior to 1993
- Major medical equipment

Certificate of Need in NC

Linear Accelerator*

- Linear accelerator: A machine used to produce ionizing radiation in excess of 1,000,000 electron volts in the form of a beam of electrons or photons to treat cancer patients. NCGS 131E-176(14g)
- Used in the treatment of cancer - destroying cells with ionizing radiation
  - 2010 date shows 20 linear accelerators in 15 locations
  - More have a certificate of need in hand or for which there is a prior year need determination

Air Ambulance

- Air ambulance: Aircraft used to provide air transport of sick or injured persons between destinations within the State. NCGS 131E-176(1a)

- FAA laws preempt

Certificate of Need in NC

Gamma Knife*

- Gamma knife: Equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery. NCGS 131E-176(7c)

- Uses radiation to perform brain surgery without opening the skull.

  - Wake Forest Baptist Hospital
  - Pitt County Memorial Hospital

Certificate of Need in NC

Lithotripter*

- Lithotripter: Extra-corporeal shock wave technology used to treat persons with kidney stones and gallstones. NCGS 131E-176(14l)
  - FY 2009-2010: 14 lithotripsy units operated by 8 providers.
  - One fixed unit and 13 mobile units

Certificate of Need in NC

Magnetic Resonance Imaging Scanner (MRI)*

- Magnetic resonance imaging scanner: Medical imaging equipment that uses nuclear magnetic resonance. NCGS 131E-176(14m)
- Mobile MRI: a scanner and transporting equipment that is moved at least weekly to provide services at two or more host facilities.
  - Fixed: 231 MRI scanners
  - Fixed equivalent : 263.53

Certificate of Need in NC

Positron Emission Tomography Scanner (PET)*

- Positron emission tomography scanner: Equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures. NCGS 131E-176(19a)
- Typically used in cancer diagnostics.
- Mobile PET: Scanner and its transporting equipment that is moved to provide services at two or more host facilities.
  - Fixed: 27
  - Mobile: 2 (one in East and one in West)

Certificate of Need in NC

Major Medical Equipment

- Major medical equipment: Costs more than seven hundred fifty thousand dollars ($750,000).
- The costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making the equipment operational is included. The capital expenditure for the equipment is the fair market value of the equipment or the cost of the equipment, whichever is greater. NCGS 131E-176(14o)

Certificate of Need in NC

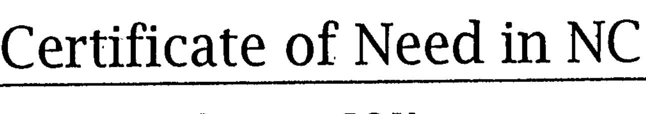
Also regulated by CON as a "new institutional health service"

- Change in bed capacity
  - Relocation of health service facility beds or dialysis stations
  - Change of heath service facility beds from one category to another
  - Increase in dialysis stations or health service facility beds
- Conversion of non-health care beds to health care beds

Certificate of Need in NC

Also regulated by CON as a "new institutional health service"

- Change in project
  - Cost overrun of 15%
  - Addition of a health service
- Opening of an additional office by existing home health agency or hospice
- Relocation of a facility from one service area to another
- Conversion of specialty ambulatory surgical program



Exceptions to CON process

(NCGS 131E-184)

- Include:
  - Parking
  - Heating and cooling systems
  - Elevators
  - Replacement Equipment
  - Conversion of semi-private rooms to private rooms
  - Elimination or prevention of imminent safety hazards

Certificate of Need in NC

Changes from Session Law 1993-7

- Definition of "new institutional health services" expanded:
  - Pre-1993: Regulated health services expenditures by health service facilities only
  - S.L. 1993-7: Regulates health service expenditures by **any person**

North Carolina's Certificate of Need Program

Review Schedules

- Review schedules for CON are established in the State Medical Facilities Plan each year.
- Schedules groups health services by review categories and health service areas. Similar proposals in the same area can be reviewed competitively.
- Review categories run from A to M and include:
  - Category A – proposals submitted by acute care hospitals.
  - Category B – increase in nursing care or adult home beds.
  - Category C – new psychiatric facilities and new beds in existing facilities.

North Carolina's Certificate of Need Program

Application Process

- G.S. 131E-182
- Applications, including the filing fee, must be received by 5:30p on the 15th day of the month prior to the beginning of the scheduled review period.
- Applications:
  - Must be deemed complete by the first day of the scheduled review period.
  - May not be amended. However, after the review begins, the analyst may request additional information.
- Minimum application fee is $5,000. Maximum $50,000.

North Carolina's Certificate of Need Program

Review Process

- G.S. 131E-185
- Time limit for review is 90 days. May be (and usually is) extended an additional 60 days.
- Any person may file written comments about an application under review during first 30 days.
- Within 20 days of the close of the written comment period, the Department must hold a public hearing in the health service area if one or more of the following apply:
  - The review is competitive.
  - The project involves expenditures of $5 million or more.
  - A written request for a public hearing is received from an "affected party".
  - Agency determines a hearing is in the public interest.

North Carolina's Certificate of Need Program

Expedited Reviews

- G.S. 131E-176(7b)
- Applicant may file a petition for an expedited review. Department may allow if:
  - Review is not competitive
  - Project expenditures are < $5 million.
  - No request for a public hearing is received during the 30 day written comment period.
  - Agency determines the public interest does not require a public hearing.

North Carolina's Certificate of Need Program

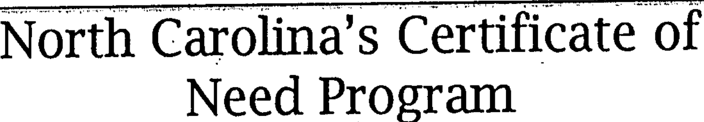
Review Criteria

- G.S. 131E-183
- Applications are reviewed against statutory criteria and standards for particular health service facilities and health services established in the rules.
  - A proposed project must be consistent with the policies and need determinations set forth in the State Medical Facilities Plan.
  - The population to be serve must be identified:
    - Applicant must demonstrate the need that the population identified has for the proposed services.
    - Must demonstrate the extent to which all residents will have access, including low income persons, minorities, elderly, and other underserved groups.

North Carolina's Certificate of Need Program

Review Criteria: (continued)

- Projects involving reduction/elimination/relocation of services must demonstrate that the needs of the population presently served will be adequately met and the effect on underserved groups to obtain health care.
- If alternative methods exist to meet the need, the applicant must demonstrate that the proposal is the least costly or most effective alternative.
- Financial and operational projections must show availability of funds and financial feasibility of the project.



North Carolina's Certificate of Need Program

Review Criteria: (continued)

- Applicant must demonstrate that the project will not result in the unnecessary duplication of health services or health service facilities.
- Applicant must show the availability of resources such as health manpower.
- Applicant must demonstrate that the ancillary and support services will be available.
- Applicants proposing to serve a substantial number of persons outside the health service area or adjacent areas must document the special needs and circumstances to warrant the service.
- The application shall show that the design, means, and cost are the most reasonable alternative and will not unduly increase health care costs by the applicant/provider.

North Carolina's Certificate of Need Program

Review Criteria (continued)

- Applicant must demonstrate the contribution of the proposed service in meeting the health care needs of the elderly, medically underserved, and Medicare-Medicaid recipients.
- Current use of applicants existing services.
- Past performance in meeting obligations.
- Existence of any civil rights access complaints against the applicant.

North Carolina's Certificate of Need Program

Review Criteria (continued)

- Offer by applicant of a range of means by which a person will have access.
- Applicant shall demonstrate the proposed health services will accommodate the clinical needs of the health care professional training programs in the area.
- Applicant must demonstrate the expected effects of the proposed services on competition in the proposed service area.

North Carolina's Certificate of Need Program

Decision and Issuance of CON:

- G.S. 131E-186/131E-187
- Decision to approve, approve with conditions, or deny an application should issue within statutory time frame (90-150 days).
- The Department must provide written notice of all findings and conclusions that are the basis for the decision within 5 business days of the decision.
- The CON shall issue within 35 days of the decision if there has been no request for a contested case hearing.

North Carolina's Certificate of Need Program

Appeals:

- G.S. 131E-188
- Petition for a contested case hearing must be filed within 30 days of the Department's decision.
- May be filed by any "affected person".
- Includes applicants, persons living in the service area or geographic area, providing similar services in the service area, and third party payers who reimburse facilities in the service area.
- Petitioner must file a bond equal to 5% of the cost of the project. No < $5,000, No > $50,000.
- Approved applicant may file against bond if petition for contested case deemed frivolous or filed to delay.

North Carolina's Certificate of Need Program

Timetable for Appeals:

- G.S. 131E-188
- Appointment of ALJ – 15d after petition filed.
- Completion of discovery – 90d after assignment of ALJ.
- Hearing – w/n 45d of completion of discovery.
- AlJ decision – w/n 75d after hearing.
- Deadlines may be extended for discovery through ALJ decision to a total of 270d from filing petition.
- Effective January 1, 2012, the ALJ makes the final decision in a contested case. S.L. 2001-398.

North Carolina's Certificate of Need Program

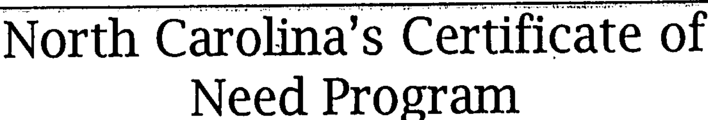
Court of Appeals:

- G.S. 131E-188(b) and (b1)
- Appeal from the decision of the ALJ is to the Court of Appeals.
- Taken w/n 30 days of receipt of the final decision.
- Bond must be posted with the Clerk of the Court of Appeals. Amount of bond ranges from $5,000 to $50,000.
- If the Court of Appeals finds that the appeal was frivolous or filed to delay, the Court shall remand the case to the Superior Court for a hearing on the bond and shall award the CON holder reasonable attorneys' fees and costs incurred in the appellate action.

North Carolina's Certificate of Need Program

Exemptions from review:

- G.S. 131E-184
- New institutional health services are exempt from CON review if required to:
  - Eliminate or prevent an imminent safety hazard.
  - Comply with State licensure standards.
  - Comply with accreditation or certification standards necessary for reimbursement under Medicare/Medicaid.
  - Provide data processing equipment.



North Carolina's Certificate of Need Program

Exemptions from review: (continued)

- Provide parking, hvac, elevators, or other basic plant or mechanical improvements.
- Repair or replacement of facilities after accidents or natural disasters.
- Replacement of nonhealth service facilities.
- Provide replacement equipment.
- Acquire an existing health service facility including equipment owned by that facility.
- Develop or acquire a physician office building.

North Carolina's Certificate of Need Program

Capital expenditures of > $2million are exempt where:

- The expenditure involves an existing nursing home, adult care home, or intermediate care facility for the mentally retarded, that is renovating or replacing the facility on the same site and there is no change in bed capacity or addition of a health service facility or new institutional health service; and
- The expenditure will be used for conversion of semiprivate to private rooms, providing homelike residential dining areas, or renovating or expanding residential living or common areas.

North Carolina's Certificate of Need Program

Other Exemptions:

- G.S. 131E-184(c) provides an exemption from CON review of any conversion of existing acute care beds to psychiatric beds if:
  - The hospital seeking the conversion has a contract with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and one or more Area Mental Health Authorities to provide psychiatric beds to patients referred by the contracting agencies.
  - The total number of beds converted shall not exceed twice the number of beds under the contract.

North Carolina's Certificate of Need Program

- G.S. 131E-184 (d) provides an exemption from review for the construction and operation of a new chemical dependency or substance abuse facility for the purpose of providing such inpatient services solely to inmates of the Department of Correction.
- If such facility provides services to members of the general public as well as inmates, only the portion of the facility serving inmates is exempt from review.

North Carolina's Certificate of Need Program

- G.S. 131E-179 allows the agency to exempt a health service facility from CON review for a new institutional health service to be used solely for research purposes.
- The health service facility must file notice of intent with the agency and the agency must find:
  - The new service will not affect the charges of the facility for other medical or patient care services other than those included in the research.
  - The new service will not substantially change bed capacity or the medical and other patient care services.
- The health service facility shall not charge patients for the use of the service exempted from CON review.(Without first obtaining a CON).

North Carolina's Certificate of Need Program

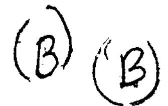
Progress Reports/Withdrawal of CON:

- G.S. 131E-189
- A CON will a timetable for the holder to complete a project or make a service available.
- Periodic reports are required on the progress in meeting the established timetable.
- Failure to make good faith efforts to meet the timetable may result in the CON being withdrawn.
- Failure to develop a service in a manner consistent with the representations in a CON application or the conditions imposed on its issuance may result in a withdrawal of the CON.
- A CON may be immediately withdrawn if the holder transfers ownership or control of the facility, project or CON before completion of the project.

North Carolina's Certificate of Need Program

Enforcement and Sanctions:

- G.S. 131E-190
- Offering a new institutional health service without first obtaining a CON may result in:
- Withholding of Medicare and Medicaid funding for the reimbursement of capital and operating expenses relating to the new institutional health service.
- Revocation or suspension of licenses.
- Civil penalties of not more than $20,000 for failure to obtain a CON or to conform to the conditions of a CON. A violation occurs each time the service is offered.
- Injunctive relief requiring the holder of the CON to materially comply with the representations in the holder's application.



One example of an articulated policy exemption is the AC3 which is an exemption from need determination in the State Medical Facilities Plan for certain academic medical center teaching hospitals projects.

In addition to the some of the earlier responses sent to address outstanding questions by the Committee, I wanted to follow up by clarifying/correcting a response from the previous meeting. I spoke with Kory Goldsmith, an attorney within our division who has a great deal of expertise with the State Ethics Act, and she indicated that the State Health Coordinating Council (SHCC) **is not** considered a Board under the regulation by the State Government Ethics Act, rather Executive Order 10 (issued by Governor Perdue) imposes certain disclosure requirements and conflict of interest standards. EO #10 (attached) requires the following:

- Members are reminded each meeting of their duty to act in the best interest of the public without regard to professional, institutional, or financial interest.
- Before conducting any business, each member must disclose any professional or institutional interest in any matter coming before the SHCC or a SHCC subcommittee. The chair determines if the member must be recused.
- Before conducting any business, each member must disclose any "financial benefit" (term is narrower than in the SGEA) he or she or his or her spouse may derive from a matter before the SHCC or a subcommittee. If the member indicates they will derive a benefit they must recuse themselves, but may deliberate in the matter within the Chair's discretion.

(X)

BEVERLY EAVES PERDUE
GOVERNOR

EXECUTIVE ORDER NO. 10

ETHICAL STANDARDS FOR THE STATE HEALTH COORDINATING COUNCIL

WHEREAS, the State Health Coordinating Council (SHCC) is a public advisory body established by Executive Order No. 139 (March 3, 2008) for the purpose of advising the Governor on the statewide planning of health care facilities, equipment, and services provided under the Certificate of Need Law; and

WHEREAS, the SHCC works with the Department of Health and Human Services (DHHS) to prepare and recommend the State Medical Facilities Plan (SMFP) to the Governor for approval or amendment; and

WHEREAS, the advice and collective judgment of the SHCC has proven invaluable in ensuring that quality health care services are made available broadly to all citizens of this State regardless of whether they live in rural or urban areas, whether they have the means to pay for those services or whether they are insured by public or private payors; and

WHEREAS, to provide the expertise necessary to perform its complex advisory functions, the membership of the SHCC includes persons knowledgeable about healthcare services and delivery including medical educators, researchers, physicians, and representatives of professional associations; and

WHEREAS, because of the diversity of the SHCC membership, conflicts between competing economic interests are inherent in, but also beneficial to, the development of the SMFP; and

WHEREAS, the General Assembly has concluded that the State Government Ethics Act does not cover public entities that only have advisory authority, and the State Ethics Commission has determined that the SHCC only has advisory authority; and

WHEREAS, it is nevertheless important that the SHCC exercise its advisory responsibilities in a transparent manner so that the Governor and citizens will have full knowledge of the professional and economic interests that the members of the SHCC have as the

Governor evaluates their expert advice in adopting or amending the SMFP recommended by the SHCC; and

WHEREAS, the members of the SHCC in the past have voluntarily followed ethical standards; and

WHEREAS, this is a salutary practice, which should be formalized by Executive Order;

NOW, THEREFORE, by the power vested in me as Governor by the Constitution and laws of the State of North Carolina, **IT IS ORDERED:**

1. The members of the SHCC shall always act in the best interests of the public and shall bring their particular knowledge and experience to the SHCC to serve the public interest as identified in the Certificate of Need Law, Chapter 131E, Article 9 of the General Statutes;

2. The following process shall be observed for all meetings of the SHCC and SHCC subcommittees at which the SHCC or SHCC subcommittee takes any action:

    a. At the beginning of each meeting, the Chair shall remind all members of their duty to act always in the best interest of the public without regard for their own professional, institutional or financial interests and that they should recuse themselves from voting on any matter on which they cannot meet this standard.

    b. Prior to conducting any business, each member shall disclose any professional or institutional interest he or she may have in any matter coming before the SHCC or SHCC subcommittee for action at that meeting. The Chair will determine if the member needs to recuse himself or herself from voting on the matter in order to ensure the integrity of the actions of the SHCC or SHCC subcommittee.

    c. Prior to conducting any business, each member shall also disclose any financial benefit he or she may derive from any matter coming before the SHCC or SHCC subcommittee for action at that meeting. A member derives a financial benefit from a matter under consideration if the person or his/her spouse (i) has an ownership interest in an entity that is a party to the matter under consideration; (ii) will derive any income or commission as a direct result of action on the matter under consideration; or (iii) will acquire property as a direct result of action on the matter under consideration. When any member indicates that he or she will derive a financial benefit from a matter coming before the SHCC or any subcommittee, the member shall recuse himself or herself from voting on the matter.

    d. A member who has recused himself or herself from voting is not prohibited from deliberating on the matter unless the Chair determines, after review, that participation by the member in deliberations would impair the integrity of the actions of the SHCC or SHCC subcommittee.

e. The minutes of the SCHCC and its subcommittees will reflect all disclosures and recusals made pursuant to this section, and such minutes will be provided to the Governor for review with the SMFP.

f. A challenge to a member's participation in a vote on issues under this Executive Order may be raised only by a member of the SHCC or an employee of the Division of Health Services Regulation of DHHS. In such case where a challenge is made, the Chair, in consultation with the DHHS legal counsel, shall determine whether the challenge is valid and the action that should be taken.

g. For the purposes of this Executive Order, the term "Chair" means the Chair of the SHCC or the Chair of any SHCC subcommittee. In the absence of the Chair or if the professional, institutional, or financial interests of the Chair must be reviewed pursuant to this section, then the Vice-Chair of the SHCC or SHCC subcommittee shall make the determinations required by this section.

3. Members of the SHCC are expected to and should confer with DHHS on any matters that come before them in development of the SMFP. No member of the SHCC, however, shall improperly influence or attempt to influence DHHS in performing its role in developing the SMFP as to any provision in which the member has a direct, conflicting professional, institutional or financial interest;

4. This Executive Order is for the Governor's purposes in reviewing and approving or amending the proposed SMFP submitted by the SHCC and DHHS. This Order does not and shall not be construed to create any rights, nor create claims, under the Certificate of Need Law, State Government Ethics Act, or otherwise.

This Executive Order is effective immediately and shall remain in effect until rescinded in writing.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed the Great Seal of the State of North Carolina at the Capitol in the City of Raleigh, this third day of March in the year of our Lord two thousand and nine, and of the Independence of the United States of America the two hundred and thirty-third.

Beverly Eaves Perdue
Governor

ATTEST:

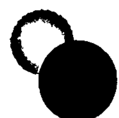
Elaine F. Marshall
Secretary of State

by and through Rodney Maddox Chief Deputy Secretary of State

In addition to the some of the earlier responses sent to address outstanding questions by the Committee, I wanted to follow up by clarifying/correcting a response from the previous meeting. I spoke with Kory Goldsmith, an attorney within our division who has a great deal of expertise with the State Ethics Act, and she indicated that the State Health Coordinating Council (SHCC) **is not** considered a Board under the regulation by the State Government Ethics Act, rather Executive Order 10 (issued by Governor Perdue) imposes certain disclosure requirements and conflict of interest standards. EO #10 (attached) requires the following:

- Members are reminded each meeting of their duty to act in the best interest of the public without regard to professional, institutional, or financial interest.
- Before conducting any business, each member must disclose any professional or institutional interest in any matter coming before the SHCC or a SHCC subcommittee. The chair determines if the member must be recused.
- Before conducting any business, each member must disclose any "financial benefit" (term is narrower than in the SGEA) he or she or his or her spouse may derive from a matter before the SHCC or a subcommittee. If the member indicates they will derive a benefit they must recuse themselves, but may deliberate in the matter within the Chair's discretion.

09/14/2011



Certificate of Public Advantage

Presentation to the House Select Committee on the Certificate of Need Process and Related Hospital Issues

Research Division Staff, September 14, 2011

What is a COPA?

- An agreement among two or more hospitals
  - for the sharing, allocation, referral of patients, personnel, programs, services, facilities, equipment, or procedures traditionally offered by hospitals, or
  - that results in the purchase of assets pursuant to a merger or sale, a partnership, a joint venture, or any other affiliation by which ownership or control over all or substantially all of the stock, assets, or activities of a hospital are transferred to another hospital
- Must demonstrate benefits outweigh reduction of competition
- Conditions of Operation included to control prices of health care services

Purpose of COPA

- Authorize and encourage activities under regulatory and judicial oversight designed to ensure consumer protections from potentially anti-competitive behavior that:
  - Foster improvements in the quality of health care
  - Moderate increases in cost
  - Improve access to services in rural areas
  - Enhance likelihood smaller hospitals remain operation

Effect of COPA

Activities conducted in accordance to an approved cooperative agreement are immune from challenges or scrutiny of State or federal anti-trust law.

- State- G.S. 131E-192.13
- Federal- Case Law
  - State Purpose Doctrine (*Parker v. Brown*)
  - Two-prong test (*FTC v. Ticor*)
    - Articulated a clear and affirmative policy
    - Provide active supervision

Distinguished from CON

Certificate of Need

- Grants permission to buy (*build, convert, etc.*) health care related items generally allowed under a system of free enterprise
- Application to Division of Health Service Regulation
- Finite process authorizes activities under certificate

Certificate of Public Advantage

- Allows relationships between systems generally not permitted under antitrust laws
- Application to Division of Health Service Regulation and Attorney General
- Continuous review of authorized activities within agreement after issuance

State laws referencing COPA

Idaho- (1994)
- *§ 39-4902~4904*

Kansas- (1994)
- *§ 65-4957~4961*

Louisiana- (1994)
- *§ 40-2254.1~2254.12*

Maine- (2005)
- *22 M.R.S. §1842-1851*

Mississippi-(2004)
- *§ 41-9-305~307*

Montana- (1993*)
- *§ 50-4-601~603*

Nebraska-(1994)
- *§ 71-7703~7711*

North Carolina (1993*)
- § 90-21.24~21.36 and
- § 131E-192.1~192.13

North Dakota (1993*)
- *§ 23-17.5-02~17.5-10*

South Carolina (1994)
- *§ 44-7-510~7-580*

Tennessee (1998*)
- *§ 33-2-704~2-706*

Texas (1993*)
- *§ 314.002~314.006*

Wisconsin (1991*)
- *§ 150.85~150.86*

Legislative History in North Carolina

Hospital Cooperation Act of 1993

- Session Law 1993-529 (House Bill 729)
  - Ratified July 24, 1993
  - Incorporated language from Section 9 of Senate Bill 554 (committee substitute adopted June 17· 1993)

Hospital Cooperation Act Amendment

- Session Law 1995-205 (Senate Bill 886)
  - Ratified June 8, 1995
  - Expanded definition of cooperative agreement to include purchase of assets language and authorizes additional application fee for contracting with consultants to complete a review of a COPA application.

COPA - Application

- Parties to a cooperative agreement apply to DHSR
- The application includes:
  - an executed written copy of the cooperative agreement or
  - letter of intent with respect to the agreement,
  - description of the nature and scope of the activities and cooperation in the agreement,
  - any consideration passing to any party under the agreement, and
  - any additional materials necessary to fully explain the agreement and its likely effects.
- A copy of the application and related materials is submitted to the Attorney General at the same time the application is submitted to the Department.

- The Department reviews the application in accordance with the statutorily articulated standards
- A public hearing is held for the submission of oral and written public comments
- The Department provides its determination whether the application within **90 days** of the date the application is filed.

COPA - Standards for review

- Applicant must demonstrate
  - *clear and convincing evidence*
- The **benefits** likely to result from the agreement outweigh the **disadvantages** likely to result from a reduction in competition from the agreement

Benefits considered

- Enhancement of the quality of hospital and hospital-related care provided to North Carolina citizens.
- Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.
- Lower costs of, or gains in, the efficiency of delivering hospital services.

Benefits considered

- Improvements in the utilization of hospital resources and equipment.
- Avoidance of duplication of hospital resources.
- The extent to which medically underserved populations are expected to utilize the proposed services.

Disadvantages considered

The extent to which the agreement may:

- Increase the costs or prices of health care at a hospital which is party to the cooperative agreement.
- Have an adverse impact on patients in the quality, availability, and price of health care services.
- Reduce competition among the parties to the agreement and the likely effects thereof.
- Have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payors to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers.
- Result in a reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals.

Disadvantages considered

- The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.

COPA - Issuance of Certificate

The Department makes determination **and** the Attorney General has not stated an objection

Certificate issued
- Includes conditions of operation
- Includes conditions to control prices of health care services

COPA - Review

- The agreement is subject to review by the Department or the Attorney General *at any time* following the issuance of a certificate of public advantage.
- Holders must also submit biennial reports

COPA- Review, cont.

Report of activities must include all of the following:

- A description of the activities conducted pursuant to the agreement.
- Price and cost information.
- The nature and scope of the activities pursuant to the agreement anticipated for the next two years, the likely effect of those activities.
- A signed certificate by each party to the agreement that the benefits or likely benefits of the cooperative agreement as conditioned continue to outweigh the disadvantages or likely disadvantages of any reduction in competition from the agreement as conditioned.
- Any additional information requested by the Department or the Attorney General.

COPA- Review, cont.

- 30 days to file written comments on the report
- The Department determines if any changes in the conditions of the certificate should be made.

10 NCAC Subchapter 14I

- Division of Health Service Regulation responsible
- Application fees
  - $3,750 for each provider participating in the application ($15,000 maximum)
- Filing Fees
  - $500 with biennial reports to offset cost of review and maintenance
  - Additional fees up to $2,000 for costs associated with investigating and assessing compliance
- Public Hearings
  - Must be held within 45 days of receipt of an application
  - Published not less than 10 days prior in at least one newspaper of general circulation

History of COPA in North Carolina

Initial (Revised) COPA- 1995

- Mission-St. Joseph's Health System to manage and operate Memorial Mission Hospital, Inc. and St. Joseph's Hospital as integrated entities

First Amended- 1998

- Memorial Mission Hospital, Inc. acquired St. Joseph's Hospital in a statutory merger

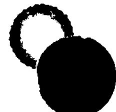
Second Amended- 2005

Second Amended and Restated COPA-2007

- Currently in operation as amended

Third Amended COPA-2011

- 2nd amended remains in full force and effect for the combined hospitals now known as Mission Health System with an adjustment to the provision relating to the employment of contracting with Physicians



Mission Health

Provisions include:

- Accreditation
- Charity and Indigent Care
- Contract restrictions
  - Purchase through Competitive Bidding
  - Non-exclusivity and Nondiscrimination
  - Prohibits "Most Favored Nation" provisions
- Cost and Margin Controls
- Physician Employment controls

Mission Health

COPA contains three principal regulatory constraints:

- <u>Cost Cap</u>-Under the COPA, the rate at which Mission Hospital's "cost per adjusted patient discharge" increases must not exceed the rate of increase in the producer price index for general medical and surgical hospitals in the U.S.
- <u>Margin Cap</u>- Under the COPA, the operating margin of MHS over any three-year period shall not exceed by more than one percent the mean of the median operating margin of comparable hospitals.
- <u>Physician Employment Cap</u> - Under the COPA, MHS is not permitted to employ, or enter into exclusive contracts with, more than 30 percent of the physicians practicing in Buncombe and Madison counties except those practicing in cardiology, genetics, hospitalists, neuro-hospitalists, and neurology.

Viddia Torbett (Rep. Torbett)

From:	Shawn Parker (Research)
Sent:	Thursday, September 15, 2011 11:01 AM
To:	Rep. Fred Steen; Rep. John Torbett; Viddia Torbett (Rep. Torbett)
Cc:	Barbara Riley (Research); Janice Paul (Research); Amy Jo Johnson (Research); Susan Barham (Research)
Subject:	Some follow up responses from the COPA presentation

Chairmen,

Enclosed is the Division of Health Service Regulations response to some of the questions posed during the COPA portion of the presentation.
Shawn

1. The number of DHHS employees whose job responsibility include COPA.
As Division Director Drexdal [Pratt]'s responsibility includes the COPA. As a practical matter the day to day responsibility for the administration of the COPA resides with me [Chris Taylor]

2. Any additional oversight activities beyond the biennial report? Mission files an Annual Report with us [DHSR]. We meet informally at least once a year and in most years have met twice a year to review and discuss the COPA. In addition Dixon-Hughes, an independent CPA firm prepares an annual report for us setting forth a comparison of Mission with certain other comparable hospitals in NC, SC and Va.

The supervision also consists of Mission, at all times between the formal report and review events, having to stay in compliance with the COPA, including its pricing, cost and margin, accreditation &c. &c.(From Office of the Attorney General).

3. Have any other entities applied for a COPA?
We have not received applications from any other entities for a COPA.

4. Beyond the initial legislative acts, has there been any involvement from the NCGA or any members in recent amendments.
There has not been any involvement from the NCGA or any of its members with us in connection with any recent amendments.

Shawn P. Parker, JD, MPA
Staff Attorney, Senior Legislative Analyst
Research Division-North Carolina General Assembly
545 Legislative Office Building
300 North Salisbury Street
Raleigh, North Carolina 27603-5925
(919) 733-2578 (919) 715-5460 (fax)

Category	Health Costs & Budgets
Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 1991
Data Type	Currency

Alabama	2538
Alaska	2593
Arizona	2383
Arkansas	2365
California	2657
Colorado	2439
Connecticu	3273
Delaware	2818
District of C	4742
Florida	2918
Georgia	2513
Hawaii	2597
Idaho	2088
Illinois	2705
Indiana	2487
Iowa	2534
Kansas	2583
Kentucky	2387
Louisiana	2601
Maine	2454
Maryland	2763
Massachus	3249
Michigan	2617
Minnesota	2566
Mississippi	2174
Missouri	2504
Montana	2331
Nebraska	2377
Nevada	2370
New Hamp	2440
New Jerse	2931
New Mexic	2209
New York	3158
North Caro	2242
North Dako	2626
Ohio	2681
Oklahoma	2344
Oregon	2282
Pennsylvar	2947
Rhode Isla	2867
South Caro	2260
South Dak	2418
Tennessee	2555
Texas	2356
United Stat	2645

Utah	1926
Vermont	2331
Virginia	2374
Washingto	2505
West Virgir	2556
Wisconsin	2539
Wyoming	2212

Notes Health Care Expenditures measure spending for all privately and publicly funded personal h
Definitions
Sources Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare

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Subcatego	Health Expenditures by State of Residence
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Full Title	Health Care Expenditures per Capita by State of Residence, 1992
Data Type	Currency

Alabama	2718
Alaska	2707
Arizona	2475
Arkansas	2490
California	2826
Colorado	2588
Connecticu	3480
Delaware	3017
District of (	5214
Florida	3125
Georgia	2698
Hawaii	2746
Idaho	2230
Illinois	2906
Indiana	2705
Iowa	2686
Kansas	2762
Kentucky	2580
Louisiana	2811
Maine	2650
Maryland	2933
Massachus	3474
Michigan	2745
Minnesota	2745
Mississippi	2304
Missouri	2732
Montana	2472
Nebraska	2575
Nevada	2553
New Hamp	2672
New Jerse	3188
New Mexic	2395
New York	3378
North Caro	2431
North Dakc	2809
Ohio	2857
Oklahoma	2521
Oregon	2473
Pennsylvar	3156
Rhode Isla	3127
South Carc	2433
South Dak	2555
Tennessee	2770
Texas	2545
United Stat	2830

Utah	2031
Vermont	2480
Virginia	2451
Washingto	2690
West Virgi	2828
Wisconsin	2724
Wyoming	2289

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Topic Health Spending per Capita
Full Title Health Care Expenditures per Capita by State of Residence, 1993
Data Type Currency

Alabama	2862
Alaska	2826
Arizona	2561
Arkansas	2605
California	2929
Colorado	2633
Connecticu	3611
Delaware	3223
District of C	5507
Florida	3286
Georgia	2854
Hawaii	2920
Idaho	2324
Illinois	3051
Indiana	2881
Iowa	2820
Kansas	2865
Kentucky	2711
Louisiana	3011
Maine	2840
Maryland	3098
Massachus	3717
Michigan	2885
Minnesota	2899
Mississippi	2484
Missouri	2880
Montana	2557
Nebraska	2700
Nevada	2613
New Hamp	2768
New Jerse	3346
New Mexic	2480
New York	3606
North Caro	2608
North Dako	2944
Ohio	3027
Oklahoma	2624
Oregon	2594
Pennsylvar	3319
Rhode Isla	3317
South Carc	2611
South Dak	2674
Tennessee	2958
Texas	2666
United Stat	2976

Utah	2134
Vermont	2629
Virginia	2580
Washingto	2765
West Virgir	3035
Wisconsin	2872
Wyoming	2469

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Sources	Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare

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Subcatego Health Expenditures by State of Residence
Topic Health Spending per Capita
Full Title Health Care Expenditures per Capita by State of Residence, 1994
Data Type Currency

Alabama	2995
Alaska	2895
Arizona	2612
Arkansas	2719
California	2985
Colorado	2709
Connecticu	3792
Delaware	3462
District of C	5663
Florida	3399
Georgia	2927
Hawaii	3127
Idaho	2385
Illinois	3185
Indiana	2966
Iowa	2972
Kansas	3021
Kentucky	2815
Louisiana	3150
Maine	2946
Maryland	3247
Massachus	3890
Michigan	3042
Minnesota	3098
Mississippi	2631
Missouri	3058
Montana	2626
Nebraska	2856
Nevada	2729
New Hamp	2882
New Jersey	3540
New Mexic	2551
New York	3791
North Caro	2771
North Dako	3105
Ohio	3142
Oklahoma	2770
Oregon	2667
Pennsylvar	3446
Rhode Isla	3377
South Caro	2776
South Dako	2840
Tennessee	3069
Texas	2733
United Stat	3095

Utah	2182
Vermont	2776
Virginia	2692
Washingto	2849
West Virgi	3206
Wisconsin	3004
Wyoming	2619

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Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 1995
Data Type	Currency

Alabama	3180
Alaska	3152
Arizona	2637
Arkansas	2893
California	3050
Colorado	2840
Connecticu	4025
Delaware	3650
District of C	5820
Florida	3516
Georgia	3082
Hawaii	3332
Idaho	2535
Illinois	3327
Indiana	3076
Iowa	3127
Kansas	3207
Kentucky	3021
Louisiana	3284
Maine	3199
Maryland	3376
Massachus	4054
Michigan	3226
Minnesota	3294
Mississippi	2877
Missouri	3170
Montana	2828
Nebraska	2999
Nevada	2783
New Hamp	3124
New Jerse	3729
New Mexic	2724
New York	3969
North Caro	2954
North Dakc	3379
Ohio	3308
Oklahoma	2968
Oregon	2813
Pennsylvar	3625
Rhode Isla	3675
South Carc	2923
South Dak	3050
Tennessee	3298
Texas	2891
United Stat	3244

Utah	2290
Vermont	3023
Virginia	2799
Washingto	2990
West Virgir	3425
Wisconsin	3185
Wyoming	2832

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Data Type	Currency

Alabama	3359
Alaska	3434
Arizona	2704
Arkansas	3021
California	3118
Colorado	2942
Connecticu	4138
Delaware	3750
District of C	6035
Florida	3669
Georgia	3192
Hawaii	3524
Idaho	2689
Illinois	3463
Indiana	3128
Iowa	3305
Kansas	3357
Kentucky	3224
Louisiana	3409
Maine	3452
Maryland	3533
Massachus	4215
Michigan	3390
Minnesota	3426
Mississippi	3068
Missouri	3339
Montana	2867
Nebraska	3212
Nevada	2862
New Hamp	3320
New Jerse	3826
New Mexic	2864
New York	4157
North Caro	3139
North Dakc	3506
Ohio	3508
Oklahoma	3137
Oregon	2900
Pennsylvar	3714
Rhode Isla	3776
South Carc	3052
South Dak	3249
Tennessee	3464
Texas	3037
United Stat	3379

Utah	2431
Vermont	3144
Virginia	2970
Washingto	3066
West Virgir	3611
Wisconsin	3360
Wyoming	2995

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Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 1997
Data Type	Currency

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Alaska	3669
Arizona	2768
Arkansas	3205
California	3192
Colorado	3060
Connecticu	4363
Delaware	3994
District of C	6087
Florida	3814
Georgia	3289
Hawaii	3507
Idaho	2820
Illinois	3602
Indiana	3346
Iowa	3451
Kansas	3512
Kentucky	3464
Louisiana	3555
Maine	3698
Maryland	3639
Massachus	4425
Michigan	3552
Minnesota	3636
Mississippi	3220
Missouri	3492
Montana	3109
Nebraska	3347
Nevada	2926
New Hamp	3513
New Jerse	3972
New Mexic	3006
New York	4310
North Caro	3303
North Dakc	3652
Ohio	3611
Oklahoma	3221
Oregon	3055
Pennsylvar	3901
Rhode Isla	3992
South Carc	3298
South Dak	3450
Tennessee	3603
Texas	3187
United Stat	3520

Utah	2615
Vermont	3359
Virginia	3115
Washingto	3153
West Virgir	3826
Wisconsin	3532
Wyoming	3176

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Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 1998
Data Type	Currency

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Arizona	2847
Arkansas	3354
California	3334
Colorado	3248
Connecticu	4592
Delaware	4135
District of (	6221
Florida	3904
Georgia	3395
Hawaii	3562
Idaho	2982
Illinois	3766
Indiana	3549
Iowa	3729
Kansas	3693
Kentucky	3625
Louisiana	3691
Maine	3929
Maryland	3679
Massachus	4646
Michigan	3605
Minnesota	3811
Mississippi	3355
Missouri	3697
Montana	3279
Nebraska	3563
Nevada	3047
New Hamp	3636
New Jerse	4129
New Mexic	3103
New York	4521
North Caro	3420
North Dakc	3873
Ohio	3728
Oklahoma	3362
Oregon	3321
Pennsylvar	4024
Rhode Isla	4160
South Carc	3460
South Dak	3638
Tennessee	3721
Texas	3320
United Stat	3663

Utah	2685
Vermont	3531
Virginia	3244
Washingto	3337
West Virgir	4000
Wisconsin	3661
Wyoming	3389

Notes	Health Care Expenditures measure spending for all privately and publicly funded personal h
Definitions	
Sources	Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare

Category	Health Costs & Budgets
Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 1999
Data Type	Currency

Alabama	3719
Alaska	4074
Arizona	2953
Arkansas	3543
California	3440
Colorado	3377
Connecticu	4755
Delaware	4488
District of C	6565
Florida	4044
Georgia	3473
Hawaii	3658
Idaho	3145
Illinois	3897
Indiana	3739
Iowa	3928
Kansas	3871
Kentucky	3851
Louisiana	3870
Maine	4265
Maryland	3917
Massachus	4749
Michigan	3751
Minnesota	3989
Mississippi	3447
Missouri	3852
Montana	3530
Nebraska	3792
Nevada	3181
New Hamp	3911
New Jersey	4271
New Mexic	3228
New York	4745
North Caro	3633
North Dakc	4033
Ohio	3946
Oklahoma	3522
Oregon	3493
Pennsylvar	4285
Rhode Isla	4322
South Carc	3661
South Dakc	3841
Tennessee	3853
Texas	3468
United Stat	3829

Utah	2717
Vermont	3862
Virginia	3406
Washingto	3592
West Virgi	4211
Wisconsin	3966
Wyoming	3573

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Category	Health Costs & Budgets
Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 2000
Data Type	Currency

Alabama	3909
Alaska	4513
Arizona	3064
Arkansas	3765
California	3569
Colorado	3629
Connecticu	4949
Delaware	4689
District of C	6496
Florida	4302
Georgia	3613
Hawaii	3786
Idaho	3354
Illinois	4137
Indiana	3947
Iowa	4151
Kansas	4089
Kentucky	4166
Louisiana	4009
Maine	4539
Maryland	4145
Massachus	5021
Michigan	3928
Minnesota	4302
Mississippi	3730
Missouri	4117
Montana	3792
Nebraska	4144
Nevada	3363
New Hamp	4106
New Jerse	4584
New Mexic	3353
New York	4957
North Caro	3895
North Dakc	4244
Ohio	4198
Oklahoma	3701
Oregon	3674
Pennsylvar	4541
Rhode Isla	4610
South Carc	3869
South Dak	4074
Tennessee	4106
Texas	3599
United Stat	4039

Utah	2937
Vermont	4261
Virginia	3673
Washingto	3778
West Virgir	4457
Wisconsin	4269
Wyoming	3907

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Sources Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare

Category Health Costs & Budgets
Subcatego Health Expenditures by State of Residence
Topic Health Spending per Capita
Full Title Health Care Expenditures per Capita by State of Residence, 2001
Data Type Currency

Alabama	4166
Alaska	5133
Arizona	3242
Arkansas	4025
California	3808
Colorado	3855
Connecticu	5336
Delaware	5056
District of (	6819
Florida	4599
Georgia	3807
Hawaii	4044
Idaho	3610
Illinois	4394
Indiana	4279
Iowa	4468
Kansas	4391
Kentucky	4477
Louisiana	4270
Maine	4972
Maryland	4480
Massachus	5458
Michigan	4162
Minnesota	4683
Mississippi	4084
Missouri	4404
Montana	4162
Nebraska	4562
Nevada	3620
New Hamp	4386
New Jerse	4832
New Mexic	3647
New York	5347
North Caro	4296
North Dak	4645
Ohio	4645
Oklahoma	4036
Oregon	4079
Pennsylvar	4887
Rhode Isla	4978
South Carc	4233
South Dak	4416
Tennessee	4460
Texas	3882
United Stat	4344

Utah	3161
Vermont	4673
Virginia	3839
Washingto	4091
West Virgir	4875
Wisconsin	4683
Wyoming	4220

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Category	Health Costs & Budgets
Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 2002
Data Type	Currency

Alabama	4481
Alaska	5666
Arizona	3559
Arkansas	4334
California	4058
Colorado	4127
Connecticu	5693
Delaware	5479
District of (	7184
Florida	4901
Georgia	4102
Hawaii	4333
Idaho	3941
Illinois	4709
Indiana	4599
Iowa	4737
Kansas	4655
Kentucky	4823
Louisiana	4532
Maine	5348
Maryland	4845
Massachus	5894
Michigan	4414
Minnesota	5086
Mississippi	4410
Missouri	4806
Montana	4456
Nebraska	4884
Nevada	3963
New Hamp	4708
New Jersey	5211
New Mexic	3936
New York	5710
North Caro	4530
North Dakc	5161
Ohio	4988
Oklahoma	4293
Oregon	4313
Pennsylvar	5201
Rhode Isla	5380
South Carc	4537
South Dak	4836
Tennessee	4656
Texas	4196
United Stat	4655

Utah	3450
Vermont	5116
Virginia	4133
Washingto	4465
West Virgir	5206
Wisconsin	5085
Wyoming	4607

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Subcatego	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 2003
Data Type	Currency

Alabama	4897
Alaska	6081
Arizona	3827
Arkansas	4597
California	4387
Colorado	4471
Connecticu	5966
Delaware	6058
District of C	7677
Florida	5117
Georgia	4304
Hawaii	4660
Idaho	4196
Illinois	5002
Indiana	4940
Iowa	5100
Kansas	5024
Kentucky	5117
Louisiana	4867
Maine	5858
Maryland	5233
Massachus	6320
Michigan	4705
Minnesota	5464
Mississippi	4701
Missouri	5192
Montana	4788
Nebraska	5209
Nevada	4280
New Hamp	5044
New Jerse	5493
New Mexic	4146
New York	6168
North Caro	4833
North Dako	5407
Ohio	5356
Oklahoma	4680
Oregon	4574
Pennsylvar	5579
Rhode Isla	5735
South Caro	4828
South Dak	5125
Tennessee	5032
Texas	4377
United Stat	4973

Utah	3719
Vermont	5683
Virginia	4477
Washingto	4812
West Virgii	5582
Wisconsin	5382
Wyoming	4950

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Subcategory	Health Expenditures by State of Residence
Topic	Health Spending per Capita
Full Title	Health Care Expenditures per Capita by State of Residence, 2004
Data Type	Currency

District of Columbia	$8,295
Massachusetts	$6,683
Maine	$6,540
New York	$6,535
Alaska	$6,450
Connecticut	$6,344
Delaware	$6,306
Rhode Island	$6,193
Vermont	$6,069
West Virginia	$5,954
Pennsylvania	$5,933
North Dakota	$5,808
New Jersey	$5,807
Minnesota	$5,795
Ohio	$5,725
Wisconsin	$5,670
Nebraska	$5,599
Maryland	$5,590
Florida	$5,483
Kentucky	$5,473
Tennessee	$5,464
Missouri	$5,444
New Hampshire	$5,432
Kansas	$5,382
Iowa	$5,380
South Dakota	$5,327
Indiana	$5,295
Illinois	$5,293
United States	$5,283
Wyoming	$5,265
North Carolina	$5,191
Alabama	$5,135
South Carolina	$5,114
Washington	$5,092
Montana	$5,080
Mississippi	$5,059
Michigan	$5,058
Louisiana	$5,040
Hawaii	$4,941
Oklahoma	$4,917
Oregon	$4,880
Arkansas	$4,863
Virginia	$4,822
Colorado	$4,717
California	$4,638

Texas	$4,601
Georgia	$4,600
Nevada	$4,569
New Mexico	$4,471
Idaho	$4,444
Arizona	$4,103
Utah	$3,972

Notes	Health Care Expenditures measure spending for all privately and publicly funded pe
Definitions	
Sources	Health Expenditure Data, Health Expenditures by State of Residence, Centers for M

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09/14/2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Metcalf	Mission Hosp
Chip Baggett	NCMS
[illegible]	NCICU
[illegible]	CAN
Angel Sams	CAN
Richard Vinroot	Robinson, Bradshaw + Hinson, Charlotte, NC (representing Mission Hospital)
Ann Y Young	Mission Hospital
Everett J Bowman	Robinson Bradshaw Mission
N. Sherrill	Mission Hosp
Brian Moore	Mission Hospital

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Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Mitch Kokai	John Locke Foundation
Tracy Colvard	AHHC
Evelyn Hawthorne	EHGR
Allison Waller	NMRS
Kristen Laster	FSP
Jason Deans	ICS
Matt Jennings	ICG
Tim Trotte	Self
Brenda Olls	LA
Cheri Floyd	LA
Elizabeth Taylor	Kochanek Law Group
Chuck Stone	SEANC

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NAME	FIRM OR AGENCY AND ADDRESS
Hugh Tilson	NCMA
Lanier Cansler	DHHS
Daniel Baum	Troutman Sanders
BJ Miller	Cone Health
Lu-Ann C[illegible]	CSS
[illegible]	Poyner [illegible]
Peyton Maynard	[illegible]
David Barnes	PS
Craig Souza	NCHCFA
Joe Vincoli	NCDOC
Mara Wilding	Novant

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Lanier	Nelson Mullins
Gretchen Kelly	FirstHealth
Breeden Blackwell	Cape Fear Valley Med. Ctr.
Marge Foreman	NCHE
Craig Smith	DHHS-DHSR
Drexdal Pratt	DHHS-DHSR
Chris Taylor	NCMCC-DHSR
Patricia Christian	DHHS-DHSR
Jesse Goodman	DHHS/DHSR
Tom West	Poyner Spruill LLP
[illegible]	DHHS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES 09/14/2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary L. Matthews	Duke Health System, Durham NC
MARC C. HEWITT	WILLIAMS MULLEN
Trey Adams	PDA, Inc.
BEECHER R. GRAY	N.C. O.A.H.
Neal Inman	Civitas Institute
MIKE VICARIO	NCHA
DEE JAY ZERMAN	UNCH
Amy Bragg	UNC Health Care
Will Pittman	Rex Healthcare
[illegible]	WM
Heather Barnett	WM

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09/14/2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lori Ann Harris	[illegible]
John Cooper	Compass NC
[illegible]	NBN HPA
Connie Wilson	Novant
Bob Fitzgerald	[illegible]
K.D. Sturgis	NC DOJ

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, October 6, 2011
TIME: 10am
LOCATION: 544 LOB
COMMENTS: 10am to 12pm Facilities Overview Presentation
12pm to 1pm Lunch Break
1pm to 3pm CON Presentations

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **12 PM** o'clock on **September 23, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

AGENDA

10:00 a.m. Thursday, October 6, 2011
Room 544 Legislative Office Building

I. Call to Order and Introductory Remarks
Representative John Torbett- presiding

II. Overview and Inventory of Regulated Facilities
Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, DHHS

III. CON Review Statistics
Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, DHHS

Lunch break 12:00 until 1:00

IV. Climate and Conditions for Hospital Operations
Hugh Tilson, Sr. Vice-President, North Carolina Hospital Association

V. North Carolina Certificate of Need Law in the 21st Century
Noah H. Huffstetler III, Partner, Nelson Mullins

VI. Committee Discussion

VII. Adjourn

Next meeting:
6:00 p.m., October 20, 2011,

WNC Agricultural Center
1301 Fanning Bridge Rd., Fletcher, NC 28732

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

THURSDAY, OCTOBER 6, 2011

10:00 a.m.

Room 544, Legislative Office Building

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 6, 2011, at 10:00 a.m. in Room 544 of the Legislative Office Building. Representatives Avila, Boles, Brandon, Collins, Current, Hollo, Randleman, Steen, and Torbett attended.

Representative Torbett presided. He welcomed members and audience and gave information on upcoming meetings. Shawn Parker, Committee Counsel, addressed questions from previous meeting that were answered concerning the ethical regulations of the SHCC: The state health coordinating council is not considered a covered board under the state ethics act, instead the regulations of their ethics falls under executive order 10, which has been issued by Governor Perdue, and it imposes certain disclosure requirements and conflict of interest standards. What it requires is that prior to each meeting members are reminded of their duty to act in the best interest of the public without regard to their professional, institutional, or financial interest. Before conducting any business, each member must disclose any professional or institutional interest in any matter coming before the SHCC or a SHCC subcommittee. The chair would determine whether the member must be recused. Before conducting any business each member must disclose any financial benefit, the term is slightly different than what would be in the state government ethics act that he or she or his or her spouse may derive in a manner before the SHCC or a subcommittee. If the member indicates they derive a benefit they must recuse themselves. They may deliberate on the matter unless the chair decides that the deliberation would not be in the best interest of the committee.

Representative Torbett asked the committee to adopt the minutes from the previous committee meeting. Representative Randleman made the motion, seconded by Representative Steen. The motion carried unanimously.

PRESENTATIONS

AC3, Drexel Pratt, Director of the Division of Health Service Regulation (see attached).

Overview and Inventory of Regulated Facilities, CON Review Statistics, Jeff Horton, Chief Operating Officer, division of Health Service Regulation, DHHS (see attached)

Representative Avila: Back on page 12 where we talked about the dialysis clinics, there was recently some work done and they are questioning whether just three days a week is sufficient and I was wondering has that trickled into any discussions in terms of capacity as far as the state is concerned?

Jeff Horton: Not to my knowledge. Three days a week is still the standard of care.

Representative Avila: Just being knit picky on this. On page 16, I don't get my numbers to add up. Because when you do the non –competitive and the competitive you only get 123 and you are saying there were 156 reviewed, where do we lose that, what kind of classification did the difference fall into?

Jeff Horton: We had 156 total received, actually, the 11 competitive reviews were 45 applications, and then that actually would be added to the 112 applications. Actually that would be 157.

Representative Current: In deciding, let me see if I can put it a way that clarifies what I am saying. In my county, town of Mount Holly area, our hospital applied for an emergency facility and then the hospital across the river contested that and so forth and I think it has been decided, but my question is who makes the decision you need any emergency room facility in Mount Holly or is that purely based on the fact that somebody applies for it?

Jeff Horton: Yes, a need for the offsite and emergency department, like you are talking about, is not in the state medical facilities plan. There is no determination in the plan for that, per se. The hospital would have to make the case and say we believe there is a need for it and then they would have to demonstrate that need and tell us why they think it is and it would have to conform to the criteria and the law.

Representative Current: You touched on something I also wanted to get a little more clarification on. In the case of a hospital, I think Hillsboro is getting ready to build one, is that correct?

Jeff Horton: Yes.

Representative Current: Now if the mission of certificate of need is to affect the cost of health care in North Carolina, would certificate of need have the authority or the committees behind it and so forth, to decide whether you need a hospital period, based on access or the other factors and so forth, up front?

Jeff Horton: Well the state medical facilities plan would determine if there is a need for acute care hospital beds. That's where the need originates from and then the plan is published every year and is signed by the governor, usually before the end of the calendar year, and its effective January 1 of the next year and that will have the need determinations in it. So if there are new hospital beds in it that would typically drive somebody building a hospital or either taking those beds and adding it to an existing hospital in the same county. Now another that hospitals can do is there may not be a need determination for hospital beds in a certain county, but let's say they want to take some beds from their big facility and just relocate those beds to another part of the county. They can do that, but they have to have a certificate of need, and again, we look at the criteria that they have to meet all the review criteria. A big part of that, I will tell you, that when reviews are done, when folks are relocating services within the county, we often look at what population are they serving. A big part of the law is medically underserved individuals. You have to show that you are serving that population, so if they want to relocate something to another area, we typically look are they still going to serve medically underserved

individuals where they want to move their beds to. So we look at things like that just to make sure that they are leaving some folks high and dry somewhere.

Representative Current: On the back page you are talking about how much the state spends in your attorney general's effort. I'm just curious to know how much money might be spent by the entities that desire certificate of needs to address the changes in the decisions. Do you have any idea how much money, because that comes from, say in the case of a hospital that wants to expand or something; those are reflected in healthcare costs?

Jeff Horton: We don't collect that data, that is typically something hospital work out with their law firms and we don't have access to that data.

PRESENTATION

Climate and Conditions for Hospital Operations, Hugh Tilson, Sr. Vice-President, North Carolina Hospital Association (see attached)

Representative Current: Talking a little bit about the Medicaid disproportionate situation, is that still in existence?

Hugh Tilson: Yes sir it is. So Medicaid pays hospitals a base rate and it is on the outpatient side 80% of cost and one the inpatient about 50% of cost. The federal government has a program called the disproportion share program that allows us to draw down federal funds to help offset those losses. The net of those losses are now about 74% of our cost of caring. So even with that it doesn't offset our entire cost of caring for Medicaid patients.

Representative Current: Now does that include the cost of Medicare services that are not paid by the government and charity and Medicaid, uncompensated portion of what they pay the hospitals?

Hugh Tilson: No sir. That's just the Medicaid portion.

Representative Current: I'm surprised to see obstetrics over here in the losing column. If that is the case, why do I see hospitals continually building and improving their birthing centers, it seems to never end?

Hugh Tilson: I'd be happy to get some hospital folks up here to really answer the question. I'd be happy to tell you my impression of it and that is when you go to the hospital there are very few positive interactions. You are usually sick, having an intervention, but having a baby is a good thing. So hospitals want to make that as positive as an experience as possible so that you have a positive experience at the hospital for the rest of your medical care. It is an important patient intervention. It's the right thing to do, we need to make it as comfortable as possible, but from a financial standpoint. The other thing is about half the babies in North Carolina are paid for by Medicaid. So you see a lot of effort to try to get those commercially insured babies being born at your hospital as well.

Representative Current: My experience has been that all of these young ladies that have babies that do have commercial insurance. They pay the cost to the hospital and the physician care before they ever are delivered has been my observation. You mentioned something about the hospitals serving people and then worrying about collecting. I want to know where you can go, every doctor I go see for whatever, the first thing we talk about is how it's going to be paid for. I have an assistant that works in our office that is having a baby in December, paying it out of pocket, and she has made arrangements for the hospital to be paid and the doctor to be paid before that baby ever comes into the world. I know in my office we take patients and don't worry about getting paid until it's done and we've got a pretty good accounts receivable. The point I want to make is that I don't know that I agreed with what you said about all this care being done out here in the field without compensation being talked about before it's ever done.

Hugh Tilson: I think you are going to see more of that with that balance of being a business and a charitable organization. If you can schedule things in advance, I think you are going to see more people talking about how you're going to pay for it. But there are an awful lot of things in a hospital that you can't schedule in advance. Those are the types of things I'm talking about when you show up in the emergency department , you need an MRI, you need an emergency heart surgery, you need all those type things, we're not going to ask how are you going to pay for it. If you show up and need to have your knee scoped or you need any of those type things, we can schedule in advance, we are increasingly asking those questions.

Representative Avila: It's just sort of like a theoretical supply and demand. On one hand you are saying that we are having more and more people needing these services, yet we have in place a program that limits the services. I'm not sure that the review process and the agreement to expand are keeping up this need to expand. Is that logical?

Hugh Tilson: Need to defer to someone who actually does this for a living to answer that question, but my impression is that because the planning process plans years out, it anticipates what is going to be there. Process is designed to reflect your question, whether it does it or not, my hospitals seem to believe it does and that we are very comfortable with that.

North Carolina Certificate of Need Law in the 21st Century, Noah H. Huffstetler III, Partner, Nelson Mullins (see attached)

Question from Representative Avila: When we talked about supply and demand and we heard Hugh make the statement that you plan far in advance and here you've got an expansion that has been hung up in discussion for three years. It's not working. You are planning for growth, but you are not providing the facilities at the rate that you need them, because the system can hang it up forever. It definitely needs to be reworked if your objective is to review, plan ahead, and build accordingly.

Noah Huffstetler: I agree, I think you hit the nail on the head. It is true that the state plan looks at a planning horizon, a couple of years in the future. What we often see is by the time that planning

horizon arrives, it's already obsolete. Even if you are planning that far in the future, if the thing is going to be held up in court for 5 years, you are going to delay the ability of folks to meet needs. The BRAC program in the Cumberland Hoke County is leading to a tremendous influx of families and both First Health located in Pinehurst and Cumberland located in Fayetteville have applied to build hospitals in that community and they are still held up in court and likely will be for a while. That is one area where we can make the program refocused more on the needs of the people it's supposed to serve.

Representative Brandon: Who is in charge of the certificate of need on the review process, particularly the competitor part? If there are 10 people applying for the certificate and they all 10 qualify, how does that decision get made to just one person getting it?

Noah Huffstetler: Unlike other states who have a board of people who make these decisions, in North Carolina, we have the decision made by a single project analyst with the oversight and the supervision of either the chief of the CON section or that chief's deputy. Two people are making the decision. Typically the person with oversight, who is responsible, does not read the whole application. These applications are hundreds of pages long. In the situation that you hypothesize with ten applicants, you could have ten applications, each of which 400 pages long, and an agency file that would fill up several volumes where they have commented in favor of their application against the other. Really, there is only one person who reviews all that. His or her decision is reviewed and approved by someone higher up in the CON section, but it is not a board or commission that makes those decisions. It's basically one person.

Representative Current: Complement presenter on appraisal of state health coordinating council, you did that eloquently and objectively. How it's appointed and the make -up and ethics. You make the comment that everybody had agreed that there needed to be an emergency room in Mount Holly. I just am going to use this as an example. I'm a Gaston County man and I think that if we are going to build one, I'd like for Caromont to have it, obviously. Which brings a second question, I picked up the paper yesterday morning and I think there were two maybe three full page ads of advertising in our newspaper in Gaston County for physicians to go see that are physicians of the Charlotte Hospital that I won't reference. I'm sitting here saying to myself how is this in the best interest of the public that you say that the certificate of need is supposed to be serving. We're spending all this money trying to take patients away from each other, and that is what this emergency room situation is about, is how to cut off the flow of patients from Gaston County to Charlotte and then Charlotte wants to get our people coming to their hospitals. It would seem to me that what we should be seeking is some type of scenario that is really in the best interest of the people.

Representative Steen: I think these reform measures are something that we need to take a strong look at. I think they are very practical and hopefully we can go down that road. You mentioned the medical care commission and SHCC, what is the interaction between those two groups?

Noah Huffstetler: They are separate groups with separate authorities. The medical care commission adopts certain rules for the practice of medicine, for example, in North Carolina and it is under its auspices that hospital revenue bonds are issued. The full faith and credit of the state is not pledged for

those bonds, but the medical care commission assists the community hospitals, and this is available only for not for profit hospitals, in being able to issue the finances they need for new projects. They don't make the CON decision. In the original CON law, the one that was declared unconstitutional and reenacted, it was the medical care commission that made those decisions. Under the present law, the state health coordinating council, which has no common representation with the medical care commission, is the entity that makes the decision about where a facility can be built. Then you go to the medical care commission if you want to get state sponsored funding for that project.

Representative Steen: You mentioned the AC3 hospitals, the acute care with the academics. How much have academic hospitals increased market share since that law was enacted in 1977?

Noah Huffstetler: It is impossible to say, I do have a slide here that shows that they are doing extraordinarily well in terms of their operating performance and metrics. (See attached) The original purpose of policy AC3 was a valid one. It was to recognize that these academic institutions may have a need for teaching or research purposes that cannot be justified in the terms of the number of patients they are going to have and, therefore, shouldn't have to go through the regular process. What we have seen is, in Wake, Forsythe, and all these other places across the state, head to head competition between academic medical centers and ordinary hospitals over issues that don't have anything to do with research and some kind of esoteric technology. In Forsyth County the state medical facilities plan says that it has 7 too many operating rooms in the county and so none of the non -academic hospitals were permitted to expand their facilities, but yet North Carolina Baptist was permitted to build a new 8 operating room ambulatory surgery facility to do kind of tonsillectomies and ear plugs and the other things that are normally done in ambulatory surgery facilities, even though none of the private hospitals could do that. As long as they weren't competing head to head, I think it was fair and appropriate for the academics to have some special provisions, but if they are going to be doing head to head competition, as indeed they are here in Wake County, I think you need to level the playing field between academics and the other guys.

Representative Torbett reminded members that the next meeting will occur on October 20th, at 6pm Western North Carolina Agricultural Center in Fletcher, NC and adjourned the meeting.

Representative John Torbett, Co-Chair Presiding

Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair

Alamance Regional Medical Center • Albemarle Health • Alleghany Memorial Hospital • Angel Medical Center • Annie Penn Hospital • Anson Community Hospital • Ashe Memorial Hospital, Inc. • Beaufort County Medical Center • Bertie Memorial Hospital • Betsy Johnson Regional Hospital • Blowing Rock Hospital • Blue Ridge Regional Hospital • Broughton Hospital • Brunswick Community Hospital • Caldwell Memorial Hospital, Inc. • Cape Fear Valley - Bladen County Hospital • Cape Fear Valley Health System • CarePartners Rehabilitation Hospital • CarolinaEast Health System • Carolinas Medical Center • Carolinas Medical Center - Lincoln • Carolinas Medical Center - Mercy • Carolinas Medical Center - Northeast • Carolinas Medical Center - Pineville • Carolinas Medical Center - Union • Carolinas Medical Center - University • Carolinas Rehabilitation • Carteret County General Hospital • CaroMont Health, Inc. • Catawba Valley Medical Center • Central Carolina Hospital • Central Regional Hospital • Charles A Cannon, Jr. Memorial Hospital • Chatham Hospital • Cherokee Indian Hospital • Cherry Hospital • Chowan Hospital • Cleveland Regional Medical Center • Coastal Plain Hospital • Columbus Regional Healthcare System • Cone Health Behavioral Health • Davie County Hospital • Davis Regional Medical Center • Department of Veterans Affairs Medical Center Asheville • Department of Veterans Affairs Medical Center Durham • Dorothea Dix Hospital • Duke Raleigh Hospital • Duke University Hospital • Duplin General Hospital, Inc. • Durham Regional Hospital • FirstHealth Montgomery Memorial Hospital • FirstHealth Moore Regional Hospital • FirstHealth Richmond Memorial Hospital • Forsyth Medical Center • Franklin Regional Medical Center • Frye [illegible] Health System • Halifax Regional Medical Center • Heritage Hospital • High Point Regional Health Sy[illegible] ialty Hospital • Holly Hill Hospital • Hugh Chatham Memorial Hospital • Iredell Health System [illegible] - Smithfield • Kings Mountain Hospital, Inc. • Lake Norman Regional Medical Center [illegible] • Lexing[illegible] LifeCare Hospitals of North Carolina • Margaret R. Pardee Memorial Hospital [illegible] Hospital • Medical Park Hospital • MedWest - Harris • MedWest - Hayw[illegible] Hospital • Murphy Medical Center, Inc. • Nash Health Care Systems • New Hanover Regional Medical Center • No[illegible] Hospital of Surry County • Onslow Memorial Hospital • Our Community Hospital • The Outer Banks Hospital • Park Ridge Hea[illegible] Hospital • Person Memorial Hospital • Pitt County Memorial Hospital, Inc. • Presbyterian Healthcare • Presbyterian Hospital Huntersville [illegible] Hospital Matthews • Presbyterian Orthopaedic Hospital • Pungo District Hospital Corporation • Randolph Hospital • Rex Healthcare • Roanoke [illegible] Hospital • Rowan Regional Medical Center • Rutherford Regional Medical Center • Sampson Regional Medical Center • Sandhills Regional Medical Center • Scotland Health Care System • Select Specialty Hospital-Durham • Select Specialty Hospital-Winston-Salem • Southeastern Regional Medical Center • St. Luke's Hospital • Stanly Regional Medical Center • Stokes-Reynolds Memorial Hospital, Inc. • The Moses H. Cone Memorial Hospital • Thomasville Medical Center • Transylvania Regional Hospital • UNC Hospitals • Valdese Hospital • Wake Forest Baptist Medical Center • Wake Forest Baptist Health – Davie Hospital • Wake Forest Baptist Health – Lexington Medical Center • WakeMed • WakeMed Cary Hospital • WakeMed Fuquay-Varina • WakeMed Zebulon/Wendell SNF and Outpatient Diagnostic Center • Washington County Hospital • Watauga Medical Center • Wayne Memorial Hospital • Wesley Long Community Hospital • Wilkes Regional Medical Center • Wilson Medical Center • Women's Hospital of Greensboro • Yadkin Valley Community Hospital

Climate and Conditions for Hospital Operations

Hugh Tilson, Sr. Vice President

North Carolina Hospital Association

Why U.S. Health Care Costs Rise

The aging of America is driving up utilization – older people use more health care services

Costly medical technologies and drug therapies more available; Americans use a lot of them – in addition to prior existing therapies

Societal expectations: Americans demand high quality health care services – without restrictions and with minimal costs to the patient

The U.S. system incentivizes providers to do more

Multiple third party payers result in higher administrative costs, including for providers

NCHA

2

Health Care Economics Are Different

Most U.S. Industries		Health Care
Consumer directly pays for the product	⇨	Government/insurers pay the majority of the bill
Demand rises when prices decline/quality increases	⇨	Price is generally not the deciding factor when medical care decisions are made – patients don't pay, deference to physician recommendations, lack of information
Buyers purchase only what they need and can afford	⇨	Consumers primarily seek care when they are sick – they want the 'best', get it now and pay for it later, rely on physician recommendations not price
Consumers are able to compare product performance and price with competing products	⇨	Little objective information is available to consumers and providers; available information difficult to use
Purchasers and sellers negotiate prices	⇨	Government sets prices for most customers – below cost; private insurers negotiate but pay more for a smaller number of consumers

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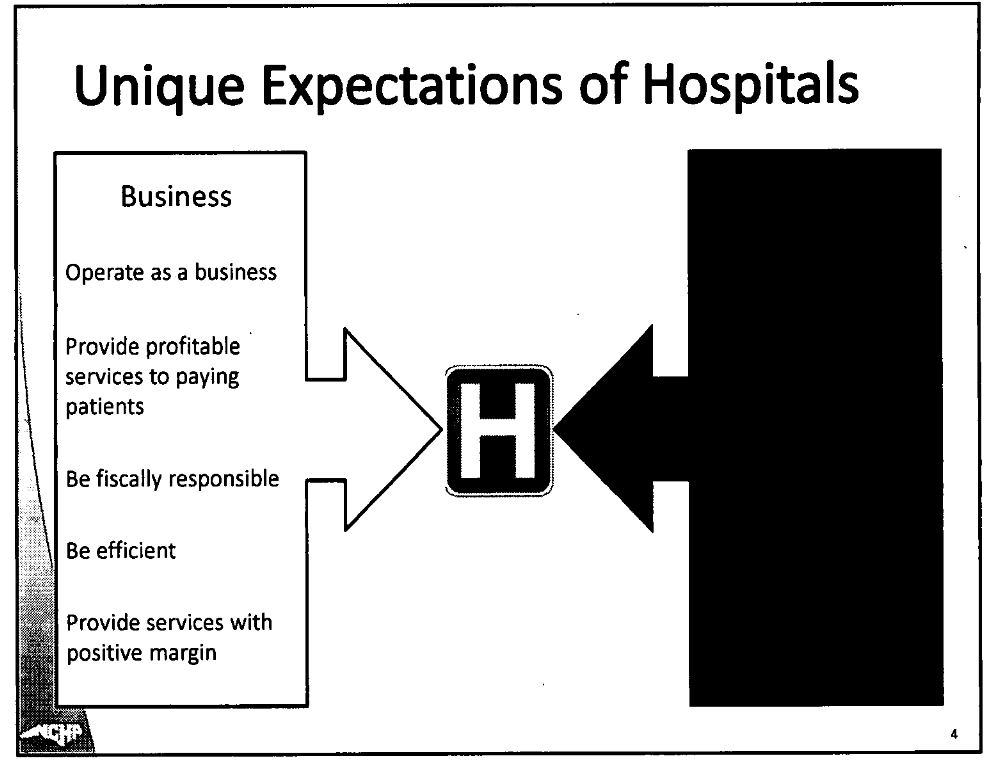
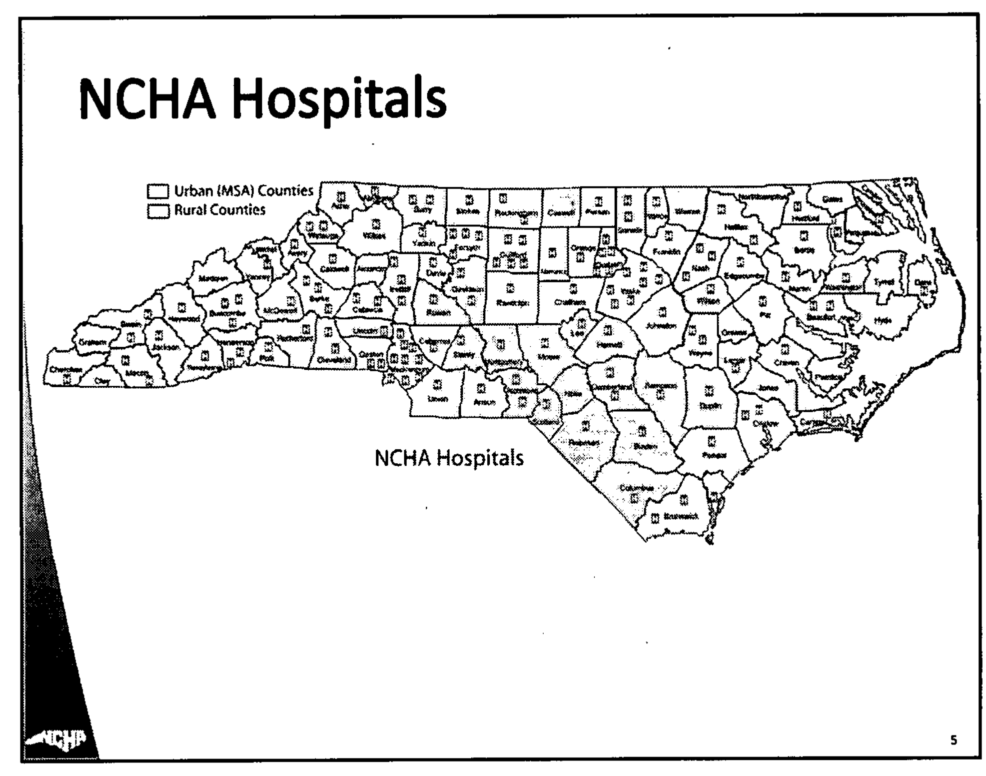
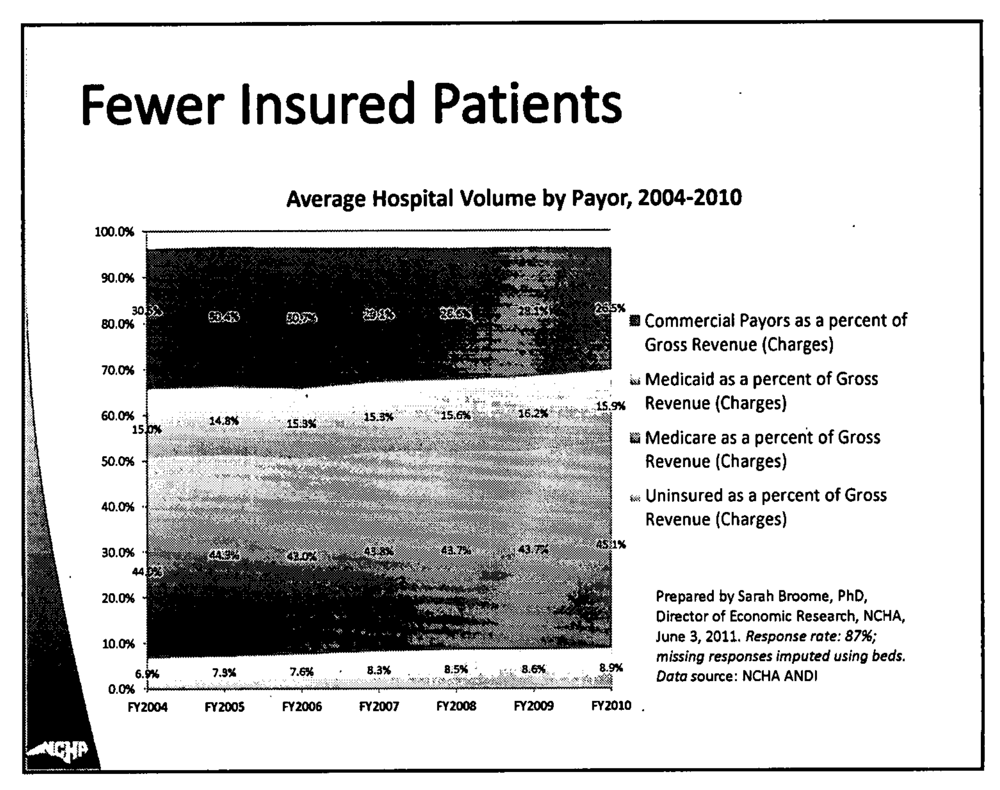
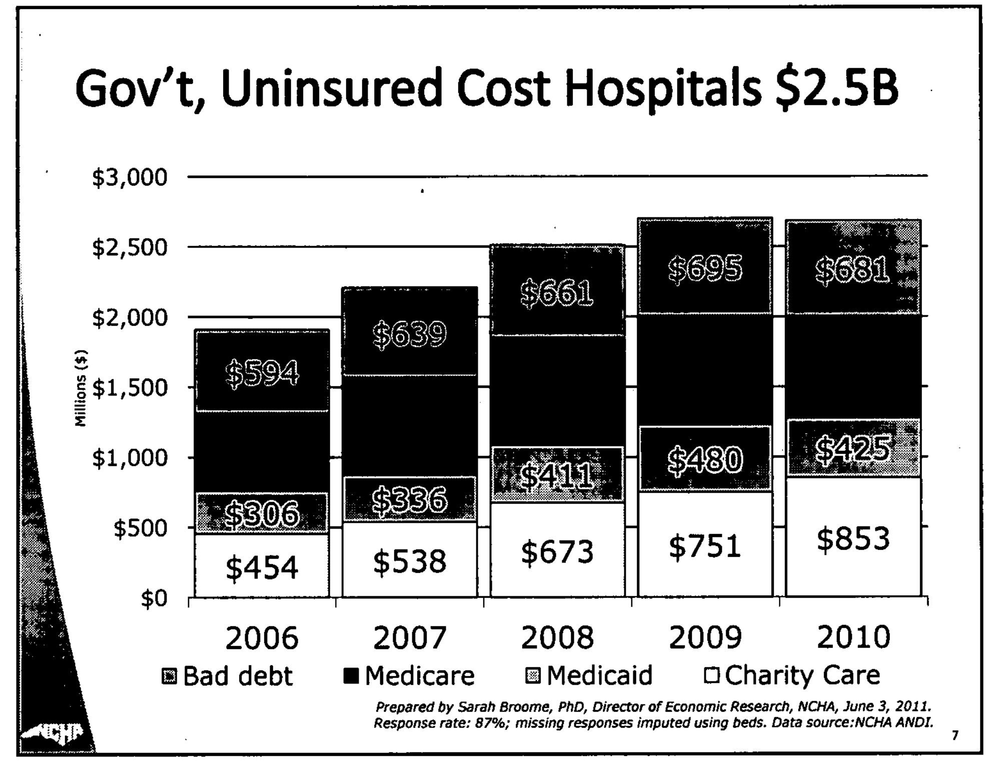


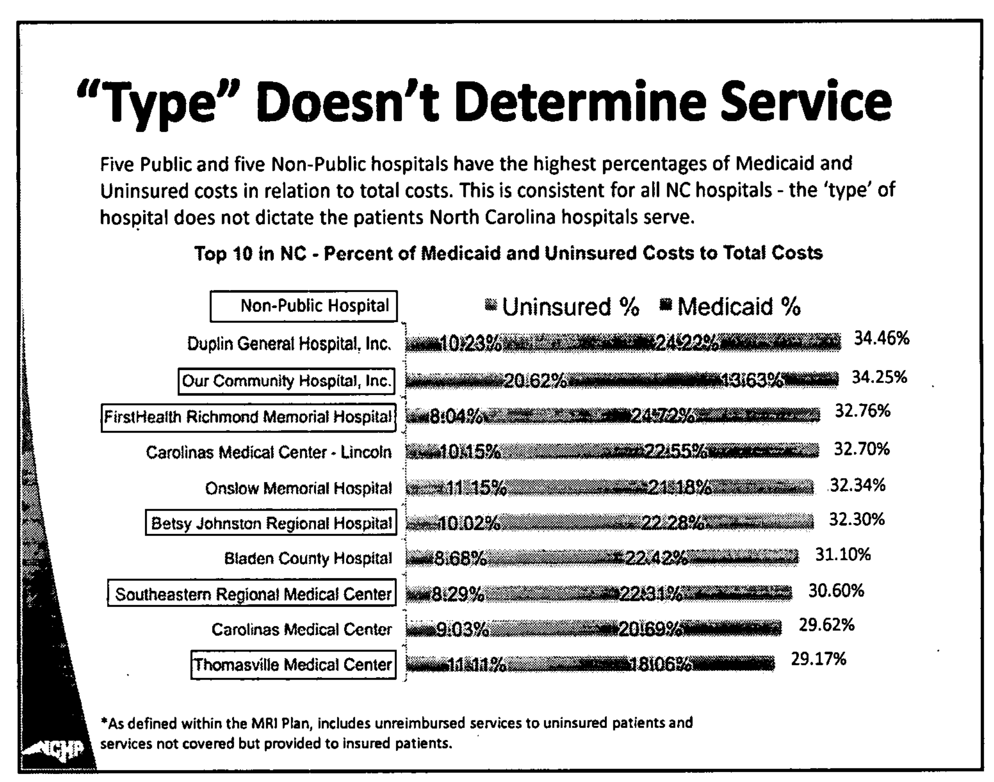


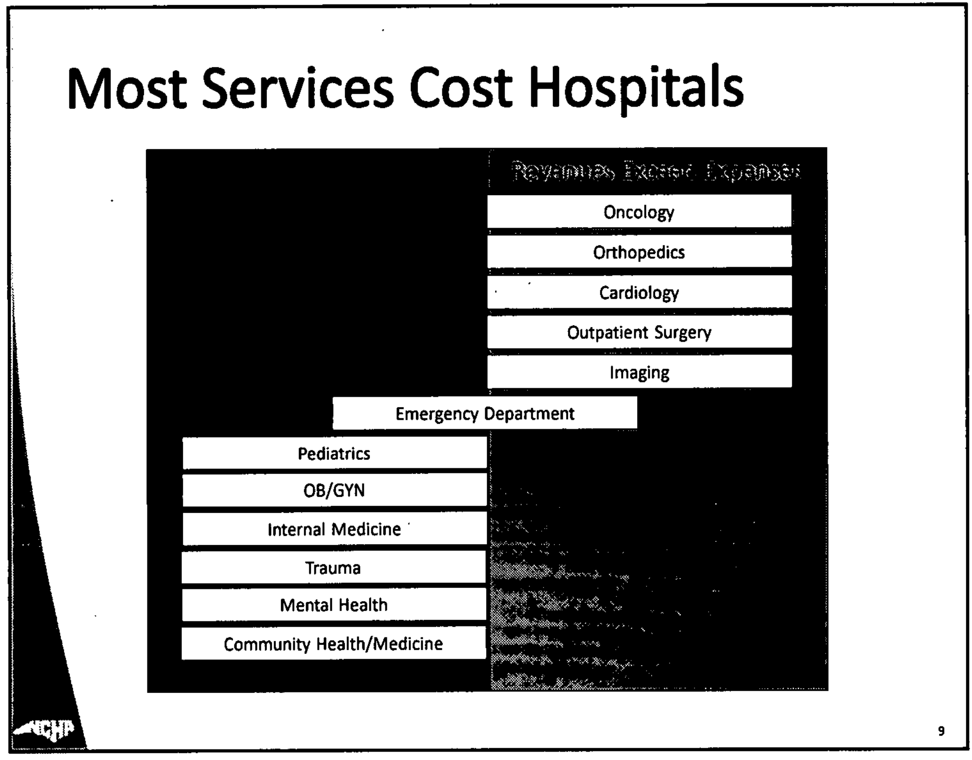
NCHA Hospitals
Urban (MSA) Counties
Rural Counties
NCHA Hospitals
5

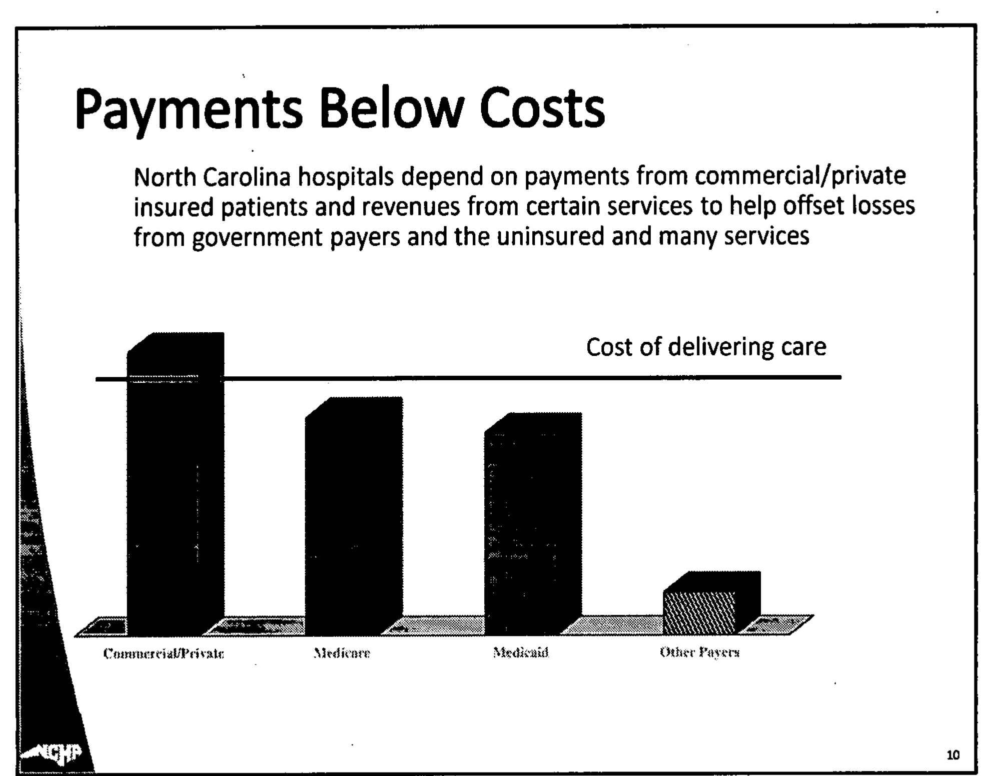


Fewer Insured Patients
Average Hospital Volume by Payor, 2004-2010
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
14.8%
15.3%
15.3%
15.6%
16.2%
15.9%
43.7%
43.7%
45.1%
7.6%
8.3%
8.5%
8.6%
8.9%
FY2004
FY2005
FY2006
FY2007
FY2008
FY2009
FY2010
Commercial Payors as a percent of Gross Revenue (Charges)
Medicaid as a percent of Gross Revenue (Charges)
Medicare as a percent of Gross Revenue (Charges)
Uninsured as a percent of Gross Revenue (Charges)
Prepared by Sarah Broome, PhD, Director of Economic Research, NCHA, June 3, 2011. *Response rate: 87%; missing responses imputed using beds. Data* source: NCHA ANDI


Gov't, Uninsured Cost Hospitals $2.5B
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
Millions ($)
$594
$306
$454
$639
$336
$538
$661
$411
$673
$695
$480
$751
$681
$425
$853
2006
2007
2008
2009
2010
Bad debt
Medicare
Medicaid
Charity Care
Prepared by Sarah Broome, PhD, Director of Economic Research, NCHA, June 3, 2011.
Response rate: 87%; missing responses imputed using beds. Data source:NCHA ANDI.
7


"Type" Doesn't Determine Service
Five Public and five Non-Public hospitals have the highest percentages of Medicaid and Uninsured costs in relation to total costs. This is consistent for all NC hospitals - the 'type' of hospital does not dictate the patients North Carolina hospitals serve.
Top 10 in NC - Percent of Medicaid and Uninsured Costs to Total Costs
Non-Public Hospital
Uninsured %
Medicaid %
Duplin General Hospital, Inc. 10.23% 24.22% 34.46%
Our Community Hospital, Inc. 20.62% 13.63% 34.25%
FirstHealth Richmond Memorial Hospital 8.04% 24.72% 32.76%
Carolinas Medical Center - Lincoln 10.15% 22.55% 32.70%
Onslow Memorial Hospital 11.15% 21.18% 32.34%
Betsy Johnston Regional Hospital 10.02% 22.28% 32.30%
Bladen County Hospital 8.68% 22.42% 31.10%
Southeastern Regional Medical Center 8.29% 22.31% 30.60%
Carolinas Medical Center 9.03% 20.69% 29.62%
Thomasville Medical Center 11.11% 18.06% 29.17%
*As defined within the MRI Plan, includes unreimbursed services to uninsured patients and services not covered but provided to insured patients.


Most Services Cost Hospitals
Oncology
Orthopedics
Cardiology
Outpatient Surgery
Imaging
Emergency Department
Pediatrics
OB/GYN
Internal Medicine
Trauma
Mental Health
Community Health/Medicine
9


Payments Below Costs
North Carolina hospitals depend on payments from commercial/private insured patients and revenues from certain services to help offset losses from government payers and the uninsured and many services
Cost of delivering care
Commercial/Private
Medicare
Medicaid
Other Payers
10

NC Hospitals - Challenges

- Declining reimbursements
- Health Information Technology
- Workforce
- Can doctors keep practices open to new Medicare and/or Medicaid patients?
- Increased alignment
  - Community hospitals continue to align to meet community needs and uncertain environment
  - 25% to 40% of NC physician are employed by hospitals; will trend accelerate?; better ways to align?

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NC Hospitals - Challenges

Affordable Care Act

- Take effect or not: must plan for either
- Reduction in NC hospital revenues: $5.6 billion
- Unknowns
  - Will hospital losses caring for the uninsured fall?
  - Will anything change the way health care is delivered?
  - What to do to get ready?

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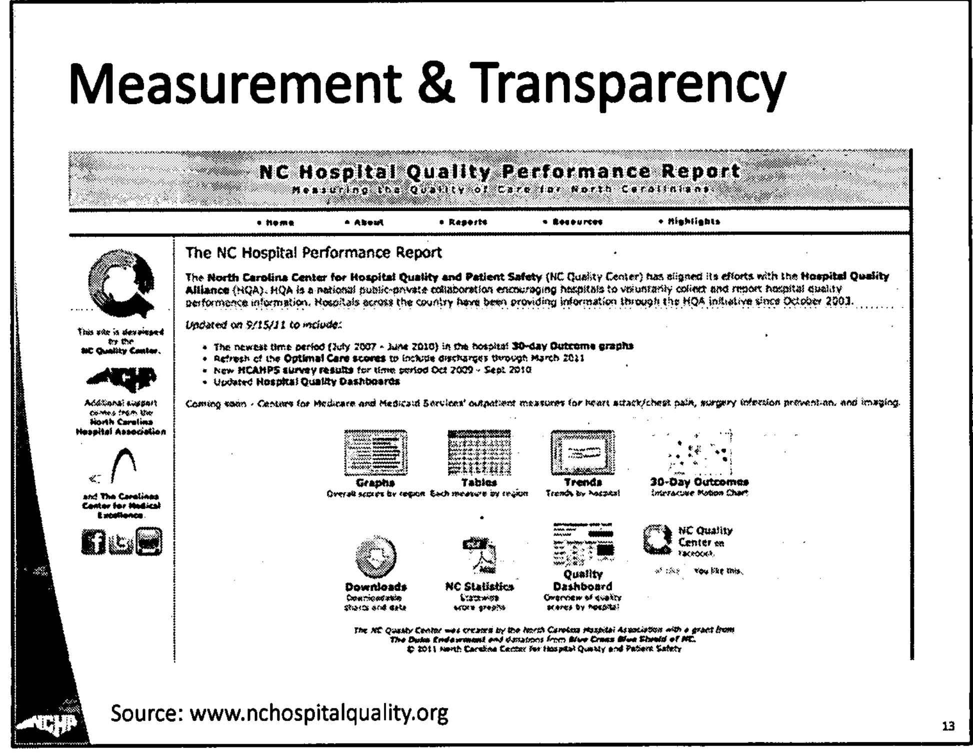
Measurement & Transparency



Source: www.nchospitalquality.org

13

Hospital Dashboard

Quality Dashboard

Quality Dashboard for

Quartiles are developed from the score distribution of NC Hospitals. For more on the development of this report, please visit the **Frequently Asked Questions (FAQ)**. For more details on the HCAHPS Survey, Mortality Rates, or Readmission Rates please visit **www.hospitalcompare.hhs.gov**.

HCAHPS Patient Perceptions Survey	10/09-9/10
Rate 9 or 10 Overall	72.0%
Always Clean and Quiet	64.0%

PSO Member

Conditions	Optimal Care Score	Mortality Rate	Readmission Rate
	10/10-3/11	7/07-6/10	7/07-6/10
Heart Attack (HA)[a]	99.0%	12.4%	17.9%
Heart Failure (HF)[a]	98.0%		20.2%
Pneumonia (PN)	89.0%	9.5%	18.2%
Surgical Care (SCIP10)	96.0%		

Color Coding
Top Quartile
2nd Quartile
3rd Quartile
No Data

Measure Benchmarks	NC 25th %-ile Score[b]	NC 50th %-ile Score[c]	NC 75th %-ile Score[d]	National Rate
Rate 9 or 10 Overall	65%	69%	74%	67%
Always Clean and Quiet	63%	66%	70%	66%
Optimal Care HA Score	93.6%	98.1%	100.0%	96%
Optimal Care HF Score	85.1%	93.0%	97.6%	90%
Optimal Care PN Score	84.5%	89.9%	95.2%	89%

Source: www.nchospitalquality.org

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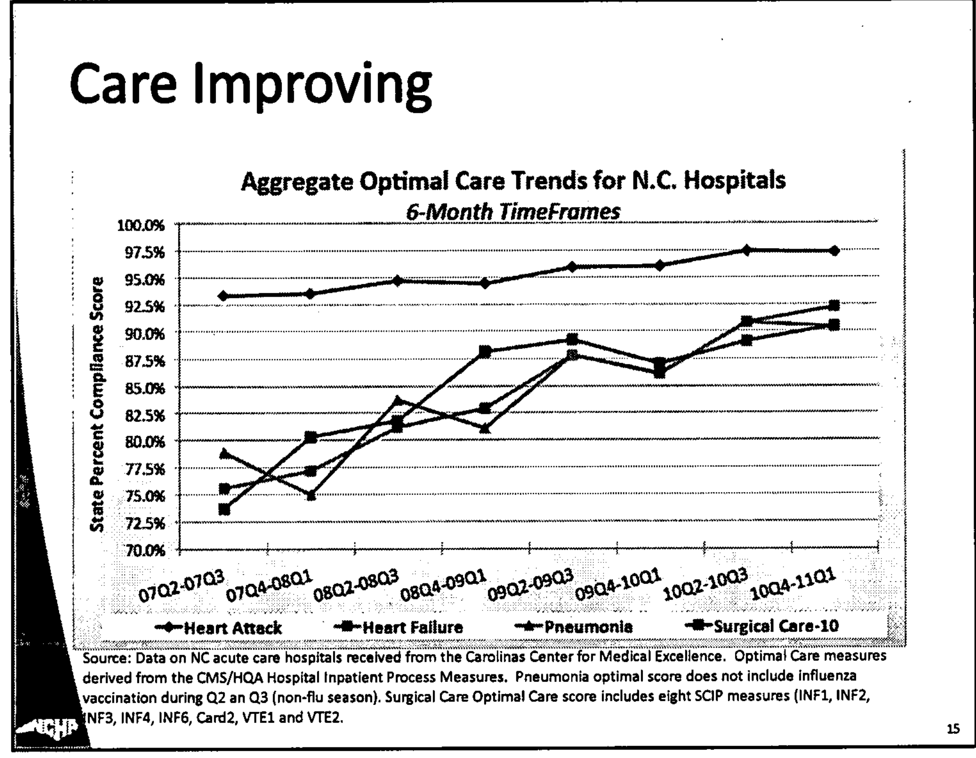
Care Improving



Source: Data on NC acute care hospitals received from the Carolinas Center for Medical Excellence. Optimal Care measures derived from the CMS/HQA Hospital Inpatient Process Measures. Pneumonia optimal score does not include influenza vaccination during Q2 an Q3 (non-flu season). Surgical Care Optimal Care score includes eight SCIP measures (INF1, INF2, INF3, INF4, INF6, Card2, VTE1 and VTE2.

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Summary

- Government paying for more hospital patients – privately insured declining but even more important
- Affordable Care Act and reimbursement cuts
  - Changes throughout health care
  - Focus on quality and efficiency
  - Consolidation/alignment/partnerships
  - Increased competition for certain services in certain communities
- Hospitals support CON to facilitate dual roles: act like a business while also providing access to needed care in an imperfect market
  - Cross-subsidization by payer
  - Cross-subsidization by service
  - Support safety net role

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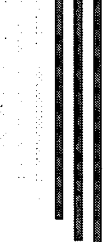


North Carolina Certificate of Need Law

Division of Health Service Regulation

Inventory of Health Care Facilities and Services

- Health care facilities & services inventories updated annually in the N.C. State Medical Facilities Plan.
- Most inventory data - from the Division of Health Service Regulation's licensing database.
- Utilization of services & patient origin data - from annual license renewal applications & data submitted by providers (hospitals and ambulatory surgical centers) to the designated statewide data processor (G.S. 131E, Article 11A).

Acute Care Hospital Data

- 114 licensed hospitals
- 20,713 licensed acute care beds
- Avg. annual occupancy rate was 58.42%
- 4,417,043 days of care provided to patients during 2010

As of Spring 2011

Acute Care Hospital Data

- Most hospitals in NC are not-for-profit.
- 10 hospitals are for-profit:
  - Central Carolina Hospital – Sanford
  - Davis Regional Medical Center – Statesville
  - Franklin Regional Medical Center- Louisburg
  - Frye Regional Medical Center – Hickory
  - Lake Norman Regional Medical Center – Mooresville
  - Martin General Hospital – Williamston
  - NC Specialty Hospital - Durham
  - Sandhills Regional Medical Center - Hamlet
  - Washington County Hospital - Plymouth
  - Yadkin Valley Community Hospital - Yadkinville

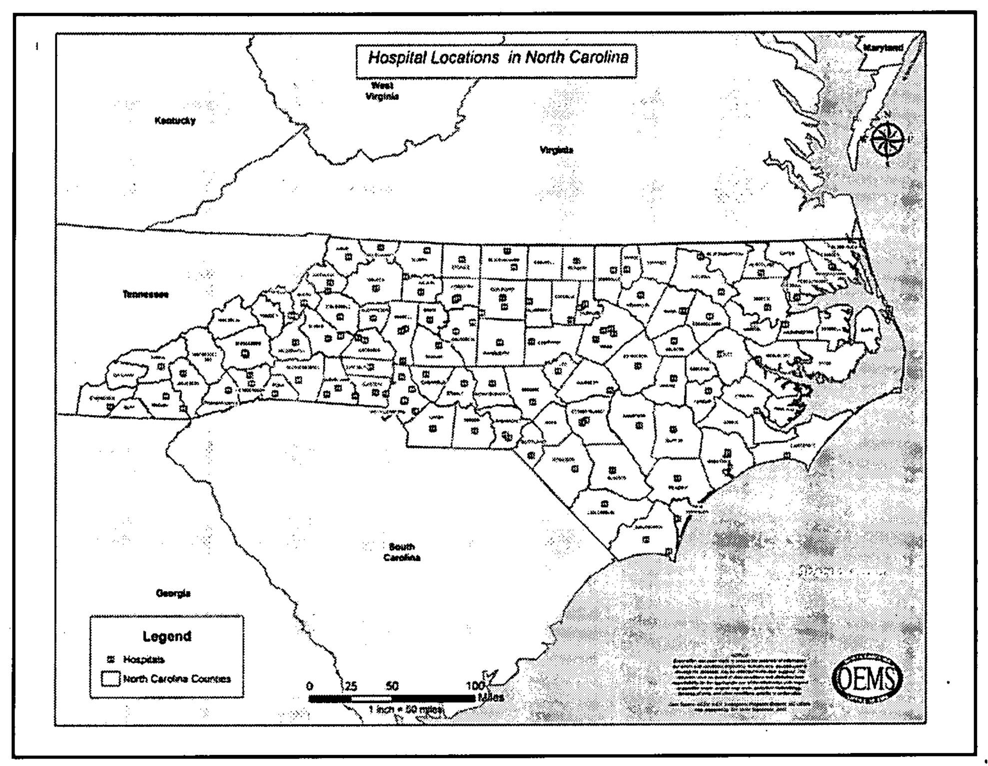
Long-Term Care Hospitals

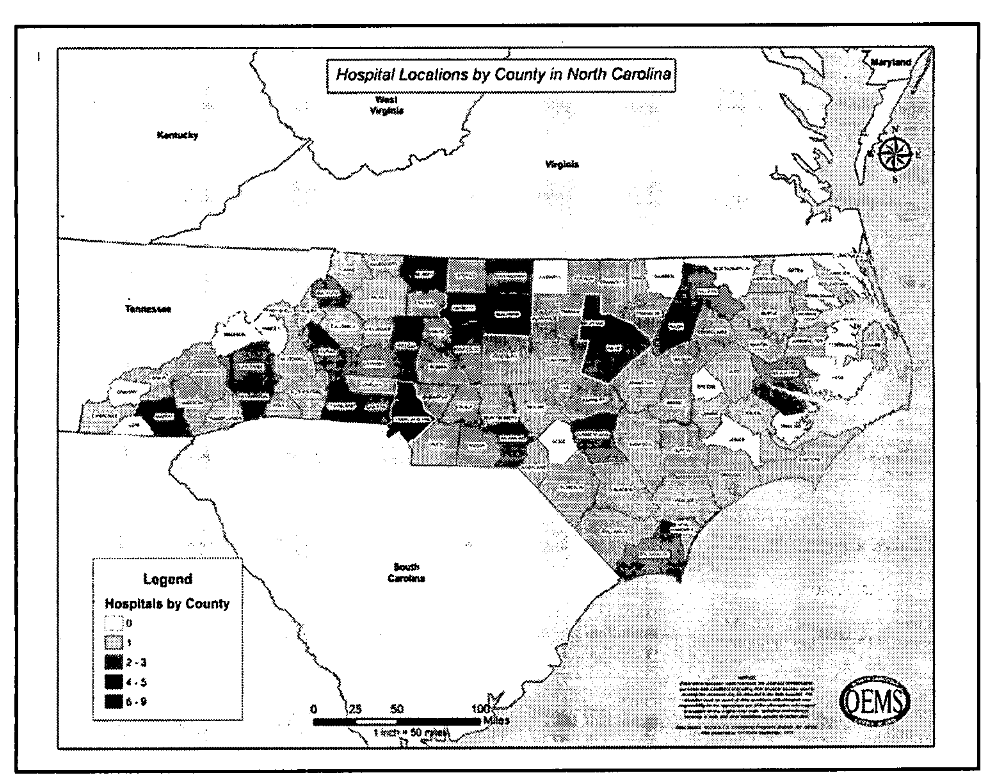
- 9 Long-Term Care Hospitals (LTCHs)
  - 434 beds
- Average length of stay > 25 days
- Provide services statewide & out of state due to their specialized services.
- 4 for-profit LTCHs:
  - Select Specialty Hospital-Durham
  - Select Specialty Hospital-Winston-Salem
  - Life-Care Hospitals of North Carolina-Rocky Mount
  - Kindred Hospital-Greensboro

As of Spring 2011

Rehabilitation Hospitals

- There are three licensed rehabilitation hospitals
  - Carolinas Rehabilitation Hospital –Mount Holly (40 beds)
  - Care Partners Rehabilitation Hospital-Asheville (80 beds)
  - Carolinas Rehabilitation Hospital – Charlotte (119 beds)
- 23 additional rehabilitation programs in acute care hospitals, with 742 beds

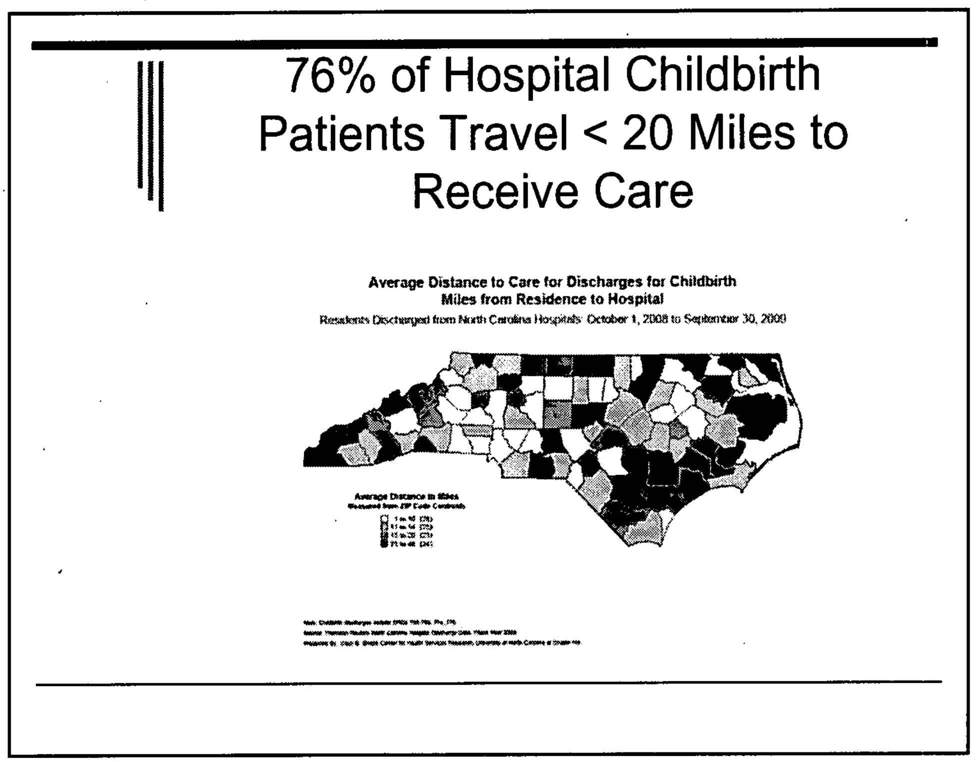

Hospital Locations in North Carolina
Kentucky
West Virginia
Virginia
Maryland
Tennessee
South Carolina
Georgia
Legend
Hospitals
North Carolina Counties
0 25 50 100 Miles
1 inch = 50 miles
OEMS


Hospital Locations by County in North Carolina
Kentucky
West Virginia
Virginia
Maryland
Tennessee
South Carolina
Legend
Hospitals by County
0
1
2 - 3
4 - 5
6 - 9
0 25 50 100 Miles
1 inch = 50 miles
OEMS

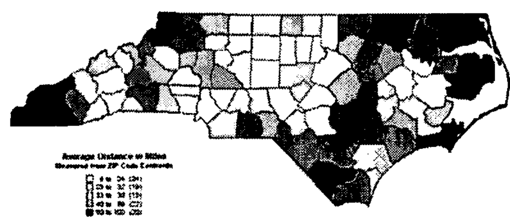
74% of All Hospital Patients Travel < 25 Miles to Receive Care

Average Distance to Care: Miles from Residence to Hospital

Residents Discharged from North Carolina Hospitals: October 1, 2008 to September 30, 2009

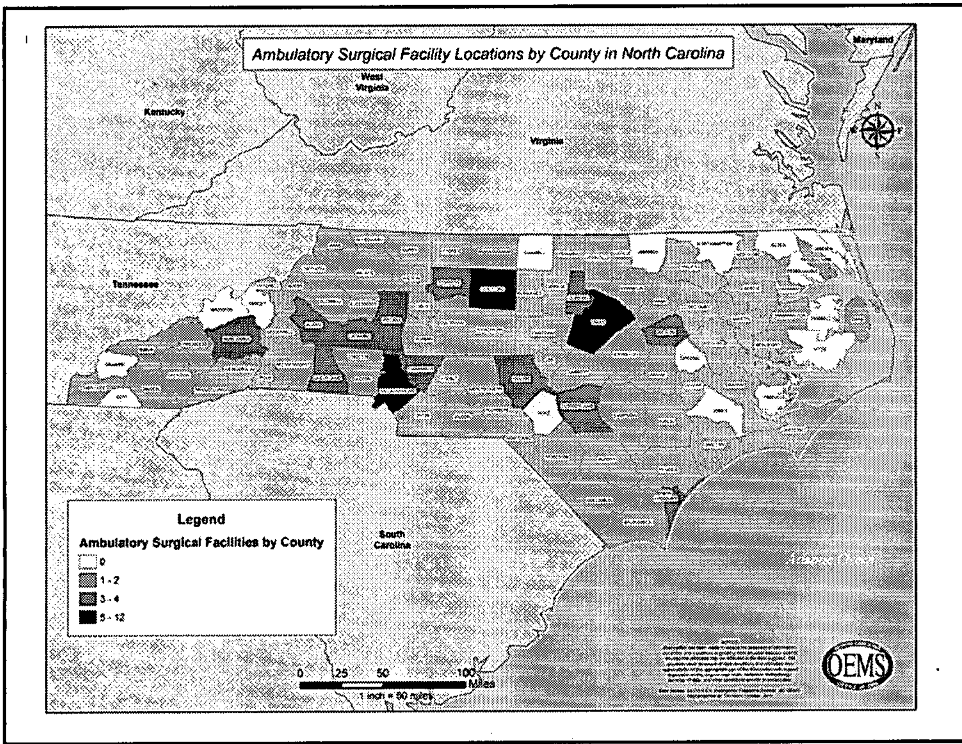


80% of Patients Receiving Open Heart Surgery Travel < 60 Miles to Receive Care



Licensed Facilities with Ambulatory Surgical Capacity

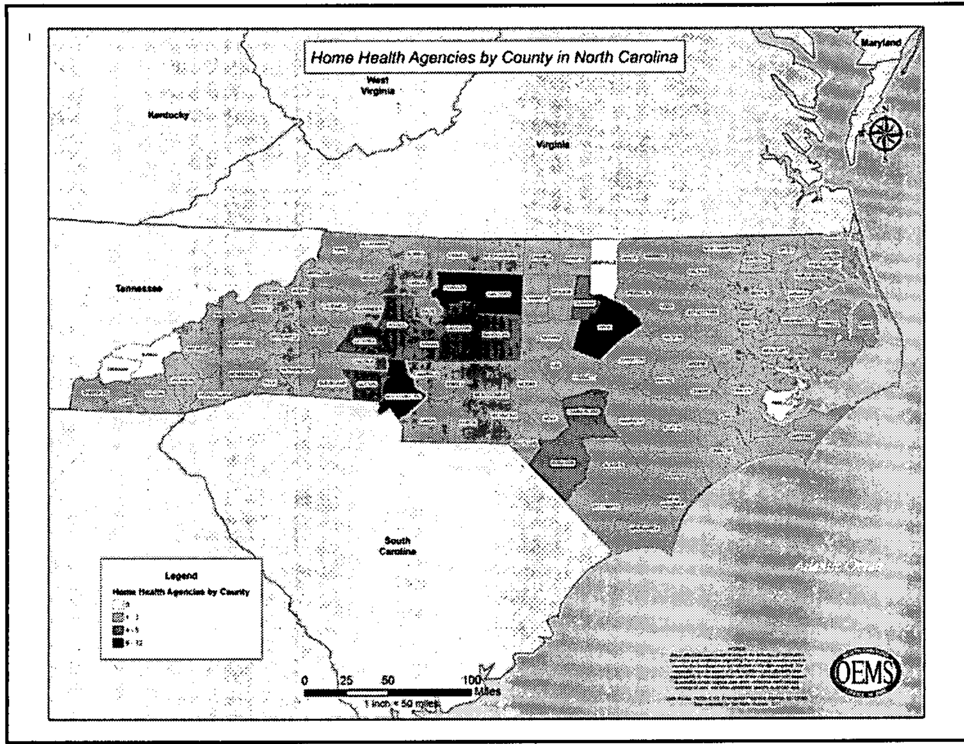
- 158 Facilities
  - 44 free-standing ambulatory surgical centers
  - 114 acute care hospitals
- 1,162 ambulatory and shared operating rooms



Home Health Agency Data

- 212 Medicare-certified Home Health Agencies
- 210,839 clients were served during 2010; a 7.73 % increase from the previous year.
- The statewide average use rates by age group have increased for all age groups, as follows:

Age Group	2010 Use Rates per 1000 Pop.
Under 18	2.91
Ages 18-64	11.28
Ages 65-74	66.71
Ages 75 and over	168.57



Nursing Home Data

- 433 nursing homes
  - 321 for-profit nursing homes
  - 112 non-profit nursing homes
  - 423 certified to participate in the Medicare/Medicaid program
  - 10 licensed only (do not participate in Medicare/Medicaid) are funded primarily by private pay

As of Spring 2011

Nursing Home Payors

- Medicaid program (68%)
- Medicare program (16%)
- Private payment (16%)

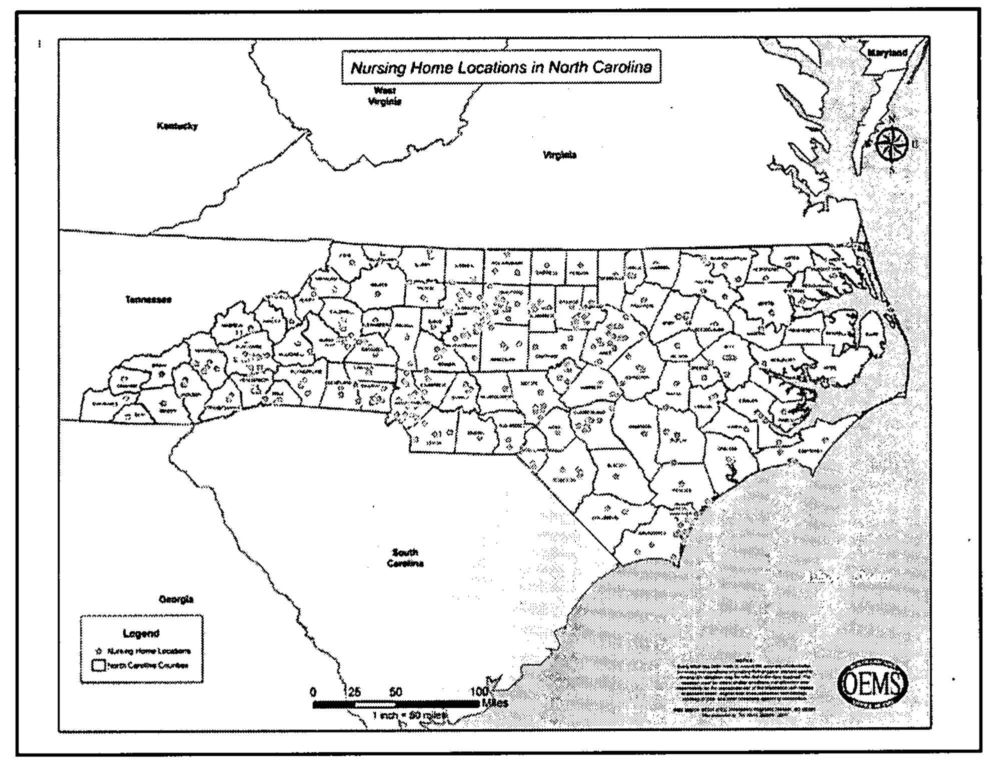
- 45,353 licensed nursing home beds
  - 96% in nursing homes
  - 4% licensed as part of a hospital

- 533 additional beds had received approval from the DHSR CON Section, not yet licensed.

Nursing Bed Use Rates

- Use Rates by Age Groups

Age Group	Bed Utilization per 1000 Population
Under 65	0.59
65-74	7.72
75-84	25.69
85 and over	90.39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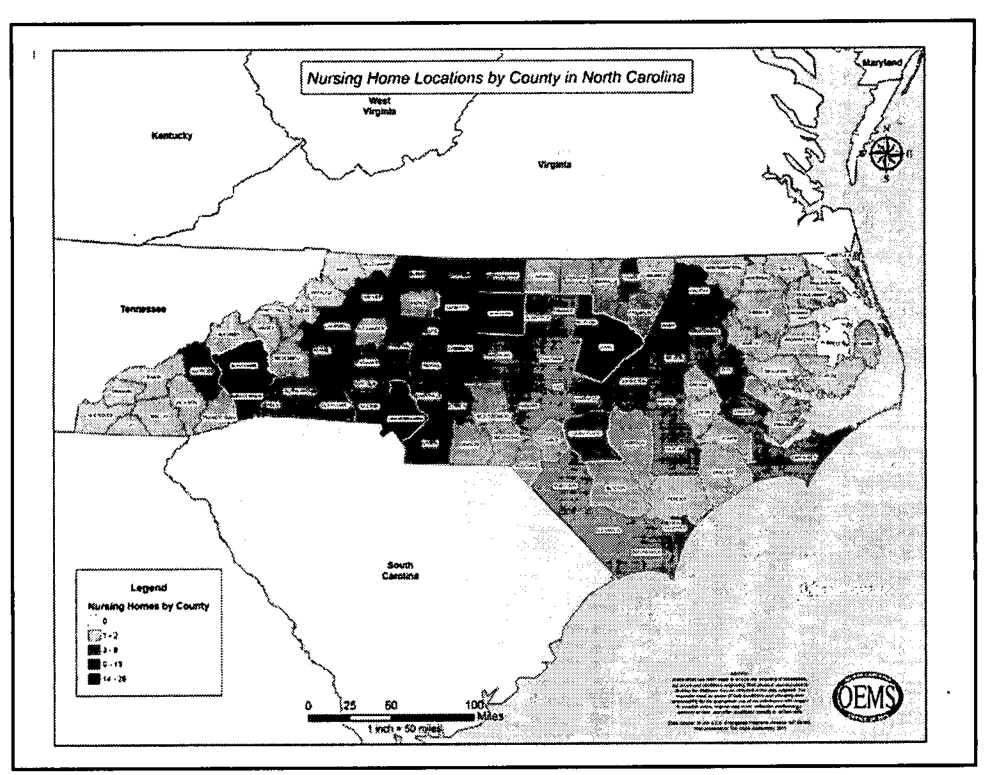
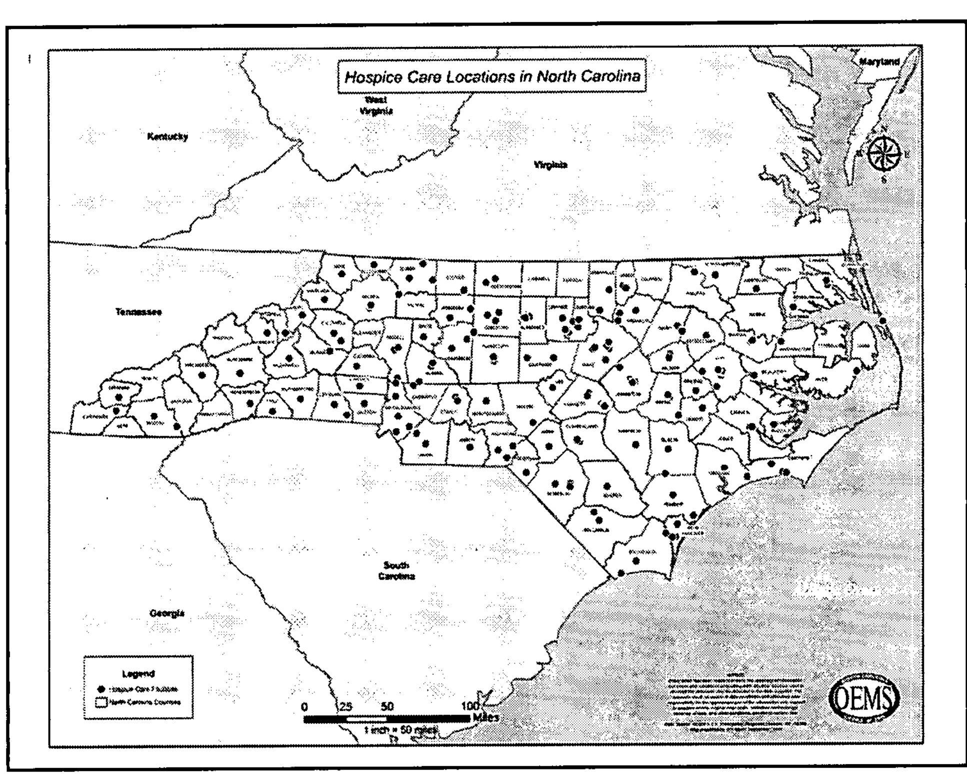

Nursing Home Locations by County in North Carolina
West Virginia
Kentucky
Virginia
Maryland
Tennessee
South Carolina
Legend
Nursing Homes by County
0 25 50 100 Miles
1 inch = 50 miles
OEMS

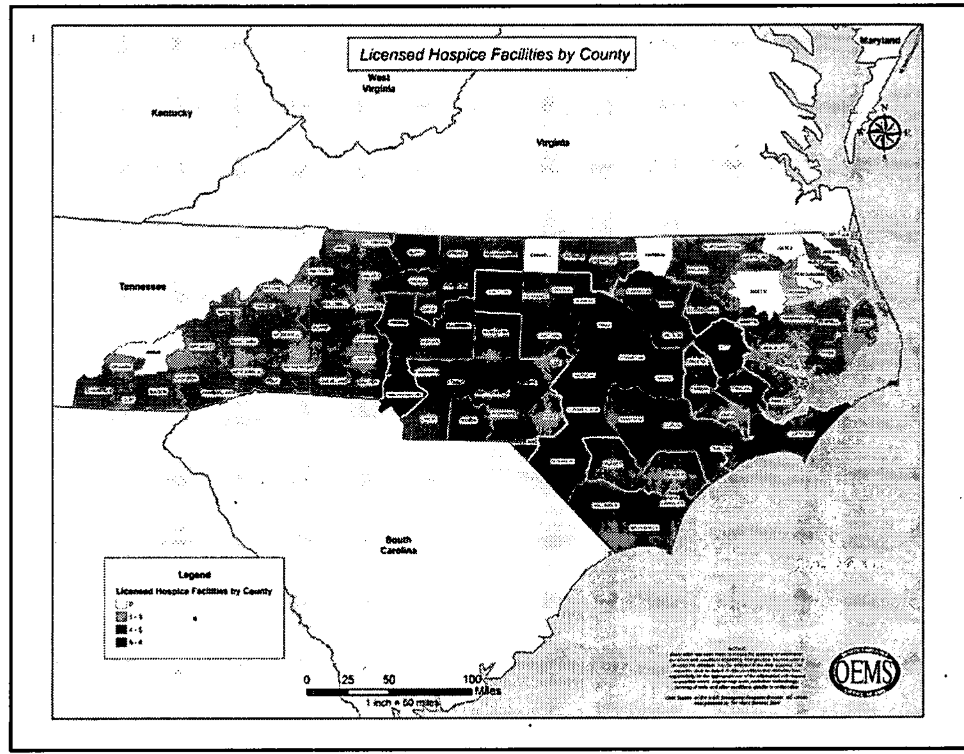
Hospice Services

- 257 licensed hospice facilities
  - Hospice home care agencies
  - Hospice facilities - 35
    - All have inpatient beds, 323 licensed beds
    - 26 have residential care beds, 177 licensed beds

- 35,219 hospice patients served in 2009-2010

As of Spring 2011





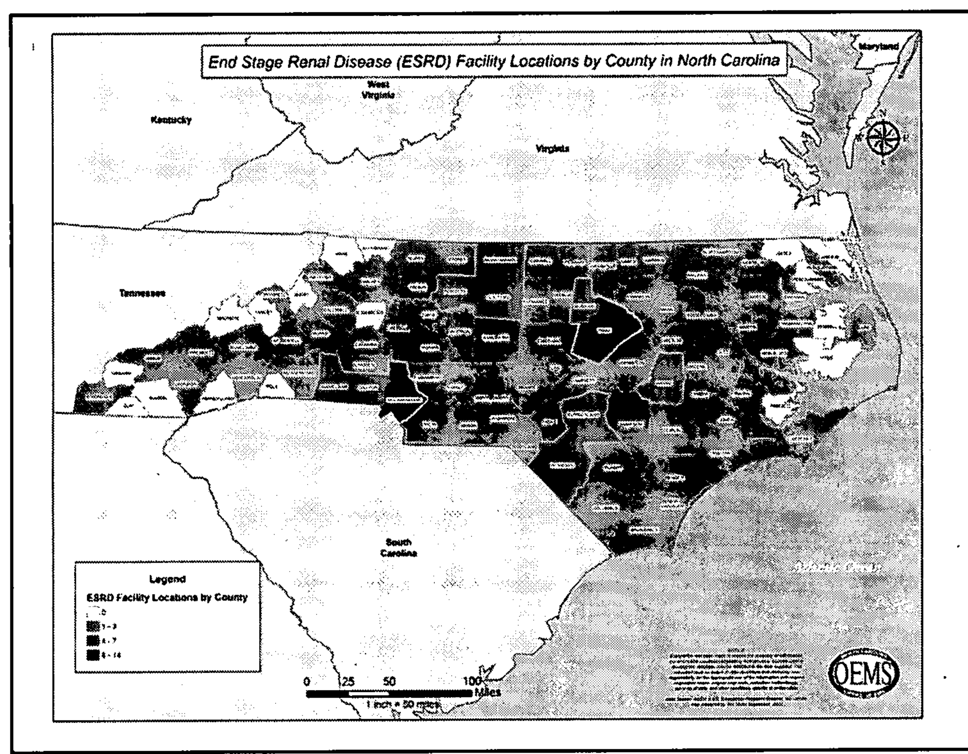
End-Stage Renal Disease Dialysis Facility Data

- 174 dialysis facilities in operation
- 4,124 certified dialysis stations
- 74 facilities were above 80% utilization

- Each dialysis station can serve four patients per week.
- 12,649 patients receiving in-center dialysis services (on 12/31/10)

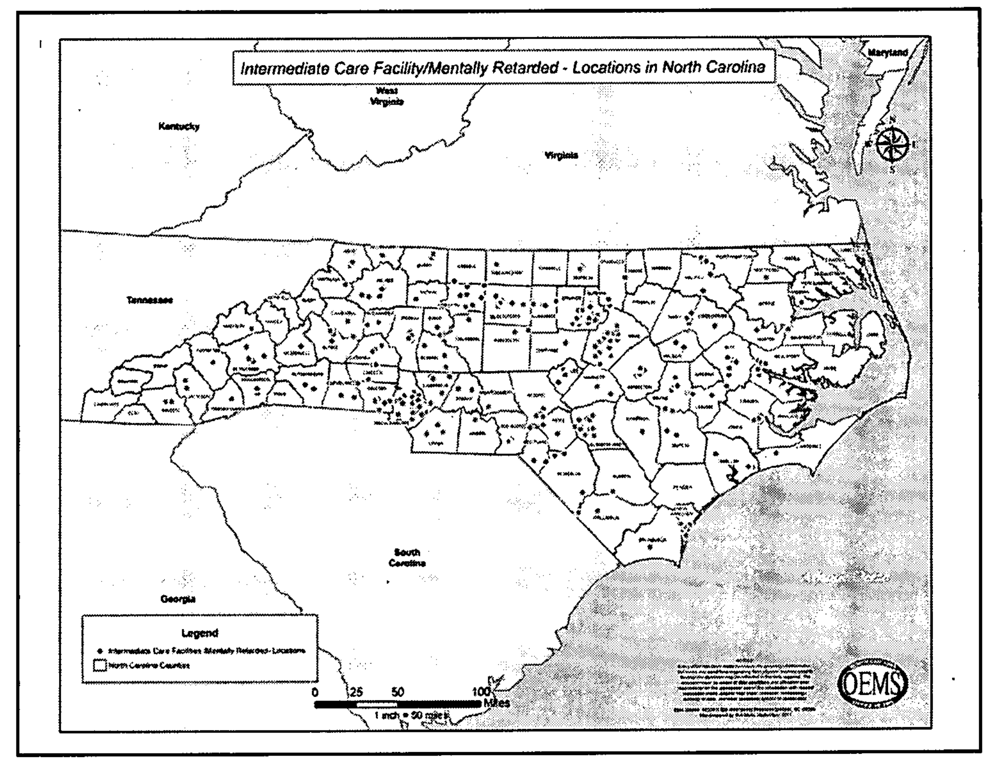
- Certificates of Need had been issued for an additional 193 dialysis stations.

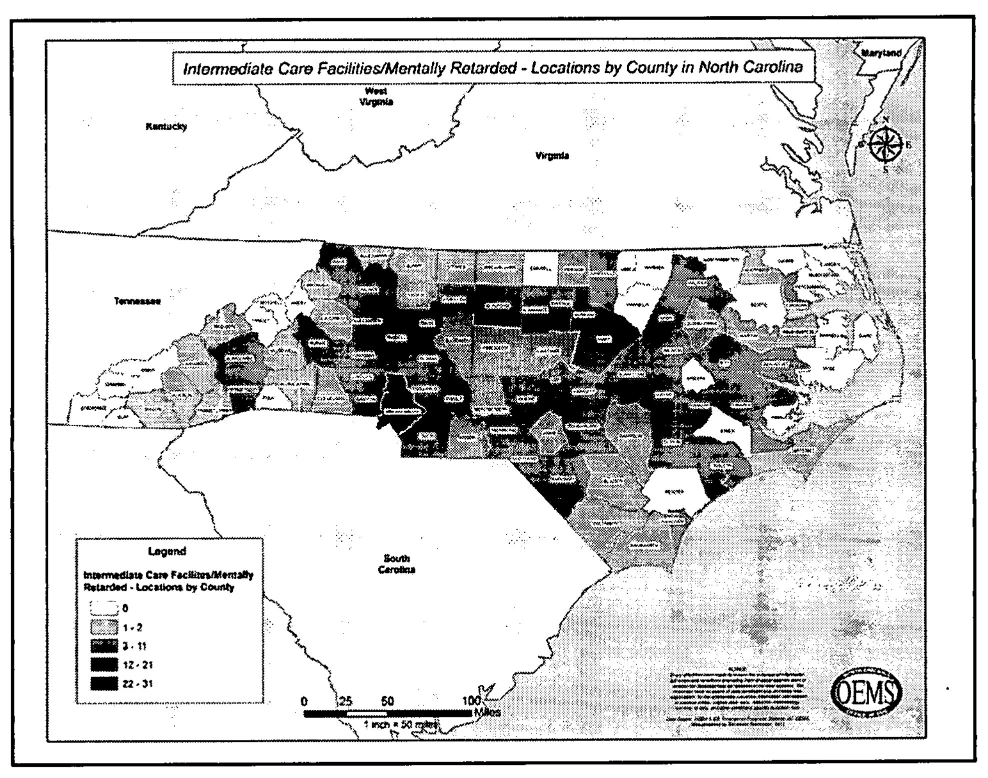
As of June 2011



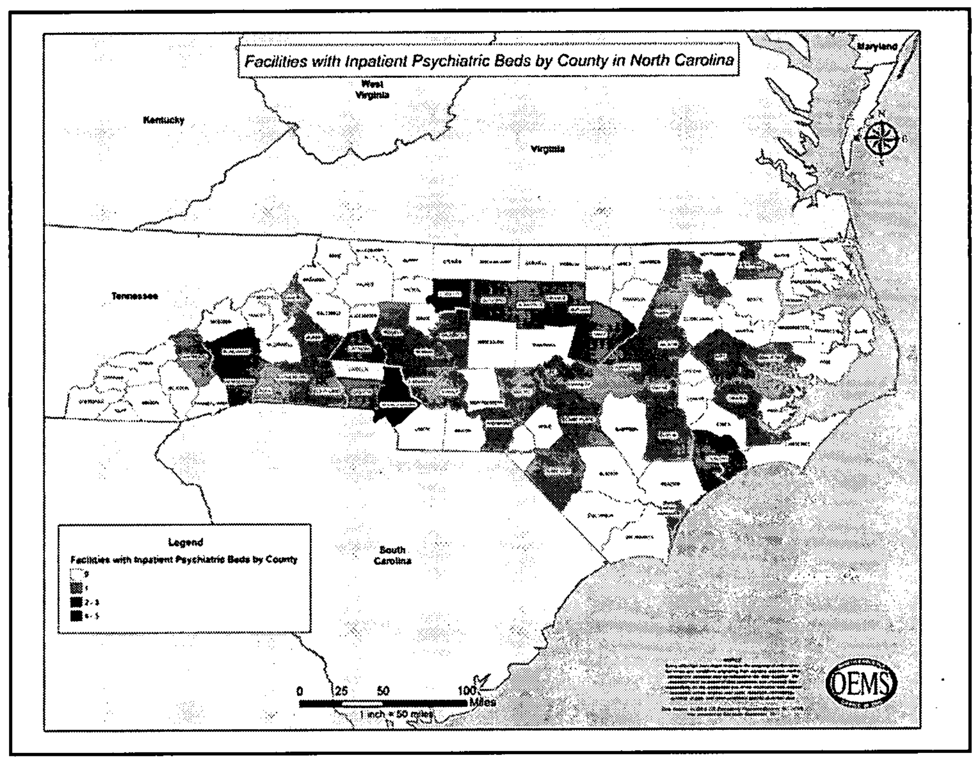
Intermediate Care Facilities/ Mentally Retarded Data

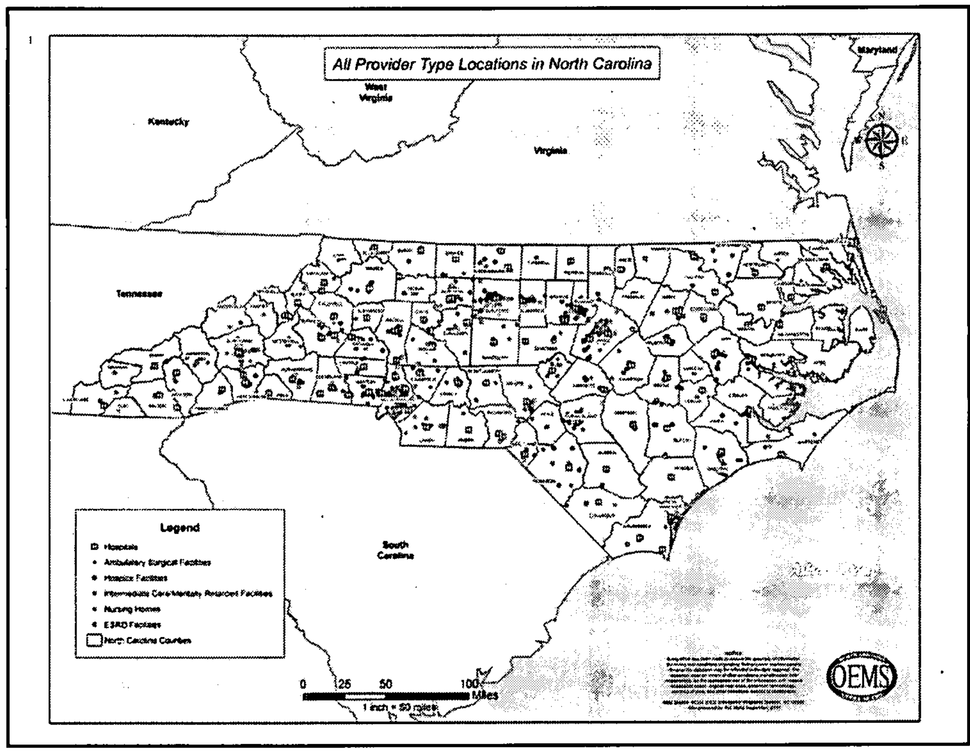
- 328 licensed ICF/MR facilities
  - 2,729 community based certified beds
- Plus 4 state-operated facilities
  - 2,355 certified beds
  - State operated ICF/MR facilities are exempt from licensure and CON review.


Intermediate Care Facility/Mentally Retarded - Locations in North Carolina
Maryland
West Virginia
Kentucky
Virginia
Tennessee
South Carolina
Georgia
Legend
0 25 50 100 Miles
1 inch = 50 miles
OEMS


Intermediate Care Facilities/Mentally Retarded - Locations by County in North Carolina
Maryland
West Virginia
Kentucky
Virginia
Tennessee
South Carolina
Legend
Intermediate Care Facilites/Mentally Retarded - Locations by County
0
1 - 2
3 - 11
12 - 21
22 - 31
0 25 50 100 Miles
1 inch = 50 miles
OEMS

- 1,744 licensed beds
- 3 free-standing psychiatric hospitals
- 56 general acute care hospitals with designated psychiatric units





2010 CON Application Reviews & Appeals

- **156 Applications Reviewed**
- **112 Non-Competitive Reviews**
  - **102 Approved**
  - **10 Disapproved**
  - **12 Appealed**
- **11 Competitive Reviews**
  - **Included 45 Applications**
  - **14 Approved**
  - **23 Appealed**
- **35 Total # Applications Appealed**

- Each application must conform to all applicable statutory and regulatory review criteria.
- CON Section determines if conforming.
- Application will be denied if CON Section determines the application is not conforming to one or more of the statutory review criteria or applicable rules.
- Under certain circumstances, CON Section may impose a condition that would correct the deficiency in the application.

When is a Review Competitive?

- If the approval of one application requires the disapproval of another application.
- Typically when there is a limit on the number of beds or pieces of equipment that can be approved due to a need determination in the State Medical Facilities Plan.
- If 10 applicants apply for 1 MRI scanner, only 1 applicant can be approved (G.S. 131E-183(a)(1)).

Competitive Review Process

- Review each application independently.
- Conduct a comparative analysis to determine which application is the most effective alternative.
- Applications that are not conforming to ALL applicable statutory and regulatory review criteria are not considered to be effective alternatives and are denied.

Appeals

- Why are non-competitive applications appealed?
  - The applicant may appeal the denial of his or her application.
  - An "affected person" (as defined in G.S. 131E-188.(c)) may appeal the approval of the application.

Time Frames for Appeals

- Administrative Law Judge (ALJ) has 270 days from the date petition is filed to submit Recommended Decision to the Director of the Division (per CON law).
- ALJ/Office of Administrative Hearings (OAH) sends the Recommended Decision and record to the Director (per CON law). Typically takes 45-60 days.
- Director of the Division has 30 days after receiving the record to make the Final Agency Decision but this can be extended for another 30 days.

Time Frames for Appeals (continued)

- Note: For petitions filed on or after 1/1/12, the ALJ will still have only 270 days to make a decision but it will be the final decision.
- Appeals to the Court of Appeals can take 1-2 years to be decided.
- Decisions by the Court of Appeals can be appealed to the Supreme Court.

State Agency Cost of Litigation FY 2010/2011

- Contract Expense (attorney salaries & fringes) = $406,802
- Litigation =$70,600
- Total Cost =$477,402

Acronyms & Abbreviations

- ALJ – Administrative Law Judge
- DHSR – Division of Health Service Regulation
- ESRD – End-Stage Renal Disease
- ICF/MR- Intermediate Care Facilities /Mentally Retarded
- LTCH – Long-Term Care Hospital
- OAH – Office of Administrative Hearings
- SMFP – State Medical Facilities Plan

North Carolina's Certificate of Need Law in the 21st Century: A Practitioner's View

October 6, 2011

Noah H. Huffstetler, III

Presented to the House Select Committee on Certificate of Need and Related Hospital Issues

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP

Outline

- Development of CON Law
- Changing Landscape of Healthcare
- Reasons to Retain CON Regulation
- Opportunities for CON Law Reform

Development of CON Law

- 1966 Congress enacts the Comprehensive Health Planning Act

  Cost-based federal reimbursement for health care expenses

- 1971 North Carolina General Assembly enacts a state CON law
- 1973 North Carolina Supreme Court struck down the law as unconstitutional

We find no such reasonable relation between the denial of the right of a person, association or corporation to construct and operate upon his or its own property, with his or its own funds, an adequately staffed and equipped hospital and the promotion of the public health. Consequently, we hold that G.S. s 90-291 is a deprivation of liberty without due process of law, in violation of Article I, s 19 of the Constitution of North Carolina insofar as it denies Aston Park the right to construct and operate its proposed hospital except upon the issuance to it of a certificate of need

Such requirement establishes a monopoly in the existing hospitals contrary to the provisions of Article I, s 34 of the Constitution of North Carolina and is a grant to them of exclusive privileges forbidden by Article I, s 32.

Supreme Court of North Carolina in the Matter of Certificate of Need for Aston Park Hospital, Inc.
Jan. 26, 1973
282 N.C. 542, 193 S.E.2d 729

Development of CON Law

- 1977 North Carolina General Assembly again enacted a CON law

The General Assembly of North Carolina makes the following findings:

. . .

(5) That a certificate of need law is required by Title XV of the Public Health Service Act as a condition for receipt of federal funds. If these funds were withdrawn the State of North Carolina would lose in excess of fifty-five million dollars ($55,000,000).

N.C.G.S. 131-175 (5)

Development of CON Law

- 1986 Federal health planning law repealed

It is also with great pleasure that I can finally lay to rest the Federal health planning authorities. I have sought their repeal since I assumed office. These authorities, while perhaps well-intentioned when they were enacted in the 1970's, have only served to insert the Federal Government into a process that is best reserved to the marketplace. Health planning has proved to be a process that was costly to the Federal Government, in the last analysis without benefit, and even detrimental to the rational allocation of economic resources for health care.

Statement of President Ronald Reagan, Nov. 14 1986

Development of CON Law

- **1993, 2001** North Carolina's CON law made more restrictive
- **2004** Federal Trade Commission & Department of Justice recommend states consider abolishing CON programs

Recommendation 2:

States should decrease barriers to entry into provider markets.

a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.

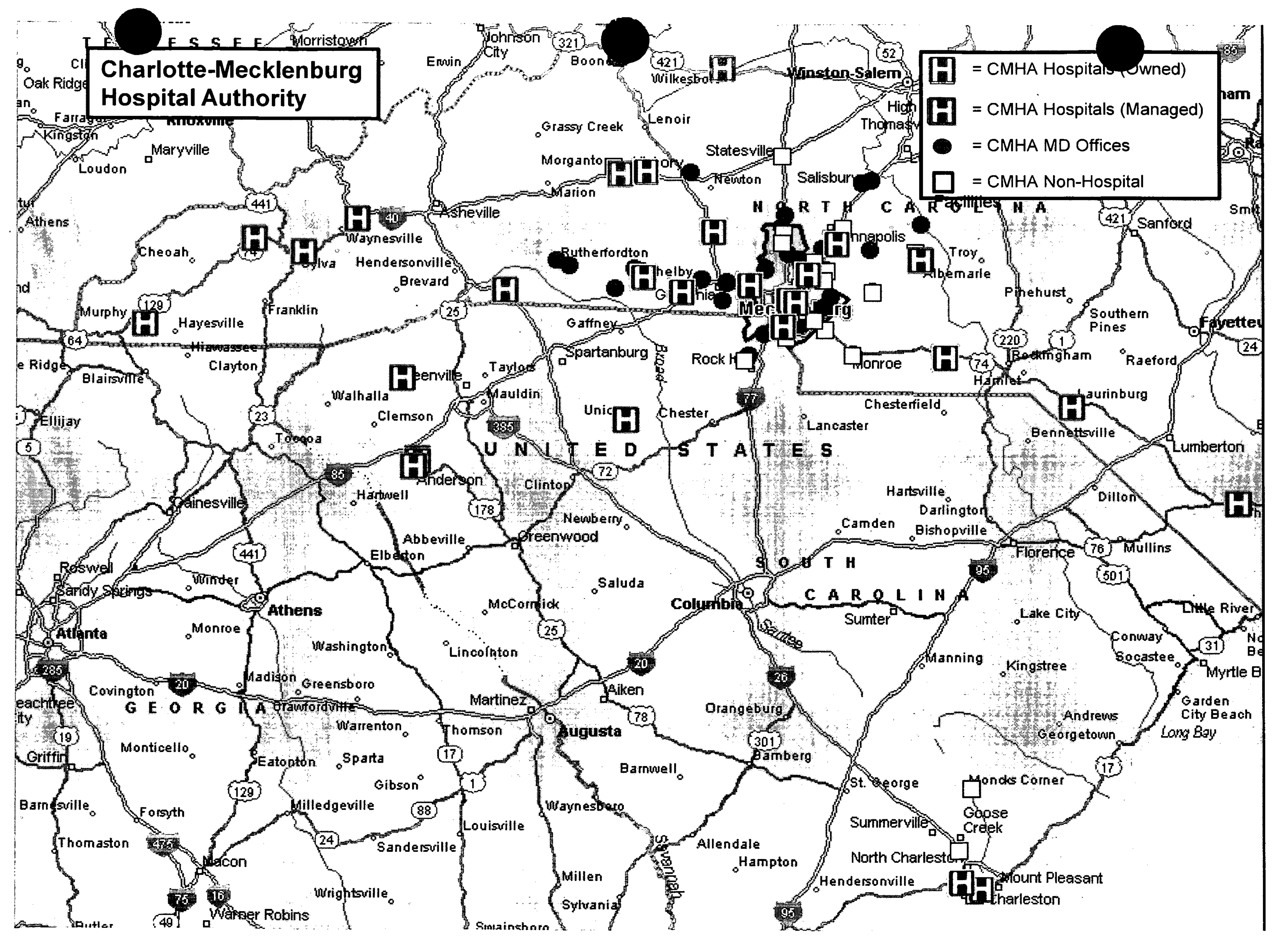
The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.

1970s versus 2011
The changing landscape of healthcare

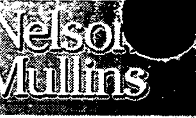
Cost-based reimbursement superseded by prospective payment ("DRGs")

1970s versus 2011
The changing landscape of healthcare

Growth of multi-hospital systems



Charlotte-Mecklenburg
Hospital Authority
= CMHA Hospitals (Owned)
= CMHA Hospitals (Managed)
= CMHA MD Offices
= CMHA Non-Hospital Facilities

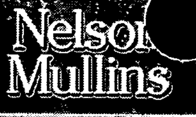


Reasons to Retain CON Regulation

As of July 30, 2011, the N.C. Medical Care Commission had $7,297,062,052 in financings outstanding.

OUTSTANDING DEBT

As of June 30, 2011, the Commission has closed 406 revenue bonds, notes and leases. The total authorized principal amount of all such financings was $17,476,806,052 and the total outstanding principal amount of all such financings as of June 30, 2011 was $7,297,062,952 excluding financings that have been refunded. Each issue is payable solely from revenues derived from each corporate entity financed, is separately secured, and is separate and independent from all other series of bonds as to source of payment and security.



Reasons to Retain CON Regulation

High bond ratings are affected by CON protection for issuers.

Some states have recently amended their certificate of need laws to reduce or remove the restrictions imposed with respect to undertaking covered activities or expenditures related to health care facilities. In each of these states there were substantial increases in the number of health care facilities such as free standing ambulatory surgery centers and imaging centers providing services in major urban areas. There have recently been some unsuccessful efforts in the North Carolina General Assembly to amend the CON Law in a similar manner. If the CON Law is so amended in the future of the Obligated Group could experience increased competition for certain health care services they currently provide, or their revenues from such services could decline, or both.

In addition, the CON Law may be amended in the future to increase or decrease the regulatory restrictions and resulting costs. For all of these reasons, the CON Law could adversely affect the revenues of the Obligated Group and may be changed in the future in ways that are adverse to the Obligated Group.

Health Care providers in these states and geographic regions benefit from a combination of strong demographic and economic trends, favorable payer environments, and the presence of strong Certificate of Need regulation. Two states in particular, Virginia and North Carolina, stand out when comparing their characteristics and hospital ratings to other states in the country.

Moody's Investors Service, 2004

Reasons to Retain CON Regulation

Impact on North Carolina's Medicaid budget

Reasons to Retain CON Regulation

Uncertainty created by federal Affordable Care Act ("ObamaCare")

The Affordable Care Act (ACA)'s ambiguity prevents states from making a clear and informed choice, requiring North Carolina and Minnesota to subject themselves to unknowable and potentially crippling obligations in order to continue their participation in the Medicaid program.

Reasons to Retain CON Regulation

Protection of rural and underserved communities

- Example: Proposed relocation of Davie County Hospital from Mocksville to Bermuda Run

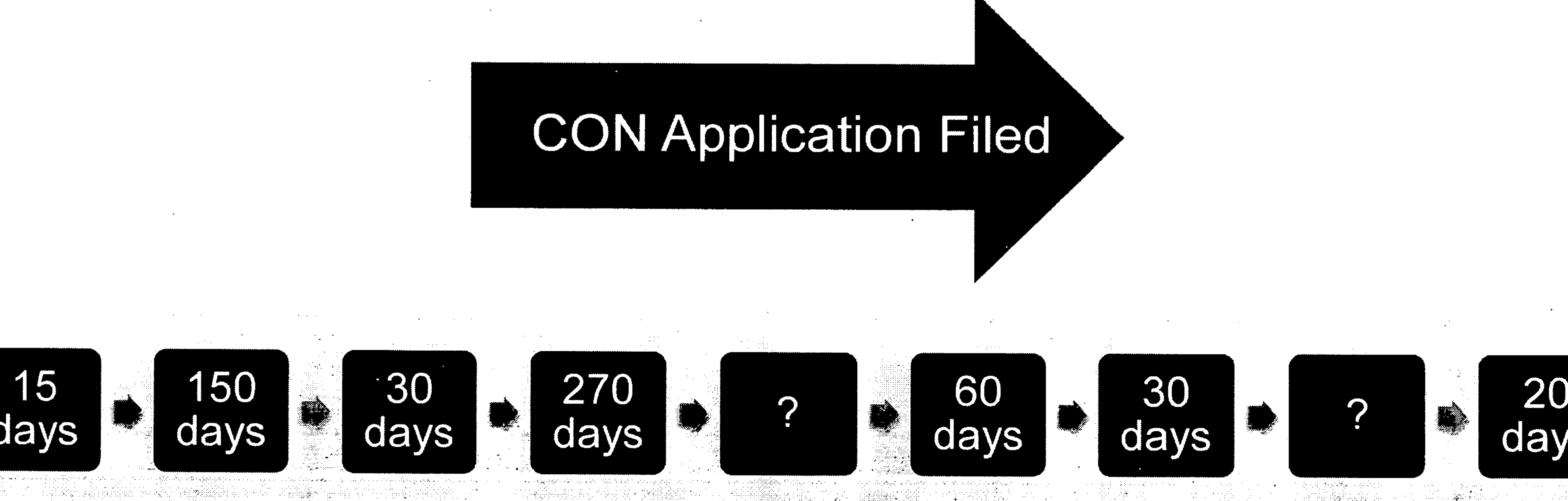
In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped person, and other underserved groups and the elderly to obtain needed health care.

N.C.G.S. 131E-183(a) (3a)

Opportunities for CON law reform

Reduce delays in provision of needed facilities and services.

CON Application Filing Timeline



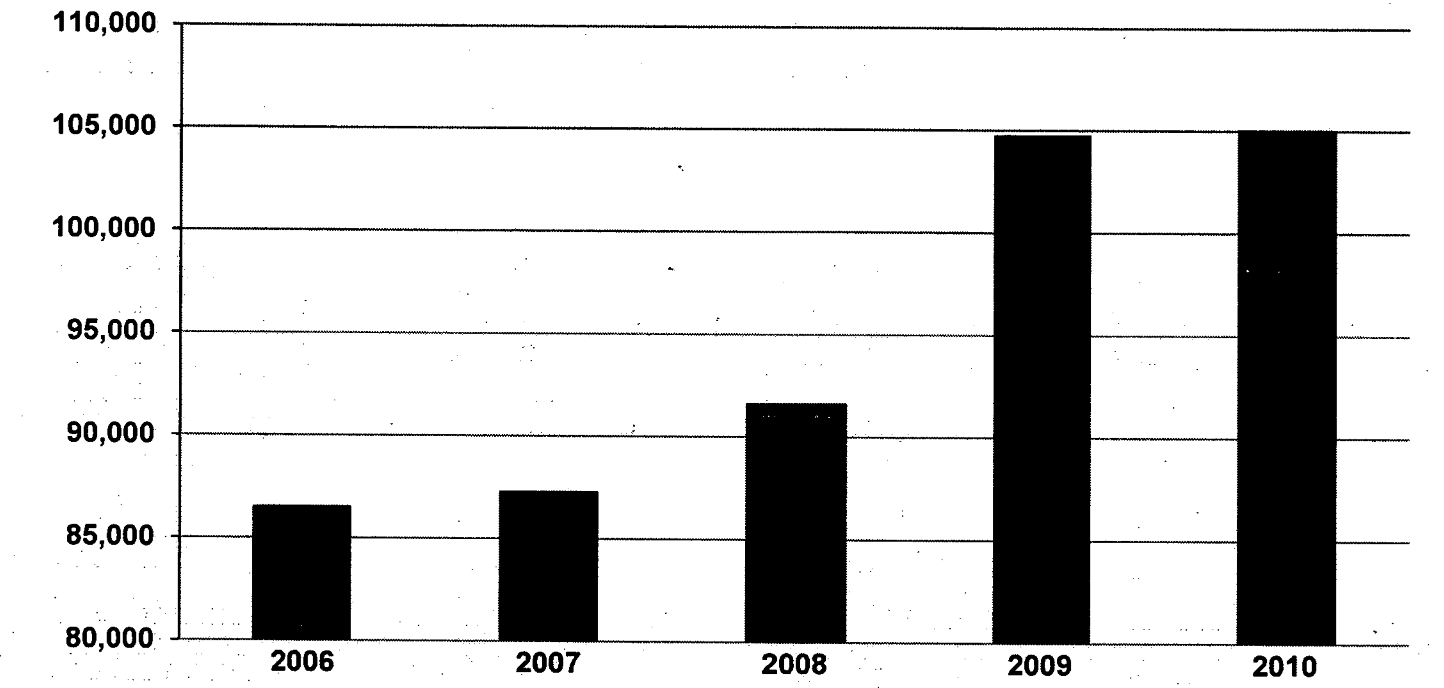
Example: Gaston Memorial Hospital

Mount Holly Emergency Room Expansion

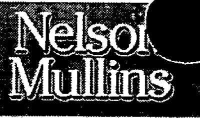
- Proposed in 2008
- Argued in Court of Appeals, Sept. 2011

Emergency Room Visits

Gaston Memorial Hospital



Visits/Year	Year
86,549	2006
87,317	2007
91,661	2008
104,776	2009
105,081	2010



Opportunities for CON Law Reform

Impossible to estimate lost revenues, jobs, higher construction costs resulting from delays, not to mention delay in needed services.

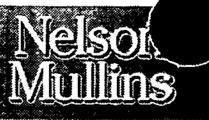
Bond requirement inadequate to deter frivolous appeals.

Opportunities for CON Law Reform

Eliminate outdated, unenforceable requirements.

"Diagnostic Center" means a freestanding facility, program or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

N.C.G.S. 131E-176 (7a)



Opportunities for CON Law Reform

Make all applicants subject to the same requirements.

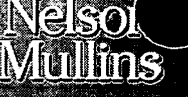
The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

N.C.G.S. 131E-183 (b)

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
3. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

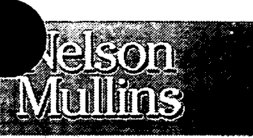
Policy AC-3, State Medical Facilities Plan



What reforms should be considered?

Make all applicants subject to the same requirements

- UNC, NC Baptist Hospitals, Duke University Medical Center, Pitt County Memorial Hospital



AMC Operating Performance & Metrics

With the exception of NCBH, all systems show strong three year growth operating revenue, operating cash flow and operating income

Duke and UNC show particularly strong operating results and ratios wh compared to respective Moody's medians

	Mission Health System		University Health Systems of Eastern Carolina		Duke University Health System		University of North Carolina Health Care System		North Carolina Baptist Hospital & Affiliates		Carolinas Healthcare System		FY Moody's Aa
	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	FY 2010	3 Yr CAGR	
Operating Revenue	$967	7.0%	$1,195	7.6%	$2,150	7.8%	$1,862	8.6%	$971	-1.6%	$3,855	8.5%	$1,648
Operating Cash Flow	$109	7.6%	$134	8.0%	$332	27.1%	$199	27.7%	$102	1.7%	$383	11.0%	$173
Margin	11.2%		11.2%		15.5%		10.7%		10.5%		9.9%		10.8%
Operating Income	$36	10.9%	$33	2.2%	$209	36.8%	$102	61.7%	$28	67.3%	$117	62.8%	$73
Margin	3.8%		2.7%		9.7%		5.5%		2.9%		3.0%		4.5%
Net Income**	$85	NM	$39	NM	$316	47.0%	$157	56.0%	$81	NM	$344	NM	$134
Margin	8.8%		3.3%		14.7%		8.4%		8.4%		8.9%		8.2%
Moody's Rating	Aa3		A1		Aa2		Aa3		Aa3		Aa3		
Cash & Investments***	$711	8.2%	$529	9.2%	$1,852	7.7%	$976	-0.2%	$730	1.2%	$2,553	7.5%	$1,044
Long Term Debt	$393	7.1%	$529	2.2%	$844	22.1%	$413	2.8%	$347	0.6%	$1,609	-1.1%	$553
Debt to Cash Flow	2.8x		4.8x		2.1x		1.7x		2.4x		2.9x		2.4
Debt to Cap	29.1%		46.1%		35.8%		21.7%		30.6%		34.0%		31.1%

Note: Shaded area denotes margin/ratio is desirable in comparison to respective Moody's median

*Moody's median financial data based on audited financial statements of freestanding hospitals and single state systems as of 7/29/2011

**For comparability, unrealized gains/losses on investments is included in net income for all healthcare systems profiled for all years. Interest expense is also included as an operating

***Cash & Investments include: cash & equivalents, short-term & long-term investments and short-term & long-term assets limited as to use

in

en

2010 Medians*
A
$510
$51
10.0%
$14
2.6%
$31
6.3%
$252
$194
3.3x
38.6%

expense

The legislation creating the (UNC Health Care) System reflects a clear legislative intent to authorize the System to act with such degree of autonomy and flexibility as may be necessary to achieve these goals within the increasingly competitive health care industry.

North Carolina Attorney General's Opinion requested by UNC Health Care System re: Authority to Acquire Rex Hospital, February, 2000

Presented to House Select Committee on State Owned Assets, September 2011

Opportunities for CON Law Reform

Make decisions of the State Health Coordinating Council (SHCC) more transparent and accountable

- All members appointed by Governor – not General Assembly
- In recent litigation, at least 22 of 29 members were recognized to be employed by or affiliated with providers regulated under the SMFP

Opportunities for CON Law Reform

SHCC's decisions not subject to scrutiny by the Rules Review Commission.

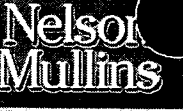
Not subject to review on appeal.

The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health offices that may be approved.

N.C.G.S. 131E-83(a)(1)

The correctness, adequacy, or appropriateness of criteria, plans, and standards shall not be an issue in a contested case hearing.

10A NCAC 14C .0402



Opportunities for CON Law Reform

SHCC members not subject to State Ethics Act.

Questions?

Noah H. Huffstetler, III

October 6, 2011

Presented to the House Select Committee on Certificate of Need and Related Hospital Issues

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES 10/06/2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee-Ann [illegible]	Carolina State Strategies
[illegible]	[illegible]
[illegible] Metcalf	Policy Group, Inc.
April Culver	Johnston Health
Dawn Carter	Health Planning Source, Inc.
Elise Bouchard	Sen. Bingham
TRACY COLVARD	AHHC
Chris Taylor	NCMCC
Patricia Christian	DHSR
Jim Keene	DHSR
DAVID STONE	The Carolinas Center for Hospice and End of Life Care

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10/06/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wes Southern	Community Care - 8212 Village Harbor, Cornelius, N.C.
Boyd Russell	Community Health Inc Rocky Mt
Trey Adams	PDA, Inc. , Raleigh, NC
Barb Freedy	Novant Health, Inc,
Amy Whited	NC Med Society
Gretchen Kelly	FirstHealth of the Carolinas
[illegible]	Duke
Breeden Blackwell	Cape Fear Valley Med. CTR,
[illegible]	UM
Matthew A. McConnell	Carolinas HealthCare
Greg Barr	Carolinas HealthCare System

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10/06/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Cooper	Compass NC
Tina Shanahan	Compass NC
Frank Rogers	NCDOC
Paula Y Smith	NCDOC
Doris L Collett	NCDOC
Joe Ingle	NC DOC
Nicole Sullivan	NCDOC
Kristi Huff	NCHCFA
Elizabeth Taylor	Kochanek Law Group
Carol Jones	K & L Gates
Mary Jennings	KS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10/06/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Duncan Yaggy	Duke University Health System Box 3229 DUMC Durham 27710
Catharine Cummer	Duke University Health System Box 3229 DUMC Durham 27710
David Meyer	Keystone Planning Group Durham, NC 2530 Meridian Parkway, Suite 200 27713
[illegible]	WM
Kevin FitzGerald	UNC
Robert Wilson	Smith Moore Leatherwood LLP 434 Fayetteville St., Ste 2800 ~~Raleigh 27601~~
Maeve Goff	Smith Anderson
Kristen Laster	Fetzer Strategic
Robbie Roberts	WakeMed
Risa Whatley	JLF
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10/06/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Brunger	The Carolinas Center for Hospice & End of Life Care
[illegible]	Mission Hospitals
Karen Duquette	Civitas
Clark [illegible]	Civitas
Chip [illegible]	NCMS
Hugh Tilson	NCHA
BJ Miller	Cone Health
Matt Wolfe	Parker Poe
Joel Mainard	GPM & Assoc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
2011-2012 SESSION

You are hereby notified that the Committee on **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, October 20, 2011
TIME: 6:00 PM
LOCATION: WNC Ag Center LOB
COMMENTS: Virginia C. Boone Mountain Heritage Building, 1301 Fanning Bridge Road, Fletcher, NC 28732
Regular House Select Committee on Certificate of Need and Related Hospital Issues Meeting with Presentations on COPA and public comment to follow.

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **2 PM** o'clock on **September 29, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

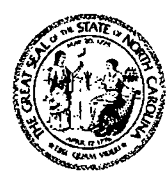
REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee On the Certificate of Need Process and Related Hospital Issues

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

State Legislative Building
Raleigh, North Carolina



AGENDA

6:00 p.m. Thursday, October 20, 2011
WNC Agricultural Center Boone Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Certificate of Public Advantage- Presentations to the Committee
Presentation I.
- *Dr. Ron Paulus, Chief Executive Officer, Mission Health System*
- *Richard Vinroot, Legal Counsel, Mission Health System*
- *Dr. Tom McCarthy, Economist*
- *Brandon Sutherland, Senior Manager, Dixon Hughes Goodman LLP*

Presentation II.
- *Jim Bunch, President and Chief Executive Officer, Park Ridge Health*
- *Graham Fields, Asst. to the President for External Relations, Park Ridge Health*
- *Dr. Brian Quaranta, Physician, 21st Century Oncology*
- *Gail Cummings, Regional Administrator, 21st Century Oncology*
- *Dr. Nathan Williams, Physician and Coalition Member, Western North Carolina Community Healthcare Initiative*

III. Public Comment
Individuals who wish to comment may sign up between 5:00 and 6:00 p.m. at the meeting. Submission of written comments is also encouraged.

Next meeting:
6:00 p.m., Tuesday, November 1, 2011,
The Citizens Center-Council Chamber
400 East Central Avenue, Mount Holly, NC 28120

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, October 20, 2011

6:00 p.m.

WNC Agricultural Center, Boone Building, Fletcher, NC

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 20, 2011 at the WNC Agricultural Center, Boone Building, Fletcher, NC at 6:00 p.m. Representatives Collins, Steen, and Torbett were present. Representative Ray Rapp, area representative also attended.

Representative Steen presided. He welcomed members and audience and gave information on upcoming meetings. Shawn Parker gave a presentation on the committee charge and mission. (See attached)

The following presentations were given:

Presentation I.

- *Dr. Ron Paulus, Chief Executive Officer, Mission Health System*
- *Richard Vinroot, Legal Counsel, Mission Health System*
- *Dr. Tom McCarthy, Economist*
- *Brandon Sutherland, Senior Manager, Dixon Hughes Goodman LLP*
  (See Attached)

Presentation II.

- *Jim Bunch, President and Chief Executive Officer, Park Ridge Health*
- *Graham Fields, Asst. to the President for External Relations, Park Ridge Health*
- *Dr. Brian Quaranta, Physician, 21st Century Oncology*
- *Gail Cummings, Regional Administrator, 21st Century Oncology*
- *Dr. Nathan Williams, Physician and Coalition Member, Western North Carolina*
  (See Attached)

Public Comment followed. (See attached)

Representative Collins: I can only say to the concern of the gentleman who spoke about us trying to get in between him and his patients, the last thing I want to do is to tell any physician how to treat their patients. I hope you will not be concerned about that. I am sure that is not this committee's intent. I would certainly say that as a great believer in the free market, when I've been reading through all the CON laws and COPA laws in preparation for these committee meetings, frankly I was just completely chagrinned. I believe in a free market and I hate the fact that we even have such a thing as certificate of need and Copa, I really do, the whole system just is repulsive to me. But having said that, let me say this, I live in northeastern North Carolina in the other outback side of the state and I feel like if there were absolutely no regulation on who could start hospitals and doctor's offices and so forth, there would probably be a lot more of them in Charlotte and the Triangle and a lot fewer of them where I live and a lot fewer of them where you live. I agree that what we need to do is maximize choice, the biggest problem we have, the biggest thing we are going to have to solve I think as a committee, in my point of view, is how to allow one entity which has been allowed to form to some degree a monopolistic practice in the past, how to allow them not to have limitations that other people don't have, while at the same time, not allowing the other people not to be blown away by the monopolistic size that this group has. Frankly, that is the dilemma that we've got to solve, because I do want you folks in western North Carolina to have as much choice as you can. We don't have much choice where I live in Rocky Mount. We have very little choice and I'd like for you to continue to have as much choice as you can, but that's out dilemma and we're going to have to try to solve it.

Representative Rapp: I hope that folks will understand that I am not a member of this committee, but I came because of a deep and abiding concern for the issues that have been raised and I wanted to get as much information as I possibly could. I just have to say and so that this committee will understand that as well, that Mission Hospital has served this region, not just the city, Buncombe County, but this region very well for a very long time. I live in Madison County. Without Mission's support, without the work it's done to provide healthcare for our rural area, we would be in deep, deep, deep trouble. That is true for many of the other areas. I visited the Spruce Pine Hospital, that was really about to close. Had it not been for the intervention of Mission, that community would not have those services. When I heard this, I believe in choice, it's a wonderful thing, but this isn't about a business issue from my perspective, this is about providing basic healthcare for our region, and God bless Mission and what it's doing. God bless Park Ridge, God bless people that are doing the work they are doing, and through their hearts they're doing it. But I think we have to tread very carefully on what we are doing here. I hope this committee will tread carefully in what it does, because we've got just a phenomenal health care system in western North Carolina, but it's a very delicate system, one that can be upset very easily and so tread carefully, please.

Representative Torbett: The issue is broad. It came to my recognition how broad it was when I talked to professionals, people that eat, drink, and sleep these issues and the health care provision issues across our state and actually in other states across our nation. I keep getting the same answer about the myriad of issues. When I ask what is health care looking at as we go down this path with the advent of the federal rules and regs they have coming down, what are we looking at in health care in years to come? The only certain answer I receive is we don't know. So with the degree of uncertainty, I think it is up to us and up to you all to make sure we end up with the best available, accessible, and cost affordable way to provide health care and hopefully after we, as my dad would say, whittle down through all the comments we've received. We will also be going on two more road trips, one in Mount Holly and one in Wilmington, and then we'll be back in Raleigh for committee meetings and you are all welcome to come to committee meetings in Raleigh. That's what we have to get to, we've got to strive and find, there's not a right or wrong, these people are providing our health care. These people are saving lives, every one of them. We just have to make sure as the good doctor said earlier, the focus, the central focus is on the person that needs that care and that's where we are going to end up.

Representative Steen: We appreciate you allowing us to come to your community tonight. This is a great community and we heard a lot of good things that we need to consider and we're not going to consider anything lightly. We appreciate what you've done. I've seen a lot of compassion. Jim, I've talked to your and I've talked to Ron. I wouldn't expect any less, great compassion from both hospitals and the community. Dr. Hathaway, I agree that you are very compassionate about what you think about it. The last thing we want to do is come in and tell you how to run your operation. I don't want to do that. We want to take a good close look at this with the input of you folks and make the best decision. I apologize for not getting to everyone, we still have 4 pages to go and we're not going to get to you tonight, but if you would like to send us anything in writing to the legislative clerk here for our committee, it is torbettla@ncleg.net. Send Viddia any information you would like and we'll have it recorded with the committee and will take a look at it.

Representative Steen adjourned the meeting.

Fred F. Steen II

Representative Fred Steen, Co-Chair Presiding

John A. Torbett

Representative John Torbett, Co-Chair

Viddia Torbett

Viddia Torbett, Committee Clerk

I. Committee Authorization, Powers , and Duties

1. Appointed by letter- requires a Q of 6 members be established prior to taking official action
2. Authorized to meet in the interim or between sessions
3. Meet in Raleigh or with approval elsewhere (public hearing)
4. Deemed a committee of the House
    a. Permanent House rules apply
    b. Limitation to matters contained in the authorization
5. Powers under Articles 5 and 5A
    a. Compel state agencies to provide all information and data in their possession or attainable from their records
    b. Call witnesses and compel testimony (under oath)
        i. Process for the committee to subpoena a witness if warranted

II. Matters properly before the committee:

1. Review concepts and provisions as provided in House Bill 743 and 812
    a. H743- Requires all rules, policies, and need determinations in the State Medical Facilities Plan apply equally to particular types of health services.
    b. H812 requires any hospital authority engaging in activities outside its territorial boundary obtain a Certificate of Public Advantage
2. Study the provisions of law relating to Certificate of Need
3. Roles of state-owned and publically owned hospitals and public hospital authorities to operate beyond the boundaries
4. Issues related inconsistencies in rules, policies, and limitations within each county that a hospital with a COPA operates
5. Business relationships among and between publically owned hospitals and entities that are operating under a CON or COPA.
6. Other matters reasonably related.

III. Reports required

1. Interim report is authorized to be submitted on or before May 1, 2012
2. Final report required by the convening of the 2013 General Assembly- Committee terminates upon filing.

Background Material

North Carolina House Select Committee
On the Certificate of Need Process
And Related Hospital Issues

October 20, 2011
WNC Ag Center
Fletcher, North Carolina

TrueMission.org

Data supplied on hospital license renewal applications

Mission Hospital	2009	2010	2011
Total Beds	730	730	730
Total Admissions	37,221	38,104	38,559
ER Rooms	75	75	89
ER Visits	100,453	100,061	100,299
ER Admissions	18,122	19,554	20,421
OR Rooms	43	43	43
Endoscopy Rooms	6	6	6
Endoscopy Cases (GI)	7,064	6,741	6,563

ParkRidgeHealth	2009	2010	2011
Total Beds	103	103	103
Total Admissions	3,713	3,226	3,128
ER Rooms	12	12	12
ER Visits	16,191	17,409	19,486
ER Admissions	2,091	1,807	2,046
OR Rooms	6	6	6
Endoscopy Rooms	1	1	1
Endoscopy Cases (GI)	762	649	676

Pardee Hospital	2009	2010	2011
Total Beds	222	222	222
Total Admissions	6,649	6,369	6,557
ER Rooms	25	25	25
ER Visits	30,682	32,225	32,209
ER Admissions	5,606	5,837	5,695
OR Rooms	10	10	10
Endoscopy Rooms	3	3	3
Endoscopy Cases (GI)	3,891	3,344	2,444

Missi[illegible] Hospital County-Level Market [illegible]hare over time in WNC

County	Patients (2009)	2005	2009	1st Half of 2010	Point Gain	% Gain
Buncombe	26,045	86.3%	89.6%	90.5%	4.2	5%
Henderson	12,740	22.1%	29.6%	36.4%	14.3	65%
Burke	10,548	5.3%	5.8%	5.8%	0.5	1%
Rutherford	8,613	5.9%	7.2%	7.2%	1.3	22%
Haywood	8,298	28.7%	33.5%	32.8%	4.1	14%
McDowell	5,131	31.5%	37.8%	35.8%	4.3	14%
Jackson	3,807	17.5%	27.3%	28.8%	11.3	65%
Macon	3,734	27.5%	29.3%	29.6%	1.8	7%
Transylvania	3,523	32.1%	34.6%	35.8%	3.7	12%
Cherokee	2,671	18.8%	18.5%	19.8%	1.0	5%
Swain	2,494	22.7%	26.8%	23.7%	1.0	4%
Yancey	2,329	45.5%	50.2%	49.5%	4.0	9%
Madison	2,172	88.9%	90.8%	91.2%	2.3	3%
Mitchell	2,138	27.4%	28.1%	29.6%	2.2	8%
Polk	1,790	11.9%	16.6%	18.0%	6.1	51%
Graham	1,116	22.3%	27.5%	29.2%	6.9	31%
Clay	916	20.8%	21.4%	21.6%	0.8	4%

Thompson Reuters: Inpatient Data for North Carolina

Mission Hospitals

Carolina Hospitals

Other

15%
Market Share Growth in WNC in the past 5 years

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I. Comments As Prepared Not Delivered

a. Ronald A. Paulus, M.D., M.B.A., President and CEO, Mission Health, Asheville, N.C.

b. Richard Vinroot, Partner, Robinson, Bradshaw & Hinson, Charlotte, N.C.

c. Thomas McCarthy, PhD, Senior Vice President, NERA Economic Consulting, Los Angeles, CA

II. Other Supporting Materials

Prepared Remarks of Ronald A. Paulus, M.D., M.B.A.
President and CEO, Mission Health

Introduction

Hello, I'm Ron Paulus, the CEO of Mission Hospital and Mission Health System. I very much appreciate your having me here to speak on behalf of Mission, our patients, staff, and medical staff. Your interest in healthcare generally and in western N.C. specifically is to be commended. You have an incredibly important and very challenging job – to ensure that the people of western N.C. have life-saving, quality, affordable healthcare, close to home regardless of where they live or their ability to pay for that care.

The topics that we are about to discuss are filled with emotion and opportunity. Healthcare by its very nature is filled with emotion. It is personal and involves life and death decisions. It affects each and every one of us. Healthcare can be complex, and our rapidly changing environment requires that all of us remain flexible and have a willingness to change. Mission's presentations will focus on the facts – that the COPA was the right solution at the time, how it has served its purpose and how Mission has performed under significant government oversight for the past 15 years and how moving forward Mission needs the freedom to serve the region's critical health care needs.

Theme: Personal Introduction and Background

Allow me to begin with a brief introduction, since many of you don't know me or Mission. Mission has been an integral part of life and service in western N.C. for 126 years. It was started by a determined group of women – The Ladies of the Flower Mission -- who believed that the people of their community deserved the best that medicine had to offer. That remains the essence of Mission today as manifest in our Mission Statement which says it all: *To improve the health of the people of Western N.C.* That spirit is alive and well today in Mission's local, volunteer board – business leaders and physicians – who are just as determined in their pursuit of excellence, affordability and access for all in our region who need care. We are proud of our work and it is an honor to be western N.C.'s home grown health system.

As for me, I'm a relative newcomer, which you can no doubt tell from my accent. You know me as the President and CEO of Mission Health. What you may not know, is that I grew up in a rather similar mountainous area of Pennsylvania (though compared to here, those "mountains" were really just hills). Born into a village of 35, I lived with my brother, sister, parents and grandparents in a small home without the benefit of indoor plumbing early on. My father is a farmer turned barber, my mother now deceased was a school secretary. There isn't a crop that I haven't harvested, nor a farm animal I haven't tended. I worked my way through college and medical school, going to business school along the way.

As a physician, I've focused my entire career on improving the quality and efficiency of care delivery for as many people as I can.

When I decided to move my family to NC, I did so because it's the right place to raise my children, it's a place that reminded me of my roots and that would become home, and somewhere I thought something unique, special and very much needed could be accomplished: building a regional network of care that can be a real-world, national model of healthcare excellence. That goal is within reach given the impressive group of physicians, staff and hospitals that we have in western N.C.

Theme: COPA paid in full

Ok, that's more than enough about me... Now to the topic at hand – the 1995 Certificate of Public Advantage or COPA.

Few of us in this room tonight were involved in creating the COPA, and many understandably have no true understanding of what it really is, how it came about or all that it has accomplished. The COPA was originally created as a response to market demands of business and patients to allow St. Joseph and Mission Hospital to share services and provide greater efficiencies. What few knew at the time was that St. Joseph's was dangerously close to closing its doors or that business leaders who found that contracting with both hospitals was increasingly difficult were the advocates of the merger. Sixteen years ago is a long time - some drivers today weren't even born; no PET scans, Cyberknife, beating heart surgery or TeleMedicine for that matter. It was the right solution at the time, BUT times have changed, and changed dramatically.

T The COPA was designed to do one thing – to allow two hospitals to come together and eventually merge. In fact, under the COPA, Mission is THE MOST REGULATED hospital in N.C. and one of the most regulated in the U.S. Except for enabling the merger itself, all other aspects of the COPA place Mission at a significant disadvantage in the market.

In a few minutes you will hear from independent experts. They will share data that Mission has done everything asked under the COPA and more.

- We have kept our costs, margins and charges completely in line with our peer hospitals across the state.
- We met our obligation to deliver more than $86 million in savings to the community during the first 5 years under the COPA through free clinics, like ABCCM Doctor's Clinic, school nurses, and community-based mental health services. This commitment continues. In 2010 alone Mission's Community Benefit Contribution exceeded $60 Million.
- We have increased access to care, particularly for the most vulnerable in our region, and kept community hospitals open where they may have closed.
- We have raised the bar on quality, not just at Mission but in the region.
- We have been integral partners with others in finding new ways of delivering care through community-based initiatives like The Asheville Project and Memory Care. These innovations are now being replicated nationwide, and they started right here in western N.C.

Since 1995, Mission has complied fully with the COPA each and every year, as independent experts hired by the State have attested.

Theme: Changing Competitive Landscape

Fast forward to 2011. It's a very different world. The competitive landscape in western N.C. has changed dramatically. In 1995 there was only one hospital in Western North Carolina that was a part of a large health system. By 2010 there was only one hospital in Western North Carolina that was NOT part of a major health system. One of the competing health systems in Western North Carolina, Carolinas Health System, grew from 10% of the NC acute care hospital days to over 16% in 2010. A region that seemed so secure and insulated from national healthcare trends now finds itself struggling to meet the needs of our residents, particularly the very young and the chronically ill.

- Today there are 11 counties in our region that are federally designated underserved areas, woefully short of primary care physicians.

- No one envisioned the economic decline and loss of manufacturing that have left so many of our loved ones, neighbors, and friends without jobs and without health insurance. Mission was there for them when they had health insurance, and Mission remains there for them now.

- A federal debt burden approaching $15 Trillion, massive budget cuts pending at all levels (with Medicare and Medicaid comprising 15% of federal spending and 14% of state spending) and a "health care reform" package that is unlikely to remain intact, and unlikely to solve our core problems even if it did.

These problems create both challenges and opportunitiesfor all of us. THAT is why I believe that our region is well positioned to transform healthcare, not just in western N.C. but in the nation. We have an opportunity to create a regional system of care that keeps people healthy, provides better access to care, lowers the cost of care, dramatically improves quality, and makes life better for those who live here. The entire Mission family shares this vision. We are here tonight because we believe deeply that the people of western N.C. deserve the best healthcare our nation has to offer...close to home.

You know all too well how our nation's economic woes are impacting our state's healthcare providers. Nowhere is the impact more profound than in western N.C. Consider these facts:

- Western North Carolinians are older, sicker and poorer than state and national averages.
- As a result of our demographics and our regional safety net role, Mission serves a disproportionately high number of Medicare, Medicaid and self pay patients
  - Among large N.C. hospitals, Mission has the most challenging payor mix – healthcare jargon for the ability of patients (based upon their insurance or lack thereof) to cover the costs of their care, with nearly 80% of our reimbursement coming from insurance

like Medicare and Medicaid that pay far below the actual costs of care (not charges) or patients who can pay nothing at all.
    - Pick us up and move us to Charlotte, Greenville, Chapel Hill or Raleigh and we increase our margin by $100 million. As realtors like to say, location, location, location. It's the same in healthcare. It may not be fair, but it is our reality.
- Across the region, we have significantly fewer doctors per capita, and we die at significantly greater rates from all of the common diseases. It's not fair, it's not right, and we can do something about it.
- Our physicians are under tremendous pressure at the same time their reimbursement continues to decline. I've spoken with several primary care physicians recently who were literally in tears because they can't cover their costs and are questioning whether they can continue practicing medicine (which is their passion) in the community they love.

Winston Churchill said that "difficulties mastered are opportunities won" and I believe it. That is why Mission Health has embarked on a bold initiative that we call our BIG(GER) AIM: getting each and every patient to their desired outcome, first without harm, second without waste, and with an exceptional experience.

- The fact is that over the next several years every hospital in America will have to significantly lower its annual operating costs. Mission is no exception.
- The question is, How are we going to do it? That's where the BIG(GER) AIM comes in.
- We will fundamentally re-engineer how we care for patients, thoughtfully and with the full engagement of our hospital and medical staff.
- In fact, we already are. In six months even starting from a position of strength, we have made dramatic progress addressing problems that plague every hospital in the U.S. -- hospital-acquired infections, medication errors and falls just to name a few. And this is just the beginning.

Imagine for just a moment a regional network of care providers that are engaged with their communities and each other in pursuit of our BIG(GER) AIM. It is within our reach. But we need your help to get there. Our more than century long track record speaks for itself. Mission is an organization that keeps its word. To tell you just how we have done that, I will now turn the podium over to Richard Vinroot.

Closing Comments

Theme: Freedom to Serve

Mission is the region's only home-grown health system. For 126 years we have been focused on one thing and one thing only – serving the people of western N.C. In order to do that --not just tomorrow or next year but for many generations to come -- Mission needs the **freedom to serve**.

- There are those who don't share this point of view. They are quick to say that they want a strong Mission Hospital to take care of the sickest, weakest and most vulnerable in our region.
- They support our having a neonatal ICU that has one of the best survival rates in the state.
- They think it's wonderful that we have the only inpatient psychiatry unit in the region providing care for pediatric, adolescent, adult and geriatric patients.
- They are delighted that we have pediatric specialists available to care for their children and their grandchildren.
- What they don't say is that many of these programs lose money, and will lose increasingly more money in today's reimbursement climate.
- And even while choosing to come to Mission for their own personal care, what they don't say is this. They don't want Mission competing with them for patients based on quality, cost and service. In essence, they are asking you to restrict where patients go for care and limit the integration choices available to physicians, if and when they choose to affiliate.

Freedom to serve allows us:

- To bring needed services to patients and their families through affiliations with other hospitals, physician practices and academic medical centers. .
- To bring physicians to medically underserved counties.
- To freely compete for patients like all of our competitors across western N.C.
-
- Bottom line, it means letting patients and physicians choose where to go, who to align with and letting performance – on quality, efficiency and service determine winners and losers, not the government.

With all this discussion, where, you might ask, is the patient in all of this? We wanted to know, and so we asked them. In a recent random telephone survey of registered voters, a large majority (close to 80%) believe Mission's size is good for the region. When asked about the COPA, fully two-thirds believe the COPA restrictions should be removed.

And when it comes to their health care, they STILL want the freedom to choose. Outside of Buncombe and Madison Counties, consumers prefer their local hospitals for acute care. That has been the case

since 1995 and it is still true today. Likewise, their preference for specialty care is equally consistent – they want to come to Mission for care.

At the end of the day, our discussions and your deliberations will focus on one thing – what is the right thing to do for the patients and people of western N.C.

- People like Lori Jessee. Lori is a wife and mother. She was joined earlier by her 41-year-old husband Taylor and their 10 year old son John. Unfortunately, Taylor and John had to leave; tonight is football practice. Sounds pretty ordinary, except for one fact. Ten weeks ago, Taylor suffered a near fatal heart attack. They called it a widow-maker. Fortunately for Lori and John, it wasn't, thanks to skilled physicians and an outstanding heart rehabilitation team.
- And McKenzie Moore, who had a screening colonoscopy that revealed a cancerous polyp. With the help of the DaVinci Robot, and the skill of a surgeon who has performed more colon resections using this technology than anyone in N.C., McKenzie was back at work in 10 weeks, cancer free and with an excellent prognosis.
- And Shirley Geter. Shirley is part of an innovative diabetes disease management program done in collaboration with the YWCA of Asheville. Diabetics and pre-diabetics in the program have embraced a new lifestyle that includes more fresh fruits and vegetables, less fat, salt and sugar and more exercise. What is so special about this? Shirley and the 79 other participants have been able to come of medications, come off dialysis, and manage their disease better.

There is an old Irish proverb that says "God likes help when helping people." Those of us who have chosen careers in healthcare know that very well. It's why I became a doctor. Medicine provides opportunities to serve in ways few professions do. We are passionate about what we do because we know how important our work is to our patients and their families.

We don't make widgets. We are nurses and doctors, therapists and cooks, accountants and engineers, and a lot more. We provide comfort and solace when needed, cures when we can, hope in the face of the unknown, encouragement to change for the better, and healing regardless of the diagnosis or the prognosis. All of us in the Mission family are asking you to support our Freedom to Serve.

Thank you Mr. Chairman.

Prepared Remarks of Richard A. Vinroot, Partner
Robinson, Bradshaw & Hinson, Charlotte, N.C.

RAV Comments to COPA Committee on 10/20/11

- **1995 to 2011 (Mission/St. Joes J/V = subsequently, Merger)**

- **COPA is added "regulation"**
  - Anti-Trust Laws
  - CON
  - All others affecting health care
  - ∴ NC's (and indeed, the nation's) Most Regulated Hospital!

- **Purpose of COPA Law (G.S. 131 E – 192.1 – 13)**
  - State oversight alternative to Fed.

    Anti-Trust Litigation
    (a "defense," not an "avoidance")
  - (1) improve quality of care

    (2) contain costs

    (3) improve access in rural areas

    (4) Keep small rural hospitals open

    Such as with Pardee here! ⟶ (5) encourage "co-op" agreements between hospitals

- **Mission's COPA (1995)**
  - "Cost" and "Margin" Caps Imposed
  - Physician Employment "Safe Harbor"
    - 20% ⟶ now 30%

      (Buncombe and Madison Counties)
  - $87 Million in Savings ⟶ Return to Community

- **Annual Reports / Bi-ennial Hearings**
  - $5 Million spent "complying"
  - To DHHS / AG's office

- **Met all requirements (Repeatedly)**
  - $87 Million "savings promised" (and delivered!)

Threatened by competition from Mission! →

- **One local area hospital – Park Ridge (Adventist affiliate) has complained to DHHS/AG throughout 16 year compliance period – <u>All complaints rejected</u>**

  ("No evidence" or Rationale is "weak or lacking" entirely)

All <u>rejected</u> (Appropriately!)

  - <u>Most Recent</u>

    (1) 2 year moratorium – No new facilities in Henderson or Transylvania counties or within 5 miles from county lines

    (2) 20% employment (2 counties) cap → to 17 county WNC area without "practice group" limitations

    (3) Make all "strategic plans" public

    (4) All contracts with other hospitals offered to Park Ridge as well (most favored Nation!)

Died in Senate Committee

  - <u>Sen. Jim Davis</u>

    (1) Moratorium on "all acquisitions" til 12/31/11

    (2) Price Cap

    (3) Advance notice for all acquisitions

    (4) 10% employment cap → 17 counties

- **So, ironically, other competitors have tried to "pile on" Mission, notwithstanding it's N.C.'s most regulated hospital now (and has been for 16 years!)**

<u>Example</u>: Carolinas (Charlotte) now in 8 of 24 WNC counties (Cherokee to Wilkes) (because "scale" = reduced cost/more efficient use of capital) →

- **Meanwhile, the healthcare industry / market have changed dramatically**
  - Very large hospitals <u>outside WNC</u> have now penetrated this market (and all others in NC and beyond) and will grow exponentially
  - Doctors are increasingly becoming employed by hospitals throughout NC and America (o/a 60% now → heading to 75%)

  vs. Mission limited to 30% in Buncombe/Madison Counties

- **These changes (competition from without, etc.) plus (a) Mission is a low cost-high quality hospital, (b) in a poor payor-mix area, (c) trying to compete with higher cost and (d) better payor mix hospitals from without:**

  - Charlotte
  - Orlando (Adventist - Park Ridge's owner)
  - UNC
  - Greenville/Spartanburg
  - Novant
  - and others

  = This COPA is now outdated and has out-lived its original utility (i.e., permit the '95 JV and subsequent Mission – St. Joe's Merger) (and provide limitations in 2 counties)

- **In summary:**

  - Mission's COPA has served its intended purpose
    - been "Paid in Full"
  - The times/market conditions have now changed; thus Mission's COPA should soon be phased out
  - If Mission engages in Misconduct, Anti-trust laws provide a remedy / not continued, expensive "over-regulation" *via* COPA

NB: Dr. Tom McCarthy employed by both states to provide guidance

  - Only 3 other COPA's in America
    (1) Montana (now phased out entirely)
    (2) SC (Columbia – now phased down)
    (3) SC (Greenville – relatively new)
  - Only 19 states now have COPA laws
    - and now those laws are only used in 2 of those 19 states (NC and SC)
  - 31 states without such COPA laws do just fine

- And 48 of 50 states without any COPA hospitals do as well
- Because significant competition is now coming to this area from without, Mission's COPA should also be phased out
- Within the near future, phase out the COPA -- and free Mission to effectively compete and serve WNC as intended

- **Someday soon, the State must – as Moses beseeched the Pharaohs 2000 years ago – "let these people go!"**
  - Thank you!

- **Glad to answer any questions you may have at appropriate time (tonight or later)**
  - My law partner Everett Bowman is also available (involved in 1995 — and throughout the 16 year COPA oversight process since then) and quite knowledgeable

Robinson Bradshaw

Memorandum

TO: Members of the House Select Committee on Certificate of Need and Hospital-Related Issues

FROM: Richard A. Vinroot and Everett J. Bowman

Robinson, Bradshaw & Hinson, P.A., Attorneys for Mission Health System, Inc.

DATE: September 14, 2011

RE: Background information regarding Mission Health System, Inc. and its Certificate of Public Advantage (COPA)

- Mission Health System, Inc. ("Mission") in Asheville, is the 7th largest hospital in North Carolina and the largest employer in the 18-county Western NC ("WNC") region. It was founded in 1885 and has always operated as a nonprofit organization. Its governing Board consists primarily of local businesspeople and other civic leaders who have an interest in high-quality, low-cost medical care and who have no ties to Mission. All of Mission's revenues are utilized for Mission and those served by Mission. Unlike many hospitals in North Carolina, Mission is private and receives no subsidies from either the State or any county. Mission competes with other regional and national hospital systems, including hospitals affiliated with Carolinas Healthcare System, UNC Health Care System, and Adventist Health System.

- For many years there were two acute care hospitals in Asheville, located literally across the street from each other: Mission and St. Joseph's, a Catholic hospital owned by the Sisters of Mercy. In the early 1990s, Asheville's business community began urging Mission and St. Joseph's to combine or merge. They were motivated by their desire to reduce health care costs while maintaining and increasing quality of care, and by the desire to streamline and simplify the process of contracting with the two hospitals. At the same time, Mission's board and management team were concerned that St. Joseph's financial performance appeared weak and seemed to be getting worse, and there was a risk that the hospital would fail unless it joined with Mission to save costs and increase efficiency.

- In March 1994, Mission and St. Joseph's announced that they had entered into a "letter of intent" to integrate their operations.

- Although there was no requirement that they do so, the two hospitals promptly notified the Antitrust Division of the U.S. Department of Justice of their proposed integration, or "virtual merger," so that the agency would have an early opportunity to evaluate any concerns about the hospitals' ceasing to compete with each other. The DOJ did choose to conduct a review, examining more than 200,000 of the two hospitals' documents—mainly business and financial records—and taking the depositions of members of management and boards of both hospitals.

- While still considering the proposed combination, the DOJ indicated that the agency would promptly end the review if the State of North Carolina: (1) concluded that the merger would, on balance, be beneficial to the people of North Carolina, and (2) provided sufficient and continuing oversight to Mission following the combination.

- Accordingly, in July 1995, Mission and St. Joseph's applied to the State to have their proposed transaction evaluated by the NC Department of Justice and Department of Health and Human Services under the State's newly-amended "Hospital Cooperation Act." That amendment was enacted in 1995 by the General Assembly expressly to cover mergers between competing hospitals. Essentially, the hospitals' application for a COPA under the Act asked those State agencies to weigh the "advantages" vs. "disadvantages" of the proposed combination of the two hospitals.

- The State then conducted the requested review, holding public hearings, as well as having access to all materials previously collected by the USDOJ.

- In December 1995, the State authorities, in a carefully written analysis, concluded that the benefits of the transaction would outweigh any disadvantages and therefore granted the requested COPA, permitting Mission and St. Joseph's to combine. Initially, the hospitals established a joint operating and organizational partnership (that is, a "virtual merger"). In October 1998, under the authority of a reconsidered and revised COPA, Mission purchased St. Joseph's outright from the Sisters of Mercy (a "full merger").

- The 1995 COPA legislation has worked well—and as intended. As the State regulatory agencies have repeatedly confirmed, Mission has achieved all aspects of the "advantages" that the original COPA envisioned. Mission is a low-cost hospital and has enhanced the quality of and access to healthcare in Buncombe County and the surrounding more-rural areas of WNC. As a result of the merger of the two hospitals, substantial savings have been generated, and those dollars have been pumped back into the community.

- As the COPA has required, Mission's board is composed primarily of local businesspeople and other local community leaders. As employers (and potential Mission patients) themselves, these board members have a keen interest in keeping down Mission's charges and costs, because their own businesses and personal interests would suffer from any unjustifiable increases in the expense of providing hospital care for employees.

- Mission has the 3rd lowest charges in NC—a direct testament to Mission's Board restricting the hospital to single-digit price increases during an extended period of double digit increases nationally. This is particularly remarkable in that 80% of its patients are covered by Medicare or Medicaid or are residents of relatively poor rural areas who are simply unable to pay. No other large hospital in the State has such a financially disadvantageous patient mix, without any financial support from governmental entities.

- Over the past couple of years, more and more physicians in Asheville, as well as all over the country, have sought to become hospital employees, giving up their private practices. Those physicians, who are facing ever-growing practice costs and complexity, wish to focus on caring for patients and to reduce costs by turning over to a well-managed, efficient hospital their administrative responsibilities (such as billing, hiring, accounting, electronic health records and all the other paperwork associated with providing healthcare services). Moreover, healthcare reform is pushing both doctors and hospitals to form integrated healthcare delivery systems because it is anticipated that these systems will be increasingly accountable for the care and outcomes of, and the per-capita costs for, their patients.

- The COPA put a cap on Mission's employment of or exclusive contracting with primary care physicians at a time when physician employment was very uncommon. In the fall of 2010 Mission requested that the State regulatory agencies modify the COPA so that Mission could employ more physicians and achieve cost savings in doing so, in order to compete with much larger regional hospitals. At the end of last month, the agencies did modify the COPA, making it less restrictive regarding Mission's hiring of physicians. In making that decision, the State was advised by one of the top health care antitrust economists in the country. Moreover, the NC regulatory agencies had both the USDOJ and FTC review and sign off on the COPA modification. In view of all that attention, and the continuing oversight of the State agencies, this Committee can rest assured that Mission's COPA is being properly administered and is pro-competitive.

- Mission—having volunteered to be supervised under the COPA legislation in 1995—is NC's most-regulated hospital: the only hospital in the state subject to a COPA, and is still subject to the Certificate of Need legislation. Despite that fact, others—such as Park Ridge, part of the much larger Orlando-based Adventist

Health system—continue to urge that the COPA be made more restrictive and Mission be subjected to "more regulation," in an effort to avoid completely appropriate competition from Mission. The State regulatory agencies have carefully considered and rejected those efforts.

- The position that the COPA be made more restrictive and that regulatory oversight be increased is particularly wrongheaded in view of the dramatically increased competition that Mission faces from other tertiary care hospital systems, such as Charlotte-based Carolinas Healthcare System ($6.5 billion in net revenues), which now manages and controls Haywood County's largest hospital (Haywood Regional Medical Center, in Waynesville and two other local hospitals), and UNC Health Care System ($1.86 billion in net revenues), which very recently contracted to manage and control the largest hospital in Henderson County (Pardee Hospital in Hendersonville), both almost on Mission's doorstep. Mission currently employs approximately 150 physicians, compared with 1,712 employed by Carolinas and 1,053 employed by Adventist ($6.7 billion in net revenues), both of which are better financed "competitors" of Mission in WNC.

- Mission doesn't object to or try to obstruct such free market competition, but would note that the rapid changes occurring in the health care marketplace, including growing competition from hospitals that are owned by large tertiary care systems, is likely soon to render the continuation of the COPA unnecessary. In any event, this increasing competition certainly makes any effort to change the COPA so as to clamp tighter "handcuffs" on Mission particularly inappropriate.

- In summary, the original goals of the COPA from 1995 to the present were that:

  (a) medical care be improved in WNC;
  (b) costs be contained;
  (c) access to quality care in rural areas be enhanced; and
  (d) smaller rural hospitals (such as Angel Hospital in Franklin, Transylvania Hospital in Brevard, Blue Ridge Regional Hospital in Spruce Pine, and McDowell County Hospital, through their association with Mission) be helped to survive.

- Consistently and repeatedly, and most recently in the exhaustive review in 2010-2011 that included the DOJ and FTC as well as the NC DHHS and the NC Attorney General, the regulatory authorities have determined that all of these goals have been met and that Mission has operated within the rules. The 1995 Mission COPA has worked well, and as planned. For that, the State—and this Legislature, which enacted the COPA law—should be very proud.

COPA

Larry V. Hughes, CPA
Brandon S. Sutherland, CPA
Dixon Hughes Goodman LLP

Agreed Upon Procedures

- We were engaged to perform specific procedures and report our findings. The procedures include:

1. *Obtaining the data elements from several hospitals in NC, SC and VA that were selected by the NC Medical Care Commission*
2. *Calculate and report certain ratios based on the data elements collected*

The Hospitals*

Organization	Hospital
Novant Health	Presbyterian Hospital and Forsyth Medical Center
Palmetto Health	Palmetto Baptist Hospital
Spartanburg Regional Healthcare System	Spartanburg Regional Medical Center
First Health of the Carolinas	Moore Regional Hospital
Wake Medical	Wake Medical - New Bern Avenue Campus
New Hanover Health Network	New Hanover Regional Medical Center
Cape Fear Valley Health System	Cape Fear Valley Medical Center
Centra Health, Inc.	Lynchburg General Hospital and Virginia Baptist Hospital, Combined
Mission Health System, Inc.	Memorial Mission Hospital and St. Joseph's Hospital, Combined

* Hospitals used in 2009 COPA procedures, list has been modified during the term of COPA

The Data Elements

- Cost Report (Gross Inpatient Revenue, Gross Outpatient Revenue, Net Patient Service Revenue, Operating Expenses, Other Revenue)
- Number of Inpatient Discharges, excluding newborns
- Overall Case Mix Index for all patients, excluding newborns
- Total Bad Debt Expense
- Total Charity Care (based on charges)

Information was for hospital activity only, excluding psych, rehab, newborns, joint ventures, skilled nursing facilities, and investments

The Ratios

- Discharges Adjusted for Case Mix Index, excluding newborns
- Inpatient Revenue per Discharge Adjusted for Case Mix Index ("CMI"), excluding newborns
- Outpatient Revenue per Discharge Adjusted for CMI, excluding newborns (labeled as Equivalent Outpatient Discharge)
- Total Adjusted Discharges Adjusted for CMI
- Total Operating Expenses per Adjusted Discharge Adjusted for CMI
- Operating Margin (Total Net Patient Service Revenue plus Other Revenue less Total Operating Expenses divided by Total Net Patient Service Revenue plus Other Revenue).

Example of Selected Ratio Calculations for 2009

Ratio	Mission Health	Average
Discharges Adjusted for Case Mix Index, excluding newborns	64,900	43,081
Inpatient Revenue per Discharge Adjusted for Case Mix Index ("CMI"), excluding newborns	$15,646	$21,490
Outpatient Revenue per Discharge Adjusted for CMI, excluding newborns (labeled as Equivalent Outpatient Discharge)	31,904	26,891
Total Adjusted Discharges Adjusted for CMI	96,804	69,972
Total Operating Expenses per Adjusted Discharge Adjusted for CMI	$7,782	$8,145
Operating Margin (Total Net Patient Service Revenue plus Other Revenue less Total Operating Expenses divided by Total Net Patient Service Revenue plus Other Revenue).	5.29%	4.48%

The Mission Health System COPA
Presentation to the House Select Committee
on the Certificate of Need Process and Related Hospital Issues

October 20, 2011

Thomas McCarthy, Ph.D.
Senior Vice President
NERA Economic Consulting

I. Qualifications

A. General:

a. I am an economist and senior vice president employed by NERA Economic Consulting (NERA), an international economic consulting firm. I am the head of NERA's health care practice. For more than 25 years, I have specialized in the study of industrial organization and health economics, focusing principally on antitrust and competition issues in the health care marketplace.

b. I have made many presentations to state and federal antitrust agencies on the likely competitive effects of a wide range of hospital mergers, health plan mergers, and medical device company mergers being reviewed by those agencies. During 2003, I was invited by the Federal Trade Commission and the U.S. Department of Justice to testify at three sessions of their joint hearings on Health Care and Competition Law and Policy. The topics I was asked to testify on included hospital contracting issues and monopsony issues in the health insurance industry. I have also testified multiple times in federal and state courts on antitrust issues involving whether a particular hospital does or does not have market power.

B. COPAs:

a. Last spring, I was asked by Mission Health to analyze and comment on a report submitted by health economist, Dr. Gregory Vistnes. His report was produced at the request of the North Carolina Departments of Justice ("DOJ") and Health and Human Services ("DHHS") (collectively "the State") following Mission's request to ease one of the restrictions in its COPA—the 20 percent Physician Cap.[1] My findings were submitted to the State, which subsequently agreed with my finding (and that of the Dr. Vistnes) that the Physician Cap was too restrictive. The State recently replaced the 20 percent physician cap with a 30 percent physician employment threshold after which higher employment shares would be reviewed under normal antitrust principles that try to balance greater efficiencies with concerns about whether competition is threatened.

[1] The Physician Cap (which is no longer part of Mission's COPA) limited to 20 percent the share of primary care physicians in a two-county area that Mission could employ or contract with under an exclusive contract

b. In addition to my work in this Mission COPA review, I have worked on the only other two Certificates of Public Advantage ("COPA") that I know have been issued.

c. In the first instance, I advised the Montana State Attorney General on devising a method to regulate the Benefis Healthcare System in Great Falls, Montana. Benefis was formed by the merger of the only two hospitals in that city, Montana Deaconess Medical Center and Columbus Hospital. The ensuing COPA was phased out over two years after a decade in operation.

d. I also advised the South Carolina Department of Health and Environmental Control (DHEC) on whether the merger of the Baptist Healthcare System and Richland Memorial Hospital in Columbia, South Carolina would require state oversight through DHEC's COPA authority. It was determined by the state that the resulting Palmetto Health system did require such oversight to assure competitive outcomes. I did not assist in the design of the COPA. My understanding is that the South Carolina COPA has since been modified to remove all the benchmarks used to monitor costs and pricing, but is still in place on issues involving guaranteed access and charitable care.

II. Purpose and Structure of the Mission COPA:

A. Purpose of the Mission COPA:

a. Similar to the other COPAs, the purpose of the Mission COPA was to (1) allow Mission Hospital and St. Joseph's Hospital to jointly attain certain efficiencies in providing care and to (2) act as a substitute for the disciplining effects of competition that may have been reduced as a result of their joint operations starting in 1997. A well-executed COPA should lead to pricing and efficiency outcomes similar to those observed in other comparable competitive markets. This means the COPA should encourage the merged entity to be efficient and prevent it from raising prices above competitive levels or allowing its quality to fall below competitive levels.

b. Further, if Mission produces services efficiently, the COPA should also allow Mission to earn normal competitive margins that allow it to accumulate capital sufficient to keep its facilities and equipment up to date and to invest in projects that allow it to adapt to market changes and, thus, assure its financial stability.

c. Ideally, the COPA should be structured to avoid restricting the dynamic changes that are necessary in a competitive market, allowing Mission to adopt innovations similar to those being introduced in competitive hospital markets. This is a big challenge for any COPA as it must anticipate how a market will evolve.

d. The healthcare industry is a very dynamic one. Over the past 15 years or so, competitive forces in the area have increased for Mission. Eventually, competition in the area will likely develop to the point that the COPA is no longer necessary. These changes will likely happen quickly. I would be surprised if this did not play out within the next several years, say 3 to 5 years.

With that eventuality in mind and given the history of the other COPAs, the State may want to at least begin considering the conditions under which the COPA can be sunsetted.

e. Finally, the Mission COPA is expected to ensure that access to health care services is maintained. Specifically, the COPA seeks to preserve hospital facilities in the Western North Carolina ("WNC") area, avoiding any loss of geographical access to needed services or loss of access for medically underserved populations (i.e., Medicare, Medicaid, and a particular focus on uninsured and underinsured patients.)

B. Structure of the COPA

a. Cost Cap: The cost per case mix "adjusted patient discharge" for inpatient and outpatient services at Mission's Asheville hospital facilities should not exceed a cap based on the average of three benchmarks, including two sets of comparable peer hospitals and the change in the hospital producer price index (PPI).

b. Margin Cap: The operating margin in percentage terms for Mission's system-wide operations over any 3-year period should not exceed by more than one percentage point the mean of the median operating margin of hospitals with good debt ratings. This cap has a floor of 3 percent.

c. Physician Employment Safe Harbor: If Mission wishes to employ more than 30 percent of the physicians in its primary service area of Buncombe and Madison Counties (other than those practicing in cardiology, genetics, hospitalist, neuro-hospitalist, and neurology), it must provide 30 days advance notice to federal and state antitrust authorities and the State Department of Health and Human Services.

III. Effectiveness of the COPA:

A. If the COPA has been working well over the last 15 years, the economic performance of the market should look like a competitive outcome. This means production efficiency and quality should be high, costs low, and prices and margins should be at competitive levels. My research on the Mission COPA included an evaluation of its effectiveness in meeting these goals. I found that the COPA has worked very well by these measures. It has been achieving its goals consistently and is doing its job to mimic competition.

B. Mission's Performance:

a. By all the competitive benchmarks, Mission has generally performed in line with other competitive hospital systems in terms of its pricing, quality of services provided, margins, and costs. That is, the system has done what it has been asked to do.

i. Prices: Based on the available data, I found that pricing at Mission is well within the mainstream of competitive hospital pricing:

- On an all-payer basis, Mission's prices at its Asheville hospital facilities are just below the median price level of its current COPA peer group. (See pricing chart.)
- I do not have access to commercial-payer only data for any of the current COPA peer hospitals, however, Dixon Hughes conducted a 2003 comparison of commercial pricing levels at Mission's Asheville hospital facilities with those at the COPA peer hospitals at that time. Dixon Hughes found that Mission Hospital's commercial rates were 18 percent lower than hospitals in the COPA Benchmarking Group.[2]
- So whether we look at the prices to payers overall or just prices to the commercial payers, the information I have indicates that Mission's prices are well within the mainstream of how other hospitals in competitive markets price.

ii. Costs: Mission's Asheville hospital facilities have maintained cost levels well within the median of its current COPA peer group. (See cost chart.)

- In addition, Mission has met its COPA Cost Cap requirements every year, with the possible momentary exception of 2002, just before the cost cap benchmark was revised. Mission's 2002 cost levels were subsequently reevaluated in comparison with the COPA's revised Cost Cap and were found to be in compliance relative to the new cost benchmark.

iii. Margins: Mission has met its COPA Margin Cap requirements every year. The Mission system's margins are generally below those of its AA-rated benchmark group. (See margin chart.)

iv. Quality: In addition to effectively maintaining its physical plant,[3] Mission has been recognized by national experts as a leader in health care quality and efficiency, as Dr. Paulus addressed earlier.

v. Financial stability without excess returns: Although Mission is financially healthy, it has not built up a large reserve to finance major projects. As you have heard from Dr. Paulus, Mission balances the need to maintain reserve levels sufficient to ensure its financial stability and bond rating against the many financial demands of keeping its facilities and systems up to date and competitive. Like other hospitals in competitive environments, Mission has to pick and choose among projects, delaying or even foregoing opportunities because of limited resources.

vi. Ability to Adapt to Dynamic Changes: As Dr. Paulus has also discussed, Mission has been restricted in its ability to build and prepare for the future.

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2 Dixon Hughes commercial rate comparison study performed for Mission Hospitals, Inc., based on fiscal year-end 2003 information for hospitals in the COPA Benchmarking Group. ["Mission Hospitals, Inc. Commercial Rate Comparisons Presented by Larry Hughes and Greg Taylor"]

3 In 2009, Mission had an average age of 8.9 years for its physical plant compared with a national average age for the physical plant facilities of acute care hospitals of 9.3 years.

Some of this involves difficulties in building up reserves to start major capital projects, but more of it involves the changing trends in medicine, particularly in preparation for expected changes in health care financing and delivery. For example, the recent appeal to the State to modify the COPA's limits on physician contracting and employment was directly related to a major trend in health care...trying to align physician incentives with hospital incentives by employing physicians. Below, I briefly review some of these trends and suggest that there is evidence these trends are alive and well in North Carolina and western North Carolina.

C. State's Monitoring:

a. There are three key oversight elements that drive the COPA's reasonably strong success as a proxy for competitive forces: (1) good benchmarking based on reasonably comparable hospital systems (2) regular updating by continued checking against competitive benchmark systems, and (3) assessing the general performance of the markets in which Mission operates. Benchmarking against comparable hospital systems allows the regulator to ensure that the COPA is continuing to hold Mission to competitive standards without restricting its ability to stay up to date with competitive trends.

b. Over their 15 years of oversight, the DOJ and the DHHS have actively monitored and updated the Mission COPA with large and small amendments to take account of new situations or to avoid unnecessary distortions.

IV. Competitive Developments:

A. National and Regional Competitive Trends

a. There is a growing and widespread emphasis on greater integration of health care services. This shift has resulted in a number of trends observed nationally and in the WNC region:

i. Acquisition of smaller stand-alone hospitals: Smaller stand-alone hospitals are partnering with larger hospital systems, looking for the size and scale a system can provide to meet growing demands for information technology and integrated care.[4]

ii. Growth of outpatient services outpacing inpatient service growth: There has been a longstanding trend of shifting all kinds of patient services out of inpatient settings to less expensive outpatient facilities whenever

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[4] K. Terry, "ACO's Forging the Links." *Hospitals & Health Networks*, January 1, 2011, p. 20; V. Gallloro, "The urge to merge; With growing economic pressures and reform looming, hospitals and systems are reconsidering who they want as partners for the foreseeable future," *Modern Healthcare*, August 17, 2009; and J. Carlson, "The strong, the integrated; Annual ranking of the nation's integrated health networks shows the critical roles played by outpatient care, implementation of information technology," *Modern Healthcare*, January 26, 2009, p. 26.

medically possible. This trend is expected to accelerate in the face of expected needs for more integrated and lower cost care. [5]

iii. Hospital employment of physicians is substantial and growing: More than half of practicing U.S. physicians are employed by hospitals or integrated delivery systems. This trend appears to be accelerating, with a recent survey of hospital leaders indicating that 74 percent have plans to increase physician employment in the next 12 to 36 months. Hospitals are targeting both primary care and specialist physicians in contrast to the 1990s when their efforts focused on primary care physicians. [6]

iv. Provider Risk Sharing Expected: A major reason for stand-alone hospitals merging and integrating the physicians, outpatient care and the many other parts of the health care system into larger systems is that providers expect to bear more risk for the services they provide to patients. Since providers are closer to patients and are better at controlling utilization and costs than are insurers, they will increasingly be rewarded by Medicare and by commercial insurers for saving money. The hope is that the hospital system will better align everyone's interests to produce high quality coordinated care for their patients.

b. Carolinas HealthCare System, Novant Health and Greenville Hospital System each serve as a good example of how competitive tertiary hospital systems have adopted these strategies. Each illustrates how integration across facilities and services, affiliations with many medium and small hospitals, a substantial outpatient presence outside the hospital setting, and high levels of physician employment and affiliation. (See health system diagrams.)

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[5] T. Johnson, "Ambulatory care stands out under reform," *Healthcare Financial Management* (May 2010), p.57; D. Scalise, "Strange Bedfellows," *Hospitals & Health Networks* (December 2006), p. 10; and M. Romano, "Now Entering the Outpatient Zone; Hospitals invest in 'big box' centers for outpatient services to help reap rising revenue in that sector and expand their reach," *Modern Healthcare*, August 28, 2006, p. 64.

[6] "U.S. hospitals have begun responding to the implementation of health care reform by accelerating their hiring of physicians. More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations (ACOs) and the prospect of more risk-based payment approaches. Whether physicians, hospitals, or payers end up leading ACOs will depend on local market factors, competitive behaviors, and first-mover advantage, but employment decisions made by physicians today will have long-term repercussions for the practice and management of medicine." [R. Kocher, MD and N. Sahni, "Hospitals' Race to Employ Physicians — The Logic Behind a Money-Losing Proposition," *New England Journal of Medicine*, March 30, 2011 (accessed via nejm.org)]

K. Terry, "ACOs Forging the Links." *Hospitals & Health Networks*, January 1, 2011, p. 20; G. Edmiston and D. Wofford, "Physician alignment the right strategy, the right mind-set," *Healthcare Financial Management* (December 2010), p. 61; and J. Cantlupe, "Physician Alignment in an Era of Change," *HealthLeaders*, September 14, 2010.

B. Competition in WNC Area:

a. Regional Health Care Systems in the WNC Area:

i. The longstanding competition [7] that Mission has faced for tertiary care services is expanding, especially over the last year. Other regional hospital systems have become more prominent in the local area. (See hospital location and affiliation map.)

- Carolinas HealthCare System: Carolinas HealthCare System is already affiliated with seven hospitals in WNC.
  - Murphy Medical Center entered into a management services with Carolinas HealthCare System that was effective July 1, 2011.
  - Effective January 1, 2010, Carolinas also signed a management services agreement with MedWest Health. This agreement added three hospitals to the three already affiliated with Carolinas in the area. MedWest Health includes: (1) Swain County Hospital, (2) Harris Regional Hospital, and (3) Haywood Regional Medical Center. MedWest is also expanding its outpatient services in the region by opening new urgent care centers in Sylva and Canton in 2011 and an ambulatory surgery center in Haywood in 2012.
  - Prior to the 2010 agreement, Carolinas was already affiliated with three other hospitals in western North Carolina: (1) St. Luke's Hospital, (2) Grace Hospital, and (3) Valdese Hospital.
  - After signing the 2010 management agreement with MedWest, Carolinas has announced a $25 million joint venture ambulatory center in Clyde, the opening of an urgent care center in Sylva and the employment of 100 physicians offering in-office and specialty care.
- UNC Health Care: In June of this year, Pardee Hospital in Hendersonville signed an affiliation agreement with UNC Health Care, a large academic health care system. UNC Health Care has seven hospitals (both public academic and private) and of course a medical school. This health system has two physician groups with over 1,100 physicians and plans for substantial growth. UNC's medical school also has a 10-doctor residency presence in Asheville at Mission.
- Adventist Health System: Park Ridge Hospital in Hendersonville is one of over 40 hospitals in Adventist Health System. Adventist is a large national health care system with operations in 12 states. The Adventist System has a strong commitment to physician alignment. In addition to its hospital campus, Park Ridge has 31 physician offices

[7] "Competition for tertiary care services currently exists and will continue to exist from points around Asheville such as Charlotte; Johnson City, Tenn.; Greenville/Spartanburg S.C.; and Atlanta, Ga." [*Second Amended and Restated Certificate of Public Advantage*, p.11]

and care centers delivering patient care. I understand that Park Ridge employs about 60 physicians in the local area. (See Park Ridge physician practice map.)

- There are several systems in and around the Greenville/Spartanburg area that provide tertiary care that have competed with Mission for these patients.
- Even the Cleveland Clinic, which has no facilities in WNC, is competing for tertiary patients in the area. In 2010, Lowe's (a significant employer in the WNC area) began offering its full-time employees the option to schedule certain heart surgery procedures at the Cleveland Clinic at enhanced benefits coverage levels.[8]

b. Physician employment:

i. Other hospital systems are aggressively hiring physicians and acquiring physician practices in WNC. These acquisitions have already seriously affected the referral rates to one of Mission's rural hospital facilities. The COPA has often prevented Mission from competing for these physician practices. Recently, negotiations with a premier medical practice ended specifically as a result of the physicians' concern that the COPA's physician employment restriction on specialty employment would split their group. As a result, unregulated competitors can rapidly acquire and consolidate important sources of hospital referrals in WNC without the same type of competition from Mission.

c. Competition for outpatient services:

i. Mission also faces substantial competition from a wide variety of competing local and regional outpatient facilities. These include ambulatory surgery centers, imaging centers, endoscopy facilities, cardiac and pulmonary rehabilitation centers, gastroenterology facilities, orthopedic surgery centers, oncology facilities, and urgent care clinics. Many such facilities are owned or affiliated with other hospitals.

- Open MRI & Imaging of Asheville (Asheville): The diagnostic imaging facilities offered by this center include arthrograms, diagnostic x-rays, high field closed MRIs, and high field open MRIs. Open MRI & Imaging of Asheville is owned by North Carolina Diagnostic Imaging, which is owned by MedQuest Associates, a subsidiary of Novant Health.
- Park Ridge Urgent Care (Asheville, Arden, and Hendersonville): ParkRidge Health owns and operates urgent care centers in Asheville, Arden, and Hendersonville

[8] "Lowe's Expands Heart Healthcare Benefits with Cleveland Clinic," Cleveland Clinic website at my.clevelandclinic.org, February 16, 2010.

- Med-West Urgent Care Centers (Canton, Clyde and Waynesville): These locations provide walk-in urgent care and diagnostic imaging services. They are owned by Haywood Regional Medical Center, which is affiliated with the Carolinas HealthCare System.

- Park Ridge-Southeastern Sports Center (Asheville, Waynesville and Hendersonville): Southeastern Sports Medicine is an orthopedic practice with walk-in clinics that provide diagnostic and physical therapy services. It is owned by ParkRidge Health, which is affiliated with the Adventist system.

- CarePartners: CarePartners has outpatient physical therapy clinics throughout Buncombe County, including locations in Enka, Asheville, and Woodfin. These outpatient locations are owned by the Care Partners Rehabilitation Hospital in Asheville.

ii. In varying degrees, payers can steer patients to other outpatient facilities. Not only does this bring competitive discipline to outpatient service pricing, payers can also use their ability to steer outpatient volume away from Mission to negotiate better rates for other Mission services, even for inpatient pricing. Outpatient centers not only represent an opportunity for the payers to discipline Mission pricing, they represent another type of lost volume for Mission—physicians tend to steer their patients to their own facilities. Many local outpatient facilities are owned by physician practices.

iii. As a result of these many competing outpatient facilities, Mission Hospital reports that it receives a relatively low percent of its revenues from providing outpatient services compared to inpatient services (33 percent at Mission Hospital relative to a national average of 41 percent from outpatient revenues and a target of 50 percent reached by some of the healthier systems).

d. Blue Cross Blue Shield of North Carolina:

i. BCBSNC is a large and sophisticated buyer of health services across North Carolina, and a particularly important payer in WNC. It covers about 60 percent of the commercial patients that use Mission facilities, which gives it significant negotiating strength.

C. Mission's Competitive Conduct:

a. Mission's conduct is consistent with competitive strategies being adopted by other hospital systems, both regionally and nationally. Moreover, Mission's strategic initiatives are consistent with the competitive changes going on across North Carolina and most of the U.S.

b. Mission's affiliations with rural hospitals: This conduct is consistent with normal procompetitive conduct and the COPA's goal of maintaining the community's access to local services.

i. Bidding to manage Haywood Regional Center & WestCare Health System: Mission sought this management contract, but lost to the winning "bidder," Carolinas HealthCare System. As a result, Mission anticipates a loss of patient referrals for higher level care. Rural hospitals in this area have options other than Mission if they wish to affiliate with a larger hospital system. Mission cannot coerce local rural hospitals to affiliate with it.

ii. Bidding to manage Murphy Medical Center: Mission sought a management contract with Murphy, but again lost to the winning "bidder," Carolinas HealthCare System.

iii. Affiliation with Blue Ridge Regional Hospital & McDowell Hospital: Prior to approaching Mission, each of these hospitals had come to the conclusion that continuing to operate as a smaller stand-alone hospital was no longer a viable long-term strategy. Both found it necessary to form some sort of affiliation that would allow them to (1) lower their operating costs, (2) gain access to less expensive credit to fund needed capital investments,[9] and (3) improve their recruitment and retention of physicians. By affiliating with these hospitals, Mission assisted in maintaining the community's access to health care services in their local area. Mission has actively sought to revive the financial health and operating efficiency of these institutions.

iv. Management agreement with Transylvania Regional Hospital: This affiliation grew out of a process initiated by Transylvania Regional Hospital in 2008. The hospital board met with several different organizations and reviewed multiple potential opportunities over a two-year period before deciding to sign a management agreement with Mission. This indicates again, that there are competitive reasons for affiliating with a rural hospital, as demonstrated by the presence of other interested parties, including Carolinas. In addition, this hospital had hospital system options other than Mission.

v. Management agreement with Angel Medical Center: Angel Medical Center was looking for many of the same benefits from affiliations as other smaller hospitals in the area (e.g., lowering their operating costs, gaining access to less expensive credit, and improving their retention and recruiting of physicians). Angel considered following WestCare and Haywood with an affiliation with Carolinas, but instead chose Mission as a better fit, having had a long-standing relationship with Mission.

---

[9] McDowell received $8 million in low-interest loans over a three-year time period. These funds were used for an MRI, to expand its emergency department, and to renovate its obstetrics area and operating rooms. Once Blue Ridge became part of the Mission system, it was able to finance an $18.6 million facility modernization program with the proceeds from a bond issuance through Mission.

c. Mission's employment of and affiliation with physicians:

i. There is little danger of rival hospitals being foreclosed by Mission's employment of physicians. To the contrary, limiting Mission's employment of physicians effectively handicapped Mission's ability to compete with other health care providers and prevented it from potentially lowering overall health care costs and increasing quality by providing more integrated care.

- Example: Grace Hospital's aggressive physician recruitment efforts have seriously affected the financial health of McDowell Hospital. Grace Hospital (which is managed by Carolinas) recruited and hired McDowell's only two OB/Gyn physicians in 2008. These physicians shifted their deliveries and surgeries to Grace Hospital and are no longer on staff at McDowell Hospital. It took Mission over 6 months to recruit two new OB/Gyn physicians to the area to establish a new practice. Then in 2009, Grace Hospital hired five family practice physicians who had offices in Marion and Nebo and traditionally referred patients to McDowell.

d. Mission's planned joint venture outpatient facility with Pardee Hospital:

i. As I discussed already, a hospital system expanding into other services (especially outpatient services) and geographies is a natural response to the competitive pressures hospitals face. This planned outpatient center is consistent with behavior of other hospital systems in competitive settings. It also increases the competitive overlap that is continuing to develop among Park Ridge, Pardee, and Mission in the fast-growing southern portion of the Asheville area.

e. Consistency of Mission's conduct with trends in competitive strategies:

i. Mission's strategies and operational structures should not be viewed as an effort to game or evade regulation. These are responses to competitive pressures and the need to assure rural access. With no ability to adapt to new market conditions, Mission may be prevented from developing as a competitive hospital system and may not be able to compete effectively against other regional hospital systems that are becoming more active in the local area.

ii. Therefore, it is important to understand Mission's conduct in the broader context of the changing competitive health care landscape. Mission's conduct is consistent with widespread trends in health care that would generally be considered normal conduct consistent with procompetitive business reasons.

V. Challenges of Operating a Hospital under the COPA:

A. Mission continues to face operational constraints beyond those intended by the COPA to mimic competitive outcomes.

a. Physician Employment Safe Harbor: The artificial constraint implied by the 30 percent physician employment threshold (raised from a previous 20 percent cap) still limits Mission's ability to join the trend with many other health systems to provide integrated services and prepare for more risk-based contracting with payers. Mission's competitors do not face these same constraints. In addition, physicians who would prefer to be employed may choose to join these rival systems of leave the Asheville area if Mission cannot offer them employment, even though they and Mission would prefer that they affiliate with Mission.

b. Ability to modernize facilities: Mission is restricted in its ability to effectively modernize its Asheville hospital facilities. These facilities are subject to an annual Cost Cap, so Mission generally avoids large capital expenditures that might cause a spike in expenditures. This results in a series of smaller incremental improvements in the Asheville facilities, rather than fewer larger investments that may be more efficient and effective over the long-term.

VI. As Competitive Constraints Increase, the COPA Is Less and Less Necessary

A. Competitive forces in the area and tough negotiations with payers will continue to increase for Mission. The healthcare industry is very dynamic. These changes will likely happen quickly. Rather than continuing to tinker with the COPA, the State may want to consider the conditions under which the COPA can be sunsetted. If Mission's competitive environment continues to develop to the point that a regulatory proxy for competition is not needed, then the COPA should no longer be enforced.

B. The two largest insurers in the Asheville area indicate that such a discussion would be premature—they believe the COPA is still needed to protect pricing but recognize that the COPA sometimes constrains Mission's ability to respond to competition. Still, like the examples of Benefis in Montana and Palmetto in South Carolina, competition has been growing in the shadow of the COPA-regulated hospital, and the regulatory oversight will soon not be necessary, even assuming it is needed today.

a. Benefis example: In Montana, the Benefis COPA was phased out in part due to the reintroduction of competition in the Great Falls area. The decision to phase out the Benefis COPA was largely based on the reintroduction of sufficient competitive forces in the area, particularly from an 85-doctor multispecialty clinic and surgery center, the Great Falls Clinic, and a short-stay hospital, the Central Montana Surgery Hospital. The hospital and the regulator found that Benefis had become too constrained in how it could compete, particularly as it became more and more subjected to an adversely selected patient pool of servicing most of the sickest and poorly insured patients in the area. The COPA was then phased out.

b. Palmetto example: In South Carolina, the state determined Palmetto Health system (which resulted from the merger of the Baptist Healthcare System and Richland Memorial Hospital in Columbia, South Carolina) would require oversight through a COPA to assure competitive outcomes. The original

COPA was issued in May of 1997 (the same year as Mission's COPA). Among other restrictions and requirements, the COPA addressed Palmetto's expected cost savings, price and cost levels, and its ability to exclusively contract with other health care providers and health plans. By November 2003, the state deemed most of the COPA's requirements had been satisfied or were no longer applicable. The remaining COPA requirements are not about competitive pricing, costs, quality or margins. Instead, the COPA now primarily addresses Palmetto's ongoing obligation to fund public health initiatives and community outreach programs and to continue to maintain access to services for competing facilities that do not offer such services.

C. I would be surprised if the same general process did not play out in WNC, perhaps within the next 3 to 5 years or so. If anything, health care reform initiatives will speed up this process. For that reason, as well as the many others already discussed, I respectfully suggest that there is no need to change the regulatory approach—it is working—and by the time that might happen to the point where both the State and Mission are comfortable managing Mission under the new system, the debate will have already turned to whether the COPA should be phased out.

1961 ▪ 50th ANNIVERSARY ▪ 2011

The Mission Health System COPA

Presentation to the House Select Committee on the Certificate of Need Process and Related Hospital Issues

Thomas McCarthy, Ph.D.

Senior Vice President

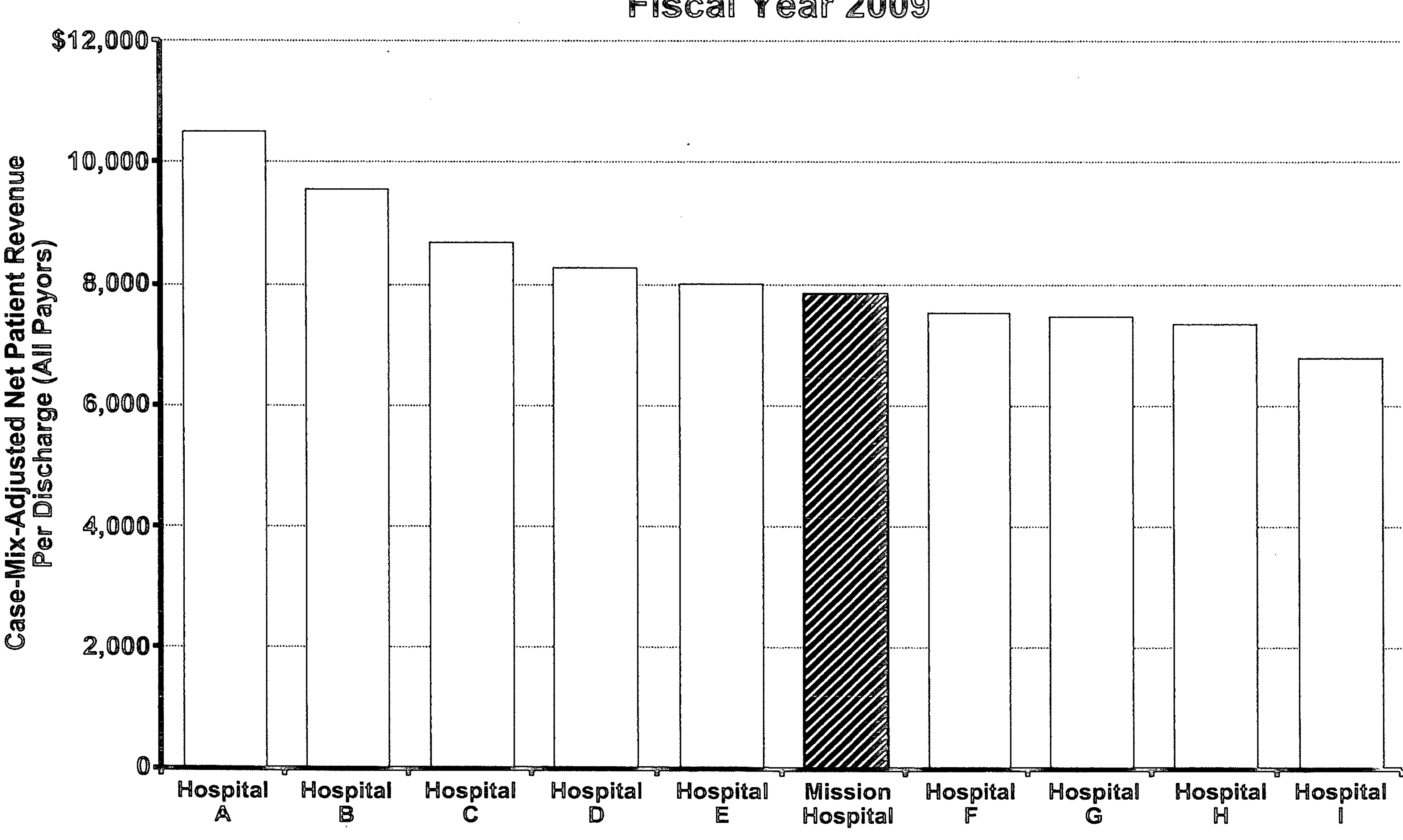
October 20, 2011

Insight in Economics™

Effectiveness of the COPA Mission's Performance

- **Prices:** Well within the mainstream of competitive hospital pricing

Mission Hospital's Pricing
Compared with Current COPA Peer Group

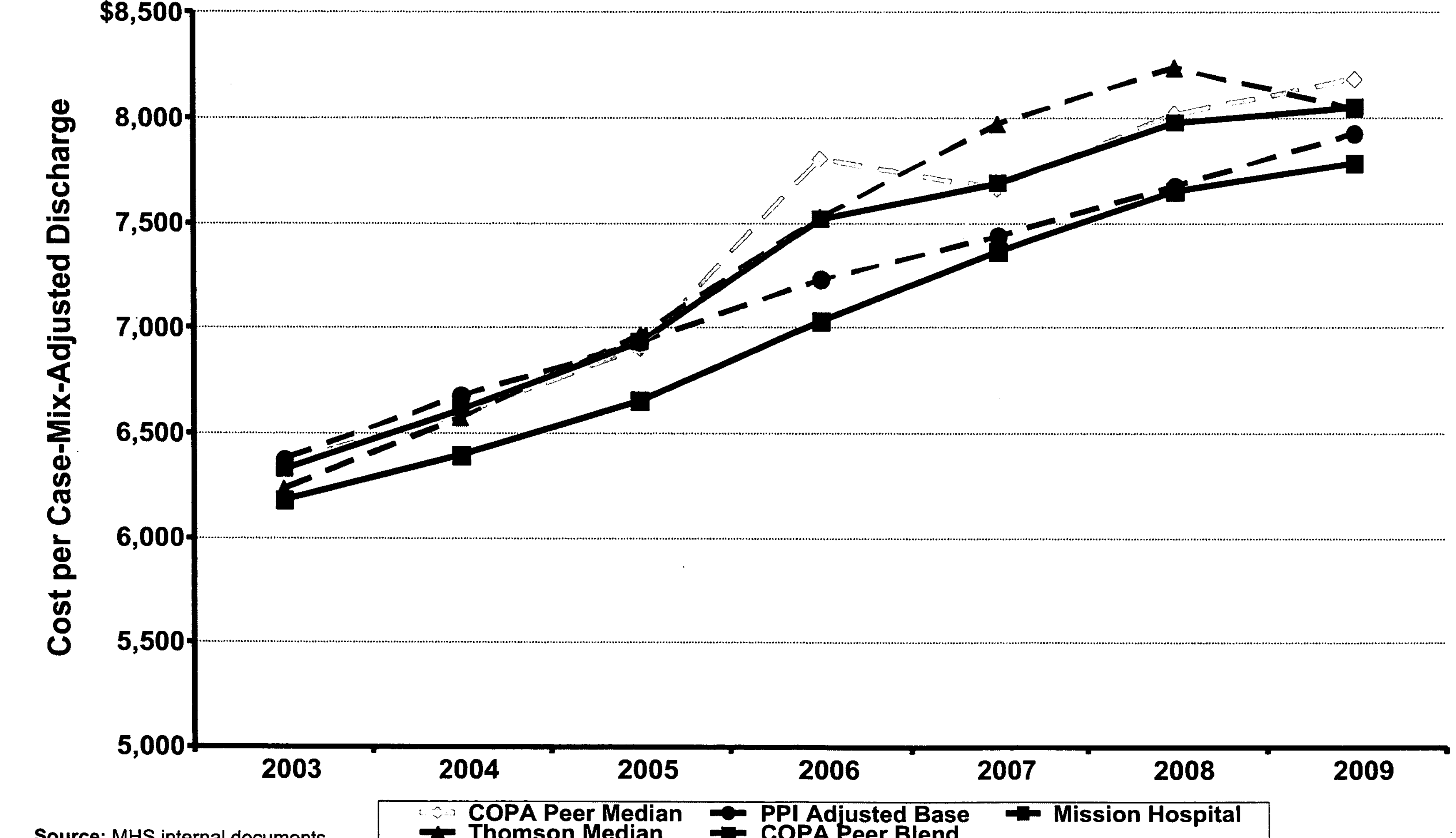


Source: Dixon Hughes, PLLC.

Effectiveness of the COPA Mission's Performance

- **Prices:** Well within the mainstream of competitive hospital pricing
- **Costs:** Well within the median of current COPA peer group

Mission Hospital's Cost Levels
Compared with COPA Peer Benchmarks

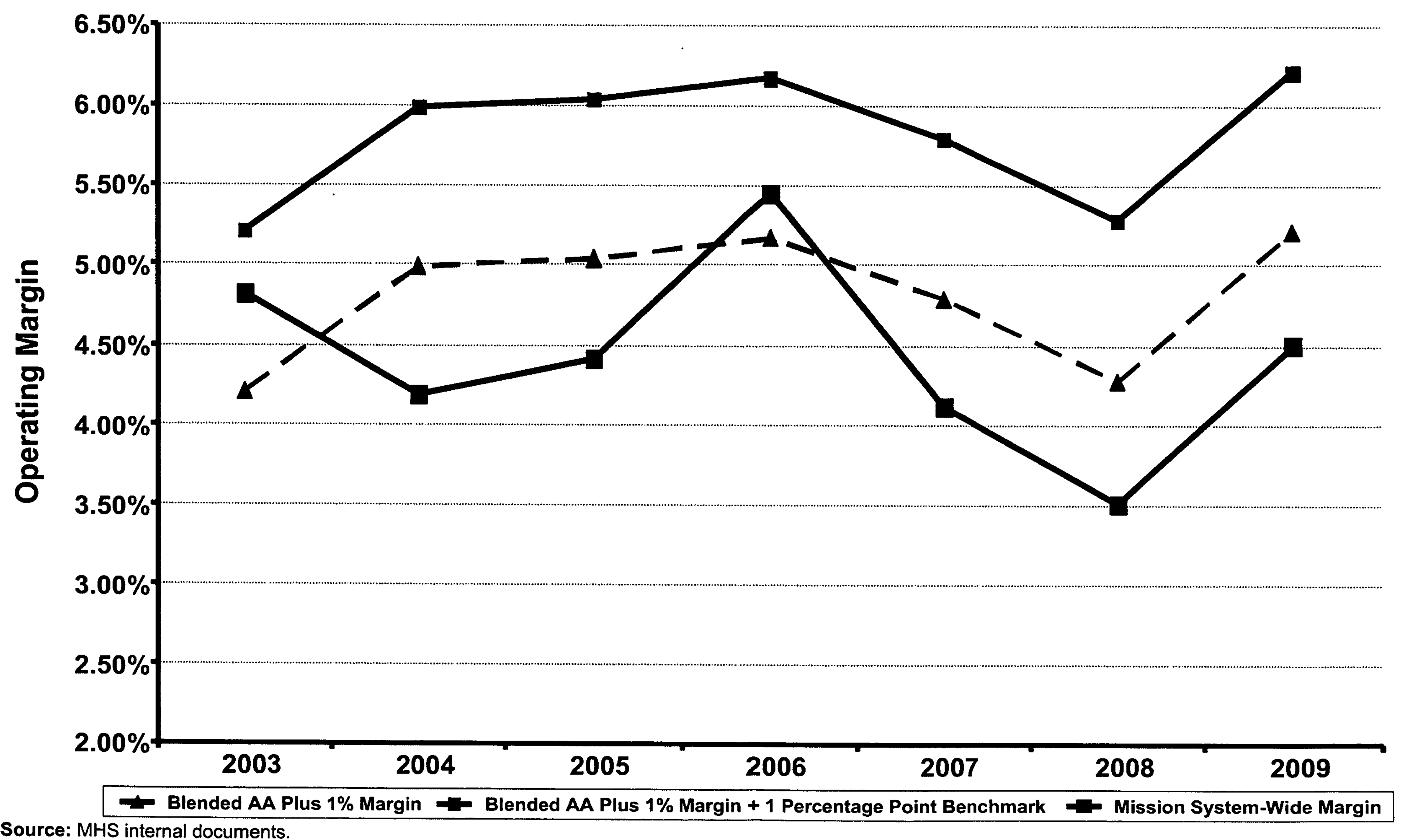


Source: MHS internal documents.

Effectiveness of the COPA Mission's Performance

- **Prices:** Well within the mainstream of competitive hospital pricing
- **Costs:** Well within the median of current COPA peer group
- **Margins:** COPA Margin Cap requirements met every year

Mission System-Wide Margin Levels
Compared with those of AA-Rated Benchmark Hospital Systems



Source: MHS internal documents.

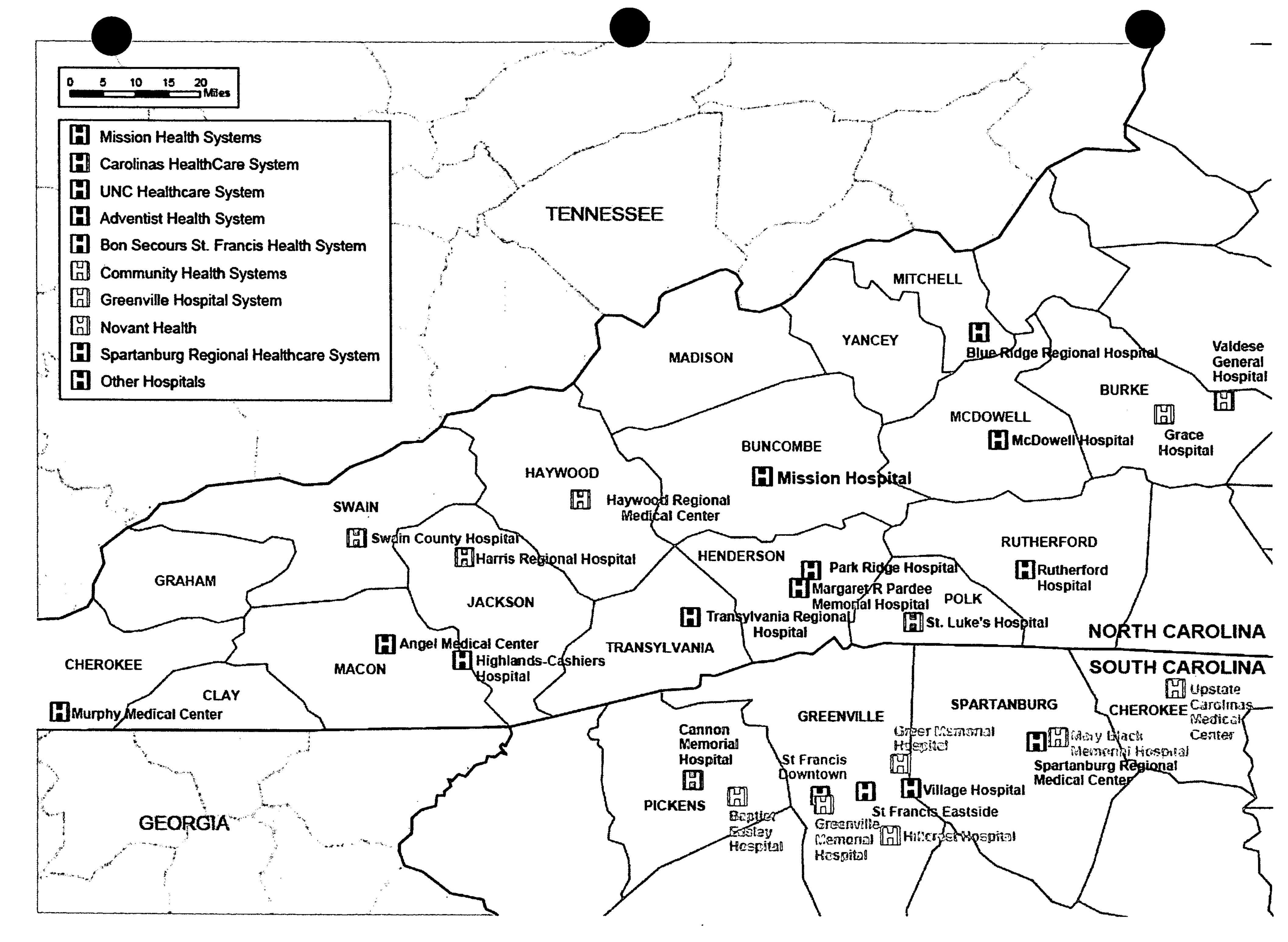
Effectiveness of the COPA Mission's Performance

- **Prices:** Well within the mainstream of competitive hospital pricing
- **Costs:** Well within the median of current COPA peer group
- **Margins:** COPA Margin Cap requirements met every year
- **Quality:** Leader in health care quality and efficiency
- **Financial stability without excess returns:** Financially healthy, but must prioritize and even forego projects

Competitive Developments

National and Regional Competitive Trends

- Acquisitions of smaller stand-alone hospitals
- Growth of outpatient services outpacing inpatient service growth
- Hospital employment of physicians is substantial and growing
- Provider risk sharing expected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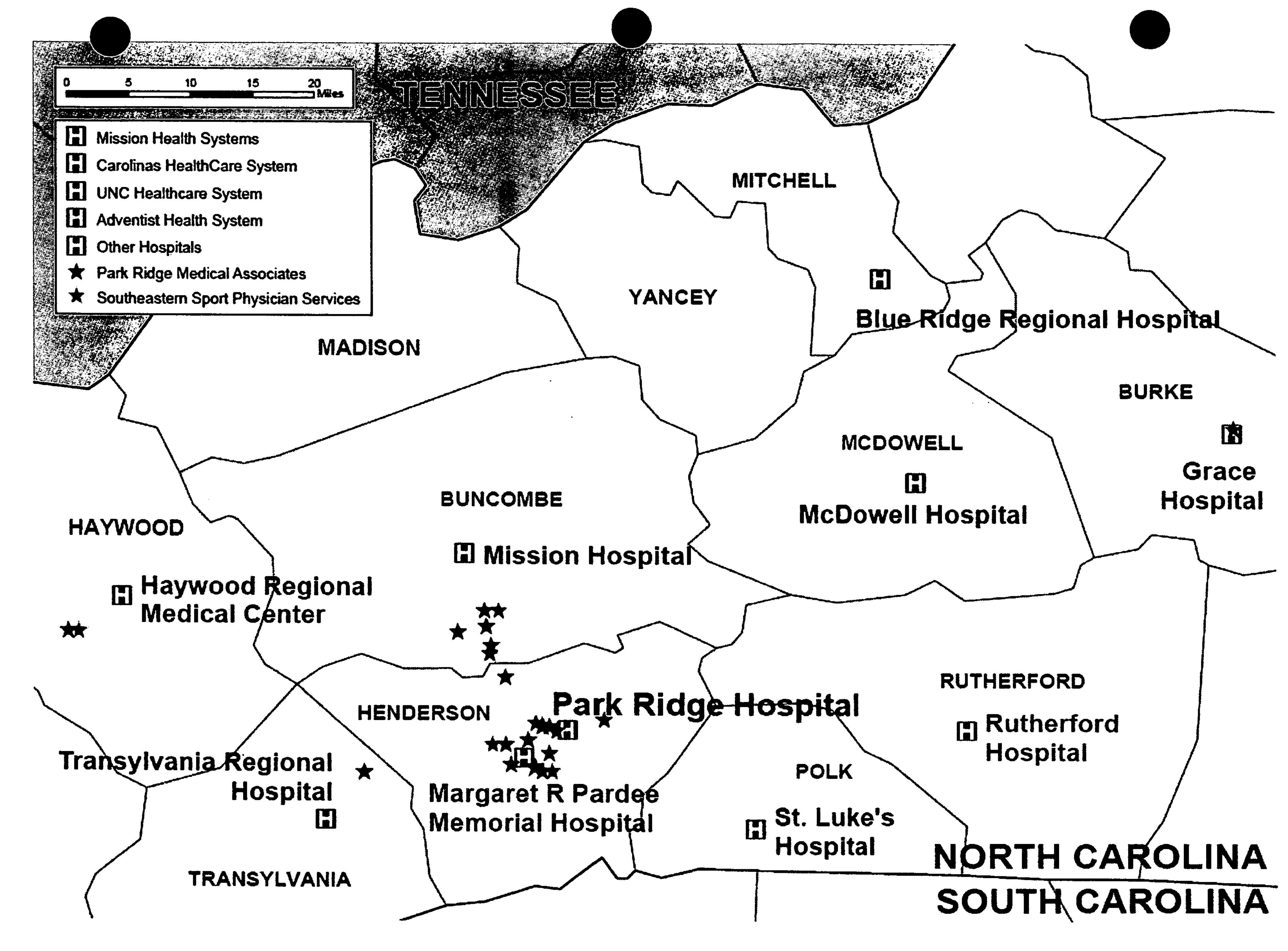
Mission Health Systems
Carolinas HealthCare System
UNC Healthcare System
Adventist Health System
Bon Secours St. Francis Health System
Community Health Systems
Greenville Hospital System
Novant Health
Spartanburg Regional Healthcare System
Other Hospitals
TENNESSEE
MITCHELL
YANCEY
MADISON
BUNCOMBE
MCDOWELL
BURKE
HAYWOOD
SWAIN
GRAHAM
JACKSON
HENDERSON
RUTHERFORD
POLK
TRANSYLVANIA
MACON
CHEROKEE
CLAY
NORTH CAROLINA
SOUTH CAROLINA
SPARTANBURG
CHEROKEE
GREENVILLE
PICKENS
GEORGIA
Blue Ridge Regional Hospital
Valdese General Hospital
McDowell Hospital
Grace Hospital
Mission Hospital
Haywood Regional Medical Center
Swain County Hospital
Harris Regional Hospital
Park Ridge Hospital
Rutherford Hospital
Margaret R Pardee Memorial Hospital
Transylvania Regional Hospital
St. Luke's Hospital
Angel Medical Center
Highlands-Cashiers Hospital
Murphy Medical Center
Upstate Carolinas Medical Center
Cannon Memorial Hospital
Greer Memorial Hospital
Mary Black Memorial Hospital
St Francis Downtown
Spartanburg Regional Medical Center
Village Hospital
St Francis Eastside
Baptist Easley Hospital
Greenville Memorial Hospital
Hillcrest Hospital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Mission Health Systems
Carolinas HealthCare System
UNC Healthcare System
Adventist Health System
Other Hospitals
Park Ridge Medical Associates
Southeastern Sport Physician Services
TENNESSEE
MITCHELL
YANCEY
MADISON
Blue Ridge Regional Hospital
BURKE
MCDOWELL
Grace
Hospital
BUNCOMBE
McDowell Hospital
HAYWOOD
Mission Hospital
Haywood Regional
Medical Center
RUTHERFORD
HENDERSON
Park Ridge Hospital
Rutherford
Hospital
Transylvania Regional
Hospital
POLK
Margaret R Pardee
Memorial Hospital
St. Luke's
Hospital
TRANSYLVANIA
NORTH CAROLINA
SOUTH CAROLINA

Carolinas HealthCare System

ACUTE CARE HOSPITALS

1. Carolinas Medical Center, Charlotte [748 beds]

Western North Carolina Hospitals

2. MedWest-Harris Regional Hospital, Sylva [86 beds]
3. MedWest-Haywood Regional Medical Center, Clyde [105 beds]
4. Grace Hospital, Morganton [162 beds]
5. St. Luke's Hospital, Columbus [25 beds]
6. MedWest-Swain County Hospital, Bryson City [24 beds]
7. Valdese General Hospital, Valdese [131 beds]
8. Murphy Medical Center, Murphy [57 beds]

Other North Carolina Hospitals

9. Anson Community Hospital, Wadesboro [52 beds]
10. Carolinas Medical Center-Lincoln, Lincolnton [101 beds]
11. Carolinas Medical Center-Mercy, Charlotte [281 beds]
12. Carolinas Medical Center-Northeast, Concord [447 beds]
13. Carolinas Medical Center-Pineville, Charlotte [109 beds]
14. Carolinas Medical Center-Union, Monroe [157 beds]
15. Carolinas Medical Center-University, Charlotte [130 beds]
16. Cleveland Regional Medical Center, Shelby [233 beds]
17. Columbus Regional Healthcare System, Whiteville [154 beds]
18. Kings Mountain Hospital, Kings Mountain [42 beds]
19. Scotland Memorial Hospital, Laurinburg [97 beds]
20. Stanley Regional Medical Center, Albemarle [94 beds]
21. Wilkes Regional Medical Center, N. Wilkesboro [118 beds]

South Carolina Hospitals

22. AnMed Health Medical Center, Anderson [357 beds]
23. Bon Secours St. Francis, Charleston [204 beds]
24. Cannon Memorial Hospital, Pickens [42 beds]
25. Mount Pleasant Hospital, Mount Pleasant [106 beds]
26. Roper Hospital, Charleston [414 beds]
27. Wallace Thomson Hospital, Union [107 beds]

"Carolinas HealthCare System is one of the finest providers of healthcare in the country. However, we are much more than just a collection of physician practices, hospitals and other facilities. We are an interlocking set of partnerships operating together for the good of the patients and communities we serve."

OUTPATIENT FACILITIES

- 9 Surgery Centers
- 7 Endoscopy Facilities
- 8 Cancer Centers
- 18 Imaging Centers
- 3 Mobile Imaging Units
- 9 Wellness Centers
- 18 Urgent Care Centers
- 19 Physical Rehab and Therapy Facilities

PHYSICIANS

- 1,712 employed physicians
- Physician Networks
  - Carolinas Physicians Network [CPN]
    - Practices in 11 counties in NC and SC
  - NorthEast Physician Network [NEPN]

SPECIALIZED HOSPITALS

North Carolina Hospitals

1. Levine Children's Hospital, Charlotte
2. Carolinas Medical Center Randolph, Charlotte
3. Carolinas Rehabilitation- Mt. Holly, Belmont
4. Crawley Memorial Hospital, Boiling Springs
5. Carolinas Rehabilitation, Charlotte

South Carolina Hospitals

6. AnMed Health Rehabilitation Hospital, Anderson
7. AnMed Health Women & Children's Hospital, Anderson

Novant Health

"Novant Health provides comprehensive health services in many locations in North Carolina, South Carolina and Virginia. From hospitals to outpatient surgical and rehabilitation centers to primary care physician offices, these buildings provide the foundation for delivering exceptional healthcare services..."

ACUTE CARE HOSPITALS

1. Forsyth Medical Center, Winston-Salem [818 beds]

Other North Carolina Hospitals

2. Presbyterian Hospital, Charlotte [463 beds]
3. Rowan Regional Medical Center, Salisbury [171 beds]
4. Thomasville Medical Center, Thomasville [121 beds]
5. Presbyterian Hospital Matthews, Matthews [102 beds]
6. Presbyterian Hospital Huntersville, Huntersville [60 beds]
7. Kernersville Medical Center, Kernersville [46 beds]
8. Brunswick Community Hospital, Supply [60 beds]
9. Franklin Regional Medical Center, Louisburg [70 beds]

South Carolina Hospitals

10. Upstate Carolina Medical Center, Gaffney [125 beds]

Virginia Hospitals

11. Prince William Hospital, Manassas [148 beds]

SPECIALIZED HOSPITALS

North Carolina Hospitals

1. The Oaks at Forsyth, Winston-Salem
2. Springwood Care Center, Winston-Salem
3. Medical Park Hospital, Winston-Salem
4. Presbyterian Orthopaedic Hospital, Charlotte
5. Presbyterian Hemby Children's Hospital, Charlotte

Virginia Hospitals

6. Caton Merchant House, Manassas

OUTPATIENT FACILITIES

- Presbyterian Mid-Town Surgery Center, Charlotte
- Presbyterian Surgery Center – Ballantyne, Charlotte
- Presbyterian Surgery Center, Monroe
- Presbyterian Bariatric and General Surgery, Matthews
- South Park Surgery Center, Charlotte
- Rowan Regional Medical Park Outpatient Surgery, Salisbury
- Forsyth Medical Center Hawthorne Outpatient Surgery Center, Winston-Salem
- Forsyth Regional Cancer Center (6 locations)
- Presbyterian Rehabilitation Center (4 locations)
- Presbyterian Urgent Care (3 locations)
- Prime Care Urgent Care (5 locations)
- The Wound Center of Forsyth, Winston-Salem
- Heathcote Health Center, Haymarket, VA
- Marblestone Health Center, Woodbridge, VA
- Sea Trail Medical Center, Supply
- Presbyterian Imaging Center (7 locations)
- Forsyth Medical Center Imaging (4 locations)
- Presbyterian Endoscopy Center, Huntersville
- MedQuest (108 diagnostic imaging centers across 13 States)

PHYSICIANS

- Novant Medical Group
  - 1,053 employed physicians
  - 265 clinic locations in NC, SC, and VA

Greenville Hospital System

ACUTE CARE HOSPITALS

1. Greenville Memorial Hospital, Greenville [723 beds]

Other South Carolina Hospitals

2. Greer Memorial Hospital, Greer [58 beds]
3. Hillcrest Memorial Hospital, Simpsonville [43 beds]
4. Baptist Easley Hospital, Easley [88 beds]

SPECIALIZED HOSPITALS

South Carolina Hospitals

1. Marshall I. Pickens Hospital, Greenville
2. Roger R Peace Rehabilitation Hospital, Greenville
3. Patewood Memorial Hospital, Greenville
4. North Greenville Hospital, Travelers Rest
5. The Cottages at Bushy Creek, Greer

"Our five campuses provide integrated healthcare to communities across Greenville County and beyond through a tertiary referral and education center, community hospitals, a long term acute care hospital, nursing home, outpatient facilities and wellness centers."

OUTPATIENT FACILITIES

- Patewood Medical Campus, Greenville [outpatient surgery, diagnostic radiology, laboratory services]
- North Greenville Medical Campus, Travelers Rest [ER, diagnostic radiology, laboratory services]
- Institute for Vascular Health, Greenville
- MD360 Urgent and Primary Care, Greenville
- MD360 Urgent and Primary Care, Simpsonville

PHYSICIANS

- 542 employed physicians
- 722 affiliated medical staff physicians (excluding employed physicians)

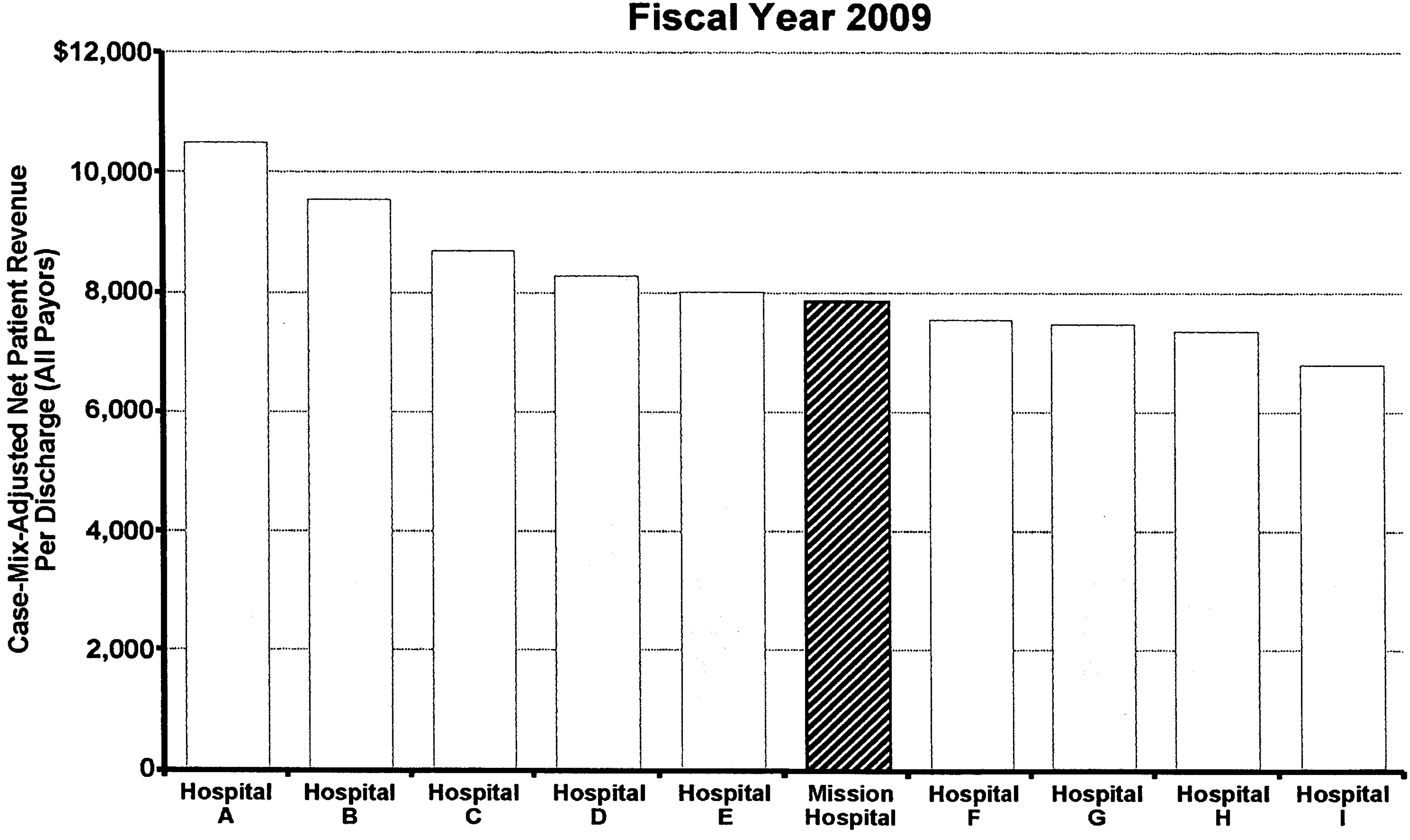
Presentation to The North Carolina House Select Committee On the Certificate of Need Process And Related Hospital Issues

WNC Agricultural Center| 10.20.2011

To Best Serve the Healthcare Needs of Western North Carolina

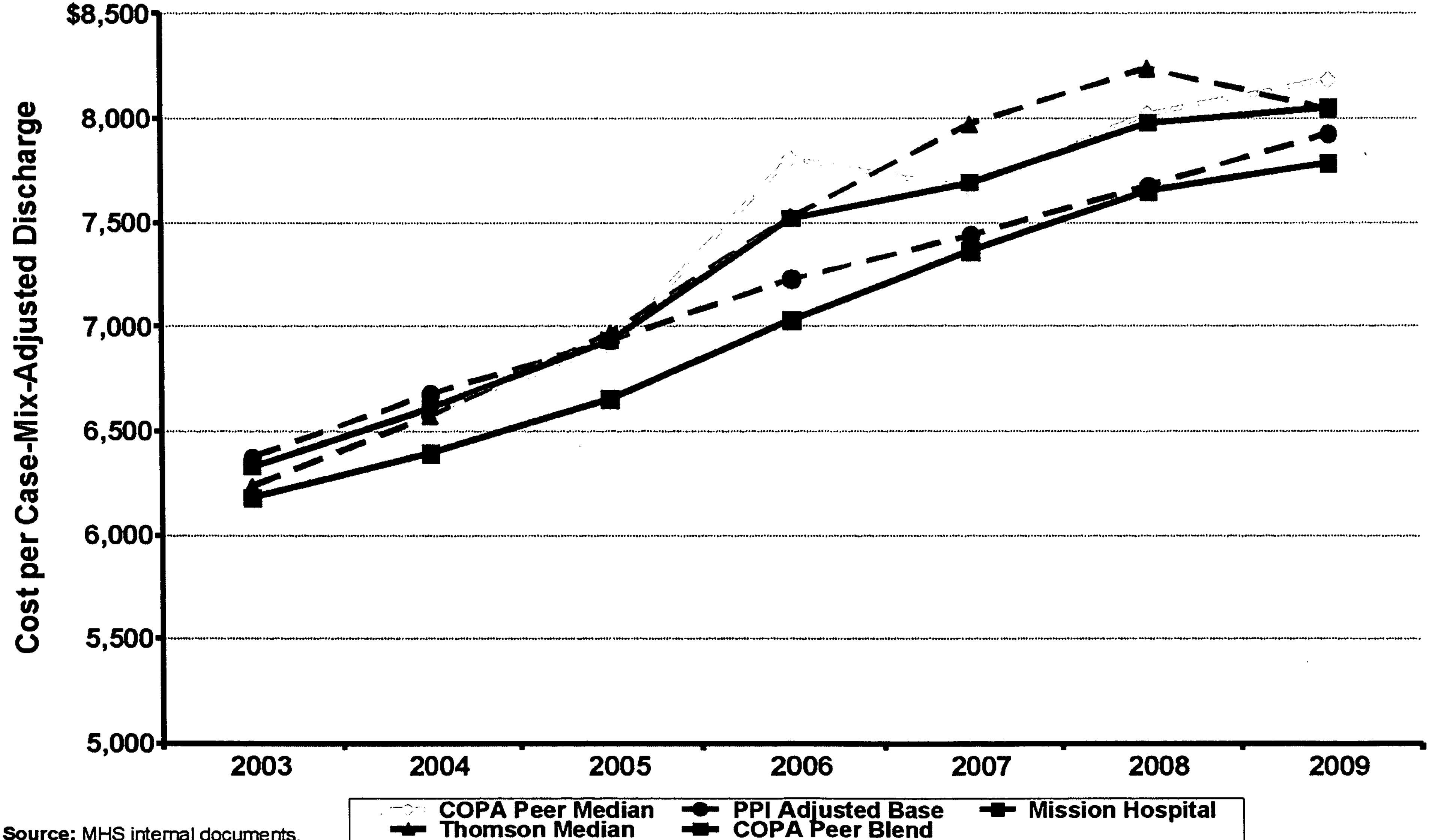
- The Certificate of Public Advantage (COPA) was the right solution—at the time.
- The COPA has been paid in full.
- The competitive landscape has changed.
- We ask for the Freedom to Serve.

Mission Hospital's Pricing
Compared with Current COPA Peer Group



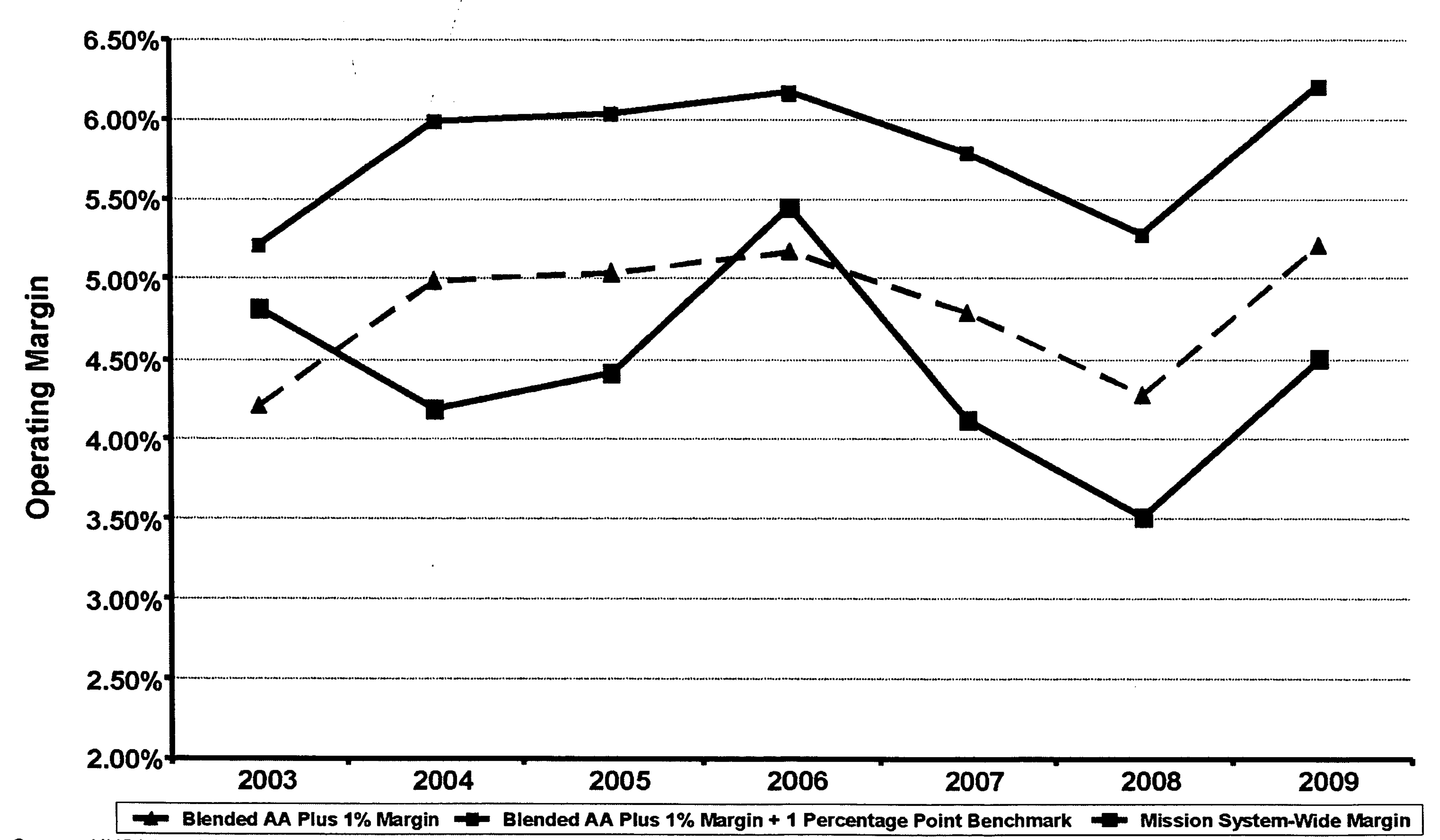
Source: Dixon Hughes, PLLC.

Mission Hospital's Cost Levels
Compared with COPA Peer Benchmarks



Source: MHS internal documents.

Mission System-Wide Margin Levels
Compared with those of AA-Rated Benchmark Hospital Systems



Source: MHS internal documents.

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ASHEVILLE CITIZEN-TIMES • VOICE OF THE MOUNTAINS

Hospitals change with economy, WNC

Hospitals have no choice but to seek economies of scale as they struggle to survive in a difficult environment. This is particular vital for Mission Hospital Systems, Western North Carolina's flagship institution.

Virtually every hospital in WNC — Highlands-Cashiers is the lone exception — has entered some sort of partnership during the past 15 years. The hospital in Andrews fought off any merger and wound up going under.

Mission has merged with hospitals in Spruce Pine and Marion and is partnering with Pardee Hospital of Hendersonville in an outpatient complex. Through a subsidiary it employs 159 physicians. It is the dominant health-care provider in WNC.

That bothers some people. "They'll duplicate all our community services to drive all the potential competitors out of business, so one day there will be a dogwood on every single hospital health care provider in this region," said Jason Wells. (Mission's symbol is the dogwood flower).

Wells is vice president of Park Ridge Hospital, which sees the Mission-Pardee center as questionable competition. The new facility will be on the Buncombe-Henderson county line, just four miles from Park Ridge.

Mission officials say they have no choice but to grow in the face of ever-decreasing Medicare and Medicaid reimbursements. By the year, 2030 North Carolina will have 19 counties in which more than 25 percent of the people are elderly. Eleven of those counties are in the mountains.

Also, as more people become insured under the new health-care law, demand for hospital services will increase and reimbursements for Medicare and Medicaid will decrease further.

Controlling medical costs is difficult. For one thing, there has been so much cost-shifting in order to provide care for 50 million uninsured people that it's difficult to determine what any given procedure should cost. The health-care law should help, but it will take time.

On top of that, medicine is a highly regulated profession. There are few places to reduce cost in the direct providing of

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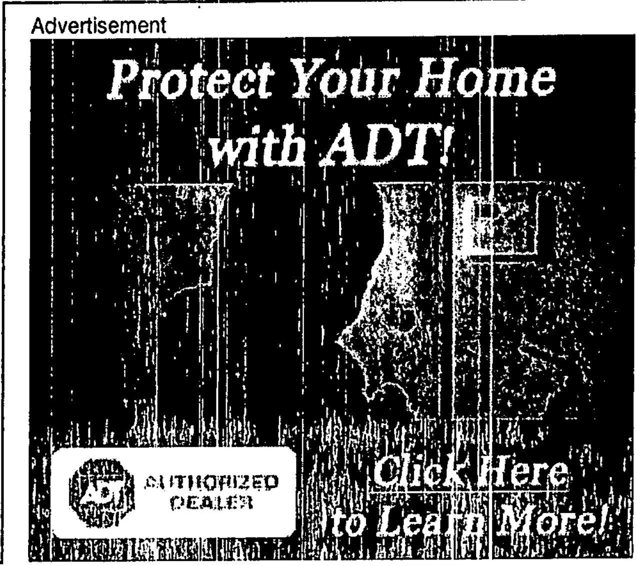

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care. An excess of exotic high-cost equipment drives costs up, not down. That's why North Carolina has a certificate of need law.

The greatest potential for savings is in such things as automation of patient records, the direct employment of physicians by hospitals and in hospital functions aside from patient care.

MedWest, which operates hospitals in Haywood, Jackson and Swain counties, now uses one company rather than five for diet, environmental and facilities engineering services, at a savings of $1 million. In all, Carolinas HealthCare System has found $15 million in savings since taking over management of MedWest.

The worst thing that could happen is the sort of political meddling exemplified by a failed General Assembly bill that would have curtailed Mission's ability to expand and to hire physicians. The idea remains under study, despite the majority party's distaste for regulation.

Mission, with its size and location and expertise, will continue to be the region's provider of much specialized and trauma care. As it strives to meet the challenges of tomorrow, it must not be unduly shackled.

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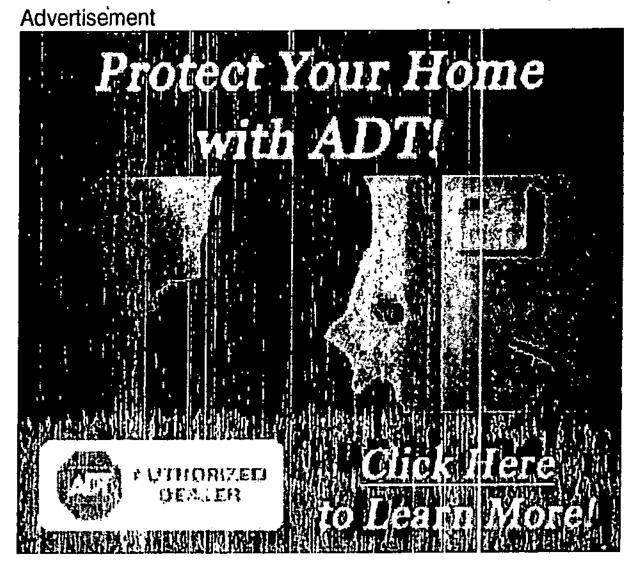

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Comments from Community Leaders Unable to Attend the

COPA Public Hearing

(Note: There were many letters from community leaders who were unable to attend the hearing. What follows are two representative letters for the Committee's review and consideration.)

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 (828) 277-4800 WWW.CAREPARTNERS.ORG

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

To:	House Select Committee on the Certificate of Need Process and Related Hospital Issues
From:	John Pierce, Vice Chancellor Finance, UNC Asheville
Date:	October 17, 2011
Subject:	Certificate of Need Process and Related Hospital Issues

I am writing this letter not as the Vice Chancellor of Finance at UNC Asheville, but as a former leader of the business community in Asheville. I cannot attend the October 20th meeting, as I am on university business in Chapel Hill. I have been the CFO of several companies in Asheville since 1987, the first of which was Beacon Manufacturing, the nation's largest blanket manufacturer, a roughly $100 million company owned by billionaire David Murdock. In the early 90's while at Beacon, I helped organize a health care purchasing coalition of self insured companies that contracted directly with the two hospitals in Asheville, Mission and St. Joseph's through their joint contracting venture, HDI. Prior to the hospital partnership formation, an aggressive listening and public speaking campaign was launched with dozens of area community groups. This was documented in Asheville's All America City award application in 1997. Asheville was one of the ten cities nationwide to win the All America City designation in 1997 and Community Healthcare Partnerships were one of three pillars upon which Asheville won the award.

Earlier, in 1992, a group of interested employers had gotten together with the Buncombe County Medical Society and the two Asheville hospitals and had agreed upon a Statement of Health Care Principles for Improved Health Care Cost Containment. One of those principles was "Minimize Cost Shifting". One of the things that we learned was the difficult payor mix, Medicare, Medicaid, and self pay, that the local hospitals faced compared to other state hospitals, and the impact of this cost shifting on the charges to local employers. The payor mix has gotten worse over the last almost 20 years, now close to 80% of Mission's reimbursements come from Medicare, Medicaid, and self pay. Given this payor mix, having a strong local hospital is critical for Asheville.

As a result, at the time, the employers wanted a solution that could reduce unnecessary duplication of services between the two hospitals, the streamlining and cost reduction that could come with a merger, combined with the price monitoring that could come with the Certificate of Public Advantage. All of these factors could lead to a significant public benefit from the two hospitals merging. Gauging the strength of Mission today in times of declining health care reimbursements, I feel that the support for the merger by the employers back in the 90's was justified. This doesn't mean that the employers didn't continue to challenge the merged hospitals for cost effective solutions as we moved into the last 10 years. Mission has fully complied with the COPA and has kept its margins and charges in line with peer hospitals, and has delivered more than $86 million in savings back to the community.

Having a fair COPA and dealing with issues such as the burden of trauma care, and the ability to compete fairly for other services that have higher reimbursement, is critical to Mission's future. Today, there are large, well-financed health systems operating in the region (Adventist Health System, Carolinas Healthcare, and others) which provide significant competition.

A major quality tertiary health system helps to attract and retain a quality workforce in Western North Carolina. Mission has been a wonderful corporate citizen to this community, and the local nature of Mission is very important to Asheville and Western North Carolina. As an example, I am chair of the Finance Committee for the YMCA of Western North Carolina. The YMCA is partnering with Mission on a program to automatically track the steps taken by Mission employees using readers installed at Mission, and the Mission employees are getting reductions on their health care premiums by participating in the program. The program is the result of innovative thinking on the part of both the YMCA and Mission. Over 2,000 Mission employees have signed up for the program which has the potential to track exercise patterns and link these patterns to the health care costs of these employees, and to their electronic medical record. This is the type of collaboration that comes with a local health care provider like Mission working closely with leading organizations in the community.

I appreciate the opportunity to share my views. Please contact me if you have questions.

Regards,

John Pierce

John Pierce
Vice Chancellor, Finance
UNC Asheville

Comments for Meeting re: COPA
October 20, 2011
By Jimm Bunch

Thank you for investing your time in this issue. My name is Jimm Bunch; I am blessed to be the CEO of Park Ridge Health, a hospital with a 101-year history in Western North Carolina. We have common ground with Mission and all other providers in the area: the improved health and wellness of our community.

Baseball fans have long recognized that the higher ones payroll, the more likely it is that a team will be successful over the long-run. In 2011 the Yankees had a payroll of $202 million, the Red Sox had a payroll of $161 million. Because of their ability to pay such high salaries, the Yankees and Red Sox have an enormous advantage and have won seven of the last 16 World Series.

Imagine that baseball decided it was in the best interest of the game for the Yankees and Red Sox to combine their resources. Well you say, "That is ridiculous and would be unfair!" Exactly and yet that is what happened here in WNC. Back in 1998, the misnamed Certificate of Public Advantage, allowed the two largest, most successful hospitals in WNC to combine. One of the most successful Civil War general was Nathan Bedford Forrest. When asked about his strategy he is quoted as saying, "Get there firstest with the mostest." When the legislature approved the COPA in 1998, they assured Mission that they would almost always get there firstest with the moistest. Getting there firstest with the mostest has been very good for Mission but what about the rest of WNC? On an average day in WNC 57% of the pts in the hospitals are at Mission. With their affiliates the number is close to 2/3. The amazing thing is this, there's only 1/3 of the pie left and their appetite has not diminished.

Before I arrived in WNC, I heard of the COPA. I mistakenly assumed it provided real protection for the citizens of WNC, I was wrong. As I read the COPA I discovered there are some but not many real protections for our citizens. However, allow me to read just one small section of the COPA.

> "If a report, or the Department of Health & Human Services, indicates that the future survival of any one of the other general acute care hospitals in the region is in jeopardy, Mission Health will be requested to evaluate the

situation and report to the Div. of Facility Services . . ." (P. 30 Amended COPA & P. 21 of 2nd Amended COPA)

You talk about the fox guarding the hen house. It's as if the state is saying, "If the local Ford dealer is in danger of going out of business, we'll ask the local Chevy dealer to investigate and provide a report." This one forces one to wonder who it was who originally wrote the COPA.

Under the circumstances in which we find ourselves, the COPA is the right vehicle; it simply needs to be changed to reflect the realities of our current healthcare environment.

Graham did a very effective job painting a picture of Mission's expansion across WNC. Here is the irony of the situation. We need Mission to be strong just not at the expense of all the communities throughout WNC, not by strangling healthcare throughout WNC and funneling more and more care to Buncombe County. Hospitals are generally huge financial engines for communities. Not only is healthcare being strangled but economic activity is shifting to Buncombe County also, from communities that can't afford to lose another job.

We believe in competition and love to compete. However, WNC should be competing against an entity with the advantages Mission had before the COPA, not the one with the extraordinary advantages they have because of the COPA. Either they are a monopoly or they are not. If they are, they should be treated as such and regulated as such. Mission should not be able to have it both ways.

Allow me to conclude my remarks with a couple quotes.

In 2005, Joe Damore, CEO of Mission stated, "We're almost like a utility rather than a hospital." March 2005 BusinessNC.com. I would remove one word (almost) and I'd agree with Joe Damore, because of the advantages the COPA has afforded to them they are really a utility and should be treated as such.

August 4, 2004 The Asheville Citizen-Times headline read "McDowell Hospital to join with Mission". In the article, then CEO Bob Burgin was quoted as stating, "The agreement allows Mission to expand its referral network" and "prevent another provider from entering a local market." I believe what Mr. Burgin was

saying is, 'we like the healthcare landscape and want to do all we can to keep anyone from challenging Mission in WNC.'

In June 2009, a letter was sent from 12 physician groups to the board of Mission Hospital. The letter described the then current CEO as preferring "control and domination" instead of "partnership and collaboration". The question must be asked, since that letter was sent has Mission changed? Are they now moving aggressively into all parts of WNC in a spirit of collaboration or domination? That ultimately is what you must decide. I have my opinion and Mission has theirs. Fortunately the only opinion that matters is yours.

Introduction:

Good evening. My name is Graham Fields and I'm grateful for this opportunity to address such a distinguished group of legislators. As a former Western State Director for US Senator Elizabeth Dole, I know firsthand the vital role our state legislature plays to solve problems impacting the citizens they represent and how legislators are sometimes called upon to address issues when another branch fails to meet its responsibilities.

Simply put, we are here today because we believe the State of North Carolina has failed to fully enforce and manage the Certificate of Public Advantage (COPA) it entered into with Mission Health System in 1995.

I'm here this evening representing the Western North Carolina Community Healthcare Initiative—a grassroots group of physicians and healthcare providers who have been impacted by Mission's actions and the State's lack of oversight.

The group's goal is simple: to modify the existing COPA to better reflect the region's rapidly changing healthcare landscape and extend it to Mission's true service area.

Mission spent a lot of time talking about itself and extolling its own virtue. What you didn't hear is what it's like for patients, physicians and providers living in the shadow of a monopoly.

Truthfully, I agree with much of what Mission said about its work in the region. We have never questioned whether Mission is a good hospital. In fact, I believe Mission is an excellent hospital, but simply being a quality provider does not exempt an organization from basic anti-trust laws or excuse predatory behavior.

A benevolent dictator is a dictator nonetheless.

On the surface, Mission's comments appear to be a glowing overview of the hospital system's contributions to our community, but just below the surface, they may be a veiled *threat*—a *threat* to *this committee*, our community and *other healthcare providers*.

Listen carefully to what they're saying. I believe the true message might actually be: "We've made all of you dependent upon us. We're too critical to this region for you to even dare consider the necessary modifications to preserve choice and competition in the region"

Mission has actually suggested that you consider scrapping the COPA altogether. Should any of be surprised that a monopoly would ask for nothing short of everything? Instead of thoughtfully exploring ways to collaborate with other providers, Mission has devoted its considerable resources to ensuring that it is never challenged and the State never truly investigates its activities under the COPA.

This is what happens when monopolies go unchecked and I don't think it's the intention of this committee to further empower a monopoly.

If Western North Carolina were a normal healthcare market, I would agree with Mission that competition should dictate future expansion, affiliation and acquisition. **But this is not a normal situation.**

Free markets should be free of **monopolies** and **coercion**.

Unfortunately, Western North Carolina seems to have both.

Mission is a monopoly.

You don't have to take my word for it. That's what Mission's Director of Marketing said at conference in Arizona recently.

Listen as she shares her thoughts on Mission's market position:

"There was a lot of talk about the fact that we are a monopoly, and we are. We're kinda the five hundred pound gorilla in Western North Carolina"

Let's hear that statement one more time.

I think that quote speaks for itself.

I also mentioned that **coercion** may have been introduced into the Western North Carolina healthcare market.

Recent public comments from hospital leaders exploring a possible joint-venture with Mission clearly reflect how local providers feel they have no choice but to acquiesce to Mission Health System.

Pardee Hospital Board Chairman Bill Lapsley shared the following comment in a presentation to the Henderson County Board of Commissioners:

"If Pardee does not participate in this project (the proposed county-line facility), Mission will proceed on its own and attract Pardee's existing patients."

New Pardee CEO Jay Kirby volunteered the rationale for ultimately exploring this project in comments shared with a local Rotary club and the Henderson County Board of Commissioners.

As you listen, please keep in mind that Mr. Kirby is a seasoned healthcare executive and Pardee Hospital is the second largest hospital in Western North Carolina.

"He who holds the gold makes the rules and Mission holds the gold."

"Rest assured, if Mission Hospital wants to own Pardee Hospital, it will, and if it (Mission) wants to own Park Ridge Hospital, it will. It'll take its $550 million, buy up the physicians in the area and open up retail outlets and send everything back to Asheville."

"No matter what I say, no matter what Mr. Bunch (CEO of Park Ridge) says, no matter what these fine folks in this community say, Mission Hospital is going to build a building with or without endoscopy. Period." (1:52)

"I would rather join someone (Mission) who has $550 million than compete against someone who has $550 million."

I think these comments really tell the story. This unmodified COPA has all but removed true competition from our market.

Physicians:

Area physicians have also been profoundly impacted by Mission's actions.

You might ask yourself, if so many providers have been negatively affected by Mission's aggressive behavior, why more physicians aren't with us tonight to share their experiences. The simple reason is fear.

For many area doctors Mission is both the poison and the pathology—a fierce competitor that is both the only place to practice and the only back-up plan for possible employment. To speak out against Buncombe County's only hospital would be akin to drilling a hole in their lifeboat.

The unfortunate reality in the region is that the more physicians become dependent on Mission for survival, the more patients in the area become dependent on Mission for survival and that's an unhealthy equation indeed.

Patients:

The truth is, this whole discussion comes down to patients—the people who live here.

Mission's activities are not just squelching completion in the region, they are potentially endangering patients.

Area hospitals not owned by or affiliated with Mission Health System recently received a disturbing letter informing them that Mission—the region's tertiary care provider—will no longer offer its lab to assist with complicated blood matching cases.

Local hospitals will now be forced to send these samples to Charlotte or Greenville, potentially forcing very ill patients to wait days for surgery.

Judging from this letter, Mission appears comfortable to severely inconvenience patients in a poorly veiled attempt to punish competitors and reward allies.

Closing:

The fact is, you don't have to be an attorney, an economist or an accountant to know how Mission's government-sanctioned monopoly impacts our lives.

The COPA is *vital* to protecting patients, physicians and hospitals in the area.

In preparation for today's meeting, Mission's website and social media outlets challenged the community to: "imagine Western North Carolina without Mission Children's Hospital, the neonatal intensive care unit (NICU) and Mission's MAMA helicopter," implying that true compliance with the COPA would mean the region loses vital, beloved institutions.

These assertions are **patently untrue**—scare tactics designed to mask the real issue and confuse the public.

Mission sought this COPA to avoid federal anti-trust violations and it was understood that it would evolve over time as the region's healthcare landscape changed. The process of examining and potentially updating this critical contract with the people of this region should be a healthy process for Mission and the community.

Contrary to Mission's assertion, **the COPA has not outlived its usefulness; in fact, it has only outlived their usefulness.**

We have an opportunity to reexamine the COPA and ensure that the "advantage" it provides shifts from Mission back to the patients of Western North Carolina as it was originally intended.

Our humble request is that this committee would simply consider *modifying* the exiting COPA to better reflect Western North Carolina's rapidly changing healthcare landscape and then *extending* it to Mission's entire service area.

Several years ago, I was lucky enough to have my water heater explode. I hope none of you have had this experience. Water was gushing from a huge hole in the tank and the ensuing flood threatened to destroy all my prized treasures in the garage. I still remember my panicked call to a plumber. In my frenzy to bail water, I forgot the most important step. He reminded me to *turn the water off*.

When you consider the COPA, please don't forget to *turn the water off* while you study this important issue. Mission is moving rapidly to complete a series of

aggressive expansion projects in the region to avoid the scrutiny of this committee. Please ask them to **pause** these projects until they can be evaluated under a newly modified COPA.

Good evening and thank you for the opportunity to speak. My name is Brian Quaranta. I am a board-certified radiation oncologist with 21st Century Oncology, and I have been practicing in this area since 2005. I am on the medical staff at Mission Hospital, have had good relations with them, and believe that a strong Mission Hospital is important for our community.

I also believe that it is vitally important for our community to have high quality cancer care available at local facilities throughout western North Carolina. This is my area of expertise and is where I will concentrate my remarks.

Most people in attendance will have someone close to them who has undergone treatment for cancer. As you may know, there are three primary ways to treat cancer; surgery, chemotherapy, and radiation therapy. Surgery is typically a single event, and chemotherapy schedules vary considerably, but radiation is notable for requiring multiple treatments on a daily basis; typical schedules would be anywhere from 10 to 45 treatments given over 2 to 9 weeks, Monday through Friday. Side effects vary depending on the area being treated, but can include nausea, skin reactions, diarrhea, and fatigue, among other problems. Many patients are also in significant pain as a result of their illness. As you can imagine, patients who are suffering from their illness and from side effects do not want to add a lengthy commute to their daily plans.

Prior to moving to Asheville, I was on the faculty of Duke University Medical School. The Duke radiation oncology department recognized the need for quality care in local communities, and while I was there I would make trips out to Raleigh, Henderson, and even Martinsville, VA, to provide care at our local clinics in those areas. Part of the appeal of the WNC 21st Century Oncology practice was that there was a similar model in place. We provide radiation at seven facilities throughout Western North Carolina.

[[show map]]

Each of these cancer treatment centers was developed with the support of the local hospital and physicians. Our practice has installed state-of-the-art equipment in each of these centers, enabling patients to receive carefully targeted radiation delivered with a high degree of precision. These centers are equipped to equal or exceed the technology available at any other center in the area.

My six years of practice in this area have only reinforced my impression of how important it is to make radiation treatment available locally. I was surprised to find that patients in this region are even more concerned with travel than in my previous experience. Many of our patients are elderly and find the steep and winding roads treacherous to drive on, and snowy winters make lengthy daily travel particularly concerning. Other patients are unable to drive and have to rely on family members who are working to take them to their treatments; still others are doing well enough that they can work themselves, as long as they can make the time to fit the treatment in. All of these problems are greatly reduced by making treatment available as close as possible

to the patient. If an extra hour of drive time in each direction is added, the daily grind of radiation can become too difficult, and patients can miss out on important cancer treatment.

While it may seem obvious, actual scientific data supports these assertions. Studies published in Cancer Causes & Control in 2006, and the Journal of Clinical Oncology in 2005, demonstrated that living more than 20 miles from a radiation treatment center was a frequent cause for women with breast cancer to choose a full mastectomy over the generally preferred treatment of lumpectomy plus radiation, or to avoid needed radiation after a lumpectomy. In another study, conducted by physicians from Harvard Medical School, they concluded:

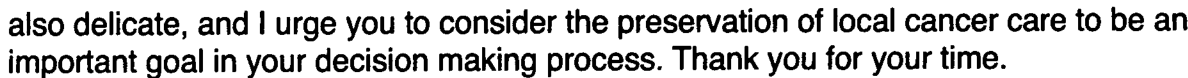
"Oncologists must be cognizant of the potential barrier to quality care that is posed by travel distance, especially for elderly patients; and policy makers should consider this fact in resource allocation decisions about radiation treatment centers"

Finally, I want to mention that our multiple centers allow us to provide local care for our veterans. We are the provider of radiation therapy care for the Asheville VAMC, which draws oncology patients from a very large area. Our local presence allows patients who travel long distances to Asheville for their diagnosis, to receive their treatment close to home. In times when so many are struggling economically, and gasoline costs over $3.00 per gallon, I cannot overstate how important this is to our patients.

As you know, Mission hospital has recently completed construction of a new $59 million cancer center. You are also probably aware that the new center has caused considerable controversy among our community's physicians on a number of fronts. From our perspective, one concern is that the development plan stated that the radiation oncology department was to be the economic driver of the cancer center. It is difficult to understand how such a large project could be funded primarily by the radiation department without bringing in many patients from the outlying communities.

Having practiced in these communities, I know how grateful the patients are to be able to have their treatment done locally. Most would not voluntarily choose to come to Asheville each day for treatment. And if there was some plan in place for diverting these patients to the new Mission cancer center, the decreased patient volume would create a considerable threat to our small local centers, very possibly forcing closure of some or all of them; a circumstance which would remove even the option for patients to receive care locally, and would inevitably lead to some patients missing out on vitally important care.

Ladies and gentlemen, academic studies as well as common sense support the notion that it is important for patients to have access to radiation treatment in their local community. Patients in Western North Carolina are fortunate in that they already have a large network of local centers, where well trained physicians provide high-quality radiation therapy using cutting edge technology. While this situation is beneficial, it is


also delicate, and I urge you to consider the preservation of local cancer care to be an important goal in your decision making process. Thank you for your time.

Good evening. My name is Gail Cummings and I am a Western North Carolina Regional Administrator for 21st Century Oncology. I have worked for the company for thirty-four years and I am also a Registered Radiation Therapist. Previously I was the Technical Director for all our US operations. One of my responsibilities was to go to our various sites to open new locations so I have treated cancer patients in our facilities throughout the country. I also have significant experience in the business side of the delivery of cancer services.

My purpose in speaking this evening is to be certain that you are aware of the repercussions to our cancer patients who live outside of Buncombe County, which will develop over time with the opening of the Mission cancer building. This fifty-nine million dollar building, equipment and staff cannot be supported by the cancer patients that live in Mission's primary service area of Buncombe and Madison County. Cancer patients from throughout the Western North Carolina region will have to be drawn away from their communities to meet the financial demands of operating such a facility. This will be accomplished through slick marketing campaigns and the strategic placement of Mission's "fraternity physicians" who will funnel the patients to Asheville, bypassing quality treatment in their local communities.

Cancer patients face great difficulty when they do not have a radiation treatment facility in their local community. In my experience and the company's experience, cancer patients will opt for no treatment or a reduced course of treatment if they have to travel farther than 20 miles away from home. Dr. Quaranta has previously noted peer reviewed studies that support this conclusion. This is particularly true if the region is mountainous or if the winter climate is harsh as it is in our Western North Carolina region. An average treatment course is administered five days a week for anywhere from a two to nine week period. The patient's are often already weakened, many are elderly and many have recently finished a course of chemotherapy. This makes it difficult for them to drive themselves, so often family members have to miss work to bring them. The travel time and distance to treatment also increase expenses. A younger patient with a family cannot take the extra time from work or parental responsibilities to travel outside their community for treatment. In fact, patients treated at our seven centers often ask if we can bring a treatment facility even closer to their homes.

Healthcare is local and should remain that way. Our facilities have the most advanced accelerators, on site medical physicists, nationally recognized in-house systems for quality control, dedicated Board Certified physicians and registered staff, all at a location convenient for the patients. However, all seven of these local cancer treatment facilities are at risk for closure if Mission continues with its stated operational plan. Mission should not be allowed to prey on our regional cancer patients and use them as the financial engine to pay for the cancer building that has little to no support from the cancer specialists in the area. It is time for the State to supervise the COPA and take an in-depth look at the monopoly they have created.

On behalf of 21st Century Oncology and cancer patients from throughout the region, I want to thank you for your commitment and dedication to this task.

Thank you.

I would like to speak with you this evening about Mission's abuse of the COPA (Certificate of Public Advantage), a law that was enacted at their request to protect the citizens of WNC from monopolies and high medical prices. We would not be here if they had not broken their pledge and trust to the people of WNC. Dr. Greg Vistnes, a noted economist who was hired at the request of Mission, also believes they have played a shell game, telling everyone about their low charges while receiving high reimbursements.

My name is Nathan Williams, MD. I have practiced Gyn Oncology for 28 years at Mission Hospital. I started Hope Women's Cancer Center in 1991. Our practice has 6 physicians, 92 employees and treated over 900 new patients with cancer this past year. I have been intrinsically involved in the insurance aspects of our practice and the business of medicine. I know how hard it is to build up reserves and make capital purchases if you are a hospital or medical practice in North Carolina. Yet Mission has made hundreds of millions of dollars, using it to purchase land, buildings, and hospitals. How can they do that with a 4 to 5 % margin on their business as they report? However, there is only one issue tonight that is important .... that is the violation of the COPA by Mission Hospital. The monies they have garnered have been from the toil and sweat of the average working citizen and the multiple small businesses of WNC.

Dr. Vistnes, the economist, notes that the State gave Mission a significant monopoly with unprecedented access to power in WNC. Over time they have felt that they have the right to compete like other large medical systems in the state. They tell everyone "we need to merge to survive" and that is not true. Mission Hospital is not like any other hospital in North Carolina. By being a monopoly and also having made a pledge of public trust called the COPA, they have promises to keep. They do not have the right to act like the Carolina's Medical System or Novant.

According to Dr. Vistnes they have been incentivize to circumvent the safe guards in the COPA in a number of ways. One is by negotiating higher payments from insurers. It appears they have a special deal with Blue Cross that allows them to collect a higher percent of dollars than Physicians and other hospitals in our region. All of us know in the business of medicine that it doesn't really matter what you charge. The real issue is "THE DOLLARS YOU COLLECT". You can submit a lower charge but if your contract allows you to collect a higher percent, you make more money. Rather than reporting this windfall Mission just increases its spending and acquisitions looking as if they do have only a 4 to 5 % margin. These extra dollars have come from the pockets of the people of WNC. It has allowed

Mission to build an unprecedented empire at a rapid rate, at the direction of the board and at the expense of our patients.

It also appears they may have violated the percentage of MDs they are allowed to employ or have exclusive contracts with. Mission physicians rely on referrals. In the past it was a benevolent relationship with the region's hospitals and providers. Over time they became greedier wanting not only the patients with specialized needs but they wanted all the patients who are the very life blood of a small hospital or a private practice. Mission has a powerful incentive to employ as many physicians as it can to make sure its services are kept as busy as possible. I and others have been told a number of times ...that once Mission owns enough practices in the region...those of us in private practice will not be able to survive. I agree with them on this. Let me repeat that. I and others have been told a number of times....that once Mission owns enough practices in the region...those of us in private practice will not be able to survive. I agree with them on this.

Mission has told my group that they can increase our reimbursement by as much as 20% if we join them. At the same time, Mission has vigorously sought to reduce its payments to physicians in private practice. This is a laudable goal if the ultimate purpose is to reduce the cost to the patient, but I have seen no evidence that is the case. Dr. Vistnes says that Mission cannot force any physician into an employment relationship, but this is not really true. Mission uses a "Carrot and Stick" approach, which is a powerful incentive for many physicians in these times of decreasing reimbursements to their practices. The "Carrot" is the prospect of higher reimbursement and the "Stick" is the threat of lost patient referrals due to Mission's expansion into Buncombe, Madison, Yancey, Mitchell, Transylvania, Henderson, Graham and McDowell Counties.

Hopes story: We met a few years back with the former CEO of Mission, in hopes that we could develop a better relationship that was less destructive to our practice. As we talked I mentioned the amount of money we had invested in fighting with Mission over CON issues. He stated that there were some issues we would always compete over... I asked him how he would feel if we opposed his CON application for a new outpatient facility he was planning at the Buncombe - Henderson county line. He paused and told me and my group he would "CRUSH US". I said we would still consider it. He said he would bring in GYN Oncologists to compete with us. He made it crystal clear that anyone who attempted to challenge Mission or compete with Mission would pay a price. With the Mission Board's support he was a man of his word. They defeated our Declaratory filling for a PET/CT and MRI at our office in 2008 and they have continued their plan to monopolize

oncology services by recently completing their Cancer Center in spite of the many concerns raised by the Oncologists and other physicians. The committee may wonder why has Mission not been challenged more during the years? Mission has far deeper pockets than any of us providers, so that they are able to outspend any or all of us because the violation of the COPA has lined their pockets.

With the recent association between the University of North Carolina and Mission, we have real concerns that the added payments from the government will place on all of us.....patients, businesses and private practice physicians alike at an even greater disadvantage.

The State of North Carolina has an important role and responsibility to supervise Mission's conduct because of the COPA. They cannot just allow them to let the COPA go away. They have made and broken promises to the people of WNC. There has been significant harm done already. The State has not been supervising Mission under the COPA. Dr. Vistnes' report contains a number of useful recommendations that purposefully have not been implemented by Mission. These recommendations would help in a small way, to level the playing field for those providers who have had to operate under a more restrictive set of rules. I would recommend that the State adopt all of these recommendations as well as maintain the 20% physician cap which I believe should also expand to other counties to protect consumers and small business. If the COPA is not enforced or is allowed to go away, we, the citizen of WNC, will have been done irreparable harm by allowing this state sanctioned monopoly to continue.

I want to thank you all for allowing me to speak this evening and I want to thank the committee for taking on this most important task of true over sight of the COPA.

Nathan E. Williams, MD

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ORIGINAL PAPER

Travel distance and season of diagnosis affect treatment choices for women with early-stage breast cancer in a predominantly rural population (United States)

Maria O. Celaya · Judy R. Rees · Jennifer J. Gibson · Bruce L. Riddle · E. Robert Greenberg

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Abstract
Objective Current standards of care for early-stage breast cancer include either breast-conserving surgery (BCS) with post-operative radiation or mastectomy. A variety of factors influence the type of treatment chosen. In northern, rural areas, daily travel for radiation can be difficult in winter. We investigated whether proximity to a radiation treatment facility (RTF) and season of diagnosis affected treatment choice for New Hampshire women with early-stage breast cancer.
Methods Using a population-based cancer registry, we identified all women residents of New Hampshire diagnosed with stage I or II breast cancer during 1998–2000. We assessed factors influencing treatment choices using multivariate logistic regression.
Results New Hampshire women with early-stage breast cancer were less likely to choose BCS if they live further from a RTF ($P < 0.001$). Of those electing BCS, radiation was less likely to be used by women living >20 miles from a RTF ($P = 0.002$) and those whose diagnosis was made during winter ($P = 0.031$).
Conclusion Our findings indicate that a substantial fraction of women with early-stage breast cancer in New Hampshire receive suboptimal treatment by forgoing radiation because of the difficulty traveling for radiation in winter. Future treatment planning strategies should consider these barriers to care in cold rural regions.

Keywords Breast cancer · Breast-conserving surgery · Geographic factors · Radiotherapy · Season

Introduction

Most women with early-stage breast cancer have a choice between two roughly equivalent treatment options: either breast conserving surgery (BCS) followed by radiation therapy (RT), or a modified radical mastectomy (MRM) [1, 2]. Both approaches have been shown in randomized clinical trials to result in similar long-term survival [3–6]. BCS without subsequent radiation carries an increased risk of local recurrence, and current guidelines recommend against this approach [2].

Previous studies have shown that the use of BCS and post-operative radiation is influenced by age [7–10], psycho-social factors [11–13], and hospital characteristics [14–17]. Ease of access to treatment may also affect treatment choice for rural patients with cancer [12, 18–21]. Geographic factors, particularly proximity of treatment facilities to patients' residence may play a role in treatment choice for rural patients with cancer. In a study of lung cancer patients in New Hampshire and Vermont, Greenberg et al. [18, 19] found that patients living further from a radiation therapy unit were less likely to receive radiation for their disease.

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We assessed whether distance from a radiation treatment facility (RTF) and season of diagnosis affected choice of treatment among women with early stage breast cancer in New Hampshire, a state with a largely rural population [22] and which is noted for severe winter weather [23].

Materials and methods

Data collection

We identified women for study from the population-based New Hampshire State Cancer Registry (NHSCR). This statewide cancer surveillance program collects information on cases of *in situ* and invasive cancers seen and/or treated in the 27 hospitals and by other health care providers in New Hampshire and also receives data for state residents with cancer who are cared for in the three adjacent New England states, as well as Florida, New York, and other states with cancer registries. The quality of case reports and the case completeness of data meet standards set by the North American Association of Central Cancer Registries (NAACCR) [24]. Our study population consisted of all women residents of New Hampshire who were diagnosed between 1 January 1998 and 31 December 2001 with breast cancer histology and morphology codes 8500–8543 defined by ICD-O-2 for cases diagnosed in 1998–2000 and ICD-O-3 for cases diagnosed in year 2001. We excluded women diagnosed at autopsy or identified only through death certificates. The American Joint Commission on Cancer (AJCC) staging group was used to classify cases by stage. Each case had either a pathologic or clinical AJCC stage group, and these were pooled into a combined stage group. Cases were defined as early-stage if the AJCC stage group was I–IIB (Fig. 1).

The treatment types studied were first course of surgery and radiation. Surgical treatment was categorized as BCS and non-BCS, regardless of whether axillary lymph node dissection was performed. BCS included partial mastectomy, nipple resection, lumpectomy, re-excision, wedge resection, tylectomy, quadrantectomy, and segmental and subcutaneous mastectomies. Non-BCS consisted of total/simple, radical and extended mastectomies. Only the most definitive surgical treatment within each type was considered. For example, if a patient had both BCS and non-BCS, the non-BCS was considered to be the most definitive. We collected information about possible predictors of treatment choices, including patient residence, date of diagnosis, marital status, age, presence of multiple primary cancers, and tumor stage and size. We classified the season of diagnosis as winter (December–February) or non-winter (March–November). Marital status was defined as married or unmarried (single, separated, divorced, or widowed). We defined women as having their first primary cancer (sequence 00 or 01) or multiple primaries (sequence 02–04) based on data in the registry.

Proximity of residence to radiation therapy facilities

We identified all facilities providing radiation treatment in New Hampshire (5), Maine (5), Massachusetts (30) and Vermont (3) during the years 1998–2001 [25–28]. Each facility and the addresses of the patients were geocoded by Geographic Data Technology (GDT) of Lebanon, NH to an exact street address (n = 2292; 80.1%), or to the zip code centroid if only a post office box or rural route address (n = 569; 19.9%) was provided. The shortest straight-line distance to a RTF was estimated for each case [29]. Of the 38 candidate RTFs, 9 were the nearest to at least one patient in the study (5 in NH, 3 in MA, and 1 in ME).

Statistical analysis

We performed simple descriptive analyses for all variables as well as tabulations of their treatment choices. We used univariate analyses (chi-square) to test the variables for statistical significance in relation to BCS and post-BCS RT. We then calculated odds ratios and 95% confidence intervals with multiple logistic regression to identify factors that determine treatment choices for women with early-stage

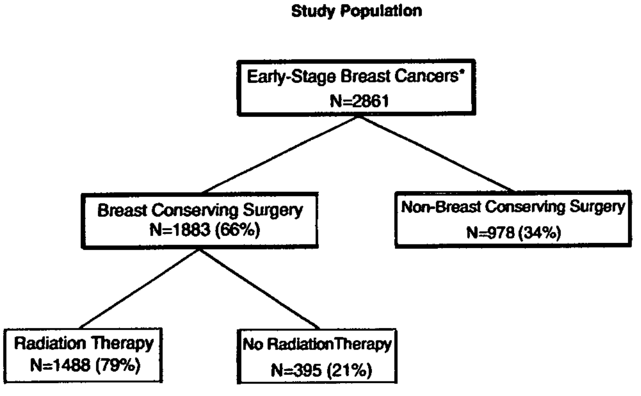

Fig. 1 Choice of treatment among New Hampshire women diagnosed with early-stage breast cancer in 1998–2001. *Includes only New Hampshire women identified as having had surgical treatment

breast cancer. Statistical analyses were performed using SPSS for Windows version 11 [30] and SAS statistical software [31].

Approval for the study of human subjects

This study was reviewed and approved by the Institutional Review Boards of Dartmouth College and the University of New Hampshire. Authorization was also granted by the State of New Hampshire, Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management.

Results

The mean age of patients was 61 years (range 24–101). The mean distance between patient residence and the nearest RTF was 15.1 miles (range 0.1–89.9; median 13.9). Almost one quarter of patients lived ≥20 miles from the nearest RTF. Of the 1,883 (65.8%) women who were treated with BCS, 79% received post-operative RT. Of the 978 (34.2%) women who had non-BCS, 17.8% also had RT. Overall, 1,662 women (58.1%) had RT as part of their initial therapy.

In univariate analyses the shortest distance to a RTF ($P \le 0.001$), smaller tumor size ($P \le 0.001$), lower stage ($P \le 0.001$), first primary cancer ($P \le 0.001$), and age 75 or older ($P = 0.001$) were all predictors of women undergoing BCS. Diagnosis in the winter ($P = 0.740$) and marital status ($P = 0.188$) were unrelated to the choice of BCS. Even so, we included these two variables in our multivariate regression analysis given their relevance to this study.

In the multivariate model, we confirmed that women were less likely to have BCS with increasing distance from residence to RTF ($P < 0.001$), higher stage disease ($P \le 0.001$), increasing age ($P = 0.003$) or previous primary cancer (OR = 0.56, 95% confidence interval [CI] 0.45–0.71). Diagnosis in the winter ($P = 0.907$) and marital status ($P = 0.551$) remained unrelated to the choice of BCS (Table 1). Interactions between distance and the patient's

Table 1 Factors predicting BCS in 2795 New Hampshire women diagnosed with early-stage breast cancer in 1998–2001

	Total		BCS		Non-BCS		Adjusted OR (95% CI)[a]	p value
	No.	%	No.	%	No.	%		
Age at diagnosis								0.003
≤44	349	100.0	219	62.8	130	37.2	1.00	
45–54	670	100.0	457	68.2	213	31.8	1.11 (0.83–1.47)	0.480
55–64	598	100.0	427	71.4	171	28.6	1.30 (0.97–1.74)	0.082
65–74	637	100.0	402	63.1	235	36.9	0.83 (0.62–1.10)	0.195
≥75	541	100.0	337	62.3	204	37.7	0.86 (0.64–1.17)	0.347
Marital status[b]								
Married	1,776	100.0	1,190	67.0	586	33.0	1.00	
Not married	1,019	100.0	652	64.0	367	36.0	0.95 (0.79–1.13)	0.551
Primary sequence								
1st primary	2,429	100.0	1,635	67.3	794	32.7	1.00	
Subsequent primary	366	100.0	207	56.6	159	43.4	0.56 (0.45–0.71)	<0.001
Distance (mi.)								<0.001
0 to <20	2,089	100.0	1,426	68.3	663	31.7	1.00	
20 to <40	546	100.0	324	59.3	222	40.7	0.65 (0.53–0.79)	<0.001
40 to <60	130	100.0	79	60.8	51	39.2	0.77 (0.52–1.12)	0.176
≥60	30	100.0	13	43.3	17	56.7	0.31 (0.15–0.65)	0.002
Time of Year—Dx								
Non-winter	2,103	100.0	1,388	66.0	715	34.0	1.00	
Winter	692	100.0	454	65.6	238	34.4	1.01 (0.84–1.22)	0.907
Tumor size (cm)[b]								0.133
<1	669	100.0	486	72.6	183	27.4	1.00	
1 to <2	1,213	100.0	863	71.1	350	28.9	1.01 (0.81–1.26)	0.915
2 to <5	858	100.0	472	55.0	386	45.0	0.87 (0.65–1.17)	0.370
≥5	55	100.0	21	38.2	34	61.8	0.49 (0.26–0.92)	0.027
Stage at Dx								<0.001
I	1,700	100.0	1,244	73.2	456	26.8	1.00	
IIA	747	100.0	451	60.4	296	39.6	0.57 (0.45–0.72)	<0.001
IIB	348	100.0	147	42.2	201	57.8	0.28 (0.20–0.39)	<0.001

Note: In this analysis there was no significant interaction between the distance variable and the patient's age

[a]Odds ratios (OR) and 95% confidence intervals (CI) calculated using multiple logistic regression analysis, with all variables included

[b]Cases with unknown marital status ($n = 58$) and unknown tumor size ($n = 8$) excluded for the logistic regression model

age, and distance and winter diagnosis were not significant predictors in the model.

Following BCS, 395 women did not have RT; among this group, 22% (n = 87) had adjuvant chemotherapy, and 23% (n = 90) had adjuvant hormonal therapy. Univariate analysis showed that post-BCS RT was less likely in women diagnosed in the winter (P = 0.019) and those living further from the RTF (P < 0.001). Married women and women with no history of were also less likely to have RT (P < 0.001). Among women choosing BCS, stage did not affect whether they defaulted from RT (P = 0.962).

Using the same variables, we developed a multivariate logistic regression model for women who had BCS (Table 2). Patients were less likely to have radiation after BCS with increasing distance from residence to RTF (P = 0.002); diagnosis in winter months (OR = 0.75, 95% CI 0.57–0.97); age ≥75 (OR = 0.41, 95% CI 0.27–0.63); unmarried status (OR = 0.65, 95% CI 0.50–0.83); previous primary cancer (OR = 0.60, 95% CI 0.43–0.84), or tumor size 2–5 cm (OR = 0.76, 95% CI 0.50–1.17). There was no statistically significant interaction between distance and age or distance and winter diagnosis.

Discussion

Our study confirms previous findings that the choice of BCS may be influenced by the distance a patient lives from the nearest RTF [12, 20, 21]. We also found that, among women treated with BCS, those diagnosed during the winter months and those living more than 20 miles from a RTF were less likely to receive post-operative radiation. The use of BCS without radiation may put women at increased risk of recurrence [6] and lower survival [32]. However, the choice of treatment may not be completely clear-cut, especially for women over 70 who also receive adjuvant treatment [33–35].

One previous report, based on older women in 10 northern states, assessed the effects of season on therapy choice in breast cancer and noted no association overall

Table 2 Factors predicting RT following BCS in 1842 New Hampshire women with early-stage breast cancer in 1998–2001

	Total		RT		No RT		Adjusted OR (95% CI)[a]	P value
	No.	%	No.	%	No.	%		
Age at diagnosis								<0.001
≤44	219	100.0	178	81.3	41	18.7	1.00	
45–54	457	100.0	393	86.0	64	14.0	1.40 (0.90–2.18)	0.131
55–64	427	100.0	364	85.2	63	14.8	1.41 (0.90–2.19)	0.131
65–74	402	100.0	330	82.1	72	17.9	1.17 (0.75–1.82)	0.483
≥75	337	100.0	198	58.8	139	41.2	0.41 (0.27–0.63)	<0.001
Marital status[b]								
Married	1,190	100.0	997	83.8	193	16.2	1.00	
Not married	652	100.0	466	71.5	186	28.5	0.65 (0.50–0.83)	0.001
Primary sequence								
1st primary	1,635	100.0	1,322	80.9	313	19.1	1.00	
Subsequent primary	207	100.0	141	68.1	66	31.9	0.60 (0.43–0.84)	0.003
Distance (mi.)								0.002
0 to <20	1,426	100.0	1,156	81.1	270	18.9	1.00	
20 to <40	324	100.0	246	75.9	78	24.1	0.71 (0.52–0.96)	0.025
40 to <60	79	100.0	55	69.6	24	30.4	0.51 (0.30–0.87)	0.013
≥60	13	100.0	6	46.2	7	53.8	0.24 (0.07–0.78)	0.017
Time of Year—Dx								
Non-winter	1,388	100.0	1,119	80.6	269	19.4	1.00	
Winter	454	100.0	344	75.8	110	24.2	0.75 (0.57–0.97)	0.031
Tumor size (cm)[b]								0.002
<1	486	100.0	377	77.6	109	22.4	1.00	
1 to <2	863	100.0	714	82.7	149	17.3	1.47 (1.10–1.97)	0.010
2 to <5	472	100.0	355	75.2	117	24.8	0.76 (0.50–1.17)	0.212
≥5	21	100.0	17	81.0	4	19.0	1.13 (0.34–3.78)	0.839
Stage at Dx								0.542
I	1,244	100.0	990	79.6	254	20.4	1.00	
IIA	451	100.0	356	78.9	95	21.1	1.15 (0.80–1.66)	0.454
IIB	147	100.0	117	79.6	30	20.4	1.36 (0.78–2.38)	0.279

Note: In this analysis there was no significant interaction between the distance variable and the patient's age

[a]Odds ratios (OR) and 95% confidence intervals (CI) calculated using multiple logistic regression analysis, with all variables included

[b]Cases with unknown marital status (n = 37) and unknown tumor size (n = 4) excluded for the logistic regression model

between season and treatment received [36]. However, in three of these states (New Hampshire, Vermont, and South Dakota), the proportions of women having BCS were substantially lower in winter than summer. The effect of season on choice of RT in these three states was not specified. Another study by Greenberg et al. reported that New Hampshire and Vermont lung cancer patients diagnosed in January and February were more likely to be referred to a university cancer center for treatment, and that referral was more likely in winter only if the patient lived within 25 miles of a cancer center [19]. Possible reasons for the decreased use of BCS and/or RT among early-stage breast cancer patients living further from a RTF include women's perceived access to care [20], regional practice patterns [21], access to transportation [36], and socioeconomic status [37].

A strength of our study was its use of a large population-based sample from the New Hampshire State Cancer Registry. However, we did not consider other types of treatment (i.e. axillary lymph node dissections, chemotherapy, and hormones), which in conjunction with certain clinical indicators, are all incorporated into the treatment guidelines. Additional limitations of the study relate to the procedures used by NHSCR to collect data. Most cases are reported to the registry within 6 months of diagnosis. Because the stage of cancers is generally determined at the time of the most definitive surgery, we would have misclassified stage if additional staging information was obtained after surgery. It has been reported that RT information may be incomplete in central registries [7, 38]. We would have misclassified the use of radiation if there was a significant delay before the course of radiation was given, for example, if patients in remote locations diagnosed during winter preferred to defer their treatment until spring.

Our estimate of straight-line distance to the nearest RTF only approximates the true travel distance, and estimates based on post office boxes addresses also entail some misclassification. A more precise representation of distance-related barriers to health care might be the travel time, which may reflect road quality. Future studies to confirm our findings might be to investigate travel time, which would also be a useful measure of access to healthcare. It is also possible that distance to treatment represents other factors that might vary by region and affect treatment choices, such as employment or income. Our database did not include the individual level variables that might have clarified this issue. Finally, it has been shown that women in rural areas tend to be diagnosed with breast cancer at a later stage. These women would be under-represented in a study of early-stage breast cancer such as ours [39].

In conclusion, early-stage breast cancer treatment is influenced by several factors; in New Hampshire, barriers to care include distance to nearest RTF and season of diagnosis. Women living more than 20 miles from a radiation treatment facility are not only less likely to have breast conserving surgery, but, if they do so, they are significantly less likely to receive post-operative radiation that would reduce their risk of recurrence. Of those electing BCS, a substantial fraction appear to forgo radiation because of the difficulty traveling during winter.

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Access to Care and Stage at Diagnosis for Patients With Lung Cancer and Esophageal Cancer: Analysis of the Savannah River Region Information System Cancer Registry Data

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ABSTRACT

Background. Disparities have been observed in both the incidences of lung and esophageal cancers and the survival of those patients. Our goals were to determine if race was associated with stage of cancer at diagnosis, and to identify predictors of advanced-stage lung and esophageal cancers.

Methods. All cases of lung and esophageal cancer between 1991 and 1995 in the Savannah River Region Information System cancer registry were studied. Data were analyzed using logistic regression to identify independent predictors of advanced disease at the time of diagnosis.

Results. Among lung cancer patients, histology and distance to nearest hospital predicted diagnosis at an advanced stage. Residence in an area with a high proportion of Medicaid recipients was a predictor of advanced stage in esophageal cancer patients.

Conclusions. In this predominantly rural area, decreased utilization of health services was evident among older, poor, black, rural cancer patients. Further investigation involving prospective data collection from cancer patients is warranted.

LUNG CANCER is the second most frequent malignancy and the leading cause of cancer-related deaths in both men and women. It was estimated that there would be 169,500 new cases of lung cancer and 157,400 lung cancer deaths in the United States in 2001.[1] The burden of lung cancer is greater in the black than in the white population of the United States. The Surveillance, Epidemiology, and End Results (SEER) program reported that the age-adjusted incidence of lung cancer was 56.3 per 100,000 among whites and 72.4 per 100,000 among blacks in 1998. The 5-year relative survival for lung cancer between 1992 and 1997 was 14.8% among whites and 11.7% among blacks.[2] Cancer of the esophagus is less common than lung cancer but imposes an especially high burden on the black population.[3,4] It was estimated that there would be 13,200 new cases of esophageal cancer in the United States in 2001, and 12,500 esophageal cancer deaths. According to SEER, the age-adjusted incidence of esophageal cancer in 1998 was 3.6 per 100,000 among whites and 7.5 per 100,000 among blacks. The 5-year survival for esophageal cancer patients between 1992 and 1997 was 15.1% among whites and 9.0% among blacks.[2]

The two overarching goals of the US Healthy People 2010 program are to increase the quality and years of healthy life, and to eliminate health disparities. The Healthy People 2010 goal for cancer is to reduce the number of new cases, as well as the disability and death it causes.[5] The

KEY POINTS

- Advanced stage of cancer at diagnosis may indicate limitations in access to oncology services and other health care services.
- Patients with unstaged disease were significantly more likely to be older, black, not living with a spouse, and reside in lower income rural areas with fewer primary care physicians.
- Distance to nearest hospital and histology were associated with advanced stage for lung cancer patients, and residence in an area with a higher proportion of Medicaid recipients was associated with advanced-stage esophageal cancer.

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overall target is a 21% reduction in cancer deaths, focusing on the more prevalent and preventable cancers. The specific objective for lung cancer is a 22% reduction in deaths; no specific targets are included in Healthy People 2010 for esophageal cancer.[5] The overall goals of the National Cancer Institute (NCI) Strategic Plan to Reduce Health Disparities are to understand the causes of health disparities and to develop effective interventions to eliminate them[6]; the objectives are to conduct cancer control and population research to elucidate the causes of cancer-related health disparities, and to define and monitor them. Our study addresses these national priorities.

The Savannah River Regional Health Information System (SRRHIS) is a population-based cancer registry jointly developed by the Medical University of South Carolina in Charleston, and Emory University in Atlanta, Georgia. All incident cancer cases in the 22 counties surrounding the Savannah River (10 counties in South Carolina, 12 in Georgia) occurring from 1991 through 1995 were identified.[4] The SRRHIS documented racial disparities in the incidence of lung and esophageal cancer.[4,7] The incidence of lung cancer is higher in young black men than in white men, but is lower in black women than in white women. The incidence of esophageal cancer is higher in black men than in white men and higher in black women than in white women. Thus, racial disparities reported nationally are also present in this predominantly rural region with a high proportion of African Americans.

For patients with lung or esophageal cancer, the stage of cancer at diagnosis and treatment received are the major determinants of outcome. Stage of cancer at diagnosis varies by the age, sex, and race of the patient, and by the histology of the cancer. In addition, personal illness behavior and health-system factors may influence access to health care, and could be related to the stage of cancer at diagnosis.

Access to care has been defined by the Institute of Medicine as "the timely receipt of personal health care services to achieve the best possible outcome."[8] Reduced access to care is believed to be associated with reduced use of health services, more severe illness, and worse health outcomes. In this study, we adapted a conceptual framework for the investigation of access to health care[8-10] and used data from the SRRHIS cancer registry and the US census to identify factors that may be associated with advanced stage of cancer at diagnosis. We hypothesized that socioeconomic factors (education, marital status, military service), geographic factors (distance to nearest hospital, number of primary care physicians), and health system factors (health insurance) are associated with having advanced-stage lung cancer or esophageal cancer at the time of diagnosis.

METHODS

Subjects

We identified for analysis a total of 3,477 subjects included in the SRRHIS registry with lung cancer (International Classification of Diseases–Oncology [ICD-O] primary-site codes 34.0-34.9) and 323 subjects with esophageal cancer (ICD-O primary-site code 15.0-15.9) diagnosed between 1991 and 1995. For patients with more than 1 cancer recorded in the registry, only data from the first-occurring cancer were included in the analysis, ensuring that all observations were independent.

Data Collection

The cancer registry provided information regarding subject age at diagnosis, sex, race, marital status, and county and zip code of residence, in addition to primary cancer site, histology, and stage. The county and zip codes were linked with data obtained from the 1990 US census regarding per capita income, education, military status, and patient residence in a rural or urban area. Although this type of linking is not a perfect substitute for primary data collection, it has been shown to be a useful method of controlling for confounding factors in other studies of cancer registry data.[11-14]

Per capita income is available directly from the census data files; methods to assign education, military status, and patient residence in a rural or urban area were developed for the study. For each zip code, census data provided tables of the number of persons by level of education, the number who were on active duty in the military or were veterans, and the number who lived in rural and urban areas. From these zip code tables, percentages of residents in the various education, military, and rural/urban groupings were calculated. These percentages thus reflected the probability of having some college education, being or having been active in the military, and residing in a rural area. Patients in the cancer registry were linked to these census data using their zip codes.

The distance to the nearest hospital for each patient was calculated using the MapInfo software package (MapInfo Corp, Troy, NY). All

TABLE 1. Characteristics of Study Sample, Including Patients With Unstaged Tumors

Variable	*Lung Cancer (n = 3,477)*	*Esophageal Cancer (n = 323)*
Patient-level data		
Age at diagnosis (yrs)*		
Mean ± SD	66.4 ± 19.1	64.8 ± 11.7
Range	26-100	28-93
Race (% white)*	72.6	42.7
Sex (% male)*	65.5	76.2
Marital status*		
Living with spouse (%)	57.3	47.4
Histology (%)*		
Squamous cell carcinoma	27.8	67.2
Adenocarcinoma	27.4	24.1
Small cell carcinoma	15.4	-
Large cell carcinoma	11.2	-
Other	18.2	8.7
Stage at diagnosis (%)		
Local	22.3	27.6
Regional	30.6	31.9
Distant	34.9	17.0
Unstaged	12.2	23.5
Zip-code-level data		
Per capita income ($)†		
Mean ± SD	12,736 ± 5,913	10,435 ± 6,134
Range	3,379-46,353	3,379-46,353
Education (%)†		
Completed <9th grade	12.7	17.0
Range	0-55	0-39.7
Military status (%)†		
Active or veteran	29.7	32.1
Range	0-100	0-82
Place of residence (%)†		
Residing in rural area	37.1	41.2
Range	0-100	0-100
Distance to nearest hospital (miles)**		
Mean ± SD	5.65 ± 4.70	6.03 ± 5.70
Range	0.02-30.12	0.02-30.12
County-level data		
Primary care physicians per 10,000 people‡		
Mean ± SD	6.9 ± 3.2	6.8 ± 3.3
Range	0-12	0-12
Medicaid benefits (%)§		
Recipients	19.2	19.4
Range	8.4-33.9	8.4-33.9

*Obtained from SRRHIS cancer registry.
†Determined by linking census data and zip code of patient residence.
**Defined as the distance from the center of a patient's zip code to the nearest hospital.
‡Obtained from the Area Resource File.[14]
§Obtained from the South Carolina Office of Research and Statistics and the Georgia Department of Medical Assistance.
SD = Standard deviation.

general medical/surgical hospitals in Georgia and South Carolina were geocoded, along with the centroid of each patient's zip code; then the distance from each patient's zip code centroid to each hospital was calculated. The distance to the nearest hospital for each patient in our analyses was defined as the minimum of these distances.

The Area Resource File (ARF) provided information for the calculation of the number of primary care providers per 10,000 persons.[15] Because ARF data were not available for each of the 5 years in which data was collected in the SRRHIS cancer registry, we chose the number of physicians per capita for the year 1994 as the covariate to be used in the analyses.

Cancer Stage

The SRRHIS cancer registry used the SEER staging classification, which categorizes cancers as either localized, regional by direct extension, regional to lymph nodes, regional by direct extension and to lymph nodes, regional not otherwise specified, distant metastases, or unstaged. For the analysis of potential demographic, geographic, and clinical variables that could be considered as independent predictors of distant metastatic disease, the stage of cancer at diagno-

TABLE 2. Characteristics of Patients with Staged vs Unstaged Lung or Esophageal Cancer at Diagnosis

Variable	*Staged (n = 3,289)*	*Unstaged (n = 514)*	P *Value*
Patient-level data			
Age at diagnosis (yrs)			
Mean ± SD	65.6 ± 10.6	68.7 ± 11.3	< .001
Race (% white)	70.9	64.9	.006
Sex (% male)	66.5	65.6	NS
Marital status (% living with spouse)	57.5	49.1	.0004
Histology (%)			
Lung cancer			< .001
Squamous cell carcinoma	28.7	21.2	
Adenocarcinoma	28.9	19.4	
Small cell carcinoma	15.9	12.5	
Large cell carcinoma	11.7	7.5	
Other	14.8	41.9	
Esophageal cancer			NS
Squamous cell carcinoma	68.8	61.8	
Adenocarcinoma/other	32.2	38.2	
Zip-code-level data			
Per capita income ($)			
Mean ± SD	12,622 ± 6,001	12,007 ± 5,704	.032
Education (% completed <9th grade)	13.0	13.7	NS
Military status (% active or veteran)	29.7	31.1	NS
Place of residence (% rural area)	36.7	42.7	.0009
Distance to nearest hospital (miles) (Mean ± SD)	5.7 ± 4.9	5.8 ± 4.4	NS
County-level data			
Primary care physicians per 10,000 people			
Mean ± SD	6.5 ± 3.5	5.5 ± 3.5	< .0001
Medicaid recipients (%)	19.3	18.5	.012

SD = Standard deviation, NS = not statistically significant

sis was collapsed into 2 categories. Subjects staged as having distant disease were classified into one group, while those whose stage was localized or regional were classified in the other group. All subjects were included in the calculations of the descriptive statistics of the study sample, regardless of stage. Those subjects whose stage was unknown, however, were not included in the logistic regression.

Histologic Groupings

Histologic groups chosen for analyzing lung cancer were the same as those used in a recent analysis of the 1973 to 1996 SEER data.[16] The 5 lung cancer histology groups were small cell carcinoma, squamous cell carcinoma, large cell carcinoma, adenocarcinoma, and other. Because the stage at diagnosis was least likely to be distant for those subjects with squamous cell carcinoma, that was chosen as the referent category.

Histologic groupings chosen for esophageal cancer were the same as those reported in a paper by Devesa et al[17]: adenocarcinoma, squamous cell carcinoma, and other. Because of the small number of those with the "other" histology (n = 12), however, this group of subjects was combined with the adenocarcinoma group for our final analysis.

Model Construction

Logistic regression models were constructed separately for lung and esophageal cancer. Initially, we included histology, age, race, sex, marital status, education, income, military status, physicians per 10,000 persons in county of residence, distance from residence to nearest hospital, and urban/rural status of residence as potential predictors of distant metastatic disease. Because of multicolinearity between several of the variables, however, the list was reduced. Income was highly correlated with education (correlation coefficient [r] = 0.84), as was urban/rural status with distance to nearest hospital ($r = 0.62$) and physicians per 10,000 persons in county of residence ($r = -0.64$). The final models for both lung and esophageal cancer therefore included histology, age, race, sex, marital status, education, military status, physicians per 10,000 people in county of residence, and distance from residence to nearest hospital. Using the logistic models, odds ratios (OR) and their respective 95% confidence intervals (CIs) were calculated.

RESULTS

Characteristics of the study sample are shown in Table 1. These descriptive statistics included all subjects, even those whose tumors were un-

TABLE 3. Results of Logistic Regression Analysis Predicting Distant Stage at Diagnosis for Lung Cancer Patients

	Univariate Analysis		Multivariate Analysis	
Variable	*OR*	*95% CI*	*OR*	*95% CI*
Patient-level data				
Histology				
Squamous cell carcinoma	1.00	Referent	1.00	Referent
Adenocarcinoma	1.74*	1.42-2.13	1.77*	1.44-2.18
Small cell carcinoma	3.58*	2.82-4.51	3.64*	2.87-4.62
Large cell carcinoma	2.09*	1.61-2.70	2.11*	1.63-2.73
Other	2.58*	2.03-3.27	2.62*	2.06-3.33
Race (nonwhite)	0.93	0.79-1.09	0.98	0.76-1.26
Sex (female)	0.91	0.78-1.06	0.88	0.64-1.20
Age at diagnosis	0.99	0.99-1.00	0.99	0.99-1.00
Marital status (married)	0.96	0.83-1.11	0.91	0.77-1.06
Zip-code-level data				
Education (completed <9th grade)	0.79	0.35-1.75	1.06	0.28-3.96
Military service (active or veteran)	1.18	0.88-1.59	1.23	0.66-2.30
Distance to nearest hospital (miles)	1.19*	1.03-1.39	1.21*	1.02-1.44
County-level data				
Primary care physician per 10,000 population	1.00	0.98-1.02	1.01	0.99-1.04
Percent Medicaid-eligible	0.99	0.98-1.00	0.99	0.98-1.01

*$P < .05$
OR = Odds ratio, CI = confidence interval.

staged. There were 3,477 incident cases of lung cancer in the 22 SRRHIS counties from 1991 through 1995. The mean age at diagnosis was 66.4 years. Approximately two thirds of patients were male and three fourths were white. Squamous cell carcinoma and adenocarcinoma were the most frequent histologies; small cell carcinoma occurred in 15.4% of the patients. Distant disease at the time of lung cancer diagnosis occurred in 34.9% of cases. Between 1991 and 1995, there were 323 incident cases of esophageal cancer in the 22 SRRHIS counties. The mean age of patients with esophageal cancer was 64.8 years, similar to the mean age of patients with lung cancer. In contrast, approximately three fourths of patients with esophageal cancer were male and approximately 60% were black. Squamous cell carcinoma accounted for approximately two thirds of the cases of esophageal cancer. At the time of diagnosis, distant disease was found in 17% of the esophageal cancer cases. Compared with subjects having lung cancer, those with esophageal cancer were significantly less likely to be white, female, married, earn a high income, or have any college education. Patients with lung cancer were significantly more likely to be diagnosed with distant disease.

There were 3,286 patients with cancers of the lung or esophagus whose cancer stage was known at the time of diagnosis and 514 patients for whom insufficient information was available to assign a stage. Patients with staged disease differed from those with unstaged disease (Table 2). In general, patients with unstaged cancer were older, poorer, less likely to be white or married, and more likely to reside in a rural area with fewer primary care physicians and fewer Medicaid recipients. The unstaged lung cancer patients were more likely to have "other" histologic types of cancer.

Multivariate logistic regression analysis was done on the 3,040 incident cases of lung cancer with information on stage at diagnosis and the variables of interest (Table 3). As expected, histology was statistically significantly associated with advanced stage at diagnosis, with the highest risk associated with small cell carcinoma. After adjusting for histology, race was not associated with advanced stage (for nonwhite race, OR = 0.98; 95% CI, 0.76-1.26). The only variable associated with advanced stage of lung cancer was distance to nearest hospital (for every 10 mile increment, OR = 1.21, 95% CI, 1.04-1.44). Alternately, persons living >10 miles from a hospital were 1.25 (95% CI, 1.00-1.57) times as likely to be diagnosed with advanced stage than those living <10 miles away ($P = .047$). Age, sex, and marital status were not significantly associated with advanced stage of lung cancer at diagnosis. Residence in an area with a high proportion of persons with less than a ninth-grade education, veterans or active-duty military personnel, or Medicaid-eligible residents, and the number of primary care physicians per 10,000 population were associated with advanced stage of cancer at diagnosis.

Multivariate logistic-regression analysis was done using information from the 246 esophageal cancer patients with information on stage of

TABLE 4. Results of Logistic Regression Analysis Predicting Distant Stage at Diagnosis for Patients with Esophageal Cancer

Variable	Univariate Analysis OR	Univariate Analysis 95% CI	Multivariate Analysis OR	Multivariate Analysis 95% CI
Patient-level data				
Histology				
Squamous cell carcinoma	1.00	Referent	1.00	Referent
Adenocarcinoma/other	1.84	0.99-3.42	1.35	0.64-2.84
Race (nonwhite)	0.55	0.30-1.01	0.73	0.29-1.89
Sex (female)	0.73	0.34-1.56	1.05	0.31-3.56
Age at diagnosis	0.99	0.96-1.01	0.98	0.95-1.01
Marital status (married)	1.87*	1.02-3.46	1.57	0.80-3.08
Zip-code-level data				
Education (completed <9th grade)	0.10	0.01-1.91	0.25	0.00-38.6
Military service (active or veteran)	1.35	0.36-5.03	1.32	0.12-14.2
Distance to nearest hospital (miles)	0.98	0.93-1.04	0.99	0.93-1.05
County-level data				
Primary care physician per 10,000 population	0.98	0.89-1.08	0.94	0.84-1.04
Percent Medicaid-eligible	1.03	0.98-1.08	1.06*	1.00-1.11

*$P < .05$
OR = odds ratio, CI = confidence interval.

cancer at diagnosis and the variables of interest (Table 4). Neither histology nor race were associated with advanced stage of esophageal cancer (for nonwhite race, OR = 0.73; 95% CI, 0.29-1.89). The only factor significantly associated with advanced-stage esophageal cancer at diagnosis was residence in a county with a large proportion of Medicaid-eligible residents. Similar to the findings for lung cancer, age, sex, and marital status were not associated with advanced stage of esophageal cancer. In contrast to lung cancer, however, residence in an area with a high proportion of persons with less than a ninth grade education, a high proportion of veterans or active duty military personnel, distance to the nearest hospital, and number primary care physicians per 10,000 population were not associated with advanced-stage esophageal cancer either.

DISCUSSION

This study explored the potential relationship of demographic, socioeconomic, and geographic factors with advanced stage of lung cancer or esophageal cancer at diagnosis. The SRRHIS cancer patients with unstaged cancer were more likely to be older, unmarried, black, poor, and residents in rural counties with fewer primary care physicians. Among the approximately 3,000 incident cases of lung cancer and 250 incident cases of esophageal cancer in the predominantly rural counties surrounding the Savannah River region, histology, as expected, was associated with advanced stage of lung cancer at diagnosis. After adjusting for histology, the only factors that were associated with advanced stage at diagnosis were distance to the nearest hospital for lung cancer patients and residence in a county with a high proportion of Medicaid recipients for esophageal cancer patients. None of the other patient-level variables (race, age, sex, marital status), or aggregate-level variables (education, military service, number of primary care physicians per 10,000 population) were significantly associated with advanced stage of cancer at diagnosis.

Our analysis has 2 major implications. First, the pattern of available information on cancer stage at diagnosis raises concerns about access to care. There was insufficient information on a substantial proportion of patients (approximate 12% of patients with lung cancer and 30% of patients with esophageal cancer) to assign the stage at diagnosis. This may reflect decreased access to care, patient preferences regarding diagnostic evaluation and treatment, provider practice styles, or incomplete abstraction of data from the medical record by the SRRHIS cancer registry staff. The high-level ascertainment of incident cases of cancers in the SRRHIS cancer registry[4] and the high level of success in identifying incident cases of cancer in persons who sought care across state boundaries in nearby hospitals or cancer centers[18] suggest that problems in obtaining available medical record data is an unlikely explanation for the incomplete information on stage of cancer at diagnosis. Unstaged patients were more likely to be older, black, poor, and reside in rural areas with low numbers of physicians per capita. All of these traits are consistent with the characteristics of vulnerable patients who may have reduced access to cancer-care services.[19] Limited information on stage, however, may also reflect patient preferences for diagnostic evaluation, cancer

treatments, or provider practice styles. Previous studies have documented that older age, distance from a cancer center, functional status,[20] marital status,[21] and patient attitudes toward treatment risks[22] are associated with treatment for lung cancer.

The second implication of our study is that, in contrast to findings from other types of cancer, none of the demographic variables were associated with advanced stage of cancer for lung or esophageal cancer patients whose stage of cancer at diagnosis was known. The only factors that were significantly associated with advanced stage of cancer at diagnosis were distance to nearest hospital for lung cancer patients and residence in a county with a high proportion of Medicaid recipients for esophageal cancer patients. Previous studies have documented that distance is associated with referral to university cancer centers for patients with lung cancer.[20] Health insurance was not associated with referral to a university cancer center but was associated with the treatment received.[23] Thus, for lung cancer, demographic and socioeconomic variables appear less likely to explain disparities in survival. Racial disparities in survival of patients with lung cancer appear to be explained by racial disparities in surgery for patients with resectable disease.[24]

In contrast to our findings in patients with lung cancer, studies of patients with other cancers have documented a variety of demographic and socioeconomic variables associated with advanced-stage cancer at diagnosis.[13,14,25-30] In addition to cancer biology, stage at diagnosis may reflect patients' cancer knowledge, attitude, and beliefs; patients' illness behavior; ability to access cancer-care services; health system factors, such as health insurance; and geographic availability of providers and cancer services. All of these factors may themselves vary by patient age, sex, race, and socioeconomic status.[8-10] Access to preventive services may be a more important factor in stage at diagnosis for those cancers for which there is evidence of the effectiveness of preventive services in reducing incidence or mortality (eg, breast, cervical, and colorectal cancers). For these cancers, socioeconomic status, health insurance, and beliefs about cancer are important factors associated with stage at diagnosis.[14,25,29] The absence of a relationship between demographic and socioeconomic factors in advanced-stage lung and esophageal cancers in our study is, therefore, plausible. Our use of ecologic variables to supplement information available from the cancer registry, and the small number of cases of esophageal cancer suggests caution in interpreting our negative findings.

Although our study did not identify racial disparities in stage of lung and esophageal cancer, it is important to recognize that there are racial disparities in the incidence of both cancers. The highest lung cancer incidence occurs in blacks,[23] and the incidence of esophageal cancer (and mortality rates due to esophageal cancer) in coastal South Carolina is among the highest in the United States.[3,31] In the SEER program, the age-adjusted rates of lung and esophageal cancer are higher in the black than in the white population.[2] In the 22 SRRHIS counties, the incidence of both lung and esophageal cancer are also higher in the black than in the white population.[4] A recent analysis of lung cancer in the SRRHIS cancer registry showed a higher incidence of lung cancer in younger black men (less than age 55 years) but not in older black men; the incidence of lung cancer was lower in black than in white women.[7] Racial disparities in the incidence of lung cancer can be explained by education, income, and population density.[32] Socioeconomic differences in incidence of lung cancer can be explained, in part, by differences in smoking habits.[33,34] Racial disparities in incidence of lung cancer are consistent with historical patterns of cigarette smoking.[16] In a recent population-based case-control study of esophageal cancer, four major risk factors—low income, moderate/high alcohol intake, tobacco use, and infrequent consumption of raw fruits and vegetables—accounted for almost all of the squamous cell esophageal cancer in whites, and most of the excess incidence of esophageal cancer in black men.[35]

Racial disparities have also been observed in the survival of cancer patients; lung and esophageal cancer survival rates are lower for blacks than for whites.[2] In an analysis of patients with a diagnosis of lung cancer in the SEER program between 1985 and 1993 with resectable (stage I or stage II) cancer, the rate of surgery was 12.7% lower for black than for white patients. The 5-year survival rate was also lower for black than for white patients. For patients having surgery, however, blacks and whites had similar survival rates, as did black and white patients not treated surgically.[24] Thus, racial disparities in survival for patients with lung cancer appear to be explained by treatment. Surgery and other treatment modalities (radiation therapy and/or chemotherapy) may be the major factors in explaining disparities in outcomes of patients with cancer. Access to treatment for lung cancer may

vary due to a variety of patient demographic, socioeconomic, and geographic factors. Greater distance from a cancer center, lower functional status, and age over 75 years have been associated with the use of a university cancer center for patients with lung cancer.[20] Social and economic factors influence the choice of lung cancer treatment. Marital status, medical insurance coverage, and proximity to a cancer treatment center were associated with treatment for lung cancer in patients from a rural, predominantly white population. Patients who were married or who had private medical insurance were more likely to receive surgery for lung cancer. Among lung cancer patients who did not have surgery, patients with private insurance were more likely to receive either radiation therapy or chemotherapy.[23]

Patients' attitudes toward risk and survival also influence their decisions about having surgery or radiation therapy for lung cancer.[22] Thus, for patients with lung or esophageal cancer, racial disparities in incidence of cancer may reflect disparities in lifestyle and health-related behaviors. Racial disparities in survival may reflect disparities in access to treatment and patient attitudes and decisions regarding treatment for cancer. Although several factors are associated with decisions about treatment, after adjusting for treatment, stage of disease, performance status, and clinical factors are the predominant determinants of survival.[36,37] The medical literature suggests that racial and other disparities in the outcomes of lung cancer may be more dependent on decisions to evaluate the stage of disease at diagnosis and decisions about treatment than on racial and other disparities in the outcomes of the treatments that are appropriate for the stage of cancer. We speculate that this may also apply to patients with esophageal cancer.

Analysis of population-based incident cases of lung and esophageal cancer from a predominantly rural area of 2 states that includes a high proportion of black residents is a strength of our study. A second strength is the investigation of 2 distinct cancers known to impose disparate burdens on the black population. A limitation of the study is that some data of interest, such as socioeconomic status, health insurance, distance to nearest hospital, and the number of primary care physicians per 10,000 population, were not directly available from the SRRHIS cancer registry and were obtained from the US census data for persons who reside in the same area. The inclusion of ecologic variables in an analysis introduces bias if the characteristics of the zip code or county differ systematically from the characteristics of the patients with incident cases of lung or esophageal cancer. A further potential limitation is the number of zip codes (132) and counties (22), which may limit the range of the independent variables of interest, and thus limit the power of the study to detect significant differences due to the factors for which the ecologic variables are used. Our analysis was appropriately modified to avoid problems of colinearity that often result when group-level variables are analyzed.[38]

We explored the relationship of race and other factors to advanced stage at diagnosis of lung and esophageal cancer. Among incident cases of lung and esophageal cancer, persons with unstaged disease were more likely to be older, black, poor, unmarried, and reside in a rural area with fewer primary care physicians and more Medicaid recipients. Appropriate treatment for these cancers is based on histology and stage of disease. Unfortunately, we do not have direct information on the utilization of health care services for our incident cases of lung and esophageal cancer. Cancer patients with unstaged disease most likely had decreased utilization of the health services necessary for ascertaining the anatomic location and extent of disease. It is likely that the patients with unstaged disease also had decreased use of health services for treatment of their cancer and lower survival rates. The decreased utilization may reflect patient and family preferences or provider recommendations, possibly due to associated comorbid medical conditions. These disparities raise concern about barriers to access of cancer-care services.

The patients with cancer staged at diagnosis were more homogeneous. Race was not significantly associated with advanced stage of lung or esophageal cancer at diagnosis. After adjusting for histology, only distance to nearest hospital for lung cancer patients and residence in an area with a high proportion of Medicaid recipients for esophageal cancer patients were associated with advanced stage at diagnosis. Our analysis was limited by the use of census data when individual patient-level data were not available. Additional prospective studies of factors associated with stage of lung and esophageal cancer are warranted.

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ORIGINAL REPORT

Factors Associated With Participation in Breast Cancer Treatment Clinical Trials

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ABSTRACT

Purpose

It is well established that recruitment to clinical trials (CTs) is difficult and time consuming. This article reports on factors related to CT participation among women who were invited to participate in a CT for breast cancer.

Patients and Methods

Breast cancer patients who were eligible for a CT were identified by 16 different cancer centers. After their invitation to participate in a trial, patients who were undecided about participation in a CT were recruited into the present study at that time. After a patient made a decision about trial participation, a telephone interview was conducted to assess knowledge of CTs, perceived benefits and drawbacks of CTs, and personal factors affecting the women's decision regarding participation.

Results

A total of 208 patients participated in the study. Fifty-eight percent of the patients decided to participate in a trial. Logistic regression analyses showed that the factors best explaining participation were trial phase, perceived drawbacks, time and travel considerations, therapeutic benefit of trial, and physician recommendation. Participation rates were similar for both phase I and phase III trials. However, a higher percentage of women recruited to phase II trials accepted.

Conclusion

This study suggests that reducing drawbacks of CT participation, particularly travel time, and improving physician communication of trials are needed to increase trial participation.

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INTRODUCTION

As with most diseases, progress in treatment of breast cancer is best accomplished through well-designed, prospective clinical trials (CTs). However, patient accrual to CTs is a difficult problem.[1-9] A review of 41 randomized CTs in the United States found that 34% of trials recruited less than 75% of their planned sample.[8] It is generally found that only approximately 2% to 3% of adult cancer patients are entered onto CTs,[10,11] whereas approximately 5% all of women with breast cancer participate in a CT.[12] Although this low rate of participation is partly a function of lack of trial availability at any given time, an evaluation of National Cancer Institute–sponsored trials at 15 sites found that patient refusal accounted for the nonenrollment of nearly 40% of patients clinically eligible for a trial.[9]

Patient obstacles to participation in CTs include negative attitudes towards or beliefs about CTs,[6,13-16] lack of knowledge or adequate information,[14,16-18] concern about random assignment or wanting a specific treatment,[8,19-24] inconvenience,[6,8,25-27] possible risks or discomfort,[25] and lack of family support.[15,21]

The analyses reported here further our understanding of trial participation among breast cancer patients by examining factors related to CT participation. Although numerous studies have examined factors related to CT participation in general, only a few focus specifically on breast cancer patients.[17,20,28,29] In the present article, we compare women who agreed to participate in a CT with women who declined participation on a range of variables including sociodemographics, medical factors, trial type, knowledge about CTs, perceived benefits and barriers of CTs, and factors that affected one's personal decision regarding participation. The analyses are part of a larger study that was originally undertaken to compare the effectiveness of a novel videotape with a standard brochure for increasing participation in CTs. The videotape was designed to address two of the previously mentioned patient-related factors, specifically negative attitudes toward

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CTs and lack of knowledge about CTs. Previous analyses found no significant differences between the two education groups in terms of knowledge or attitudes toward CTs or trial participation.

PATIENTS AND METHODS

Study Overview

Potential study participants included all female breast cancer patients at participating institutions who were determined eligible to participate in a treatment CT for breast cancer and were undecided about participation in the CT. The focus was necessarily on undecided women because trial participation was a primary outcome. Patients were English or Spanish speaking and at least 18 years of age. A total of 16 different sites, including major cancer centers and Community Clinical Oncology Programs, participated in the study.

Immediately after the invitation to participate in a CT, at the same clinic visit, patients were recruited onto the present study. Patients were told that the study was designed to test various educational materials about CTs and that they would be given some materials to review and later contacted for a telephone interview for which they would be paid $25. After obtaining informed consent for the study, patients were randomly assigned to one of two educational groups (either a booklet or videotape group) and given the educational materials to take home and keep. Random assignment to the videotape or booklet group was performed within site.

After a patient made a decision regarding trial participation, the site notified the New England Research Institutes, where three authors (N.E.A., K.W.S., and C.L.L.) were affiliated at the time of the study. A follow-up telephone interview was arranged with the study participant. The telephone interview was designed to assess knowledge of CTs, perceived benefits and drawbacks of CTs, and factors affecting the women's personal decision regarding participation.

Intervention Materials

The intervention materials consisted of a videotape developed specifically for this project and the booklet entitled "What You Need to Know About Clinical Trials" developed by the National Cancer Institute.[14] The videotape was documentary in style and consisted of interviews with patients and health care providers. Both materials were available in English and Spanish.

Measures

The primary outcome was trial participation as reported by the clinical site. Reporting options included agreed to participate, declined to participate, and trial no longer available. Participation was defined as executing an informed consent form for the CT. Decisions reported by patients during the telephone interviews were compared with those reported by the site, and discrepancies were referred back to the sites before making a final determination. Also obtained from the site was the type of trial to which the woman was being recruited (phase I, II, or III). The following information was collected during the telephone interview.

Sociodemographic factors. Sociodemographic factors included age, level of education, race/ethnicity, employment status, income, health insurance, and insurance coverage of the CT.

Medical factors. Medical factors included self-report of time since diagnosis, stage of breast cancer, type of surgery, type of treatment, and self-assessed health.

Knowledge of CTs. A list of 22 items was developed to assess knowledge of CTs. Respondents rated each item on a 4-point scale (definitely true, probably true, probably false, or definitely false). Items were derived from information presented in the educational materials and were designed to assess a wide range of aspects of CTs. The items covered such topics as the purpose of CTs, random assignment, eligibility, participant rights, and informed consent. Items were pretested in an earlier phase of the study. A reliability analysis of the pretest data identified poorly performing items that were subsequently reworded or omitted.

Attitudes toward CTs. Attitudes toward CTs were assessed with two separate scales. One scale asked about beliefs about the benefits of CTs, and the

Table 1. Sociodemographic and Medical Characteristics of Patients (N = 183)

Characteristic	No. of Patients	%
Age, years		
30-39	25	13.7
40-49	57	31.7
50-59	57	31.7
60-69	33	18.3
≥ 70	8	4.4
Education		
< High school	17	9.4
High school	44	24.4
Some college	54	30.0
4-year college graduate	36	20.0
≥ 4-year college graduate	29	16.1
Race		
Non-Hispanic white	138	75.8
Black	14	7.7
Hispanic	26	14.3
Asian American	4	2.2
Employment status		
Employed	104	57.8
Full-time homemaker	37	20.6
Unemployed	11	6.1
Retired	20	11.1
Doing something else	8	4.4
Health insurance		
Yes	167	92.8
No	13	7.2
Live alone		
Yes	28	15.4
No	154	84.6
Income		
< $20,000	22	13.2
$20,000-$49,999	59	35.3
$50,000-$79,999	40	24.0
$80,000-$99,999	20	12.0
≥ $100,000	26	15.6
Self-assessed health		
Excellent	48	26.2
Very good	66	36.0
Good	45	24.6
Fair	14	7.7
Poor	10	5.5
Time since diagnosis, months		
≤ 6	20	10.9
> 6	163	89.1
Stage		
0	1	0.5
I	29	15.8
II	76	41.5
III	23	12.6
IV	4	2.2
DK	50	27.3
Type of surgery		
Lumpectomy	74	40.4
Mastectomy	96	52.4
Neither	13	7.1
Treatment*		
Chemotherapy	151	82.5
Radiation	19	10.4
Hormone therapy	15	8.2
Bone marrow treatment	1	0.6
Trial type		
Phase I	8	4.4
Phase II	32	17.5
Phase III	143	78.1

Abbreviation: DK, don't know.
*These total more than 100% because they are not mutually exclusive.

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Table 2. Bivariate Associations Between Trial Participation and Categorical Variables: Percent of Women in Each Category Who Accepted or Declined

Variable	No. of Patients	Accepted		Declined		χ^2	P
		No.	%	No.	%		
Trial type						13.93	.0009
Phase I	8	4	50.0	4	50.0		
Phase II	32	28	87.5	4	12.5		
Phase III	143	74	51.8	69	48.2		
Site						4.78	.0288
M.D. Anderson Cancer Center	124	65	52.4	59	47.6		
Other	59	41	69.5	18	30.5		
Race/ethnicity						2.49	.4773
Non-Hispanic white	138	76	55.1	62	44.9		
Black	14	10	71.4	4	28.6		
Hispanic	26	18	65.2	8	34.8		
Asian American	4	3	75.0	1	25.0		
Education						5.05	.2825
< High school	17	12	70.6	5	29.4		
High school graduate	44	24	54.5	20	45.5		
Some college	54	36	66.6	18	33.3		
4-year college graduate	36	18	50.0	18	50.0		
> College degree	29	14	48.3	15	51.7		
Employment						0.93	.9282
Employed	104	59	56.7	45	43.3		
Full-time homemaker	37	23	62.2	14	37.8		
Unemployed	11	6	54.5	5	45.5		
Retired	20	12	60.0	8	40.0		
Doing something else	8	4	50.0	4	50.0		
Does insurance cover clinical trial						10.16	.0062
Yes	56	42	75.0	14	25.0		
No	16	7	43.8	9	56.2		
Don't know	95	48	50.5	47	49.5		

other scale asked about drawbacks. For both scales, respondents indicated how much each item was a benefit (or drawback) on a 5-point scale from "not at all a benefit" (or drawback) to "very much a benefit" (or drawback). Items were derived from the literature and an earlier pilot phase of the study of focus groups with breast cancer patients. The benefits scale consisted of seven statements that covered issues such as helping others, the opportunity for new treatments, and getting better medical care. The drawbacks scale consisted of 15 statements covering items related to privacy and confidentiality, adverse effects of treatment, feeling like a "guinea pig," time and inconvenience, and lack of trust in medical research.

Factors in personal decision. Women rated how much each of nine items influenced their personal decision to participate in a CT. For each factor, women rated whether it was a factor strongly against their participation, somewhat against their participation, neither against nor in favor of their participation, somewhat in favor of their participation, or strongly in favor of their participation. Factors included items such as potential adverse effects of treatment, attitude toward random assignment, trust in medical research, amount of time and travel required, and recommendation of others (physician, family, and friends).

Feelings about knowing about CTs. Davis et al[30] previously evaluated the booklet by asking questions related to how knowing about CTs makes a person feel. Respondents were asked whether their understanding of CTs was clear or confusing and whether knowing about CTs made them feel upset or relieved and hopeful or doubtful. Davis et al[30] found that, compared with a control group, the booklet group was more likely to feel clear in their understanding of CTs and more likely to feel relieved. These questions were also included in our interview.

Table 3. Means for Selected Continuous and Ordinal Variables for Trial Accepters and Decliners*

Variable	Accepters	Decliners	t Test	P
Age, years	51.02	52.12	0.49	.4844
Time since diagnosis, years	0.76	0.58	0.47	.4942
Understanding of clinical trial is clear	4.33	4.13		.3051
Knowing makes me feel relieved	4.32	3.88		.0020
Knowing makes me feel hopeful	4.47	4.09		.0053
Knowledge score	18.70	18.50	0.53	.5942
General beliefs about benefits score	4.56	4.28		.0003
General beliefs about drawbacks score	2.03	2.93		< .0001

*For ordinal data, P values are from a nonparametric Wilcoxon test.

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Table 4. Response Scores* to General Beliefs About Benefits by Trial Participation

Item	Accepters (mean score)	Decliners (mean score)	P†
Way to help others	4.80	4.56	.0176
Way of being involved in new treatments	4.78	4.68	.4076
Health observed more closely	4.63	4.39	.0456
See health care provider more often	4.34	4.01	.0598
Get best medical care	4.23	3.88	.0116
Way of doing something positive	4.68	4.23	.0001
Chance to ask questions/get more info	4.50	4.25	.0462
Total score	4.56	4.28	.0003

*Response scores range from 1 (not at all a benefit) to 5 (very much a benefit).
†P values are from the nonparametric Wilcoxon test.

Statistical Analyses

Scale reliability. The psychometric properties of the multi-item scales for knowledge, benefits, and drawbacks were evaluated using Classical Test Theory. Item-total correlations were reviewed to assess the fit of individual items, and Cronbach's α was computed as a measure of scale reliability. Scale scores were computed as the mean of the individual item scores; the knowledge score was a count of the number of items answered correctly (definitely or probably).

Participation decision analysis. The influence of factors hypothesized to affect the decision to participate in the CT was estimated using logistic regression. The explanatory variables in the model consisted of variables of particular interest including scale scores for benefits, drawbacks, and knowledge; ratings of personal decision factors, race, intervention group status (video *v* booklet); and factors significant in bivariate analyses (clinical site and trial type).

RESULTS

Sample Characteristics

Sites reported identifying 211 eligible patients and recruited a total of 208 patients to participate in the study. Of these patients, we were able to interview 191 women. Reasons for not obtaining a completed interview included deceased (n = 2), refused (n = 3), too ill (n = 2), ineligible (n = 1), unable to complete interview (n = 2), and unable to reach (n = 7). Of those women who were interviewed, eight were excluded from analyses because the trial was no longer available before they made a decision, thus producing an analytic sample of 183 women. Women were interviewed between 1 and 50 days after their decision (median, 13 days).

Sociodemographic and medical characteristics of the patients are listed in Table 1. Women ranged in age from 30 to 83 years, with a mean age of 51.5 years (median, 51 years). The majority of women were white (77.1%) and worked full or part time (57.8%). Approximately half had a household income more than $50,000 per year, with 13% having an income of less than $20,000.

Time since diagnosis ranged from within the past month to 14 years (mean, 8 months; median, 1.7 months). The majority of respondents had stage II cancer, but 27.3% of patients did not know their stage. More than half of the patients (52.4%) reported having a mastectomy. The majority of women (82.5%) had had chemotherapy by the time they were interviewed, whereas fewer had radiation (10.4%) or hormone therapy (8.2%). Most women (78%) were being recruited for phase III trials. The majority of the respondents (68%) were from a single site (M.D. Anderson Cancer Center, Houston, TX).

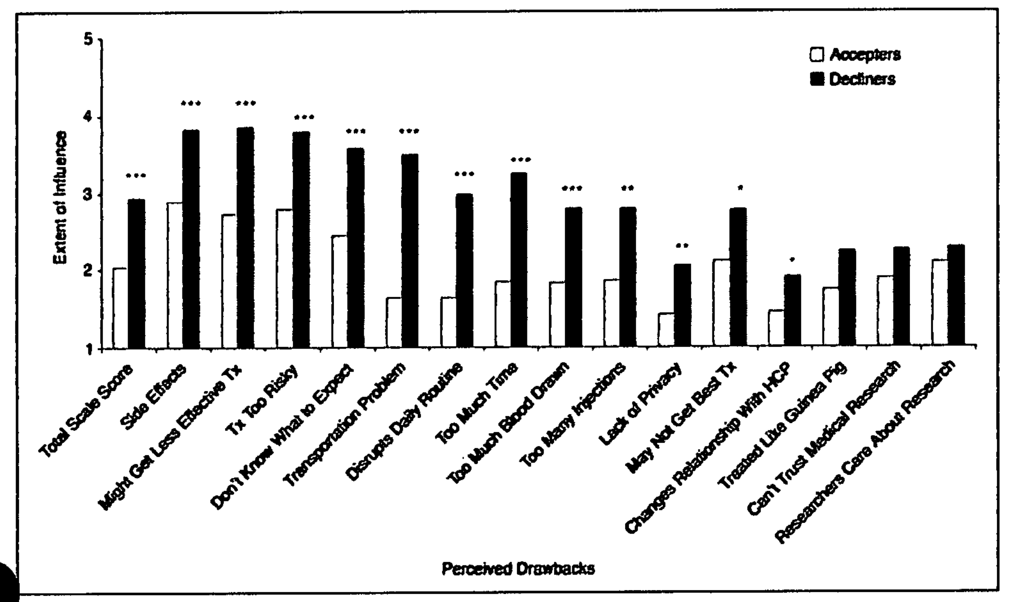

Fig 1. Mean score on perceived drawbacks to clinical trials by accepters and decliners. HCP, health care provider, tx, treatment.

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Scale Reliability

All of the composite scales were found to have adequate reliability. Cronbach's α = 0.79 for the knowledge scale (22 items), 0.86 for the perceptions of trial benefits scale (seven items), and 0.91 for the drawbacks scale (15 items). Respondents exhibited high levels of knowledge about CTs, answering an average of 85% of the items correctly.

Trial Participation: Bivariate Associations

Overall, 57.8% of women agreed to participate in the CT for which they were being recruited. Tables 2 and 3 show the bivariate associations between trial participation and variables of interest. Table 2 lists results for categoric variables, and Table 3 lists results for ordinal and continuous variables. As seen in Table 2, trial type was significantly associated with participation (χ^2 = 13.93; P = .0009), with women being recruited to phase II trials being more likely to accept participation than women recruited to phase I or III trials. Site was significantly associated with participation, with women from M.D. Anderson Cancer Center more likely to decline (χ^2 = 4.78; P = .028). Also significantly associated with participation was knowledge of whether insurance covers the CT (χ^2 = 10.16; P < .006). Women who accepted trial participation were more likely to report that their insurance covered the cost of the trial, whereas decliners were more likely to report that they did not know if their insurance covered the cost of the trial. None of the sociodemographic or medical factors was significantly related to trial participation, although non-Hispanic whites were somewhat less likely to agree to participate (55% of whites agreed, whereas 68% of nonwhites agreed), as were women with less than a high school education; however, race/ethnicity and education are confounded.

As seen in Table 3, women who agreed to participate had significantly higher benefit scores (P = .0003) and lower drawback scores (P < .0001). They were also more likely to report that knowing about CTs made them feel relieved (P = .002) and hopeful (P = .005). There were no significant differences in age, time since diagnosis, or knowledge.

Beliefs About benefits and Drawbacks and Personal Decision

Table 4 lists mean responses to the perceived benefits by accepters and decliners. Helping others and being involved in new treatments were given the highest benefit ratings by both accepters and decliners, although accepters rated helping others significantly higher. The following reasons were also rated significantly higher by accepters: a way of doing something positive, a way to get best medical care, having health followed more closely, and a chance to get more information. Overall, accepters perceived significantly more benefits to trial participation than decliners.

Figure 1 shows the mean response to the individual drawbacks. Ratings on most of the items were significantly different between accepters and decliners. The biggest drawbacks for both groups were undesirable adverse effects of treatment, potential for less effective treatment, experimental treatment too risky, and not knowing what to expect, although all of these factors were significantly greater for decliners. Factors that most differentiated accepters from decliners were transportation problems, disruption of daily routine, too much time, and don't know what to expect. Other significant factors were too much blood drawn, too many injections, lack of privacy, and possible change in relationship with health care provider.

The individual personal decision items show clear differences between accepters and decliners (Table 5). Accepters were more likely to rate benefit to others, potential therapeutic benefits, physician and family recommendation, and trust in medical research as factors in favor of their own decision to participate in the CT. Decliners were likely to report amount of time and travel, potential adverse effects, and attitude toward random assignment as the biggest factors against their own participation. For all personal decision factors, there were significant differences between accepters and decliners. Subsequent analyses by trial type showed that women recruited to phase III trials were more likely than women recruited to phase II trials to say that concern about potential adverse effects and amount of time and travel were factors against participation.

Logistic Regression of Trial Participation

The logistic regression model included variables of theoretical interest in our model (knowledge, benefits, drawbacks, factors in personal decision, race, and educational group), as well as variables significant in bivariate analyses (trial type, site, feeling relieved, and feeling hopeful). The only significant variables were trial type (odds ratio [OR] = 6.44), drawbacks score (OR = 0.37), and two personal decision factors, time/travel (OR = 2.64) and physician recommendation (OR = 2.00; Table 6). Women recruited to phase II trials were more likely to participate, as were women with lower perceived drawbacks, women who saw physician recommendation as a factor in favor, and women for whom time/travel was less a factor against participation.

We next used backwards elimination to obtain a parsimonious model containing only statistically significant variables (model 2). Results are similar to model 1, with the addition of potential therapeutic benefits as a significant positive factor in trial participation.

Table 5. Percentage in Each Response Category to Personal Decision Factors by Participation*

Factor	% of Patients		
	Against	Neither Against nor in Favor	In Favor
Accepters			
Potential adverse effects	12.4	55.2	32.4
Attitude toward random assignment	12.4	47.6	40.0
Trust in medical research	1.0	12.4	86.7
Amount of time/travel required	10.5	61.0	28.6
Physician recommendation	1.9	17.1	81.0
Family recommendation	4.8	28.6	66.7
Friends recommendation	3.8	46.7	49.5
Potential therapeutic benefits	1.0	16.3	82.7
Benefit to others	0.0	5.8	94.3
Decliners			
Potential adverse effects	40.8	54.0	5.3
Attitude toward random assignment	44.7	43.4	11.9
Trust in medical research	13.2	51.3	35.5
Amount of time/travel required	58.7	33.3	8.0
Physician recommendation	6.6	61.8	31.6
Family recommendation	25.3	56.0	18.7
Friends recommendation	9.2	80.3	10.5
Potential therapeutic benefits	14.6	42.7	42.7
Benefit to others	1.3	31.6	67.1

*Significant difference (P < .0001) in χ^2 analysis between accepters anddecliners for all factors.

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Table 6. Logistic Regression Models of Factors Related to Trial Participation

Variable	Model 1		Model 2	
	Odds Ratio	95% CI	Odds Ratio	95% CI
Trial type				
Phase I	2.80	0.18 to 43.01	2.91	0.29 to 29.63
Phase II	6.44	1.20 to 34.69	6.44	1.83 to 32.37
Phase III	1.00	Reference	1.00	Reference
Site				
M.D. Anderson Cancer Center	1.00	Reference		
Other	2.10	0.68 to 6.51		
Race				
White	1.00	Reference		
Nonwhite	1.23	0.34 to 4.56		
Feel relieved	1.13	0.46 to 2.76		
Feel hopeful	0.66	0.23 to 1.90		
Knowledge score	1.01	0.77 to 1.33		
Benefits score	0.72	0.30 to 1.72		
Drawbacks score	0.37	0.18 to 0.76	0.36	0.20 to 0.63
Group				
Booklet	1.98	0.64 to 6.11		
Video	1.00	Reference		
Factors in personal decision				
Adverse effects	1.67	0.88 to 3.18		
Attitude toward random assignment	1.05	0.59 to 1.89		
Trust in medical research	1.71	0.84 to 3.46		
Time/travel	2.64	1.40 to 4.99	2.86	1.68 to 4.87
Physician recommendation	2.00	1.00 to 4.01	2.29	1.34 to 3.90
Family recommendation	1.37	0.69 to 2.72		
Friends recommendation	0.69	0.30 to 1.64		
Potential therapeutic benefits	1.68	0.82 to 3.42	2.28	1.37 to 3.80
Benefit to others	1.23	0.52 to 2.94		

DISCUSSION

It is well recognized that many oncology patients do not participate in CTs, and trial recruitment is often difficult and slow. In this study of patients being recruited to breast cancer treatment trials, we found that trial type, perceived drawbacks, time and travel, and physician recommendation best explained trial participation. Women recruited for phase II trials were much more likely to accept participation than women recruited for phase I or III trials. Potential adverse effects and amount of time and travel were greater factors against participation for women recruited to phase III trials. Random assignment may also be a major drawback for phase III trials,[19,24,22] and phase II trials may also be seen as more cutting edge than phase III trials. Drawbacks, such as concerns about the treatment and time and travel, were also important factors. These factors have previously been found to be major barriers to trial participation.[4,20,22,23,26,31-35] On the basis of the multivariate model, drawbacks were more important than benefits, which is consistent with another study that found that negative aspects of trial participation were more influential than perceptions about advantages.[29]

Although all physicians had invited women to participate in a trial, decliners were significantly less likely to view their physician recommendation as a factor in favor of participation. Either physician recommendation was less important to decliners or they viewed their physicians as less strongly in favor of participation. Other studies have also shown that physician willingness to refer a patient to a trial is one of the major factors affecting a patient's decision[19,36] and that a patient's intentions are significantly related to the type of information physicians provide about CTs.[37] Physicians have views about the value of particular trials for individual patients and may convey these either directly or indirectly to patients. Although several studies have focused on the physician's role in recruitment,[28,37-40] more work is needed on how physicians and other health care professionals communicate CTs to patients.

Knowledge about CTs was not related to participation. However, all study women received educational materials, and knowledge for both groups was high. This finding is consistent with the findings of Davis et al,[30] who found that a booklet improved cancer patients' knowledge about CTs but did not affect recruitment. It is also consistent with research showing that knowledge is not sufficient to affect behavior[29,41-43] and that interventions need to go beyond imparting knowledge.

There are several implications of this study for the clinical oncologist and those who design CTs. First, to improve trial recruitment, trial logistics need to be easier for patients. Greater participation by community oncologists in CTs could help increase participation by reducing patient travel time. Reducing clinic visits, protocol burden, and other potential drawbacks may also help. Second, physicians may be unaware of how they present trial information to patients and need to be cognizant of their biases and how these influence patients. Third, future research on CT recruitment might focus primarily on phase III trials.

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There are several limitations of the present study. First, women who declined trial participation at the time of trial recruitment were not included in the study. Although this group was small (n = 5), their decision may be influenced by different factors compared with women more open to participation. Second, although the percentage of nonwhite women was higher than most other studies of breast cancer patients,[20,28,44] the sample consisted of young, predominantly white women of higher education seeking treatment at a major cancer center. Thus, results cannot be generalized to all women being recruited for CTs. Despite this limitation, however, our results are remarkably consistent with those of other studies.

In conclusion, this study suggests that additional interventions and strategies beyond imparting knowledge are needed to reduce trial drawbacks and increase participation. Physician recommendation is an important factor related to participation, and greater attention to this is needed in the recruitment process.

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Acknowledgment

The Acknowledgment is included in the full-text version of this article, available online at www.jco.org. It is not included in the PDF version (via Adobe® Reader®).

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Thur. | Oct. 20, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ruffin Bynton MD	Chief of Staff / Transylvania Regional Hospital
Kinneil Coltman	N/A
MARK HADDAD	None
Bill McClement	Asheville Radio Group
Mary Fruci	CCNC-A
Aimee McNeill	
Mike Dowling	
[illegible]	
Steve Metcalf	
Barbara Jordock	
Jim Lawson	

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NAME	FIRM OR AGENCY AND ADDRESS
John Garrett	Resident / AVL Gastroenterology
Frank Cox	Benefit Planners
Matthew Guffey	N/A
Nancy Righi	Mission
Rich Rigle	Mission
Miriam Schwarz	WCMS
[illegible]	Mission
REID DAVIS	MISSION
Matt Wolfe	Parker Poe
C Bryan	[illegible]
Stephen Hulkower	MAHEC

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Maureen Murray	Smith Moore Leatherwood
Marth Patt	MISSION FOUNDATION
Barbara Blomberg	" "
Kevin O'Connell	" "
ROBERT FORD	HOT Springs Health Program
CALVIN TOMKINS MD	ASHEVILLE PEDIATRICS
Sharon Hathaway, MD	Mission Hospital
Val Reagor	" "
James Keel	Mission Hospital
Jeff Coston	
Linda Ross	Mission Hospital

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NAME	FIRM OR AGENCY AND ADDRESS
Karen Romy	Mission Health
Mark Stone	First Citizens
Becky Pitts	Mission Health
Julia Hicks	Citizen
Linda Hopp	citizen
Jennifer Sizemore	Mission
JACK SPIES	M.M.H.
RANDY M. LEDFORD	———
Joe & Helen Sandven	Mission
Chuck Bryan	CCWNC / Physician
Celeste Collins	OnTrack 50 S. French Broad Ave Aville

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Gwen McKinney	Mission
Margaret Williams	Mountain Xpress - 2 Wall St Asheville NC 28806
Rudy Ziegler	Mission Health System
Al [illegible]	" " "
Walter Aill	Mission
Jody Bender	" "
Scott Dedman	Mountain Housing Opportunities 64 Clingman Ave, Ste 101 28801
Scott Donaldson	1216 6th Ave West Hville NC 28739
Bonnie Reece	2 Medical Park Dr. WMC.
Selena Cittrell	Mission
Rebecca	Mission

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NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	21st Century [illegible] [illegible]
Dana Jones	Mission hospitals
John E. Stewart III	Mission Hospital
Valen W. Vera Cruz	Prudential Lifestyle Realty
Ted Rhenney Jr	Asheville Head Neck + Ear
Beverly Gottfried	Candler NC
Nick Osborne	Mission
Shirley Geter	Mission (Diabetes Wellness)
Harold Moore	Pardee Hospital
Sandra Howard	Zirconia N.C.
William Howard	Zirconia, NC.

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John E Black	
Kelli Moore	Mission
William Schellwolfe [illegible]	Mission
Myron Gottfried	
Steve Kolotnik	
~~Heather~~ Powell	MISSION
Lisa Klein Fisher	Mission
Margaret Noel ws	MemoryCare
Alan S Baumgarten	Asheville Family Hlth Ctr
Caitlin Byrd	Mountain Xpress
Alan Vern	Looking Glass Eye Center

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NAME	FIRM OR AGENCY AND ADDRESS
Ray Hudson	for Park Ridge
Juanita Hudson	for Park Ridge
TRACY Buchanan	Care Partners
[illegible] Bowers	Care Partners
David Bailey	United Way of Asheville & Buncombe County
David, Kay Poorbaugh	MH
[illegible]	MH
Deanne G. [illegible]	MH
Denise Ebert	Mission
STEVE SEAL	
Dolph Diamond	

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H Wesley Garbee	Asheville Pediatrics
Darlene Schleider	Mission Health System
Christine Dresbach	Mission Hospital
[illegible]	ABRBJ
Diane Schermann	Mission Hosp
Arlene Fecks	Resident
Katie Garner	Mission
Tricia Trinito	Resident
Bob Roberts	Mission Board
Pamela Holt	BCBSNC
Stephen T. Hill	Mission Physician

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John Lendfors, ret.	127 Fulton Dr. H'ville, NC 28792
Kristen Weaver / Kristen Weaver	YMCA of WNC 53 Asheland Avenue, Suite 105, 28801
AAJC Steve Kovach MD	175 Busbee Mtn Rd Asheville NC 28803
Carol Ringer	Resident
Susan Sutherland	Mission
Fred Ringer	Park Ridge -
Michael LeCroy	Mission Health
ALAN JOHNSON MD	ASHEVILLE CT
ALFEED MINA, MD	Haywood County
Bob Davy	Henderson Co
Frank Moore	Asheville Anesthesia Assn

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Mark Schulm[illegible]	Times-News
Chris Batson	Mission
Mary Walker	Mission
Karen Moore	Mission
Cindy Brown	Mission
Kimberly Baker	PPA, Inc.
[illegible]	Asheville Radiology
Terri Hill	Mission
Frank DiBari	MISSION
Bob Moore	Mission
Jill Gunther	Park Ridge Health

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Gus Wilde	Angel Med Ctr
Crystal Boyd	Mission
Brandilyn Poolbaugh	Mission
William Roberts	Citizen
Karen Grogan	Mission
Donna Donaldson	Mission
Robin Bran	Mission
Sandi Boyer	Irene Wortham Ctr.
Candy Shivers	Mission
J G Shweis, MD	Mission
Robert Park MD	Carolina Ophthalmology

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Nancy Dexter	Asheville Anesthesia Associates
Roger Dexter	Mission
Carrie Castellon	Mission
Roger Haught	Mission
Kay Fenger	Mission
Allison Weller	Nelson Mullins
Karen Gortney	Mission
Mary Silver	Mission
Anna S Osborne	Mission
Mary Null	Mission
John Ruhl Jr	Mission

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Lisa Cummings	Catawba Valley Medical Center
Doug Saddrker	NCHCFA
ANDREW HART	ASHEVILLE ANESTHESIA ASSOCIATES
Dudu Murphy	HPS
Kathy Poling	Mission
Terry Poling	The Poling Group, Inc.
Charles Blankenship	Mission Health
Mary Haynor	Mission
Chris Shelton	Mission
Marta Stineman	Mission
Renee Huffman	Mission

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Trevor R Davidson	Fletcher Park Inn
George Cecil	Biltmore Farms Asheville, (NMA)
Chris Taylor	NCMCC
Gloria Myers	
Walter Wayne Kuttle	Fletcher Park Inn
JASON Wells	PARK RIDGE HEALTH
[illegible]	CVMC
Robert [illegible], MD	PARDEE Hospital
Ken Martin	Resident
FRANK Ford	Mission Health
BOB BURGIN	Retired Citizen

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Ana Sandin	Mission Hospital
Nancy Rubinic	Mission Hospital
Ann Owen	
Christie Mebean	Volunteer Mission
Connie Cathey	Vol. Mission
Fran Osten	" "
[illegible]	Murphy Medical Center
Jack Cecil	Biltmore Farms, LLC
John Cooper	Compass NC, Raleigh NC
Jim Harrell, III	WakeMed
Kathy Blake	21st Century Oncology

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	Robert W. Olson
Lorraine Olson	
C. F. Hergel	FPI
Arlene Dennison	FPI
Ralph W Royo MD	MD Fletcher Park Inn, Naples Rd
Jill Mahuey	Mission Hospital
Albert & KB Parker	FPI
George Renfrow	Nash Renfro Companies
Ben Escobar	Mission Health System
Drexdal Pratt	NC DHSR
Tina Shanahan	Citizen

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NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	Mission
[illegible signature]	Mission
Cathy Ralston	Mission
Heather Wells	Citizen
KARL H BAHR	CITIZEN
Mary Richard	Citizen - Mission
David Richard	Citizen
Dale Twomley	Fletcher Academy, Inc
Connie Twomley	" " "
Jean Johnson	" " "
Liz Harris	" " "

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NAME	FIRM OR AGENCY AND ADDRESS
Tinka King	Park Ridge Health
Brandon Sutherland	Dixon Hughes Goodman LLP
Cherry Odom	Mission Health
John Metcalf	Mission Health
Betty M Bahr	Park Ridge Health
Jim Barrett	Pisgah Legal Services
Cindy Benton	Mission Health
Genalia Gibson	Horse Shoe
Nita Morehead	Horse Shoe
Joseph Eigman	Fletcher Park Inn
Ina Eigman	Fletcher Park Inn

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NAME	FIRM OR AGENCY AND ADDRESS
David Prest, Sr.	Park Ridge Health
Barbara Prest	Park Ridge Health
Orian [illegible]	Citizen
Stephanie Kiso	Mission Health
[illegible]	Dixon Hughes Goodman
[illegible]	Mission Health
Alison Whipple	Mission Health
Phil Davis	Mission Foundation
Karen Bianchini	Mission Health
Salvador Varejas	WACCHS 10 Ridgelawn Rd.
HUGH TILSON	NC HOSP ASSn

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Anthony Wyatt	Park Ridge Health
Angie Rau	PRH
R Craig Lindsey RN	Park Ridge Health
Tracy Lindsay	PRH
Melisse Church	PRH
BART Boeckler	PRH
Lyndi French	PRH
Emily French	PrH
Susie Bunch	PRH
Gerald Nash	PRH
Becky Holt	PRH

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Rebecca Carter	Transylvania Reg. Hosp.
Robert Bednarek	Transylvania Reg Hosp
Kristi Sink	Mission Hospital
Alan D. House	Pardee Hospital
Dorothy Phillips	Park Ridge Health
KIT CRAMER	ASHEVILLE AREA CHAMBER
Stacy Quaranta	21st Century Oncology
RICHARD CHURCH	UPM RAFLATAC
Andrew Byrd	Park Ridge Health
Jean Long	21st Century Oncology
Harold Long	" " "

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Kelli King	Park Ridge Health
Tyler Harris	PRH
Jennifer DeCurtis	Resident of Fletcher and Park Ridge employee
Janet Moore	Mission
Jill Hoggard Green	Mission
David H Bauer	Park Ridge Hosp
C A Scarborough	" " "
Charles Ayscue	Mission
John Short	Asheville Radiology
Jon Brown	Mission
Jennifer Lawrence	Citizen

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Allison Robinson	PRK Ridge oncology
Kirsten Aumann	PRH
Michael Lindsey	Park Ridge Health
Cathy Maillard	Park Ridge Health
Caitlyn French	PRH
[illegible] J Bauman	Robinson, Bradshaw, [illegible]
Jeanie Howard	Park Ridge
Gary Carlson	Park Ridge Health
Chuck Jones	PRH
Michael Calloway	PRH
Jennifer Roberts	Park Ridge Health

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Blake Hill	Parkridge Health
Debbie Gentry	Park Ridge Health
WENDELL ROBERTS	PRH
Amanda Maillard	PRH
Sharon Barnwell	Park Ridge Health
Jerry Barnwell	Park Ridge Health
Ann Young	Mission Health
Sylvia Donahue	PRH
Bernie Veltman	Park Ridge Heath
Jackee Clodio	" " "
Elizabeth Culver	Park Ridge Foundation

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NAME	FIRM OR AGENCY AND ADDRESS
Donida Fleming	Mission Hospital 501 Biltmore Ave Asheville NC 28801
Jonathan Bailey	Mission Hospital 501 Biltmore Asheville NC 28801
TRUE MORSE	Mission
Barbara Platz	Pardee Hospital
[illegible] Phillips	PARK RIDGE
Adam Reed	park Ridge
John Locke	Mission
Bill Kelly	mission
Heather Scarborough	Park Ridge
Denise Gunter	PRH
John [illegible] Freeman	

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Debra Williams	PRHealth
David Roberts	Park Ridge Health
Bruce Thorsen	Mission Health
Karsten Randolph	Park Ridge Health
Brent Sedgwick	Hville
Cynthia Cook	PRH
[illegible]	PRH
Jessica Henderson	PRH
[illegible]	PRH
Marc Westle	Mission 16 Huntington Chase Dr Asheville
Lauran Adams	Mission 4970 Hunting Country Rd Tryon NC

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NAME	FIRM OR AGENCY AND ADDRESS
Kathleen McNeel	Mission Hospital
Tom Wise	Concerned Citizen
Elaine + Gerry McGuire	Mission Advocates

REMINDER: IF YOU HAVE WRITTEN COMMENTS AND WISH TO BRING THEM FORWARD PLEASE DO SO.

(1)

Speakers' Sign-In Sheet

10/20/11

YES WITH ✓ HAS TURNED IN COMMENTS.

	NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
1 M	Bleke Fagan	MAHEC	X
2 P	Suzanne Watkins	Private Citizen	NO
3 P	Elizabeth Davey	Citizen	Yes ✓
4 P Bruce Pearlman	[illegible signature] MD	Physician	No
5 P	Todd Guffey	Citizen	No
7 P	Daniel T. Walker	Henderson Cty Citizen	Yes
8 P	WENDELL ROBERTS.	Henderson Co citizen	no
9 P	Ken Cobb	HDC RESIDENT	YES ✓
11 P	Debbie Wooton	New Hendersonville Resident	NO
12 M	Jennifer Bock	Racquet club Rd	NO
13 M	Tim Hubbs	Angel Medical	NO
14 P	PAUL DONAHUE	CITIZEN	YES ✓
6 M	Scott Joslin MD	Physician · Mission Hospital	yes
15 P	SUSAN Hoy	Henderson County Resident	NO
16 P	Diane Beerbower	Henderson Co Resident	N

(2)

Speakers' Sign-In Sheet

8:42

	NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
17P	Renae Johnson	Henderson Co Resident	NO
18	Kent Williams	"	Yes
19M	Bob Morrow	McDowell Hosp.	YES
10M	Dale Fell	Mission	NO
20M Spradling	Bonnie Spradling	Mission	YES
21M	GLENN W. Wilcox Sr	Wilcox Travel / Mission Foundation Brd.	NO
22	Mark Murrill	Fletcher Resident	YES
23P	Brandon Nudd	Hendersonville Resident	Yes
24P	Alan Guyton	Henderson County	Yes
25M	Elizabeth Brazas	Community Foundation	no
26M	Aimee McNeill	Mission Patient	No
27M	Wyatt Stevens	Mission Board	No
28M	Kit Cramer	Asheville Chamber of Commerce	N
32P	Sandra Page	Polk Co. Resident	No
	Diane Sedgwick	Hendersonville	No
29P	Ann Pardee		
30M	Will Hathaway		
31P	Jim Puckett		

(3)

Speakers' Sign-In Sheet

	NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
	Susan Mims	Mission	Yes
32P	Arthur Slagle	Buncombe	NO
33	Bob Maxwell	Transylvania Reg Hospital Board Chair	NO will like only 7 PM
	BRANDON SUTHERLAND	Mission	No
	RL CLARK	Former N.C State Senator	NO
31	JAMES B. PUCKETT MD	AT LARGE	yes
	Barton R Paschal, MD	Haywood Cancer Ctr	yes ✓
	KIT CRAMER	ASHEVILLE AREA CHAMBER OF COMMERCE	yes ✓
30 →	WILLIAM R HATHAWAY	ASHEVILLE CARDIOLOGY MISSION	No
	Steve Hill	Asheville Womens	NO
	JENNIFER BOCK	PATIENT / CITIZEN	Y ✓
	Dr Dickerson	Asheville Radiology	NO
	Matt Guffy	son of 2 patients	NO
	Jeff Bromme	Park Ridge	Yes
	~~[illegible] Lawrence~~	~~Citizen~~	~~[illegible]~~

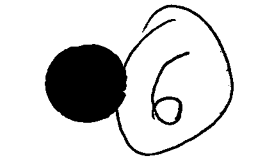
Speakers' Sign-In Sheet

NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
David Bailey	~~YMCA~~ UNITED WAY	YES
Robert Ford	Hot Springs Healthcare	no
Richard Bock	Private Practice Surgery &	Mission Board no
Bob Roberts	Mission Bd.	No
Bob Morrow	McDowell Hospital	NO
Al Whitesides	Mission FB	NO
Carlos Gomez	WNC Community Health Servics	No
Bob Maxwell	Transylvania	No
Bob Decker	Mission - Heart Patient	No
David Manly	Park Ridge Hospital	NO
Carlos Gomez	WNC CHS	Yes
Jim Barrett	Pisgah legal Services	No.
Nancy Robinson	Cancer Patient	Yes
Ann Pardee	Cancer Patient	No
Paul Bellows	Buncombe Cty resident	No

(5)

Speakers' Sign-In Sheet

NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
LARRY HUGHES	DIXON HUGHES GOODMAN	NO
Brandon Sutherland	Dixon Hughes Goodman	No
BARTON PASCHAL	Physician	Yes
Jim Puckett	Physician	Yes
Al Mina	Physician	No
Bill Miller	Physician	No
Bryan Dickerson	MD	No
Mary Sloop	RN	Yes
Keith Maxwell	physician	No
Bill O'Connor	County Commissioner	No
BOB BURGIN	Retired citizen	Yes
ANDREW HART	MD	NO
CLAUDIA MUSE	WNC HEALTH COALITION	YES
Keith Maxwell	Physician	No
Jeff Costan	Physician	No



Speakers' Sign-In Sheet

NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
~~Carrie Castellon~~	~~Mission~~	N
Gus Wilde MD	Angel Med Ctr	N
Robert Park MD	Carolina Ophthalmology	Y
John Ashley MD	Self	Y
Bob Decker (written comment)	Mission	Y by Karen Moore
Leon Elliston	- mission	No-
Darlene Ann	Mission	N
Elizabeth Brazas	Citizen	N

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, November 17, 2011
TIME: 6:00 p.m.
LOCATION: Cape Fear Community College
COMMENTS: McLeod Building, Room S-002, 411 North Front Street, Wilmington, NC 28401, Doors will open at 5:00 p.m. for Speaker Sign Up, Meeting will be from 6:00 p.m. to 9:00 p.m.

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **8 AM** o'clock on **October 30, 2011.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

2011-2012

CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES HOUSE SELECT COMMITTEE

MINUTES

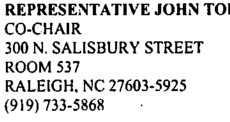
General Assembly of North Carolina

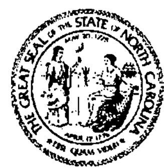
EPRESENTATIVE FRED STEEN
O-CHAIR
0 N. SALISBURY STREET
OOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina


REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868



AGENDA

6:00 p.m. Tuesday, November 17, 2011
Cape Fear Community College, Wilmington, NC

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Presentations to the Committee

- *Denise Mihal, RN, MBA*
  President, Brunswick Novant Medical Center COO, Novant Health's Eastern Carolina Market

- *Dennis Coffey*
  Chief Financial Officer, Dosher Memorial Hospital

- *Sue Collier, RN, MSN*
  Vice President, University Health Systems of Eastern Carolina

  Herbert G. Garrison, MD, MPH
  Vice President, Medicaid Affairs, Pitt County Memorial Hospital
  Professor of Emergency Medicine, Department of Emergency Medicine, The Brody School of Medicine at East Carolina University

  Brian Kuszyk, MD
  Chief of Staff, Department of Radiology, Chief of Staff Elect, Pitt County Memorial Hospital

- *John Gizdic*
  Vice President of Strategic Services and Business Development. New Hanover Regional Medical Center

III. Public Comment

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

THURSDAY, NOVEMBER 17, 2011

6:00 p.m.

CAPE FEAR COMMUNITY COLLEGE, WILMINGTON, NC

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, November 17, 2011 at the Cape Fear Community College in Wilmington, NC at 6:00 p.m. Representatives Avila, Brandon, Steen, and Torbett were present.

Representative Steen presided. He welcomed members and audience and introduced members and staff. Representative Torbett welcomed everyone.

The following presentations were given:

Denise Mihal, RN, MBA, President, Brunswick Novant Medical Center COO, Novant Health's Eastern Carolina Market (see attached)

Dennis Coffey, Chief Financial Officer, Dosher Memorial Hospital(see attached)

Sue Collier, RN, MSN, Vice President, University Health Systems of Eastern Carolina(see attached)

Herbert G. Garrison, MD, MPH, Vice President, Medicaid Affairs, Pitt County Memorial Hospital Professor of Emergency Medicine, Department of Emergency Medicine, The Brody School of Medicine at East Carolina University(see attached)

Brian Kuszyk, MD, Chief of Staff, Department of Radiology, Chief of Staff Elect, Pitt County Memorial Hospital (see attached)

John Gizdic Vice President of Strategic Services and Business Development, New Hanover Regional Medical Center (see attached)

Representative Torbett: On line 7 you mentioned 29.6 million in bad debt, is that fiscal year?
John Gizdic: That is an annual amount that we provide in bad debt, and bad debt as opposed to charity care, those who qualify with guidelines, as Denise went over in her presentation as it relates to the poverty level, bad debt are accounts that we would expect to collect, but people do not pay.
Representative Torbett: Slide 8, can you give me your qualifiers for your listing of uncompensated care clause?
John Gizdic: Two ways to look at uncompensated care. On this slide this is the total amount of bad debt and charity care. This is gross charges, on the prior slide I mentioned the ANDI report because that is a consistent way for hospitals across the state to identify community benefit.

Representative Avila: Back in your uncompensated care slide, how does your cost per patient compare from 2001 to current? And in the number, are you serving more patients? You just have a gross number here. Serving more people is going to make that go up.
John Gizdic: Probably the easier way to describe that would be on a percentage basis or percent of our revenue that is uncompensated. About seven years ago I believe our uncompensated care was running about three percent and today it is approaching seven percent. Proportionately it has gone up dramatically. Those are the dollar amounts. So certainly serving more patients, as we have grown, that has grown with it, but is has grown at a higher rate than the patient volume has grown.
Representative Avila: The gross patient revenue by payer is probably one of the most amazing things I have ever seen. How in the world are you able to go with 67%, with those that do not pay 100% or not at all if you are staying in business. What is the secret?
John Gizdic: I think that is the struggle of every not for profit hospital in the country right now, is how much longer can we survive with cuts in reimbursement and our expenses continuing to go up. I think almost half of the hospitals in North Carolina lost money last year. So it is certainly a challenge. Through collaboration, through our commitment to our employees, we've been able to sustain solid financial performance, but it is a greater challenge every year as that payer mix changes and reimbursements go down.

Representative Brandon: If you are a public hospital, that is also a teaching hospital, are you able to qualify an AMC exemption also, how does that work?
John Gizdic: No we are not classified as an academic medical center, we are just a teaching hospital. We get residents from those fine facilities.

Public Speakers deferred.

Representative Avila: The resident program has always been an issue for me, because I find a number of young people I know, that have gone to medical school and they go outside of the state for residency because there are issues with having enough slots here. How is that program set up and what happens with it?
Paul Vick, East University Medical Center: It is a national system in which there are x number of slots for students to apply. There is actually a national matching system, matching students to their first choices and institutions to their first choices. So students from North Carolina choose programs that are out of state or there may be a specialty in which there are residency slots in North Carolina.
Representative Avila: One of the things that I have seen that happens is that most of the time the students that stay in the general area where their residency is. Where does the money come from?
Paul Vick, East University Medical Center: Part of the money comes from Medicare, which is payment in the GME system, but in most cases GME only pays a portion of the cost of residents. The individual institutions have to come up with the additional dollars. There are a limit to the number of residencies that Medicare will pay for. Most of the institutions in North Carolina, we may have 400 slots that Medicare compensates part for, but most of us have residents in excess of that.

Representative Torbett: Is there some way to increase the number of slots?
Paul Vick, East University Medical Center: There has been legislation from the federal level for several years to try to increase the number of slots by 15,000 and it has not been successful at the federal level. The thing that you could do at the state level would be for the state to increase the compensation at public institutions at East Carolina and UNC by actually funding additional residency slots.

Representative Steen adjourned the meeting.

Representative Fred Steen, Co-Chair, Presiding

Viddia Torbett, Committee Clerk

Representative John Torbett, Co-Chair

House Select Committee on the Certificate of Need Process

My name is Dennis Coffey. I am the Chief Financial Officer for Dosher Memorial Hospital in Southport. Dosher is a Critical Access Hospital that has served the needs of Southeast Brunswick County for over 80 years. First, let me say that I am supportive of the CON law and believe it is necessary to avoid unnecessary duplication of services and "skimming of profitable services" that financially harm community hospitals. It is far too difficult in today's environment to cover the cost of those patients without the ability to pay who use community hospitals as their primary source of healthcare. I do believe there are many opportunities to improve the process and reduce the administrative burden on healthcare providers.

These issues are fresh on my mind, as our Hospital filed on November 15th the document I have with me tonight. You can see that this I quite a large amount of paper for a project that will renovate patient rooms that were built in the 70's, do not meet ADA requirements for toilet facilities, and do not have a sprinkler system. We have incurred costs of over $100,000 just to file this application. And this does not count the staff time expended to gather the data required to fulfill the requirements. Many of the documents requested could be avoided if the facility making the request is Joint Commission Accredited. Copies of policies required for accreditation should not be needed.

I would offer the following suggestions for improving the process:

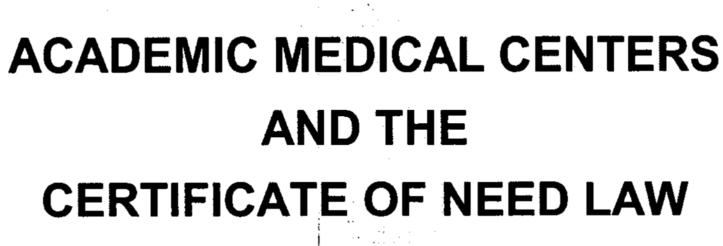
- The current $2,000,000 limit is too low. This has not changed in far too many years.

- There needs to be an expansion of the categories of what can be expedited. $5 million is a good start, but replacement / modernization project limits could move up to a higher level, maybe $15 million and save everyone time and money.

- Appeals process is too long and costly; should be shortened; penalties for frivolous appeals should be higher and more enforceable. There should be particular focus on appeals by competing entities so that appeals are not filed merely to slow down a competitor.

- Small hospitals are penalized by current target occupancy tiers. Critical Access Hospital's (CAH) target occupancy should not be same as 99 bed hospital. Daily fluctuations in census have a much greater impact on smaller facilities. Five patients in a CAH would be 20% of the licensed bed capacity, vs. 5% of the 99 bed hospital. CAH should have lower target, no more than 50%.

- Failure to recognize dual role of beds for observation/inpatient acute care is not realistic. CON methodologies and state plan need to keep up with reality of way small hospitals are operated. Observation patients occupy the same beds as patients counted in current methodologies. Using these patients in the census count would reflect the reality of using the same beds, which is far more cost effective than building and staffing a separate unit. This would hold true up for most hospitals with less than 100 beds.



ACADEMIC MEDICAL CENTERS AND THE CERTIFICATE OF NEED LAW

UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital

Academic Medical Centers and the CON Law

Key Points

- **Academic Medical Centers (AMC's) provide a unique and vital service for North Carolina citizens**
- **Policy AC-3 (the AMC exemption) is not exemption from all Certificate of Need requirements and is limited to individual AMCs**

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Pitt County Memorial Hospital

AMCs – Unique & Vital Service

AMCs	Medical School
Pitt County Memorial Hospital, Greenville →	Brody School of Medicine at ECU
Duke University Hospital, Durham →	Duke University School of Medicine
UNC Hospitals at Chapel Hill, Chapel Hill →	UNC-Chapel Hill School of Medicine
Wake Forest Baptist Health, Winston-Salem →	Wake Forest University School of Medicine

University Health Systems
Pitt County Memorial Hospital

AMCs – Unique & Vital Service

- **NC's four medical schools host 1831 medical students**
- **Over 80% of the medical residents in North Carolina are trained at the four AMCs**
- **AMC teaching activities are critical to the education of the state's healthcare providers.**
  - Nearly 40% of NC medical school graduates practice in our state
  - Over 40% of physicians who did their residency in NC stay in state
  - 59% of Brody School of Medicine's (BSOM) graduates practice in NC
  - 28% of BSOM graduates practice in rural North Carolina
  - 4,477 UNC-CH School of Medicine medical students and residents practice in NC

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Pitt County Memorial Hospital

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AMCs – Unique & Vital Service

- **AMCs provide unique clinical education and training, including:**
  - Full-time clinical education for 3rd & 4th year medical students
  - Full-time clinical training for residents of many clinical specialties
  - Full-time clinical training for nurses, physician assistants and medical technicians
  - Basic science research
  - Clinical research that results in advancements in clinical care, clinical trials and treatment protocols
- **AMCs have integrated research, teaching and clinical missions**
  - Clinical services are needed to train learners and conduct clinical research
  - Clinical operating margins defray the unfunded cost of research and education

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Pitt County Memorial Hospital

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Requirements of Policy AC-3

Policy AC-3 is only available under defined circumstances:

- Bona fide academic need
  - Academic accreditation requirements
  - Documented expansion of research activities
  - Documented expansion of students or residents
  - Equipment necessary for the recruitment or retention of faculty
- Demonstration that other non-AMCs within 20 miles cannot meet the need, after consultation regarding possible collaboration

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Why is AC-3 Needed?

- **Research and education needs are not reflected in the regular need methodologies of the State Medical Facilities Plan.**
- **AMC's need flexibility to submit CON applications to accommodate:**
  - Approved expansions of residency programs
  - Newly won research funds
  - Changes in requirements of specialty education accrediting bodies

Examples of AC-3 Projects

- Duke acquired a dedicated pediatric heart-lung bypass machine to support research, teaching, and clinical service in pediatric open-heart surgery
- UNC was approved to acquire a linear accelerator solely dedicated to intra-operative use to support research, teaching, and clinical needs related to particular oncology patients.
- Baptist has an MRI and PET/CT simulator obtained through Policy AC-3 for the exclusive use of radiation oncology treatment planning and related research and education
- Pitt County Memorial Hospital added 20 pediatric and traumatic brain injury rehabilitation beds to provide specialty training to physical medicine and rehab residents *(previously residents had to travel across the state for the specialty training)*

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AMCs and Policy AC-3

- **Academic Medical Centers must comply with the Certificate of Need Law**
- **Policy AC-3 is not an exemption from all CON requirements**
  - Policy AC-3 provides an alternative to the need determinations set forth in the State Medical Facilities Plan for academic projects under defined and very narrow conditions.
  - Using Policy AC-3, AMCs must still meet all CON statutory criteria, **in addition to** the requirements of the Policy.
  - Like all CON applications, AC-3 applications are subject to review, public comment and hearing, and appeal, and they are not always approved.

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AMCs and Policy AC-3

- **Applicants must consult with non-AMC providers within 20 miles before filing applications under Policy AC-3 about possible collaboration to meet academic need. No other applicants must consult with other providers before filing applications.**
- **Other providers may participate in the public comment and hearing process, and may appeal approvals of applications.**
- **All providers have the ability to seek changes or exceptions to the need determinations for non-academic needs, through petitions to the State Health Coordinating Council.**

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Pitt County Memorial Hospital

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AC-3 Over Time

- **In almost 30 years of the Policy, we are aware of opposition to only three AC-3 applications** *(Two were resolved quickly; the third is still in litigation, the appellant has availed itself of its statutory appeal rights to challenge the approval of the application)*
- **For decades there were no petitions filed with the State Health Coordinating Council to modify the Policy, despite annual opportunities**
- **Last year, the issue was raised with the SHCC**
  - Extensive analysis and discussions among all stakeholders about the Policy
  - NCHA convened a task force, including representatives of those parties opposed to the Policy, to examine the issue and make recommendations
  - NCHA produced a recommendation unanimously endorsed by the task force and the NCHA Board, which was subsequently approved by the SHCC
  - Novant Health expressly supported the revised Policy and endorsed its adoption

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AMCs in 1983 and 2011

- **The "footprint" of the AMCs remains unchanged since Policy AC-3's inception in 1983**
- **The Policy is expressly limited to the 4 hospitals directly attached to the state's 4 medical schools.**
- **While AMCs may be in systems with other hospitals, the Policy is strictly limited to the academic medical center teaching hospital itself**

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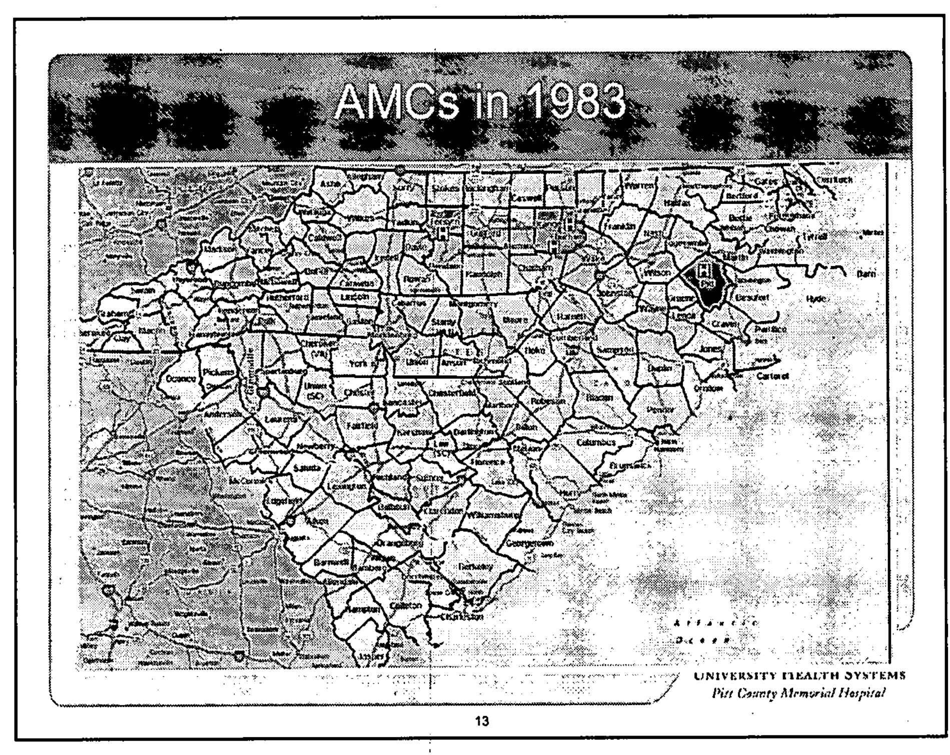
AMCs in 1983
UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital
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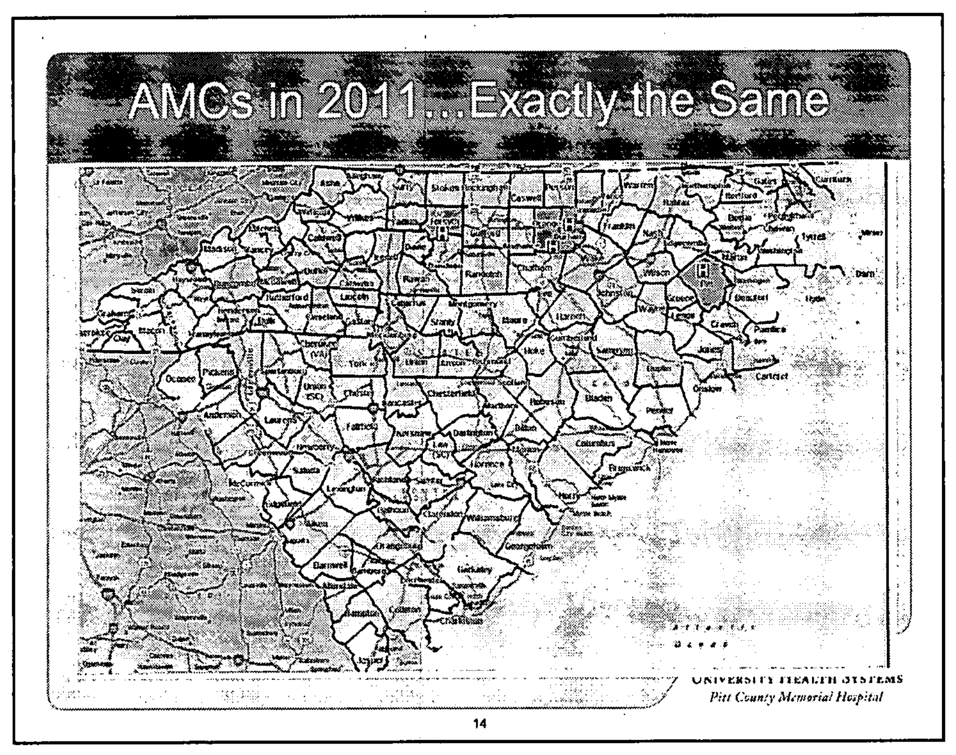
AMCs in 2011...Exactly the Same
UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital
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AMC and CON Law Summary

- Academic Medical Centers are not just large hospitals, they offer unique and vital services
- AMCs must be able to meet teaching and research needs that do not exist at other hospitals, AC-3 recognizes this need
- AMCs can only use Policy AC-3 within narrowly defined circumstances
- The current Policy AC-3 has been unanimously supported by the State Health Coordinating Council, the North Carolina Hospital Association, the academic medical centers, and other non-AMC hospitals

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Pitt County Memorial Hospital

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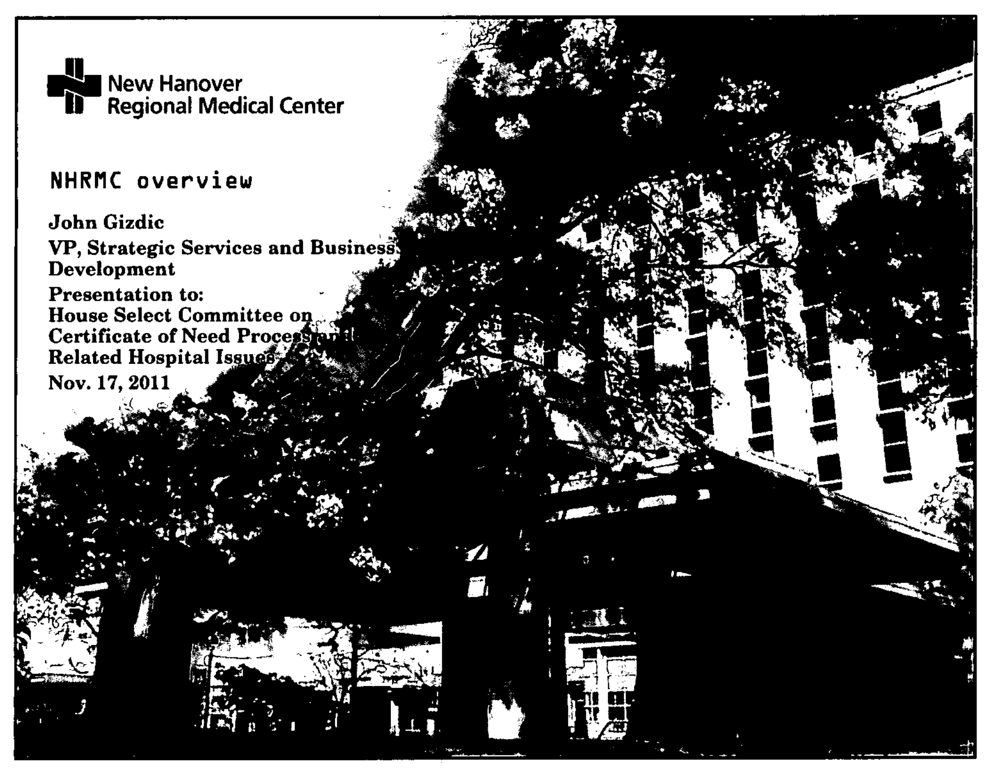
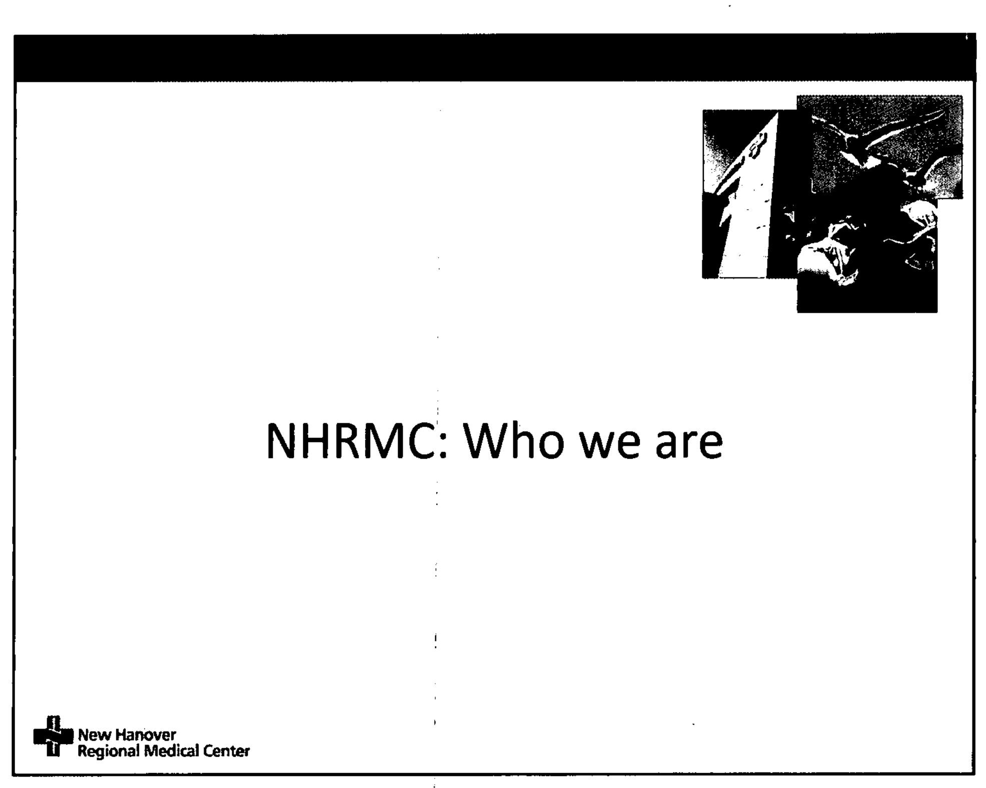
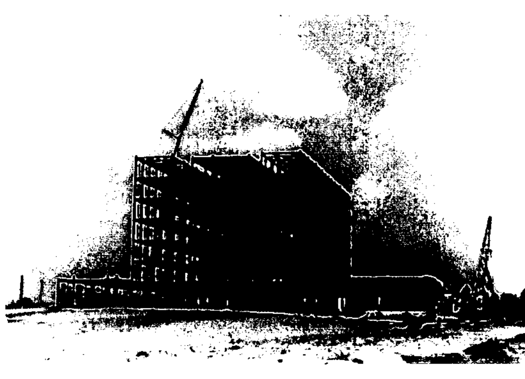

New Hanover
Regional Medical Center
NHRMC overview
John Gizdic
VP, Strategic Services and Business
Development
Presentation to:
House Select Committee on
Certificate of Need Process
Related Hospital Issues
Nov. 17, 2011


NHRMC: Who we are
New Hanover
Regional Medical Center

A historical overview

- Voters approved bonds for New Hanover Memorial Hospital in November 1961. Issue passed by 272 votes
- Voters rejected funding hospital operations
- Hospital opened June 14, 1967, merging black and white hospitals without violence, protest or demonstration - this region's shining civil rights moment
- Mission of serving all – regarding of race, creed, or ability to pay – continues today



Today, taxpayers in New Hanover County pay this much toward NHRMC's budget:

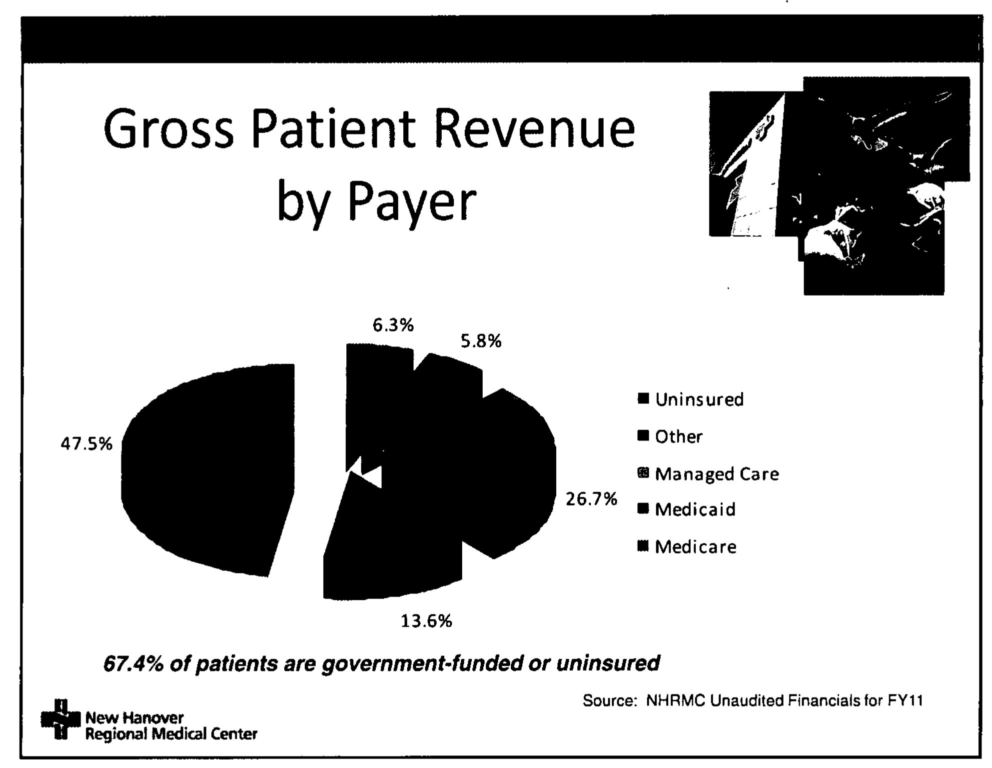
$0

Organization overview

- NHRMC is ninth-largest hospital in North Carolina. Licensed for 769 beds
- By far the state's largest county-owned public hospital (NHRMC and Carolinas Health System – a hospital authority – are only county-owned hospitals among state's largest 25 hospitals)
- NHRMC includes:
  - Main campus on 17th Street
  - Cape Fear Hospital
  - Coastal Rehabilitation Hospital
  - Behavioral Health Hospital
  - Cameron Women's and Children's Hospital
  - New Hanover Regional EMS
    - Relieved county taxpayers of annual $2 million debt
    - Cardiac save rate went from 4% in 1998 to 33% today
- Management agreement with Pender Memorial Hospital – Critical Access Hospital – preserving access in rural county

Clinical excellence

- NHRMC offers specialized services in cardiac, orthopedic, oncology, vascular, trauma and neonatal care
- Orthopedic program consistently ranking among nation's top 10%
- Centers of Excellence in Cardiac and Bariatric services. Designated as Teaching Hospital Cancer Program. Working toward certification as Stroke Care Center
- Teaching hospital in four residency programs: Internal Medicine, OB/GYN, Surgery, and Family Medicine. Affiliated with the UNC School of Medicine
  - Family Medicine's mission is training physicians to serve rural areas
- Physician staff of 540+ offers specialties comparable to larger metro areas

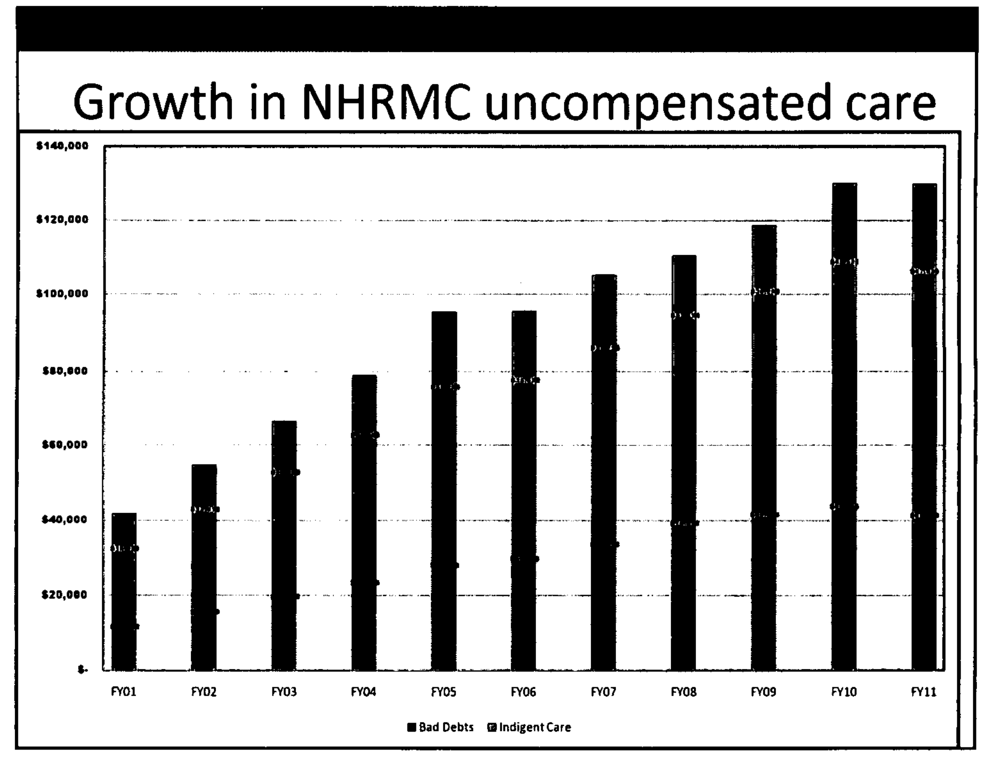


NHRMC benefit to the community

- Per ANDI report: $40 million in community benefit; $29.6 million in bad debt
- Safety net for seven counties
- Lose millions providing psychiatric care, outpatient clinics and EMS
- Other examples of community outreach:
  - Outpatient pharmacy – vouchers for poor patients who cannot afford medications
  - About 440 free mammograms to poor women through Pink Ribbon program
  - About 530 free cardiac screens, mostly for women, through Red Dress program
- Community sponsorships exceed $280,000

NHRMC pediatric nurses coordinate care twice a year at Camp Special Time in Camp Lejeune

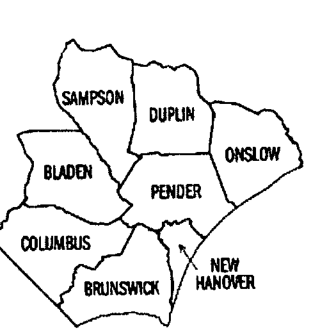
Growth in NHRMC uncompensated care



Local economy depends on NHRMC

Within NHRMC

- Employer of 5,118, including 1,414 staff nurses
- In worst economy since the Depression ...
  - No layoffs
  - Raises kept in place – market adjustment this year
  - Basic health insurance rates flat for seven years
- Added employee gym and employee health clinic last year



In the region

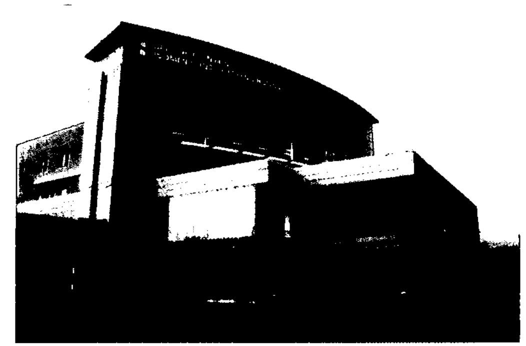
- Impact of more than $1.5 billion annually on New Hanover County's economy
- More than 9,000 jobs depend, directly or indirectly, on our viability
- Largest employer in Southeastern NC
- Industry cannot recruit key personnel without presence of strong medical center

Source: NC Office of Research, Demonstrations and Rural Health Development

Keys to our current success

Growing to meet demand

- Facilities upgrade in 2006-09, CON-approved project
- No public tax money
- Added:
  - Women's and Children's hospital, with region's first PICU
  - New surgery center, with robotic surgery
  - Renovated patient tower, with almost all private rooms



Cameron Women's and Children's Hospital

Collaborating in the region

Pender Memorial Hospital

- Critical Access Hospital in Burgaw, rural area 25 miles north of Wilmington
- NHRMC began operating agreement in 1999, an arrangement credited with keeping Pender open
- Through CON process, Pender partnered with NHRMC to open two new ORs and expand ED
- NHRMC contracted with two primary care doctors in Burgaw to increase access
- In FY 2011, NHRMC funded about $3M for Pender - $1.4 million in capital and $1.6 million in operating loss

Collaborating in the region

Brunswick County

- Affiliation agreement with Dosher Memorial Hospital, Critical Access Hospital in Southport
- NHRMC manages hospitalist program at Dosher
- NHRMC physician specialists expanded services to Brunswick County
- NHRMC helps with physician recruitment to rural Brunswick County
- Partnered with physicians through CON process to establish radiation oncology in Supply
- NHRMC works on patient transport issues in Southport/Supply area

In the region

- Founding member of Coastal Carolinas Health Alliance, which includes 12 partners in eastern NC
- Help recruit physician specialists to make rotations to Columbus County
- Established urgent care in Duplin County

Physician relationships

- NHRMC partnered in joint venture with physicians on CON project to open operating rooms in northern New Hanover County
- Working with physicians and other agencies to expand access to medical records through Health Information Exchange
- Continue to partner on increased clinical integration with physicians over entire continuum of care

Our CON experience

CON's three primary goals

- Increase access
  - Protect access in rural counties by partnering with Critical Access Hospitals, recruiting primary and specialty doctors to rural areas and opening services closer to where patients live
  - CON projects such as ambulatory surgery center, outpatient radiation oncology center, and master facility expansion plan brings services closer to patients, allowing them to stay home for care.
- Improve quality
  - Achieved 99% of core measure quality indicators in FY 2011
  - Top quality designations in areas such as cardiac, orthopedics and bariatrics
- Reduce costs
  - Community Value Five-Star Hospital by Cleverley + Associates
  - Reduce duplication of services through collaboration and regional planning

Our view of CON

- CON allows us to provide community benefit and unprofitable services, such as a regional trauma center, psychiatric hospital, and teaching clinics. We are able to serve as the region's safety net provider, fulfilling our mission
- CON allows us to perform dual roles that would otherwise contradict one another: Compete as a business – without taxpayer subsidy - while providing access at all times to all in need, regardless of ability to pay
- Minor adjustments could be warranted. Major overhaul is not needed and would harm health care in this state

Brunswick Novant Medical Center

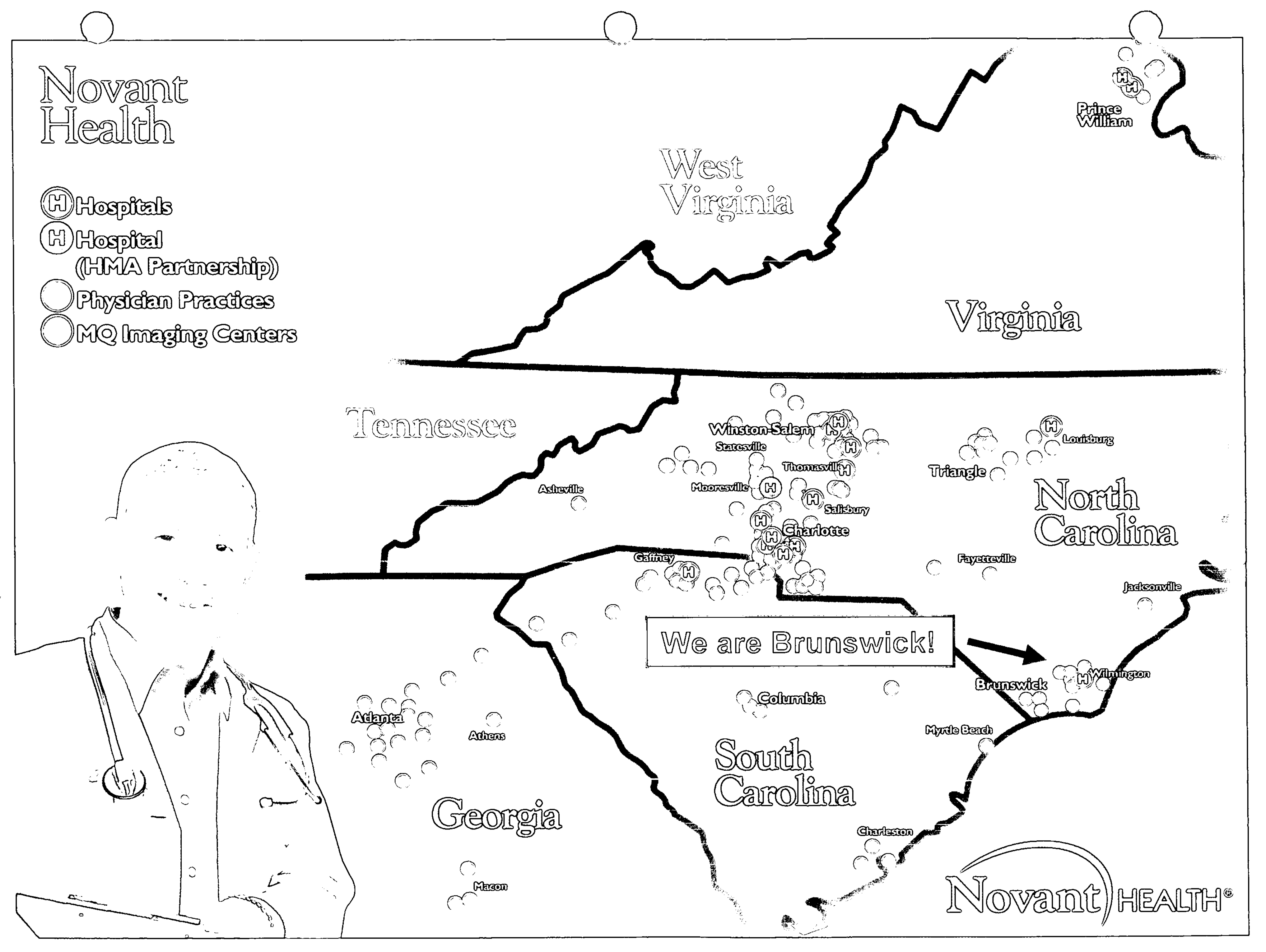
Address to the NC House Select Committee on CON Process & Related Hospital Issues

November 17, 2011 Wilmington, NC

Presented by: Denise Mihal, RN, MBA
President, Brunswick Novant Medical Center &
COO, Novant Health Eastern Market

An Affiliate of Novant Health

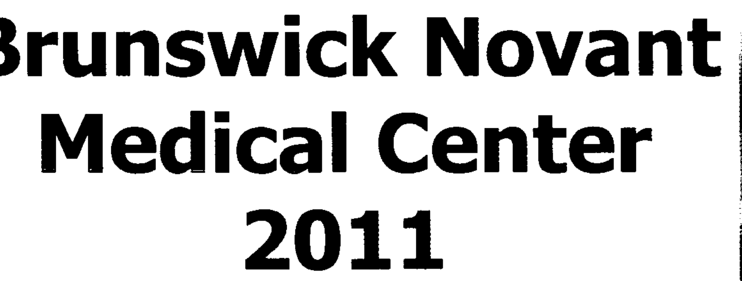
A Non-Profit Healthcare System


Novant Health
Hospitals
Hospital (HMA Partnership)
Physician Practices
MQ Imaging Centers
West Virginia
Virginia
Prince William
Tennessee
Winston-Salem
Statesville
Thomasville
Mooresville
Salisbury
Charlotte
Asheville
Gaffney
Triangle
Louisburg
North Carolina
Fayetteville
Jacksonville
We are Brunswick!
Brunswick
Wilmington
Myrtle Beach
Columbia
South Carolina
Charleston
Atlanta
Athens
Georgia
Macon
Novant HEALTH®

Brunswick Novant Medical Center
Bolivia, North Carolina

Our Journey

Brunswick Community Hospital 2006



Brunswick Novant Medical Center 2011

Steps to Modernize BCH

	BCH	BNMC
Acute Beds	60	74
Observation Beds	0	4
ICU Beds	5	5
LDRP Rooms	2	5
Operating Rooms	3 ORs 1 C-Section	4 ORs 1 C-Section
ED Treatment Rooms	12	20
Square Feet	72,500	251,540

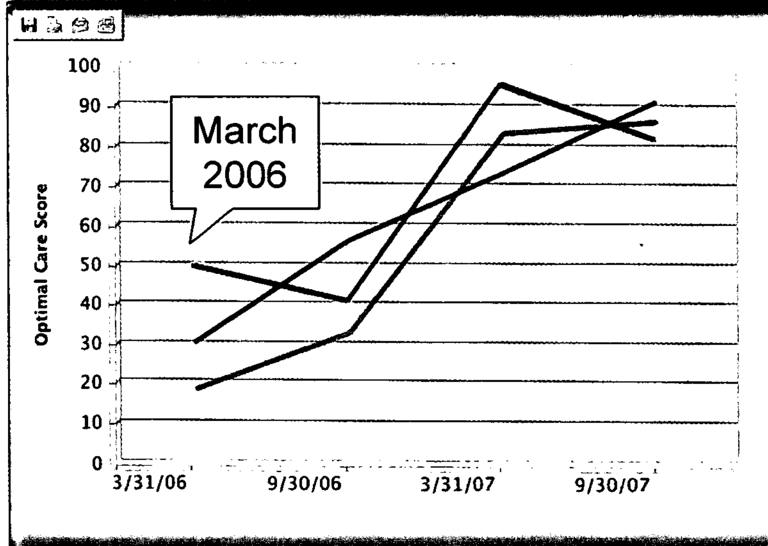
Growth from 2006 to 2011

	BCH – 2006	BNMC – 2011
Admissions	3,700	3,230
ED Visits	20,000	23,500
Births	260	405
Surgeries	2,700	4,000
Employees	~350	~430
Medical Staff	~100	~165

Patient Safety and Quality of Care

- Patients are able to access independently collected quality data on Novant websites in order to make informed decisions
  - Novant hospitals participate voluntarily in many of these programs
  - Novant hospitals often exceed state and national quality benchmarks
- Novant continues to improve medical care and services for our patients by sharing such knowledge, technology and other resources, with participation across the Novant continuum of care

BNMC Quality Story



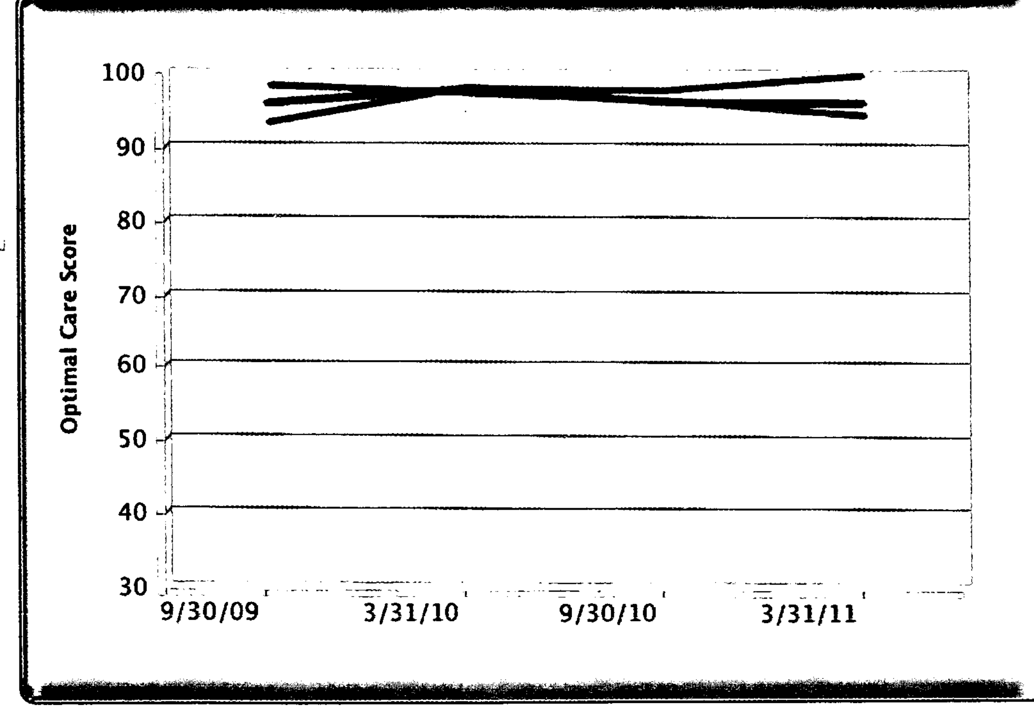
NC Quality Center Recognition

•2008 - Most Improved, Pneumonia & Surgical Care

•2009 – Most Reliable, Surgical Care

•2010 – Most Reliable, Heart Failure & Surgical Care

NCHospitalQuality.org



Legend
Blue line - Heart Attack treatment optimal care score
Green line - Heart Failure treatment optimal care score
Red line - Pneumonia treatment optimal care score
Yellow line - Surgical Care Improvement optimal care score

Quality Awards & Recognition

- **Brunswick Novant Medical Center**
  - VHA 2009 Award: Excellence in MRSA Reduction
  - 2007-2011 of American Assoc for Respiratory Care Recognition for *Quality Respiratory Care for Cardiopulmonary Services*
  - Lab Accredited by American College of Pathology
  - Digital Mammography accredited by American College of Radiology
  - "Gold Seal" Award from The Joint Commission
- **Novant Health**
  - Two-Time Codman Award Winner (Hand Hygiene, Reduce Medication Complications)
  - 91% of NMG Physicians NCQA-recognized for quality care to diabetes patients
  - CMS Indicators: 88% of Indicators above 90th Percentile

Financial Access

- Financial Assistance Programs
- Community Benefit
- Community Outreach

Accessible Care

- ***Novant/BNMC Charity Care Policy***
  - Annual household income at 300% of the Federal Poverty Level
  - Charity Care process is <u>simple</u>: a one-page form
  - Charity Care process is <u>accessible:</u> posted on the Novant website
  - Uninsured Discount
  - Catastrophic Settlement
  - Payment Plan

- ***BNMC Access For Medically Underserved Populations:***

  -87% of Births at BNMC for Medicaid patients

  -74% of BNMC Emergency Dept Visits for Medicare, Medicaid and indigent patients

  -76% of BNMC Inpatient Cases are provided to Medicare, Medicaid and indigent patients

  -64% of BNMC Surgical Cases performed on Medicare, Medicaid and indigent patients

Community Benefit & Outreach

- ***Community Benefit – 2010***
  - *Novant Community Benefit $469 million*
  - *BNMC Community Benefit $18.2 million ($6.1 million charity care)*
- ***BNMC Community Outreach***
  - *Monthly "Focus on Health Seminars" presented by MDs & Health Professionals*
  - *Monthly health show on ATMC-TV featuring local health topics*
  - *Annual Brunswick Beacon Health Expo & other health fairs*
  - *Sponsorships: Lower Cape Fear Hospice Foundation, American Cancer Society Relay for Life, March of Dimes March for Babies*

CON Success Story: Brunswick Novant Medical Center

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/17/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barb Freedy	Novant Health
Mari Wolf	Novant Health
GRAHAM FIELDS	WNC COMMUNITY HEALTHCARE INITIATIVE
Denise Mihal	Novant Health
John Gizdic	NHRMC
JESSE GOODMAN	DHHS/DHSR
Scott Whisnant	NHRMC
Nancy Bres Martin	NBM HPA
CRAIG SMITH	DHHS/DHSR
Emily R. Coble	Concerned citizen
Steve Metcalf	Mission Hospital

(2)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/17/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dee Jay Zerman	UNCHCS
Hugh Tilson	NCHA
Matthew McConnell	Carolinas HealthCare
Debbie Murphy	HPS
Sandy Sands	WM
LISA FAWCETT	NCFOM
Michelle Brooks	University Health Systems
Brian Kuszyk	"
ROSE HORAN	NC HEALTH NEWS.
Kristy Hubard	NHRMC
JOE LANIER	NELSON MULLINS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/17/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Lutz	PDA, Inc.
Doug Whitman	Liberty Healthcare

Speakers' Sign-In Sheet

11/17/11

	NAME	AFFILIATION	WRITTEN COPY OF COMMENTS (YES/NO)?
	Everett Bowman	Mission Hospitals	
	Richard Vinroot	" "	
(presenter)	~~Sue Collier~~	~~University Health System~~	~~Yes~~
(presenter)	~~Hal Garrison MD~~	~~" " "~~	~~Yes~~
(presenter)	~~Brian Kumpf MD~~	~~" "~~	~~Yes~~
	GRAHAM FIELDS	WNC COMMUNITY HEALTHCARE INITIATIVE	

SHAWN PARKER

AMY JO JOHNSON

JAN PAUL

BARBARA RILEY

SUSAN BARHAM

Corrected Notice

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Tuesday, November 1, 2011 (Date Change)
TIME: 6:00 PM
LOCATION: The Citizens Center LOB
COMMENTS: Council Chamber, 400 East Central Avenue, Mount Holly, NC 28120
Regular House Select Committee on Certificate of Need and Related Hospital Issues with Public Comments

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **8 AM** o'clock on **October 17, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

Viddia Torbett (Rep. Torbett)

om: NCGA Committee Notices <noreply@ncleg.net>
ent: Thursday, September 29, 2011 3:08 PM
Subject: <NCGA> House Select Committee on Certificate of Need Process and Related Hospital Issues Committee Meeting Notice for Thu, 11-03-2011 at 6:00 PM

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, November 3, 2011
TIME: 6:00 PM
LOCATION: The Citizens Center
COMMENTS: Council Chamber, 400 East Central Avenue, Mount Holly, NC 28120
Regular House Select Committee on Certificate of Need and Related Hospital Issues with Public Comments

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **2 PM** o'clock on **September 29, 2011**.

Principal Clerk
Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

--
This message was sent to you by Viddia Torbett (Rep. Torbett) (torbettla@ncleg.net) because you signed up to eceive NC General Assembly Committee Notices by email. To unsubscribe, visit
tp://www.ncleg.net/gascripts/Committees/Committees.asp?sAction=ViewDLForm&sActionDetails=House%20Standing

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

AGENDA

6:00 p.m. Tuesday, November 1, 2011
Citizens Center-Council Chamber, Mount Holly, NC

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Presentations to the Committee

- *Darise D. Caldwell, RN, PhD, FACHE*
  President of Rowan Regional Medical Center

- *Carol Lovin*
  President, Management Company, Carolina HealthCare System

- *Doug Luckett*
  Acting Chief Executive Officer, CaroMont Health
  Maria W. Long
  Executive Vice President and Chief Legal Officer, CaroMont Health

III. Public Comment
Individuals who wish to comment may sign up between 5:00 and 6:00 p.m. at the meeting. Submission of written comments is also encouraged.

Next meeting:
6:00 p.m., November 17, 2011
Cape Fear Community College
McLeod Building, Room S-002
411 North Front Street,
Wilmington, NC

MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Tuesday, November 1, 2011
6:00 p.m.
Mount Holly Citizens Center

The House Select Committee on Certificate of Need and Related Hospital Issues met on Tuesday, November 1, 2011 at 6:00 p.m. at the Mount Holly Citizens Center, Council Chamber, and 400 East Central Avenue, Mount Holly, NC 28120. Representatives Torbett, Steen, Alexander, Avila, Boles, and Randleman attended.

Representative Torbett presided. He welcomed everyone and took a moment of silence for Senator James Forrester who passed away October 31, 2011. Shawn Parker, staff attorney presented the committee charge. (See attached)

PRESENTATIONS

Darise D. Caldwell, RN, PhD, FACHE
President of Rowan Regional Medical Center(see attached)

Carol Lovin President, Management Company, Carolina HealthCare System(see attached)

Doug Luckett, Acting Chief Executive Officer, CaroMont Health(see attached)
Maria W. Long, Executive Vice President and Chief Legal Officer, CaroMont Health(see attached)

Public Comment(see attached)

The Committee adjourned at 8:00 p.m.

Representative John Torbett, Co-Chair, Presiding

Representative Fred Steen, Co-Chair

Viddia Torbett, Committee Clerk

PUBLIC COMMENTS
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES
NOVEMBER 1, 2011
6:00 P.M.
MOUNT HOLLY, NC

Bill Gary

Resident of Mount Holly, have been for about 16 years and I'm also pleased to serve on the board of Caromont. I am a certified financial planner by training and kind of unique as I have experienced service from all three of the hospital systems that have spoken here tonight and all of them have given excellence service. My wife is a graduate of Presbyterian Nursing School, I had two granddaughters that were born at Carolinas HealthCare System, one of them they operated on her tremendously and were not able to save her, but the other one, we are glad her, thanks to their efforts, and my wife has had excellent care at Caromont. I am proud of all three of those institutions. I think you have heard loudly from all groups concerned so far that the certificate of need process is a very valuable process to the state of North Carolina. I think it helps us impact the cost of care as well as the quality of care that we are getting here. The only thing that I would disagree with at all with is that the costs of the certificate of need process is minimum. I that depends if you've got 6 ½ billion dollars of revenue a year, several million dollars is not a lot of money to you. It can be a lot of money to some systems, and more than that, the length of time that it takes. At some point in time after you have gone through the process and you've been awarded here, in our particular case, in 2008, Caromont filed to build a free standing ED here in Mount Holly. Caromont Health proposed that, Carolinas Health Care said there was no need. The state ultimately found that there was a need and then Carolinas Health Care reversed and said wait a minute, we want to do it. That's fine, we went before the CON, we win the CON. We have now had two CONs, but there is an unending appeals process. We're three years down the road and we are no closer to getting that ED that we need and we have a rapidly expanding population here and we need those services. At some point we need to say uncle. To endlessly tie things up in court just to try to mark out a territory seems not to be serving the citizens of this community.

Scott Griffin

This is not the first time I have stood before you, but you may not remember me. If James Forrester were here, he would remember me and Senator Hoyle as I was I was marched down the isle as the 1997 state teacher of the year. I got to speak before that distinguished body at that time, I was on your turf. Tonight you are on my turf. I live in Mount Holly and I love this community and have great respect for the people to try to do things for us. You should know that I am now getting to the age of having to really go through our health care system. I really struggle with how I can come before you and make my point. My grandson found a ping pong ball. As legislators, everytime you have a tough decision, think about a ping pong ball. That is kind of how we find ourselves in Mount Holly right now, we have some outstanding players. My community is the ping pong ball. While this game is being played, health care is needed in this community.

Todd Young

Like Bill and Scott, I want to welcome everyone here. We're used to Representative Torbett, he is a great member of our community and we welcome his colleagues to our community. Well, my mom doesn't look like a ping pong ball, but thank you for the analogy, Scott, because recently I've begun to feel like that is exactly what she is. My appeal to you tonight is, and I've learned more about CON than I

ever thought that I could and being a banker I know about government regulation, that was a joke. About 5 weeks ago my mom suffered the second of five strokes. She is 87 years years old and if you can picture the little old lady on Sylvester and Tweety cartoon, that's my mom. The second of the stroke we drove about 16 ½ miles to the hospital to get her there in time in that golden hour. Why are we dickering between two great giant? She went to Caromont ED and then was moved to the floor. About a week later she was moved to Carolinas Health Systems Rehabilitation Hospital here in Mount Holly and what a great facility. For the last three years people like my mom have been that ping pong ball and these are people. There was a quote made tonight that did not sit well with me, that said more care does not insure a better outcome. Please stop this endless, senseless appeal so that people can stop fighting over territory money.

Graham Fields

I am here representing the Western Carolina Community Health Care Initiative. I had the great pleasure of speaking to this committee in Fletcher. The great opportunity of addressing the issue of the COPA in Asheville was very important as a native of Buncombe County. In that process I had the opportunity to represent physicians, providers, and the public and really what it feels like to live in the shadow of a government created monopoly. The two largest hospitals in the region came together and how that affects patient care. People continued to share their testimonials. It is really a simple take away as a quote from Mission's former CEO, Bob Burgen, a person who was sort of the virtual author of the COPA, and this is a quote that is actually from Business North Carolina. "It wasn't until the state agreed to monitor Mission that the Justice Department backed off. Sure, we were setting up a monopoly, but it was justifiable and in the community's best interest." I guess my simple take away from that meeting and from some degree from this evening, is that Mission is a monopoly and the state has an obligation to monitor that COPA. Unfortunately the state has failed to monitor it and offer the adequate oversight for the COPA. The WNC Community Health Care Initiative would humbly ask that you would consider modifying the COPA to better reflect the region's changing landscape and also to extend the modified COPA to Mission's service area and also to pause Mission's current activities until they can get evaluated under that new COPA.

Jason Well

I'm on the administrative team on Park Ridge Health. We are a small 103 bed hospital in the town of Fletcher, NC. CON law has a significant impact on us and the patients that we serve. We have served that community for 101 years. We recently fought a CON with Mission. They called themselves a monopoly. The recent vice-president called themselves even a 500 pound gorilla as early as September, 2011. They wanted to build a 130,000 square foot outpatient facility in our back yard. We are the town of Fletcher of 7500 people. Reuter's projects a 1% growth rate in the next five years. We live on outpatient services. Everything serious from a 17 county area goes to Mission. So all of these small community hospitals are trying to compete with this state sanctioned monopoly. It is very tough for all of us to compete. They know that the town of Fletcher can't support two health campuses, one is going to have to go. Is it going to be the organization that has 550 million dollars in the bank or is it going to be the organization like Park Ridge Health that has 28 million dollars in the bank. I can't say thank you enough for this team to take a deep look at them and go deep and look at this organization and look at what is happening that is absolutely unprecedented in health care. There is no where in the Carolinas that exists the market share that Mission has. I please ask that you do something to reject their application for AC3. Can you imagine if they can get out of the anti-trust, they used the COPA to get out

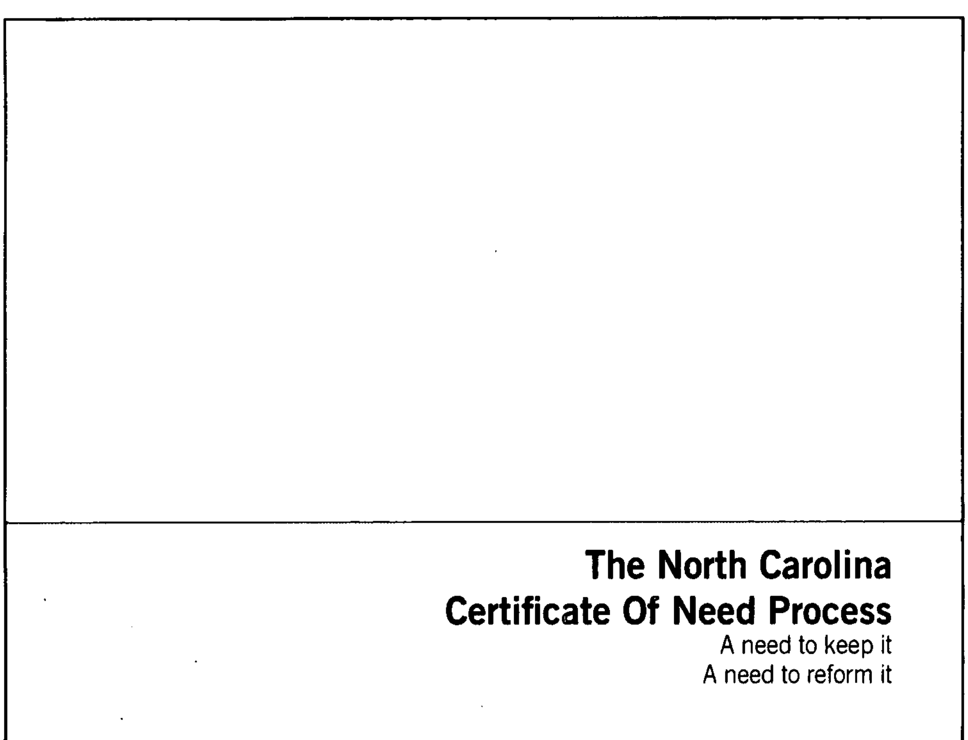
of anti-trust and now they want to use AC3 to get out of anti-trust. You've heard Mr. Vinroot stand up and say let my people go, it's time, Moses, let my people go. They get out of the COPA first of all and then they use AC3 to get out of anti-trust.

Dr. Jayne Kendall

I'm the medical director and chairman of the emergency department of Gaston Memorial Hospital with Caromont Health. Gaston Memorial Hospital's emergency department provides outstanding cardiac and hospital care to the citizens of the county. We have more than 105,000 patients annually, making us one of the busiest emergency departments in the state. We have minimized our turnaround time. From the minute a person walks through our door, it takes less than 3 hours to have all the lab tests, radiology tests, and procedures done for the patient to be discharged or admitted. We have implemented operations improvements and our volume continues to grow. We need another facility. We could have built and began operating the new ED over a year ago, but we have been delayed by unnecessary and continued appeals through this process. The appeals process takes years and years to get underway.

Richard Vinroot

I will simply say that you have before you a little white notebook that presents the information. It talks about why we were merged some 15 years ago and about the fact that Mission Hospital is not only the most regulated hospital in North Carolina, but the most regulated hospital in America. There are now only two states in America that apply the COPA. There were 19 at one time. Seventeen have never used it at all. One has abandoned it and the only two that still do are the one regulated COPA hospital in North Carolina, Mission. It was a merger between the old Saint Joe's Catholic Hospital and the Mission Hospital to essentially save health care in the Asheville region at the time they both were struggling to survive. It has worked and worked well. For 15 years the DHHS and Attorney General have carefully regulated and set standards for performance in terms of price and cost for Mission Hospital and every year of those 15 we have complied with those standards. We brought experts last week who talked about that in some detail. And I did say, as this gentleman just accused me of saying correctly, as Moses did, let my people go. We don't need to be the most regulated hospital for the next 15 years, not when we are doing everything we were asked to do in addition to giving back 86 million dollars in savings to the community as one of the conditions of COPA at that time. Read a letter from former Representative Jack Stephens who was the chairman of the board many years ago when the merger occurred. Read that letter which is in a package that came to you today or yesterday and have him tell you a little bit about the origin of the COPA. Folks down the road don't like that, they don't really like the competition that we provide. Folks in the region, however, do and spoke loudly and clearly about that. They don't want us to continue to succeed and do the things we do so well with the most regulation of any hospital in America. So they provided last week this information about our growth and I sent you a letter in a package that I think has been delivered to you by Shawn and the others today that points out in this information that was distributed last week that clarifies that and explains to you that they told you that we were three times as successful in our growth as is, in fact, true. They also said tonight, I just heard this, that somehow we are applying for AC3 exemption status. Never have and not to my knowledge do we plan to. Don't know where they got that, but if you can throw around loose information enough, I suppose some of it will stick. Read our notebook please. Read my letter please. At the end of the day I say again, I think it is time to let these people go and do the things so well that they are doing.



The North Carolina Certificate Of Need Process

A need to keep it
A need to reform it

CaroMont Health System

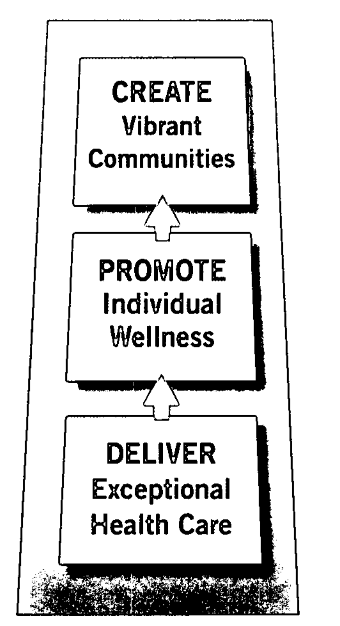
- Gaston Memorial Hospital, with 435 beds
- Courtland Terrace, a 96-bed skilled nursing community
- Gaston Hospice, includes the inpatient 12-bed Robin Johnson House
- CaroMont Medical Group, an extensive network of physician practices in 5 counties and 2 states with:
  - Nearly 200 employed physicians
  - 3,800 employees
  - Self-insured health plan

Vision

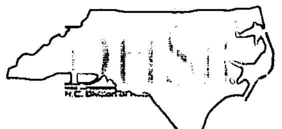
To be a nationally recognized leader and valued partner in promoting individual health and vibrant communities.

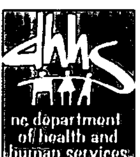
Mission

To provide exceptional health care to the communities we serve



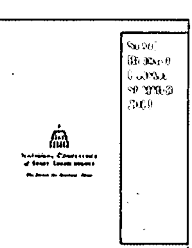
The fundamental premise of the CON law is that increasing health care costs may be controlled by governmental restrictions on the unnecessary duplication of medical facilities. To accomplish its purpose, the CON law provides that "no person shall offer or develop a new institutional health service without first obtaining a certificate of need.





From the National Conference of State Legislatures...

- A study conducted by the "big-three" automakers claims lower health care costs in CON states than in non-CON states
- AHPA (The American Health Planning Association) also asserts that CONs have a valuable impact on the quality of care.
- When facilities and equipment are monitored, hospitals and other treatment centers can acknowledge what sort of services are in demand and how effectively patients are being taken care of.



From the National Conference of State Legislatures...

- Additionally, according to supporters, the programs distribute care to areas that could be ignored by new medical centers.
- CON programs are a resource for policymakers. CON regulations are described as a reliable way to implement basic planning policies and practices, and aid in distributing health care to all demographic areas.
- The CON process can call attention to areas in need because planners can track and evaluate the requests of hospitals, doctors and citizens and see which areas are underserved or need to be improved and developed.

Managed Competition

- Good for independent health systems like CaroMont
- Helps protect access to the most needed services in the community served by the hospital or health system
- Helps prevent overbuilding of health services that have to be funded by high utilization

Managed Competition

- On 9/9/2011, The U.S. House of Representatives Committee, Ways and Means Subcommittee on Health held a hearing to examine stepped-up consolidation in the wake of health reform legislation.
- Subcommittee on Health Chairman Wally Herger (R-CA) and Ranking Member Pete Stark (D-CA) both expressed significant concern over harmful effects resulting from health industry consolidation. Chairman Herger cited a Rand Corporation study published in the September 2011 edition of Health Affairs as evidence that provider consolidation limits beneficiary choice, compromises patient care and drives up prices.

Managed Competition

- With increased consolidation on the horizon, the DOJ and FTC are expected to continue to closely scrutinize, and potentially seek to block, health care industry mergers and acquisitions that, in the agencies' view, would create market dominance and restrain competition
- On the provider side, the FTC's primary concern is that market power may drive up prices paid by health plans and their insured population (in the form of higher premiums and co-pays and reduced access)
- CON (with reforms) can be an instrument to help keep the healthcare ecosystem in balance.

Is the CON process still Relevant in NC?

Gaston poverty rate rising- From the Gaston Gazette
October 30, 2011 2:24 AM
Wade Allen
While Gaston's poverty rate has risen 36.7 percent from 2007-10, neighboring Cleveland County has seen a drop in their poverty rate.
Gaston's poverty rate rose from 15 percent in 2007 to 20.5 percent in 2010, which is above both the national and state averages.
Cleveland's poverty rate decreased 6.3 percent during those three years, from 22.1 percent of the population living at or below the poverty level to 20.7 percent. These numbers are also above the national and state averages.
The North Carolina Justice Center compiled the figures using data from an American Community Survey in 2010.
Lincoln County saw a 75.6 percent rise in people living at or below the poverty level, jumping from 9 percent in 2007 to 15.3 percent in 2010.
North Carolina's unemployment rate statewide rose from 14.3 percent in 2007 to 17.5 in 2010.
The poverty rate in the United States increased in 2010 to 15.1 percent, the highest level since 1993, according to CNN Money. America's poverty rate in 2009 was 14.3 percent.
Donny Hicks, director of the Gaston Economic Development Commission, called Gaston's poverty increase a "pretty large change" and directly attributable to the economy and loss of employment.

With issues like these, it seems more relevant now than ever...there's no competition for uninsured or underinsured patients

NCHA Position on CON

The fabric of most North Carolina communities is woven around its hospital. CON has benefited community hospitals. In turn, through CON, hospitals benefit their communities and the State.
North Carolina's CON law **protects communities' investments in their hospitals**. Most hospitals in North Carolina are either non-profit or public hospitals. The state invests directly in public hospitals and indirectly in non-profit hospitals by offering state guaranteed subsidized debt. By law, hospitals must provide certain services to any patient. By mission, hospitals frequently provide virtually any service to any patient. Financially viable hospitals are the State's assurance of economical, readily available health care for all populations.
The Certificate of Need laws are aimed at **restraining health care costs, promoting access and allowing for coordinated planning of new services and construction**.

CON Repeal Will Not Reduce Costs or Improve Quality of Care

- Concentration of health care services leads to quality care.
- Hospitals cannot maintain state-of-the-art facilities and highly skilled staff if carve-out companies take away paying services.
- Health care costs are increasing because the cost of prescription drugs, blood, labor, technology and the number of uninsured are growing – not a lack of hospital competition.

*from the NCHA's Position Paper on Certificate of Need

CaroMont Health
in LOVE with LIFE

CON Repeal Will Not Reduce Costs or Improve Quality of Care

- If CON is repealed, hospital costs will rise as fixed overhead is spread across fewer patients. CON repeal would add competitors and redistribute paying patients but would not reduce costs, reduce prices or improve quality. Further, since many carve-out companies control their own referrals, they have no incentive to reduce prices to gain volume.
- Deterioration of the healthcare infrastructure in North Carolina won't happen fully next month or even next year. But it would happen if CON is repealed and patients would be the ones to suffer.

*from the NCHA's Position Paper on Certificate of Need

The Process...

- **Publication of *State Medical Facilities Plan***

  At the beginning of the calendar year DHSR publishes the State Medical Facilities Plan (SMFP) which contains the maximum number of health facility beds, by category, which can be approved by the CON section. There are currently 8 CON project categories. The SMFP also contains the batching cycle dates for the year. Batching cycles allow the CON section to review all applications for the same service at once.

- **Letter of Intent (LOI)**

  An LOI must be submitted to the CON Section no later than the date the application is due. However, most applicants submit their LOI as soon as possible. If an LOI is submitted before the beginning of a review period, the CON Section forwards a letter to the applicant indicating whether or not CON review is required. If review is required the letter will indicate the review dates and application forms necessary.

- **Application Submission**

  Applications and accompanying fees must be received by 5:30 p.m. on the 15th day of the month preceding the beginning of the review period (as published in the SMFP). An application may not be amended after it is submitted. However, the Con Section may request clarifying information from the applicant: If an application is deemed incomplete, the CON Section will notify the applicant within 5 days.

- **Public Comment Period**

  During the first 30 days of the review period, any person may file written comments, letters of support concerning the applications under review.

Public Hearing

Although a hearing is not required for all reviews, it is required for competitive reviews, any proposal over $5,000,000 and can also be requested by any affected parties. The public hearing will take place no more than 20 days before the conclusion of the review period.

CON Section Application Review

The CON section has from 90 to 150 days to review an application. All written comments and public hearings are taken into consideration during the decision making process.

Decision Appeals

If an interested party wants to appeal the CON Section's decision, they must file a petition for a contested case hearing with the Office of Administrative Hearings within 30 days of the date of the decision. The administrative law judge will make his recommended decision to the director of DHSR within 270 days of the petition's filing. The director will then make the final agency decision.

Appealing Final Decision

If a party wishes to appeal the final agency decision, they must do so through the North Carolina Court of Appeals.

Monitoring

After a CON has been issued the CON Section will monitor the development of the project through required progress report. The CON Section may withdraw a CON if the holder does not develop and operate services consistent with their CON application.

So, What's Good for the CON Process?

- Consider who actually constitutes an "interested" party in the comment and appeals process
- Consider having shorter, more defined timeline for the statutory "right of appeal" process
- Consider what drives the true cost of obtaining a CON and focus on reforming those components

What's Good for Gaston County?

- A process that maintains the health services needed for those with and without the ability to "pay their way"
- A process that allows the same chance for independent health systems to provide a CON-based service as it does an academic medical center or hospital authority
- A process that allows for the citizens of a county to have a voice in choosing regulated services in their community

What's Good for Gaston County?

- Legislation like H 812 Hospital Authority Territorial Jurisdiction.
- Legislation like H 743 Equal Treatment Under SMFP.

- These legislative actions help promote equity in managed competition and helps promote equitable access to care for communities

Carolinas HealthCare System

House Select Committee on CON and Related Issues

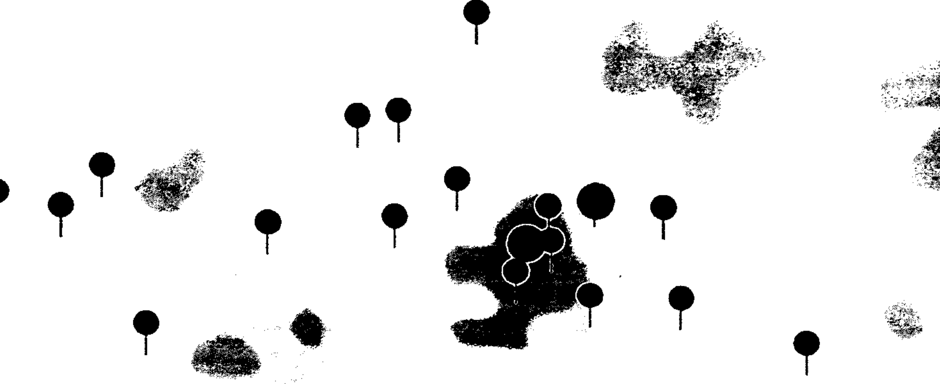
Mount Holly, North Carolina

November 1, 2011

Agenda

- Carolinas HealthCare System
- Certificate of Need regulation
  - CON as good public policy
  - CON benefits
  - CON challenges

Carolinas HealthCare System



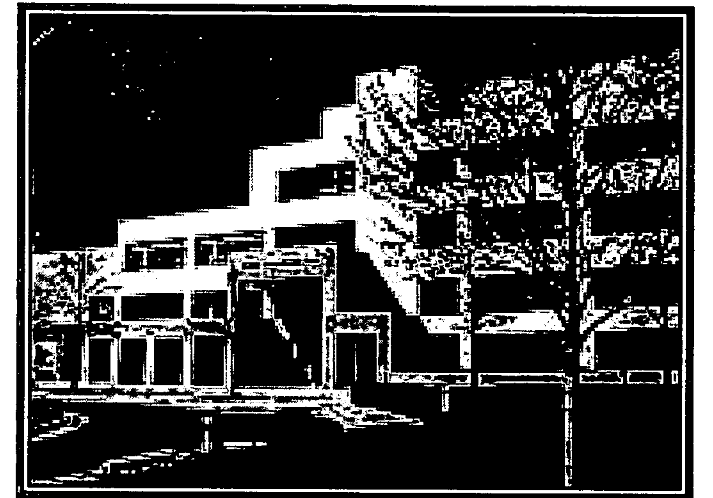
- 48,000 **employees**
- 6,300 beds
- 700 care locations
- 33 hospitals

- Annual community benefit $608 million
- Annual business volume impact $5.5 billion

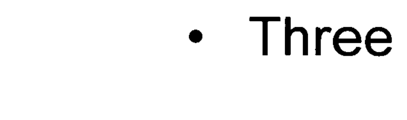
- **Self-pay/other: 13.1%**
- **Medicaid: 16.8%**
- **Medicare: 34.0%**
- **Commercial: 36.1%**

- 34-county primary service area with 4 million people
- 9 million total encounters
- 2 million people use CHS primary care physicians

Medical Education and Research



- **Education**
  - UNC School of Medicine for third and fourth year students
  - 26 residency and fellowship programs
  - Three health sciences schools



- **Research**
  - Published over 300 publications
  - Clinical trials

Mission Statement

The mission of Carolinas HealthCare System is to create and operate a comprehensive system to provide ***healthcare*** and related services, including ***education*** and ***research*** opportunities, for the benefit of the people it serves.

CON as Good Public Policy

First, why have CON regulation? The healthcare industry is complex and very different from any other industry.

1. The government sets prices
2. Price is not a factor in most buying decisions
3. The overwhelming majority of services are consumed in the last few years of the consumer's life
4. Care must be provided by hospitals regardless of the consumer's ability to pay
5. Consumers do not make buying decisions alone; payers and physicians are almost always involved in the buying decision

CAN YOU NAME ANOTHER INDUSTRY THAT COMES ANYWHERE CLOSE TO OPERATING IN THIS MANNER?

Some critics of CON regulation suggest the simple application of the free-market system will increase competition, lower healthcare costs and improve patient outcomes

<u>This proposed solution for our industry is not that simple</u>

- The free-market system has an impressive track record for spurring economic growth
- A primary goal of free-market enterprise is to increase consumption…in healthcare we are trying to reduce consumption
- *<u>The industry conundrum</u>:* how can we bring down healthcare costs through a totally free-market system where the goal is to sell more services?

***Dartmouth University research*: regions of the U.S. with more facilities and resources have higher costs**

Medicare Expenditures per Enrollee

Region	Medicare Expenditures per Enrollee	Legend
Dallas (TX)	$10,852	No CON
Los Angeles (CA)	$10,444	No CON
New Orleans (LA)	$9,880	No CON
Gary (IN)	$9,773	No CON
Philadelphia (PA)	$9,671	No CON
Raleigh (NC)	$8,640	CON
Charlotte (NC)	$8,238	CON

Researchers at the Dartmouth Institute of Health Policy and Clinical Practice have concluded that regions with the greatest number of facilities and resources also have higher costs. ***Further, the researchers have concluded that more care does not translate into better outcomes***.

Source: *The Dartmouth Institute for Health Policy and Clinical Practice, 2008 data.*

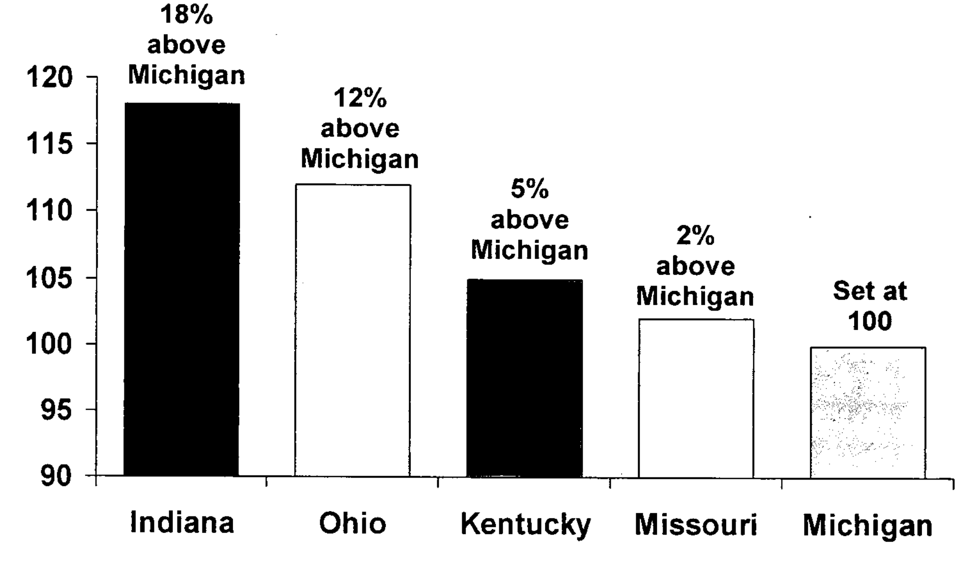
The Benefits of CON Regulation

Based on independent research, there are three critical and direct benefits of CON regulation

- Lower healthcare costs
- Better clinical outcomes
- Improved access for the underinsured

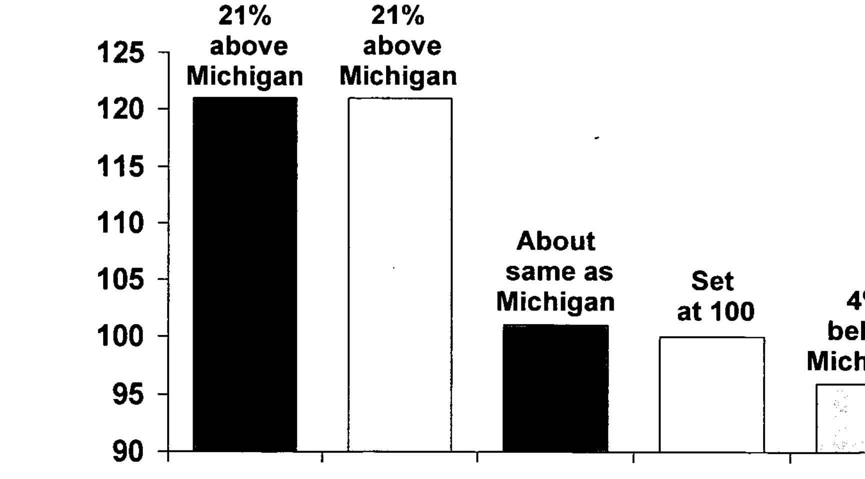
Supporting independent research examples follow

***Research example*: employer healthcare costs are lower in CON states**



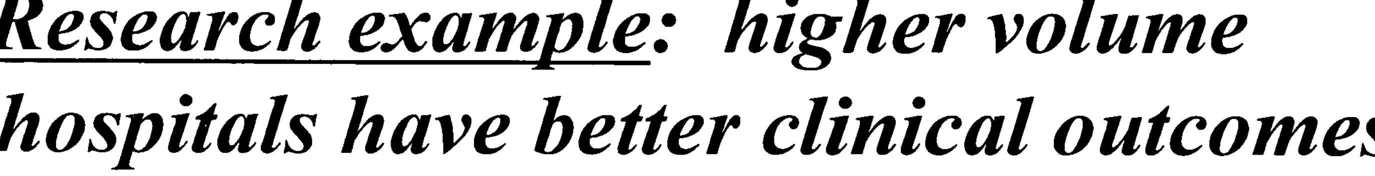
Hospital Inpatient Relative Cost
(Per 1,000 Members Normalized to Michigan Year 2000 = 100)
Ford Motor Company

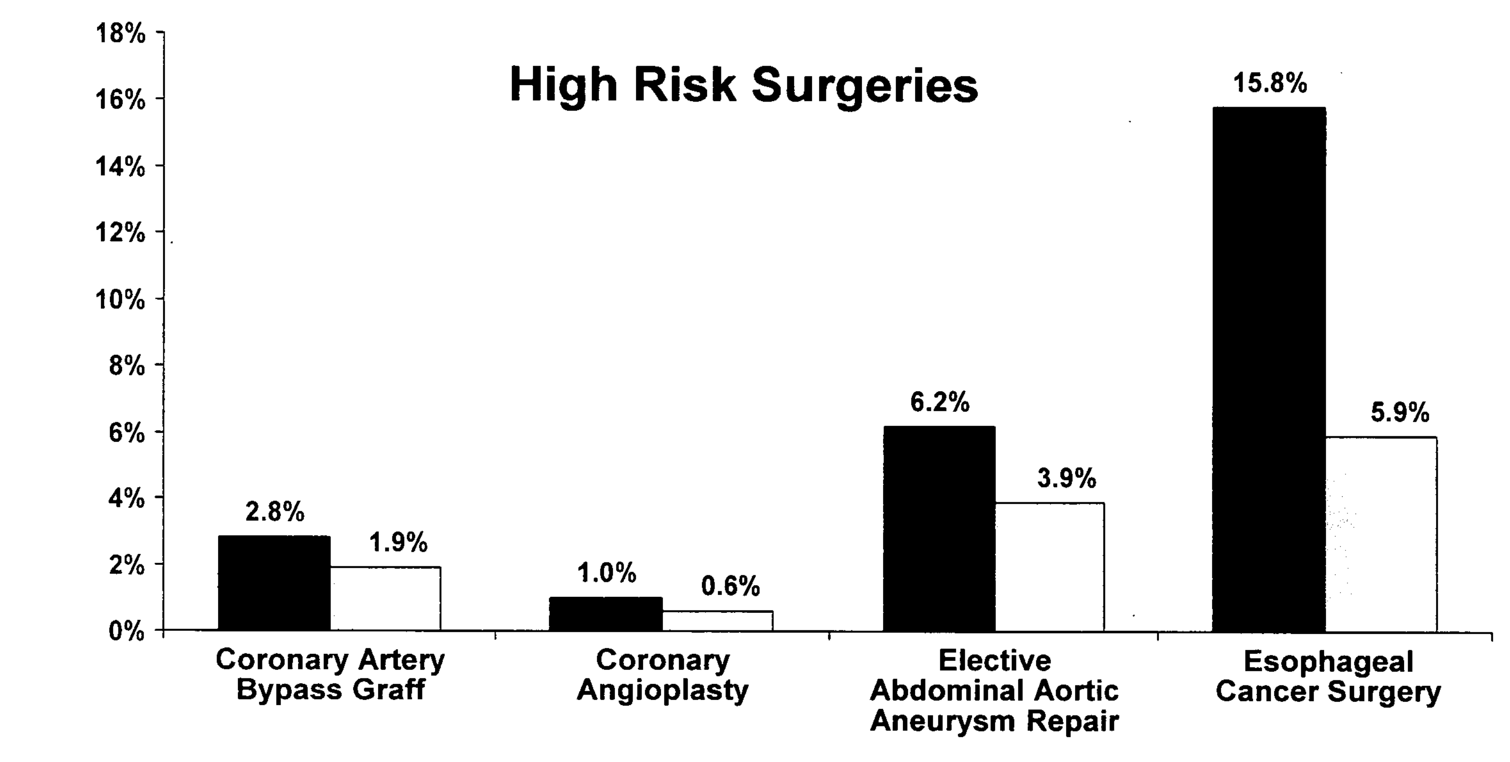
Hospital Outpatient Relative Cost
(Per 1,000 Members Normalized to Michigan Year 2000 = 100)
Ford Motor Company



Source: The Wall Street Journal, January 20, 2004.

***Research example:* higher volume hospitals have better clinical outcomes**





Source: John D. Birkmeyer, Leapfrog Patient Safety Standards: The Potential Benefits of Universal Adoption, November 2000.

Research example: CON regulations improve access to care for the medically underserved

- ***Access to care***. Most respondents agreed that CON regulations protect access to safety net hospitals and access to care in rural communities, either by requiring the provision of charity care or by having applicants address the potential impact on the safety net. Though research on this topic is scant, studies have indicated that CON regulations improve access to care for the underserved.

  - National Institute for Health Care Reform – The National Institute for Health Care Reform is a 501(c)(3) nonprofit, nonpartisan organization established to conduct health policy research and analysis to improve the organization, financing and delivery of health care in the United States.
  - Health Care Certificate-of-Need Laws: Policy or Politics – May 19, 2011.

<u>CHS research</u>: North Carolina hospitals care for over one million inpatients annually. Approximately 68 percent of these patients are government-sponsored or uninsured.

Source: Thomson, Inc. 2011 data are annualized based on YTD June.

In summary, we believe the these benefits are derived from the effective utilization of healthcare facilities

Hospital Utilization and Efficiency Comparisons (2007 Data)

Admissions Per Hospital (2007 Data)

11,000
10,000
9,000
8,000
7,000
6,000

44% Higher

6,267 — States With No Acute Care CON Regulation

8,999 — North Carolina

Total Surgeries Per Hospital (2007 Data)

8,000
6,000
4,000
2,000

65% Higher

4,831 — States With No Acute Care CON Regulation

7,943 — North Carolina

Source: American Hospital Association, 2009.

Challenges to CON Regulation

Challenges to CON Regulation

- Is the CON application process and the appeals process driving up healthcare costs?
- Do certain policies only benefit a select few, e.g. Policy AC-3?

Is the CON application process and the appeals process driving up healthcare costs?

Total spending on healthcare

- Total healthcare spending in the United States
  - $2.5 trillion *(2010)*
- Total healthcare spending in North Carolina
  - $75.4 billion *(2010 estimate based on 2004 data)*

CON costs

- Typical CON application costs – $30,000 to $50,000
- Maximum CON filing fee – $50,000
- CON litigation costs – vary depending on nature of the case

Do certain CON policies only benefit a select few, e.g. Policy AC-3?

Exemption provisions

- Necessary to complement a specified and approved teaching expansion
- Necessary to accommodate patients related to an approved expansion of research activities
- Necessary to accommodate changes in the requirements of specialty education accreditation bodies

Four hospitals in North Carolina qualify for AC-3 exemption

- Duke University Medical Center
- UNC Hospitals
- Wake Forest Baptist Medical Center
- Pitt County Memorial Hospital

Closing Comments

Strong Words About Rules on Fair Competition in the Healthcare Industry

"As a free-market conservative I strongly favor competition. In fact, I think Adam Smith's description of markets creating more choices of higher quality at lower cost was one of the great breakthroughs in human productivity. His publication of the "Wealth of Nations" in 1776 was as liberating as our own Declaration of Independence that same year...

Congress should act now to protect our health system by establishing the right rules for fair competition."

— **Newt Gingrich**

Former Republican Representative From Georgia and Speaker of the House

Source: Washington Post, November 12, 2005.

Thank You For This Opportunity!

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Novant HEALTH®

The Changing Healthcare Landscape in North Carolina

Address to the NC House Select Committee on CON Process and Related Hospital Issues

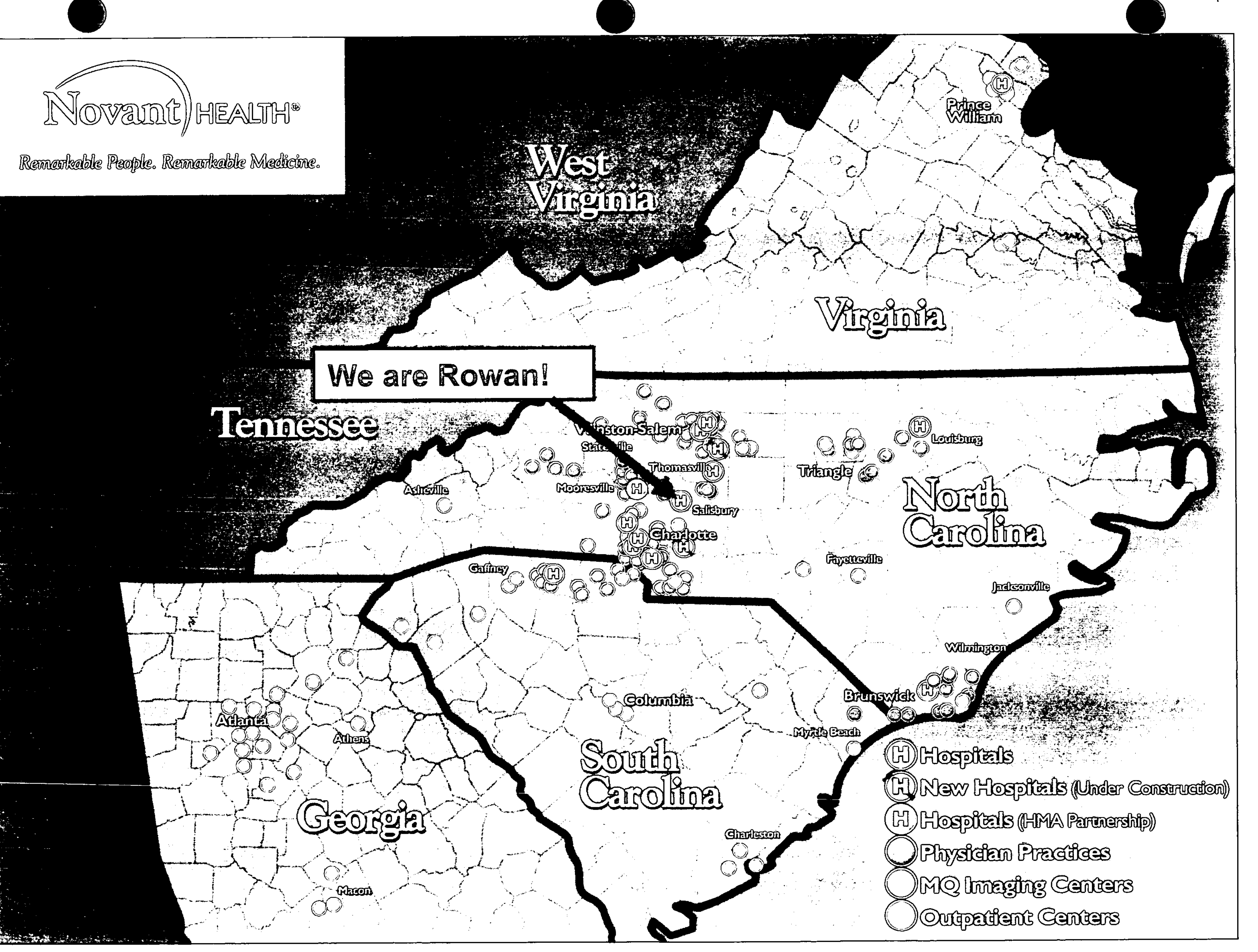
November 1, 2011

Presented by: Dari Caldwell, RN, PhD, FACHE

President, Rowan Regional Medical Center

An Affiliate of Novant Health

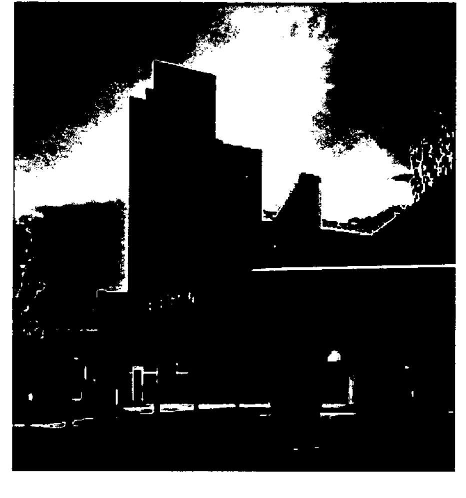
A Non-Profit Healthcare System



Novant HEALTH®
Remarkable People. Remarkable Medicine.
West Virginia
Virginia
Prince William
We are Rowan!
Tennessee
Winston-Salem
Statesville
Thomasville
Mooresville
Salisbury
Asheville
Charlotte
Triangle
Louisburg
North Carolina
Fayetteville
Jacksonville
Gaffney
Wilmington
Brunswick
Myrtle Beach
Columbia
South Carolina
Charleston
Atlanta
Athens
Georgia
Macon
Hospitals
New Hospitals (Under Construction)
Hospitals (HMA Partnership)
Physician Practices
MQ Imaging Centers
Outpatient Centers

Rowan Regional Medical Center

- RRMC service area: Rowan (86%) & Cabarrus, Davie, Davidson & Stanly counties
- ~1,200 RRMC Employees
- 268 bed acute care hospital, imaging & physical medicine center, surgery center, radiation oncology center
- RRMC Active Medical Staff of >275 physicians in >20 specialties
- Rowan county has current unemployment rate of 11.8% Majority payor for RRMC is Medicare, Medicaid and self pay
- RRMC provided Community Benefit services valued at $28.7 Million in 2010 *(includes $10.4 Million in Hospital Charity Care)*
- RRMC recognized in top 10% nationally for quality services & effective operational management by The Joint Commission



FFY 2010 Vital Statistics-RRMC

- 8,400 discharges
- 53,170 ED visits
- 11,170 surgeries
- 105,000 outpatient cases
- 780 births

Novant Value Imperatives

- ***Quality and Transparency***
  - Quality measure results posted on Novant's website
  - Exceed national averages – Rowan Regional Medical Center recently recognized by The Joint Commission
  - Novant shares best practices across our system

- ***Charity Care- Access to Care***
  - Annual household income of 300% X Federal Poverty Level
  - Charity Care process is <u>simple</u>: a one page form
  - Charity Care process is <u>accessible:</u> posted on the Novant web site
  - Uninsured Discount
  - Catastrophic Settlement
  - Payment Plan

North Carolina's CON Law

North Carolina's State Medical Facilities Plan ("SMFP")

SMFP Policy AC-3

Hospital Authorities

Novant's Position on NC CON

- We strongly support North Carolina Certificate of Need and Health Planning.
- Both programs must be ***fair*** and ***transparent***.
- Both programs need to keep up with the rapidly-changing health care landscape.

MEND IT, DON'T END IT.

NC Health Planning Overview:
The Annual State Medical Facilities Plan

- The State Medical Facilities Plan (SMFP) is North Carolina's health planning document:
  - SMFP regulates many basic elements of the health care system (beds, operating rooms, MRI scanners and cardiac catheterization units).
  - The general rule is that if the SMFP does not contain a "need" for more beds, ORs, MRI scanners, etc., these things cannot be added by providers
- The SMFP is published annually and signed by the Governor.
  - Results from a year-long planning process
  - DHSR Medical Facilities Planning Section staff and volunteers (the State Health Coordinating Council) spend hundreds of hours on the development of the SMFP every year.

SMFP Policy AC-3
(adopted in 1983)

- The exception to the rule that allows ***certain*** providers to add services/facilities even when there is ***no need*** and even when there is a significant surplus of assets
- Only applies to four providers in North Carolina- the Academic Medical Centers (AMCs):

    North Carolina Baptist Hospital

    Duke University Medical Center

    Pitt Memorial Hospital

    UNC Memorial Hospital
- North Carolina is the **only state** with a health planning process that has such an exemption for AMCs.

The Text of Policy AC-3: Required Conditions

Exemption from the provisions of need determinations of the NC State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

1. Necessary to complement a specified and approved **expansion of the number or types of students, residents, or faculty**, as certified by the head of the relevant associated professional school; or
2. Necessary to **accommodate patients, staff, or equipment** for a specified and approved expansion of **research activities**, as certified by the head of the entity sponsoring the research; or
3. Necessary to accommodate changes in **requirements of specialty education accrediting bodies**, as evidenced by copies of documents issued by such bodies.

Text of Policy AC-3: The 20 Mile Rule

- A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions ***shall also demonstrate*** that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project ***cannot be achieved effectively*** at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and ***which is within 20 miles of the Academic Medical Center Teaching Hospital***.

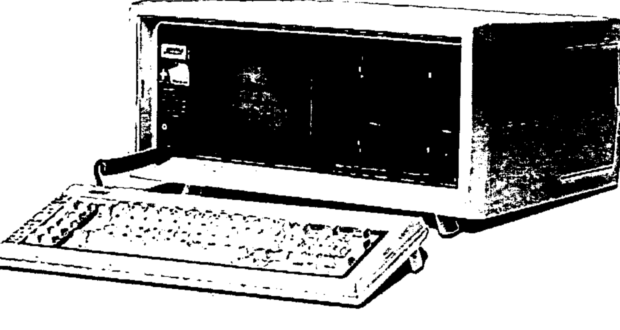
Real Life Example

- The 2010 SMFP showed a surplus of 5.52 ORs in Forsyth County.
- North Carolina Baptist Hospital (NCBH) proposed to add **7 new operating rooms** in Winston-Salem in an outpatient surgery center to do **basic outpatient surgeries** such as tonsillectomies.
  - Based on an AMC-identified "need" to support expanded faculty & student teaching
- The medical school associated with **NCBH also owns three underutilized ORs** located in Forsyth County.
- There are multiple operating rooms **less than 3 miles away** at Novant facilities that **have capacity** to take on more cases and that do the procedures NCBH proposes to do in its surgery center.
- Novant facilities are involved in training NCBH residents, including surgical residents.
- NCBH filed a CON application that was approved under Policy AC-3. NCBH could file this application because it is an AMC; Novant could not because Novant is not an AMC.
- **No discussion** in the CON application of the **20 Mile Rule** and the **underutilized** facilities.
- Population/surgical use rates not growing at a rate to sustain NCBH's project so volumes will have to be shifted from other facilities, including Novant.
- Novant projects to lose $7 million to $11 million annually because of this project.

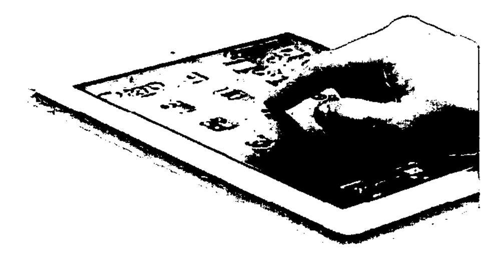
Continued Improvements to Policy AC-3

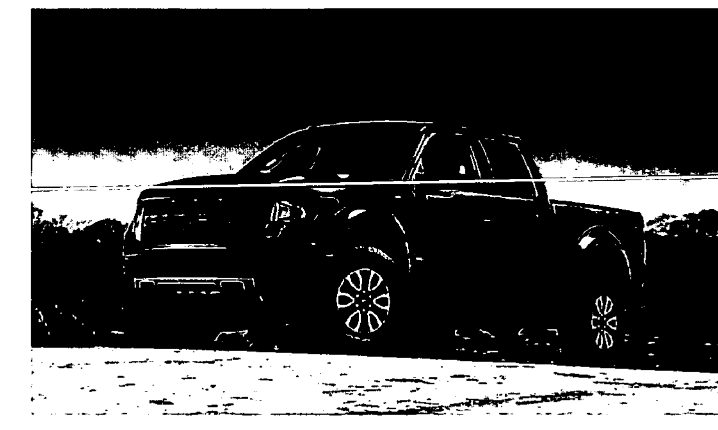
- The health care landscape has changed dramatically since 1983.

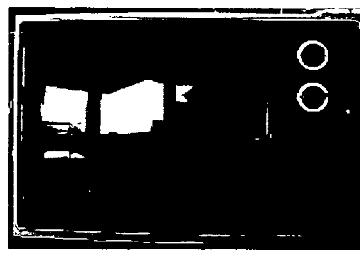
- Health planning policies must reflect the current landscape.

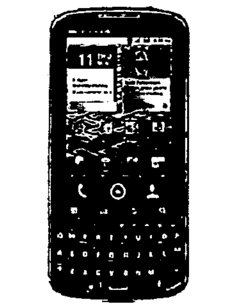


1983 v. 2011









1983 v. 2011

Then

- There were 4 AMCs that were focused on 4 hospitals in four counties.
- AMCs tended to stay on their campus.
- Their only faculty were true academicians heavily involved in teaching and research.
- AMCs did not affiliate with non-AMCs.
- Competition with community-based providers was minimal.
- AMCs handled the majority of medical school and resident teaching
- AMCs handled the majority of research

Now

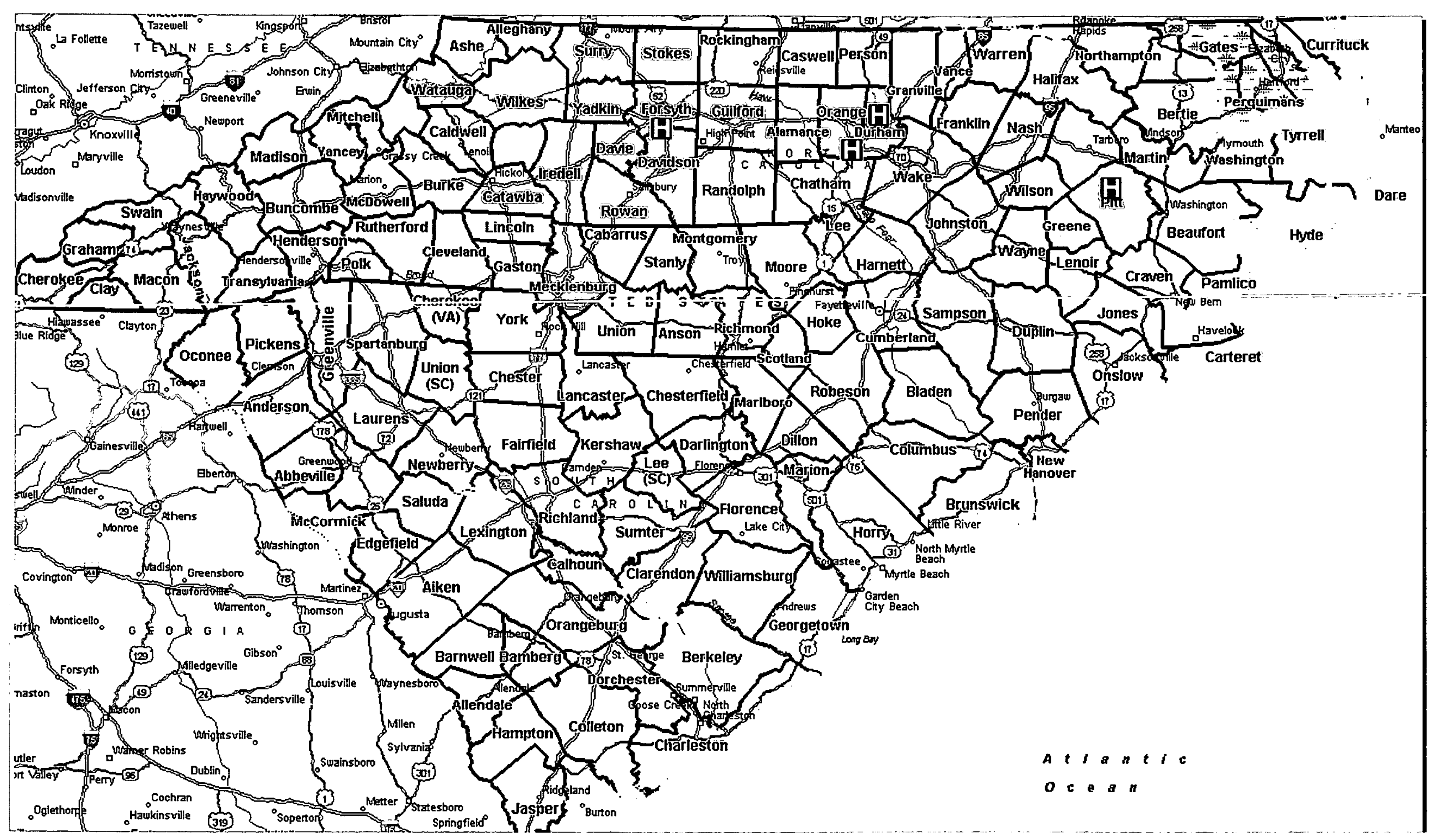
- AMCs serving patients in all 100 North Carolina counties
- AMCs have moved off campus (example: UNC's community hospital in Hillsborough, on the Alamance County line)
- Faculty includes many community physicians
- AMCs affiliate with non-AMCs (example: Duke's joint venture with LifePoint, a for-profit company)
- AMCs are direct competitors of community hospitals, community based surgery and imaging centers, and private practice physicians
- Non-AMC tertiary providers heavily involved in training medical students and residents
- Non-AMC tertiary providers involved in research including clinical trials

1983 v. 2011

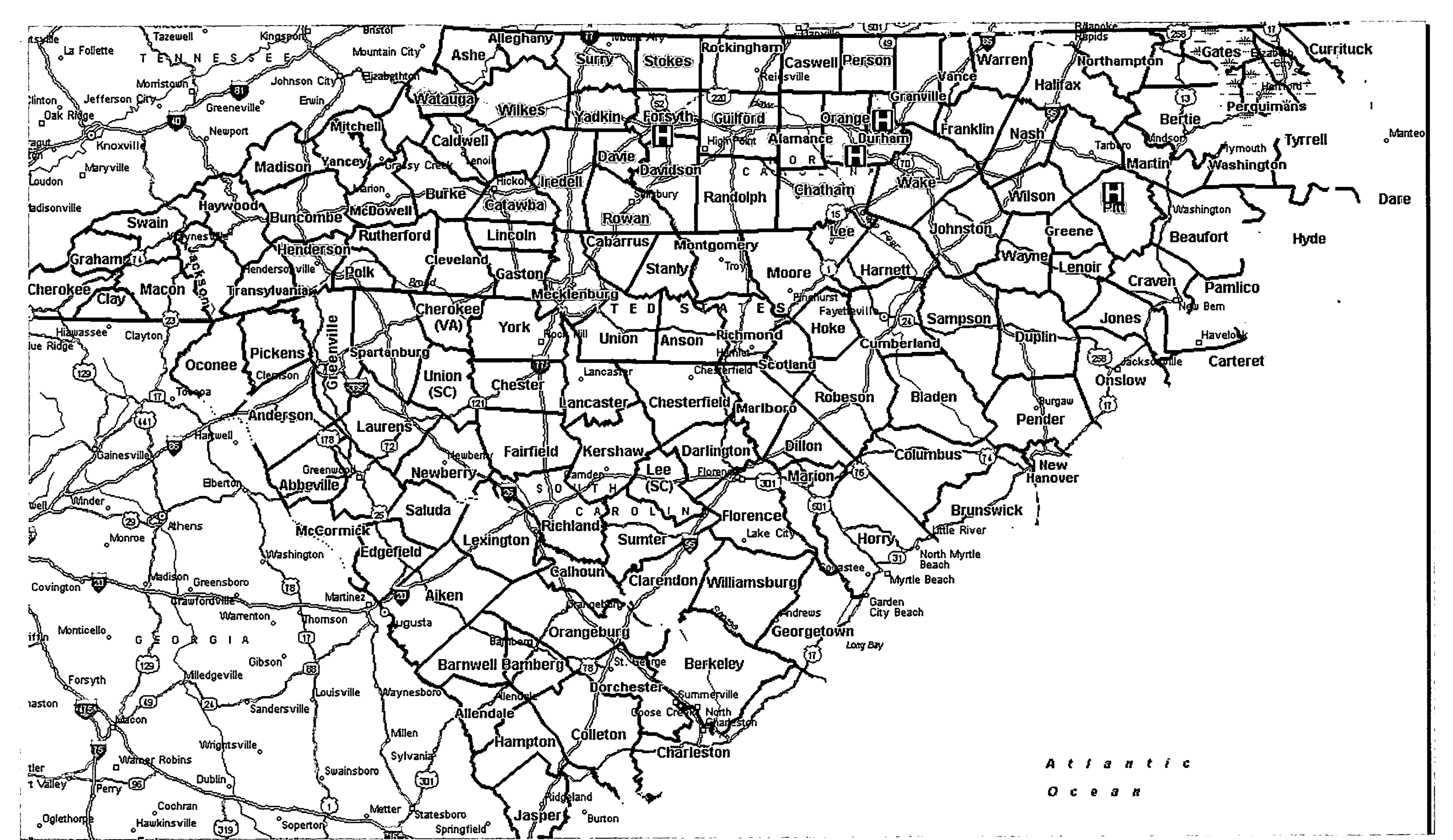
Academic Medical Center Growth

1983: Footprint of Four AMCS in North Carolina

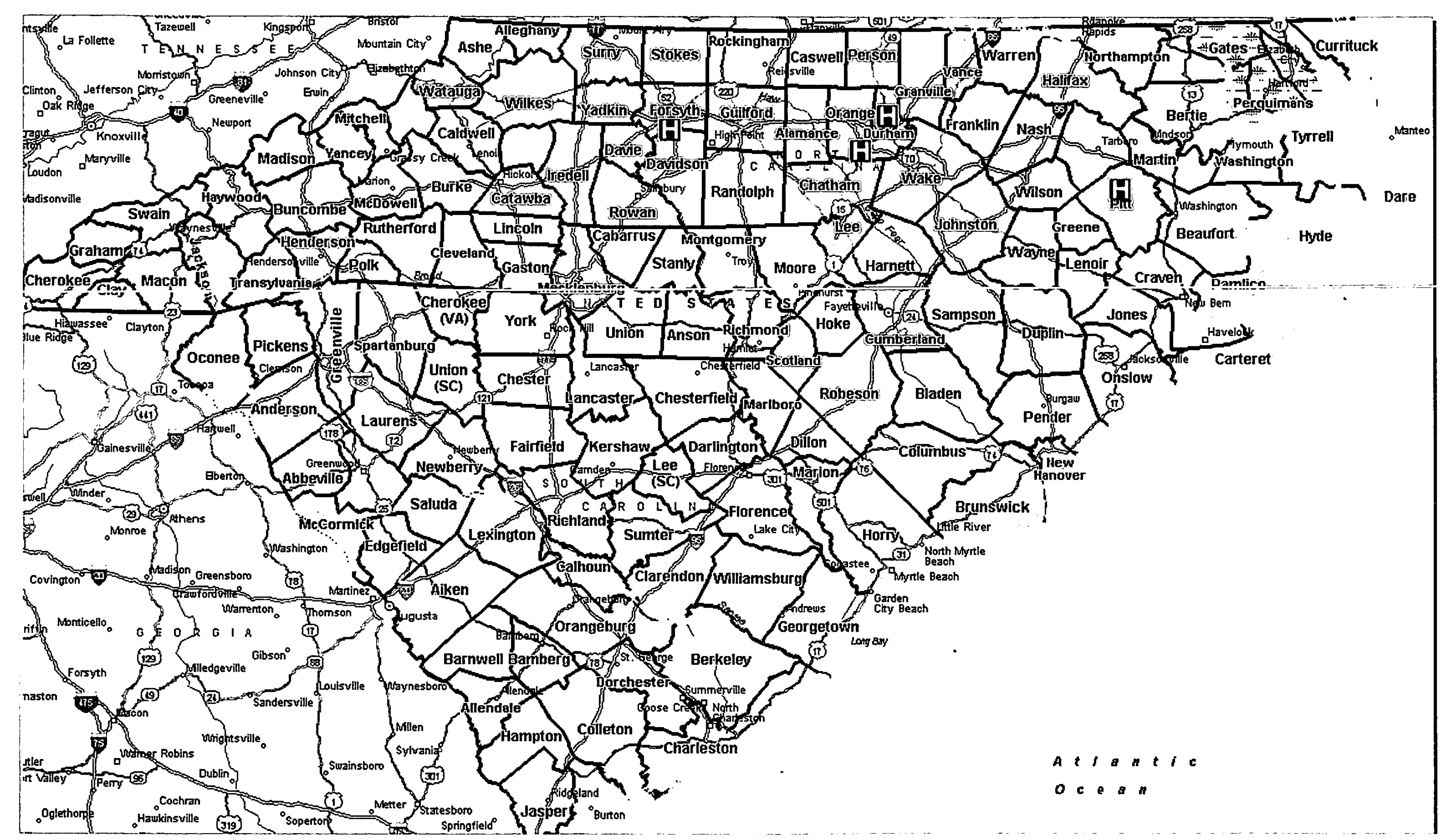
Wake Forest Baptist Health Footprint- 2011



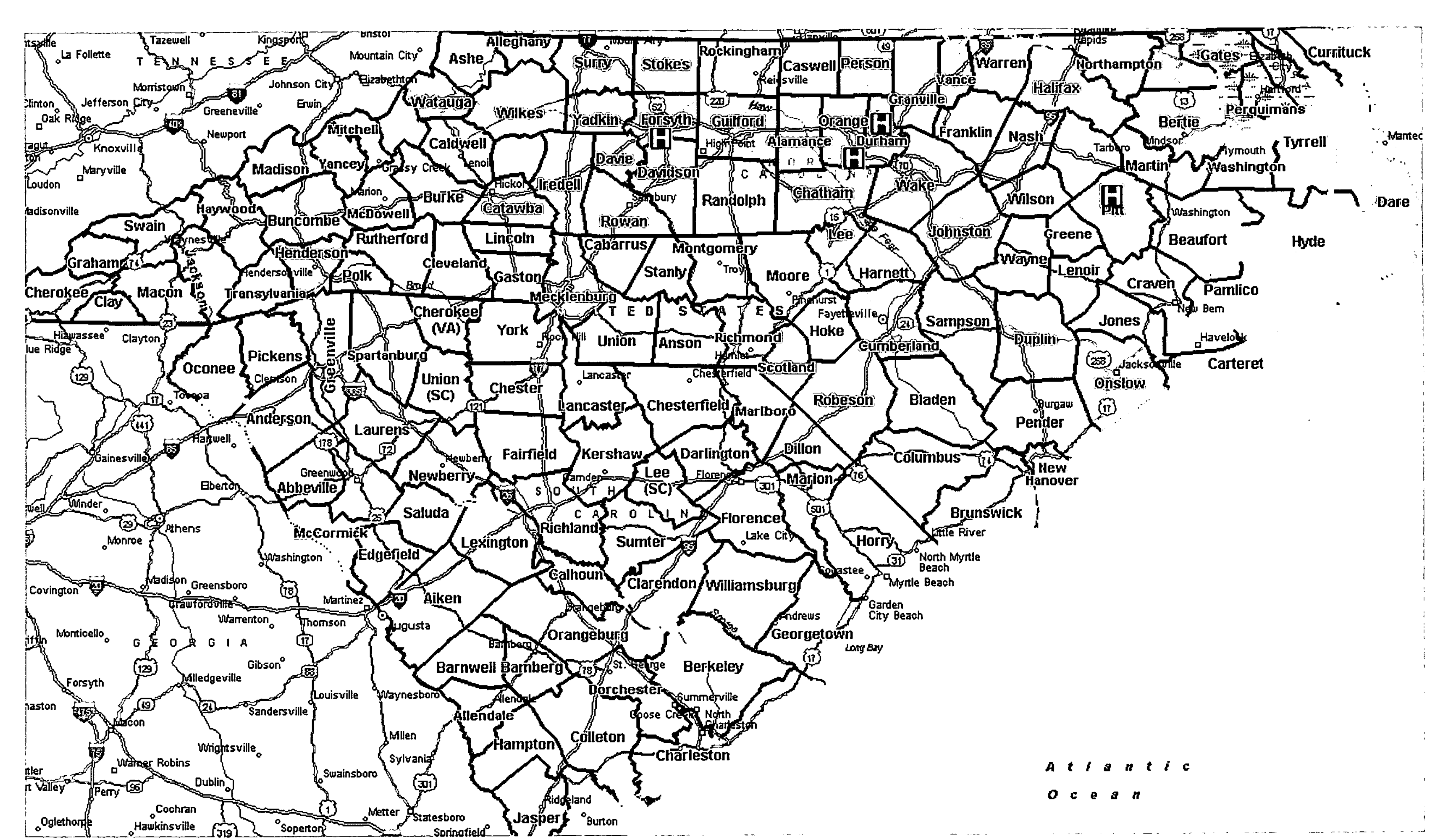
UNC Healthcare- Footprint 2011



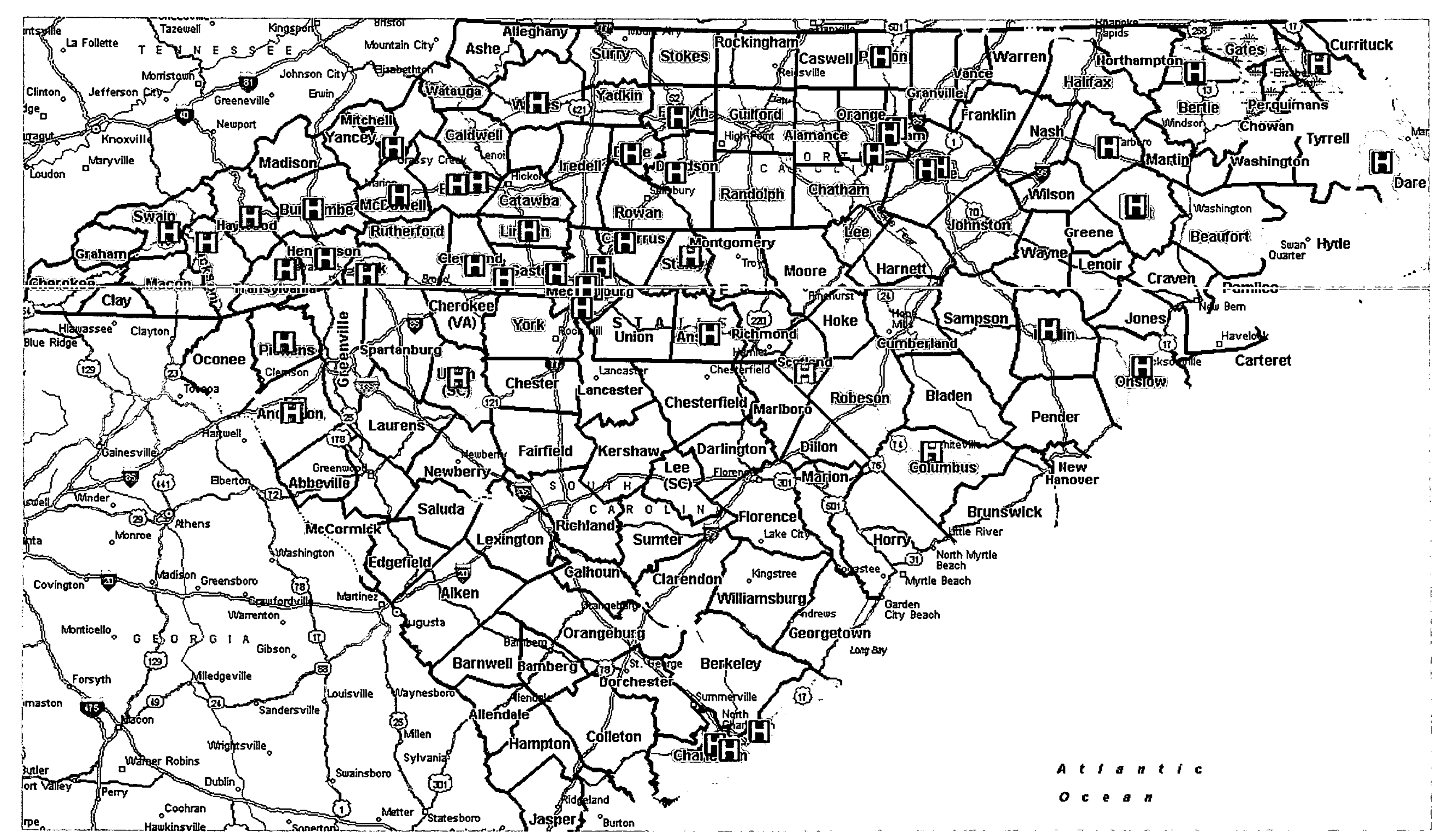
Duke University Health System- Footprint 2011



Pitt/University Health Systems-2011 Footprint



CMHA, Mission and Duke, Pitt, UNC, & Wake Forest Baptist Footprint 2011



Changing Landscape

"The legislation creating (UNC Health Care) System reflects a clear legislative intent to authorize the system to act with such degree of autonomy and flexibility ***as may be necessary to achieve these goals within the increasingly competitive healthcare industry***."*

*Source: NC Attorney General's Opinion requested by UNC Health Care System re: authority to acquire Rex Hospital (February 2000)

Presented by UNC to the House Select Committee on State-Owned Assets, September 2011

AMC Operating Performance & Metrics

FY 2010 results highlight the systems' strong performance as most profitability margins exceed the respective Moody's medians

Duke University Health System's results are particularly strong having margins that significantly exceed the Moody's medians and those of other systems

($ in millions)	Mission Health System	University Health Systems of Eastern Carolina	Duke University Health System	University of North Carolina Health Care System	North Carolina Baptist Hospital & Affiliates	Carolinas Healthcare System	FY 2010 Moody's Medians[2]	
	FY 2010	FY 2010	FY 2010	FY 2010	FY 2010	FY 2010	Aa	A
Operating Revenue	$967	$1,195	$2,150	$1,862	$971	$3,855	$1,648	$510
EBIDA[3]	$109	$134	$332	$199	$102	$383	$173	$51
Margin	11.2%	11.2%	15.5%	10.7%	10.5%	9.9%	10.8%	10.0%
Net Income[4]	$85	$39	$316[1]	$157	$81	$344	$134	$31
Margin	8.8%	3.3%	14.7%	8.4%	8.4%	8.9%	8.2%	6.3%
Moody's Rating	Aa3	A1	Aa2	Aa3	Aa3	Aa3		

Note: Shaded area denotes margin/ratio is desirable in comparison to respective Moody's median

1 Duke net income excludes a one time gain of $307m caused by a reclassification of investment securities from available-for-sale to trading in FY 2010

2 Moody's median financial data based on audited financial statements of freestanding hospitals and single state systems as of 7/29/2011

3 EBIDA is defined as operating income + interest + depreciation & amortization + (-) any non-cash loss (gain)

4 For comparability, unrealized gains/losses on investments is included in net income for all healthcare systems profiled

North Carolina's Two-Tier Health Planning System

- AMC's which benefit from Policy AC-3 vs
  ~ 110 "other" acute care hospitals in NC not eligible for Policy AC-3

- All providers are facing same challenges
  - rising indigent care
  - costly IT and technology requirements
  - rapidly declining reimbursement
  - advent of health care reform

- October 2011 <u>*USA Today*</u> article notes that "*hospital revenue is at a 20 year low according to Moody's.*"

.......but the two tier system in North Carolina continues.

First Major Proposed Changes to Policy Since 1983: Spring 2011

- Petition filed by the four AMCs with the State Health Coordinating Council - proposed to expand this unfair advantage beyond the 4 AMCs
  - To include Charlotte Mecklenburg Hospital Authority (CMHA) and Mission Hospitals under Policy AC-3
- Novant filed petition to propose more ***transparent*** and ***consistent reporting*** on AC-3 CON- approved assets and more clarity in the ***20-mile rule*** to compel real consideration of non-AMCs within a 20-mile radius of the AMCs

Policy AC-3 and Hospital Authorities

- CMHA already enjoys special privileges that many other hospitals do not have because it is a **Hospital Authority**. These special privileges include:
  - Territorial boundaries include the city or county creating the authority and the area within 10 miles from the territorial boundaries of that city or county (N.C. Gen. Stat. § 131E-20)
  - Eminent domain (N.C. Gen. Stat. § 131E-24)
  - County appropriations (N.C. Gen. Stat. § 131E-30)
  - Ability to accept transfers of property from the county for nominal consideration (N.C. Gen. Stat. § 131E-31)
  - Antitrust Immunity (means they can acquire and merge as they wish)
- In 2010, CMHA had combined annual net revenues in excess of $6.5 billion. *(Source: CMHA 2010 Annual Report)*
- In 2010, CMHA owned or managed 33 hospitals in two states, employed more than 1,700 physicians and controlled more than 6,300 licensed beds *(Source: CMHA 2010 Annual Report)*

Does CMHA need to be AC-3 exempt from health planning in order to compete effectively?

House Bill 812

- In the 2011 session, Representative Torbett introduced HB 812 which **removed the 10-mile extra-territorial jurisdiction** of hospital authorities.
- Boundary could only be extended by obtaining a Certificate of Public Advantage.
- Additionally, the hospital authority must obtain an agreement with a hospital facility in the county of the expansion if there is only one hospital, or an agreement with at least one hospital if there are more than one, or obtain an agreement with a health care agency if a hospital does not exist.

Novant supported this legislation

HB 743/SB 505
Proposed Changes to Policy AC-3
Equal Treatment Under SMFP

- During the 2011 legislative session Representative Steen and Senator Hartsell introduced legislation to ensure that future abuse of Policy AC-3 does not occur
  - This legislation, *Equal Treatment Under SMFP*, proposed a straightforward amendment to the CON law that would ensure a level playing field for all hospitals

Novant supported this legislation

The Journey Toward Modernization

- The North Carolina Hospital Association convened a group to make recommendations to the SHCC for improvements and updates to SMFP Policy AC-3.

- August 2011: Novant supported the proposed revision which was voted on favorably by the SHCC. We hope this revision will be included in the 2012 SMFP.

Lingering Questions

- Why have such a detailed health planning process if major exceptions are created?
- Should some providers be treated differently or should we have a health planning process that is ***fair and equitable*** to all providers?
- What is the empirical basis for treating some providers differently?
- What is the impact on providers who must follow health planning completely?
- Has Policy AC-3 *really* benefitted teaching and research?
- How have academic medical centers in the other 49 states been able to succeed without a local Policy AC-3 in those CON laws?
- Is North Carolina serious about avoiding ***unnecessary duplication of services*** and its cost consequences?

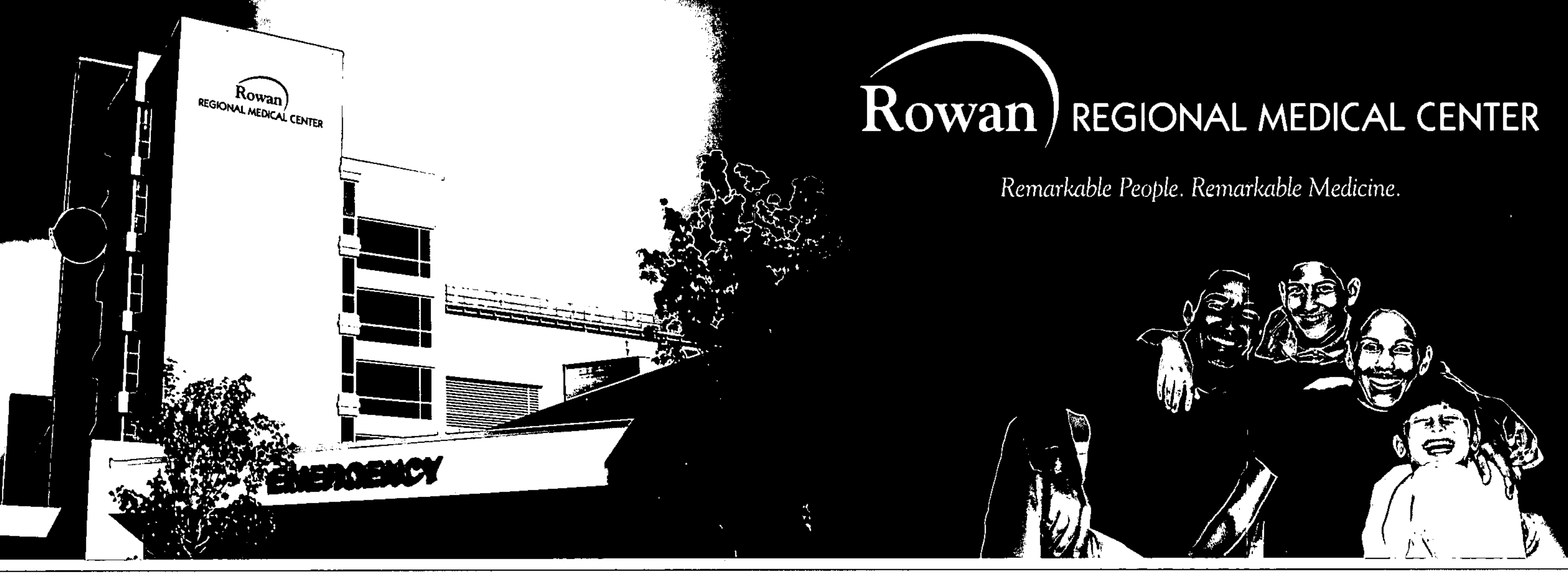
Ongoing Review To Keep Up with the Times

- Novant supports proposed revised Policy AC-3

  AND ongoing review of this and other policies within the SMFP as well as related provisions of the CON law is critical to reflect changing times.
- ***Recommend:***

  Continue to Modernize SMFP, its Policies, and related provisions of the CON Law:
  - All CON Applicants are subject to the same CON requirements
  - Transparency
  - Updating & Indexing for inflation of Dollar Ceilings for CON Exempt Projects *(small hospital construction projects, replacement of existing medical equipment, etc.)*
  - Other?
- We have been contacted by the NC Hospital Association and would be pleased to work with them on recommendations for changes.

Mend it, don't end it.



REMARKABLE CARE FOR YOUR ENTIRE FAMILY

At Rowan Regional Medical Center, our doctors and staff take pride in providing expert healthcare to the same people we call our neighbors, family and friends. Our personalized and compassionate care, combined with advanced technology, provides you excellent care with a hometown address.

Cardiovascular Services

The Smith Heart & Vascular Center houses a cardiac catheterization lab, interventional radiology vascular lab, stress testing area, and echocardiography services. The Smith Heart & Vascular Center also encompasses the nationally certified Cardiac and Pulmonary Rehabilitation & Wellness Center which offers programs to physician-referred patients that include exercise instruction, nutrition and lifestyle approaches to promote heart health.

Cancer Services

The Cancer Care Center offers all three treatment types for cancer including radiation therapy, surgery and chemotherapy. Our cancer specialists are board-certified in oncology and stay up-to-date on the latest advancements and improvements in the treatment of cancers. Our Cancer Care Center has a linear accelerator with treatments supervised by a board-certified radiation oncologist.

Maternity Services

The Maternity Center includes private maternity suites, lactation consultants and a Level II nursery providing care to newborns requiring specialized care. The nursery's equipment and supplies are geared to the needs of these infants and staffed by specially trained neonatal nurse practitioners 24 hours a day, seven days week. We help families prepare for the arrival of baby through educational classes led by certified nurse educators. One-on-one tours are available to families. To schedule, please call 704-210-5544.

Novant Inpatient Care Specialists

This team of board-certified physicians, known as hospitalists, are available 24-7 for consultation and to care for those hospitalized in our inpatient units.

Neurology Services

Neuroscience services provide comprehensive clinical care for the diagnosis and treatment of neurological and nerve disorders of the brain, spinal cord, peripheral nerves and muscles. We offer an extensive array of services, including the treatment of epilepsy, Parkinson's disease, stroke and sleep disorders.

Stroke Care

The Stroke Center provides comprehensive clinical care for the diagnosis and treatment of neurological and nerve disorders, including disorders of the brain, spinal cord, peripheral nerves, muscles and neurobehavioral disorders. Rowan Regional Medical Center is certified as a primary stroke center by the Joint Commission on Accreditation of Healthcare Organizations.

Center for Sleep Disorders

The Sleep Medicine Center of Salisbury, located on the hospital campus, is one of only a few centers in North Carolina fully accredited by the American Academy of Sleep Medicine. The center provides advanced diagnosis and treatment of sleep-related problems such as sleep apnea, narcolepsy and insomnia in both adults and children.

Emergency Services

Our "nurse first" triage program allows each patient to be triaged within minutes of arrival at our Emergency Department. Serious cases are then sent immediately into the department to begin diagnosis and treatment. Other emergency services include access to Critical Care Transport which is staffed 24 hours a day to transport the most critically ill patients from one facility to another.

Coronary Care and Intensive Care

Rowan Regional Medical Center has both a coronary care unit (CCU) and an intensive care unit (ICU) that provides intensive nursing and medical care to critically ill and coronary care patients. A landing pad for a helicopter to transport critically ill or injured patients is located on our medical center.

Respiratory Services

Our respiratory care services specialize in diagnosing and treating problems relating to the lungs. Our well-trained respiratory therapists work in all areas of the hospital assisting physicians in diagnosing and treating respiratory symptoms.

Surgical and Endoscopy Services

Surgical services range from same-day outpatient surgery to more complex surgeries such as hysterectomy. We offer minimally invasive surgeries that leave less scarring and allow the patient to recover more quickly. Endoscopy services include: colonoscopy, sigmoidoscopy, bronchoscopy and esophagogastroduodenoscopy (EGD). Our outpatient surgery center is located in our medical park off of Julian Rd.

Diabetes and Nutrition Services

Our outpatient Diabetes and Nutrition Education Program provides a comprehensive team to assess the patient and design a plan to properly manage complications often experienced with diabetes. Our registered dietitians offer nutritional classes designed to help patients manage their diet. Support groups are available for patients and community members.

Rehabilitation Services

Elizabeth C. Stanback Rehabilitation Unit provides a full-range of inpatient rehabilitation services for treatment of stroke, brain injuries and neurological disorders, neuromuscular disorders, amputations, arthritis and orthopaedic injuries. Our team includes physicians, rehabilitation nurses, physical therapists, occupational and speech therapists and case managers.

Outpatient rehabilitation services are located in our medical park off of Julian Road. Services include physical therapy, speech therapy and occupational therapy to treat a wide range of injuries such as neck, back and sports injuries, trauma, joint replacements and neurological conditions including stroke and traumatic brain injury as well as circulatory problems. We also have speech and physical therapists specializing in pediatrics.

Imaging and Diagnostic Radiology Services

Our team of doctors, nurses and technologists specialize in advanced imaging technology and interventional treatment options. Services include MRI, CT and PET scan, digital mammography, bone density testing, ultrasound, nuclear medicine and x-ray. Outpatient services are offered at the hospital and off Julian Road.

Orthopaedic Services

We offer a wide range of services and programs for individuals with orthopaedic problems, including total joint replacement for knees, hips and shoulders, sports medicine procedures, tendon/nerve repair, specialized hand, wrist and elbow surgery and foot and ankle surgery.

The Joynt Camp is designed for those patients who have undergone orthopaedic surgery such as a total knee or hip replacement. At the Camp, participants interact with other patients during meals, physical therapy and other activities, allowing patients constant interaction with family members and caregivers creating an environment that promotes healthy healing.

Wound Care

Wound care services offer advanced treatment options for wounds and ostomies including diabetic foot wounds, post-operative wounds, arterial wounds, venous stasis wounds, burns, traumatic injuries, decubitis ulcers, colostomy, ileostomy and urinary diversion care.

Prescription Services

The Rowan Prescription Center's convenient location allows patients to quickly and easily fill a prescription on their way home from the hospital.

Hospice Services

Hospice services care for people facing end-of-life illnesses so they may live as comfortably as possible. A team of health professionals and volunteers provide emotional, social and spiritual care as well as personal help with daily activities to assist patients and families moving through this final life transition.

Behavioral Health Services

LifeWorks Behavioral Health Center is designed to help patients with mental health issues. Our team of physicians, therapists, counselors and nurses is dedicated to meet the needs of our patients and families while they work to achieve a balanced and productive life, on an inpatient and outpatient basis.

Pain Management Services

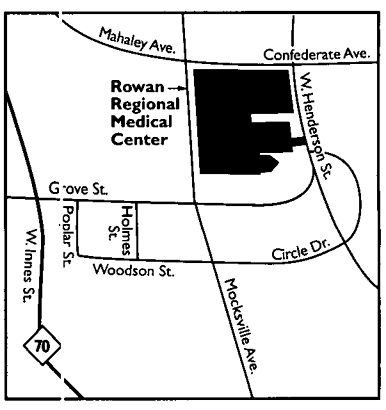
The Pain Management Center features a group of physicians with special credentials for managing chronic pain, from low back pain, neck and headache pain to pain associated with such diseases as cancer.

Infusion Services

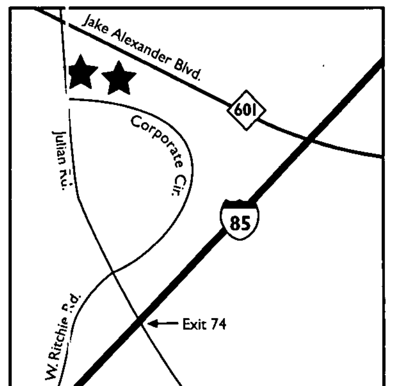
We offer a range of outpatient infusion services to address the medical needs of the entire family. The infusion area is designed to foster health and wellness under the direct supervision of a qualified, well-trained nursing staff that is specially trained in chemotherapy and oncology. Open Monday through Friday with weekend coverage for patients whose treatment regimen falls on those days.

Children's Services

Rowan Regional is dedicated to providing children and their families compassionate care in a family-centered environment. We encourage parents to be actively involved in their child's health and invite you to stay around-the-clock at our facility.



Rowan Regional Medical Center
612 Mocksville Avenue
Salisbury, NC 28144
704-210-5000
www.rowan.org



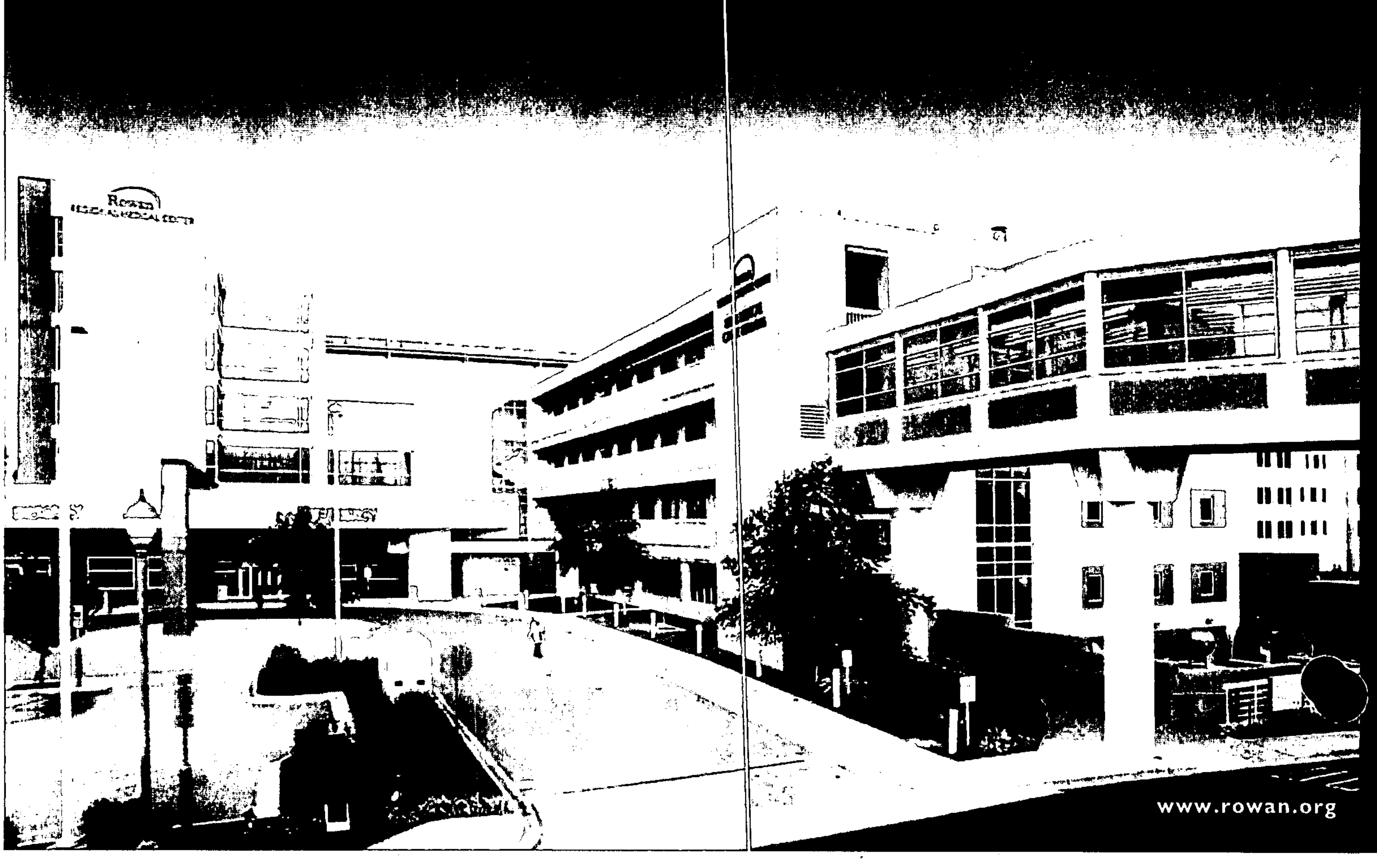
Rowan Regional Medical Park
522 Corporate Circle
Salisbury, NC 28146
Surgery: 704-210-6955
Imaging: 704-210-5238
Rehabilitation: 704-210-6918

Remarkable People. Remarkable Medicine.

Caring for Our Communities

This is Your Hospital

Since 1936, Rowan Regional Medical Center has provided excellent medical care to Salisbury and surrounding communities. Throughout the years, our hospital has evolved into a major medical campus, with 268 beds and an extensive outpatient services center. Our physicians have trained in many of the top medical programs in the nation, and our staff works hard to ensure our patients leave knowing they have received the best in healthcare and that we knew them as a person.



www.rowan.org

Recognized for Quality

As a not-for-profit hospital, Rowan Regional receives no city or county taxes. We are governed by a board of directors comprised of local business executives, physicians and community leaders who donate their time to provide leadership for the hospital. Rowan Regional is nationally accredited by The Joint Commission which is recognized as the "Gold Seal" of approval in healthcare. The high quality care at Rowan Regional has received statewide and national recognition by such organizations as the NC Center for Hospital Quality and Patient Safety, VHA, Blue Cross Blue Shield of North Carolina and Professional Research Consultants. We are affiliated with Novant Health, a North Carolina not-for-profit healthcare system that is nationally recognized for quality care.

The Remarkable Patient Experience

When it comes to your hospital stay, it's often the little things that make a difference. Things like compassionate care, great food and a friendly smile at every turn. At Rowan Regional Medical Center, we have created an environment focused on the things that mean the most when you need them.

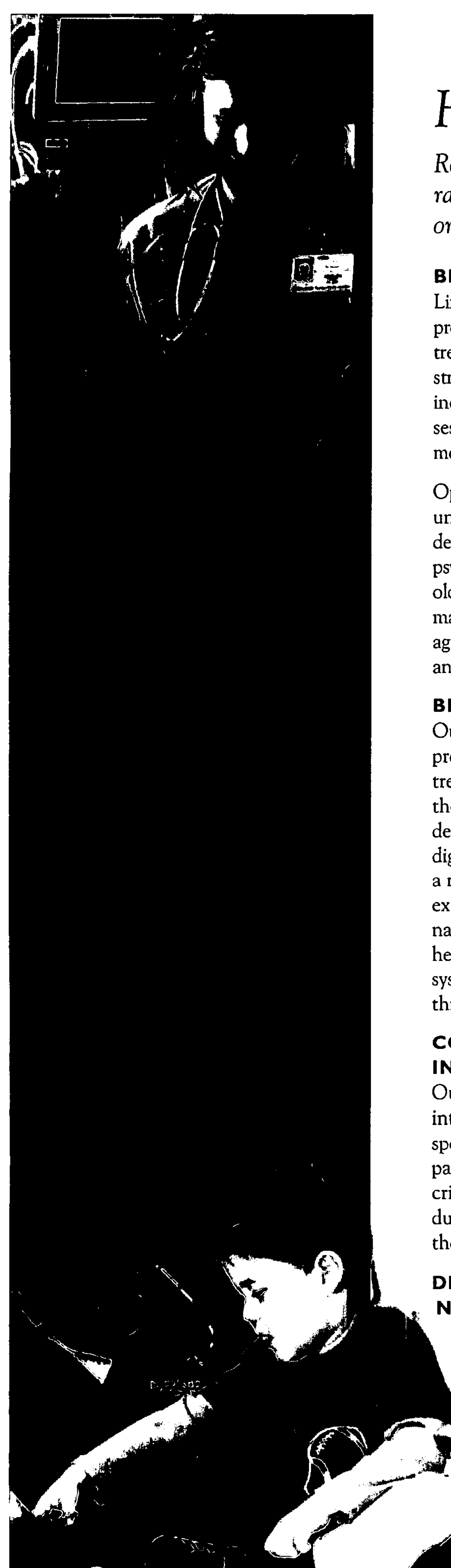
While we can't recreate the feeling of home, we have taken special efforts to include features that will help you relax while you are here. Our private rooms are designed with you in mind, complete with a private bath, television, free wireless internet and space for guests. You will even receive a free copy of the *Salisbury Post* each day. We know that patients are more comfortable when they are surrounded by people they love. That is why we do not have formal visiting hours and your loved ones are welcome to visit you whenever it is most convenient.

Special Amenities

Meals for guests are close by in the cafeteria, Café Rowan, which serves breakfast, lunch and dinner. If you're looking for personal care items, reading material, flowers or gifts for baby and others, the gift shop in our main lobby has a wonderful selection. For your convenience, an ATM is located off our main lobby.

The hospital chapel can serve as a quiet place for you to reflect or connect with family and our chaplain. There is also an outdoor courtyard where guests can relax. For the safety of our patients, Rowan Regional Medical Center is a tobacco-free campus which includes the streets, sidewalks and parking areas. For patients who do not speak English and/or communicate using American Sign Language, Rowan Regional provides access to interpreters and other communication aids at no cost.

During an inpatient stay, you may be cared for by a doctor from Novant Inpatient Care Specialists Rowan. These board-certified physicians, known as hospitalists, are here at the hospital 24 hours a day, seven days a week. They will oversee your care and keep your primary care physician updated on your condition. This system allows primary care physicians to be at their practices, and it ensures that there are physicians at the hospital dedicated to your care.



Hospital Services

Rowan Regional Medical Center provides our community with a complete range of medical services, from cancer treatment and leading edge orthopaedic surgery, to advanced cardiology and maternity care.

BEHAVIORAL HEALTH SERVICES
LifeWorks Behavioral Health Center provides adult inpatient psychiatric treatment for those coping with life's struggles. Short-term intensive treatment includes group therapy, educational sessions, coping skills training and medication management.

Opening in 2011, the geriatric psychiatric unit will be a short-term, inpatient unit dedicated and staffed to meet the primary psychiatric needs of patients 55 years and older. Our skilled staff will be trained to manage distinctive issues related to the aging brain and body for both patients and family members.

BREAST HEALTH SERVICES
Our breast health services include the prevention, screening, diagnosis and treatment of breast cancer using the latest in breast technology. Our dedicated Breast Health Center offers digital mammography and access to a multidisciplinary team of medical experts, including a breast health navigator who coordinates your care, helps you navigate the health care system, and supports you and your family throughout your cancer experience.

CORONARY & INTENSIVE CARE SERVICES
Our coronary care unit (CCU) and intensive care unit (ICU) provide specialized nursing and medical care to patients in these units. Board-certified critical care specialists treat patients during their stay and follow-up with them after they have left the hospital.

DIABETES & NUTRITION SERVICES
Our Diabetes & Nutrition Center, recognized by the American Diabetes Association, hosts a team of experts that provides comprehensive care to manage each patient's complications. The program offers diabetes and nutritional education to hundreds of patients in our community, helping them lead healthier lives.

DIALYSIS
We provide hemodialysis treatment for inpatients that need help with kidney function.

EAR, NOSE & THROAT SERVICES
Disorders of the ear, nose, and throat are part of the medical field of otolaryngology, or ENT, a specialty that also encompasses related structures of the head and neck. Rowan Regional is proud to have nationally board-certified physicians on our staff trained in the medical and surgical treatment of otolaryngological disorders.

EMERGENCY CARE SERVICES
Our emergency team is always ready to treat serious and life-threatening emergencies. Our goal is to minimize wait times, with new processes that provide for you to meet with a nurse upon arrival, be quickly admitted to an exam room and triaged by a team of physicians and specialists. Staffed around the clock with board-certified emergency medicine physicians, we offer a full spectrum of care.

Our stroke unit is nationally recognized as a certified stroke center by The Joint Commission. Patients suspected of having a stroke are seen within minutes of arrival by a team of highly-trained specialists who provide immediate treatment 24/7.

For non-life threatening emergencies, please visit our Urgent Care located at 1035 Lincolnton Rd.

ENDOSCOPY SERVICES
Nationally board-certified gastroenterologists and pulmonologists provide state-of-the-art endoscopy services for inpatient and outpatient procedures, including colonoscopy, sigmoidoscopy, bronchoscopy and esophagogastroduodenoscopy (EGD).

MATERNITY SERVICES

Our private, spacious and comfortable maternity suites are the perfect place to welcome the newest member of your family. With Dining on Call, room service-style gourmet meals are just a phone call away. A cart with complimentary snacks and fresh baked goodies cart stops by your room each day.

Families are able to spend quality time together, with mother-baby couplet care and rooming-in. Babies spend most of the day in their mothers' rooms to encourage bonding between newborns, their parents and siblings. Moms can request that their baby room-in all night or that their baby sleeps in the nursery and be brought to mom for feedings.

For high-risk mothers, our Level II nursery is equipped to care for newborns with special needs, and is staffed by specially trained neonatal nurse practitioners 24/7. Also, a state-of-the-art infant security system and constant surveillance keep you and your baby safe.

Certified lactations consultants and maternity educators help you through pregnancy and prepare you to care for your baby at home, with a variety of classes and personal consultations during your stay in the maternity center. Private family tours are available to fit your schedule by calling 704-210-5544.

HEART & VASCULAR SERVICES

The Smith Heart & Vascular Center provides advanced cardiovascular testing and treatment. We are a regional leader in cardiovascular care, with groundbreaking peripheral arterial disease (PAD) treatment, a dedicated radial artery catheterization program and fellowship-trained interventional cardiologists and radiologists. Diagnostic tests and treatments include:

- 24/7 heart attack care
- Radial cathetrization
- Electrocardiograms (EKG)
- 2D echocardiograms
- Stress echo testing
- Holter and event monitoring
- Transesophageal echo (TEE)
- Kyphoplasty
- TIPPS
- Tumor ablations
- Carotid stenting
- Venous and arterial evaluations
- Carotid ultrasounds
- Coronary stenting
- Pacemaker implantation
- AICD
- Loop recorder

The nationally certified Cardiac Rehabilitation & Wellness Center helps cardiac patients regain health and stamina through physical exercise and education.

HOSPICE & PALLIATIVE CARE SERVICES

Rowan Regional Medical Center provides compassionate inpatient and outpatient care for individuals facing advanced diseases or end-of-life-illnesses in order to help them maintain the best possible quality of life. A team of healthcare professionals and volunteers provide emotional, social and spiritual support to patients and family members so they may live comfortably. Rowan Hospice & Palliative Care will open our first Hospice House in 2012.

IMAGING SERVICES

Nationally board-certified radiologists, nurses and technologists offer advanced diagnostic imaging and interventional treatments. Imaging services include:

- Computed tomography (CT) scan
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET)
- Ultrasound
- Diagnostic X-ray
- Fluoroscopy
- Nuclear medicine
- Digital mammography
- Stereotactic and ultrasound-guided biopsy
- MRI-guided biopsy
- Bone density testing

Imaging services are offered at Rowan Regional Medical Center and Rowan Regional Medical Park.

INFUSION SERVICES

For those who require IV therapy, we offer a wide range of infusion services including antibiotic therapy, chemotherapy, pain management, blood transfusions, hydration and anti-nausea treatments.

INPATIENT CARE SERVICES

A team of board-certified physicians, known as hospitalists, is available 24/7 for consultation and to care for those hospitalized in our inpatient units.

LABORATORY SERVICES

Our hospital offers lab services using state-of-the-art technology, giving patients and physicians the highest quality lab test results. The lab is nationally accredited by multiple quality organizations, and our expert staff includes medical technologists, histology technicians, phlebotomists and pathologists.

NEUROSCIENCE SERVICES

Our comprehensive neurological services include a team of board-certified neurologists, neuroradiologists and neurosurgeons for the diagnosis and treatment of disorders of the brain, spinal cord, peripheral nerves and muscles. We offer an extensive array of services, including the treatment of epilepsy, Parkinson's disease, stroke and sleep disorders. Rowan Regional is a nationally certified primary stroke center.

ORTHOPAEDICS SERVICES

Our nationally board-certified orthopaedic surgeons offer a wide range of services for individuals with orthopaedic problems including advanced total joint replacement for knees, hips and shoulders; sports medicine procedures including arthroscopic surgery of knees, shoulders, ankles and wrists; Birmingham hip resurfacing; tendon/nerve repair; and specialized procedures for the spine, including microscopic surgery.

Rowan Regional Medical Center has been named Blue Cross Blue Shield of North Carolina Blue Distinction Center for Knee and Hip Replacement, a recognition awarded to facilities who demonstrate an expertise in quality care, resulting in better overall outcomes for patients.*

For patients undergoing a total joint replacement, Rowan Regional offers a group-focused recovery program at our Joynt Camp. This unique concept allows patients to share the recuperation experience with others, creating an environment that promotes healthy healing.

ONCOLOGY SERVICES

Surgical and medical oncology, including chemotherapies and immunotherapies, are among the cancer treatments available at Rowan Regional Medical Center. Our Cancer Care Center offers radiation oncology treatment and houses the IMRT Linear Accelerator, which has been called the most significant technological advancement in radiation oncology in recent years. Additionally, our imaging and radiology services enable improved accuracy in evaluating various types of cancer. Our cancer specialists are board-certified in oncology and stay up-to-date on the latest advancements and improvements in the treatment of cancer.

PHARMACY SERVICES

Our convenient on-site pharmacy allows patients to quickly and easily fill prescriptions on their way home from the hospital.

REHABILITATION SERVICES

The Elizabeth C. Stanback Rehabilitation Unit provides a full range of inpatient rehabilitation services for treatment of stroke, brain injuries and neurological disorders, neuromuscular disorders, amputations, arthritis and orthopaedic injuries. Our team includes board-certified physical medicine and rehabilitation physicians, rehabilitation nurses, physical therapists, occupational and speech therapists and case managers. Outpatient rehabilitation includes physical, speech and occupational therapy, and is available at Rowan Regional Medical Park.

RESPIRATORY SERVICES

Specially-trained respiratory therapists work in all areas of the hospital 24/7, assisting physicians in diagnosing and treating respiratory symptoms. Services include breathing assessments and treatments, pulmonary function studies, vascular testing and blood gas analysis. Our pulmonary rehabilitation program provides individualized pulmonary reconditioning to enhance strength, endurance and breathing ability as well as reduce the symptoms of lung disease.

SLEEP MEDICINE SERVICES

Our comprehensive sleep center is one of only a few centers in North Carolina to be fully accredited by the American Academy of Sleep Medicine. We provide advanced diagnosis and treatment of sleep-related problems such as sleep apnea, narcolepsy and insomnia.

Designated as a
Blue Distinction®
Center for Knee and Hip Replacement

*Note: Designation as Blue Distinction Centers® means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan.

SURGICAL SERVICES

Our nationally board-certified surgeons and anesthesiologists provide the highest level of surgical care for inpatient and outpatient procedures. Our high-tech operating rooms provide surgical services for a variety of specialties including orthopaedics, plastic surgery, neurosurgery, urology, gynecology, gastroenterology, ophthalmology, ear, nose and throat, and general surgery. Many surgeons perform advanced minimally invasive surgeries such as laparoscopic surgery for gallbladder removal and total hysterectomy. Benefits of these procedures include less pain, faster recovery times and no visible scarring. Outpatient surgeries are performed at Rowan Regional Medical Center and Rowan Regional Medical Park.

UROLOGY SERVICES

For prostate, kidney and urinary health, nationally board-certified urologists offer the latest advancements in surgical and non-surgical procedures. Advanced treatments include vasectomy, lithotripsy, urologic laser surgery, urodynamic testing and other advanced treatments.

WOMEN'S & CHILDREN'S SERVICES

Rowan Regional Medical Center has a dedicated women's and children's unit, where specially-trained nurses care for patients after surgical procedures and other conditions that require a hospital stay. Our nationally board-certified physicians, including pediatricians and obstetricians and gynecologists, are available 24/7 to meet your medical needs.

WOUND CARE SERVICES

Our skilled and experienced wound, ostomy and continence nurses offer advanced treatments for diabetic foot wounds, post-operative wounds, arterial wounds, venous stasis wounds, burns, traumatic injuries, decubitis ulcers, colostomy, ileostomy and urinary diversion care.

Beyond the Hospital

ROWAN REGIONAL MEDICAL PARK

Our medical park offers the convenience of outpatient services in one location. Services include outpatient surgery, outpatient rehabilitation and imaging services, including digital mammography.

PHYSICIANS

Rowan Regional Medical Center's physician partners span across the region so that remarkable care is just around the corner. Our primary care and specialty care physicians are dedicated to keeping your family healthy with comprehensive quality care. To find a physician call 1-800-335-4921 or visit www.rowan-md.org.

CORPORATE WELLNESS

Rowan Regional offers a wide range of corporate wellness services, including on-site employee screenings and health risk assessments, lifestyle modification programs such as tobacco cessation, occupational medicine services such as pre-employment physicals and connection with primary and specialty care physicians. For more information, call 704-210-6887.

COMMUNITY RESOURCES

We offer educational classes and support groups to help our community lead a healthier life. Topics include childbirth preparation, diabetes management and nutrition and more. Visit www.rowan.org for more information about support groups, classes and upcoming health events.

We are proud to serve un- and underinsured local children with a free mobile medical clinic called the Community Care Cruiser. It provides free care such as immunizations, physicals and check-ups.

For health education and wellness programs, visit the Rowan Regional Medical Center Wellness Connection located within each Rowan County Y. A registered nurse provides health screenings and information, educational sessions and lifestyle programs to Y and community members.

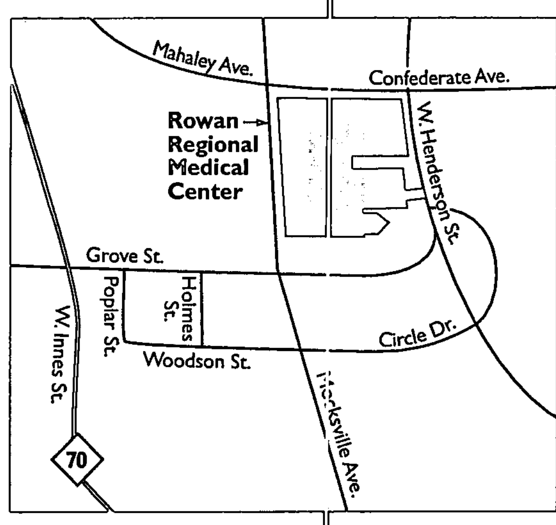
FOUNDATION

The Rowan Regional Medical Center Foundation advances healthcare in Rowan County through philanthropy, relationships and stewardship. One hundred percent of funds raised through our Foundation stay with Rowan Regional and donations of $25,000 or more are matched by Novant Health. For more information on our Foundation, please call 704-210-6880.

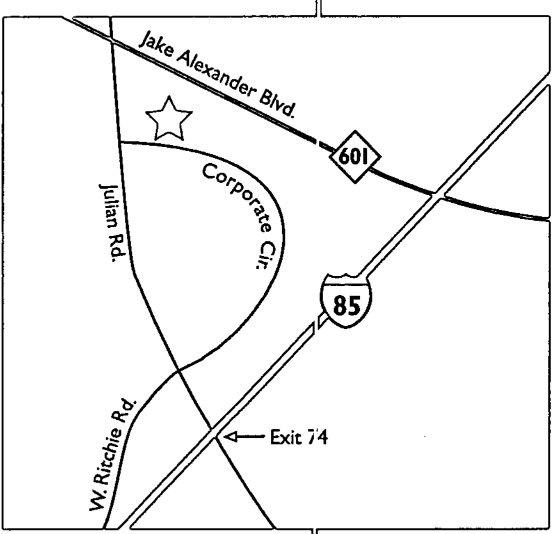
JOB INFORMATION

If you are interested in a career at Rowan Regional, visit www.novanthealthcareers.com or call 704-210-5088.

For more information about Rowan Regional's services or to find a physician, call 1-800-335-4921 or visit www.rowan.org.



Rowan Regional Medical Center
Conveniently located near downtown Salisbury



Rowan Regional Medical Park
Conveniently located off Julian Road

612 Mocksville Avenue, Salisbury • NC 28144
704-210-5000 • www.rowan.org • www.facebook.com/rowanregional

Novant Health does not discriminate against any person on the basis of race, color, national origin, religion, disability, sex, veteran's status, sexual orientation, gender identity or age with regard to admission, treatment or participation in its programs, services and activities, or in employment. Free foreign language interpreters are available for individuals who are limited English proficient. Free sign language and oral interpreters, TTY's and other services are available to deaf and hard-of-hearing persons. For further information about this policy, contact: Novant Health Director of Internal Audit & Compliance, 1-704-384-7638 or TDD 1-800-735-8262.

Novant Health Overview:
A Non-Profit Healthcare System

Nov. 1, 2011

Briefing Book for

NC House Select Committee on CON Process and Related Hospital Issues

Novant Health

Mission

Novant Health exists to improve the health of communities, one person at a time.

Vision

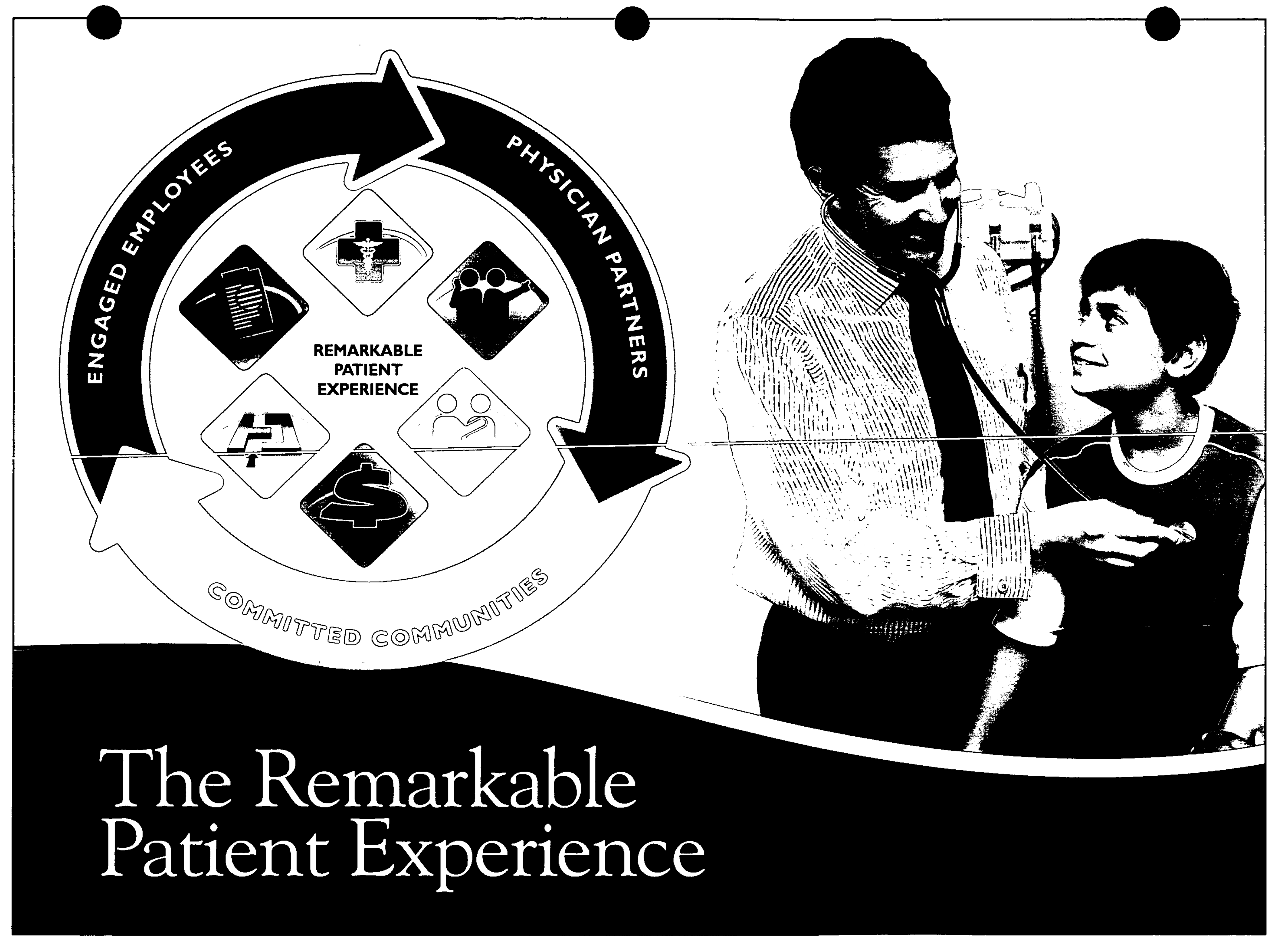
We, the employees of Novant and our physician partners, will deliver the most Remarkable Patient Experience, in every dimension, every time.

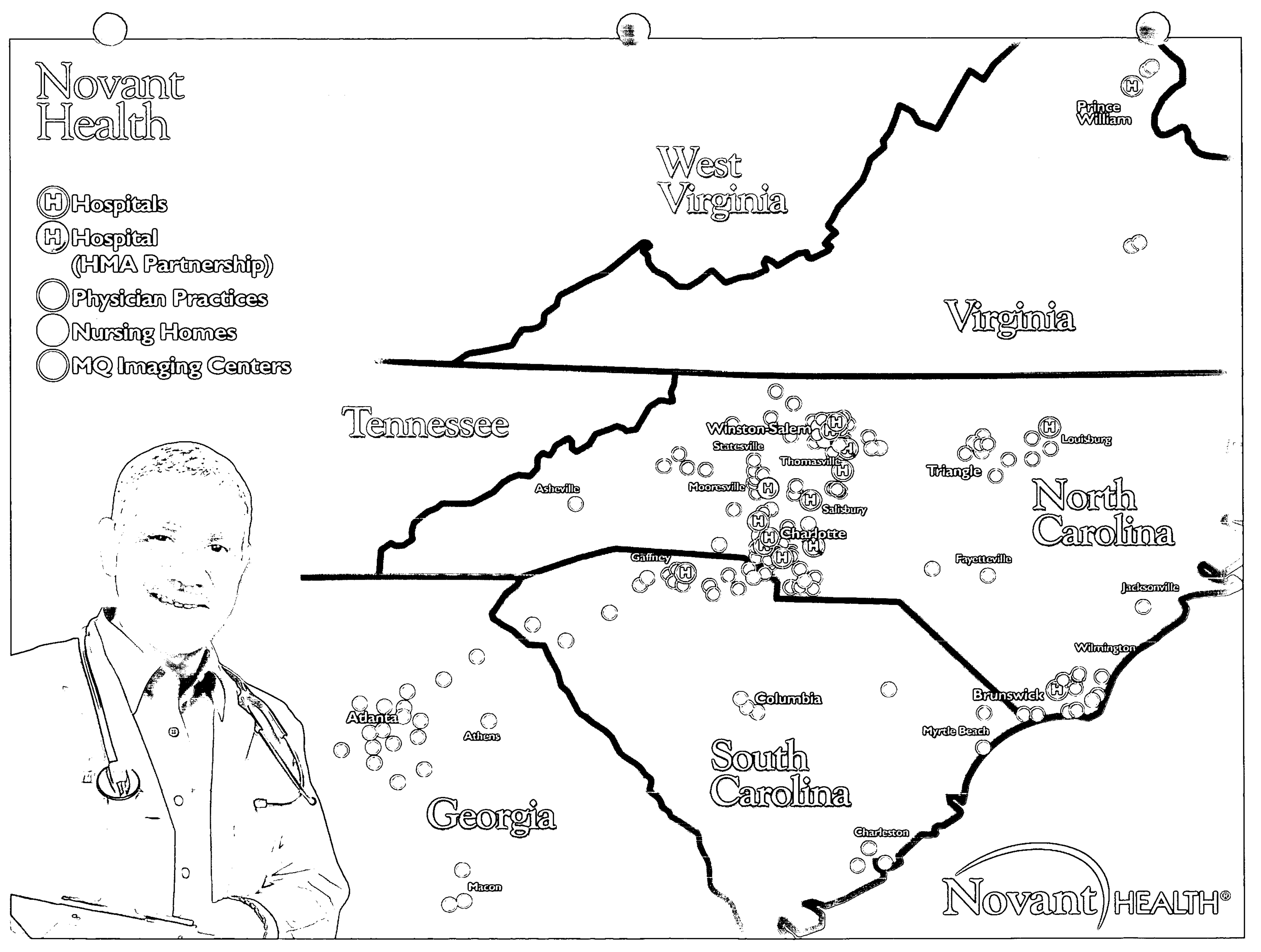
Values

- Compassion
- Personal Excellence
- Diversity
- Teamwork

Our Vision

We, the employees of Novant and our physician partners, will deliver the most remarkable patient experience in every dimension, every time.


ENGAGED EMPLOYEES
PHYSICIAN PARTNERS
COMMITTED COMMUNITIES
REMARKABLE PATIENT EXPERIENCE
The Remarkable Patient Experience

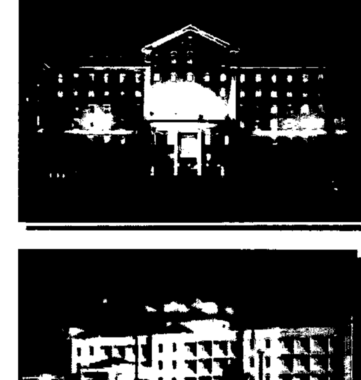

Novant Health
Hospitals
Hospital (HMA Partnership)
Physician Practices
Nursing Homes
MQ Imaging Centers
West Virginia
Virginia
Prince William
Tennessee
North Carolina
South Carolina
Georgia
Winston-Salem
Statesville
Thomasville
Mooresville
Salisbury
Charlotte
Asheville
Gaffney
Triangle
Louisburg
Fayetteville
Jacksonville
Wilmington
Brunswick
Myrtle Beach
Columbia
Charleston
Atlanta
Athens
Macon
Novant HEALTH®

Integrated Healthcare System

- $3.4 billion in revenue in fiscal year 2010
- Primarily serves North and South Carolina and parts of Virginia and Georgia
- 13 acute care hospitals
- 158 ambulatory centers
- Over 5,000 physician partners
  - ~1,100 NMG physicians at 360 locations

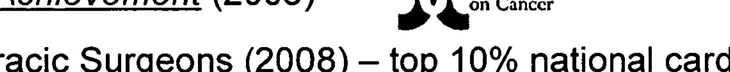
2010 Vital Statistics

- 124,000 discharges
- 119,000 surgeries
- 19,000 births
- 495,000 ED visits
- 885,000 outpatient cases
- 3,700,000 physician encounters



Awards and Recognitions-Clinical Care

- Two-time *Codman Award* Winner - hand hygiene/MRSA reduction (2008), reduce medication complications anti-coagulation drug (2004) awards
- Five *"Magnet"* recognized hospital nursing programs - excellence and quality in nursing care
- Commission on Cancer - *Outstanding Achievement* (2008)



- "3-Star Designation" by Society of Thoracic Surgeons (2008) – top 10% national cardiac care
- Region's first certified Stroke Center and Gold Plus Quality Achievement Award

- Over 91% of eligible Novant Medical Group physicians are recognized by the NCQA for providing quality care to patients with diabetes
- CMS indicators : ~88% of indicators above 90th percentile

- VHA *National President's Award of Honor* - clinical and supply chain management excellence (2009)
- Two-time VHA *Superior System Performance Award* - FMC and PHC (2008, 2009)

- VHA *Gold Award for Excellence* in MRSA Reduction - PHH and TMC (2011)
- **Award for Excellence in Medication Use Safety by the American Society for Health System Pharmacies** to Novant Health Medication Reconciliation Program for patients ("SafeMed") and, and chosen as the **American Pharmacist Association Foundation 2009 Pinnacle Award winner**

- **The NC Alliance for Healthy Communities 2007 Eagle Award** to Novant for **Diabetes Care Programs** focused on medically under-served populations

Awards and Recognitions-Operations & Management

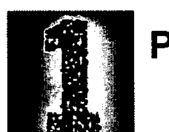
- *PRC President's Award* (2006, 2011) - only two-time award recipient for patient, physician & employee satisfaction (462 other awards)
- **Carolina Parenting Magazine Family-Friendly 50 Companies list from 2001-2011:** Novant Health included in the top 50 for the past 11 consecutive years.
- ***Working Mother* Magazine's "Top 100 Best Companies for Working Mothers" (2000,2001, 2002)**: Ranked Novant Health in its national list of Top 100 Employers for three consecutive years & "***Best in Industry***" (2002)
- **Platinum-level recognition** as a **Start! Fit-Friendly** company by the American Heart Association for Presbyterian Healthcare (2010-2011)
- Ranked 14th in Top 100 Integrated Healthcare Networks by Verispan (2011)
- Presbyterian Hospital named one of *50 best hospitals in America* Becker's Hospital Review (2011)
- Novant Health one of three "*TOP BOX" organization* per AHA Health Education & Research Trust, "*Striving for Top Box: Hospitals Increasing Quality and Efficiency*" (June 2011)

- Novant Health named **Public-Private Sector Organization of the Year** by the Carolinas Minority Supplier Development Council (2010)
- The **NBA Charlotte Bobcats** selected Presbyterian Hospital as the **team's healthcare provider.**

- Novant's Outstanding Leadership:
  - HealthLeaders Media *Top Leadership Teams in Healthcare* (2010)
  - Leadership North Carolina, *Governor's Award* - Paul Wiles, Novant CEO (2011)

Culture of Patient Safety

- *Know 5ive Save Lives* consists of safety behaviors and error prevention tools for employees and serves as another example of Novant's dedication to patient safety



Practice with a Questioning Attitude
- Stop, Reflect and Resolve in the face of uncertainty

Communicate Clearly
- Use SBAR-Q to share information and phonetic and numeric clarifications
- Communicate using three-way repeat backs and read backs

Know and Comply with Red Rules
- Practice 100% compliance with Red Rules from all team members
- If Red Rule compliance is not possible, stop action until uncertainty is resolved

Self-Check: Focus on Task
- Use the STAR technique

Support Each Other
- Use 5:1 Feedback to encourage safe behavior
- Cross-check/assist and speak-up using ARCC – "I have a concern"

High Standard of Quality

All Novant Facilities

Producing Superior Outcomes

CMS Quality Indicator Scores

- Top 10% in NC
- Above NC Avg
- Below NC Avg

Recent Partnerships: Franklin Regional Medical Center, Upstate Carolina Medical Center, Prince William Hospital

	Forsyth Medical Center	Medical Park Hospital	Presbyterian Hospital Charlotte	Presbyterian Hospital Huntersville	Presbyterian Hospital Matthews	Presbyterian Orthopedic Hospital	Thomasville Medical Center	Brunswick Community Hospital	Rowan Regional Medical Center	Franklin Regional Medical Center	Upstate Carolina Medical Center	Prince William Hospital
Heart Attack												
Aspirin at Arrival		NA				NA						99%
Aspirin at Discharge		NA				NA				NA	88%	
ACE or ARB for LVSD	99%	NA				NA				NA		
Smoking Counseling		NA		NA		NA		NA		NA		
Beta Blocker at Discharge		NA				NA				NA		
Fibrinolytic at Arrival	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
PCI at Arrival	98%	NA	99%	NA	NA	NA	NA	NA	92%	NA	NA	NA
Heart Failure												
Discharge Instructions		NA	99%	96%	96%	NA			99%	89%	90%	86%
LVS Evaluation		NA				NA		99%			99%	
ACE Inhibitor		NA				NA	97%			89%	91%	99%
Smoking Counseling		NA				NA						
Pneumonia												
Pneumonia Vaccine		NA	99%	99%		NA				97%	99%	99%
Blood Culture		NA				NA		99%		90%	99%	99%
Smoking Counseling		NA				NA						99%
Antibiotic at Arrival		NA	99%	99%		NA	99%		99%	97%	98%	99%
Appropriate Antibiotic	97%	NA	99%	98%	98%	NA	96%	94%	97%	93%	98%	97%
Flu Vaccine		NA	99%		99%	NA					96%	
Surgical Care												
Peri-Op Beta Blocker	99%			96%	98%	98%						98%
Antibiotic Prior		99%	99%	99%								99%
Antibiotic Selection					99%						96%	99%
Antibiotic Stopped				98%	98%	99%	98%	99%			99%	98%
Glucose Control Cardiac	99%	NA		NA	NA	NA	NA	NA	NA	NA	NA	NA
Appropriate Hair Removal												
Removal of Urinary Catheter	97%	93%	88%	97%	93%	97%	94%	96%	98%	90%	93%	98%
VTE 1 Ordered	98%	98%	97%	95%	98%		99%	99%		87%		96%
VTE 2 Received	97%	96%	98%	94%	96%		98%	98%	98%	87%	97%	92%

Note: CMS indicator scores benchmark data collected Jan 2010 – Dec 2010; NC Top 10% as of March 2011

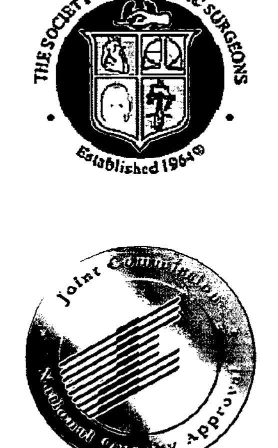
High Quality Success

Novant	Base	2006	2007	2008	2009	2010
Percentage of CMS Quality Indicators above $\geq$ 90th percentile	76%	81%	84%	86%	88%	90%

- Set performance expectations
- Concurrent review effective at all sites
- Expectation of responsibility by all clinical team members
- Internal best practices for achieving and sustaining results
- Reinforced organization's commitment: quality is a system-wide responsibility
- Communicated scorecard regularly across all levels of the organization
- Early adoption of new quality indicators best practices
- Recognized by The Health Research and Educational Trust (AHA) as #1 in the country among the top 250 systems on CMS indicators

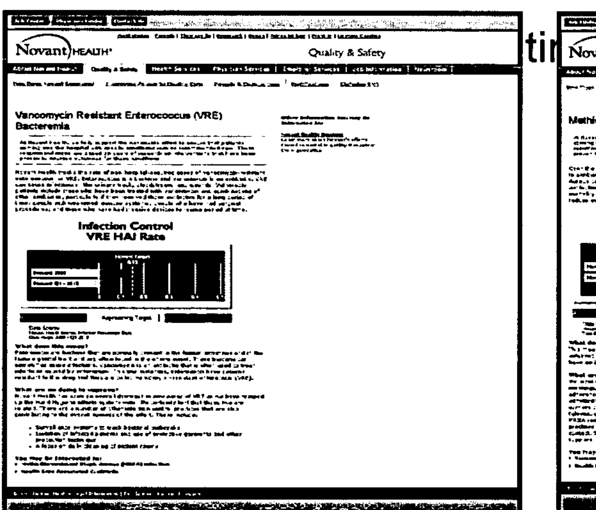
Nationally Recognized Care

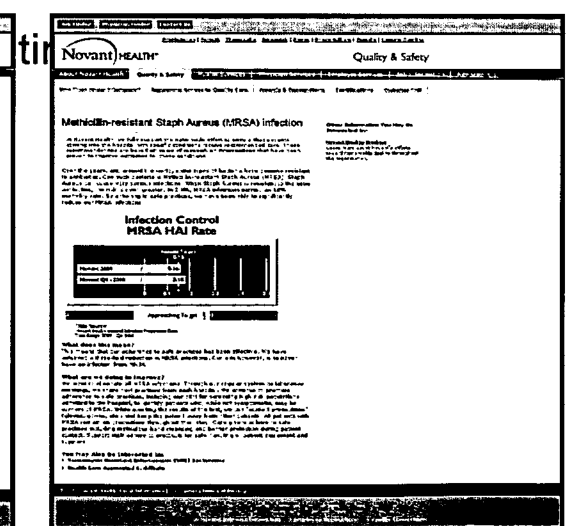
- Nursing Care
  - Five "Magnet" designated hospitals – Only 5% of US hospitals achieve Magnet designation from the ANCC (American Nurses Credentialing Center)
- Heart Care
  - Five hospitals - nationally accredited Chest Pain Centers
  - Presbyterian Hospital and Forsyth Medical Center - 3-Star designation by Society of Thoracic Surgeons (2009)
  - Presbyterian Hospital - first NC Cycle II Chest Pain center (Percutaneous Coronary Intervention)
  - Forsyth Medical Center - first in Carolinas for certification in Congestive Heart Failure
- Neurosciences
  - Six hospitals - nationally certified Primary Stroke Centers
  - Forsyth Medical Center and Presbyterian Hospital - first nationally certified stroke centers in Carolinas
- Orthopaedics
  - Presbyterian Orthopedic Hospital (region's only dedicated orthopedic hospital) - certification in Total Joint Hip, Total Joint Knee, Hip fracture, Laminectomy and Spinal Fusion
  - Two hospitals - Total Hip & Total Knee Joint Replacement Surgery certified
- Cancer
  - Five hospitals - Outstanding Achievement recognition from the Commission on Cancer
  - Prince William Hospital - 3-year accreditation from the Commission on Cancer

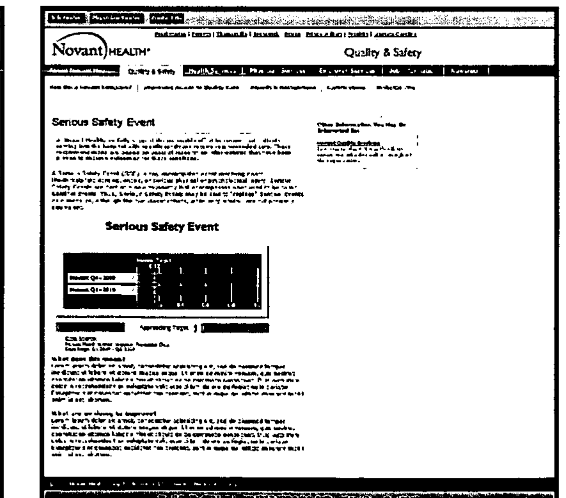


Transparency

- Patients have easy access to independently collected data in order to make informed decisions
- Performance measurement programs
  - Novant hospitals voluntarily participate
  - Provide results on Novant's website
  - Novant hospitals often exceed state and national quality benchmarks
- Novant continues to improve medical care and services for our patients by sharing such knowledge, technology and other resources



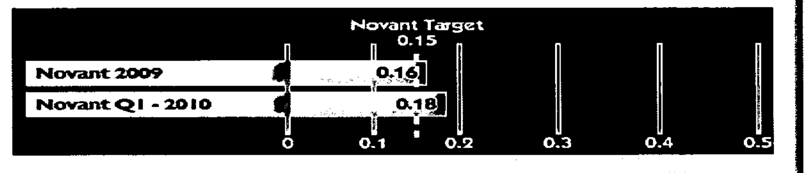




Methicillin-resistant Staph Aureus (MRSA) infection

At Novant Health, we fully support the nationwide effort to ensure that patients coming into the hospital with specific conditions receive recommended care. These recommendations are based on years of research on interventions that have been proven to improve outcomes for these conditions.

Over the years, and around the world, some types of bacteria have become resistant to antibiotics. One such bacteria is Methicillin-resistant Staph Aureus (MRSA). Staph Aureus can cause very serious infections. When Staph Aureus is resistant to the usual antibiotics, the risk is even greater. In 2005, MRSA infections carried an 18% mortality rate. By adhering to safe practices, we have been able to significantly reduce our MRSA infections.



Data Source:
Novant Health Internal Infection Prevention Data
Date Range: 2009 - QI 2010

What does this mean?
This means that our adherence to safe practices has been effective. We have achieved a three-fold reduction in MRSA infections. Our aim however, is to never have an infection from MRSA.

What are we doing to improve?
We want to eliminate all MRSA infections. Through our regular system collaborative meetings, we share best practices from each hospital. We continue to promote adherence to safe practices, including our pilot for screening high risk populations admitted to the hospital, to identify patients who, while not symptomatic, may be carriers of MRSA. While awaiting the results of the test, we use "contact precautions" (gloves, gowns, etc.) and keep the patient away from other patients. All patients with MRSA remain on precautions throughout their stay. Care givers adhere to safe practices including meticulous hand cleansing and barrier protection during patient contact. Support staff adhere to protocols for safe handling of patient equipment and supplies

Other Information You May Be Interested In:

Novant Quality Brochure
Learn more about Novant's efforts toward remarkable quality throughout the organization.

You May Also Be Interested In:
- **Vancomycin Resistant Enterococcus (VRE) Bacteremia**
- **Health Care Associated C. difficile**

Novant's Journey to Affordability-PNR

- We use existing tools (Trendstar) and existing information (Expected Medicare Payment) to create a relative value system & tracking tools - we call this system ***Payor Neutral Revenue***
- We understand structural changes taking place in our industry and will transform our health care system to survive (or thrive) at Medicare rates
- **Why?**
- *Improve safety and quality for patients with increased affordability for all*
- *Eliminate cost differences among facilities or regions*
- *Prioritize opportunities for transformation activities*
- We share our approach and methods with other healthcare systems

PNR Performance Update

- Novant is actively tracking progress towards becoming more affordable
- From 2008 to 2010, costs as percent of Payor Neutral Revenue decreased by 7%

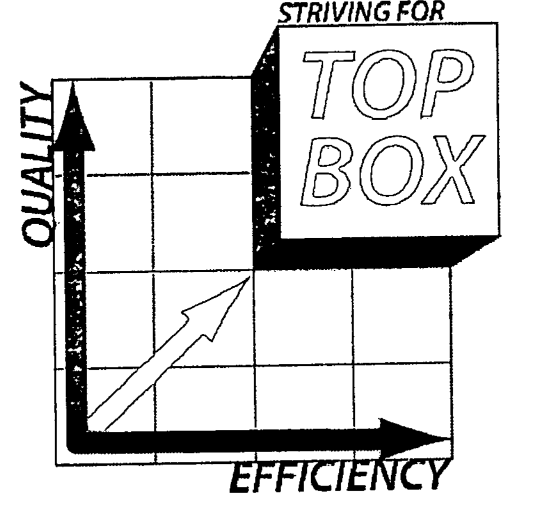
Operating Expense as % of Medicare Equivalent Revenue

Facility	Baseline 2008	June YTD 2010	Full Year 2010	'08-'10 % Decrease
Presbyterian Main/Orthopedic	120%	114%	109%	9%
Presbyterian Matthews	104%	101%	98%	6%
Presbyterian Huntersville	109%	100%	99%	9%
Forsyth Medical Center/Medical Park	110%	107%	102%	7%
Thomasville Medical Center	111%	107%	105%	5%
Brunswick Community Hospital	126%	116%	111%	12%
Rowan Regional Medical Center	113%	103%	104%	8%
Total	**113%**	**108%**	**105%**	**7%**

System Financial Status & Strategy

- *Novant's transformation must incorporate the financial health of the organization to:*
  - Position Novant to proactively address changes in the economic and legislative environment
  - Execute on capital plans and strategic opportunities
  - Operate knowing our future price increases will be lower
  - Explore and capitalize on new reimbursement models designed to reward improved quality and lower cost
  - Redefine care delivery model and reduce variation

Novant will be recognized as a leader in the healthcare industry, proving that it can achieve what other industries have delivered to their customers – improved quality and lowered costs



Striving for Top Box: Hospitals Increasing Quality and Efficiency

- *Striving for Top Box: Hospitals Increasing Quality and Efficiency* is part of the HPOE Signature Leadership Series, created to share best practices and key lessons from innovative organizations on a variety of topics including Care Coordination, Health and Wellness, Equity of Care, and New Payment and Care Delivery Models.
- Striving for Top Box showcases three organizations working toward improving both quality and efficiency: **Novant Health** in North Carolina, **Piedmont Health** in Georgia, and **Banner Health** in Arizona.
- During site visits to these organizations, we conducted interviews with key leaders who provided us with a variety of strategies they are implementing to meet their Top Box goals.
- This guide summarizes our discussions with each organization and provides a series of cultural characteristics, key strategies and successful practices common across each of these health systems that any organization can consider implementing.

Cultural Characteristics
Precise Execution
Accountability
Engaged Physicians
Focused
Consistent Communication
Team-oriented
Transparent
Data Dependent
Standardized

Key Strategies
Start by addressing the low-hanging fruit of cost reduction – supplies and staffing
Focus on achieving incremental improvements, which accumulate to dramatic gains
Focus on areas with substantial cost and quality impact (e.g., reducing left-without-being-treated rates in the ER)
Focus on developing action plans with crisp aim statements for improvement opportunities
Be transparent in sharing data across the organization
Manage according to payer neutral revenue strategy
Reduce unnecessary clinical variation as a next step in improving quality
Invest in data infrastructure for frequent and detailed data reporting

Successful Practices
Use dashboards and/or scorecards at all levels of the organization. Ensure they are linked to the overall strategic goals and are displayed publicly
Use a standardized framework and decision-making approach for all leadership meetings
Set and track well-defined short- and long-term measurable goals
Conduct weekly accountability meetings of all leaders to review weekly productivity and staffing targets
Use data frequently and at a detailed level (e.g., department and service line)
Rerun claims as if Medicare was the payer and simulate financial statements based on Medicare-only rates
Balance use of cost measures and quality/satisfaction measures
Standardize supply selections

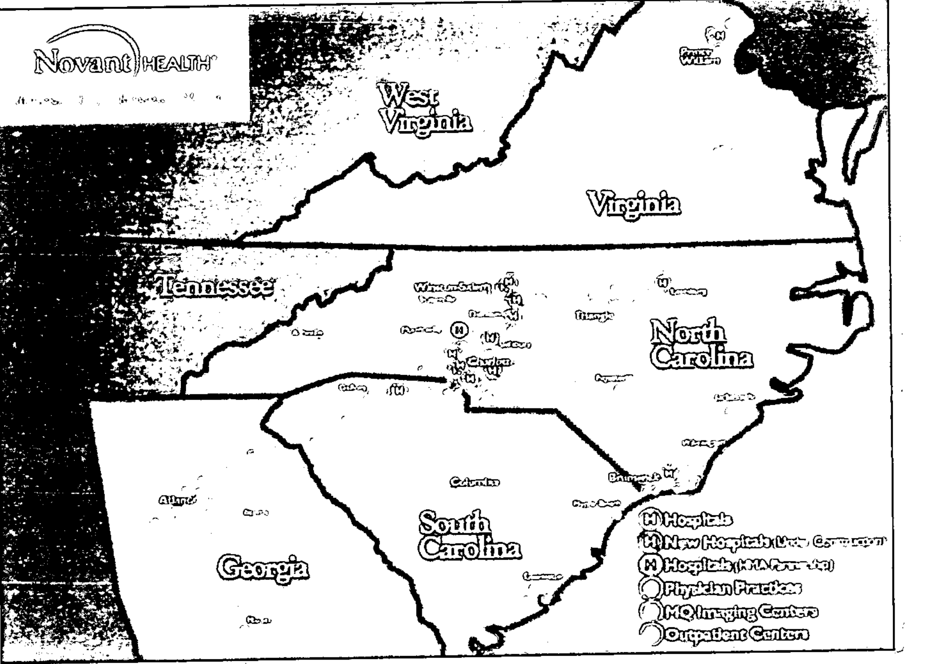
Top Box Organizations are implementing strategies to improve both efficiency and quality of care by:

1. Standardizing Processes
2. Increasing IT Infrastructure and Data Reporting
3. Reducing Variation in Cost
4. Creating Accountability for Performance Improvement
5. Identifying and Implementing Best Practices Across Organization
6. Engaging Clinicians and Physicians

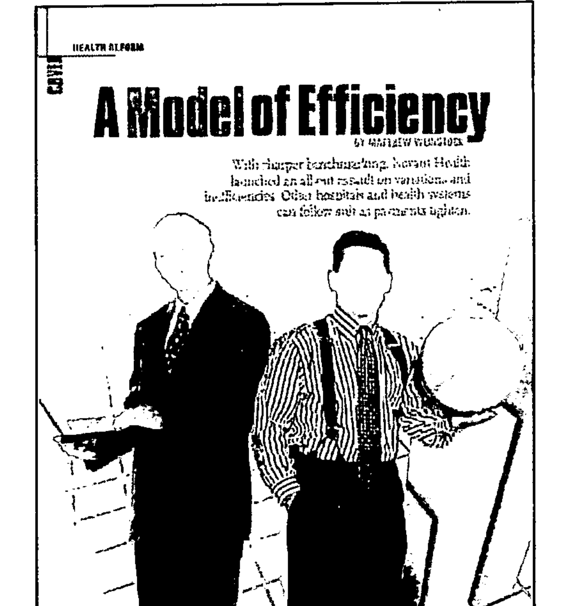
This report focuses on three Top Box organizations: Novant Health System, Piedmont Health, and Banner Health System

Novant Health System

- 12-hospital integrated health care system
  - Service area covers North Carolina, South Carolina, Virginia, and Georgia
  - Centered in Charlotte and Winston-Salem metro areas
  - Two more hospitals by 2012
  - 1100 physician partners, 5000 medical staff



- Novant embraced the reality that increasing quality and decreasing costs goes hand in hand
- This led them to pursue two parallel strategies:
  1. Creating a Remarkable Patient Experience
  2. Moving toward a Payer Neutral Revenue System



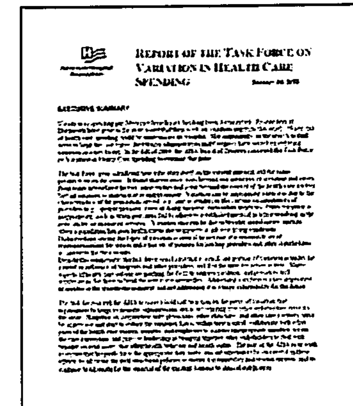
Click on image to read article.

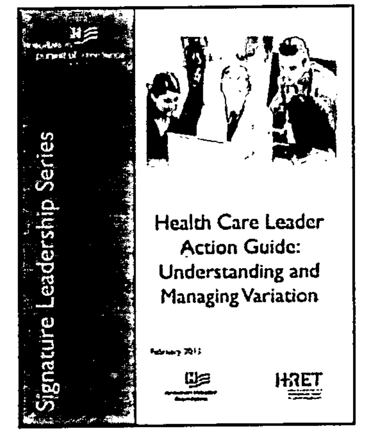
American Hospital Association

- Moved from cost-shifting to a Payer Neutral Revenue (PNR) System where:
  - Novant considers all payers as if they were Medicare to prepare for a day when lower payments could be a reality
- Strategies used to achieve PNR
  - Rigorous use of data to study variation
  - Moving to matrix leadership structure
  - Focusing on transparency, communication, and creating goal-oriented partnerships with board members and physicians

Click here to listen to Greg Beier, president of operations at Novant Health, discuss the PNR system and creating the Remarkable Patient Experience.

- Novant examined clinical product lines across their 12 hospitals
  - Variation was used as an opportunity to find best practices
  - Best practices from hospitals within the system are presented to hospital leaders
  - These best practices are put in place systemwide to standardize and reduce variation





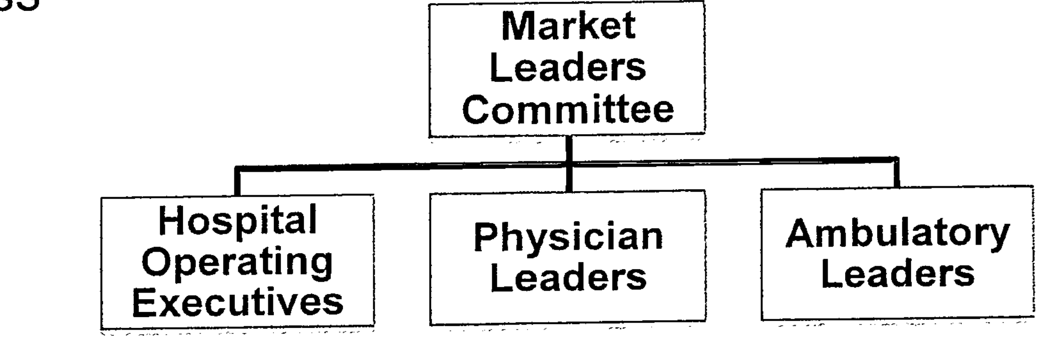
Click on the images to read the latest AHA resources on managing variation.

Next Step: Implement a Novant Science that creates standard practices across all clinical product lines

American Hospital Association

Matrix Leadership Structure

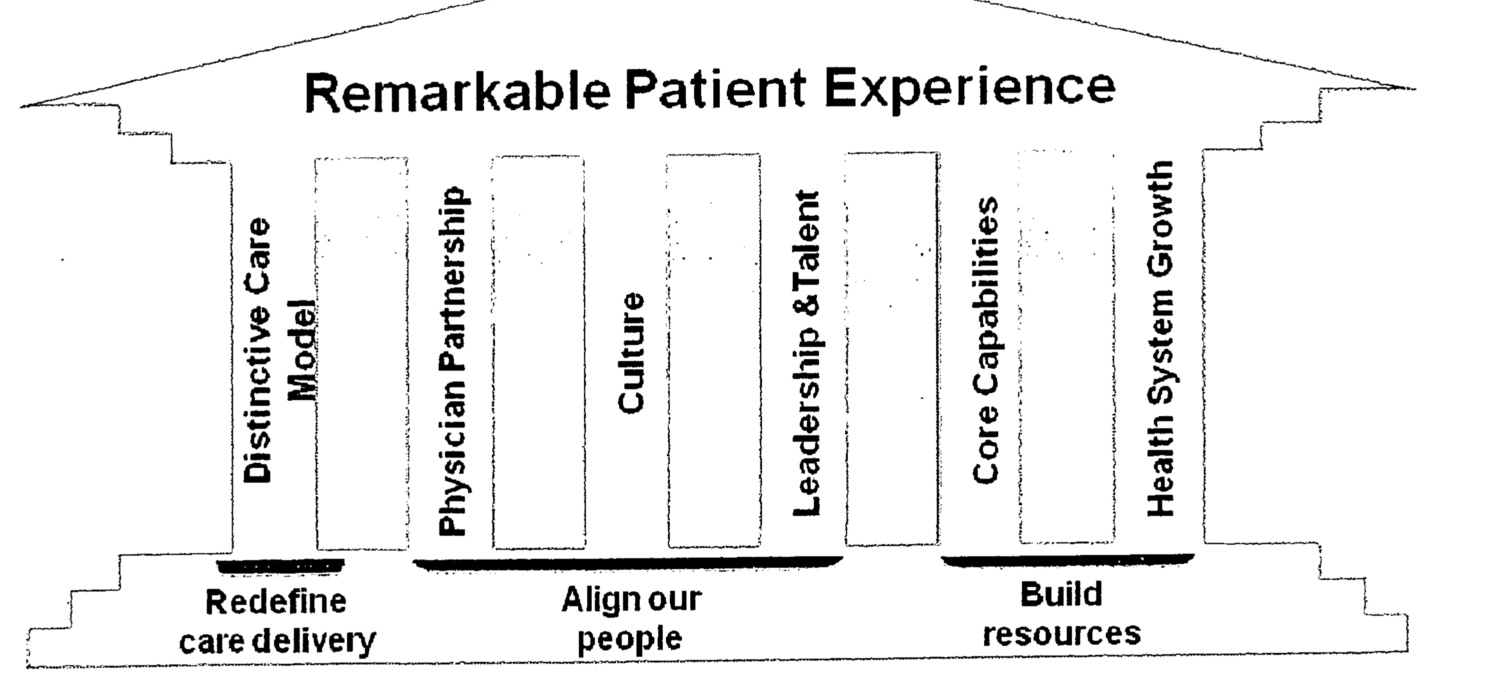
- Novant matrix leadership structure creates a higher level of interdependence between markets and their centers of expertise:
  - Operational executives are responsible not only vertically in their hospitals, but also horizontally across the system
  - Executives need to lead through influence not through power
  - Continuous meetings for executives in different responsibilities leads to cross-pollination of ideas and easy diffusion of success



Novant's Remarkable Patient Experience

- Creating the Remarkable Patient Experience is founded on three key elements:
  1. Redefining Care Delivery
  2. Aligning People
  3. Building Resources

Click here to hear Greg Beier, president of operations at Novant Health, discuss how creating the Remarkable Patient Experience will prepare Novant for the future.



American Hospital Association

- Novant's goal is to develop services that are:
  1. Safer and higher quality
  2. More patient-focused
  3. More integrated
  4. More affordable
- Critical success factors:
  1. Engaging the board and physicians in the long-term goal of creating a Remarkable Patient Experience under the PNR system
  2. Creating partnerships through teams
  3. Providing leadership incentives based on Novant's success, not just individual responsibilities

Novant's culture embraces:

1. Transparency (both interior and exterior)
   - *The State of Novant:* Provides financial data, satisfaction numbers, CMS measures, future goals, dashboards, etc.
   - Online, Novant even highlights where it struggles
2. Physician engagement
   - All physicians are partners not employees
   - Physicians participate in all major decisions
   - Specialists and PCPs are engaged
3. Standardization (language and processes)
   - All members of the system use the same words, same acronyms, same way of communicating
   - All processes use the same templates and follow the same deliberate steps
   - The same framework is used in every presentation regarding a decision: **ARCIE** (Approve, Recommend, Consult, Inform, Execute)

Novant's culture embraces:

4. Crisp aim statements
   - Set clear, measurable short- and long-term goals
   - Focus on actionable goals; stay away from fluffy, lofty sounding goals
5. Multiple incremental changes, which lead to transformative change
   - Plan and work on hundreds of little things instead of one large initiative
   - Processes and systems are rethought, revised, and tweaked to continue achieving a precise execution

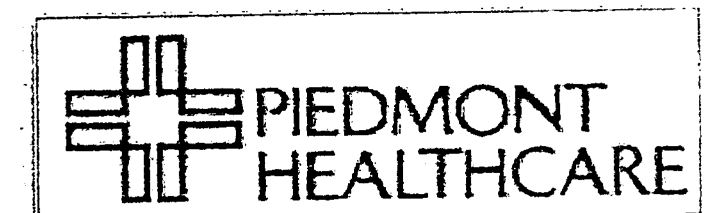
- Novant's results demonstrate their success in improving quality and efficiency
  - A 42% reduction in the rate of Serious Safety Events (defined as SSE/10,000 adjusted patient days) from 2009 to 2010
  - A focus on reducing variation resulted in cost savings of $32 million in 2009
  - 90% of individual CMS reported metrics in 2010 were in top 10th percentile vs. national benchmarks, and improvement over 2009 performance

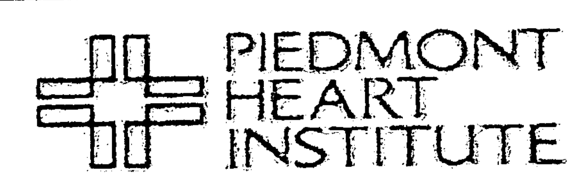
Click here to listen to Greg Beier, president of operations at Novant Health, discuss how reducing variation has led to increased efficiency and clinical performance.

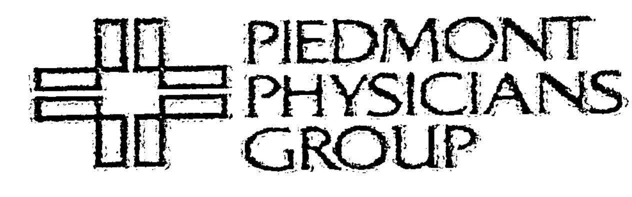
Source: *Novant Health*

Piedmont Healthcare

- Piedmont Clinic (PHO)
- Four hospitals in Georgia
- 640 physicians; one-third employed by health system
- Piedmont Heart Institute
  - Leadership is integrated matrix-style with the hospitals

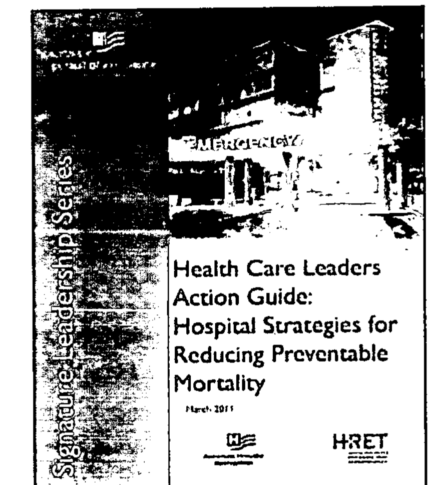




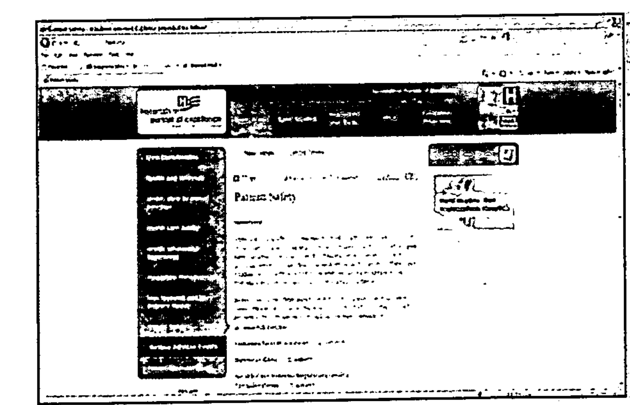


Piedmont's Top Box Strategy

- Strong physician alignment and ultimate goal of clinical integration strategy
- Robust use of clinical data and information systems for performance measurement
  - Focus on cost management and increasing efficiency
  - Overall goal is to improve quality by reducing infection rates and preventable mortality.



Click on the images to read the latest AHA resources on reducing mortality and improving patient safety.



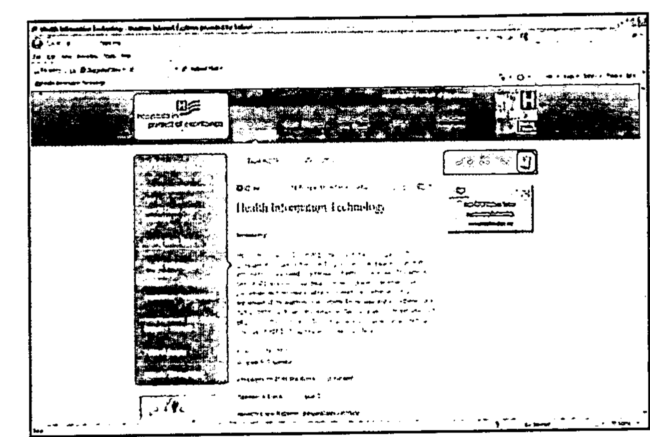
- Shared governance of clinical programs
  - Dyads: One physician and one administrator for every program; creates fiscal accountability for the clinicians
- Quality targets included in their compensation
  - Look at cost-effective measures like congestive-heart failure readmissions and imaging use in the ED
- Open communication channels
  - 1 FTE dedicated to physician communications
  - CEO conducts physician cabinets
    - Dinner meetings to discuss concerns
    - Meet with physicians who are not the "usual suspects"

Click here to listen to Piedmont Healthcare EVP & CAO Ed Lovern discuss the importance of physician alignment and clinical integration.

Click here to listen to Piedmont Healthcare EVP & CAO Ed Lovern discuss physician communcation and decision making.

Standardize Information and Cost Management Processes

- Invest in an IT system that integrates HR, finance, and supply chain information
  - Helps to manage care and costs
    - Across episodes of care
    - Within different settings
- Standardize supply costs
  - Involve physicians in reducing supply costs to help build physician alignment
    - Ensure that physician choice is retained
    - Show cost savings from standardization to increase physician buy-in
  - Can result in major cost savings



Click on the image to read the latest AHA resources on Health Information Technology.

Piedmont Clinical Integration Trust (CIT)

- Data warehouse that gives Piedmont Clinic physicians access to metrics:
  - Patient satisfaction (Press Ganey)
  - CMS core measures (inpatient quality)
  - PQRI performance (CMS Physician Quality Reporting Initiative metrics)
  - Population health (physician compliance with data submission of population health information)
  - Efficiency and cost

Click here to listen to, Piedmont Healthcare Ed Lovern discuss CIT and the importance of standardizing data.

Source: *Integrated Quality Measures Improve Patient Safety & Care*; Patient Safety & Quality Healthcare, November/December 2010, pgs. 28-31.

- Improves Performance Reporting
  - Organizational performance summarized in system risk scorecard
  - PQRI measures on dashboard can be filtered by practice, specialty, or individual physicians
- Promotes Efficiency by Automating Manual Processes
  - CIT automatically identifies patients eligible for patient satisfaction survey including name and address information
  - Negotiated fee schedules from commercial insurers are built into CIT
- Facilitates Population Health Management
  - Patients assigned to physicians can be monitored to ensure that they receive appropriate preventive care
  - Physicians can view quality measures for patients assigned to specific disease populations (diabetes and cardiovascular care)
  - Multiple measures built in to assess entire episode of care (e.g., AHRQ's prevention quality metrics, lab results, medications, vital statistics, procedures, visits)

Source: *Integrated Quality Measures Improve Patient Safety & Care*; Patient Safety & Quality Healthcare, November/December 2010, pgs. 28-31.

- Within nine months of the CIT program, overall performance has improved by 11%
  - The proportion of clinic patients receiving care according to PQRI standards moved from 32% to 43% affecting the care of 55,000 patients
- After nine months the number of practices submitting bills has doubled. The volume of bills received has nearly quadrupled in the same time frame
- Administrative monitoring functions alert the Piedmont team to inactive software and lapses in file submission, enabling prompt intervention and resolution
- Physician adoption of the web-based dashboard has nearly doubled in nine months (from approximately 150 physicians to almost 300)

Source: *Integrated Quality Data to Improve Care;* The Piedmont Clinic and Recombinant Data 2010 IHI Poster; Piedmont Healthcare.

American Hospital Association

Banner Health System

- Centered in Phoenix, Arizona
- 23 hospitals including children's, heart, and cancer hospitals
- Locations in Alaska, Arizona, California, Colorado, Nebraska, Nevada, and Wyoming
- Banner Desert Medical Center
  - 549-bed facility in Mesa, Arizona
  - 40,000 inpatients; 65,000 outpatients; 90,000 ED visits
- Cardon Children's Medical Center
  - 248-bed adjoining facility in Mesa, Arizona
  - Recently completed in 2009

- Banner's strategy for performance improvement is based upon
  1. Creating a culture of accountability that starts with leadership and involves every level of the organization
  2. Consistently communicating and measuring performance measures and initiatives
  3. Identifying and sharing best practices across the health system
  4. Recognizing employees for achieving performance improvement

- Banner's board sets performance targets each year
- Senior leadership then identifies initiatives to achieve targets
- Four categories of performance are measured:
  - Operations (patient safety, clinical performance)
  - Leadership (retention)
  - Finance
  - Patient Satisfaction

American Hospital Association

Banner ensures that performance targets and initiatives are communicated and measured consistently across the system:

- "Gallery Walks"
  - Front-line managers to C-suite leadership participate in 30-minute sessions on each initiative: how it relates to each performance target, and suggested best practices to achieve improved performance
- Weekly Leadership Meetings
  - Focus is on efficiency as well as patient satisfaction
  - Efficiency is measured using a matrix analyzing hours worked
  - Patient satisfaction is measured using a matrix analyzing care rating and "percentage of patients who would recommend"
  - All hospital services are analyzed by cost center

Click here to listen to Banner Cardon Children's Medical Center CEO Rhonda Anderson discuss their approach to communicating performance initiatives to all employees.

- Unit Scorecards
  - Scorecards are posted throughout the hospital in cafeterias, hallways, and other public places for all to see.
  - Cost centers are either at goal (green) or not (red)
  - Managers within each cost center study their efficiency numbers daily and are expected to make workforce decisions to try to make "green" each week
- Part of On-boarding Process
  - During orientation, all new employees meet with direct managers to review the scorecard and identify specific actions that the employee can take to directly impact the performance metrics
- Systemwide Steering Committees
  - One for each performance initiative
  - Share best practices on improving performance from across the system and from external sources
  - Successful best practices are identified and implemented across the system

- Performance Improvement Awards
  - Two awards for each of the four performance categories are given to various Banner hospitals that have achieved the best performance at or over target in each of the initiatives
- Employee Financial Incentive
  - If patient experience targets are met or exceeded, as measured by scoring either a 9 or 10 on the Press Ganey survey, then all employees are eligible for a financial incentive payout the past two years

Click here to listen to Banner Cardon Children's Medical Center CEO Rhonda Anderson discuss creating a culture of performance improvement.

- Banner eliminated $126 million in costs in 2009
- Productivity improved by 4.5% between 2008 and 2009
- Employee turnover percentages decreased from 7.4% to 6.4% between 2009 and 2010
- Banner Health continues to provide high quality of care while remaining financially viable, despite several challenges:
  - Housing crisis has greatly impacted the local economy in Arizona where a majority of Banner hospitals are located
  - Major shifts in payer mix in recent years away from private insurers and toward Medicaid
  - Seasonal differences in volume due to the "snowbird" population

- Asthma Home Management Plan (HMP)
  - Despite high satisfaction scores, documentation of Home Management Plan was not occurring consistently for asthma patients at Cardon Children's Medical Center
  - Teams working on performance identified that physicians were not being held accountable for completing the HMP
  - Implemented "2 strikes, and then you go" penalty for physicians. Any physician who failed to document HMP two times, would be sent to discuss the issue with the department chair

	Target	January 2010	December 2010
Composite Score	95.4%	76.7%	92.2%
Use of Relievers	100%	100%	100%
Use of Systemic Corticosteroids	100%	100%	100%
HMP Given to Patient/Family	73%	30%	76.2%

American Hospital Association

Cultural Characteristics
Precise Execution
Accountability
Engaged Physicians
Focused
Consistent Communication
Team-oriented
Transparent
Data Dependent
Standardized

Key Strategies
Start by addressing the low-hanging fruit of cost reduction – supplies and staffing
Focus on achieving incremental improvements, which accumulate to dramatic gains
Focus on areas that have substantial cost and quality impact (e.g., reducing left without being treated rates in the ER)
Focus on developing action plans with crisp aim statements for improvement opportunities
Be transparent in sharing data across the organization
Manage according to payer neutral revenue strategy
Reduce unnecessary clinical variation as a next step in improving quality
Invest in data infrastructure for frequent and detailed data reporting

Successful Practices
Use dashboards and/or scorecards at all levels of the organization. Ensure they are linked to the overall strategic goals and are displayed publicly
Use a standardized framework and decision-making approach for all leadership meetings
Set and track well-defined short- and long-term measurable goals
Conduct weekly accountability meetings of all leaders to review weekly productivity and staffing targets
Use data frequently and at a detailed level (e.g., department and service line)
Rerun claims as if Medicare was the payer and simulate financial statements based on Medicare-only rates
Balance use of cost measures and quality/satisfaction measures
Standardize supply selections

American Hospital Association

Novant HEALTH®

The Journey to Becoming More Affordable

Greg Beier
President of Market Operations, Novant Health

Can you Transform Your Health Care System to Survive (or Thrive) at Medicare Rates?

Lessons Learned…

- “The last time the federal budget was balanced, in the Balanced Budget Act of 1997, it was done on the backs of the hospital industry.”
- “Learn to run on regular gas! You cannot expect to shift costs indefinitely…”
- “Cost shifting is like heroin – it’s time to kick the habit. This means instilling rigorous cost discipline in collaboration with physicians.”

Source: “Beyond Healthcare Reform”
Jeff Goldsmith, President of Health Futures, Inc.
October 2009

Model of Efficiency?

12 | Carolyn Clancy's Quality Mission 33 | Hospitals Go Wireless 36 | AHA NOVA Winners 2009

H&HN

HOSPITALS & HEALTH NETWORKS

AUGUST 2009 www.hhnmag.com

Could Your Organization Survive on Medicare Rates Alone?

A Novant Health experiment aims to find out—and the results so far may surprise you.

COVER

HEALTH REFORM

A Model of Efficiency

BY MATTHEW WEINSTOCK

With sharper benchmarking, Novant Health launched an all-out assault on variations and inefficiencies. Other hospitals and health systems can follow suit as payments tighten.

One of the Top 10 requested articles for 2009

2009 Acute Care Statistics

	Licensed Beds	Adjusted Discharges	Emergency Visits	IP and OP Surgeries
Forsyth	932	60,978	104,752	25,359
Presbyterian	531	49,434	81,939	22,452
Rowan	268	21,588	58,320	9,666
Prince William	170	28,048	68,925	8,543
Thomasville	149	10,125	33,812	3,748
Upstate Carolina	125	7,793	31,609	3,190
Matthews	114	18,488	48,812	6,191
Orthopaedic Hosp	156	5,129	NA	6,889
Huntersville	60	13,292	33,935	5,731
Brunswick	60	8,617	24,223	3,798
Franklin	70	5,127	19,246	2,255
Medical Park	22	5,848	NA	11,416

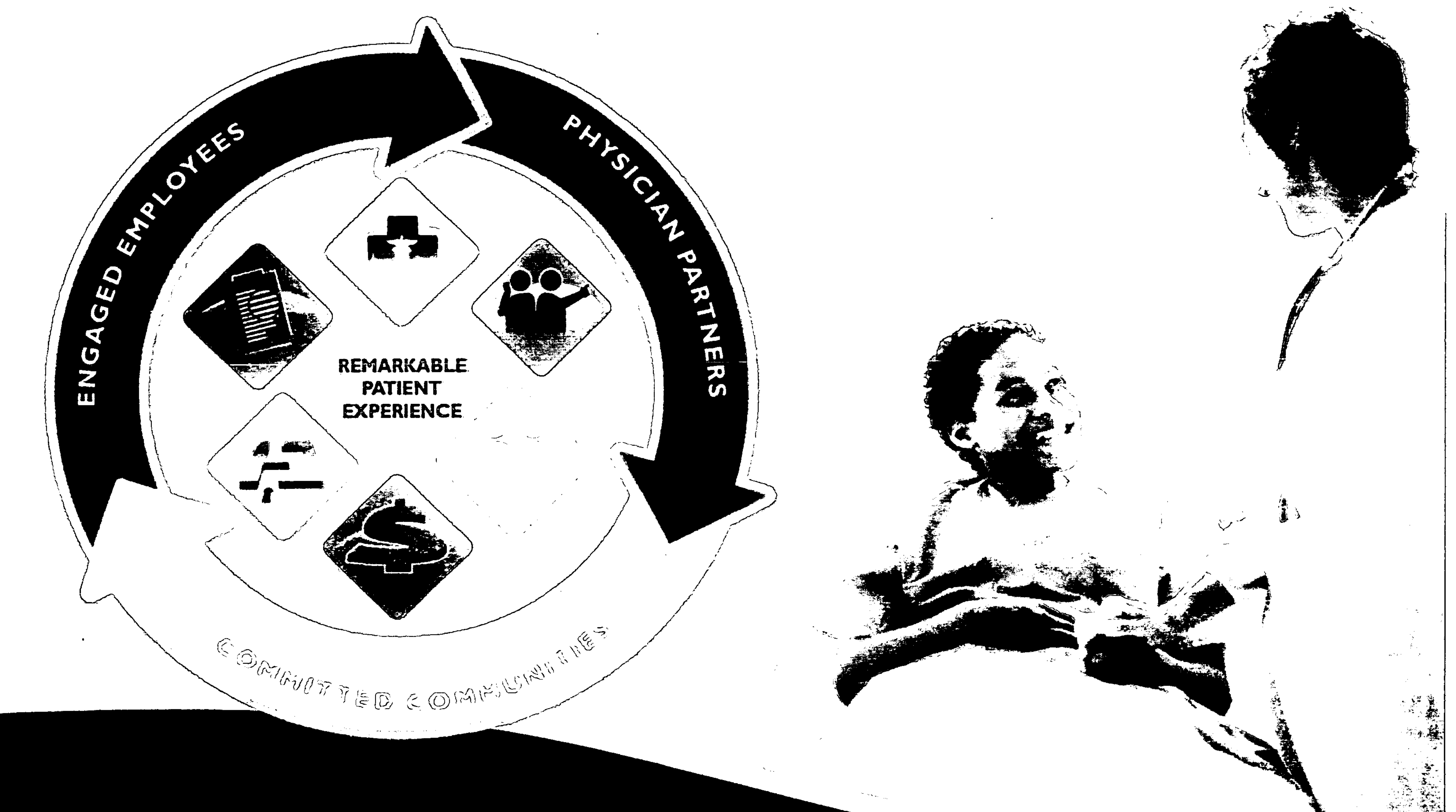
Six Steps

1) We defined the destination and made it a key element of our strategy
2) We created a structure to support changing our model.
3) We are shining a bright light on every type of variation and identifying promising opportunities.
4) We are engaging all groups in Novant to go on our journey.
5) We are using all tools to change and take advantage of our promising opportunities.
6) We are tracking our progress towards becoming more affordable.

1) We defined the destination and made it a key element of our strategy.

- Inspirational
- About the patient and community
- Simple

Our goal is to deliver a Remarkable Patient Experience in every dimension, every time.

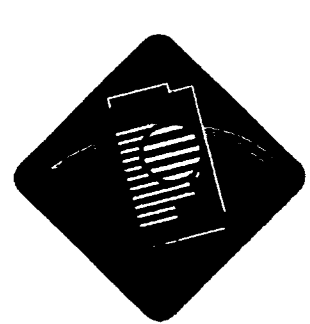


The Remarkable Patient Experience

Novant Vision Elements

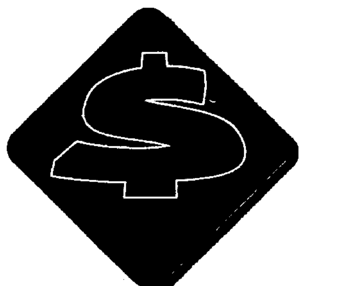
Safety

Our patients are safe and free from harm when they are in our care. Our work environment is one of open communication and timely feedback about the patient's safety and care experience which is guided by the expectation *"First, Do No Harm."*



Quality

An integrated system of healthcare services which delivers superior outcomes as measured against national, state and regional benchmarks, peer databases, internal standards, and the patient and family experience. Incorporates prevention, early detection, treatment and ongoing health across all venues of care. Our public transparency about our outcomes data creates a compelling reason for patients, communities, physicians and employees to affiliate with Novant and choose us for their healthcare needs.



Affordability

Commitment to develop a system of care that provides value, as judged by our patients and their payers. Novant will compare favorably to a similar group of top performing health systems. Our sustained financial strength will allow us to grow strategically and invest to meet the needs of the communities we serve.

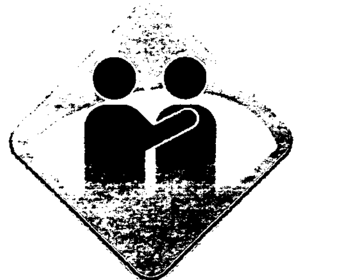
Novant Vision Elements

Easy for Me

A convenient and seamless patient and family experience which is accessible and welcoming. Patients understand they are part of a system of care and can describe what is going to happen during their journey and why. Resources and information are readily available and waits are filled in ways that add value to patients and their families.

Voice & Choice

Patients are genuinely engaged as partners with their caregivers in a dialogue about their health conditions and treatment options. Patients and their families are provided with necessary information consistent with their level of interest to make knowledgeable and confident care decisions.



Authentic Personalized Relationships

Patients receive care with sensitivity to their cultural differences and always with compassion. Our caregivers take time to know their patients' needs and preferences and recognize the mind, body and spirit connection in the healing process. Our genuine and caring relationships make patients feel like family.

Affordability

While Novant must deliver a product that provides value to our patients, it is critical that we deliver the Remarkable Patient Experience through a care model and support system that recognizes the external forces impacting our system and creates sustained financial performance

- In 2015
  - Patients in the communities we serve receive remarkable care through a financially strong system that is truly integrated and recognized nationally for the value provided
  - Our health care services are known by our patients for their value, when compared to our competitors
  - The overall financial health of our health care system allows us to grow strategically in terms of new facilities and other services to meet the needs of patients and communities

2) We created a structure to support changing our model.

- Matrix Organization
  - Optimize care for each community
  - Develop the “Novant Way” to execute the Remarkable Patient Experience in a unified low variation model.

Greater Charlotte Market
PH Charlotte

Corporate Centers of Expertise

CAO (Jacque Gattis)

CFO (Fred Hargett)

CMO (Stephen Wallenhaupt, MD)

Imaging Leader (Chris Winkle)

Novant Market Operations President (Greg Beier)

Market Leader (Mark Billings)

Hospital Executive (Amy Vance)

Physician Executive (Herb Clegg, MD, Michael Hoben, MD, Yele Aluko, MD)

Ambulatory Executive (Wendy Burkhart)

CCO (Sallye Liner, RN)

Physician Leader (Herb Clegg, MD)

NMG COO (Michele Grier)

*this model is not meant to be all inclusive

3) We are shining a bright light on every type of variation and identifying promising opportunities.

- We use existing tools (Trendstar) and existing information (Expected Medicare Payment) to create a relative value system and tracking tools.

"Faced with the choice between changing and proving there is no need to…Almost everyone chooses to get to work on the proof."

-John Kenneth Galbraith, American Economist circa 1980

Payor Neutral Revenue

	Net Revenue vs. Payor Neutral Revenue		*Operating Expense as % Net Rev & PNR*	
	Net Rev July YTD 2010	PNR July YTD 2010	Net Rev Baseline 2008	PNR Baseline 2008
Presbyterian Main/Orthopedic	$406,228	$283,071	89%	120%
Presbyterian Matthews	95,966	62,946	69%	104%
Presbyterian Huntersville	74,949	49,189	70%	109%
Forsyth Medical Center/Medical Park	462,490	325,830	84%	110%
Thomasville Medical Center	38,993	30,236	89%	111%
Brunswick Community Hospital	31,826	25,590	105%	126%
Rowan Regional Medical Center	103,193	76,155	94%	113%
	$1,213,645	***$853,017***	***85%***	***113%***

4) We are engaging all groups in Novant to go on our journey.

- Board and Physician Leadership own the destination with us and see affordability as part of Remarkable Patient Experience.
- Leaders embrace the accountability for becoming affordable as part of their balanced scorecard
- Physicians partner with us to understand the variation and help us create the Novant approach to clinical care.
- Employees are engaged in learning and helping us transform our process of care to reduce waste and improve quality and safety.

5) We are using all tools to change and take advantage of our promising opportunities.

- Management precision 2009 - 2015
- How we support care 2010 – 2015
- Create the Novant Science 2010 - ?
- Transform care processes 2011 - ?

Payor Neutral Revenue helps us ask the following kinds of questions:

1) Management Precision
   - Why does one hospital consume 30% less of PNR for labor in the OR to do hip procedures?

2) How we support delivering the Remarkable Patient Experience
   - Why does the % of PNR consumed for pharmacy services vary 20% in similar hospitals?

3) How clinical practice variation impacts affordability
   - Why does one team of hospitalists get excellent clinical outcomes with CHF patients and consume 50% less of PNR for imaging services.

Examples of Management Precision

- We found several hospitals were consuming a much lower % of PNR for nursing labor than other hospitals in our system. One pay practice was changed and $5.5 million was saved.
- We internally benchmarked what % of PNR was being consumed in leadership structures at each hospital. Nearly $3 million was saved in two hospitals by eliminating a layer of management.

Examples of Transforming Support Structure

- High variation in the % of PNR being consumed for Pharmacy led to the creation of a virtual pharmacy. This will result in safer more consistent care and $9 million in savings. *Case study to follow…*

- High capital cost, as a % of PNR, in our new community hospitals showed the need for a new plan. Square footage will be reduced by 33% for the next hospital we build. In a recently filed CON application it is worth noting the construction cost of Novant's 50 bed hospital was $77M and the competing proposal was at $127M.

Example of creating the Novant Science to reduce clinical variation.

- Drug costs in one cath lab are 50% less than at other comparable hospitals, as a % of PNR. Currently physicians decide on their individual protocol.

  A Cardiac Council was formed to develop a single protocol for all cardiac services in 12 hospitals.

Example of Transforming Care at the Bedside

- Clinical Documentation Team has been launched to transform documentation for care. Expected savings of two hours per nurse per shift. We have approximately 5,000 nurses.

6) We are tracking our progress towards becoming more affordable.

	Net Revenue vs. Payor Neutral Revenue		*Operating Expense as % of PNR*		
	Net Rev 2010	**PNR 2010**	**Baseline 2008**	**2010**	**24 Month Improvement**
Presbyterian Main/Orthopedic	$691,647	$484,264	120%	109%	$53,197
Presbyterian Matthews	164,309	108,683	104%	98%	3,488
Presbyterian Huntersville	127,296	83,623	109%	99%	5,531
Forsyth Medical Center/Medical Park	724,408	557,574	110%	102%	39,328
Thomasville Medical Center	67,052	51,896	111%	105%	2,743
Brunswick Community Hospital	53,620	43,649	126%	111%	6,337
Rowan Regional Medical Center	159,307	130,082	113%	104%	11,500
	$1,987,639	***$1,459,771***	***113%***	***105%***	***$122,124***

PNR versus Net Revenue

- ***Use PNR to Assess…***
  - Variation in resource consumption between nursing units, product lines, physician groups and hospitals
  - Operational improvements over time
  - Where you should focus your operational improvement efforts
  - Helping to set targets for budget
- ***Use Net Revenue to Assess…***
  - Revenue cycle improvements
  - Growth & pricing strategies over time
  - Where you should focus your marketing & contracting efforts
  - Strategic investments

"Traditional" Income Statement

	Hospital 1	*Hospital 2*
Gross Revenue	$278,803,000	$100,335,000
Charity Care	$11,536,000	$13,046,000
Net Revenue	$124,925,000	$39,737,000
Salaries % of Net Revenue	43.65%	45.60%
Supplies % of Net Revenue	11.40%	9.75%
Other Expenses % of Net Revenue	14.46%	16.53%
Total Expense % of Net Revenue	69.51%	71.89%
Bad Debt % of Net Revenue	12.84%	8.53%
Margin	$22,052,000	$7,784,000
Margin %	*17.65%*	*19.59%*

Which hospital is the most productive and efficient? *Hospital 1*

"PNR" Income Statement

	Hospital 1	*Hospital 2*
Gross Revenue	$278,803,000	$100,335,000
Charity Care		
Payor Neutral Revenue (PNR)	$78,391,000	$30,236,000
Salaries % of PNR	69.56%	59.93%
Supplies % of PNR	18.16%	12.81%
Other Expenses % of PNR	23.05%	21.73%
Total Expense % of PNR	110.77%	94.47%
Bad Debt % of PNR	0.00%	0.00%
PNR Margin	-$8,441,000	$1,671,000
PNR Margin %	*-10.77%*	*5.53%*

Which hospital is the most productive and efficient? *Hospital 2*

Case Studies

- Pharmacy Transformation
- Physician Facilitated Practice

Novant HEALTH®

Novant Pharmacy Transformation

How Did We Find This?
2008 Pharmacy Drug Cost % PNR

	Hosp 1	Hosp 2	Avg PNR
IP Invasive Cardiology PL	7.7%	5.7%	$17,005,459
OP Oncology PL	15.8%	37.1%	$16,082,864

In early 2009, we partnered our like facilities into ‘couplets’ for comparative purposes.

Why Did We Do This?

- Improve safety and quality for patients with increased affordability for all
- Eliminate drug cost differences among facilities or regions
- Reduce high variation in % of PNR across system pharmacies

Physician Involvement

- Physicians involved from the beginning
- Transparent/Inclusive/Collaborative
- Formed System Wide P&T Committee
- Developed sub-specialty committees for specific areas

Inventory Consolidation
18 Months Into the Process

- 57% of formulary consolidated system-wide end of 2010
  - Eliminate duplications
  - Increase drug turn-around
  - Enhance system-wide contracts
  - Optimize select 340-B Pricing
- Contract optimization – VHA
  - Net savings $700k
- Mitigation of drug shortages

Clinical Pharmacists – Pharm D's

- Medication safety guiding principle in transformation efforts
- IV to PO drug conversions
- Auto substitutions to formulary medications
- Clinical Decision Support
  - Zosyn IV over 8 hours q8° instead of q6°
    - More effective for patient
    - Less nurse & pharmacist time
    - Saved 1 dose per day of therapy
    - Saved $151,000 drug cost alone in 2010

Pharmacy Personnel

- Improved resource management

- Top of the License
  - Pharm D’s
    - (Clinical Pharmacists)
  - Rph
    - (Starts, Revisions, Cancels)
  - Pharmacy Tech
    - Pyxis Optimization
    - Proactive monitoring of drugs for expiration

Where We Are Going

- Software for a ‘virtual pharmacy’
  - Inventory Control
  - Centralized Receiving & Distribution

Savings

- Inventory Consolidation $4M (one-time)
- Medication Turn-Over $2M (annual run rate)
- Optimized Formulary Selection $3 M (annual run rate)

Lessons Learned

- Involve physicians from the beginning
- Culture change process
  - Facility operator ownership
  - Integration into budget process

Novant HEALTH®

Physician Facilitated Practice

Why Did We Do This?

- To improve overall safety & patient care
- To increase affordability for patients & system

How Did We Find This?
NICS Stroke % PNR 2009

NICS GROUP	Cases	ALOS	Readmit Rate	Charges per Case	PNR per Case	Cost per Case	Cost % PNR	Pharmacy % PNR	Imaging % PNR	Lab % PNR
NICS BCH	60	2.82	6.67%	17,552	5,425	2,562	47.22%	6.12%	4.49%	5.01%
NICS PHH	**75**	**2.65**	**8.00%**	**14,838**	**5,842**	**2,796**	**47.87%**	**4.58%**	**6.74%**	**4.50%**
NICS PHM	201	3.07	4.48%	15,297	5,776	2,381	41.23%	4.63%	5.24%	3.54%
NICS TMC	96	2.24	5.21%	14,123	6,206	2,841	45.77%	3.93%	4.14%	6.91%
Grand Total	432	2.78	5.56%	15,270	5,834	2,581	44.23%	4.65%	5.14%	4.69%

Among Novant's community hospitals in 2009, PHH had the highest readmission rate and cost as a percent of PNR for Stroke cases.

PHH Physician Detail
NICS Stroke % PNR 2009

ATTENDING MD	Cases	ALOS	Readmit Rate	Charges per Case	PNR per Case	Cost per Case	Cost % PNR	Pharmacy % PNR	Imaging % PNR	Lab % PNR
Physician 1	14	1.86	14.29%	10,954	5,045	2,010	39.85%	3.17%	5.88%	4.08%
Physician 2	6	3.33	0.00%	14,903	5,994	3,072	51.25%	5.25%	6.68%	2.98%
Physician 3	6	3.17	0.00%	17,938	6,161	3,228	52.40%	4.94%	8.69%	4.14%
Physician 4	8	3.38	12.50%	16,701	5,755	3,288	57.13%	6.12%	7.97%	4.70%
Physician 5	8	2.50	12.50%	15,335	5,614	2,726	48.56%	4.22%	8.02%	4.76%
Physician 6	17	2.65	11.76%	16,519	6,348	2,889	45.50%	4.75%	6.40%	5.52%
Physician 7	16	2.63	0.00%	14,086	5,982	2,910	48.64%	4.45%	5.83%	4.13%
Grand Total	75	2.65	8.00%	14,838	5,842	2,796	47.87%	4.58%	6.74%	4.50%

Get the Data to the Physicians!

- Why Am I Different?
  - Research best practices and evidence-based medicine
  - Discuss with specialty physicians and ED
  - Present best practice models

That's Why I'm Different!!

Physician Facilitated Practice

- Establish a Physician Facilitated Practice Committee
  - Not an ALOS Committee!
- Review cost and clinical outcomes
  - Direct Cost as % of PNR for Pharmacy, Imaging, & Lab
  - Average Length of Stay
  - Readmission Rates

Outcomes

- Better Utilization
  - Pharmacy drug cost & selection
  - Lab Studies
    - Serial BNP – No evidence of benefit in Heart Failure
    - Sputum Cultures – No evidence of benefit after antibiotics administered
  - Imaging MRI & Ultrasound
    - Serial Chest X-Rays – No evidence of benefit if patient clinically improving
- Better Communication Through Use of a Priority of Service Form

NICS Stroke 2010

NICS GROUP	Cases	ALOS	Readmit Rate	Charges per Case	PNR per Case	Cost per Case	Cost % PNR	Pharmacy % PNR	Imaging % PNR	Lab % PNR
NICS BCH	104	2.88	5.77%	18,184	5,581	2,557	45.82%	5.67%	3.90%	4.80%
NICS PHH	**121**	**2.69**	**6.61%**	**15,591**	**6,085**	**2,684**	**44.12%**	**4.37%**	**6.33%**	**5.20%**
NICS PHM	205	3.21	5.37%	17,333	6,020	2,632	43.72%	4.84%	4.71%	4.42%
NICS PWH	76	3.42	9.21%	14,510	6,888	3,589	52.10%	5.52%	5.37%	3.48%
NICS RMC	175	3.91	7.43%	18,108	6,189	3,384	54.69%	6.63%	4.57%	3.97%
NICS TMC	95	2.73	5.26%	16,156	6,534	3,389	51.86%	5.21%	4.07%	6.11%
Grand Total	776	3.20	6.44%	16,930	6,157	2,986	48.50%	5.40%	4.82%	4.60%

In 2010, PHH's readmission rate declined 1.39% and cost as a percent of PNR declined 3.75%.

Lessons Learned

- Data to compare with like facilities
- Get the data out soon for discussion
- Collaboration between physicians and administrative leaders

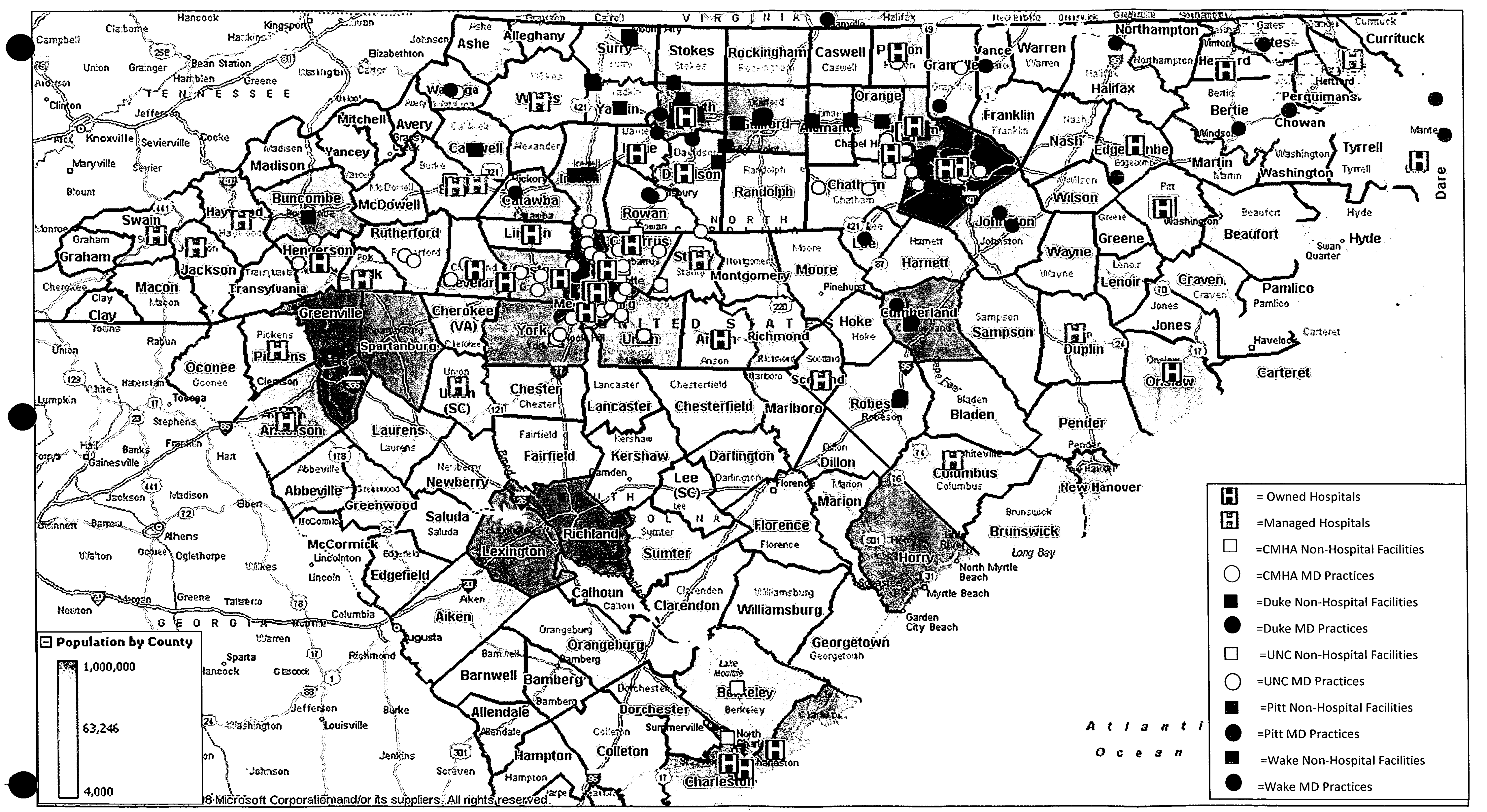
Remember…

- The most important distance to travel on this journey is the first six inches.

- Changing our mental-model *from* achieving budget *to* accountability for long term affordability.

Novant HEALTH®

Questions ?


Population by County
1,000,000
63,246
4,000
= Owned Hospitals
=Managed Hospitals
=CMHA Non-Hospital Facilities
=CMHA MD Practices
=Duke Non-Hospital Facilities
=Duke MD Practices
=UNC Non-Hospital Facilities
=UNC MD Practices
=Pitt Non-Hospital Facilities
=Pitt MD Practices
=Wake Non-Hospital Facilities
=Wake MD Practices
VIRGINIA
TENNESSEE
GEORGIA
Atlantic Ocean
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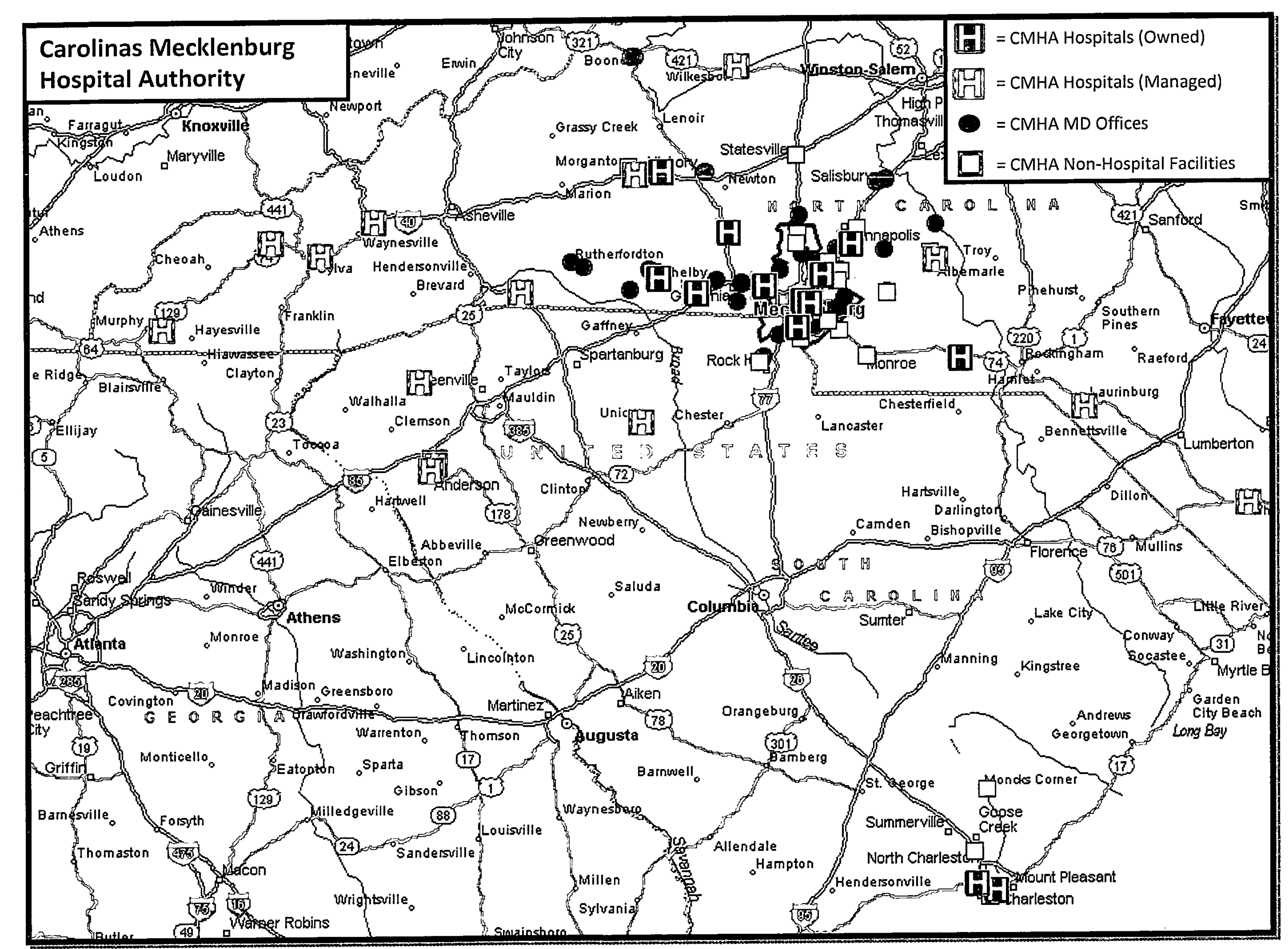


Carolinas Mecklenburg Hospital Authority
= CMHA Hospitals (Owned)
= CMHA Hospitals (Managed)
= CMHA MD Offices
= CMHA Non-Hospital Facilities
NORTH CAROLINA
SOUTH CAROLINA
GEORGIA
UNITED STATES
Knoxville
Winston-Salem
Asheville
Spartanburg
Columbia
Athens
Atlanta
Augusta
Charleston
Florence
Sanford
Lumberton
Monroe
Salisbury
Statesville
Rutherfordton
Anderson

CMHA Owned Hospitals	Address	City	State	Zip Code	
Anson Community Hospital	500 Morven Road	Wadesboro	NC	28170	Owned
Carolinas Medical Center-Lincoln	433 McAlister Road	Lincolnton	NC	28092	Owned
Carolinas Medical Center-Mercy	2001 Vail Avenue	Charlotte	NC	28207	Owned
Carolinas Medical Center-NorthEast	920 Church Street North	Concord	NC	28025	Owned
Carolinas Medical Center-Pineville	10628 Park Road	Charlotte	NC	28210	Owned
Carolinas Medical Center-Randolph	501 Billingsley Road	Charlotte	NC	28211	Owned
Carolinas Medical Center-University	8800 North Tryon Street	Charlotte	NC	28262	Owned
Carolinas Medical Center	1000 Blythe Blvd	Charlotte	NC	28203	Owned
Cleveland Regional Medical Center	201 East Grover Street	Shelby	NC	28150	Owned/Leased
Kings Mountain Hospital	706 W. King Street	Kings Mountain	NC	28086	Owned/Leased
Levine Children's Hospital	1000 Blythe Blvd	Charlotte	NC	28203	Owned
Valdese Hospital	720 Malcolm Blvd	Valdese	NC	28690	Owned
Roper Hospital	316 Calhoun Street	Charleston	SC	29404	Owned(10%)
Roper St. Francis Mount Pleasant Hospital	3500 North Highway 17	Mount Pleasant	SC	28722	Owned(10%)
Bon Secours-St. Francis Hospital	2095 Henry Tecklenburg Drive	Charleston	SC	29414	Owned(10%)
Carolinas Rehabilitation	1100 Blythe Blvd	Charlotte	NC	28203	Owned
Carolinas Rehabilitation-Mount Holly	275 Beatty Drive	Belmont	NC	28012	Owned
Crawley Memorial Hospital- Long Term Acute Care Hospital	315 West College Avenue	Boiling Springs	NC	28017	Owned/Leased

CMHA Managed Hospitals	Address	City	State	Zip Code	
Stanley Regional Medical Center	301 Yadkin Street	Albemarle	NC	28002	Managed
Scotland Memorial Hospital	500 Lauchwood Drive	Laurinburg	NC	28352	Managed
Columbus Regional Healthcare Systems	500 Jefferson Street	Whiteville	NC	28472	Managed
Grace Hospital	2201 South Sterling Street	Morganton	NC	28655	Managed
Valdese Medical Center	720 Malcolm Blvd	Valdese	NC	28690	Managed
Wilkes Regional Medical Center	1370 West D Street	North Wilkesboro	NC	28659	Managed
MedWest Swain County Hospital	45 Plateau Street	Bryson City	NC	28713	Managed
Med-West Haywood Regional Medical Cente	262 Leroy George Drive	Clyde	NC	28721	Managed
St. Lukes Hospital	101 Hospital Drive	Columbus	NC	28722	Managed
Med-West Harris Regional	68 Hospital Road	Sylva	NC	28779	Managed
Wallace Thomson Medical Center	322 W. South Street	Union	SC	29379	Managed
AnMed Health Medical Center	800 North Fant St.	Anderson	SC	29621	Managed
AnMed Women's and Children Hospital	2000 East Greenville Street	Anderson	SC	29621	Managed
Cannon Memorial Hospital	123 W G Acker Drive	Pickens	SC	29671	Managed
AnMed Health Rehabilitation Hospital	1 Springback Way	Anderson	SC	29621	Managed
Murphy Medical Center	3990 East US Highway 64 Alternate	Murphy	NC	28906	Managed

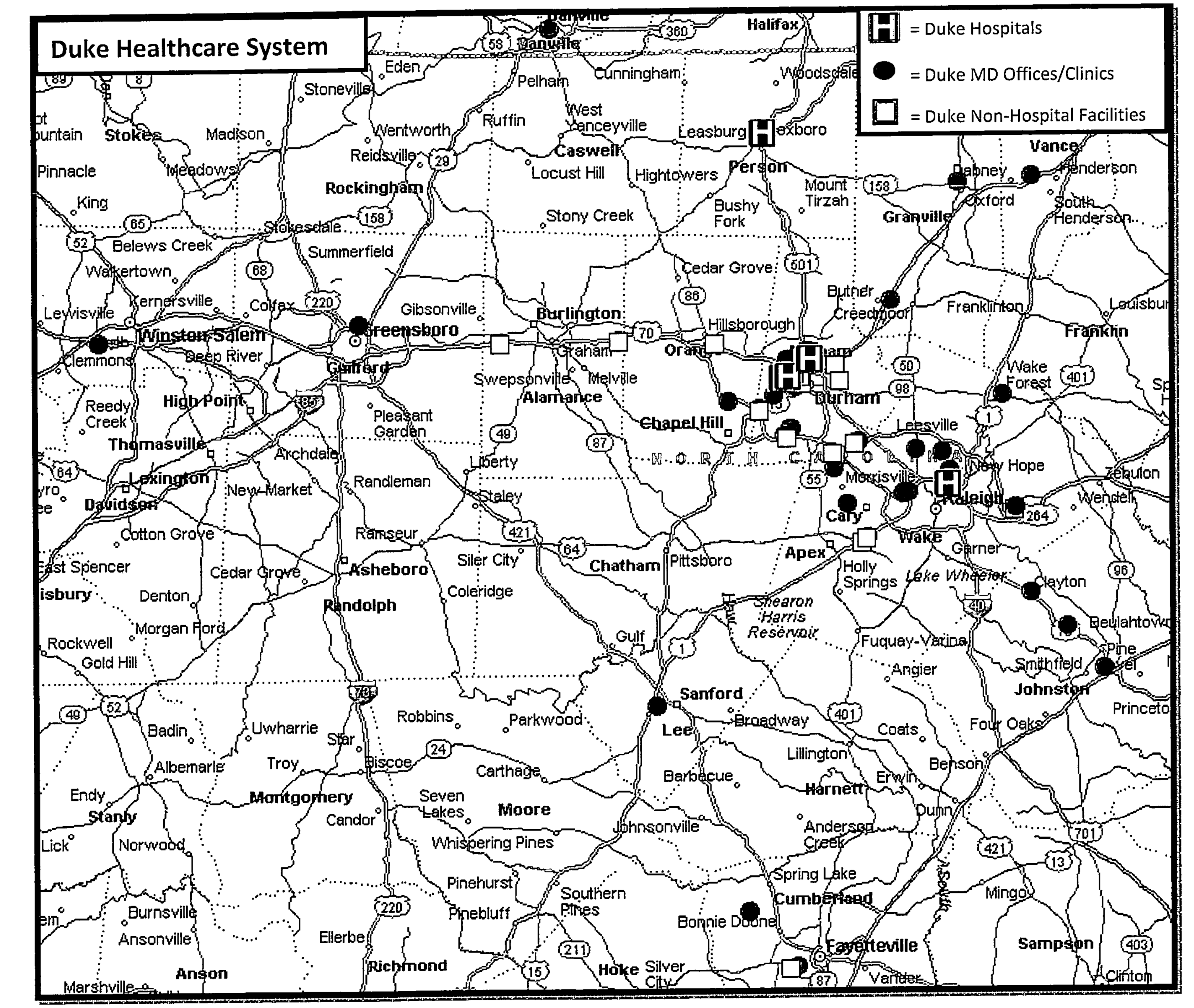
CMHA Non-Hospital Facilities	Address	City	State	Zip Code	
Ballantyne Imaging Center (CIS)	15110 John J. Delaney Drive	Charlotte	NC	28277	Owned(60%)
Carolina Center for Specialty Surgery	1822 Brunswick Avenue	Charlotte	NC	28207	Owned(50%)
Carolina Gastroenterology Ballantyne	15110 John J. Delaney Drive	Charlotte	NC	28277	Owned
Carolinas Surgery Center Randolph	2621 Randolph Road	Charlotte	NC	28211	Owned
Cleveland Ambulatory Services. LLC	1100 North Lafayette Street	Shelby	NC	28150	CCHS(60%)
CMG Psychiatric and Psychological Associates	251 Eastway Drive	Charlotte	NC	28213	Owned
College Pines Nursing Center	95 Locust Street	Valdese	NC	28690	Owned
Edwin Morgan Center	517 Peden Street	Laurinburg	NC	28352	Managed
Gateway Ambulatory Surgery Center, LLC	1025 NE Gateway CT NE	Concord	NC	28025	Owned(42.5%)
Grace Heights Health and Rehab Center	109 Foothills Drive	Morganton	NC	28655	Managed
Grace Ridge Retirement Community	500 Lenior Road	Morganton	NC	28655	Managed
Hospice and Palliative Care of Cabarrus	5003 Hospice Lane	Kannapolis	NC	28081	Owned
Iredell Surgical Center	1720 Davie Avenue	Statesville	NC	28677	Owned(55%)
Jesse Helms Nursing Center	1411 Dove Street	Monroe	NC	28112	Owned/Leased
Lillie Bennett Nursing Center	500 Morven Road	Wadesboro	NC	28170	Owned
Matthews Imaging Center (CIS)	1401 Matthews Township Pkway	Matthews	NC	28105	Owned(60%)
North Mecklenburg Nursing Home, LLC	19600 Zion Street	Cornelius	NC	28031	Owned(10%)
Northcross Imaging Center (CIS)	16455 Statesville Road	Huntersville	NC	28078	Owned(60%)
Rock Hill Radiation Therapy Center	228 South Herlong Avenue	Rock Hill	SC	29730	Owned(50%)
Roger Hospital Ambulatory Surgery - Berkeley	730 Stoney Landing Road	Moncks Corner	SC	29461	Owned(10%)
Roger Hospital Ambulatory Surgery - James Island	325 Folly Road	Charleston	SC	29412	Owned(10%)
Roger Hospital Diagnostics & ER - Berkeley	730 Stoney Landing Road	Moncks Corner	SC	29461	Owned(10%)
Roger Hospital Diagnostics & ER - Northwoods	2233 Northwoods Blvd	North Charleston	SC	29406	Owned(10%)
Roger West Ashley Surgery Center	18 Farmfield Avenue	Charleston	SC	29407	Owned(10%)
Sardis Oaks	5151 Sardis Road	Charlotte	NC	28270	Owned
Southpark Imaging Center (CIS)	4525 Cameron Valley Parkway	Charlotte	NC	28211	Owned(60%)
Stanly Imaging Service	103 Stanly Parkway	Locust	NC	28097	Owned(49%)
Stanly Manor	625 Bethany Road	Albemarle	NC	28001	Managed
Union Medical Services, LLC	6030 W. Highway 74	Indian Trail	NC	28079	Owned(50%)
Carolinas Medical Center-Union/First step Recovery Center	1623 E. Sunset Drive	Monroe	NC	28112	Owned/Leased
CMHA Freestanding ED--North Huntersville (under development)-Mecklenburg County	16455 Statesville Road	Huntersville	NC	28078	Owned
CMC Freestanding ED--Steele Creek (Mecklenburg County)	13460 Steelecroft Parkway	Charlotte	NC	28278	Owned
CMC Freestanding ED Waxhaw Union County)	Providence Rd. (Highway 16) & Gray Byrum Rd.	Waxhaw	NC	28173	Owned
CMC-NE Freestanding ED-Kannapolis (Cabarrus County)	2711 Lane St.	Kannapolis	NC	28083	Owned
CMC-NE Freestanding ED-Harrisonburg (Cabarrus County)	9566 Rocky River Rd.	Harrisburg	NC	28075	Owned
CMC-NE Harrisburg Medical Office Bldg (Psych, Sleep Med, Peds) (Cabarrus County)	5427 Highway 49 South	Harrisburg	NC	28075	owned
CMC Mint Hill Medical Plaza--Mint Hill NC (Mecklenburg County)	10545 Blair Rd.	Mint Hill	NC	27227	Owned
CMC Mount Holly Freestanding ED (Gaston County)	275 Beatty Dr.	Belmont	NC	28021	Owned
CMC Morrocroft Freestanding ED	I-485 and Providence Rd	Charlotte	NC	28105	Owned
CMC Providence Freestanding ED	Fairview Rd. & Cameron Valley Parkway	Charlotte	NC	28211	Owned

CMHA Physician Offices/Clinics	Address	City	State	Zip Code	
Arboretum Pediatrics - Main	7800 Providence Road	Charlotte	NC	28226	Owned
Barnett Family Practice - Carolina Lakes	7666 Charlotte Hwy	Indian Land	SC	29707	Owned
Bessemer City Family Medicine	3326 Bessemer City Road	Bessemer City	NC	28016	Owned
Boiling Springs Women's Care	335 W. College Avenue	Shelby	NC	28152	Owned
Cabarrus Family Medicine	270 Copperfield Blvd	Concord	NC	28025	Owned
Cabarrus Family Medicine	5641 Poplar Tent Road	Concord	NC	28027	Owned
Cabarrus Family Medicine	4315 Physicians Blvd	Harrisburg	NC	28075	Owned
Cabarrus Family Medicine	4949 Professional Park Drive	Kannapolis	NC	28081	Owned
Cabarrus Family Medicine	103 Stanly Pkwy	Locust	NC	28097	Owned
Cabarrus Family Medicine	8560 Cook Street	Mt. Pleasant	NC	28124	Owned
Cabarrus Family Medicine	137 Hwy 49 North	Richfield	NC	28137	Owned
Cabarrus Family Medicine	300 N. Salisbury Avenue	Spencer	NC	28159	Owned
Cabarrus Family Medicine	10320 Mallard Creek Road	Charlotte	NC	28262	Owned
Cabarrus Family Medicine	5435 Prosperity Church Road	Charlotte	NC	28269	Owned
Cabarrus Family Medicine - Psychological & Behavioral Health	270 Copperfield Blvd	Concord	NC	28025	Owned
Cabarrus Family Medicine - Psychological & Behavioral Health	4949 Professional Park Drive	Kannapolis	NC	28081	Owned
Cabarrus Family Medicine - Psychological & Behavioral Health	8560 Cook Street	Mt. Pleasant	NC	28124	Owned
Cabarrus Family Medicine - Psychological & Behavioral Health	5435 Prosperity Church Road	Charlotte	NC	28269	Owned
Cabarrus Family Medicine - The Sports Medicine & Injury Center	5651 Poplar Tent Road	Concord	NC	28027	Owned
Cabarrus Family Medicine-The Urgent Care at Harrisburg	4315 Physicians Blvd	Harrisburg	NC	28075	Owned
Cabarrus Family Medicine-The Urgent Care at Mt. Pleasant	8560 Cook Street	Mt. Pleasant	NC	28124	Owned
Cabarrus Family Medicine-The Urgent Care at Poplar Tent	5651 Poplar Tent Road	Concord	NC	28027	Owned
Carolina Cancer Specialists	225 S. Herlong Avenue	Rock Hill	SC	29732	Owned
Carolina Gastroenterology Medical Center Plaza	1001 Blythe Blvd	Charlotte	NC	28203	Owned
Carolina Neurological Clinic - Ballantyne	12311 Copper Way	Charlotte	NC	28277	Owned
Carolina Neurological Clinic - University	10320 Mallard Creek Road	Charlotte	NC	28262	Owned
Carolina Neurological Clinic - Uptown	3541 Randolph Road	Charlotte	NC	28211	Owned
Carolina Neurological Clinic Gastonia	2550 Court Drive	Gastonia	NC	28054	Owned
Carolinas Cancer Associates	1650 Faulk Street	Monroe	NC	28112	Owned
Carolinas Hematology - Oncology Associates	1100 South Tryon Street	Charlotte	NC	28203	Owned
Carolinas Hematology - Oncology Associates	101 E. W T Harris Blvd	Charlotte	NC	28262	Owned
Carolinas Hematology - Oncology Associates	15830 John J. Delaney Drive	Charlotte	NC	28277	Owned
Charlotte OB/GYN Associates - Arboretum	7810 Providence Road	Charlotte	NC	28226	Owned
Charlotte OB/GYN Associates - Huntersville	16455 Statesville Road	Huntersville	NC	28078	Owned
Charlotte OB/GYN Associates - Main	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
Charlotte OB/GYN Associates - Morrocroft	4525 Cameron Valley Parkway	Charlotte	NC	28211	Owned
Charlotte Pediatric Clinic - Main	4501 Cameron Valley Parkway	Charlotte	NC	28211	Owned
Charlotte Pediatric Clinic - Matthews	332 Sam Newell Road	Matthews	NC	28105	Owned
Charlotte Pediatric Clinic - Pineville	10348 Park Road	Charlotte	NC	28210	Owned
Charlotte Pediatric Clinic - Steele Creek	13640 Steelecroft Pkwy	Charlotte	NC	28278	Owned
Cleveland Endocrinology	502 West King Street	Kings Mountain	NC	28086	Owned
Cleveland Medical Associates	608 W. King Street	Kings Mountain	NC	28086	Owned

Cleveland Pines Nursing Center	1404 North Lafayette Street	Shelby	NC	28150	Owned/Leased
Cleveland Plastic and Hand Surgery	807 Schenck Street	Shelby	NC	28150	Owned
Cleveland Pulmonary and Sleep Associates	802 N. Lafayette Street	Shelby	NC	28150	Owned
CMC - Cosmetic and Plastic Surgery	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
CMC Orthopaedic Surgery	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
CMC Orthopaedic Surgery - Lincoln	441 McAlister Road	Lincolnton	NC	28092	Owned
CMC Surgery - Specialty : Bariatric Surgery	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
Copperfield OB/GYN - Concord	349 Penny Lane NE	Concord	NC	28025	Owned
Copperfield OB/GYN - Harrisburg	4315 Physicians Blvd	Harrisburg	NC	28075	Owned
Dove Internal Medicine	6030 W. Highway 74	Indian Trail	NC	28079	Owned
Dove Internal Medicine	1423 E. Franklin Street	Monroe	NC	28112	Owned
Eastover OB/GYN - Arboretum	7810 Providence Road	Charlotte	NC	28226	Owned
Eastover OB/GYN - Main	1025 Morehead Medical Drive	Concord	NC	28204	Owned
Eastover OB/GYN - Union West	6030 W. Highway 74	Indian Trail	NC	28079	Owned
Endoscopy Center Monroe, LLC	1321 East Sunset Drive	Monroe	NC	28112	Owned(60%)
Endoscopy Center Northcross, LLC	720 E. Morehead Street	Charlotte	NC	28202	Owned(60%)
Endoscopy Center Pineville, LLC	10520 Park Road	Charlotte	NC	28210	Owned(60%)
Endoscopy Center University, LLC	101 E. W T Harris Blvd	Charlotte	NC	29262	Owned(60%)
Gastonia Children's Clinic	2544 Court Drive	Gastonia	NC	28054	Owned
Greater Carolinas Women's Center - Harris Blvd	101 E. W T Harris Blvd	Charlotte	NC	28262	Owned
Greater Carolinas Women's Center - Hawthorne	11304 Hawthorne Drive	Mint Hill	NC	28227	Owned
Greater Carolinas Women's Center - Prosperity	5435 Prosperity Church Road	Charlotte	NC	28269	Owned
Huntersville Oaks	12019 Verhoeff Drive	Huntersville	NC	28078	Owned
Indian Trail Pediatrics - Main	6030 W. Highway 74	Indian Trail	NC	28079	Owned
Kings Mountain Infectious Disease	502 West King Street	Kings Mountain	NC	28086	Owned
Kings Mountain Internal Medicine	502 W. King Street	Kings Mountain	NC	28086	Owned
Kings Mountain Women's Care	821 E. King Street	Kings Mountain	NC	28066	Owned
Klein Neurology and Sleep	222 N. Lafayette Street	Shelby	NC	28150	Owned
McAlister OB/GYN Associates	441 McAlister Road	Lincolnton	NC	28092	Owned
McKay Urology - Charlotte	1023 Edgehill Road	Charlotte	NC	28207	Owned
McKay Urology - Lincolnton	441 McAlister Road	Lincolnton	NC	28092	Owned
Mecklenburg Medical Group - Carolinas Cancer Associates	1650 Faulk Street	Monroe	NC	28112	Owned
Mecklenburg Medical Group Ballantyne	15110 John J. Delaney Drive	Charlotte	NC	28277	Owned
Mecklenburg Medical Group Brunswick	1900 Brunswick Avenue	Charlotte	NC	28207	Owned
Mecklenburg Medical Group Carolina Lakes	7666 Charlotte Hwy	Indian Trail	SC	29707	Owned
Mecklenburg Medical Group Matthews	332 Sam Newell Road	Matthews	NC	28105	Owned
Mecklenburg Medical Group Morehead	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
Mecklenburg Medical Group Museum	3030 Randolph Road	Charlotte	NC	28211	Owned
Mecklenburg Medical Group NorthCross	16455 Statesville Road	Huntersville	NC	28078	Owned
Mecklenburg Medical Group Pineville	10650 Park Road	Charlotte	NC	28210	Owned
Mecklenburg Medical Group SouthPark	4525 Cameron Valley Parkway	Charlotte	NC	28211	Owned
Mecklenburg Medical Group Steele Creek	13640 Steelecroft Pkwy	Charlotte	NC	28278	Owned
Mecklenburg Medical Group Uptown	200 S. College Street	Charlotte	NC	28202	Owned

Medical Associates of Fort Mill	704 Gold Hill Road	Fort Mill	SC	29715	Owned
Medical Associates of Rock Hill	2450 India Hook Road	Rock Hill	SC	29732	Owned
MMG - Dermatology - Ballantyne	15110 John J. Delaney Drive	Charlotte	NC	28277	Owned
MMG - Dermatology - Brunswick	1900 Brunswick Avenue	Charlotte	NC	28207	Owned
MMG - Dermatology - Carolina Lakes	7666 Charlotte Hwy	Indian Trail	SC	29707	Owned
MMG - Dermatology - Matthews	332 Sam Newell Road	Matthews	NC	28105	Owned
MMG - Dermatology - Morehead	1025 Morehead Medical Drive	Charlotte	NC	28204	Owned
MMG - Dermatology - Museum	3030 Randolph Road	Charlotte	NC	28211	Owned
MMG - Dermatology - NorthCross	16455 Statesville Road	Huntersville	NC	28078	Owned
MMG - Dermatology - Pineville	10650 Park Road	Charlotte	NC	28210	Owned
MMG - Dermatology - South Park	4525 Cameron Valley Parkway	Charlotte	NC	28211	Owned
MMG - Dermatology - Steele Creek	13640 Steelecroft Pkwy	Charlotte	NC	28278	Owned
MMG - Dermatology - Uptown	200 S. College Street	Charlotte	NC	28202	Owned
Mooresville Internal Medical Associates	137 Professional Park Drive	Charlotte	NC	28117	Owned
North Charlotte Medical Specialists Huntersville	16455 Statesville Road	Huntersville	NC	28078	Owned
North Charlotte Medical Specialists University	101 E. W T Harris Blvd	Charlotte	NC	28262	Owned
NorthCross OB/GYN - Huntersville	16455 Statesville Road	Huntersville	NC	28078	Owned
NorthCross OB/GYN - Mountain Island Lake	9908 Couloak Drive	Charlotte	NC	28216	Owned
Palmetto Pediatrics - Main	2450 India Hook Road	Rock Hill	SC	29732	Owned
Pediatric Endocrinology Diabetes Specialists	1781 Tate Blvd SE	Hickory	NC	28054	Owned
Pediatric Endocrinology Diabetes Specialists	2550 Court Drive	Gastonia	NC	28054	Owned
Pediatric Endocrinology Diabetes Specialists	709 N. Dekalb Street	Shelby	NC	28150	Owned
Pediatric Endocrinology Diabetes Specialists	4501 Cameron Valley Parkway	Charlotte	NC	28211	Owned
Pediatrics Associates	3030 Randolph Road	Charlotte	NC	28211	Owned
Pediatrics Urology Associates	3125 Springbank Lane	Charlotte	NC	28226	Owned
Piedmont GYN/OB - Ballantyne	15110 John J. Delaney Drive	Charlotte	NC	28277	Owned
Piedmont GYN/OB - Rock Hill	200 S. Herlong Avenue	Rock Hill	SC	29732	Owned
Piedmont GYN/OB -Steelecroft	13640 Steelecroft Pkwy	Charlotte	NC	28278	Owned
Providence Pediatrics	14214 Ballantyne Lake Road	Charlotte	NC	28277	Owned
Randolph Internal Medicine	330 Billingsley Road	Charlotte	NC	28211	Owned
Riverwood Medical Associates	3715 Union Road	Gastonia	NC	28056	Owned
Rock Hill Pediatric Associates - Fort Mill	704 Gold Hill Road	Fort Mill	SC	29715	Owned
Rock Hill Pediatric Associates - Main	1601 Ebenezer Road	Rock Hill	SC	29732	Owned
Rutherford Internal Medicine Associates	181 Daniel Road	Forest City	NC	28043	Owned
Sanger Heart & Vascular Institute - Albemarle - Adult	307 Yadkin Street	Albemarle	NC	28001	Owned
Sanger Heart & Vascular Institute - Ballantyne - Pediatrics	14214 Ballantyne Lake Road	Charlotte	NC	28277	Owned
Sanger Heart & Vascular Institute - Boone	175 Mary Street	Boone	NC	28607	Owned
Sanger Heart & Vascular Institute - Charlotte - Adult	1001 Blythe Blvd	Charlotte	NC	28203	Owned
Sanger Heart & Vascular Institute - Charlotte - Pediatrics	1001 Blythe Blvd	Charlotte	NC	28203	Owned
Sanger Heart & Vascular Institute - Concord - Pediatrics	100 Medical Park Drive	Concord	NC	28025	Owned
Sanger Heart & Vascular Institute - Concord -Adult	100 Medical Park Drive	Concord	NC	28025	Owned
Sanger Heart & Vascular Institute - Davidson - Pediatrics	705 Griffith Street	Davidson	NC	28036	Owned
Sanger Heart & Vascular Institute - Gastonia - Adult	2551 Court Drive	Gastonia	NC	28054	Owned

Sanger Heart & Vascular Institute - Gastonia - Pediatrics	2550 Court Drive	Gastonia	NC	28054	Owned
Sanger Heart & Vascular Institute - Hickory Pediatrics	1781 Take Blvd	Hickory	NC	28602	Owned
Sanger Heart & Vascular Institute - Huntersville - Adult	16455 Statesville Road	Huntersville	NC	28078	Owned
Sanger Heart & Vascular Institute - Indian Trail - Pediatrics	6030 W. Highway 74	Indian Trail	NC	28079	Owned
Sanger Heart & Vascular Institute - Kings Mountain - Adult	706 W. King Street	Kings Mountain	NC	28086	Owned
Sanger Heart & Vascular Institute - Lake Norman - Adult	134 Medical Park Road	Mooresville	NC	28117	Owned
Sanger Heart & Vascular Institute - Lincolnton - Adult	441 McAlister Road	Lincolnton	NC	28092	Owned
Sanger Heart & Vascular Institute - Mercy	2001 Vail Avenue	Charlotte	NC	28205	Owned
Sanger Heart & Vascular Institute - Monroe -Adult	1550 Faulk Street	Monroe	NC	28112	Owned
Sanger Heart & Vascular Institute - Morganton - Adult	2209 South Sterling Street	Morganton	NC	28655	Owned
Sanger Heart & Vascular Institute - Pediatrics	579 Greenway Road	Boone	NC	28607	Owned
Sanger Heart & Vascular Institute - Pineville - Adult	10650 Park Road	Charlotte	NC	28210	Owned
Sanger Heart & Vascular Institute - Rock Hill - Adult	197 Piedmont Blvd	Rock Hill	SC	29732	Owned
Sanger Heart & Vascular Institute - Rock Hill - Pediatric	197 Piedmont Blvd	Rock Hill	SC	29732	Owned
Sanger Heart & Vascular Institute - Rutherfordton - Adult	290 N. Main Street	Rutherfordton	NC	28139	Owned
Sanger Heart & Vascular Institute - Rutherfordton - Pediatrics	290 N. Main Street	Rutherfordton	NC	28139	Owned
Sanger Heart & Vascular Institute - Salisbury - Pediatrics	129 Woodson Street	Salisbury	NC	28144	Owned
Sanger Heart & Vascular Institute - Shelby - Adult	111 W. Gover Street	Shelby	NC	28150	Owned
Sanger Heart & Vascular Institute - Shelby - Pediatrics	709 N. Dekalb Street	Shelby	NC	28150	Owned
Sanger Heart & Vascular Institute - University - Adult	101 E. W T Harris Blvd	Charlotte	NC	28262	Owned
Shelby Children's Clinic - Main	709 N. Dekalb Street	Shelby	NC	28150	Owned
Shelby Women's Care	110 W. Grover Street	Shelby	NC	28150	Owned
South Charlotte Primary Care - Main	7030 Pineville-Matthews Road	Charlotte	NC	28226	Owned
South Lake Pediatrics - Huntersville	9625 Northcross Center Court	Huntersville	NC	28078	Owned
South Lake Pediatrics - Mountain Island Lake	9908 Couloak Drive	Charlotte	NC	28216	Owned
Union Obstetrics and Gynecology - Main	1550 Faulk Street	Monroe	NC	28112	Owned
Union Obstetrics and Gynecology - Union West	6030 W. Highway 74	Indian Trail	NC	28079	Owned
Union Pediatrics - Main	1653 Campus Park Drive	Monroe	NC	28112	Owned
Union Urgent Care, LLC Monroe Urgent Care	613 E. Roosevelt Blvd	Monroe	NC	28112	Owned(50%)
Union Urgent Care, LLC Union West Urgent Care	6030 W. Highway 74	Indian Trail	NC	28079	Owned(50%)
University Internal Medicine	1525 W T Harris Blvd	Charlotte	NC	28288	Owned
University Pediatrics - Mint Hill	10545 Blair Road	Mint Hill	NC	28227	Owned
University Pediatrics - Prosperity Crossing	5435 Prosperity Church Road	Charlotte	NC	28269	Owned
University Pediatrics- Main	101 E. W T Harris Blvd	Charlotte	NC	28262	Owned
Charlotte Medical Clinic	1001 Blythe Blvd	Charlotte	NC	28203	Owned
Charlotte Medical Clinic	10650 Park Road	Charlotte	NC	28210	Owned
Charlotte Medical Clinic	3025 Springbank Lane	Charlotte	NC	28226	Owned
Charlotte Medical Clinic	10545 Blair Road	Mint Hill	NC	28227	Owned
SouthPark Acupuncture	2001 Vail Avenue	Charlotte	NC	28207	Owned
SouthPark Acupuncture	4525 Cameron Valley Parkway	Charlotte	NC	28211	Owned


Duke Healthcare System
= Duke Hospitals
= Duke MD Offices/Clinics
= Duke Non-Hospital Facilities

Duke Owned & Managed Hospitals	Address	City	State	Zip Code	
Duke Children's Hospital & Health Center	2301 Erwin Road	Durham	NC	27710	Owned
Duke Raleigh Hospital	3400 Wake Forest Road	Raleigh	NC	27609	Owned
Duke University Hospital	2301 Erwin Road	Durham	NC	27710	Owned
Durham Regional Medical Center	3643 Roxboro Road	Durham	NC	27704	Owned
Lenox Baker Children's Hospital	3000 Erwin Road	Durham	NC	27705	Owned
Person County Memorial Hospital	615 Ridge Road	Roxboro	NC	27573	Managed

Duke Non-Hospital Facilities	Address	City	State	Zip Code
Adult Bone Marrow Transplant Outpatient Clinic	2400 Pratt Street	Durham,	NC	27705
Behavioral Medicine Research Center	2212 Elder Street	Durham,	NC	27705
Center for Child and Family Health	411 W. Chapel Hill Street	Durham,	NC	27701
Duke ADHD Clinic	718 Rutherford Street	Durham,	NC	27705
Duke Adult Comprehensive Sickle Cell Center	200 Trent Drive	Durham,	NC	27710
Duke Aesthetic Center	3475 Erwin Road	Durham,	NC	27705
Duke ALS Clinic	200 Trent Drive	Durham,	NC	27710
Duke Ambulatory Surgery Center	2400 Pratt Street	Durham,	NC	27705
Duke Anesthesia of Person County	615 Ridge Road	Roxboro,	NC	27573
Duke Center for Minimally Invasive Gynecologic Surgery	3116 North Duke Street	Durham,	NC	27704
Duke Center for Vision Correction	3475 Erwin Road	Durham,	NC	27705
Duke Dermatologic Laser Center	200 Trent Drive	Durham,	NC	27710
Duke Diagnostic/Computed Tomography	200 Trent Drive	Durham,	NC	27710
Duke Diet and Fitness Center	501 Douglas Street	Durham,	NC	27705
Duke Electroconvulsive Therapy	200 Trent Drive	Durham,	NC	27710
Duke Electromyography Laboratory	200 Trent Drive	Durham,	NC	27710
Duke Electrophysiology Consultative Clinic at Kernodle Clinic	1234 Huffman Mill Road	Burlington,	NC	27215
Duke Home Infusion	4321 Medical Park Drive	Durham,	NC	27704
Duke Hospice	4321 Medical Park Drive	Durham,	NC	27704
Duke Hospice Inpatient Facility	4023 Roxboro Road	Durham,	NC	27704
Duke Hospice Inpatient Facility	1001 Corporate Drive	Hillsborough,	NC	27278
Duke Medicine Plaza	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Mohs Micrographic Surgery	5324 McFarland Drive	Durham,	NC	27707
Duke MRI Knightdale	162 Legacy Oaks Drive	Knightdale,	NC	27545
Duke Occupational Health at RTP	1005 Slater Road	Durham,	NC	27703
Duke Outpatient Clinic	4220 North Roxboro Road	Durham,	NC	27704
Duke Physical Therapy	200 Trent Drive	Durham,	NC	27710
Duke Physical Therapy (Mebane)	1352 Mebane Oaks Road	Mebane,	NC	27302
Duke Physical Therapy and Occupational Therapy at Page Road	4709 Creekstone Drive	Durham,	NC	27703
Duke Physical Therapy and Occupational Therapy Brier Creek	10211 Alm Street	Raleigh,	NC	27617
Duke Physical Therapy at Dresser Court	1108 Dresser Court	Raleigh,	NC	27609
Duke Physical Therapy at Keisler Drive	401 Keisler Drive	Cary,	NC	27518
Duke Physical Therapy of Knightdale	162 Legacy Oaks	Knightdale,	NC	27545
Duke Psychiatry	2213 Elba Street	Durham,	NC	27705
Duke Psychiatry Sleep Clinic	200 Trent Drive	Durham,	NC	27710
Duke Psychiatry Specialty Clinic in Cary	2000 Regency Parkway	Cary,	NC	27518
Duke Raleigh Hospital Sleep Laboratory	3400 Wake Forest Road	Raleigh,	NC	27609
Duke Raleigh Outpatient Imaging Center	3480 Wake Forest Road	Raleigh,	NC	27609
Duke University AIDS Research and Treatment Center	200 Trent Drive	Durham,	NC	27710
Duke University Faculty Practice in Psychiatry	2200 W Main Street	Durham,	NC	27705
Duke Wound Management Clinic	200 Trent Drive	Durham,	NC	27710
E K Powe Elementary Wellness Center	913 9th Street	Durham,	NC	27705

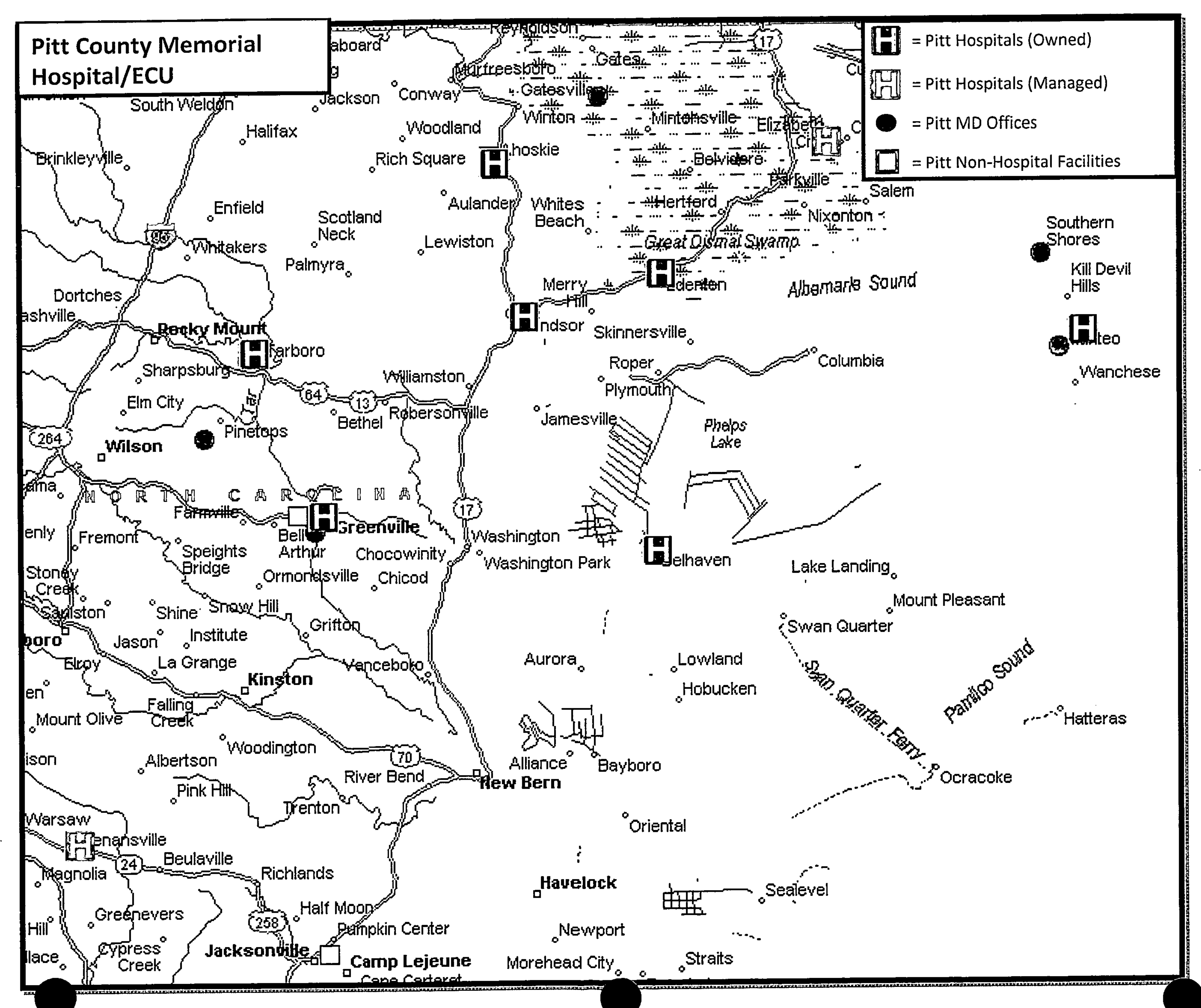
Employee Occupational Health and Wellness Clinic	200 Trent Drive	Durham,	NC	27710
Employee Occupational Health and Wellness Clinic at Durham Regional Hospital	3643 North Roxboro Road	Durham,	NC	27704
General and Thoracic Surgery, Transplant	200 Trent Drive	Durham,	NC	27710
George Watts Elementary Wellness Center	700 Watts Street	Durham,	NC	27701
Geriatric Evaluation and Treatment Clinic	200 Trent Drive	Durham,	NC	27710
Gibson Cancer Center	1200 Pine Run Drive	Lumberton,	NC	28359
Glenn Elementary Wellness Center	2415 East Geer Street	Durham,	NC	27704
Hospice at The Meadowlands	1001 Corporate Drive	Hillsborough,	NC	27278
James E. Davis Ambulatory Surgical Center	120 E. Carver Street	Durham,	NC	27704
PepsiCo Fitness Center	3475 Erwin Road	Durham,	NC	27705
Preoperative Screening Clinic	200 Trent Drive	Durham,	NC	27710
Scotland Cancer Treatment Center	500 Lauchwood Drive	Laurinburg,	NC	28352
Sleep Disorders Laboratory	2800 Campus Walk Avenue	Durham,	NC	27705
Southern High School Wellness Center	800 Clayton Road	Durham,	NC	27703
Southern Regional Area Health Education Center	1601 Owen Drive	Fayetteville,	NC	28304
Southpoint Imaging Services	6301 Herndon Road	Durham,	NC	27713
Teer House	4019 North Roxboro Street	Durham,	NC	27704
The Preston Robert Tisch Brain Tumor Center	200 Trent Drive	Durham,	NC	27710
Williams Inpatient Psychiatric Unit	200 Trent Drive	Durham,	NC	27710

Duke Physician Offices and Clinics	Address	City	State	Zip Code
Burlington Medical Practice	1248 Huffman Mill Road	Burlington,	NC	27215
Cardiovascular Surgery of Danville	201 South Main Street	Danville,	VA	24541
Donayre Cancer Care Center	711 North Franklin Street	Whiteville,	NC	28472
Duke Asthma, Allergy, and Airway Center	4309 Medical Park Drive,	Durham,	NC	27704
Duke Behavioral Medicine	200 Trent Drive,	Durham,	NC	27710
Duke Bone and Metabolic Disease	200 Trent Drive,	Durham,	NC	27710
Duke Cardiology and Cardiovascular Surgery of Lumberton	2936 N. Elm Street	Lumberton,	NC	28358
Duke Cardiology Consult Clinic	200 Trent Drive	Durham,	NC	27710
Duke Cardiology Consultative Clinic at Person Memorial Hospital	615 Ridge Road	Roxboro,	NC	27573
Duke Cardiology of Raleigh	3320 Wake Forest Road	Raleigh,	NC	27609
Duke Cardiology of Raleigh (Knightdale)	162 Legacy Oaks Drive	Knightdale,	NC	27545
Duke Cardiology of Raleigh (Morrisville)	10950 Chapel Hill Road	Morrisville,	NC	27560
Duke Cardiology of Sanford	1309 Carthage Street	Sanford,	NC	27330
Duke Cardiothoracic Surgery	200 Trent Drive	Durham,	NC	27710
Duke Center for Living Campus	3475 Erwin Road	Durham,	NC	27705
Duke Center for Metabolic and Weight Loss Surgery	407 Crutchfield Street	Durham,	NC	27704
Duke Child and Family Studies Center	2608 Erwin Road	Durham,	NC	27705
Duke Child and Family Studies Center	718 Rutherford Street	Durham,	NC	27705
Duke Children's Cardiology of Laurinburg at Scotland Memorial Hospital	500 Lauchwood Drive	Laurinburg,	NC	28352
Duke Children's Cardiology of Burlington	1236 Huffman Mill Road	Burlington,	NC	27215
Duke Children's Cardiology of Charlotte at Presbyterian Pediatric Cardiology	1718 East 4th Street	Charlotte,	NC	28204
Duke Children's Cardiology of Fayetteville	1991 Fordham Drive	Fayetteville,	NC	28304
Duke Children's Cardiology of Fort Bragg at Womack Army Medical Center	Normandy Drive	Fort Bragg	NC	28310
Duke Children's Cardiology of Greensboro	1126 North Church St.	Greensboro,	NC	27401
Duke Children's Cardiology of Morrisville	10950 Chapel Hill Road	Morrisville,	NC	27560
Duke Children's Cardiology of Roanoke Rapids at Halifax Regional Medical Center	250 Smith Church Road	Roanoke Rapids	NC	27870
Duke Children's Consultative Services of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Children's Primary Care Pickett Road	3024 Pickett Road	Durham,	NC	27705
Duke Children's Primary Care Southpoint	6301 Herndon Road	Durham,	NC	27713
Duke Colon and Rectal Surgery	200 Trent Drive	Durham,	NC	27710
Duke Colon and Rectal Surgery of Raleigh	3404 Wake Forest Road	Raleigh,	NC	27609
Duke Dermatology	200 Trent Drive	Durham,	NC	27710
Duke Dermatology Patterson Place	5324 McFarland Drive	Durham,	NC	27707
Duke Eating Disorders	718 Rutherford Street	Durham,	NC	27705
Duke Endocrinology	200 Trent Drive	Durham,	NC	27710
Duke Eye Center	2351 Erwin Road	Durham,	NC	27710
Duke Eye Center at Page Road	4709 Creekstone Drive	Durham,	NC	27703
Duke Eye Center at Southpoint	6301 Herndon Road	Durham,	NC	27713
Duke Eye Center of Cary	2000 Regency Parkway	Cary,	NC	27518
Duke Eye Center of North Durham	3116 North Duke Street	Durham,	NC	27704
Duke Eye Center of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Eye Center of Winston-Salem	2025 Frontis Plaza Blvd	Winston-Salem,	NC	27103
Duke Eye Contact Lens Service	2351 Erwin Road	Durham,	NC	27710
Duke Family Care Program	2222 Erwin Road	Durham,	NC	27712
Duke Family Medicine Center	2100 Erwin Road	Durham,	NC	27705

Duke Fertility Center	5704 Fayetteville Road	Durham,	NC	27713
Duke Gastroenterology	200 Trent Drive	Durham,	NC	27710
Duke Gastroenterology of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Gastroenterology of Raleigh (Knightdale)	162 Legacy Oaks Drive	Knightdale,	NC	27545
Duke General Surgery of Raleigh (American Institute of Healthcare & Fitness Offices)	8300 Health Park	Raleigh,	NC	27615
Duke General Surgery of Raleigh (Duke Medicine Plaza)	3480 Wake Forest Road	Raleigh,	NC	27609
Duke General Surgery of Raleigh at Cedarhurst Drive	1212 Cedarhurst Drive	Raleigh,	NC	27609
Duke Gynecology/Oncology	3404 Wake Forest Road	Raleigh,	NC	27609
Duke Health Center at Morreene Road	932 Morreene Road	Durham,	NC	27705
Duke Health Center at Morreene Road (Biofeedback)	932 Morreene Road	Durham,	NC	27705
Duke Health Center at Morreene Road (Pain and Palliative Care Clinic)	932 Morreene Road	Durham,	NC	27705
Duke Health Center at North Duke Street	3116 North Duke Street	Durham,	NC	27704
Duke Health Center at Roxboro Street	4020 North Roxboro Street	Durham,	NC	27704
Duke Health Center at Southpoint	6301 Herndon Road	Durham,	NC	27713
Duke Health Center of Cary	3700 NW Cary Parkway	Cary,	NC	27513
Duke Health Center of Clayton	11618 US Highway 70 Business West	Clayton,	NC	27520
Duke Hematology	200 Trent Drive	Durham,	NC	27710
Duke Hematology / Oncology at Community Memorial Healthcenter Cancer and Specialty Care Center	750 Lombardy Street	South Hill	VA	23970
Duke Hemostasis and Thrombosis Center	200 Trent Drive	Durham,	NC	27710
Duke HomeCare & Hospice	4321 Medical Park Drive	Durham,	NC	27704
Duke Hyperbaric Medicine Clinic	200 Trent Drive	Durham,	NC	27710
Duke Integrative Medicine	3475 Erwin Road	Durham,	NC	27705
Duke Lupus Clinic	200 Trent Drive	Durham,	NC	27710
Duke Mammography	200 Trent Drive	Durham,	NC	27710
Duke MDA Clinic	200 Trent Drive	Durham,	NC	27710
Duke Medical Plaza Brier Creek	10211 Alm Street	Raleigh,	NC	27617
Duke Medical Plaza Knightdale	162 Legacy Oaks Drive	Knightdale,	NC	27545
Duke Medical Plaza Morrisville	10950 Chapel Hill Road	Morrisville,	NC	27560
Duke Medical Plaza Page Road	4709 Creekstone Drive	Durham,	NC	27703
Duke Medical Plaza Patterson Place	5324 McFarland Drive	Durham,	NC	27707
Duke Medicine at Brier Creek (GI Services)	10441 Moncreiffe Road	Raleigh,	NC	27617
Duke Neonatology at Alamance Regional Medical Center	1240 Huffman Mill Road	Burlington,	NC	27215
Duke Neurology of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Neuromuscular Services	200 Trent Drive	Durham,	NC	27710
Duke Neurosciences/Spine	200 Trent Drive	Durham,	NC	27710
Duke Neurosurgery of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Neurosurgical Associates of Lumberton	2936 N. Elm Street	Lumberton,	NC	28358
Duke OB-GYN	200 Trent Drive	Durham,	NC	27710
Duke OB-GYN Consultants	2406 Blue Ridge Road	Raleigh,	NC	27607
Duke Oncology-Medical	200 Trent Drive	Durham,	NC	27710
Duke Oncology-Surgical	200 Trent Drive	Durham,	NC	27710
Duke Oral Surgery	200 Trent Drive	Durham,	NC	27710
Duke Orthopaedics	200 Trent Drive	Durham,	NC	27710
Duke Orthopaedics at North Duke Street	3116 North Duke Street	Durham,	NC	27704
Duke Orthopaedics at Page Road	4709 Creekstone Drive	Durham,	NC	27703
Duke Orthopaedics of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609

Duke Orthopaedics of Vance County	511 Ruin Creek Drive	Henderson,	NC	27536
Duke Otolaryngology of Durham	2609 N. Duke Street	Durham,	NC	27704
Duke Otolaryngology of Person County	783 C Doctor's Court	Roxboro,	NC	27573
Duke Otolaryngology of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Otolaryngology, Head and Neck, ENT	200 Trent Drive	Durham,	NC	27710
Duke Pediatric Dentistry	2711 North Duke Street	Durham,	NC	27704
Duke Perinatal Consultants of Burlington	1240 Huffman Mill Road	Burlington,	NC	27715
Duke Perinatal Consultants of Cary	600 New Waverly Place	Cary,	NC	27518
Duke Perinatal Consultants of Greensboro	1126 N. Church St.	Greensboro,	NC	27401
Duke Perinatal Durham / Fetal Diagnostic Center	2608 Erwin Road	Durham,	NC	27705
Duke Primary Care Brier Creek	10211 Alm Street	Raleigh,	NC	27617
Duke Primary Care Butner-Creedmoor	2503 East Lyon Station Road	Creedmoor,	NC	27522
Duke Primary Care Creedmoor Road	7200 Creedmoor Road	Raleigh,	NC	27613
Duke Primary Care Harps Mill	7021 Harps Mill Road	Raleigh,	NC	27615
Duke Primary Care Henderson	480 Ruin Creek Road	Henderson,	NC	27536
Duke Primary Care Knightdale	162 Legacy Oaks	Knightdale,	NC	27545
Duke Primary Care Mebane	1352 Mebane Oaks Road	Mebane,	NC	27302
Duke Primary Care Morrisville	10950 Chapel Hill Road	Morrisville,	NC	27560
Duke Primary Care of Galloway Ridge	3000 Galloway Ridge	Pittsboro,	NC	27312
Duke Primary Care Pickett Road	3024 Pickett Road	Durham,	NC	27705
Duke Primary Care Timberlyne	77 Vilcom Circle	Chapel Hill	NC	27514
Duke Prostate Clinic	200 Trent Drive	Durham,	NC	27710
Duke Pulmonary Medicine	200 Trent Drive	Durham,	NC	27710
Duke Radiation Oncology	200 Trent Drive	Durham,	NC	27710
Duke Radiation Oncology of Raleigh	3400 Wake Forest Road	Raleigh,	NC	27609
Duke Radiology at Patterson Place	5324 McFarland Drive	Durham,	NC	27707
Duke Raleigh Cancer Center	3404 Wake Forest Road	Raleigh,	NC	27609
Duke Renal Medicine	200 Trent Drive	Durham,	NC	27710
Duke Rheumatology	200 Trent Drive	Durham,	NC	27710
Duke Sleep Apnea Clinic of Raleigh	10441 Moncreiffe Road	Raleigh,	NC	27617
Duke Speech Pathology and Audiology	200 Trent Drive	Durham,	NC	27710
Duke Sports Medicine	280 Frank Bassett Road	Durham,	NC	27710
Duke Thoracic Surgery of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Urgent Care Brier Creek	10211 Alm Street	Raleigh,	NC	27617
Duke Urgent Care Hillandale	1901 Hillandale Road	Durham,	NC	27705
Duke Urgent Care Knightdale	162 Legacy Oaks	Knightdale,	NC	27545
Duke Urgent Care Morrisville	10950 Chapel Hill Road	Morrisville,	NC	27560
Duke Urgent Care South	5716 Fayetteville Road	Durham,	NC	27713
Duke Urogynecology	5324 McFarland Drive	Durham,	NC	27707
Duke Urology	200 Trent Drive	Durham,	NC	27710
Duke Urology of Raleigh	3480 Wake Forest Road	Raleigh,	NC	27609
Duke Vascular Surgery	200 Trent Drive	Durham,	NC	27710
Duke Vein Clinic	200 Trent Drive	Durham,	NC	27710
Duke Women's Health Associates at Patterson Place	5324 McFarland Drive	Durham,	NC	27707
Duke Women's Health Associates Brier Creek	10211 Alm Street	Raleigh,	NC	27617
Durham Child Development & Behavioral Health Clinic	402 Trent Drive	Durham,	NC	27710

Durham Medical Center (Internal Medicine)	4220 North Roxboro Road	Durham,	NC	27704
Durham Obstetrics and Gynecology (OB-GYN) at North Duke Street	2609 N. Duke St.	Durham,	NC	27704
Durham Obstetrics and Gynecology (OB-GYN) at Sutton Station	5726 Fayetteville Road	Durham,	NC	27713
Durham Pathology Associates	3643 North Roxboro Road	Durham,	NC	27704
Durham Pathology Associates (Raleigh)	3400 Wake Forest Road	Raleigh,	NC	27609
Durham Pediatrics at Highgate Drive	5315 Highgate Drive	Durham,	NC	27713
Durham Pediatrics at North Duke Street	2609 North Duke Street	Durham,	NC	27704
Durham Rehabilitation Institute	3643 North Roxboro Road	Durham,	NC	27704
Family Medical Associates of Durham	1901 Hillandale Road	Durham,	NC	27705
Harris & Smith OB-GYN	4116 Capitol Street	Durham,	NC	27704
Harris & Smith OB-GYN at Patterson Place	5324 McFarland Drive	Durham,	NC	27707
Hematology/Oncology at Duke Raleigh Hospital	3404 Wake Forest Road	Raleigh,	NC	27609
Hillsborough Family Practice	405 Meadowlands Drive	Hillsborough,	NC	27278
Hock Family Pavilion	4023 N. Roxboro Road	Durham,	NC	27704
Johnston Hematology / Oncology - Clayton	2076 NC Hwy 42	Clayton,	NC	27520
Johnston Hematology / Oncology - Smithfield (Duke Oncology Network)	514 N. Bright Leaf Blvd.	Smithfield,	NC	27577
Lumberton Children's Clinic	400 Liberty Hill Rd	Lumberton,	NC	28358
Lyon Park Clinic	1313 Halley Street	Durham,	NC	27707
Maria Parham Oncology Center	566 Ruin Creek Road	Henderson,	NC	27536
Metropolitan Durham Medical Group	1901 Hillandale Road	Durham,	NC	27705
Morris Cancer Clinic	200 Trent Drive	Durham,	NC	27710
North Carolina Orthopaedic Clinic	3609 Southwest Durham Drive	Durham,	NC	27707
North Hills Internal Medicine	3320 Wake Forest Road	Raleigh,	NC	27609
Northern Carolina Cardiology	568 Ruin Creek Road	Henderson,	NC	27536
Oncology Treatment Center	200 Trent Drive	Durham,	NC	27710
Orthopaedics of Raleigh (Knightdale)	162 Legacy Oaks Drive	Knightdale,	NC	27545
Oxford Family Physicians	101 Professional Park Drive	Oxford,	NC	27565
Piedmont Spine Specialists	3480 Wake Forest Road	Raleigh,	NC	27609
Raleigh Pulmonary & Allergy Consultants	3480 Wake Forest Road	Raleigh,	NC	27609
Raleigh Pulmonary & Allergy Consultants (Knightdale)	162 Legacy Oaks Drive	Knightdale,	NC	27545
Sutton Station Internal Medicine	5832 Fayetteville Road	Durham,	NC	27713
Tolnitch Surgical Associates	2301 Rexwoods Dr	Raleigh,	NC	27607
Triangle Family Practice	6020 Fayetteville Road	Durham,	NC	27713
Triangle Heart Associates	2609 North Duke Street	Durham,	NC	27704
University Orthopaedics and Sports Medicine (Clayton)	11618 US Highway 70 West	Clayton,	NC	27520
University Orthopaedics and Sports Medicine (Smithfield)	507 North Brightleaf Boulevard	Smithfield,	NC	27577
Wake Forest Family Physicians	11635 Northpark Drive	Wake Forest	NC	27587
Walltown Neighborhood Clinic	815 Broad Street	Durham,	NC	27705
West Raleigh Internal Medicine	2304 Wesvill Court	Raleigh,	NC	27607

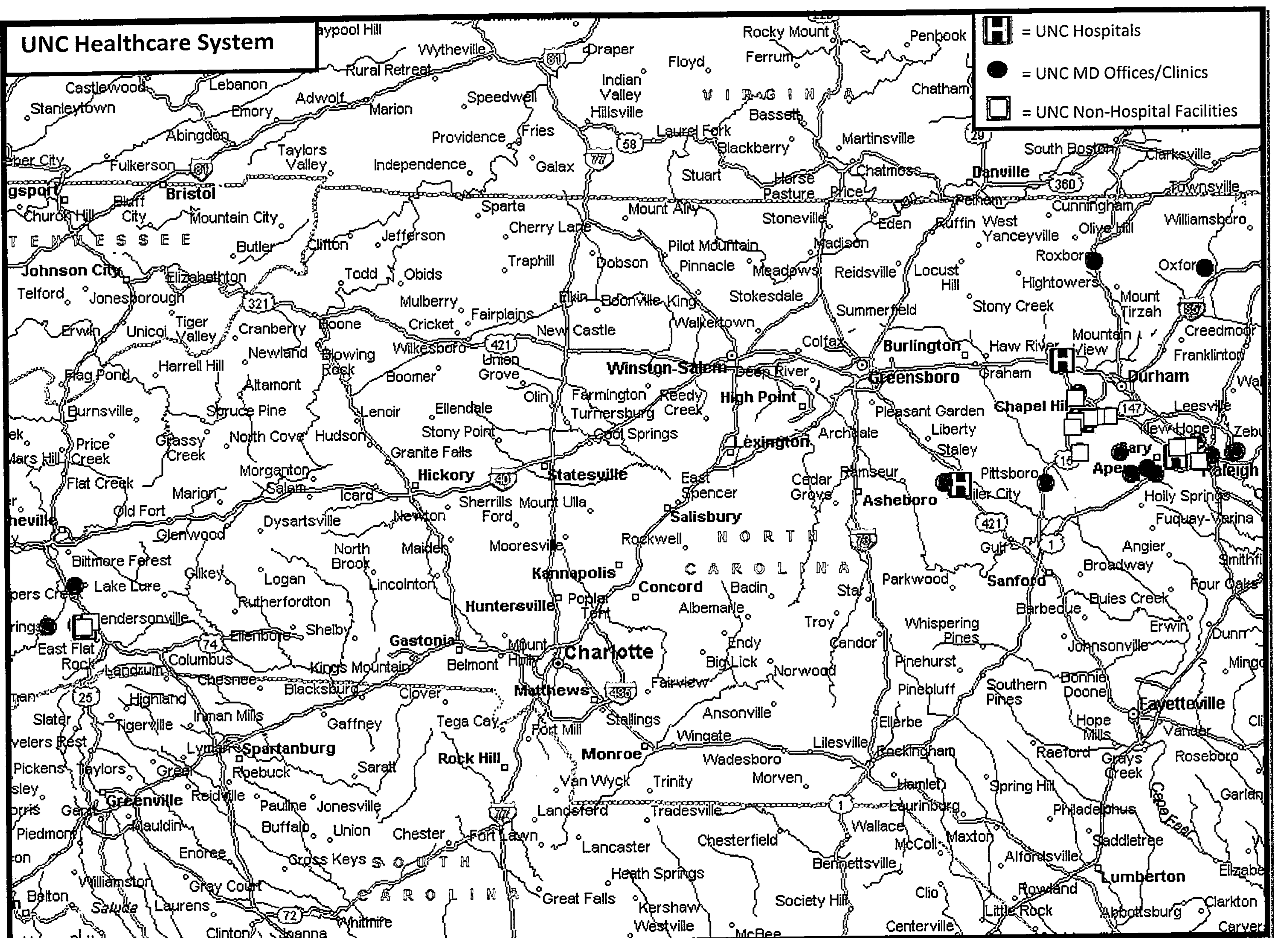

Pitt County Memorial Hospital/ECU
= Pitt Hospitals (Owned)
= Pitt Hospitals (Managed)
= Pitt MD Offices
= Pitt Non-Hospital Facilities
South Weldon
Halifax
Jackson
Conway
Woodland
Rich Square
Brinkleyville
Enfield
Scotland Neck
Whitakers
Palmyra
Lewiston
Aulander
Whites Beach
Dortches
Rocky Mount
Sharpsburg
Elm City
Pinetops
Wilson
Williamston
Bethel
Robersonville
Skinnersville
Roper
Plymouth
Columbia
Jamesville
Phelps Lake
Great Dismal Swamp
Albemarle Sound
Southern Shores
Kill Devil Hills
Wanchese
Salem
Nixonton
Hertford
Gates
Winton
Belvidere
Fremont
Speights Bridge
Greenville
Chocowinity
Chicod
Washington
Washington Park
Lake Landing
Mount Pleasant
Swan Quarter
Swan Quarter Ferry
Pamlico Sound
Hatteras
Ocracoke
Aurora
Lowland
Hobucken
Alliance
Bayboro
New Bern
Oriental
Havelock
Newport
Morehead City
Straits
Sealevel
Shine
Snow Hill
Jason
Institute
Grifton
La Grange
Kinston
Vanceboro
Mount Olive
Falling Creek
Woodington
Albertson
Pink Hill
Trenton
River Bend
Warsaw
Beulaville
Richlands
Magnolia
Greenevers
Half Moon
Pumpkin Center
Cypress Creek
Jacksonville
Camp Lejeune
NORTH CAROLINA

Pitt Owned Hospital Facilities	Address	City	State	Zip Code	
The Outer Bank Hospital	4800 S. Croatan Highway	Nags Head	NC	27959	Co-Owned
Heritage Hospital	111 Hospital Drive	Tarboro	NC	27886	Owned
Bertie Memorial Hospital	1403 South King Street	Windsor	NC	27983	Owned
Pungo District Hospital	202 East Water	Belhaven	NC	27810	Owned
Pitt County Memorial Hospital	2100 Stantonsburg Road	Greenville	NC	27834	Owned
Chowan Hospital	211 Virginia Road	Edenton	NC	27959	Owned
Roanoke-Chowan Hospital	500 South Academy Street	Ahoskie	NC	27910	Owned

Pitt Managed Hospitals	Address	City	State	Zip Code	
Albemarle Health	1144 North Road Street	Elizabeth City	NC	27909	Managed
Duplin General Hospital	401 S. Main Street	Kenansville	NC	28349	Managed

Pitt Non-Hospital Facilities	Address	City	State	Zip Code
Albemarle Regional Oncology Center	1144 North Road Street	Elizabeth City	NC	27909
Eastpointe Health MRI	402 Bowman Gray Drive	Greenville	NC	27834
Greenville Inpatient Hospice	920 Wellness Drive	Greenville	NC	27834
HealthSteps Cardiac Rehab Center	2470 Stantonsburg Road	Greenville	NC	27834
Moye Medical Endoscopy	2100 Stantonsburg Road	Greenville	NC	27834
Onslow Radiation Oncology	317 Western Blvd	Jacksonville	NC	28546
Pain Management at PCMH	2010 West Arlington Blvd	Greenville	NC	27834
Pain Management Center at Heritage Hospital	111 Hospital Drive	Tarboro	NC	27886
Patient Testing Center	626 Medical Drive	Greenville	NC	27835
Regional Rehabilitation Center	2100 Stantonsburg Road	Greenville	NC	27834
Sleep Center at Pitt	4 Doctor's Park Medical Drive	Greenville	NC	27835
Sleep Center at Roanoke-Chowan	500 South Academy Street	Ahoskie	NC	27910
Surgicenter Services of Pitt	102 Bethesda Drive	Greenville	NC	27834
Viquest Center- Greenville	2610 Stantonsburg Road	Greenville	NC	27834
Viquest Center--Fitness Center	117 Herford County High Road	Ahoskie	NC	27910
Wound Healing Center	608 South Academy Street	Ahoskie	NC	27910
Wound Healing Center at PCMH	3900 East 10th Street	Greenville	NC	27834

Pitt Physician Practices & Clinics	Address	City	State	Zip Code
Chowan Internal Medicine	105 Mark Drive	Edenton	NC	27932
Chowan Hospital Family Practice	201 Virginia Road	Edenton	NC	27932
Macciesfield Healthcare Center	201 W. Edgecombe Street	Macciesfield	NC	27852
Chowan Pediatrics	203 Earnhardt Drive	Edenton	NC	27932
Chowan OB/GYN	203 Earnhardt Drive	Edenton	NC	27932
Edenton Surgical Practice	203 Earnhardt Drive	Edenton	NC	27932
Roanoke-Chowan Urology	312 South Academy Street	Ahoskie	NC	27910
Cashie Medical Center	1403 South King Street	Windsor	NC	27983
MedDirect Urgent Care Center	2380 West Arlington Blvd	Greenville	NC	27834
Gates County Medical Center - Clinic	501 Main Street	Gatesville	NC	27938
Albemarle Health Clinic	5200 North Croatan Highway	Kitty Hawk	NC	27949
East Carolina Heart Institute	526 Moye Blvd	Greenville	NC	27834
Manteo Family Care	604 Amanda Street	Manteo	NC	27954
Women's Care of Ahoskie	606 South Academy Street	Ahoskie	NC	27910
Macciesfield Healthcare Center	700 South Academy Street	Ahoskie	NC	27910
Island Medical Center - Clinic	715 North Main Highway	Manteo	NC	27954
HealthEast Family Care of Nags Head	Milepost 14	Nags Head	NC	27959



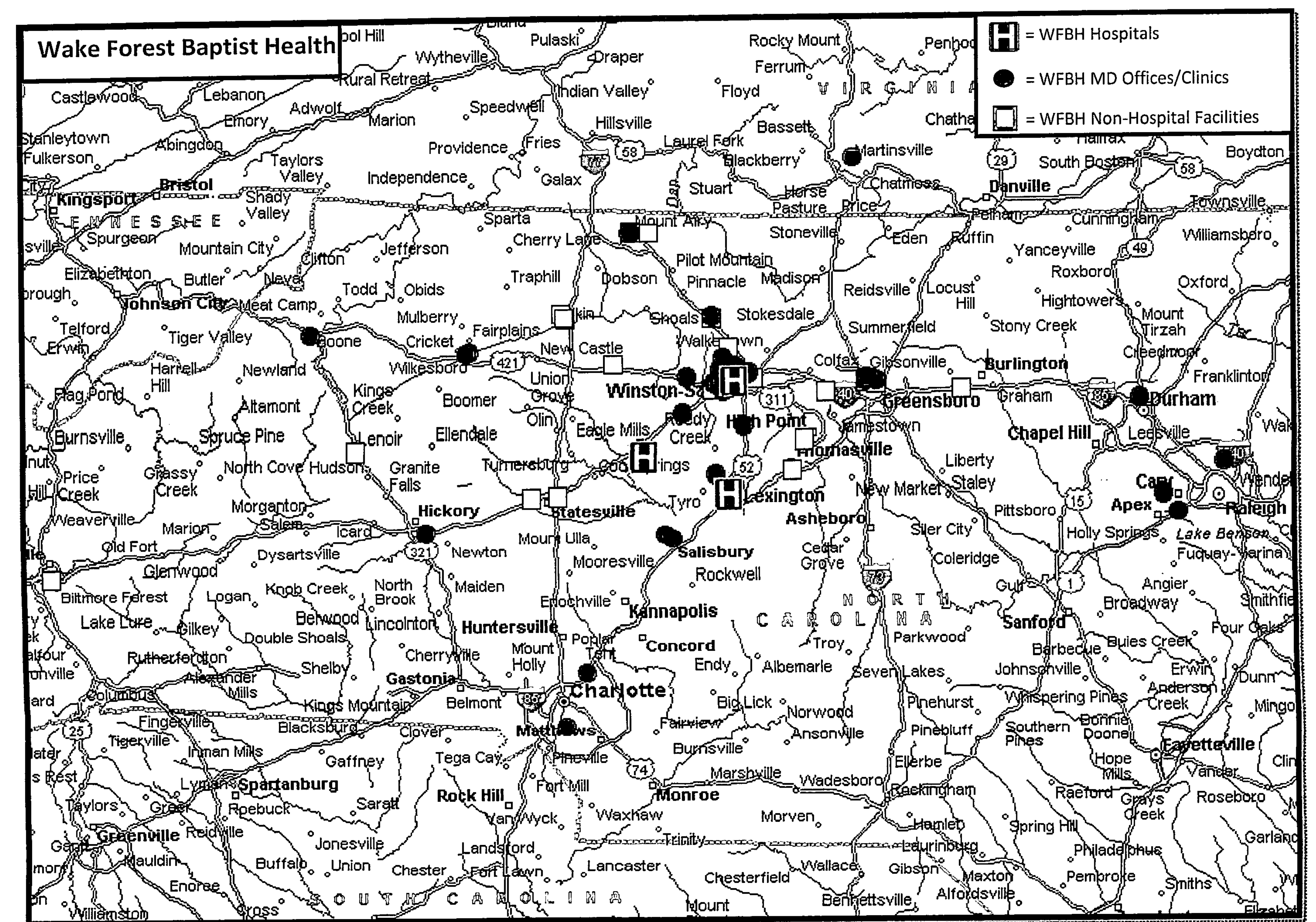
UNC Healthcare System
= UNC Hospitals
= UNC MD Offices/Clinics
= UNC Non-Hospital Facilities

UNC Hospitals--Owned & Managed		Address	City	State	Zip Code	
University of North Carolina Hospitals	UNC	101 Manning Drive	Chapel Hill	NC	27514	Owned
Rex Healthcare, Inc Hospital	REX	4420 Lake Boone Trail	Raleigh	NC	27607	Owned
Chatham Hospital	UNC	475 Progress Blvd	Siler City	NC	27344	Owned
Margaret Pardee Memorial Hospital	UNC	800 North Justice Street	Hendersonville	NC	28791	Managed
UNC Hillsborough Hospital	UNC	Waterstone Drive	Hillsborough	NC	27278	Owned

UNC Non-Hospital Facilities		Address	City	State	Zip Code	
Ambulatory Care Center	UNC	102 Mason Farm Road	Chapel Hill	NC	27514	Owned
Ambulatory Care Center	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
Chapel Hill North Medical Center	UNC	1838 Martin Luther King, Jr. Blvd	Chapel Hill	NC	27514	Owned
Comprehensive Wound Center at Pardee	UNC	800 N. Justice Street	Hendersonville	NC	28791	Owned
Executive Health (The Carolina Clinic)	UNC	315 Meadowmont Village Circle	Chapel Hill	NC	27517	Owned
Highgate Specialty Center	UNC	5316 Highgate Drive	Durham	NC	27713	Owned
North Carolina Children's Specialty Clinic	UNC	4414 Lake Boone Trail	Raleigh	NC	27607	Owned
Pardee Pain Center	UNC	800 N. Justice Street	Hendersonville	NC	28791	Owned
Pardee Rehab & Wellness Center	UNC	212 Thompson Street	Hendersonville	NC	28792	Owned
Paths Outpatient Services	UNC	800 N. Justice Street	Hendersonville	NC	28791	Owned
Rex Healthcare, Inc Hospital	REX	4420 Lake Boone Trail	Raleigh	NC	27607	Owned
Rex Rehab and Nursing Center of Raleigh	REX	4210 lake Boone Trail	Raleigh	NC	27608	Owned
Rex Senior Health Center	REX	512 E. Davie Street	Raleigh	NC	27601	Owned
UNC Comprehensive Cancer Support Program	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Ear, Nose, & Throat	UNC	5915 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Alcohol and Substance Abuse	UNC	1101 Weaver Dairy Road	Chapel Hill	NC	27514	Owned
UNC Hospitals Imaging & Spine Center	UNC	1350 Raleigh Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Physical Therapy Center	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Hospitals Physical Therapy Clinic	UNC	100 Sprunt Street	Chapel Hill	NC	27517	Owned
UNC Hospitals Radiology & Laboratory	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Trauma Surgery Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Urgent Care	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
Urgent Care at Carolina Point	UNC	6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Endoscopy Center	UNC	300 Meadowmont Village Circle	Chapel Hill	NC	27517	Owned
UNC Hospitals Pain Management Center	UNC	410 Market Street	Chapel Hill	NC	27516	Owned
UNC Hospitals Hand Rehabilitation Center	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned

UNC Physician Offices/Clinics		Address	City	State	Zip Code	
Boylan Healthcare	CP	3900 Browning Place	Raleigh	NC	27609	Owned
Boylan Healthcare	CP	8300 Health Park	Raleigh	NC	27615	Owned
Cardiovascular Care of Northern Carolina	UNC	3763 Durham Road	Roxboro	NC	27573	Owned
Cardiovascular Care of Northern Carolina	UNC	102 Professional Park Drive	Oxford	NC	27565	Owned
Carolina Children's Cardiology	UNC	3000 Ashville Avenue	Cary	NC	27518	Owned
Carolina Children's Consultants	UNC	3000 New Bern Avenue	Raleigh	NC	27610	Owned
Chapel Hill Internal Medicine	UNC	940 Martin Luther King, Jr. Blvd	Chapel Hill	NC	27514	Owned
Chatham Crossing	UNC	11312 US 15-501N.	Chapel Hill	NC	27517	Owned
Chatham Primary Care	UNC	311 N. Fir Avenue	Siler City	NC	27344	Owned
Chatham Primary Care	UNC	163 Medical Park Drive	Siler City	NC	27344	Owned
Heart and Hand Family Medicine	CP	800 W Williams Street	Apex	NC	27502	Owned
Hendersonville Family Health Center Clinic	UNC	709 N. Justice Street	Hendersonville	NC	28791	Owned
Hendersonville Hematology & Oncology Clinic	UNC	1824 Pisgah Drive	Hendersonville	NC	28791	Owned
Highgate Family Medical Center	UNC	5317 Highgate Drive	Durham	NC	27713	Owned
Kittner Eye Center	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
Knightdale Family Medicine	CP	6905 Knightdale Blvd	Knightdale	NC	27545	Owned
Pardee Center For Women's Health Clinic	UNC	512 Sixth Avenue	Hendersonville	NC	28739	Owned
Pardee Family Medicine Associates Clinic	UNC	705 D Sixth Avenue West	Hendersonville	NC	28739	Owned
Pardee Family Medicine Associates Clinic	UNC	643 Fifth Avenue West	Hendersonville	NC	28739	Owned
Pardee Family Medicine Associates Clinic	UNC	143 Lake Lure Hwy	Bat Cove	NC	28710	Owned
Pardee Family Medicine Associates Clinic	UNC	12 B Cane Creek Road	Fletcher	NC	28732	Owned
Pardee Flat Rock Family Health Center Clinic	UNC	841 Case Street	Flat Rock	NC	28731	Owned
Pardee Hendersonville Family Health Center Clinic	UNC	6503 Brevard Road	Etowah	NC	28729	Owned
Pardee Internal Medicine Associates Clinic	UNC	710 N. Justice Street	Hendersonville	NC	28791	Owned
Pardee Internal Medicine Associates Clinic	UNC	705 A Sixth Avenue West	Hendersonville	NC	28739	Owned
Pardee Mills River Family Health Center Clinic	UNC	9 Crossroad Drive	Mills River	NC	28759	Owned
Pardee Urological Associates Clinic	UNC	1216 Sixth Avenue West	Hendersonville	NC	28739	Owned
Pittsboro Family Medicine	UNC	855 East Street	Pittsboro	NC	27312	Owned
Rex Family Practice of Knightdale	REX	6602 Knightdale Blvd	Knightdale	NC	27545	Owned
Rex Family Practice of Wakefield	REX	11200 Governor Manly Way	Raleigh	NC	27614	Owned
Rex Primary Care of Cary	REX	1515 SW Cary Parkway	Cary	NC	27511	Owned
Rex Primary Care of Holly Springs	REX	208 Village Walk Drive	Holly Springs	NC	27540	Owned
Rex/UNC Family Practice of Panther Creek	REX	10030 Green Level Church Road	Cary	NC	27519	Owned
Sanford Hematology Oncology	UNC	1212 Central Drive	Sanford	NC	27330	Owned
Sanford Specialty Clinics	UNC	1301 Central Drive	Sanford	NC	27330	Owned
UNC Allergy Clinic	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Anticoagulation Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Carolina Clinic	UNC	300 Meadowmont Village Circle	Chapel Hill	NC	27517	Owned
UNC Dermatology Clinic	UNC	410 Market Street	Chapel Hill	NC	27516	Owned
UNC Diabetes Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Ear, Nose, & Throat Clinic	UNC	5915 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Family Medicine Clinic	UNC	590 Manning Drive	Chapel Hill	NC	27599	Owned
UNC Family Medicine Clinic	UNC	Manning Drive & US 15-501	Chapel Hill	NC	27514	Owned
UNC Family Medicine at Hillsborough	UNC	2201 Old N.C. Highway 86	Hillsborough	NC	27278	Owned
UNC Hearing & Communication Center	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Cardiac Rehabilitation	UNC	100 Sprunt Street	Chapel Hill	NC	27517	Owned
UNC Hospitals [illegible]trics	UNC	6011 & 6013 Farringto[illegible]oad	Chapel Hill	NC	27517	Owned

UNC Hospitals Hearing & Voice Center	UNC	5915 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Heart & Vascular Center	UNC	300 Meadowmont Village Circle	Chapel Hill	NC	27517	Owned
UNC Hospitals Hematology Clinic	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Rheumatology	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Hospitals Surgical Oncology	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Internal Medicine Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Nephrology & Hypertension Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC OB/Timberlyne	UNC	112 Perkins Drive	Chapel Hill	NC	27514	Owned
UNC Orthopaedics Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Orthopaedics Clinic	UNC	6011 & 6013 Farrington Road	Chapel Hill	NC	27517	Owned
UNC Plastic Surgery Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Pulmonary Clinic	UNC	100 Mason Farm Road	Chapel Hill	NC	27599	Owned
UNC Specialty Women's Center	UNC	4420 Lake Boone Trail	Raleigh	NC	27607	Owned
University Internal Medicine at Chapel Hill North	UNC	1838 Martin Luther King, Jr. Blvd	Chapel Hill	NC	27514	Owned
University Pediatrics at Highgate	UNC	5322 Highgate Drive	Durham	NC	27713	Owned
University Pediatrics at Highgate	UNC	3841 Browning Place	Raleigh	NC	27609	Owned


Wake Forest Baptist Health
= WFBH Hospitals
= WFBH MD Offices/Clinics
= WFBH Non-Hospital Facilities
VIRGINIA
TENNESSEE
NORTH CAROLINA
SOUTH CAROLINA
Winston-Salem
Greensboro
High Point
Lexington
Charlotte
Durham
Raleigh
Chapel Hill
Burlington
Statesville
Hickory
Salisbury
Kannapolis
Concord
Asheboro
Thomasville
Mount Airy
Martinsville
Danville
Boone
Wilkesboro
Lenoir
Cary
Apex
Fayetteville
Spartanburg
Greenville
Gastonia
Rock Hill
Monroe
Sanford
Bristol
Kingsport
Johnson City

Wake Forest Baptist Health Hospitals	Address	City	State	Zip Code	
NC Baptist Hospital	Medical Center Blvd	Winston-Salem	NC	27157	Owned
Davie County Hospital	223 Hospital Street	Mocksville	NC	27028	Owned
Lexington Memorial Hospital	250 Hospital Drive	Lexington	NC	27297	Owned

Wake Forest Baptist Health Non-Hospital Facilities	Address	City	State	Zip Code
Alamance Regional Medical Center (Surgery - Cardiothoracic)	1240 Huffman Mill Road	Burlington	NC	27215
Alamance Regional Medical Center (Surgery - Urology)	1236 Huffman Mill Road	Burlington	NC	27215
Allene Broyhill Stevens Heilman Cancer Center at Caldwell Hospital	321 Mulberry Street SW	Lenoir	NC	28645
AMOS Cottage	3325 Silas Creek Parkway	Winston-Salem	NC	27103
Best Health At Hanes Mall	3320 Silas Creek Parkway	Winston-Salem	NC	27103
Cancer Center of Davidson County	107 West Medical Park	Lexington	NC	27292
Center For Maternal Fetal Care	802 Green Valley Road	Greensboro	NC	27408
Community Health Systems, Inc.	410 Carriage Drive	Beckley	WV	25801
CompRehab Fitness Center & Outpatient Rehab	131 Miller Street	Winston-Salem	NC	27157
Comprehensive Cancer Center of WFU at Elkin	300 Johnson Ridge Road	Elkin	NC	28621
Comprehensive Cancer Center of WFU at Mt. Airy	450 Price Street	Mount Airy	NC	27030
Elkin Dialysis Center	941 Johnson Ridge Road	Elkin	NC	28621
High Point Kidney Center	1900 Westchester Drive	High Point	NC	27262
King Dialysis Center	140 Moore Road	King	NC	27021
Lake Norman Dialysis Center	154 Professional Park Drive	Mooresville	NC	28117
Lexington Center for Gastrointestinal Health	11 Medical Park Drive	Lexington	NC	27292
Lexington Dialysis Center	233 Anna Lewis Drive	Lexington	NC	27292
Lexington Medical Center Bariatric Program	10 Medical Park Drive	Lexington	NC	27292
Lillian J. Phillips Cancer Pavilion	601 North Elm Street	Greensboro	NC	27261
Memorial Mission Hospital - Graham Childrens Center	11 Vanderbilt Park Drive	Asheville	NC	28803
Miller Street Dialysis Center	120 Miller Street	Winston-Salem	NC	27103
Mount Airy OB/GYN Center (Abdominal Ultrasound)	510 S. South Street	Mount Airy	NC	27030
Mt. Airy Dialysis Center	1280 Newsome Street	Mt. Airy	NC	27030
Northside Dialysis Center	500 West Hanes Mill Road	Winston-Salem	NC	27105
Piedmont Dialysis Center	655 Cotton Street	Winston-Salem	NC	27101
Regional Cancer Center at Hugh Chatham	180 Parkwood Drive	Elkin	NC	28621
Salem Kidney Center	2705 Boulder Park Court	Winston-Salem	NC	27101
Sports Medicine at Comp Rehab	131 Miller Street	Winston-Salem	NC	27103
Statesville Dialysis Center	627 Signal Hill Drive Ext.	Statesville	NC	28625
Stokes Medical Center Park- Hospice and Physical Therapy	167 Moore Road	King	NC	27021
Thomasville Dialysis Center	10 Laura Lane	Thomasville	NC	27370
Triad Dialysis Center	4370 Regency Drive	High Point	NC	27265
Wake Forest Baptist Center For Reproductive Medicine	131 Miller Street	Winston-Salem	NC	27157
Wake Forest Baptist Center For Reproductive Medicine	526 Elam Avenue	Greensboro	NC	27403
Wake Forest Baptist Imaging	265 Executive Park Blvd	Winston-Salem	NC	27103
Wake Forest Baptist Outpatient Psychiatric Facility	791 Jonestown Road	Winston-Salem	NC	27103
Wake Forest Baptist Wound Care	Medical Center Blvd	Winston-Salem	NC	27157
Ward A. Riley Ultrasound Center	2000 West 1st Street	Winston-Salem	NC	27103

West Iredell Dialysis Center	115 Westbrook Lane	Statesville	NC	28625
Wound Care Center Of Lexington Medical Center	10 Medical Park Drive	Lexington	NC	27292
Yadkin Dialysis Center	225 Washington Street	Yadkinville	NC	27055

Wake Forest Baptist Health Physician Practices & Clinics	Address	City	State	Zip Code
Boone Cosa-Medical Genetics Clinic	2359 Highway 105	Boone	NC	28607
Brenner Children's Clinic East (Cardiology)	802 Green Valley Road	Greensboro	NC	27408
Brenner Children's Clinic East (GI)	802 Green Valley Road	Greensboro	NC	27408
Brenner Children's Clinic East (Hematology & Oncology)	802 Green Valley Road	Greensboro	NC	27408
Brenner Children's Clinic East (Pediatrics)	802 Green Valley Road	Greensboro	NC	27408
Brenner Children's Clinic East (Urology)	802 Green Valley Road	Greensboro	NC	27408
Brenner Children's Clinic West (Cardiology)	555 Kitchings Drive	Statesville	NC	28677
Brenner Children's Clinic West (Medical Genetics)	555 Kitchings Drive	Statesville	NC	28677
Brenner Children's Clinic West (Urology	555 Kitchings Drive	Statesville	NC	28677
Cardiology - Wilkes	1370 West D Street	North Wilkesboro	NC	28659
Coliseum Eye Associates	631 Coliseum Drive	Winston-Salem	NC	27106
Davidson Eye Associates	2 Hospital Drive	Lexington	NC	27292
Davidson Internists	105 Hospital Drive	Lexington	NC	27292
DEAC Clinic Free Clinic Run by Students	2135 New Walkertown Road	Winston-Salem	NC	27101
Dermatology Clinic	4618 Country Club Road	Winston-Salem	NC	27104
Downtown Health Plaza	1200 Martin Luther King. Jr. Drive	Winston-Salem	NC	27101
Endocrinology & diabetes Clinic	500 Shepherd Street	Winston-Salem	NC	27103
Fairbrook Family Practice (Cardiology)	1985 Startown Road	Hickory	NC	28602
Fairbrook Medical Clinic - Medical Genetics	1985 Startown Road	Hickory	NC	28602
Family Medicine - Reynolda	3020 BonBrook Drive	Winston-Salem	NC	27106
Foothills Primary Care	910 Worth Street	Mt. Airy	NC	27030
Healthcare Center Davie	1188 Yadkinville Road	Mocksville	NC	27028
Heart Center at Highland Oaks	755 Highland Oaks Drive	Winston-Salem	NC	27103
Hillsdale Family Practice	147 Peachtree Lane	Advance	NC	27006
Hugo Tettamanti, M.D. and Anotonia Tellamanti, M.D.	2928 Maplewood Avenue	Winston-Salem	NC	27103
Joint Replacement Center of Lexington Medical Center	250 Hospital Drive	Lexington	NC	27292
Lewisville Family Physicians	6614 Shallowford Road	Lewisville	NC	27023
Lexington Center for Family Health	101 West Medical Park Drive	Lexington	NC	27292
Lexington Memorial Hospital	250 Hospital Drive	Lexington	NC	27297
Lexington Surgical Associates	10 Medical Park Drive	Lexington	NC	27292
LexMedical Adolescent Center	14 Medical Park Drive	Lexington	NC	27292
LexMedical Pediatrics	8 Medical Park Drive	Lexington	NC	27292
MedChoice Urgent Care and Occupational Health	58-C US Hwy 64 West	Lexington	NC	27295
Mocksville Pediatrics	113 Marketplace Drive	Mocksville	NC	27028
Mt. Airy Dermatology	911 Worth Street	Mount Airy	NC	27030
Nephrology - Lexington Clinic	233 Anna Lewis Drive	Lexington	NC	27292
Newsome Family Practice	304 Mountainview Road	King	NC	27021
North Davidson Bone and Joint Center	799 Hickory Tree Road	Winston-Salem	NC	27127
North Davidson Center For Family Health	799 Hickory Tree Road	Winston-Salem	NC	27127
North Wilkesboro CDSA Medical Genetics	505 13th Street	North Wilkesboro	NC	28659
OB Gyn Comprehensive Fetal Care Center	500 Shepherd Street	Winston-Salem	NC	27103

Peace Haven Family Medicine	1930 North Peace Haven Road	Winston-Salem	NC	27106
Peace Haven Internal Medicine	1930 North Peace Haven Road	Winston-Salem	NC	27106
Pediatric Cardiology at PHC Martinsville	320 Hospital Drive	Martinsville	VA	24115
Pediatric Nephrology Clinic at Brenner Children's East	802 Green Valley Road	Greensboro	NC	27408
Pediatric Nephrology Clinic at Fairbrook Family Practice	1985 Startown Road	Hickory	NC	28602
Pediatrics Clemmons - Brenner Children's Hospital	5175 Old Clemmons School Road	Clemmons	NC	27012
Pine Ridge Family Practice - King	167 Moore Road	King	NC	27021
Reproductive Medicine Clinic - Greensboro	526 N. Elam Avenue	Greensboro	NC	27406
Rheumatology Clinic	500 Shepherd Street	Winston-Salem	NC	27103
Salisbury Pediatric Associates	129 Woodson Street	Salisbury	NC	28144
Sleep Clinic	420 High Street	Winston-Salem	NC	27101
Stokes Medical Center Park- Orthopedics	167 Moore Road	King	NC	27021
Stokes Medical Center Park- Pediatrics	167 Moore Road	King	NC	27021
Stokes Medical Center Park- Podiatry	167 Moore Road	King	NC	27021
University Dental Associates - Campus North	807 Spring Forest Road	Raleigh	NC	27609
University Dental Associates - Clemmons Village	6201 Town Center Drive	Clemmons	NC	27012
University Dental Associates - Comp rehab Plaza	131 Miller Street	Winston-Salem	NC	27103
University Dental Associates - Creedmoor	807 Spring Forest Road	Raleigh	NC	27609
University Dental Associates - Crownpoint	Ardis Road North	Charlotte	NC	28227
University Dental Associates - Durham Office	2609 North Duke Street	Durham	NC	27704
University Dental Associates - Hawthorne Practice	1615 South Hawthorne Road	Winston-Salem	NC	27103
University Dental Associates - Interchange	807 Spring Forest Road	Raleigh	NC	27609
University Dental Associates - Preston	1010 High House Road	Cary	NC	27513
University Dental Associates - SouthPark	2901 Coltsgate Road	Charlotte	NC	28211
University Dental Associates - University	8401 University Executive Parkway	Charlotte	NC	28262
University Dental Associates - Waverly	200 Keisler Drive	Cary	NC	27511
University Internal Medicine at Stratford Executive Park	500 Shepherd Street	Winston-Salem	NC	27103
Urology Clinical Offices	140 Charlois Boulevard	Winston-Salem	NC	27103
Viewmont Urology Clinic (Pediatric Urology)	1985 Startown Road	Hickory	NC	28602
Wake Forest Baptist Center For Reproductive Medicine - Beckley	Harper & Carriage Drive	Beckley	WV	25801
Wake Forest Univ Ophthalmic Consultants	1014 North Elm Street	Greensboro	NC	27401
Westgate Pediatrics	3746 Vest Mill Road	Winston-Salem	NC	27103
WFU Northwest Eye Center	1015 Worth Street	Mount Airy	NC	27030
Wilkes Internal Medicine	1916 West Park Drive	North Wilkesboro	NC	28659
Wilkes Pediatric Clinic	1925 West Park Drive	North Wilkesboro	NC	28659
Winston East Pediatrics	2295 East 14th Street	Winston-Salem	NC	27105
Women's Center of Lexington	7 Medical Park Drive	Lexington	NC	27292
Women's Center of North Davidson	799 Hickory Tree Road	Winston-Salem	NC	27127
Women's Center of Salisbury	1107 Statesville Blvd	Salisbury	NC	28144

MISSION MEMORIAL

Type	Name	Address	City	State	ZIP		County
HOSPITALS	Blue Ridge Regional Hospital	125 Hospital Drive	Spruce Pine	NC	28777		MITCHELL
HOSPITALS	McDowell Hospital	430 Rankin Drive	Marion	NC	28752		MCDOWELL
HOSPITALS	Mission Hospital	509 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
HOSPITALS	Mission Children's Hospital	509 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
HOSPITALS	ST. Joseph	429 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
OUTPATIENT	Asheville Surgery Center	5 Medical Park Drive	Asheville	NC	28803		BUNCOMBE
OUTPATIENT	Reuter Outpatient Center	11 Vanderbilt Park Drive	Asheville	NC	28803		BUNCOMBE
HOSPITALS	Transylvania Regional Hospital	260 Hospital Drive	Brevard	NC	28712	MANAGED	TRANSYLVANIA
Physicians	Asheville Cardiology Associates	5 Vanderbilt Drive	Asheville	NC	28803		BUNCOMBE
Physicians	Asheville Cardiology Associates	89 Medical Park Drive	Brevard	NC	28712		TRANSYLVANIA
Physicians	Asheville Cardiology Associates	55 Medical Park Drive,	Franklin,	NC	28734		MACON
Physicians	Asheville Cardiology Associates	691 Blythe Street Ct.	Hendersonville	NC	28739		HENDERSON
Physicians	Asheville Cardiology Associates	128 Dr. Henry Norris Dr.	Rutherfordton	NC	28139		RUTHERFORD
Physicians	Asheville Cardiology Associates	80 Healthcare Dr.	Sylva	NC	28779		JACKSON
Physicians	Fullerton Genetics Center	11 Vanderbilt Drive	Asheville	NC	28803		BUNCOMBE
Physicians	Haywood Family Medicine	490 Hospital Drive	Clyde	NC	28721		HAYWOOD
Physicians	Mission Neurology Associates	890 Hendersonville Road	Asheville	NC	28803		BUNCOMBE
Physicians	Mission Senior Services	428 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
Physicians	Mission Sports Medicine	428 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
Physicians	Tallulah Health Center	409 Tallulah Road	Robbinsville	NC	28771		GRAHAM
Physicians	Vista Family Health	2585 Hendersonville	Arden	NC	28704		BUNCOMBE
Physicians	West Buncombe Family	91 Mt. Carmel Road	Asheville	NC	28806		BUNCOMBE
Physicians	Asheville Family Medicine	41 Oakland Drive	Asheville	NC	28801		BUNCOMBE
Physicians	Mission Family Medicine	5623 Hwy 221 South	Marion	NC	28752		MCDOWELL
Physicians	Western Carolina Family Practice	1257 Hendersonville Road	Asheville	NC	28803		BUNCOMBE
Physicians	Asheville Hospitalist Group	430 Rankin Drive	Marion	NC	28752		MCDOWELL
Physicians	Mission Staff Health	50 Doctors Drive	Asheville	NC	28801		BUNCOMBE
Physicians	Mission Children's Specialists	509 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
Physicians	Psychiatric Hospitalist	428 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE
Physicians	Wound Healing & Hyperbaric Medicine	445 Biltmore Avenue	Asheville	NC	28801		BUNCOMBE

PETITION TO THE NORTH CAROLINA STATE HEALTH COORDINATING COUNCIL REGARDING STATE MEDICAL FACILITIES PLAN POLICY AC-3

Novant Health, Inc. (Novant) hereby petitions the North Carolina State Health Coordinating Council (SHCC) to repeal or revise State Medical Facilities Plan (SMFP) Policy AC-3 in the 2012 SMFP (hereafter referred to as Policy AC-3).

This Petition was originally filed on August 2, 2010 (the 2010 Petition). The Staff of the Medical Facilities Planning Section recommended, and the SHCC agreed, that the 2010 Petition was filed untimely because it addressed an issue that has a statewide effect. Novant was invited to re-submit its Petition in 2011. This Petition incorporates information from the 2010 Petition and also presents updated information.

EXECUTIVE SUMMARY

There are four academic medical centers (AMCs) in North Carolina: North Carolina Baptist Hospital, Duke University Medical Center, University of North Carolina Hospitals at Chapel Hill and Pitt County Memorial Hospital. Policy AC-3 exempts the four AMCs from the need determinations in the SMFP, provided the AMCs meet certain conditions.

There are significant legal and health policy issues associated with Policy AC-3 as it is presently written. While eliminating all aspects of this Policy would be the surest way of protecting North Carolinians from unnecessary duplication of health services that drive up health care costs, Novant recognizes that AMCs may have some unique needs that merit special consideration in the health planning process. For that reason, Novant has proposed a list of proposed modifications to Policy AC-3 in the event the SHCC is not inclined to

eliminate this policy entirely. These modifications will bridge the gap between the legal and policy problems associated with Policy AC-3 and the AMCs' legitimate needs. Following is a summary of the legal and health policy problems associated with Policy AC-3:

1. **Policy AC-3 violates the CON Law:** From a legal perspective, there is an irreconcilable conflict between Policy AC-3, which creates an exemption from the need determinations in the SMFP for four providers, and the Certificate of Need (CON) Law, N.C. Gen. Stat. § 131E-175 *et seq.*, which makes the need determinations in the SMFP binding on *all* providers. Novant has filed a Declaratory Ruling Request with the Department asking it to declare that Policy AC-3 in the 2011 SMFP is invalid.[1]

2. **Policy AC-3 conflicts with North Carolina's Health Policy:** North Carolina's stated health policy is to limit the development of health care services to those that are actually needed. *See* N.C. Gen. Stat. § 131E-175(4), (6), (7). North Carolina has therefore chosen a careful and deliberate health planning process. The purpose of the health planning process is to control cost, ensure access for all North Carolinians and avoid unnecessary duplication of services. *See* N.C. Gen. Stat. § 131E-175. The CON Law and the need determinations in SMFP are the bedrock of the health planning process in North Carolina. Novant strongly supports the work that the SHCC and the Medical Facilities Planning staff do every year in developing the SMFP, and believes that the need determinations reflect the additional facilities and services that are needed in North Carolina. Policy AC-3 undermines North

[1]Novant does not intend to reargue the Declaratory Ruling Request in this Petition. This Petition focuses on the health policy problems associated with Policy AC-3, and how those problems can be solved by adopting the modifications suggested in this Petition.

Carolina's health policy and its health planning process by allowing the four AMCs to avoid the need determinations in the SMFP and develop services even when the SMFP expressly states that there is no need for these services, and even when the services at issue are routinely provided by non-AMCs. Of all the States with health planning processes, only North Carolina gives a special exemption for AMCs.

3. **Policy AC-3 has outlived its useful life:** Policy AC-3 was first enacted (under a different title) in the 1983 SMFP, at a time when AMCs offered services far different from those offered by tertiary hospitals in the community. Given the vast changes that have occurred in health care since 1983, it is appropriate for the SHCC to consider whether it is still necessary, almost thirty years later, to "protect" AMCs and exempt them from the need determinations in the Plan.

4. **Policy AC-3 has been abused:** Rather than meeting the legitimate needs of AMCs, Policy AC-3 can be used, and has been used as a vehicle to thwart health planning and give an unfair competitive advantage to AMCs. As discussed below, North Carolina Baptist Hospital (NCBH) filed an AC-3 application in 2010 proposing to add seven new operating rooms in Forsyth County, when there is a surplus of 5.52 operating rooms in that county, and all adjacent counties in the area likewise show a surplus of operating rooms. Additionally, in 2009, NCBH's associated medical school, Wake Forest University Health Sciences, acquired three severely underutilized operating rooms at Plastic Surgery Center of North Carolina. The NCBH Policy AC-3 application gives no consideration as to how those operating rooms might have been used to meet NCBH's purported needs. The proposed ASC will perform garden variety ambulatory procedures like cataracts removal and

tonsillectomies. There was no clear "academic" reason for this project. The decision on that CON application, which has been appealed, shows that the CON Section did not properly apply Policy AC-3, and has therefore not only allowed NCBH to increase the surplus of operating rooms, but also allowed NCBH and WFUHS to hold on to three severely underutilized operating rooms for other purposes.[2]

5. **Policy AC-3 is not in the public interest:** North Carolina's health policy is to limit the development of additional health care facilities and services to only those that are actually needed. North Carolina has determined that allowing providers to unnecessarily duplicate existing services drives up cost and ultimately harms the public welfare. For this reason, need determinations are placed in the SMFP to regulate the addition of new health care facilities and services. Policy AC-3, which allows AMCs to avoid these need determinations, is directly contrary to the public interest.

6. **Policy AC-3 gives AMCs an unfair advantage:** By allowing the AMCs to avoid the need determinations in the SMFP, Policy AC-3 allows four providers in this state to propose facilities and services that their non-AMC competitors cannot propose, unless and until a need determination appears in the SMFP. This gives the AMCs a tremendous competitive advantage over their non-AMC competitors.

As noted above, Novant recognizes that there may be limited and legitimate circumstances that may prompt an AMC to seek to add services or facilities for which the

[2]Four months after the Agency decided the AC-3 application, NCBH's affiliate, Wake Forest Ambulatory Ventures, LLC, filed a CON application proposing to move the PSCNC operating rooms to an outpatient site in Clemmons.

SMFP does not contain a need, such as a demand from a graduate medical education accreditation body or a desire to acquire esoteric technology that is used mainly in the academic setting.

Novant has therefore proposed in this Petition several modifications to current Policy AC-3 that would make it more consistent with North Carolina's health policy and planning process, while also accommodating the AMCs' unique situations. Under Novant's proposal, there would be no more AC-3 exemptions from the need determinations in the SMFP. Rather, a special needs petition would be filed by the AMC, and if approved, a special need determination would be placed in the SMFP, similar to what has been done recently with regard to linear accelerator and operating room demonstration projects. Novant's recommendations are as follows:

1. AMCs that wish to add services, facilities or equipment to accommodate the expansion of faculty, students or residents, teaching or research activities, or requirements of specialty education accrediting bodies must first file a special needs petition with the SHCC. This would apply to the range of assets (beds, operating rooms, equipment, etc.) limited by the SMFP. The special needs petition shall utilize the factors contained in current Policy AC-3, as herein modified. Special emphasis must be placed on why existing non-AMCs that are within 20 miles of the AMC that offer the service the AMC proposes to offer cannot effectively meet the proposed need. For example, if an AMC proposes to add operating rooms when there is no need in the SMFP for operating rooms, it must demonstrate clearly and convincingly why other non-AMCs that have operating rooms within 20 miles of the AMC cannot meet this need. Requiring

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the AMC to file a special needs petition harmonizes the Policy AC-3 process with the CON Law (and in particular, Criterion 1 of the CON Law, N.C Gen. Stat. § 131E-183(a)(1), which says that the need determinations in the SMFP are determinative). At the present time, Policy AC-3 applications ignore the need determinations in the SMFP, and for that reason, the present Policy AC-3 process violates the CON Law. It is not unduly burdensome for AMCs to file petitions. Most Policy AC-3 applications are filed because an AMC voluntarily decides to do something, not because of exigent circumstances. Moreover, one AMC, Pitt, successfully used the petitioning process in 2007 to satisfy its need for additional operating rooms.

2. AMCs seeking to add beds, operating rooms or equipment when the then-current SMFP shows a surplus of these assets in the county where the assets are proposed to be located, or in any county within twenty miles of where these assets are proposed to be located, must demonstrate by clear and convincing evidence in the special needs petition why the SHCC should permit an increase in the inventory of these assets and why the proposed increase does not conflict with the CON Law.

3. If the special needs petition is granted, the need shall be placed in the next year's SMFP, and anyone may apply to meet the need.

4. AMCs who are approved for these special needs projects (hereafter referred to as Academic Projects) must report all Academic Project assets (beds, operating rooms and equipment) on the appropriate annual license renewal application or registration form for the asset. The information to be reported for the Academic

Project assets should include: (1) inventory or number of units of Academic Project CON approved beds, operating rooms or equipment; (2) the annual volume of days, cases or procedures performed for the reporting year on the Academic Project approved asset; and (3) the patient origin by county. This would allow providers who are not AMCs to keep better track of the Academic Project assets that compete with them. It would also provide a more complete picture of the total CON-approved assets available to serve patients in North Carolina, and may also be useful in determining future health care needs in North Carolina.

5. All Academic Project CON applications must contain written statements from all providers of comparable services in the 20 mile radius of the AMC indicating they cannot meet the need described in the Academic Project CON application.

6. An AMC that is awarded a CON pursuant to an Academic Project application must submit annual reports to the Medical Facilities Planning Section and the CON Section for each of the first five operating years of the project that shall include:

a. the number of persons treated by the new institutional health service for which the Academic Project CON was approved;

b. the number of insured, underinsured and uninsured patients served by type of payment categories;

c. a detailed description of how the new institutional health service is operating in compliance with the representations the applicant made in its application;

d. a detailed description of how the new institutional health service promoted the three basic principles of the SMFP: safety and quality, access and value;

e. a detailed description of how the new institutional health service complemented a specified and approved expansion of the number or types of students, residents or faculty; or

f. a detailed description of how the new institutional health service accommodated patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or

g. a detailed description of how the new institutional health service accommodated changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

These reporting requirements, which are modeled after the rules that were adopted for the 2009 linear accelerator demonstration project, for development of a multidisciplinary prostate health center, and the 2010 single specialty ambulatory surgery center demonstration projects, serve two purposes: (1) the Medical Facilities Planning Section receives data that can be used for further study and analysis; and (2) the CON Section receives information so that it can determine whether the applicant is in material compliance with the representations made in its application. Presently, there is no way to verify whether Policy AC-3 assets are actually being used for teaching or research, or have directly furthered the AMC's academic mission, as opposed to its competitive interests, because the CON progress report forms do not capture this information. Given the considerable economic benefits associated with the CON approvals that may flow from these special need petitions, this should not be viewed as unduly burdensome to the AMCs.

7. Special rules should also be adopted by the Department for the review of Academic Project applications which are designed to ask specific questions concerning how the project accommodates the purported teaching and research

need or the requirement of the specialty education accrediting bodies. The NCBH AC-3 application, discussed later in this document, shows that the CON Section does not always rigorously apply the Policy AC-3 requirements and that further guidance in the form of rules is needed. Novant realizes the SHCC does not implement CON regulations, but this factor is on the list of modifications so that a complete picture is presented concerning how the Policy AC-3 regime could be overhauled to ensure that the stated purpose of the CON Law is being met.

Identification of Petitioner

Novant is a non-profit corporation that operates the following hospitals in North Carolina: Forsyth Medical Center, Medical Park Hospital, Thomasville Medical Center, The Presbyterian Hospital, Presbyterian Hospital Huntersville, Presbyterian Hospital Matthews, Presbyterian Orthopaedic Hospital, Rowan Regional Medical Center, Brunswick Community Hospital and Franklin Regional Medical Center. In March 2011, Novant will open Kernersville Medical Center, a 50-bed community hospital in Kernersville. In the summer of 2011, Novant will open Brunswick Novant Medical Center to replace the existing Brunswick Community Hospital. Two of Novant's hospitals, Forsyth Medical Center and The Presbyterian Hospital, are full-service, tertiary hospitals that offer many of the same services that are found in the state's four AMCs: Duke University Medical Center, North Carolina Baptist Hospital, UNC Hospitals, and Pitt County Memorial Hospital.

Novant may be contacted about this Petition through its counsel, at the following addresses:

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POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS[3]

Policy AC-3 provides in pertinent part:

> *Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:*
>
> *1. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*
>
> *2. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*
>
> *3. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

[3] *See* 2011 SMFP, Chapter 4, at pages 22-23.

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital.

Any health service facility or health service facility bed that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that health service facility or health service facility beds in the North Carolina State Medical Facilities Plan.

In the State of North Carolina, only four facilities are permitted to use Policy AC-3: Duke University Medical Center, Pitt County Memorial Hospital, UNC Hospitals and North Carolina Baptist Hospital (collectively referred to in this Petition as the AMCs). The State of North Carolina is the only State in the country with a health planning process that gives AMCs an exemption from the health planning process.

As the plain language of the policy shows, these four hospitals receive a substantial benefit not available to any other healthcare provider in North Carolina because they are the only ones allowed to deviate from the need determinations in the SMFP. Simply because of their AMC status, they can apply to add services even where the SMFP expressly states that there is no need for additional services and even when the services in question are routinely provided by non-AMCs. This benefit extends to all kinds of SMFP-limited services such as beds (acute beds, ICU beds, psychiatric beds, rehabilitation beds, SNF beds, adult care home beds and hospice beds), operating rooms and medical equipment (such as PET scanners, MRI scanners, linear accelerators and cardiac catheterization units) regardless of capital cost. Thus, all the work that the SHCC does in developing the need determinations in the SMFP,

which is in turn presented to the Governor for her signature, is undone on an ad-hoc, case-by-case basis via Policy AC-3. As explained below, North Carolina's health policy does not support this unpredictable deviation from the health planning process.

Reasons for Proposed Adjustment

I. POLICY AC-3 CONFLICTS WITH NORTH CAROLINA'S HEALTH POLICY.[4]

A. The CON Law Clearly Articulates North Carolina's Health Policy.

The findings of fact in the CON Law, N.C. Gen. Stat. § 131E-175, clearly set forth North Carolina's health policy.

> (4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.
> ...
> (6) That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.
>
> (7) That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served.

N.C. Gen. Stat. § 131E-175(4), (6), (7).

[4]In response to the 2010 Petition, the AMCs argued that N.C. Gen. Stat. § 131E-183(b) provides evidence that Policy AC-3 is consistent with North Carolina's health planning process. They are wrong. N.C. Gen. Stat. § 131E-183(b) has nothing to do with Policy AC-3. It only says that the Department cannot adopt rules requiring an AMC to demonstrate that any facility or service at another hospital is being appropriately utilized in order for the AMC to be approved for a CON. Neither Policy AC-3, the SMFP nor the CON Law is a rule.

These findings make crystal clear the Legislature's concern over the development of costly, unneeded facilities. To ensure that only those services that are actually needed are developed, North Carolina adheres to a rigorous health planning process, which requires the development of an annual SMFP. *See* N.C. Gen. Stat. § 131E-177(4). The SMFP is subject to multiple public hearings, ensuring that all who have an interest in the topic have the opportunity to express their views about the additional health care services and facilities needed in North Carolina.

To determine which new institutional health services are actually needed, the SHCC and the Staff of the Medical Facilities Planning Section of DHSR spend countless hours each year developing the SMFP. Based on a thorough analysis of data and input from providers, the SMFP sets forth the need for new beds, operating rooms and certain types of medical equipment such as PET scanners, MRI units, linear accelerators, and cardiac catheterization units. The general rule is that a provider who files a CON application proposing to develop an SMFP-limited service cannot be approved *unless* there is a need for the service explicitly specified in the annual SMFP. *See, e.g.*,. N.C. Gen. Stat. § 131E-183(a)(1)("The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health office that may be approved.").

Policy AC-3 turns North Carolina's careful health planning process upside down and inside out. For example, in a county where there is a significant surplus of SMFP-regulated assets such as beds and operating rooms, and zero need in the SMFP for more of these assets,

an AMC can propose to spend millions of dollars adding more of these assets simply by having the Dean of its associated medical school sign a letter.

Thus, at the present time, there are two sets of health planning "rules" in North Carolina: one for the AMCs, and another set for everyone else. The AMCs may propose to add whatever they want, but all other providers remain subject to the SMFP. Yet the CON Law makes it clear there is only one set of rules, and everyone must abide by them. The CON Law does not allow anyone to "opt out" of the need determinations and invent their own need.

Therefore, Novant's recommendations for modification to Policy AC-3 attempt to harmonize the AMCs' legitimate teaching and research needs with the health policy mandate in the CON Law.[5]

B. Policy AC-3 Has Outlived Its Useful Life.

The origins of Policy AC-3 can be traced back to the 1983 SMFP and Policy B.5.:

> A hospital that has been designated an Academic Medical Center Teaching Hospital may receive a special exemption from the State Medical Facilities Plan, if justified. Requests for additional resources made by a formally designated Academic Medical Center Teaching Hospital which are subject to Certificate of Need review will be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the academic medical center teaching hospital from other acute care facilities.

See Exhibit A.

Since 1983, only the four AMCs have been designated as academic medical center teaching hospitals and therefore only these four AMCs have received this "special exemption" from the SMFP. With some wording and numbering changes,

[5]As noted above, North Carolina is the only state in the country that has this bifurcated approach to health planning.

Policy AC-3 and its predecessors have been in existence for twenty-eight years. As explained below, the evidence suggests that the policy has become outmoded.

In 1983, when the "special exemption" for AMCs was born, healthcare was obviously radically different from what we know today. Technology and pharmaceuticals (including medicines, contrast agents and chemotherapy mixtures), healthcare delivery systems, payment mechanisms and competition have all evolved dramatically over the last twenty-eight years.

For example, in the early 1980s, more care was provided in the hospital instead of in an outpatient setting. The AMCs were normally the first facilities to obtain the latest medical technology (*e.g.*, MRI scanners) and the first ones to perform medically-complex procedures such as open heart surgery. Over time, those circumstances have changed. Much more care is provided on an outpatient basis As shown in recent equipment and asset inventories included in the annual SMFPs, the "service gap" between AMCs and non-AMCs is much smaller today than it was in 1983. Many non-AMCs in this State provide open heart surgery and own technology such as MRI scanners, cardiac catheterization units, linear accelerators, PET scanners, and robotic surgical devices. Physicians own MRI scanners, CT scanners and ASCs. Services such as PET and MRI are provided on a mobile basis to a variety of host sites, such as hospitals, physician offices, and diagnostic centers. Cardiac catheterization services are also offered at outpatient sites and at a variety of smaller or rural hospitals to improve local access to this important diagnostic service. Lithotripsy, which was once believed to be the province of AMCs, is routinely performed in mobile lithotripters.

Geographically, healthcare services have become much more widely distributed throughout North Carolina. For example, a patient is no longer required to travel to a major metropolitan area for radiation therapy, as many smaller communities in North Carolina now have linear accelerators. *See* Exhibit B (Table 9E of the 2011 SMFP). This benefits cancer patients and their families by allowing them to seek care closer to home. Through SMFP Policy Gen-3, healthcare providers are also required to demonstrate that their services are economically accessible as well. While the future of health care reform is unknown, no one doubts that further changes in health care delivery will happen.

AMCs have also changed over time. While AMCs may have once been perceived as devoted solely to teaching and research and the treatment of the most complex cases, this is no longer the case. AMCs compete directly with non-AMCs (and this includes tertiary hospitals, community hospitals, ASCs, physician offices and diagnostic centers) for all kinds of patients. The NCBH AC-3 application discussed in this petition is a prime example of this phenomenon: NCBH is proposing to add seven new operating rooms to perform low-intensity procedures like tonsillectomies and cataracts removal. These procedures are done routinely in non-academic settings.

In the Triangle market of North Carolina, two AMCs, Duke University Medical Center and UNC Hospitals, compete vigorously not only with each other, but also with non-AMC providers such as WakeMed Hospitals, and imaging centers, and surgery centers owned by non-AMC providers and physicians. UNC Hospitals has recently been approved for a new imaging center in Orange County, as well as a new community hospital in Orange County. Duke has executed its competitive moves in the Triangle market by operating two community

hospitals, Durham Regional Medical Center in Durham and Duke Raleigh Hospital in north Raleigh, among other projects.

Comparing a hospital like Forsyth Medical Center with an AMC such as North Carolina Baptist Hospital (NCBH) is especially revealing, as it shows that the "service gap" at that level is indeed very small. Forsyth Medical Center, which is just three miles away from NCBH, provides nearly every service that NCBH provides.[6] The two hospitals have large, multi-county service areas and compete vigorously for patients. Forsyth and NCBH both have large and growing medical staffs. Both hospitals have large cancer programs. Both offer open heart and cardiac catheterization services. Forsyth provides one of the state's largest Neonatal Intensive Care programs. Forsyth also serves as a teaching site for many of NCBH's residency programs.[7] In fact, the vast majority of NCBH's OB/GYN residency program is conducted at Forsyth. According to the time period covered by the 2011 SMFP, Forsyth and its affiliates in Forsyth County provided significantly more acute days of care, outpatient surgeries, adult open heart surgeries, radiation oncology treatments, MRI scans, PET scans and cardiac catheterizations than did NCBH. Yet Forsyth *always* remains subject to the need determinations in the SMFP while NCBH does not.

While it is true that the case mix index (CMI) of the AMCs is higher than the CMI of the tertiary hospitals, the case mix differential does not, standing alone, justify treating AMCs differently from other providers. In fact, Policy AC-3 does not discuss CMI at all. If higher CMI alone were relevant, then Presbyterian Orthopaedic Hospital (POH), which has a

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[6]The major difference is that Forsyth does not have a trauma center designation and Forsyth does not provide burn intensive care services, gamma knife treatments, and transplant services. Due to the evolution of linear accelerator technology, FMC's cancer center does offer stereotactic radiotherapies on one of its linear accelerators.

[7]Other tertiary, non-AMC hospitals in North Carolina such as Carolinas Medical Center, Mission, New Hanover and Moses Cone, have residency programs.

significantly higher CMI than Duke, UNC, Pitt and NCBH, should be singled out for special treatment in the SMFP.[8] Yet POH does not receive special treatment in the SMFP because of its high CMI.

Given all of the changes in healthcare since the 1980s, given that the distinctions between certain tertiary hospitals and AMCs are becoming less apparent, and given that sophisticated health care services are increasingly available throughout North Carolina, it is appropriate to question whether a policy designed specifically for AMCs in 1983 needs to remain in the SMFP twenty-nine years later in 2012. It is also appropriate to ask why North Carolina is the only state in the country with a health planning process that "protects" its AMCs in this fashion. And from what exactly are the AMCs being "protected?"

Possibly the best evidence that Policy AC-3 has outlived its useful life is the fact that AMCs do not regularly use Policy AC-3 for their CON applications. In 2010, more than one hundred CON applications were filed; of these, only four were noted on the CON Monthly Reports as Policy AC-3 applications.

The hallmarks of an AMC are teaching and research. *See* page 22 of the 2011 SMFP. If Policy AC-3 were so important for teaching and research, one would expect to see many more AC-3 applications filed so that the AMCs could fulfill their teaching and research missions. The paucity of Policy AC-3 applications suggests that the AMCs are able to satisfy their teaching and research missions in other ways, such as through the need determinations in the SMFP, as well as the annual petitioning process to add need determinations – a process that

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[8]According to Solucient data for CY 2009, Presbyterian Orthopaedic Hospital's weighted CMI is 2.3038. Duke's weighted average CMI was 1.8988 with normal newborns and 1.9934 without. UNC's weighted average CMI was 1.5924 with normal newborns and 1.7043 without. Pitt's weighted average CMI was 1.6838 with normal newborns and 1.7912 without. NCBH's weighted average CMI was 1.8424 with normal newborns and 1.8432 without.

is open to everyone, including the AMCs. In fact, Pitt used the petitioning process in 2007 to propose new operating rooms in 2008. *See* Exhibit C. Pitt's actions show how the health planning process can work effectively, even for AMCs. Instead of deviating from the health planning process by using Policy AC-3, Pitt adhered to the process, filed a petition and later a CON application and was ultimately approved. Using Pitt's example, one of Novant's recommendations includes a requirement that the AMCs file special needs petitions if they wish to propose a facility, service or equipment for which there is no need in the SMFP.

It should also be noted that N.C. Gen. Stat. § 131E-179 specifically exempts from CON review the offering of a new institutional health service to be used solely for research. N.C. Gen. Stat. § 131E-179(c) even allows the new institutional health service to be used for patient care provided on an occasional and irregular basis and not as part of the research program. For example, if an AMC needs a PET scanner for research, the AMC could seek an exemption under N.C. Gen. Stat. § 131E-179, and could even use the PET scanner for occasional patient care. Thus, elimination or modification of Policy AC-3 will not unduly hamper the research or patient care activities of the AMCs.

There is also no evidence that Policy AC-3 has actually benefitted teaching or research in any meaningful way. That is because the AMCs are not required to report how, if at all, their AC-3 projects, *as actually implemented,* benefitted teaching or research. If Policy AC-3 is allowed to remain part of the SMFP, one of the suggested modifications at the end of this petition is that the AMCs report actual results so that the SHCC can measure whether Policy AC-3 actually benefits teaching or research.

Policy AC-3 may have been appropriate in the early 1980s, but times have changed greatly. The different and special treatment afforded AMCs can no longer be justified in today's environment.

C. Policy AC-3 Has Been Abused.

The AMCs may suggest that because Policy AC-3 is used relatively infrequently, there is little potential for abuse. They are wrong. Policy AC-3 has been abused, and the potential for even greater abuse looms.

The process by which an AMC receives an exemption under Policy AC-3 is simple. The AMC needs to demonstrate conformance with one of the three conditions in Policy AC-3 and comply with the 20-Mile Provision. The easiest way for the AMC to satisfy the conditions is to obtain a letter from the Dean of its associated Medical School. The Dean of the Medical School wants the CON application approved, so he or she is acting in obvious self-interest. The CON Section will typically accept the Dean's representations at face value and will not do any investigation to determine if these representations are actually correct.

The CON application filed by NCBH for an 8-operating room ambulatory surgery center project, Project I.D. G-8460-10 (the NCBH Project)[9] illustrates just how easy it is for an AMC to abuse Policy AC-3. The NCBH Project, with an estimated capital cost of approximately $39 million, was filed in January 2010 pursuant to Policy AC-3. The CON Section issued its decision on this application on June 10, 2010 and made its decision in less than the allotted 150 days for CON application review. Seven of the eight operating rooms in the NCBH Project are new operating rooms for Forsyth County; the eighth room is a relocation of an existing operating room. In addition, NCBH's Policy AC-3 CON Application

[9]Novant has appealed the Agency's decision on the NCBH Project.

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proposed two more operating rooms, with one for simulation training and one for robotics and micro-surgery training. In Forsyth County, Novant also offers robotic surgery, as does Moses Cone Hospital and High Point Regional Health System in nearby Guilford County.

The 2010 SMFP contained no need for additional operating rooms in Forsyth County; in fact, there is a surplus of 5.52 operating rooms in Forsyth County. There is also a surplus of operating rooms in each of the adjacent counties.

To satisfy the requirements of Policy AC-3 for the NCBH Project, NCBH simply provided a letter from the Dean of its affiliated medical school stating that the Project is '*necessary to complement a specified and approved expansion of the number of types of students, residents, or faculty.*' No recruitment plan for students, residents or faculty was filed with the CON application, so there was no way for the CON Section to verify the statements in the letter. Rather, the letter purported to give an estimate of surgeons that would be recruited over a 10-year time frame. No specific information was given about when the physicians would arrive over the 10-year horizon. No estimate was given concerning how many cases the surgeons would perform when and if they arrived in Winston-Salem. The CON Section accepted the letter at face value and did not question anything in it. The letter appears to have been copied over from a previously-approved Duke Policy AC-3 application.

With respect to the 20-Mile Rule, NCBH simply reported:

> *Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University reasearchers [sic], NCBH has concluded that expanding the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-*

> *campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice.*

See Exhibit D.

This answer does not address the specific requirement of Policy AC-3 that the AMC demonstrate that no non-AMC within 20 miles could meet the need. The answer reflects only NCBH's preference for keeping everything on its campus, which is not what the 20-Mile Rule requires. As reflected on page 4 of the Agency Findings, the Agency accepted this representation without question, even though NCBH did not answer the specific mandatory[10] requirement of Policy AC-3. *See* Exhibit E.

In comments that Novant filed against the NCBH Project, Novant pointed out not only that there are several Novant facilities with operating rooms within 20 miles of NCBH, but also stated that in 2009, NCBH's affiliate, Wake Forest University Health Sciences, had acquired Plastic Surgery Center of North Carolina, a facility in Winston-Salem with three underutilized operating rooms. *See* Exhibit F. According to the 2010 SMFP, in the time period October 1, 2007 through September 30, 2008, Plastic Surgery Center of North Carolina performed only 411 cases. The SMFP therefore classified Plastic Surgery Center as "underutilized." *See* Exhibit G. The Agency appeared not to have considered these comments because it approved the NCBH Project anyway, even though NCBH did not answer the 20-Mile Rule.

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[10]This provision of Policy AC-states, in part: "A project submitted by an Academic Medical Center Teaching Hospital under this Policy... *shall* also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital." (emphasis added).

According to the 2011 SMFP, Table 6A, Plastic Surgery Center of North Carolina performed significantly fewer cases (only 148) in FFY 2009 (Oct. 1, 2008 - Sept. 30, 2009) than in the prior year. The 2011 SMFP again identifies Plastic Surgery Center of North Carolina as an "underutilized facility." *See* Exhibit H. Applying the SMFP Operating Room Need Method formula and based on the FFY 2009 data, Plastic Surgery Center of North Carolina needs 0.12 operating rooms[11] and thus has a surplus of 2.88 operating rooms. The three operating rooms at Plastic Surgery Center of North Carolina were also identified as "chronically underutilized in the 2009 SMFP (page 72) and the 2008 SMFP (page 56). *See* Exhibits I and J. There is no evidence in the Agency's findings on the NCBH Project that the CON Section considered the chronic underutilization of the three operating rooms at Plastic Surgery Center of North Carolina. *See* Exhibit E. There is no explanation in the NCBH CON Application that it considered the alternative of relocating any of the Plastic Surgery Center operating rooms to the new proposed 8-operating room surgery center or otherwise using these rooms to satisfy a need. Finally, there was no discussion in the application about Novant's involvement over the last three decades training NCBH residents (including surgical residents) and medical students.

Despite these facts, NCBH was conditionally approved to develop seven new operating rooms in a county that has a surplus of 5.52 operating rooms. The 2011 SMFP, Table 6B (based on FFY 2009 data) shows that Forsyth County still has a surplus of 4.95, or almost five operating rooms. *See* Exhibit H. Had Forsyth Medical Center filed an application in 2010 proposing to develop seven new operating rooms, its application would have been summarily disapproved because it failed to comply with the SMFP. The CON Section testified that it

[11]Calculation: (148 cases X 1.5 hours per case) = 222 weighted OR case hours/1872 hours per OR per year = 0.12 ORs needed.

reviewed the NCBH application "differently" because it was a Policy AC-3 application. Yet there is nothing in the CON review criteria that allows for different treatment based on whether or not an application is filed under Policy AC-3.

The NCBH Project proposes to serve mainly patients from Forsyth County and other North Carolina counties in Health Service Area II and North Carolina counties near or adjacent to Health Service Area II. All of these counties have surplus operating rooms. At its new ASC, NCBH projects to perform only outpatient surgical procedures such as cataract surgery, arthroscopic knee surgery, tonsillectomy, ear drum openings and cystoscopy. *See* Exhibit D. These are routine outpatient surgical procedures that are performed at existing non-AMCs and ambulatory surgery centers within 20 miles of NCBH, such as Forsyth Medical Center, FMC's Hawthorne Surgery Center, and Medical Park Hospital. Furthermore, when FMC's Kernersville Medical Center, a new community hospital in eastern Forsyth County with 50 beds and 4 operating rooms opens in March, 2011, it will offer outpatient surgical procedures such as those proposed by NCBH for its new 8-operating room surgery center. There is nothing in the Policy AC-3 surgery center application to suggest that NCBH's seven new operating rooms will be used to accommodate a teaching or a research need that is unique to AMCs.

There is no need in the 2011 SMFP for additional operating rooms in Forsyth County, because there is a surplus of operating rooms in Forsyth County as discussed above. Since the physician recruitment discussed in the application was supposed to occur over a ten-year time frame, there were no exigent circumstances mandating that the NCBH application be filed in 2010. NCBH certainly could have filed a petition with the SHCC at the time it began planning for the project, just like its fellow AMC, Pitt, did in 2007. But following the "traditional"

planning process that everyone else is required to follow meant that others, including Forsyth, could have applied for those additional operating rooms. Using Policy AC-3 ensured that there would be no competition for those operating rooms.

Novant estimates that the NCBH Project could take away approximately one third to one half of Medical Park Hospital's outpatient surgical cases. Using 2009 outpatient surgical volumes for Medical Park Hospital, the estimated range of lost cases is 3,497 to 5,298 cases. The NCBH Project will also take patients away from Kernersville Medical Center. At this time, Novant estimates that the lost revenue attributable to the NCBH Project ranges from $7.8 million to $11.9 million.

The advantage that NCBH receives as a result of its AMC status is not the result of ordinary competition. Rather, Policy AC-3 has given NCBH an unfair advantage that allows NCBH to add substantial and unnecessary operating room capacity in Forsyth County solely because NCBH is an AMC.

The NCBH application is a prime example of how Policy AC-3 can be abused, but it is not the only example. Given that Policy AC-3 removes the constraints imposed by the SMFP, an AMC can propose to add beds, operating rooms, MRI scanners, PET scanners, lithotripters, dialysis units and any other SMFP-regulated assets anywhere in North Carolina at any time. Policy AC-3 does not require that the AMC seek approval for new CON assets only in the county that is home to the AMC. The probability that a Policy AC-3 CON application will be approved, either initially or in settlement, is high. As the decision on the NCBH application shows, the SHCC cannot count on the CON Section to "police" the use of Policy AC-3.

For this reason, Novant has proposed significant modifications to Policy AC-3 to ensure that the health planning process in North Carolina functions as the legislature intended.

D. Policy AC-3 Is Not In the Public Interest.

Based on the legislative intent of the CON Law as set forth in N.C. Gen. Stat. § 131E-175, our Legislature has decided that is in the public interest to specifically regulate the addition of new institutional health services, and to strictly limit the addition of certain facilities, services and equipment by imposing determinative limitations in the annual SMFP. The development of the SMFP is a public process in which all interested parties, including the AMCs, participate. Policy AC-3, which allows AMCs to bypass this public process to add facilities, services and equipment that have not been found to be needed, is directly contrary to the public interest as articulated by the Legislature.

The vast majority of AC-3 applications are filed because the AMC voluntarily decides to embark on an expansion of some kind (*e.g.*, faculty recruitment), not because an accreditation body such as the Accreditation Council for Graduate Medical Education threatened to revoke the AMC's accreditation unless it immediately added more beds, operating rooms or MRI scanners to handle teaching or research needs. There usually are not exigent circumstances associated with these applications, and the applications themselves do not usually happen overnight. As many of these projects are capital intensive, the planning process is done over a multi-month (sometimes multi-year) horizon, so the time it takes to go through the SHCC petitioning process can be factored in. That is what Pitt did in 2007 when it filed a petition to add more operating rooms in Pitt County.

Because AMCs are not required to report how much teaching and research they do with their Policy AC-3 assets, it is impossible for the Department or the SHCC to know the extent

to which Policy AC-3 is really used for teaching and research, as opposed to furthering an AMC's competitive interests.

Finally, the SHCC should not be persuaded by any suggestion that Policy AC-3 must remain intact because Policy AC-3 and its predecessors have been in place for many years. A policy cannot remain in place simply for the sake of history. As far as Novant is aware, this Petition (and its 2010 predecessor) is the first time anyone has asked the SHCC to undertake a thorough review of Policy AC-3.

E. Policy AC-3 Gives Academic Medical Centers an Unfair Advantage.

Policy AC-3 gives AMCs several unfair advantages not available to their non-AMC competitors.[12] First, Policy AC-3 allows the AMC to avoid the need determinations in the SMFP and thwart the beneficial aspects of competition.[13] Since multiple competing CON applications typically are filed for healthcare assets that are the subject of SMFP need determinations, Policy AC-3 allows AMCs to choose to avoid this type of competitive review, to the detriment of the AMCs' competitors in the service area. If an AMC wants additional beds or operating rooms, for example, it *always* has the ability to apply for them, even if the county in which the AMC is located has a significant surplus of these assets. Using Policy AC-3, an AMC could build an ASC in a county that has a surplus of operating rooms. The AMC can use its new ASC to draw patients from competitors. The competitors' option for responding to the competition created by the new ASC is limited when there is no need for additional operating rooms in the county where the AMC proposes to build the new surgery center.

[12] In response to the 2010 Petition, Duke argued that its competitors' failure to appeal Duke's Policy AC-3 applications meant that Policy AC-3 was not problematic. Silence should not be confused with acquiescence.
[13] *See* N.C. Gen. Stat. § 131E-183(a)(18a), which pertains to the requirement that the applicant must "demonstrate the expected effects of the proposed services on competition in the proposed service area."

Second, Policy AC-3 allows "double dipping." For example, an AMC can apply for operating rooms under Policy AC-3 *and* under a need determination if a county shows a need in the SMFP for more operating rooms. Thus, the AMC has doubled its chances of getting approved. The non-AMC competitor is limited to filing an application only when there is a need determination in the SMFP for more operating rooms.

Third, Policy AC-3 creates a strategic advantage for AMCs that is not available to non-AMCs. For example, in the case of a need determination for operating rooms in a county, the AMC could apply for the operating rooms under the SMFP *and* also use Policy AC-3 to propose additional acute care beds to develop a hospital. The non-AMC would not have the ability to develop a hospital unless it already had beds and was in a position to relocate them to build a hospital.

Fourth, any health service facility or health service facility bed that results from an AC-3 CON application is not included in the inventory in the SMFP. However, the volumes generated from the AC-3 project will be counted in the SMFP. Using the ASC example above, the operating rooms themselves will not be counted in the inventory of operating rooms, but the volume of cases performed in those rooms will be counted. This makes it appear that the AMC is "doing more with less" which gives the AMC an advantage in a subsequent CON review, based on the established SMFP operating room need formulas and the performance standards in the CON OR regulations, which are applicable to all operating room CON reviews. Further, when a need is generated under the SMFP for a new institutional health service, the AMC also has the opportunity to apply in that review. Alternatively, the AMC can forego the SMFP-scheduled review and argue that its Policy AC-3

created capacity makes additional services by other providers an unnecessary duplication of existing services.

Fifth, Policy AC-3 can be used for *any* SMFP-limited service such as beds, operating rooms and linear accelerators. Policy AC-3 projects are not limited to teaching or research activities; they can be used for *anything*. For example, there is no requirement that the ASC in the above example ever be used for the training of any medical students or residents.

IV. Further Reasons for the Proposed Adjustment

A. A statement of the adverse effects on providers or consumers of health services that are likely to ensue if the change is not made.

As illustrated above, Policy AC-3 violates the CON Law. Thus, it directly and adversely affects the consumers who are supposed to benefit from CON, and the non-AMC providers who are required to abide by the CON and health planning processes. As illustrated by the NCBH Project, Policy AC-3 allows AMCs to develop new institutional health services evén in cases where there is a surplus. This creation of unnecessary duplication harms providers, consumers and the health planning process, as recognized by N.C. Gen. Stat. § 131E-175(4).

B. A statement of the alternatives to the proposed change that were considered and not found feasible.

As explained in this Petition, Novant has proposed two alternatives: repealing Policy AC-3 entirely or modifying it. The modifications are suggested above, beginning on page 5. Novant does not believe that maintaining the status quo is a feasible option for the reasons explained in this Petition.

V. Evidence that the proposed change would not result in unnecessary duplication of health resources in the area.

This Petition does not request any additional health resources; rather, it is intended to prevent unnecessary duplication of services.

VI. Evidence that the requested change is consistent with the three Basic Principles governing the development of the N.C. State Medical Facilities Plan: Safety and Quality, Access and Value.

This Petition is consistent with the three basic principles governing development of the SMFP.

First, the modification of Policy AC-3 will not diminish safety and quality, and it will not harm the research activities of AMCs. As noted above, research activities are exempt from CON review under N.C. Gen. Stat. § 131E-179.

Second, modification of Policy AC-3 will not diminish geographic or economic access to healthcare. The purpose of Policy AC-3 is to promote teaching and research, not improve geographic or economic access to healthcare. There is no reason to believe that any AMC will be less able to meet the needs of those facing geographic or economic barriers to healthcare if Policy AC-3 is eliminated. If, however, an AMC believes that specific geographic and economic barriers exist such that an SMFP-limited service such as beds or operating rooms needs to be added to the SMFP, it can always petition the SHCC to add the need in the annual SMFP, and then all interested providers would be given the opportunity to comment on that petition at the SHCC and draft SMFP hearings, and later to compete to serve the need.

Third, modification of Policy AC-3 will not hamper an AMC's ability to deliver value-driven healthcare. If anything, modification of Policy AC-3 may reduce the unnecessary duplication of healthcare resources.

If the SHCC decides to modify Policy AC-3, the annual reporting requirement discussed in Novant's proposed modifications specifically requires the AMC to demonstrate that its project is consistent with the three basic principles.

Proposed Adjustment

For all of the foregoing reasons, Novant respectfully requests that the SHCC repeal or modify Policy AC-3. The list of proposed modifications is found beginning on page 5 of this Petition.

Novant appreciates the opportunity to present its views on Policy AC-3 and thanks the SHCC and Medical Facilities Planning staff in advance for their careful consideration of the information presented in this Petition.

Respectfully submitted this 2d of March, 2011.

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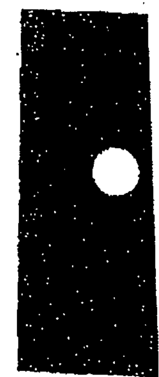
**EXHIBITS FOR NOVANT HEALTH, INC.'S
PETITION TO THE STATE HEALTH COORDINATING COUNCIL
REGARDING POLICY AC-3**

Exhibit	Name
A	Policy B.5 from 1983 SMFP
B	Table 9E from 2011 SMFP
C	Pitt County Memorial Hospital's 2007 Operating Room Petition
D	Excerpts from NCBH Application, Project I.D. No. G-8460-10
E	Agency Findings on Project I.D. No. G-8460-10
F	Comments in Opposition to Project I.D. No. G-8460-10
G	Excerpts from 2010 SMFP
H	Excerpts from 2011 SMFP
I	Excerpts from 2009 SMFP
J	Excerpts from 2008 SMFP

EXHIBIT A TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

1983



according to their size. Some of these hospitals may be experiencing difficulty in competing for patients with nearby larger community hospitals due to their small size, age, or other conditions. A few of these hospitals with low occupancy are located in counties close to large medical centers and some residents apparently are traveling to those large medical centers for care which normally could be provided by local community hospitals.

Reasons for low occupancy and bed need vary with the circumstances of a particular area. In areas where the number of licensed beds considerably exceeds the number of beds projected as needed within the next five years, consideration should be given to alternative or more efficient uses of these beds, including closing them permanently. In other areas, improved utilization of these beds would prevent the need to build additional beds elsewhere. This statement applies to the case involving other hospitals in the same county and to the situation in which patients are going to other counties, particularly large referral centers, for secondary care. A particularly opportune time for reduction of acute care bed capacity, where indicated, may be the time when renovation or replacement of a facility is being considered.

B.5. — SPECIAL CONSIDERATION FOR ACADEMIC MEDICAL CENTER TEACHING HOSPITALS

A hospital that has been designated an Academic Medical Center Teaching Hospital may receive a special exemption from the State Medical Facilities Plan, if justified. Requests for additional resources made by a formally designated Academic Medical Center Teaching Hospital which are subject to Certificate of Need review will be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the academic medical center teaching hospital from other acute care facilities.

Definition

An academic medical center teaching hospital is defined as a tertiary care facility which serves as the primary site for university-based teaching activities for the health sciences. The hospital associated with such an academic medical center would be engaged in the tripartite mission of education, research, and

patient care. Educational activities would include training programs for various levels of health professional students such as undergraduate, graduate, and professional programs in nursing, allied health, dentistry, pharmacy, health administration and others. Patient care would be offered on a broad spectrum, from primary care (including serving the patient care needs in the local community) to providing highly specialized treatment centers (including serving patients on a statewide, national, and perhaps even international basis). In terms of research, such a facility would serve to facilitate the development of new health care treatment modalities, as well as serving as a vanguard institution in developing new methods of diagnosis, disease prevention and health maintenance. In addition to clinical research, these institutions would be actively engaged in basic research in the health-related sciences and act as testing sites for development and refinement of new medical equipment and pharmaceuticals.

Characteristics of an Academic Medical Center Teaching Hospital

The major characteristics which distinguish the academic medical center teaching hospital from other hospitals is that it possesses all nine of the characteristics listed below:

(1) The presence of an academic health science center* within close proximity to the hospital and the use of that hospital as a primary teaching site for health professional students.

(2) The presence of a broad range of health science students at multiple levels of training.

(3) The existence of broad-based continuing education programs for health professionals.

(4) The presence of continuous and ongoing research programs, both basic and clinical, directed at the development of new modalities of diagnosis and treatment, disease prevention, health maintenance as well as the development and clinical evaluation of new medical equipment, pharmaceuticals and diagnostic/therapeutic procedures.

(5) The inclusion of individuals in the hospital's patient population who are being followed for specific research purposes.

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*Academic Health Science Center includes a school of medicine and at least one other health professional school or division.

(6) The presence of state and federally designated centers for the diagnosis and treatment of special conditions such as burns, cancer, trauma, perinatal disease, etc. within the hospital's programs.

(7) A patient population which reflects treatment of patients referred from extended geographical service areas within and outside the State of North Carolina for the treatment of unique and distinctive clinical conditions that require access to facilities that are uniquely equipped to treat such conditions.

(8) The provision of a broad spectrum of care ranging from primary to highly specialized levels, across a broad range of clinical specialties and in sufficient volume to meet the educational needs of the hospital's health science students.

(9) The presence of long-range plans which describes the anticipated future development and growth of the academic health science teaching hospital and its related health science programs.

Special Considerations

The Department of Human Resources in developing its Medical Facilities Plan did not attempt to take into account all of the special needs which may arise in the academic medical center teaching hospital resulting from the unique characteristics they possess which differentiate them from other types of acute care facilities. These characteristics should be taken into consideration in the evaluation of Certificate of Need applications from academic medical center teaching hospitals.

Designation Process

A hospital must be formally designated as an academic medical center teaching hospital by the Health Planning Section within the Division of Facility Services in order for this policy to be applicable. While some hospitals may engage in one or more of the activities described above, a hospital must submit evidence to demonstrate that it possesses all of the characteristics described in Items 1 through 9 in order to be designated as an academic medical center teaching hospital. A hospital desiring

this designation should submit its request along with appropriate evidence to:

Health Planning Section
Division of Facility Services
Department of Human Resources
P.O. Box 12200
Raleigh, North Carolina 27605-2200

After an application is reviewed, the applicant will be notified about its special designation status as an academic medical center teaching hospital. Once a hospital receives this status, the Certificate of Need Section will recognize this status and may allow for special exemptions from the State Medical Facilities Plan, if justified, for the formerly designated Academic Medical Center Teaching Hospital.

Once a facility receives this special designation, it can continue to maintain this status as long as the facility certifies each year that it continues to possess these characteristics. A statement on the annual licensure application form will be used to continue to monitor this designation. The State Medical Facilities Plan will contain a listing of hospitals which have been designated as academic medical center teaching hospitals.

B.6. — USE OF SWING BEDS

The Department of Human Resources supports the use of swing beds in providing long-term care services in rural acute care hospitals.

According to Public Law 96-499 (The Omnibus Reconciliation Act of 1980), Section 904, (the Swing Bed Provision), certain small rural hospitals may use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries and intermediate care facility (ICF) services to Medicaid beneficiaries. The hospital will be reimbursed at rates appropriate for these services, which are generally lower than hospital rates.

Although there has been State legislative action to contain the growth of long-term care beds, there is some evidence to support the need for additional long-term care beds in certain rural areas.

EXHIBIT B TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Murphy Medical Center	1	Cherokee	1*	0	0
Harris Regional Hospital	1	Jackson	1	4,338	4,338
NC Radiation Therapy - Franklin	1	Macon	1	633	633
Mission Hospitals (S) (b)	2	Buncombe	3	20,042	6,681
NC Radiation Therapy - Asheville	2	Buncombe	2	7,993	3,997
NC Radiation Therapy - Clyde	2	Haywood	1	4,090	4,090
NC Radiation Therapy - Marion	2	McDowell	1	1,605	1,605
Watauga Hospital	3	Watauga	1	4,169	4,169
Margaret Pardee Memorial Hospital	4	Henderson	1	6,791	6,791
NC Radiation Therapy - Brevard	4	Transylvania	1	2,580	2,580
NC Radiation Therapy - Hendersonville	4	Henderson	1	127	127
Catawba Valley Medical Center	5	Catawba	2	15,372	7,686
Frye Regional Medical Center	5	Catawba	1	689	689
Valdese General Hospital	5	Burke	2	6,325	3,163
Caldwell Memorial Hospital	5	Caldwell	1	2,651	2,651
Cleveland Regional Medical Center	6	Cleveland	1	6,217	6,217
Gaston Memorial Hospital (h)	6	Gaston	3	14,110	4,703
Lincoln Radiation Oncology Associates (s)	6	Lincoln	will be transferred	NR	NR
NC Radiation Therapy - Forest City	6	Rutherford	1	4,951	4,951
Pineville Radiation Therapy Center (n)	7	Mecklenburg	1	6,972	6,972
Carolinas Medical Center (S)	7	Mecklenburg	3**	17,268	5,756
CMC-Union (i)	7	Union	1	7,619	7,619
Matthews Radiation Oncology	7	Mecklenburg	1	11,443	11,443
Presbyterian Hospital	7	Mecklenburg	4	12,688	3,172
University Radiation Oncology	7	Mecklenburg	1	6,271	6,271
Iredell Memorial Hospital	8	Iredell	2	7,197	3,599
Lake Norman Radiation Oncology Center	8	Iredell	1	10,680	10,680
Rowan Regional Medical Center	8	Rowan	1	5,396	5,396
CMC-NorthEast Medical Center	9	Cabarrus	2	12,386	6,193
Stanly Regional Medical Center	9	Stanly	1	3,994	3,994
Forsyth Memorial Hospital	10	Forsyth	4	27,566	6,892
Hugh Chatham Memorial Hospital (d)	10	Surry	1	5,777	5,777
N. C. Baptist Hospitals (S)	10	Forsyth	4	18,597	4,649
Cancer Center of Davidson County (o)	11	Davidson	1	226	226
High Point Regional Health System	12	Guilford	2	8,442	4,221
Morehead Memorial Hospital	12	Rockingham	1	5,811	5,811
Moses Cone Health System	12	Guilford	4	24,654	6,164
Randolph Cancer Center (m)	13	Randolph	1	3,803	3,803
UNC Hospitals (S)	14	Orange	4	25,953	6,488
Alamance Regional Medical Center (j)	15	Alamance	2	9,592	4,796
Duke University Hospital (S)	16	Durham	8	36,721	4,590
Durham Regional Hospital	16	Durham	1	3,924	3,924
Maria Parham Hospital (e)	16	Vance	1	5,444	5,444
FirstHealth Moore Regional	17	Moore	2	18,953	9,477
Scotland Memorial Hospital (l)	17	Scotland	1	4,943	4,943
Cape Fear Valley Medical Center (a)	18	Cumberland	5	18,220	3,644

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit
Southeastern Regional Medical Center (v)	18	Robeson	1	7,404	7,404
Sampson Regional Medical Center	18	Sampson	1	2,519	2,519
New Hanover Radiation Oncology	19	New Hanover	2	21,634	10,817
New Hanover Regional Medical Center	19	New Hanover	1	6,954	6,954
South Atlantic Radiation Oncology (c)	19	Brunswick	1	7,640	7,640
Raleigh Hematology Oncology Associates/Cancer Centers of NC (u)	20	Wake	2	11,923	5,962
Duke Raleigh Hospital	20	Wake	1	7,268	7,268
Rex Hospital	20	Wake	4	16,932	4,233
Wake Radiology / Oncology Services	20	Wake	1	4,718	4,718
Rex Healthcare (Smithfield Radiation Oncology)	21	Johnston	1	2,432	2,432
Johnston Memorial Hospital Authority (t)	21	Johnston	1	NR	NR
Lenoir Memorial	22	Lenoir	1	5,860	5,860
Goldsboro Radiation Therapy Services dba Wayne Radiation Oncology Center	22	Wayne	1	4,799	4,799
Carteret General Hospital (g)	23	Carteret	1	119	119
CarolinaEast Medical Center	23	Craven	2	12,036	6,018
Onslow Radiation Oncology	24	Onslow	1	NR	NR
Nash Day Hospital	25	Nash	2	8,491	4,246
Roanoke Valley Cancer Center	25	Halifax	1	3,996	3,996
Wilson Medical Center	25	Wilson	1	5,178	5,178
Beaufort County Hospital	26	Beaufort	1	4,308	4,308
Ahoskie Cancer Center	26	Hertford	1	1,758	1,758
NC Radiation Therapy Management Services (prev Carolina Radiation Medicine, P.A.) (f) (S)	26	Pitt	1	8,228	8,228
ECU Brody School of Medicine (S)	26	Pitt	3	18,786	6,262
Albemarle Hospital	27	Pasquotank	1	5,276	5,276
Alliance Oncology dba Outer Banks Cancer Center	27	Dare	1	2,049	2,049
TOTALS (71 Facilities, including Murphy Medical Center)			**119**	**593,531**	**4,988**

* Murphy Medical Center stopped operating, and decommissioned, this linear accelerator on May 20, 2009.
** CMC will move one linear accelerator to CMC-Union per CON F-007525-06

(a) Cape Fear Valley Health System received a CON in May 2004 for the fourth linear accelerator, and CON M-008133-08 on 12/18/2009 to retain a linear accelerator, for a total of five, including a CyberKnife.

(b) Mission Hospitals received a CON in September 2004 for a CyberKnife linear accelerator; operational in October 2005.

(c) South Atlantic Radiation Oncology received a CON in August 2005 for a linear accelerator; operational in May 2007.

(d) Hugh Chatham Memorial Hospital became operational in March 2000 with a leased linear accelerator from NC Baptist Hospitals.

(e) Maria Parham Hospital received a CON in July 2001 to lease and install one linear accelerator.

(f) Carolina Radiation Medicine, P.A. became operational in July 1998.

(g) Carteret General Hospital received a no review in June 1999 to replace a linear accelerator and purchase a simulator. Also received a no-review for a replacement linear accelerator in 2009.

(h) Gaston Memorial Hospital received a CON in August 1999 to add one linear accelerator.

Table 9E: Hospital and Free-Standing Linear Accelerators and Radiation Oncology Procedures					
Facility Name	Service Area #	County	Number of Linear Accelerators	Number of Procedures (ESTVs) 10/1/2008-9/30/2009	Average # of Procedures per Unit

footnotes, continued:

(i) Union Regional Medical Center received a CON in April 2000 to acquire one linear accelerator.

(j) Alamance Regional Medical Center received a CON in August 2002 to add one linear accelerator.

(k) Forsyth Medical Center received a CON in August 2002 to add one linear accelerator; operational in October 2004.

(l) Scotland Memorial Hospital became operational in August 2003.

(m) Randolph Cancer Center received a CON in June 2006 for a linear accelerator.

(n) Pineville Radiation Therapy Center received a CON in June 2007 for a linear accelerator.

(o) Cancer Center of Davidson County, LLC received a CON in July 2007 for a linear accelerator.

(p) East Carolina University Brody School of Medicine received a CON in December 2007 to replace an existing linear accelerator with a CyberKnife linear accelerator.

(q) UNC Hospitals received a CON in October 2006 to replace an existing linear accelerator with a CyberKnife linear accelerator.

(r) Carolinas Medical Center - NorthEast received a CON in February 2006 to acquire a CyberKnife linear accelerator.

(s) Lincoln Radiation Oncology Associates received CON 10/27/08 to acquire existing linear accelerator through ownership transfer from Gaston Memorial Hospital, replace the linear accelerator and relocate to Lincoln Radiation Oncology Center.

(t) Johnston Memorial Hospital Authority received CON # J-8188-08 on 2/24/09.

(u) Raleigh Hematology Oncology Associates, PC d/b/a Cancer Centers of NC received CON #J-007941-07 in July 2009 for a second linear accelerator.

(v) Southeastern Regional Medical Center received CON #N-004919-93 on 2/2/94.

NA - Not Applicable, not in operation for appropriate time frame.

NR - No report

S - Has at least one linear accelerator configured for stereotactic radiosurgery

EXHIBIT C TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

PETITION FOR ADJUSTMENT TO NEED DETERMINATION TO ADD SIX OPERATING ROOMS TO THE PITT-GREENE OPERATING ROOM SERVICE AREA

Submitted To:
Mr. Michael C. Tarwater, Chair
Acute Care Services Committee
c/o Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

DFS Health Planning
RECEIVED
AUG 03 2007
Medical Facilities
Planning Section

Petitioner
Pitt County Memorial Hospital
2100 Stantonsburg Road
P. O. Box 6028
Greenville, NC 27835-6028

Stephen J. Lawler, President
(252) 847-4451

I. Request

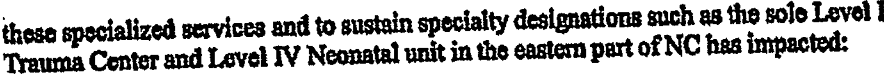
Pitt County Memorial Hospital, Inc. (PCMH) petitions for a special need determination in the 2008 State Medical Facilities Plan (SMFP) for six operating rooms (OR) in the Pitt-Greene Operating Room Service Area (P-G ORSA). The proposed 2008 SMFP shows a need for only 0.25 ORs in the P-G ORSA. A comprehensive analysis of the unique and special attributes of the geographic area and providers in the service area demonstrate the need for six or more operating rooms by 2010.

II. Rationale for the Proposed Adjustment

Background Information Regarding Petitioner

PCMH is a private, not-for-profit hospital that serves as the tertiary, regional referral hospital for eastern North Carolina. PCMH has over 750 acute care beds and has CON approval to build and operate over 100 additional acute care beds. PCMH has the only licensed inpatient and shared operating rooms in Pitt and Greene Counties. SSOP Services of Pitt, Inc. (SSOP) is an 8-bed freestanding ambulatory surgery center and a controlled affiliate of PCMH. SSOP operates the only licensed dedicated ambulatory surgery operating rooms in Pitt and Greene Counties. PCMH's Level I Trauma Center, Cardiovascular Center, Cancer Center, Children's Hospital, and Regional Rehabilitation Center are just a few examples of the highly specialized services that have been developed and expanded over the past 20 years in direct response to the primary/community care needs of Pitt and Greene Counties and the tertiary healthcare needs of the entire HSA VI region. PCMH's commitment to continue to provide

NOVANT 0002433



these specialized services and to sustain specialty designations such as the sole Level I Trauma Center and Level IV Neonatal unit in the eastern part of NC has impacted:

- the percentage growth of surgery cases at PCMH and SSOP relative to underlying population served,
- the number and mix of surgical case hours delivered by PCMH and SSOP,
- the average case time for inpatients and outpatients, and
- the capacity of existing operating rooms to manage a highly complex mix of surgical patients

These impacts are the basis for the evidence that the resource requirements for the Pitt-Greene OR service area differ from the requirements resulting from the application of the standard planning methodology for operating rooms.

PCMH & SSOP Are Sole Providers In The Pitt-Greene Operating Room Service Area

PCMH is the only tertiary regional referral center in NC located in a two-county OR Service Area. PCMH is also the sole provider of inpatient and shared operating rooms in the P-G ORSA. This attribute results in PCMH fulfilling a unique role as a community and specialized services hospital for Pitt and Greene Counties and a tertiary regional referral center for the entire HSA VI region. Greene County does not have a licensed facility providing operating rooms. Greene County is grouped with Pitt County to form the P-G ORSA since PCMH, the sole provider in Pitt County, serves the greatest number of surgical patients originating from Greene County. The majority of operating room service areas across NC has multiple providers of inpatient, shared and dedicated outpatient operating rooms. The majority of providers can therefore address any growth in surgical services demand and adjust to periodic constraints in capacity. The P-G ORSA has limited or no capacity to meet immediate or future needs for operating rooms because:

1) P-G ORSA has only one hospital and one free-standing dedicated ambulatory surgery facility,
2) The providers in the P-G ORSA historically, currently, and in the near term must serve not only as the sole primary care provider in these counties but also as the regional referral hospital for the 29 counties in HSA VI, and
3) There is no tertiary regional referral center located adjacent to the P-G ORSA that can address the demand for comprehensive surgical services that can only be met by the sole providers in the P-G ORSA.

The unique characteristics of the P-G ORSA geography and the sole providers in this OR service area make it impossible for PCMH to effectively manage the constraints in OR capacity without compromising the patients' access to timely, high quality, safe and cost effective care.

The SSOP, as the sole provider of licensed dedicated ambulatory surgery operating rooms in Pitt and Greene Counties, uses the American Society of Anesthesiologist classifications of physical status to assure surgical patients receive services in the appropriate

setting. Currently, additional specific criteria set by Medicare/Medicaid must be met in order for the provider to be reimbursed by Medicare/Medicaid. PCMH and SSOP continuously review the outpatient cases performed at the hospital to assure as many outpatients as possible and as appropriate are performed at the SSOP facility. These efforts have been especially intense in the past few years given the OR capacity constraints at PCMH. PCMH expects to see fewer gains in OR capacity using this approach since the majority of benefits in OR capacity due to this shift have already been realized.

Additionally, SSOP historical utilization data has demonstrated that this facility also serves more complex outpatients that any ambulatory surgery center in adjacent counties and in some cases in the entire region. Since SSOP is the sole provider of dedicated outpatient ORs in the P-G ORSA, it is limited in the type and complexity of patients it can serve.

PCMH & SSOP Serves Surgery Patients Beyond Pitt-Greene OR Service Area

The sole providers of licensed operating room services in the P-G ORSA have historically served a much broader service area than Pitt and Greene Counties. The table below compares the FY 2006 PCMH percent of patient origin from the P-G ORSA against the PCMH percent of patient origin from outside the P-G ORSA for acute care and surgery patients.

	Pitt & Greene Counties	Outside Pitt & Greene Counties
PCMH Patient Origin Inpatient & Outpatient Acute Care Admissions	41.9 %	58.1 %
PCMH Patient Origin Inpatient Surgery Cases	30.8 %	69.2 %
PCMH Patient Origin Outpatient Surgery Cases	41.5 %	58.5 %
PCMH Patient Origin Total Surgery Cases	35.8 %	63.2 %

The data above clearly shows that over 50% of PCMH's acute care admissions, inpatient surgery and outpatient surgery cases originate from outside Pitt and Greene Counties. PCMH, as the only tertiary regional referral center in eastern NC, serves all 29 counties of eastern NC and beyond, not just Pitt and Greene Counties. Even if other HSA VI counties have underutilized ORs, PCMH is still the only acute care provider in HSA VI who has the unique mix and availability of specialists and sub-specialist physicians, advanced centers of emphasis in cardiovascular, cancer, children's and surgical services and comprehensive services and technology to meet the demand for complex surgery services. Additionally,

PCMH is the only Level IV Neonatal facility and the only Level I Trauma Center in eastern NC. PCMH is also the only hospital that has a comprehensive Cardiovascular Center designed to address the unmet need for advanced cardiovascular care in a region with one of the nation's highest incidence of cardiac disease and mortality.

It is clear that the standard methodology used by the state to project future OR need does not recognize the unique attributes of PCMH in the P-G ORSA. The standard formula assumes that the number of surgical hours will increase or decrease in direct proportion to the change in the general population of the OR Service Area. This approach does not take into account the special role PCMH plays in eastern NC as the only tertiary, regional referral facility in HSA VI. Assuming surgical hours performed by PCMH using only Pitt and Greene Counties' general population change underestimates the volume and complexity of patients PCMH serves outside the P-G ORSA and severely underestimates projected growth.

Additionally, SSOP's historical and projected patient origin demonstrates that the SSOP serves a much broader region than just the P-G ORSA. The data table below clearly shows that over 54% of SSOP's cases originate from outside Pitt and Greene Counties. SSOP, as the only freestanding ambulatory surgery facility in the P-G ORSA, has provided services to every county in HSA VI and has served patients in 27 other counties in NC and patients from other states. Even if other HSA VI counties have underutilized dedicated ambulatory surgery ORs, SSOP has a unique and comprehensive mix of specialty surgery services. SSOP is the only freestanding ambulatory surgery center in eastern NC that offers all of the following specialty surgical services: dental, general surgery, gynecology, neurology, ophthalmology, oral, orthopedic, otolaryngology, plastics, podiatry, and urology. This comprehensive mix of surgical services makes SSOP a unique provider not only in the P-G ORSA but also in the eastern part of the state.

	Pitt & Greene Counties	Outside Pitt & Greene Counties
SSOP Patient Origin Outpatient Surgery Cases	45.7 %	54.3 %

The need for operating rooms in the P-G ORSA must consider the unique and special attributes of the geographic area served by PCMH and SSOP and the unique and special attributes associated with the services provided by the sole providers in the P-G ORSA. These attributes are not reflected in the standard methodology used to determine OR need.

Demand for ORs Exceeds Current and Projected OR Capacity In P-G ORSA

The unique and special attributes of the P-G ORSA geographic area and providers are the basis for the need for more operating rooms by 2010 in this service area. PCMH conducted an extensive analysis of the historical and projected utilization of sixteen service lines and

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found that the demand for ORs in the P-G ORSA exceeds current and projected OR capacity. Current and projected OR need in the P-G ORSA is impacted by the following:

- Growth in OR volumes based on a service area beyond Pitt and Greene Counties,
- Growth in hours per case due to a unique population of surgery patients, and
- Operational capacity needed to serve a comprehensive mix of specialized surgical patients.

Wider Service Area

PCMH and SSOP both serve patients beyond the P-G ORSA. In order to recognize the impact of serving a wider service area, the population change rate used in the standard methodology must be adjusted. Using the overall population growth rate of eastern NC counties changes the P-G ORSA growth factor to no less than 0.80 % per year, which is higher than the 2-county service area population change rate used in the standard methodology. Assuming no other changes to the standard methodology, the OR need in the P-G ORSA would be over two ORs for this unique variable alone. However, additional variables must be considered before determining total OR need for the P-G ORSA. Below are the additional variables for consideration and statistics that support the need for six new ORs in the P-G ORSA in the 2008 SMFP.

Unique Population and Growth

The sole providers in the P-G ORSA serve a unique population of surgery patients, namely, surgery patients that originate from a region that state statistics clearly document has some of the highest rates of poverty, illiteracy, infant mortality rates, heart disease, cancer, diabetes, and pulmonary disease than any other region in the state. The growth in surgery cases and the length of time to complete more complex surgery cases at PCMH are directly impacted by the unique health status attributes of eastern NC. These differences have driven growth in surgery volumes at PCMH and SSOP at a rate nearly 50% higher than local and regional population growth. Other unique attributes of the geographic area include the presence of military bases, the double-digit growth in tourism and retirement communities in the eastern counties that are not fully represented in population statistics, and the fact that the eastern counties are aging at a faster rate than any other region in the state. These unique variables increase the numbers of surgical cases, the types of surgical cases, the OR hours needed to serve current and future patients, and the capacity needed to address a comprehensive mix of surgical patients.

Additionally, patients and physicians are demanding access to ORs during the week and during the early hours of the day. Operationally that means that the hospital must have sufficient OR capacity to do the majority of elective and non-elective cases Monday through Friday. Historical growth in surgical case volumes and surgical case times have exceeded current OR capacity. PCMH leadership is unable to meet the patients' and physicians' requests for OR time during the weekdays and on day shift. For the past three years PCMH has seen the number of routine, elective and scheduled cases that must be performed after 3pm climb to nearly 25% of the total number of surgical cases performed at PCMH. The

hospital has been forced to staff an average of seven ORs during the eight hours from 3pm-11pm every day just to meet the demand for routine, elective cases. Included in these numbers is one OR that must be staffed and available at all times in order for PCMH to meet its commitment as a Level 1 Trauma Center. Additionally, PCMH routinely staffs 3 ORs plus 1 trauma OR on Saturdays and additional ORs on Sundays to meet the demand for emergency and trauma cases, and in some cases, elective surgeries.

Capacity Needed to Address Demand Growth and Unique Mix of Surgical Patients

PCMH, due to its unique attributes as a sole provider of inpatient and shared ORs in the P-G ORSA, must have sufficient capacity to address the volume and unique mix of surgical patients both now and in the future. The standard methodology for determining OR need uses an occupancy rate of 80%. This occupancy rate does not recognize the unique factors impacting PCMH's need for additional OR capacity. PCMH provides a different level of surgical specialization that requires a different number, mix and type of ORs, staff, equipment, and supplies. These differences are needed to address the special attributes of tertiary and complex inpatients and outpatients who receive care in PCMH's ORs. There is less predictability in scheduling patients when a provider such as PCMH serves a wide range of specialty surgical services (e.g. cardiothoracic, ENT, GI, general surgery, gynecology, oncology, nephrology and transplant, orthopedics, reconstructive plastics, urology and vascular) and a broad range of patient acuity (simple, elective outpatient to extensive, unstable, complex trauma patient).

The current special rules for ORs assumes that inpatient ORs, operating at 80% capacity, can serve 2.4 inpatient cases per room per 9-hour day for 260 days per year and shared ORs can serve 3.2 cases per room per 9-hour day. Over 50% of PCMH's surgical cases are inpatients, which in and of itself is a unique factor for the majority of hospital-based ORs in NC. Based on the last 12 months of data, PCMH performed 10,161 inpatient surgery cases and 9,043 outpatient surgery cases and operated at over 85% capacity in its current 25 operating rooms. Additionally, during FY 2006 and in the last 12-month period, PCMH's average case time for outpatient surgery patients was greater than two hours. Operating at greater than 80% capacity, while at the same time providing care to ambulatory surgery patients whose average case times are 30% higher than the case time used in the standard formula for OR need, are direct indications of lack of sufficient OR capacity to meet current, much less future, needs.

PCMH's ORs are already operating above desired capacity. Additional attributes that make use of an 80% capacity assumption inappropriate for the providers in the P-G ORSA include:

- PCMH has over 140 active and consulting MDs with OR privileges. Additional capacity is needed to serve a large number of physicians providing specialized services.
- PCMH has twenty-four surgery residents and one surgery fellow. Insufficient OR capacity can severely limit opportunities for surgical medical education and research.

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- The number of complex and highly specialized surgical cases at PCMH requires expanded OR capacity to manage turnaround times between complex, highly specialized cases and to separate contaminated cases from clean cases.
- By 2010, PCMH will have added over 100 new acute care medical-surgical beds. Since there is no OR need in the 2008 SMFP for the P-G ORSA, it is likely that PCMH will add these beds without being able to add a single operating room. Surgery patients' account for over 20% of PCMH's total patient admissions. Adding 100 new acute care beds without adding any ORs will result in significant gaps in services and will make it impossible for PCMH to sufficiently meet the needs of the P-G ORSA, much less the needs of a broader region.

Proposed Adjustment

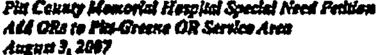
The number and types of special attributes of the P-G ORSA and its providers demonstrate the need for additional ORs by 2010. Instead of attempting to associate OR need for each attribute, the petitioner recommends the following adjustments:

- Adjust growth factor to 0.080 for the P-G ORSA to reflect the population and demand growth of the wider region and the unique health status factors in PCMH's and SSOP's service areas. These factors drove historical volumes and will drive future demand.
- Adjust capacity assumption for the P-G ORSA to 75% to reflect the complexity and mix unique to this OR Service Area and the sole providers in the P-G ORSA.
- Adjust hours per outpatient case for PCMH's ambulatory surgeries to 2.0 hours per case to reflect current (and projected) average hours per ambulatory surgery case at PCMH.

These adjustments acknowledge the unique role played by the sole providers in this service area. The standard formula for projecting OR need cannot reflect the attributes unique to PCMH and SSOP. These attributes include population growth beyond the two-county service area, volume growth unique to a region with high incidence of chronic disease and mortality, the operational capacity necessary to serve the mix and complexity of surgical patients PCMH and SSOP serve, and OR hours needed to care for the large number of specialized and complex ambulatory surgeries at PCMH.

Applying the recommended adjustments above changes the OR need for P-G ORSA in the 2008 SMFP to six additional ORs using the following assumptions:

- PCMH inpatient surgery hours = 28,851.00 (unchanged)
- PCMH ambulatory surgery hours = 17,878 (2.0 hours/case x 8,939 cases)
- SSOP outpatient hours = 14,407.50 (unchanged)
- Total surgery hours for P-G ORSA = 61,136.5
- Projected surgical hours for 2010 (using new growth rate of 0.08) = 66,027.42
- Standard hours per OR per year = 1,755 (assumes 9hrs/day, 260 days/year, 75% capacity)
- Projected ORs in 2010 for P-G ORSA = 37.62
- Current OR in P-G ORSA after adjustments = 32
- Project ORs needed = 5.62 (Rounded = 6.0)



III. Adverse Effects if Requested Changes Are Not Made

The following list describes some of the adverse effects on the population of patients served by the sole providers in the P-G ORSA if additional ORs are not included in the 2008 SMFP:

- Patients will experience increased delays in access to the specialized services provided solely by PCMH as the regional referral facility for HSA VI. These delays could impact patient morbidity and mortality.
- Limited or no access to complex, high acuity tertiary surgical services due to limited OR capacity may result in patient's not receiving surgery care at all or patient's being forced to travel long distances to access similar services at other regional referral facilities.
- Physician recruitment has already been severely affected by the lack of OR capacity at PCMH and SSOP. Hours of operation have been extended to increase the number of hours of available OR time since PCMH continues to operate above reasonable OR capacity. As a result of this operational change, physician dissatisfaction has increased. Key physicians who provide highly specialized surgical services have left the facility. Physician recruitment, especially in the areas of surgical subspecialties needed at PCMH and for eastern NC to support the 24/7 demands of a Level I Trauma Center, has been extremely difficult. The obvious lack of OR capacity to handle current, much less future surgery demand, is severely affecting the delivery of vital surgical services at PCMH and SSOP.
- Extended hours of operation to manage the demand in surgical services has increased human resources, utilities and support services costs. Staff expenses such as shift differential and overtime have continued to rise in order to accommodate surgical case demand during the 3pm to11pm shift.
- Routine and elective patients who remain without food or water prior to surgery risk having their case cancelled due to the lack of OR hours (capacity) available during the day shift to handle routine and emergent case volumes. A number of healthcare research groups are currently analyzing the impact on quality and safety for patients who have surgical procedures performed late in the day versus on day shift.
- Patients must remain in the hospital overnight because their elective or routine surgical procedure was performed late in the day or early evening due to limited OR capacity. This results in higher costs for the patient and hospital.
- PCMH will open and operate over 100 new acute care beds before 2010. If the 2008 SMFP does not include the need for more ORs, PCMH will be unable to support the increased surgical volume associated with the operation of such a large number of new acute care beds.

Continued application of the standard formula for determining OR need will not address the unique and special attributes of the P-G ORSA or its sole providers.

IV. Alternatives Considered But Not Feasible

Alternative # 1 – Modify existing resources

PCMH and SSOP cannot modify existing resources without continuing to compromise the availability and functioning of existing ORs. Procedures' volumes cannot be safely shifted to any other procedures' rooms without compromising patient safety or jeopardizing the delivery of other vital hospital services. The addition of operating rooms is contingent on CON approval and current SMFP shows no need for ORs in the P-G ORSA.

Alternative #2 - Reduce the number of ORs needed in the P-G ORSA

A need of less than six ORs in the P-G ORSA in the 2008 SMFP will significantly hinder the ability of both PCMH and SSOP to continue to serve the surgical patients who have historically used these facilities. Constructing or operating less than six more ORs will only increase the adverse effects noted above and may very well compromise the hospital's ability to sustain long-term its position as a regional referral center.

Alternative #3 - Wait until changes are made in the standard methodology

Future changes proposed by a special task force will not fully address the unique and special needs of PCMH and SSOP. Waiting until the changes are made in the 2009 SMFP will delay the construction or operation of additional ORs in the P-G ORSA and will severely compromise PCMH's ability to address the projected demand for surgery cases associated with the addition of over 100 new acute care beds beginning early 2009 through early 2010.

V. Evidence Proposed Change Would Not Result in Unnecessary Duplication of Health Resources

PCMH and SSOP are the sole providers in the P-G ORSA. Evidence presented in this petition demonstrates there is an unmet need today for ORs in the P-G ORSA given its unique attributes. No other provider in HSA VI can duplicate the scope and complexity of surgical services offered by PCMH or by SSOP. Patient waiting lists, extended operating room hours, and a growing volume of chronic health care issues in the P-G ORSA and beyond reflect an unmet need now and in the future. New ORs will address unmet need and not result in the unnecessary duplication of health resources. Projections of need presented in this petition and the proposed minor adjustments to the standard methodology do not result in any duplication of existing OR capacity.

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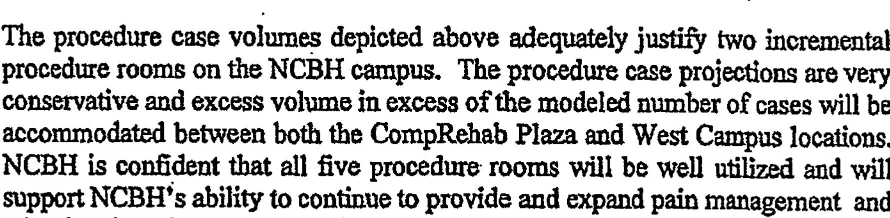
EXHIBIT D TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items included in the reimbursement; and

OP Principal CPT Procedure Code	OP Principal CPT Procedure Name	FY 2013	FY 2014	FY 2015
66984	CATARACT SURG W/IOL, 1 S	$ 2,142	$ 2,194	$ 2,247
29881	KNEE ARTHROSCOPY/SURGERY	$ 3,763	$ 3,853	$ 3,945
52353	CYSTOURETHROSCOPY W/URETERO AND/OR PYELO; WITH LITHO	$ 5,698	$ 5,834	$ 5,974
58340	CATHETER FOR SIS OR HSG	$ 871	$ 892	$ 914
20680	REMOVAL OF SUPPORT IMPLANT	$ 2,895	$ 2,964	$ 3,035
47562	LAPAAROSCOPIC CHOLECYSTECTOMY	$ 4,952	$ 5,071	$ 5,193
52332	CYSTOSCOPY AND TREATMENT	$ 2,731	$ 2,796	$ 2,863
29877	KNEE ARTHROSCOPY/SURGERY	$ 3,293	$ 3,372	$ 3,453
19125	EXCISION OF BREAST LESION	$ 3,912	$ 4,006	$ 4,102
58558	HYSTEROSCOPIC BIOPSY	$ 2,335	$ 2,391	$ 2,449
65730	CORNEAL TRANSPLANT	$ 5,244	$ 5,370	$ 5,499
49505	PRP I/HERN INIT REDUC >5	$ 2,914	$ 2,984	$ 3,055
29880	KNEE ARTHROSCOPY/SURGERY	$ 3,595	$ 3,681	$ 3,769
20670	REMOVE SUPERFICIAL WIRE,PIN,ROD	$ 1,421	$ 1,455	$ 1,490
15823	UP BLEPHAROPLAS&FAT HERN	$ 3,441	$ 3,523	$ 3,608
36561	INSERTION OF TUNNELED CVAD, W/SUBQ PORT, 5+Y	$ 4,069	$ 4,167	$ 4,267
69433	CREATE EARDRUM OPENING	$ 464	$ 476	$ 487
29888	KNEE ARTHROSCOPY/SURGERY	$ 11,931	$ 12,218	$ 12,511
47563	LAPAROSCOPIC CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY	$ 5,751	$ 5,889	$ 6,030
42826	REMOVAL OF TONSILS	$ 3,470	$ 3,553	$ 3,638

These projected rates per case include the pre-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers.


The procedure case volumes depicted above adequately justify two incremental procedure rooms on the NCBH campus. The procedure case projections are very conservative and excess volume in excess of the modeled number of cases will be accommodated between both the CompRehab Plaza and West Campus locations. NCBH is confident that all five procedure rooms will be well utilized and will support NCBH's ability to continue to provide and expand pain management and other less invasive procedures for our patients.

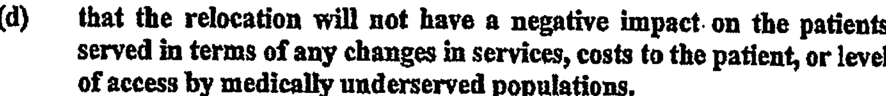
2. **Document that the facility is needed at the proposed site as opposed to another area of the service area.**

Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University researchers, NCBH has concluded that expanded the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice.

3. **If an existing facility proposes to relocate operating rooms to a new site, the applicant shall demonstrate:**

(a) **the necessity for relocation of operating rooms such as, physical inadequacy of existing facility or geographic accessibility of services;**

As previously discussed NCBH is operating its ORs to the fullest capacity and currently all 40 licensed ORs are currently located in Ardmore Tower. The surgery department in Ardmore Tower is landlocked and cannot be expanded without significant cost and disruption to the displacement of beds. Furthermore, renovation of existing ORs can occur only by sequentially closing groups of ORs temporarily. Given the high utilization of surgical services at NCBH, this is an ineffective alternative that would create major OR capacity constraints during the renovations.



(d) **that the relocation will not have a negative impact on the patients served in terms of any changes in services, costs to the patient, or level of access by medically underserved populations.**

NCBH believes the proposed project will have a positive impact on the provision of surgical services for NCBH patients. The ORs will be located on the NCBH campus and will be utilized by surgeons who already perform surgical cases there. Surgical services will be more easily accessed by patients given the proposed location will have its own parking accessed directly from Medical Center Blvd. and directly visible from Business I-40. NCBH will continue to serve a high number of medically underserved and this project will not change NCBH' s commitment to continue that.

4. **Describe how the project is consistent with each applicable policy in the State Medical Facilities Plan, including Policy Gen-3, Basic Principles.**

The need determinations of the 2010 State Medical Facilities Plan are not applicable because this application is filed under Policy AC-3 of the Plan, which provides that:

Exemption from the provision of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

A. Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or
B. Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or
C. Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

As the letter from William B. Applegate MD, president of Wake Forest University Health Sciences and dean of Wake Forest University School of Medicine demonstrates in Exhibit 8 and certifies, this CON application and its exhibit documents, comply with condition A. It should also be noted that the need determination for additional ORs will likely not be included in future iterations of

the State Medical Facilities Plan due to the surplus of ORs experienced by other Forsyth County market providers. Due to the level of faculty growth, the need to enhance and expand surgical training opportunities and the fact that NCBH ORs are operating at over 100% of capacity is important and timely that NCBH apply for incremental ORs for the NCBH campus.

Consistency with Policies

The only Acute Care Policy that is applicable to this application is Policy AC-3. As noted above, the Policy requires that the necessity for the proposed project be certified by the "head of the relevant associated professional school" and "head of the entity sponsoring research". The certification is provided in the letter from William B. Applegate, MD, president of Wake Forest University Health Sciences and dean of Wake Forest University School of Medicine and included in Exhibit 8. This application is therefore consistent with Policy AC-3.

This application is also consistent with Policy Gen-3: Basic Principles because its implementation will allow us to:

-Develop and provide clinical services that improve the cost effectiveness of surgical services. One measure of that effort is to continually refine procedures that are less invasive, reducing the need and expenditures for inpatient surgeries and stays. Expanding outpatient surgical capacity for less acute patients will enable NCBH to treat more patients efficiently and cost-effectively than can be accomplished in the current facilities.

-Expand health care services to the medically underserved. Even though NCBH must contribute substantially to the support of the education and research programs of Wake Forest University School of Medicine, NCBH also contributes substantially to the care of medically underserved including the indigent, racial and ethnic minorities, the disabled and Medicaid and Medicare patients, as well as patients who cannot find the treatment they require elsewhere in the state or region.

-Provide the clinical equipment and facilities essential to the efficient operation of the multidisciplinary teams that diagnose and treat NCBH's surgical patients.

5. **Describe the geographic boundaries of the proposed service area (i.e., area in which patients to be served reside) for the facility and explain the rationale for establishing**

EXHIBIT E TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: June 10, 2010
PROJECT ANALYST: Gebrette Miles
ASSISTANT CHIEF: Martha Frisone

PROJECT I.D. NUMBER: G-8460-10 / North Carolina Baptist Hospital / Construct a new building to house eight operating rooms (seven additional and one relocated), two procedure rooms, one robotic surgery training room, and one simulation operating room / Forsyth County

REVIEW CRITERIA FOR REPLACEMENT INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new building to house eight operating rooms (seven additional operating rooms and one relocated operating room), two procedure rooms, one simulation operating room and one robotic surgery training room. There is no need determination for additional operating rooms in Forsyth County in the 2010 State Medical Facilities Plan. However, NCBH proposes to develop the seven additional operating rooms pursuant to *Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects* in the 2010 SMFP. Policy AC-3 states,

"Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:

1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*

2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*

3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital."

NCBH was designated an Academic Medical Center Teaching Hospital by the Medical Facilities Planning Section on February 17, 1983.

In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, president of Wake Forest University Health Sciences (WFUHS) and Dean of the Wake Forest School of Medicine, which states,

> *"The purpose of this letter is to certify that the expansion of ambulatory care surgical facilities on the North Carolina Baptist Hospital West Campus proposed in a certificate of need application to be submitted by North Carolina Baptist Hospital on January 15, 2010 is:*
>
> > *'Necessary to complement a specified and approved expansion of the number of types of students, residents, or faculty'*
>
> *With the support of North Carolina Baptist Hospital, the Wake Forest University School of Medicine and Wake Forest Health Sciences has begun an expansion of the clinical and research faculty within the Division of Surgical Sciences. The expansion is driven by four factors:*
>
> - *The increasing specialization of clinical and surgical practices at academic medical centers*

- *The increasing involvement of faculty research, especially clinical trials involving new diagnostic, surgical and therapeutic tools and techniques*
- *The increasing demand for surgical services*
- *The changing paradigms for surgical training*

Over the last three years, we have successfully recruited 36 new clinical faculty within the Division of Surgical Sciences, which has largely contributed to the operating room capacity issues on the NCBH campus. The current number of surgeons practicing within the Division is 113; however, we now project to add a total of 51 faculty in the Division of Surgical Sciences, including 39 clinical FTEs by 2020. It is anticipated that by 2020 there will be a total of 193 surgical faculty within the Division of Surgical Services.

...

The expansion of the ambulatory surgery capacity and facilities on the NCBH West Campus will also allow the Wake Forest University School of Medicine to enhance the training and education of our medical students, faculty and fellows. The simulation and robotics training rooms proposed on the West Campus will simulate high-acuity conditions and utilize scenarios and associated instructor feedback to provide a safe yet lifelike learning environment for students and faculty to acquire essential skills required in surgical care. There is a great need to expand our teaching facilities for our surgical residents and medical students to ensure they have an appropriate environment to practice the fundamental skills of operating outside the clinical field in a laboratory setting where operations can be simulated.

...

The expansion of the surgical capacity on the West Campus proposed in the certificate of need application to be submitted January 15, 2010 is essential to the recruitment and retention of these new faculty as well as our existing faculty. I therefore certify the proposed project as 'Necessary to complement a specified and approved expansion' of the faculty of the Wake Forest University Health Sciences."

NCBH adequately demonstrates that the seven additional ORs are necessary to complement a specified and approved expansion of 39 clinical faculty in the Division of Surgical Sciences. See Criterion (3) for the Agency's analysis and discussion regarding the need for the additional ORs at NCBH.

Regarding NCBH's need to demonstrate that its "*teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is*

within 20 miles of the Academic Center Teaching Hospital," in Section III.2, page 64, the applicant states,

> *"Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University reasearchers, NCBH has concluded that expanding the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice."*

The applicant adequately demonstrates that developing seven additional ORs on the hospital campus would be more effective as the faculty, residents and students will be able to remain on campus rather than have to travel to an offsite location. Therefore, the applicant adequately demonstrates that the teaching need for surgical services cannot be achieved effectively at a non-academic medical center teaching hospital located within 20 miles of NCBH. The proposal is consistent with Policy AC-3 in the 2010 SMFP.

There are no other policies in the 2010 SMFP that are applicable to this review. Therefore, the application is conforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

C

North Carolina Baptist Hospital (NCBH) proposes to construct a new 72,300 square foot building on its campus, to be called the West Campus Surgery Center (WCSC). The building will house eight operating rooms (ORs), two procedure rooms, one simulation operating room and one robotic surgery training room. Of the eight proposed ORs, seven will be new (or incremental) ORs and one OR will be relocated from the existing surgical suite in Ardmore Tower. NCBH is currently licensed for 40 ORs (36 shared and four dedicated inpatient). The seven additional ORs and the relocated OR will be dedicated outpatient ORs. Therefore, upon

completion of the proposed project, NCBH will be licensed for a total of 47 ORs (35 shared, 4 dedicated inpatient and 8 dedicated outpatient).

Population to Be Served

The following table illustrates current patient origin for surgical services provided at NCBH, as reported in Section III.7, pages 75-77:

2009 NCBH Patient Origin
Inpatient and Outpatient Surgical Cases
Performed in the Surgical Suite in Ardmore Tower

County	% of Total Inpatient and Outpatient Surgical Cases
Caldwell	2%
Catawba	3%
Davidson	7%
Davie	3%
Forsyth	29%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	3%
Stokes	3%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	**74%**
Other NC Counties	15%
All Other States	11%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, page 74, the applicant states,

"Historical patient origin is often the best indicator of future patient origin, and as such the fiscal year 2009 proportions from each county were applied to Project Years 1 and 2

utilization projections with minor adjustment provided by surgical faculty leadership. NCBH anticipates that any changes to patient origin in the future will be insignificant."

In Section III.6, pages 68-70, the applicant provides the projected patient origin for outpatient surgical cases to be performed in the proposed WCSC.

Project Year 2 (2014) Patient Origin
Proposed West Campus Surgery Center
Percent of Total Surgical Cases Performed in ORs

County	**% of Total Outpatient Surgical Cases Performed in ORs**
Catawba	2%
Davidson	6%
Davie	3%
Forsyth	42%
Guilford	10%
Iredell	2%
Randolph	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	4%
Yadkin	2%
Subtotal*	**83%**
Other NC Counties	11%
All Other States	6%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

In Section III.6, pages 73-74, the applicant provides the projected patient origin for the procedures to be performed in the two proposed procedure rooms:

Project Year 2 (2014) Patient Origin
Proposed West Campus Surgery Center
Percent of Total Procedures Performed in Procedure Rooms

County	% of Total Procedures Performed in Procedure Rooms
Catawba	2%
Davidson	7%
Davie	4%
Forsyth	40%
Guilford	10%
Iredell	2%
Rockingham	2%
Stokes	4%
Surry	4%
Wilkes	3%
Yadkin	4%
Subtotal*	**82%**
Other NC Counties	10%
All Other States	8%
Total	**100%**

*Includes only those counties where the percentage of the total is 2% or greater. All other counties are included in "Other NC Counties."

The applicant adequately identified the population proposed to be served.

Need for the Proposed Project

In Section II.1(a), page 12, the applicant states,

> *"Expansion of outpatient surgical services and the surgical training capabilities will enable NCBH to accomplish the following: 1) provide adequate space to meet the current and projected block scheduling demands for outpatient and inpatient surgeries caused by the current and planned growth in surgical faculty and referrals for surgery; 2) to improve the efficiency and utilization of all NCBH's operating rooms through substantial improvements by expanding ambulatory surgery capacity in the proposed West Campus surgery center; 3) Allow NCBH to continue to recruit and attract new surgical faculty; and 4) enhance research and training abilities*

through the addition of an additional simulation OR and new robotics training room."

In Section II.1, page 14, the applicant states,

"As a tertiary, quaternary academic medical center, NCBH is at the forefront of technology and education. NCBH proposes to include an additional simulation OR and a new robotics training room as part of the proposed project. As simulation OR is a requirement by the Council on Graduate Medical Education (GME) as well as an important training tool for existing faculty community surgeons and NCBH's OR nurses.

Wake Forest University School of Medicine has established the Center for Applied Learning, a major new initiative to enhance patient care and safety through immersive learning. The Center utilizes advanced instructional technologies to increase the clinical capacities and skills of health care providers. In addition to the laparoscopic and endoscopic surgical skills training, the Simulation Lab experience includes regularly scheduled sessions and experience in Crew Resource Management in a multidisciplinary environment.

The Center combines faculty expertise from across clinical disciplines and brings together innovative resources for clinical education from a host of diverse training facilities. Among the resources are high-fidelity patient simulation laboratories, a surgery academy, an anatomical training center, a program in medical ultrasound, and standardized patient assessment examination rooms."

In Section III.1(a), page 44, the applicant states,

"The unmet need that prompted the development of the proposed project is the continued and increasing demand for OR block time due to high growth in current and future faculty recruitment of 80+ surgeons at NCBH, the continued increase in the volume of ambulatory surgery and procedures performed at NCBH, and the need to expand training programs for surgical faculty, residents, fellows and nurses."

Furthermore, the applicant states that each of the following factors supports the need for the proposed project:

- *Need in the State Medical Facilities Plan (SMFP)*
- *Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences*
- *Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital*
- *Increase in the Amount of Minimally Invasive Surgical Procedures*

- *Need to Accommodate Increasing Patient Demand*
- *NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity*
- *Need to Address Capacity Enhancement*

Each factor will be discussed separately below.

Need in the State Medical Facilities Plan (SMFP)

Based on data reported in the 2010 SMFP, the ORs at NCBH are currently operating at full capacity (see chart below). However, in Section III.1(a), page 45, the applicant states that because of the higher acuity patients seen at NCBH, both inpatient and outpatient cases take longer than the average case times of 3.00 hours and 1.50 hours for inpatient and outpatient cases, respectively, used in the 2010 SMFP methodology. In Exhibit 7, the applicant provides data for FY 2005 to FY 2009, which shows that the average case time at NCBH was 3.17 hours for inpatient cases and 1.79 hours for outpatient cases. The applicant states,

> *"When applying the NCBH average case lengths to the State's need determination formula, NCBH will be operating at 110% capacity by 2012. These figures suggest NCBH needs four additional ORs by 2012 just to keep pace with Forsyth County population growth alone. Thus, the need for additional ORs included in this application on the NCBH campus is imperative."*

The following chart compares projected OR need in 2012 using the methodology in the 2010 SMFP and projected OR need using the same methodology and assumptions except for substituting NCBH's five-year average inpatient and outpatient case times. See Section III.1, pages 44-45.

	NCBH Projected OR Need—Case Length from 2010 SMFP	NCBH Projected OR Need—NCBH Average Five-Year Case Length
Inpatient Cases* (FFY 2008)	13,251	13,251
Inpatient Case Time	3.00	3.12
Total Inpatient Hours	39,753	41,343
Outpatient Cases (FFY 2008)	17,999	17,999
Outpatient Case Time	1.50	1.79
Total Outpatient Case Hours	26,998.50	32,218.21
Total Combined Hours	66,751.50	73,651.33
Growth Factor	5.99	5.99
Projected Hours	70,749.91	77,967.65
Hours per OR per Year	1,872.00	1,872.00
Projected ORs Needed in 2012	37.79	41.65
2010 Adjusted Planning Inventory**	38	38
Projected OR Deficit or Surplus	**0**	**4**

*NCBH does not have any dedicated C-Section ORs and only performs a few emergency C-sections in a year (less than 10).
**Two of NCBH's ORs are excluded because NCBH is both a burn and a trauma center.

Need to Accommodate Current and Planned Faculty Growth in Surgical Sciences

In Section III.1(a), page 46, the applicant states,

> *"In response to population growth in Forsyth County and the patient demands of the 19 county market we serve, NCBH has recruited and employed 36 incremental surgeons in the Division of Surgical Sciences bringing the total surgical faculty to 113 surgeons in just the last three years. (This does not include surgical faculty growth in ER, OB/GYN and Dermatology). As a result we have seen significant growth in inpatient and outpatient surgeries, which has resulted in the number of surgical cases in the last two fiscal years growing by 5.52% for inpatient cases and 5.83% for ambulatory cases.*
>
> *As previously demonstrated, this increase in faculty has pushed NCBH OR case load to its maximum capacity earlier than anticipated. Wake Forest University Health Sciences (WFUHS) intends to continue to add incremental surgeons to meet patient demands and has recently released surgical faculty projections through 2020. The projections are derived from an annual assessment of faculty recruitment plans and the NCBH strategic facilities plans, which includes the expected addition of clinical faculty over the next ten years. As all surgical practices are located within the Academic Medical Center, all surgical time will be spent on the NCBH campus."*

In Exhibit 8, the applicant provides a letter from William B. Applegate, MD, President, Wake Forest University Health Sciences and Dean of the Wake Forest University School of Medicine, which includes the following chart illustrating the current and projected number of clinical and research faculty in the Division of Surgical Sciences.

Specialty	Current Faculty—Jan 2010			Projected Additional Faculty – 2010 to 2020			Projected Total Faculty—2020		
	Clinical	Research	Total	Clinical	Research	Total	Clinical	Research	Total
Cadiothoracic Surgery	9	1	10	2	0	2	11	1	12
Emergency	23	4	27	6	0	6	29	4	33
General	25	4	29	6	0	6	31	4	35
Hypertension	0	8	8	0	2	2	0	10	10
Neurosurgery	7	4	11	6	4	10	13	8	21
Ophthalmology	16	0	16	4	0	4	20	0	20
ENT	11	1	12	3	1	4	14	2	16
Plastics	6	4	10	3	3	6	9	7	16
Urology	8	3	11	6	2	8	14	5	19
Vascular	8	0	8	3	0	3	11	0	11
Total	**113**	29	142	**39**	12	**51**	152	41	**193**

As shown in the table above, WFUHS projects to add 39 clinical and 12 research faculty to the Division of Surgical Services over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% over the 10-year period. The existing and proposed clinical faculty will perform both inpatient and outpatient surgical procedures in the existing surgical suite in Ardmore Tower and outpatient surgical procedures in the proposed WCSC.

Need to Support the Innovations and Research of NCBH as an Academic, Tertiary/Quaternary Hospital

In Section III.1(a), pages 50-51, the applicant states,

> *"NCBH's patients experience a much higher acuity level than other health care providers within the region. In fact, according to the North Carolina Hospital Association, in FFY 2008 NCBH's acuity level was the second highest amongst the state's other academic medical centers and statewide.*

Facility	*North Carolina Baptist Hospital*	*Duke University Hospital*	*Pitt County Memorial Hospital*	*UNC Hospitals*
Case Mix Factor	*1.71*	*1.77*	*1.66*	*1.49*
Rank Among AMC's	*2*	*1*	*3*	*4*

**Source: North Carolina Hospital Association*

These high acuity levels provide insight into the type of patients that NCBH treats. In essence, it means that the patients seen at NCBH are sicker on average than any other provider's patient cohort in the state. These patients require more complex [sic] *and more health care services. They require subspecialties and treatments that are not offered by most providers. Thus, the needs of these types of patients, and the resulting demand on their providers, such as NCBH, Duke, Pitt, or UNC, are not comparable to other patients and community-based providers within the state."*

Furthermore, on page 50, the applicant states,

"The State Health Coordinating Council's (SHCC) Acute Care Committee State Planning methodology does not appropriately account for patient acuity and the longer case times required for higher acuity patients. As previously discussed, the 5 year average inpatient case time is 3.12 and 1.79 for ambulatory cases. Therefore, the State formula does not allow NCBH to accurately reflect its true capacity.

Absent additional capacity, NCBH will find it increasingly difficult to meet the needs of these complex patients referred have [sic] *that originate within the service area and beyond. As the only tertiary and academic medical center within western North Carolina, NCBH must be allowed the capacity and capabilities to continue to support this important need and its function as a teaching facility and tertiary, quaternary referral center.*

Currently, NCBH experiences significant wait times and/or inconvenient block scheduling with surgeries now scheduled as late at 8:00 p.m. Additional OR capacity will reduce wait times and inconvenient scheduling for patients and surgeons which impacts clinic availability. For high acuity patients in particular, the delay in treating their illness when surgery is part of the plan of care can impact their health and future prognosis. Without the proposed incremental ORs, patient-waiting time will continue to increase."

Increase in the Amount of Minimally Invasive Surgical Procedures

In Section III.1(a), pages 47-48, the applicant states,

> *"As an academic teaching hospital, NCBH is at the forefront of care delivery and as such will continue to adapt its techniques to both speed the recovery process and to enhance the outcome from surgery itself. In the last several years, NCBH surgeons have received advanced training in techniques such as laparoscopy and robotics. As a result, NCBH surgeons estimate that as much as 20 percent of the current surgeries performed use one of the minimally invasive techniques. Projections suggest that we will continue to see an increase in these laparoscopic and robotic techniques to perform surgeries because of the benefits to the patients: smaller incision, minimization of patient pain, fewer complications and a shorter recovery time. With smaller incisions and shorter recovery surgeries, NCBH expects that many surgical procedures will continue to migrate from the inpatient setting to the outpatient setting.*
>
> ...
>
> *Because of* [sic] *potential of such surgical interventions and the quality of the outcomes we have also seen an increase in the number of surgeons being trained on this and* [sic] *equipment and performing these services."*
>
> *This increase in the number of robotic assisted surgeries has also precipitated the need for the enhanced Robotics Training Institute mentioned earlier in the application. NCBH's goal* [sic] *is to become a world class multi-specialty surgical program comprised of leading urologic, gynecologic, colorectal, and cardiac physicians dedicated to providing superior patient outcomes through the use of robot assisted laparoscopic technology."*

Need to Accommodate Increasing Patient Demand

In Section III.1(a), page 49, the applicant states,

> *"Between 2009 and 2014, the average annual growth rate is projected to be 1.4%. Currently, 56% of the population who receive surgery are ages 45 and over. Therefore, this trend was taken into consideration in our analysis based on the expectation that the 45-64 and 65 and higher age groups represent the segment of the population that will most likely utilize the ORs proposed in this project...These two cohorts are expected to experience continued growth at a rate of 1.6% for ages 46-64 and 3.3% for those aged 65 and higher between 2009 and 2014. Pediatric information is included in order to provide a complete picture of the age distribution; however, all of the ORs in the proposed project are expected to be utilized by patients ages 18 and older."*

NCBH Campus—Ardmore Tower—Growth in Demand Exhausts Capacity

In Section III.1(a), pages 51-52, the applicant states,

> *"For NCBH's surgical services, the growth in demand has forced NCBH to extend operating case times well beyond the 7 am to 5 pm weekday period that is strongly preferred by surgeons and their patients. Currently NCBH schedules surgeries from 7 am to 9 pm and schedules six ORs on Saturdays as well. Between FY 2005 and FY 2009, Surgical Services experienced a 25 percent increase in the number of surgical hours. While this increase in hours has provided a temporary solution, it is unworkable in the long term to extend surgery hours from 7:30 am to 11:00 pm, which is currently planned. It should be noted, of NCBH's 32,129 current operating room cases, about 2,000 cases are now performed on nights and weekends to accommodate the increase in volume.*
>
> *Currently, wait times can exceed 2-3 hours and there is up to a two month back log for certain types of procedures such as orthopaedics/bone and joint, hip scopes, ophthalmology, and urologic robotics cases. ORs are also open on holidays to accommodate the current backlog of schedule surgeries.*
>
> *Scheduling surgeries in the evening and on weekends create inconveniences and dissatisfaction for the referring physicians, the surgeons, patients and their families. Moreover, this demand crunch in the surgical suite creates inefficiencies for patient flow, and challenges for finding, training and retaining qualified staff to fill positions ranging from RNs, surgical techs, patient transporters, lab techs and other support personnel.*
>
> *NCBH's ability to currently accommodate the growing demand is increasingly challenged. In order to develop and offer adequate capacity, both for the current level of demand and for the anticipated higher levels to come, NCBH has determined that this project is a priority for NCBH."*

Need to Address Capacity Enhancement

In Section III.1(a), page 52, the applicant states,

> *"A major complicating factor for NCBH is that its 36 shared ORs serve a wide variety of patients, including inpatient, outpatient and elective cases and as a result, patient acuity and risks also vary. As a result, OR cases comingled in our 40 ORs vary from 30 minutes to 8 hours or more, depending on the surgical specialty and patient needs creating challenges for staffing appropriately.*
>
> *NCBH currently experiences a mix of approximately 42% inpatient surgical cases and 58% outpatient surgical cases. The needs and circumstances of these two groups can be substantially different. For the less complex and lower acuity cases including certain*

ophthalmology, orthopedics, ENT, and some plastics, the surgical cases are often less complex and can take less time, NCBH feels a model that would remove these patients from the Ardmore Tower location would allow faculty to utilize ORs and equipment located in Ardmore Tower to more efficiently perform the higher acuity, more complex case."

Need for Additional Procedure Room Capacity

In Section III.1(a), pages 52-53, the applicant states,

"Over the past several decades, the healthcare system and the advent of new technology and innovation has made frequent changes to how various surgical procedures are performed. Currently, some procedures must be performed in an OR (such as open heart), but other procedures (such as sutures or partial knee replacements) do not need to be performed in an OR. Further, there are many patients who need a procedure that could be performed in either an operating room or procedure rooms. The determination about which of those rooms is most appropriate depends on the specific procedure and the circumstantial needs that are specific to an individual patient. The types of individual patient needs is based on medical judgment and include co-morbidities, complications, the patient's age, patient weight, anesthesia needs and other factors.

...

NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project."

Projected Utilization—ORs

In Section IV, pages 82-84, the applicant provides historical and projected OR through the third fiscal year after completion of the proposed project, as shown in the following table.

Location	Historical Years		Interim Years			Project Years		
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
# of Dedicated Inpatient ORs	4	4	4	4	4	4	4	4
# of Inpatient Surgical Cases*	12,743	13,446	14,091	14,683	15,344	16,111	16,917	17,763
# of Shared ORs	36	36	36	36	36	35	35	35
# of Dedicated Outpatient ORs	0	0	0	0	0	8	8	8
# of Outpatient Surgical Cases at NCBH (all locations)	17,654	18,683	19,617	20,598	19,805	20,894	22,043	23,256
Total Surgical Cases	30,397	32,129	33,708	35,281	35,149	37,005	38,960	41,019

*Includes Open Heart and C-Section cases.

NCBH proposes to shift a portion of outpatient surgical cases from the existing surgical suite in Ardmore Tower to the proposed WCSC. In Section III.1(b), page 58, the applicant states,

> *"Step 6: Calculate the percentage of FY 2009 West Campus volumes to the total outpatient surgical cases for FY 2009, which are presented in Table 13.*

Ratio of Low Acuity/Adult Only Ambulatory Cases Divided into Total Ambulatory Cases	
FY 09 NCBH Ambulatory OR Volumes	*18,683*
FY 09 West Campus Volumes	*7,473*
FY 09 Percentage	*40%*

> *For FY 2009, the criteria test discussed above resulted in* [sic] *the determination that 40% of NCBH's ambulatory case volumes would be appropriate to shift to West Campus."*

The number of outpatient surgical cases to be performed in the proposed WCSC and in the existing surgical suite in Ardmore Tower in the first three years of the project is illustrated in the following table:

Location	Project Years		
	FY 2013	FY 2014	FY 2015
# of Outpatient Surgical Cases to be Performed in Existing Surgical Suite in Ardmore Tower	12,536	13,226	13,954
# of Outpatient Surgical Cases to be Performed in the Proposed WCSC	8,358	8,817	9,302
Total # of Outpatient Surgical Cases at NCBH	**20,894**	**22,043**	**23,256**

In Section III.1(b), page 54, the applicant states,

> *"NCBH engaged in a broad based planning discussions that have evolved over time to address the issues the Division of Surgical Sciences was experiencing as it relates to current OR capacity, block scheduling, the increased number of faculty and planned recruitment efforts. The planning process included a review of historical growth rates for surgical case volumes, assessment of current and future capacity constraints and proposed growth methodologies to project future OR demand. Population growth of our 19-county service area and the growth rates reported in the Pediatric ED and Cancer Center Expansion Certificate of Need applications were considered as well. The projections were vetted through senior leadership and growth rates that reflected all of these variable were developed."*

In Section III.1(b), pages 54-64, the applicant provides the assumptions and methodology used to project OR utilization through the third project year. The applicant first determined the historical growth in inpatient and outpatient surgical case volumes at NCBH from FY 2005 to FY 2009, as shown in the following table:

Year				*Growth Rate*	*IP Growth Rate*	*OP Growth Rate*
	IP	*OP*	*Total*			
FY 2005	*12,732*	*15,637*	*28,009*	-	-	-
FY 2006	*11,435*	*16,029*	*27,464*	*-1.95%*	*-7.57%*	*2.51%*
FY 2007	*12,428*	*16,165*	*28,593*	*4.11%*	*8.68%*	*0.85%*
FY 2008	*12,743*	*17,654*	*30,397*	*6.31%*	*2.53%*	*9.21%*
FY 2009	*13,446*	*18,683*	*32,129*	*5.70%*	*5.52%*	*5.83%*
CAGR (compounded annual growth rate)				*3.49%*	*2.10%*	*4.55%*

As shown in the above table, NCBH experienced a 14.7% growth in total surgical cases between FY 2005 and FY 2009, and a compound average growth rate (CAGR) of 3.49%. Inpatient surgical cases grew by 5.77%, resulting in a CAGR of 2.10%. Outpatient surgical cases grew by a larger rate of 19.47%, resulting in a CAGR of 4.55%.

Based on these historical growth rates and the addition of 39 clinical faculty in the Division of Surgical Services (a 34.5% increase in 10 years or approximately 3.5% per year), the applicant assumes inpatient surgical cases will increase 4.5% per year and outpatient surgical cases will increase 5.0% per year in the interim years and 5.0% and 5.5%, respectively, in the project years. In Section III.1(b), pages 55-56, the applicant states,

> *"Using the historical growth rates along with assumptions for future growth including primarily faculty recruitment, NCBH calculated inpatient and outpatient surgical case volumes for FY 2010 through FY 2015 in the following table utilizing an inpatient growth rate of 5% for the project years and an outpatient growth rate of 5.5% for the project years.*

GROWTH RATE		
	Inpatient	*Outpatient*
Interim Years	*4.50%*	*5.00%*
Project Years	*5.00%*	*5.50%*

INTERIM YEARS	*Inpatient*	*Outpatient*	*TOTAL*
FY 2010	*14,051*	*19,617*	*33,668*
FY 2011	*14,683*	*20,598*	*35,281*
FY 2012	*15,344*	*19,805*	*35,149*
PROJECT YEARS			
FY 2013	*16,111*	*20,894*	*37,005*
FY 2014	*16,917*	*22,043*	*38,960*
FY 2015	*17,763*	*23,256*	*41,018*

> *NCBH chose to project future operating room utilization using conservative annual growth rates of 4.5% for inpatient surgeries and 5.0% for outpatient surgeries during the interim years. NCBH's operating rooms maximum capacity of 36,500 cases was taken in consideration when determining the growth rates for the interim years. This capacity calculation is based on the existing block hours, the existing staff, and utilizing NCBH's average case length and an average turnover for all cases. During the three project years, the annual growth rates were increased by 0.50% for both inpatient and outpatient volumes, resulting in a 5.0% increase in surgical cases and an 5.5% increase in outpatient volumes.*
>
> *Surgical volumes in Davie Certificate of Need (CON ID # G-8078-08) were taken into consideration when developing the project surgical volumes in the proposed project."*

In Section III.1(b), page 57, the applicant used the above projected growth rates and the methodology for projecting OR need in the 2010 SMFP, to determine the number of ORs needed at NCBH in Project Year 3. The result is shown in the following table:

Year	Inpatient Cases	Inpatient Case Time	Total Inpatient Case Hours	Outpatient Cases	Outpatient Case Time	Total Outpatient Case Hours	Total Combined Hours	Hours per OR per Year	Projected ORs needed in 2015
Interim Years									
FY 2010	14,051	3.0	42,153	19,617	1.5	29,426	71,579	1,872	38.2
FY 2011	14,683	3.0	44,050	20,598	1.5	30,897	74,947	1,872	40.0
FY 2012	15,344	3.0	46,032	20,482	1.5	30,723	76,755	1,872	41.0
Project Years									
FY 2013	16,111	3.0	48,334	20,894	1.5	31,341	79,675	1,872	42.6
FY 2014	16,917	3.0	50,751	22,043	1.5	33,065	83,816	1,872	44.8
FY 2015	17,763	3.0	53,288	23,256	1.5	34,884	88,172	1,872	47.1

The table above shows that NCBH will need a total of 47.1 ORs in 2015, without excluding any ORs for burn and trauma services. NCBH is both a Burn and a Trauma Center. Pursuant to the need methodology in the 2010 SMFP, two ORs would be excluded, one for each service. NCBH currently has 40 ORs. Therefore, NCBH projects a need for seven incremental ORs by Project Year 3.

The applicant determined that 40% of NCBH's outpatient cases would be appropriate to shift to the proposed WCSC. See previous discussion. In Section III.1(b), page 59, the applicant states, *"For this projection methodology, the percentage of 40% is assumed to remain constant across all years, FY 2010 through FY 2015."*

Based on the applicant's projected total outpatient surgical volumes and the percentage of cases projected to shift to the proposed WCSC, the applicant used the methodology in the 2010 SMFP to determine the number of ORs needed at the proposed WCSC. In Section III.1(b), page 60, the applicant projects the number of ORs needed at WCSC as follows:

Year	*Outpatient Cases*	*Outpatient Case Time*	*Total Outpatient Case Hours*	*Hours per OR per Year*	*Projected ORs needed in 2015*
Interim Year					
FY 2010	*7,847*	*1.5*	*11,770*	*1,872*	*6.3*
FY 2011	*8,239*	*1.5*	*12,359*	*1,872*	*6.6*
FY 2012	*7,922*	*1.5*	*11,883*	*1,872*	*6.3*
Project Years					
FY 2013	*8,358*	*1.5*	*12,536*	*1,872*	*6.7*
FY 2014	*8,817*	*1.5*	*13,226*	*1,872*	*7.1*
FY 2015	*9,302*	*1.5*	*13,953*	*1,872*	*7.5*

As shown in the table above, 8 of the 47.1 ORs are needed in the proposed WCSC. Thus, the applicant proposes to add seven incremental ORs and relocate one shared OR from the existing surgical suite in Ardmore Tower to the proposed WCSC for a total of eight ORs.

Projected Utilization—Procedure Rooms

The applicant states that the proposed WCSC will also address NCBH's need for additional procedure room capacity. In Section III.1(a), page 53, the applicant states,

> *"NCBH believes that the benefit of having an adequate supply of procedure rooms is valuable for both the hospital and the community. As previously described, NCBH must create additional surgical services capacity to meet current and future demand. Currently, the NCBH campus does not have any available physical space to develop additional procedure rooms, and therefore, two procedure rooms are service components in the proposed project."*

In Section IV, page 85, the applicant provides projected utilization of the proposed procedure rooms in the WCSC, as shown in the following table.

	Project Years		
	FY 2013	**FY 2014**	**FY 2015**
# of Procedure Rooms	2	2	2
# of Procedures/Treatments	1,439	1,532	1,632

In Section III.1(b), pages 60-64, the applicant describes the methodology and assumptions used to project utilization of the proposed procedure rooms. The applicant used historical utilization of the three existing procedure rooms in the CompRehab Plaza to project utilization at the proposed WCSC. With the addition of the two proposed procedure rooms, NCBH would have a total of five procedure rooms upon project completion. Procedures are also performed in the six

Interventional Radiology (IR) and five Cardiac Catherization rooms at CompRehab. The applicant states that the procedures performed in these rooms were excluded because only specific procedures can be performed in these rooms, such as cardiac catheterization and IR or angiography procedures, which require specialized equipment. Moreover, the IR procedures are performed by radiologists not surgeons.

In Section III.1(b), page 61, the applicant states that procedures related to pain/physiatry, OB/GYN, plastics, and ENT are performed in the three procedure rooms in the CompRehab Plaza. The applicant reviewed the Top 20 procedures performed in the CompRehab Plaza procedure rooms, as well as NCBH patient records to identify procedures that would be eligible to be performed in a procedure room at the proposed WCSC. On page 61, the applicant states,

> *"The analysis excluded emergency room patients, all endoscopy patients, all interventional radiology patients, all cardiac cath patients and all patients whose procedure*[s] *were done in an operating room. The data in the table below indicates that, overall, the number of procedures performed at CompRehab has experienced an overall increase in the number of cases by over 200% in the last five years.*

Fiscal Year	*Cases Performed in a Procedure Room Volume*	*% Change from Previous Year*
2005	*1,032*	
2006	*1,344*	*30.23%*
2007	*1,992*	*48.21%*
2008	*2,798*	*40.46%*
2009	*3,217*	*14.97%*

The applicant states it assumed volumes would increase 6.5% per year through the third project year. The CAGR between 2005 and 2009 was 32.87%. Furthermore, in Section III.1(b), pages 62-63, the applicant states,

> *"NCBH believes this 6.5% growth rate is supportable based on the following assumptions:*
>
> - *Historical growth in cases performed in procedure rooms are expected to continue growing at a slower pace than the preceding five years. The slowdown in growth can be seen in the FY 08 to FY 09 change.*
> - *NCBH has recruited additional physicians that will continue to contribute to the increase in procedure case volumes at NCBH. NCBH will be adding an additional urologist and a physiatrist in Orthopaedics and Neurosurgery in 2010. Both of these faculty recruits are anticipated to increase the volume of pain*

management procedures and implantable pain devices as well as the number of urologic cases referred for prostate biopsies and other treatment."

The applicant states that projected procedure room volumes will be split between CompRehab and the proposed WCSC, thereby decompressing procedure room volumes at CompRehab. The applicant's methodology and assumptions results in the need for a total of five procedure rooms in Project Year 3, as illustrated in the following table:

Year	# of Procedures	Procedure Room Capacity*	Total # of Procedure Rooms Needed	# of CompRehab Procedures	# of West Campus Surgery Center Procedures	Total Procedure Room Procedures
Historical Years						
FY 2007	1,992	1040	2	1,992	-	1,992
FY 2008	2,798	1040	3	2,798	-	2,798
FY 2009	3,217	1040	3	3,217	-	3,217
Interim Years						
FY 2010	3,410	1040	3	3,426	-	3,426
FY 2011	3,649	1040	4	3,649	-	3,649
FY 2012	3,886	1040	4	3,886	-	3,886
Project Years						
FY 2013	4,139	1040	4	2,700	1,439	4,139
FY 2015	4,408	1040	4	2,876	1,532	4,408
FY 2016	4,694	1040	5	3,062	1,632	4,694

*On page 62, the applicant states, *"...for the purposes of this CON application the capacity for each procedure room is determined to be 4 cases per day for 260 days per year, for a total annual capacity of 1,040 cases per procedure room, and a total annual capacity for the three rooms of 3,120."*

Need Analysis

Based on projected faculty recruitment to expand teaching, research, and training within the Division of Surgical Sciences at the Wake Forest School of Medicine and the current utilization of NCBH's existing ORs, NCBH does not have the capacity to accommodate the projected increase in surgeons without additional OR capacity. WFUHS projects to hire an additional 39 clinical and 12 research faculty for the Division of Surgical Sciences over the next 10 years, for a total of 193 clinical and research faculty by 2020, or an increase of 34.5% in clinical faculty and 41.4% in research faculty. The overall increase is 35.9% in the Division of Surgical Sciences faculty over the 10-year period. This represents an average increase of 3.9 clinical faculty members per year (39 new clinical faculty / 10 years), or 3.5% per year (34.5% increase in clinical faculty / 10 years = 3.5%). The total complement of existing and proposed ORs in the existing surgical suite in Ardmore Tower and the proposed WCSC will be utilized by the existing and future clinical and research faculty.

The applicant projects inpatient surgical cases will grow at a rate of 4.5% during the interim years and 5.0% during the project years. Based on historical information provided by the applicant, the CAGR for inpatient surgical cases from FY 2005 to FY 2009 was 2.1%. Information reported on NCBH's license renewal applications (LRAs) from 2005 to 2009 (which uses federal fiscal year data) shows that NCBH performed 11,847 inpatient surgical cases in FFY 2005 and 13,357 inpatient surgical cases in FFY 2009, resulting in a CAGR of 3.0%. Although the projected growth rate for the interim and project years is greater than the CAGR for the past four years, the actual growth rate from FY 2008 to FY 2009 was 5.52%. While the CAGR for outpatient surgical cases was from FY 2005 to FY 2009 was 4.55%, the applicant's projected growth rate of 5.0% and 5.5% for the interim and project years is less than the actual growth in outpatient surgical procedures at NCBH in recent years. Between FY 2007 and FY 2008, outpatient surgical cases grew by 9.21%, and between FY 2008 and FY 2009 by 5.83%. The applicant's assumptions regarding projected growth in surgical cases are reasonable, given current utilization, historical growth and the addition of 39 clinical Division of Surgical Services faculty. The applicant anticipates a 34.5% increase in clinical surgeons by 2020 (39 / 113 = 0.345).

Furthermore, NCBH's case length exceeds the case lengths used in the SMFP methodology for projecting OR need, which is 3.0 hours for inpatient cases and 1.5 hours for outpatient cases. The applicant states that NCBH's five year average case length from FY 2005 to FY 2009 was 3.17 for inpatient cases and 1.79 for outpatient cases. However, NCBH's 2010 LRA shows an average case length of 4.17 hours for inpatient cases and 2.13 hours for outpatient cases. This supports the applicant's assumption that patient acuity is a factor driving the need for additional OR capacity at NCBH.

The applicant adequately demonstrates the need to develop seven additional ORs pursuant to Policy AC-3 [See Criterion (1) for discussion] and to relocate one existing shared OR to a new building on campus which will house eight dedicated outpatient ORs, two procedure rooms, a robotic training room and a simulation OR.

In addition to increasing the OR capacity for current and future clinical and research faculty, the proposed WCSC will house a simulation OR and robotics training room. The simulation OR will provide students, nurses and faculty with a variety of training experiences in a real-life setting. The purpose of the robotics training room is to train surgeons interested in laparoscopic surgery and other minimally invasive procedures utilizing the da Vinci Surgical Robot. The applicant adequately demonstrates that co-locating the simulation OR and robotics training room in the same building will support the training needs of surgeons, surgical residents, fellows and medical students, and will also allow for increased operational efficiencies.

In summary, the applicant adequately identified the population to be served and demonstrated the need that the population has for proposal. Therefore, the application is conforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

CA

In Section III.8, pages 77-79, the applicant describes the alternatives considered. Further, the application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1) (3), (5), (6), (7), (8), (12), (13), (14), (18a), (20) and the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100. Therefore, the applicant adequately demonstrated that the proposal is its least costly or most effective alternative and the application is conforming to this criterion and approved subject to the following conditions.

1. **North Carolina Baptist Hospital shall materially comply with all representations made in the certificate of need application.**

2. **North Carolina Baptist Hospital shall develop no more than 7 additional operating rooms pursuant to Policy AC-3 in the 2010 SMFP and relocate 1 existing shared operating room to the new West Campus Surgery Center (licensed as part of the hospital), which shall be utilized for outpatient surgical services. The West Campus Surgery Center shall include no more than 8 operating rooms, 1 robotics training room, a simulation operating room (unlicensed) and 2 procedure rooms.**

3. **Upon completion of the project, North Carolina Baptist Hospital shall be licensed for a total of no more than 47 operating rooms (35 shared operating rooms, 4 dedicated inpatient operating rooms, and 8 dedicated outpatient operating rooms).**

4. **North Carolina Baptist Hospital shall not acquire, as part of this project, any equipment that is not included in the project's proposed capital expenditure**

in Section VIII of the application or that would otherwise require a certificate of need.

5. **Prior to issuance of the certificate of need, North Carolina Baptist Hospital shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

C

In Section VIII, page 108, the applicant projects the total capital expenditure for the project will be $38,709,009, which includes $4,008,285 for site preparation costs; $18,198,034 for construction costs; $4,331,077 for fixed equipment; $4,083,446 for movable equipment; $344,403 for furniture; $4,067,385 for consulting fees and interest during construction; $2,220,632 for contingency; and other costs of $1,455,748. In Section IX, page 113, the applicant projects working capital will not be required since the project is an expansion of existing surgical services. The applicant proposes to finance the capital cost with the accumulated reserves of NCBH. Exhibit 16 contains a letter from the Vice-Treasurer of NCBH, which states,

> *"North Carolina Baptist Hospital agrees to make available from its accumulated reserves a total of $38,709,009 for the capital costs incurred in the development of the aforementioned project."*

Additionally, Exhibit 17 contains the audited financial statements for North Carolina Baptist Hospital and Affiliates. As of June 30, 2009, NCBH had $44,061,000 in cash and cash equivalents, $1,308,427,000 in total assets, and $714,802,000 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In the pro forma revenue and operating cost statements, the applicant projects that the hospital's revenues will exceed operating costs in each of the first three full operating years. See Form B. The applicant also projects that WCSC's revenues will exceed operating costs in each of the first three full operating years. See Form C. The assumptions used by the applicant in preparation of the pro formas are reasonable, including projected utilization. See Criterion (3) for discussion of projected utilization.

In summary, the applicant adequately demonstrated the availability of funds for the capital needs of the project and that the financial feasibility of the proposal is based upon reasonable assumptions regarding projected revenues and operating costs. Therefore, the application is conforming to this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

C

The applicant adequately demonstrated the need to construct a new building on campus to house eight operating rooms (seven incremental operating rooms pursuant to Policy AC-3 and one existing to be relocated), two procedure rooms, one simulation operating room and one robotics training room. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrated the proposed project would not result in unnecessary duplication of existing or approved health service capabilities or facilities, and the application is conforming to this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

In Section VII, pages 99-100, the applicant provides the current staffing for surgical services at NCBH, as well as the projected staffing for the proposed WCSC. The applicant projects that the WCSC will be staffed with 86.8 full-time equivalent (FTE) positions in the second year of the project. In Section VII.3(a), page 100, the applicant states that none of these positions are new positions. In Section V.4, pages 87-88, the applicant identifies Joseph R. Tobin, M.D., as having expressed interest in serving as the medical director for the WCSC. The applicant demonstrates the availability of adequate health manpower and management personnel to provide the proposed services and is conforming with this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section II.2(b), the applicant states,

> *"The West Campus Surgery Center will be operated as a department of NCBH and located on the same campus. The West Campus Surgery Center will include the ancillary*

> *services that are necessary to support the surgical cases and minor procedures that will be performed including Basic Imaging, Pharmacy, Sterile Processing, Post Anesthesia Care, Recovery, Pre-admission Testing and Bio-medical Engineering services. The staffing information in Section VII includes the on-site staff to provide these services. Other support services such as Facility Services and Environmental Services will be provided through the existing NCBH support departments as is done for other existing departments."*

In Section VI.9(b), page 95, the applicant states,

> *"As an academic medical center with a teaching hospital and a regional referral center for tertiary care, NCBH routinely accepts referrals from hospitals across North Carolina."*

Exhibit 12 includes copies of letters from WFUHS physicians supporting the proposed WCSC. The applicant adequately demonstrated the availability of the necessary ancillary and support services and that the proposed services would be coordinated with the existing health care system. Therefore, the application is conforming to this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated replacement members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of replacement health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

The applicant proposes to construct a new 72,300 square foot building on the hospital campus. The certified estimate of construction costs from the architect, included in Exhibit 21, is consistent with the construction costs reported by the applicant in Section VIII, page 108. In Section XI.6(b), page 124, the applicant estimates construction costs of $252 per square foot. In Section XI.8, page 125, the applicant describes the methods to be used to maintain efficient energy operations. The applicant adequately demonstrated that the cost, design, and means of construction represent the most reasonable alternative for the proposed project and that the construction project will not unduly increase the costs and charges of providing health services. See Criterion (5) for discussion of costs and charges. Therefore, the application is conforming to this criterion.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.12 and VI.13, pages 96-97, the applicant provides the current payor mix for the entire hospital, surgical services and the existing procedure rooms, as illustrated in the following tables.

NCBH – Entire Facility (includes inpatients)	
Self Pay/Indigent/Charity	5.7%
Commercial	1.5%
Medicare/Medicare Managed Care	39.4%
Medicaid	21.6%
Managed Care	28.8%
Other	3.0%
TOTAL	**100.0%**

NCBH – Surgical Services (includes inpatients)	
Self Pay/Indigent/Charity	5.5%
Commercial	1.7%
Medicare/Medicare Managed Care	31.6%
Medicaid	17.8%
Managed Care	39.5%
Other	3.9%
TOTAL	**100.0%**

NCBH – Procedure Rooms	
Self Pay/Indigent/Charity	5.8%
Commercial	0.5%
Medicare/Medicare Managed Care	33.5%
Medicaid	12.4%
Managed Care	42.9%
Other	4.9%
TOTAL	**100.0%**

The applicant demonstrates that it currently provides adequate access to medically underserved populations, and the application is conforming with this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

In Section VI.10(a), page 95, the applicant states that no civil rights access complaints have been filed against NCBH in the last five years. The application is conforming with this criterion.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Section VI.14, pages 97-98, the applicant projects the following payor mix for the proposed WCSC in Project Year 2, as illustrated in the following tables.

WCSC—ORs (outpatients only) FY 2014	
Self Pay/Indigent/Charity	6.1%
Commercial	0.9%
Medicare/Medicare Managed Care	35.7%
Medicaid	7.7%
Managed Care	46.0%
Other	3.6%
TOTAL	**100.0%**

WCSC—Procedure Rooms FY 2014	
Self Pay/Indigent/Charity	4.4%
Commercial	0.6%
Medicare/Medicare Managed Care	35.5%
Medicaid	12.7%
Managed Care	43.6%
Other	3.2%
TOTAL	**100.0%**

In the assumptions following the pro formas and a footnote on page 98, NCBH states the projected payor mix for services to be provided in the WCSC is based on historical experience. The applicant demonstrates that medically underserved groups will have adequate access to the proposed services, and the application is conforming with this criterion.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9(a), page 94, the applicant states,

> *"Patients have access to surgical services primarily through Wake Forest University physician referrals, community physician referrals, and admissions by physicians who have privileges at the hospital. As a tertiary, quaternary hospital, NCBH also admits and treats patients referred from other facilities. Patients are also admitted and treated through the Emergency Department."*

The applicant adequately demonstrated that it offers a range of means by which patients have access to the proposed services. The application is conforming to this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Section V.1(a), page 86, the applicant states,

> *"As an acute care facility that has been providing services for more than 85 years, NCBH has established relationships with many clinical training programs in the Southeast and continues to provide teaching opportunities for these schools. With the incremental ORs, NCBH will be able to continue to provide training support to the numerous clinical programs utilizing educational opportunities at the hospital by providing more space to accommodate students and new opportunities for learning experiences in an integrated inpatient and outpatient environment."*

A list of training programs and affiliates is included in Exhibit 10. NCBH is an "academic medical center teaching hospital," as that term is defined in the 2010 SMFP. Thus, the hospital serves as the primary teaching site for WFUHS and at least one other health professional school. The application is conforming with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact

on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

C

The applicant adequately demonstrated that its proposal will have a positive impact upon the cost effectiveness, quality and access to the proposed services. See Criteria (3), (5), (7), (8), (12), (13) and (20). Therefore, the application is conforming to this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

NCBH is accredited by the Joint Commission and certified for Medicare and Medicaid participation. According to the files in the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Acute and Home Care Licensure and Certification Section, no incidents occurred within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming to this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

C

NCBH, an "academic medical center teaching hospital," as defined in the 2010 SMFP, proposes to develop seven incremental ORs pursuant to Policy AC-3 in the 2010 SMFP as part of the proposed project. Therefore, the Criteria and Standards for Surgical Services and Operating Rooms, promulgated in 10A NCAC 14C .2100, are applicable to this review. The application is

conforming, to all applicable Criteria and Standards for Surgical Services and Operating Rooms. The specific criteria are discussed below.

SECTION .2100 – CRITERIA AND STANDARDS FOR SURGICAL SERVICES AND OPERATING ROOMS

.2102 INFORMATION REQUIRED OF APPLICANT

.2102(a) *An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:*

(1) gynecology;
(2) otolaryngology;
(3) plastic surgery;
(4) general surgery;
(5) ophthalmology;
(6) orthopedic;
(7) oral surgery; and
(8) other specialty area identified by the applicant.

-NA- NCBH proposes to add the seven incremental ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable.

.2102(b) *An applicant proposing to increase the number of operating rooms in a service area, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following information:*

(1) the number and type of operating rooms in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

-C- In Section II.10, page 25, the applicant provides the following information regarding the number of ORs in each licensed facility which NCBH owns a controlling interest in the service area.

NCBH Owned Facilities
Current Operating Room Inventory

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	36	2	4	42
Dedicated Ambulatory Surgical Center				
Dedicated C-Section				
Total	40	2	4	46

(2) the number and type of operating rooms to be located in each licensed facility which the applicant or a related entity owns a controlling interest in and is located in the service area after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

-C- In Section II.10, page 26, the applicant provides the following information regarding the number of operating rooms to be located in each licensed facility which NCBH owns a controlling interest in the service area.

NCBH Owned Facilities
Projected Operating Room Inventory

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Dedicated Open Heart				
Other Dedicated Inpatient	4			4
Shared Inpatient/Outpatient	35	2	4	41
Dedicated Ambulatory Surgical Center	8			8
Dedicated C-Section				
Total	47	2	4	53

(3) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases performed in the most recent

12 month period for which data is available, in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule:

-C- In Section II.10, page 27, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases performed in the most recent 12 month period in the ORs in each licensed facility listed in response to Subparagraphs (b)(1) and(b)(2) of this Rule.

NCBH Owned Facilities
Total Inpatient and Outpatient Surgical Cases and
July 2008 – June 2009

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Inpatient	13,446	8	832	14,286
Outpatient	18,683	119	2,508	21,310
Total	32,129	127	3,340	35,596

(4) The number of inpatient surgical cases, excluding trauma cases reported by Level I, II and III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-Section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule;

-C- In Section II.10, pages 27-28, the applicant provides the following information regarding the number of inpatient surgical cases (excludes trauma cases, burn center cases, and cases performed in dedicated open heart and dedicated C-Section rooms) and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project in the operating rooms in each licensed facility listed in response to Subparagraphs (b)(1) and (b)(2) of this Rule.

NCBH Owned Facilities
Total Projected Inpatient Surgical Cases
FY 2013 – FY 2015

Type	NCBH	Davie County Hospital*	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	16,111	9	866	16,986
Project Year 2 (FY 2014)	16,917	9	874	17,800
Project Year 3 (FY 2015)	17,763	10	883	18,656

*The applicant states the replacement hospital will not offer inpatient services until 2017 (Project I.D. # G-8078-08). Thus, the number of inpatient surgeries are not anticipated to increase until the project is complete and the replacement acute care beds become operational.

NCBH Owned Facilities
Total Projected Outpatient Surgical Cases
FY 2013 – FY 2015

Type	NCBH	Davie County Hospital	Lexington Memorial Hospital	Total
Project Year 1 (FY 2013)	20,894	2,411	2,651	25,956
Project Year 2 (FY 2014)	22,043	2,508	2,689	27,240
Project Year 3 (FY 2015)	23,256	2,608	2,726	28,590

(5) A detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule

-C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

(6) The hours of operation of the proposed operating rooms;

-C- In Section II.10, page 28, the applicants states,

> "[The] *NCBH West Campus Surgery location will operate the same as the NCBH Ardmore Tower location for outpatient surgeries, Monday through Friday from 6:00 am to 6:00 pm."*

(7) If the applicant is an existing facility, the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in the facility during the preceding 12 months and a list of all services and items included in the reimbursement;

-C- In Section II.10, page 29, the applicant provides the average reimbursement per procedure for the 20 surgical procedures most commonly performed at NCBH during the preceding 12 months. On page 28, the applicant states,

> *"Current surgical services included inpatients and outpatients, therefore these reimbursement rates included an inpatient stay where necessary. In addition, the reimbursement rates include the preoperative assessment clinic."*

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items in the reimbursement; and

-C- In Section II.10, page 30, the applicant provides the average reimbursement per procedure for the 20 surgical procedures which the applicant projects will be performed in the proposed WCSC. On page 30, the applicant states,

> *"These projected rates per case include the per-operative assessment clinic services, the surgery or procedure facility charges, anesthesia used during the surgery or procedure, necessary drugs, supplies and devices and recovery. Surgeon and anesthesiologist professional fees will be billed separately by the providers."*

(9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-C- In Section II.10, page 31, the applicant states,

> *"The traditional pre-operative assessment tests such as laboratory procedures and pharmacy medication reconciliations are included in the charge data, however any physician visits or other services incurred by the patients prior to the surgery or procedure are not included."*

.2102(c) *An applicant proposing to relocate existing or approved operating rooms within the same service area shall provide the following information:*

(1) the number and type of existing and approved operating rooms in each facility in which the number of operating rooms will increase or decrease (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(2) the number and type of operating rooms to be located in each affected facility

after completion of the proposed project and all previously approved projects related to these facilities (separately identifying the number of dedicated open heart and dedicated C-Section rooms);

(3) the number of inpatient surgical cases, excluding trauma cases reported by Level I, II, or III trauma centers, cases reported by designated burn intensive care units, and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases performed in the most recent 12 month period for which data is available, in the operating rooms in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

(4) the number of inpatient surgical cases, excluding trauma cases reported by level I, II, or III trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and dedicated C-section rooms, and the number of outpatient surgical cases projected to be performed in each of the first three operating years of the proposed project, in each facility listed in response to Subparagraphs (c)(1) and (c)(2) of this Rule;

(5) a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule;

(6) the hours of operation of the facility to be expanded;

(7) the average reimbursement received per procedure for the 20 surgical procedures most commonly performed in each affected facility during the preceding 12 months and a list of all services and items included in the reimbursement;

(8) the projected average reimbursement to be received per procedure for the 20 surgical procedures which the applicant projects will be performed most often in the facility to be expanded and a list of all services and items included in the reimbursement; and

(9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

-NA- The applicant does not propose to relocate existing operating rooms between existing licensed facilities in the same service area.

.2102(d) *An applicant proposing to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan shall provide:*

(1) the single surgical specialty area in which procedures will be performed in the proposed ambulatory surgical facility;

(2) a description of the ownership interests of physicians in the proposed ambulatory surgical facility;
(3) a commitment that the Medicare allowable amount for self pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent of the total revenue collected for all surgical cases performed in the proposed facility;

(4) for each of the first three full fiscal years of operation, the projected number of self-pay surgical cases;

(5) for each of the first three full fiscal years of operation, the projected number of Medicaid surgical cases;

(6) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the self pay surgical cases to be served in the proposed facility, i.e. provide the projected Medicare allowable amount per self-pay surgical case and multiply that amount by the projected number of self pay surgical cases;

(7) for each of the first three full fiscal years of operation, the total projected Medicare allowable amount for the Medicaid surgical cases to be served in the facility, i.e. provide the projected Medicare allowable amount per Medicaid surgical case and multiply that amount by the projected number of Medicaid surgical cases;

(8) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of self-pay surgical cases;

(9) for each of the first three full fiscal years of operation, the projected revenue to be collected from the projected number of Medicaid surgical cases;

(10) for each of the first three full fiscal years of operation, the projected total revenue to be collected for all surgical cases performed in the proposed facility;

(11) a commitment to report utilization and payment data for services provided in the proposed ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2;

(12) a description of the system the proposed ambulatory surgical facility will use to measure and report patient outcomes for the purpose of monitoring the quality of care provided in the facility;

(13) descriptions of currently available patient outcome measures for the surgical specialty to be provided in the proposed facility, if any exist;

(14) if patient outcome measures are not currently available for the surgical specialty area, the applicant shall develop its own patient outcome measures to be used for monitoring and reporting the quality of care provided in the proposed facility, and shall provide in its application a description of the measures it developed;

(15) a description of the system the proposed ambulatory surgical facility will use to enhance communication and ease data collection, e.g. electronic medical records;

(16) a description of the proposed ambulatory surgical facility's open access policy for physicians, if one is proposed;

(17) a commitment to provide to the Agency annual reports at the end of each of the first five full years of operation regarding:

> *(A) patient payment data submitted to the statewide data processor as required by G.S. 131E-214.2;*
>
> *(B) patient outcome results for each of the applicant's patient outcome measures;*
>
> *(C) the extent to which the physicians owning the proposed facility maintained their hospital staff privileges and provided Emergency Department coverage, e.g. number of nights each physician is on call at a hospital; and*
>
> *(D) the extent to which the facility is operating in compliance with the representations the applicant made in its application relative to the single specialty ambulatory surgical facility demonstration project in the 2010 State Medical Facilities Plan.*

-NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2103 PERFORMANCE STANDARDS

.2103(a) *In projecting utilization, the operating rooms shall be considered to be available for use five days per week and 52 weeks per year.*

-C- In Section II.10, page 32, the applicant states,

> *"NCBH based the utilization projection of the eight multispecialty surgical operating rooms for West Campus on 5 days per week, 52 weeks a year."*

.2103(b) *A proposal to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in an existing facility (excluding dedicated C-section operating rooms), to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless:*

(1) the applicant reasonably demonstrates the need for the number of proposed operating rooms in the facility, which is proposed to be developed or expanded, in the third operating year of the project is based on the following formula: {[(Number of facility projected inpatient cases, excluding trauma cases reported by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-Section rooms, times 3.0 hours) plus (Number of facilities projected outpatient cases times 1.5 hours) plus (Number of facility's projected outpatient cases times 1.5 hours)] divided by 1,872 hours} minus the facility's total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms. The number of rooms needed is determined as follows:

(A) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number less than 0.5, then the need is zero;

(B) in a service area which has six to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference

is a negative number or a positive number less than 0.3, the need is zero; and

(C) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and the difference is a negative number or a positive number less than 0.2, the need is zero; or

(2) the applicant demonstrates conformance of the proposed project to Policy AC-3 in the State Medical Facilities Plan titled "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects."

-C- The applicant demonstrates conformance of the proposed project to Policy AC-3 in the 2010 SMFP. See Criterion (1) for discussion. The applicant also demonstrates the need for the number of ORs proposed for NCBH. See Criterion (3) for discussion.

.2103(c) *A proposal to increase the number of operating rooms (excluding dedicated C-Sections operating rooms) in a service area shall not be approved unless the applicant reasonably demonstrates the need for the number of proposed operating rooms in addition to the rooms in all of the licensed facilities identified in response to 10A NCAC 14C .2102(b)(2) in the third operating year of the proposed project based on the following formula: {[(Number of projected inpatient cases for all the applicant's or related entities' facilities, excluding trauma cases report by Level I or II trauma centers, cases reported by designated burn intensive care units and cases performed in dedicated open heart and C-section rooms, times 3.0 hours) plus (Number of projected outpatient cases for all the applicant's or related entities' times 1.5 hours)] divided by 1,872 hours} minus the total number of existing and approved operating rooms and operating rooms proposed in another pending application, excluding one operating room for Level I or II trauma centers, one operating room for facilities with designated burn intensive care units, and all dedicated open heart and C-section operating rooms in all of the applicant's or related entities' licensed facilities in the service area. The number of rooms needed is determined as follows:*

(1) in a service area which has more than 10 operating rooms, if the difference is a positive number greater than or equal to 0.5, then the need is the next highest whole number for fractions of 0.5 or greater and the next lowest whole number for fractions less than 0.5; and if the difference is a negative number or a positive number less than 0.5, the need is zero;

(2) in a service area which has six to 10 operating rooms, if the difference is a positive number greater than or equal to 0.3, then the need is the next highest whole number for fractions of 0.3 or greater and the next lowest whole number for fractions less than 0.3, and if the difference is a negative number or a positive number less than 0.3, the need is zero; and

(3) in a service area which has five or fewer operating rooms, if the difference is a positive number greater than or equal to 0.2, then the need is the next highest whole number for fractions of 0.2 or greater and the next lowest whole number for fractions of less than 0.2; and if the difference is a negative number or a positive number less than 0.2, the need is zero.

-NA- NCBH is an academic medical center teaching hospital as that term is defined in the 2010 SMFP. Pursuant to G.S. 131E-183(b), the Agency is not authorized to require NCBH to demonstrate that any facility or service at another hospital is being fully utilized in order to be approved.

.2103(d) *An applicant that has one or more existing or approved dedicated C-section operating rooms and is proposing to develop an additional dedicated C-section operating room in the same facility shall demonstrate that an average of at least 365 C-sections per room were performed in the facility's existing dedicated C-section operating rooms in the previous 12 months and are projected to be performed in the facility's existing, approved and proposed dedicated C-section rooms during the third year of operation following completion of the project.*

-NA- The applicant does not propose to develop an additional dedicated C-section room.

.2103(e) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently utilized an average of at least 1,872 hours per operating room per year, excluding dedicated open heart and C-Section operating rooms. The hours utilized per operating room shall be calculated as follows: [(Number of projected inpatient cases, excluding open heart and C-sections performed in dedicated rooms times 3.0 hours) plus (Number of projected outpatient cases times 1.5 hours)] divided by the number of operating rooms, excluding dedicated open heart and C-Section operating rooms.*

-NA- The applicant does not propose to convert a specialty ambulatory surgery program to a multispecialty ambulatory surgery program or to add a specialty to a specialty ambulatory surgical program.

.2103(f) *An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgery program shall reasonably demonstrate the need for the conversion in the third operating year of the project based on the following formula: [Total number of projected outpatient cases for all ambulatory surgery programs in the service area times 1.5 hours) divided by 1,872 hours] minus the total number of existing, approved and proposed outpatient or ambulatory surgical operating rooms and shared operating rooms in the service area. The need for the conversion is demonstrated if the difference is a positive number greater than or equal to one, after the number is rounded to the next highest number for fractions of 0.50 or greater.*

-NA- The applicant does not propose to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program.

.2103(g) *The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this Rule.*

-C- In Section III.1(b), pages 53-64, the applicant provides a detailed description of and documentation to support the assumptions and methodology used in the development of the projections required by this Rule. See Criterion (3) for discussion.

.2104 SUPPORT SERVICES

.2104(a) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide copies of the written policies and procedures that will be used by the proposed facility for patient referral, transfer, and follow-up.*

-NA- NCBH is proposing to add ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2104(b) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility, or a new hospital shall provide documentation showing the proximity of the proposed facility to the following services:*

(1) emergency services;
(2) support services;

(3) *ancillary services; and*
(4) *public transportation.*

-NA- NCBH is proposing to add 7 ORs to its license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2105 STAFFING AND STAFF TRAINING

.2105(a) *An applicant proposing to establish a new ambulatory surgical facility, to establish a new campus of an existing facility, to establish a new hospital, to increase the number of operating rooms in a facility, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:*
(1) *administration;*
(2) *pre-operative;*
(3) *post-operative;*
(4) *operating room; and*
(5) *other.*

-C- In Sections VII.1 and VII.2, pages 99-100, and Sections VII.6(a) and (b), page 101-102, the applicant provides documentation of the availability of current and proposed staff to be utilized in each of the areas listed in this Rule.

.2105(b) *The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.*

-C- In Section VII.9(b), page 104, the applicant provides the number of physicians on the NCBH medical staff by specialty. In Section II.10, page 40, the applicant states,

> *"All of the NCBH medical staff who currently perform surgeries on the NCBH campus will be eligible to perform surgery in the West Campus building."*

In Section VII.8(a), page 103, the applicant states,

> *"Counting fellows and residents as well as faculty, the number of surgeons expected to utilize the West Campus Surgery Center will exceed 42 initially, all of which* [sic] *perform surgical services.."*

Additionally, Exhibit 15 contains a copy of NCBH's physician credentialing policies and procedures, which outline the criteria used in extending privileges.

.2105(c) *The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the service area in which the facility is, or will be, located or documentation of contacts the applicant made with hospitals in the service area in an effort to establish staff privileges.*

-C- In Section VII.8(a), page 103, the applicant states,

> *"Privileges to practice at NCBH are limited to physicians with appointments to the faculty at Wake Forest University School of Medicine whose credentials have been approved by the Executive Committee of the Medical Staff of NCBH."*

The applicant states that these physicians are expected to remain in good standing.

.2105(d) *The applicant shall provide documentation that physicians owning the proposed single specialty demonstration facility will meet Emergency Department coverage responsibilities in at least one hospital within the service area, or documentation of contacts the applicant made with hospitals in the service area in an effort to commit its physicians to assume Emergency Department coverage responsibilities.*

-NA- The applicant does not propose to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan.

.2106 *FACILITY*

.2106(a) *An applicant proposing to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations of the facility in which it is located.*

-NA- The applicant does not propose to establish a licensed ambulatory surgical facility that will be physically located in a physician's or dentist's office or within a general acute care hospital.

.2106(b) *An applicant proposing a licensed ambulatory surgical facility or a new hospital shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a comparable accreditation authority within two years of completion of the facility.*

-C- NCBH is already accredited by the Joint Commission.

.2106(c) *All applicants shall document that the physical environment of the facility to be developed or expanded conforms to the requirements of federal, state, and local regulatory bodies.*

-C- Exhibit 5 contains a letter from HKS, the architects for the proposed project, which documents that the physical environment will conform to the requirements of federal, state, and local regulatory bodies.

.2106(d) *An applicant proposing to establish a new ambulatory surgical facility, a new campus of an existing facility or a new hospital shall provide a provide a floor plan of the proposed facility identifying the following areas:*

(1) receiving/registering area;
(2) waiting area;
(3) pre-operative area;
(4) operating room by type;
(5) recovery area; and
(6) observation area.

-NA- NCBH is proposing to add 7 ORS to its existing license and locate them on the existing campus. Therefore, this rule is not applicable to this review.

.2106(e) *An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:*

(1) physicians;
(2) ancillary services;
(3) support services;
(4) medical equipment;
(5) surgical equipment;
(6) receiving/registering area;
(7) clinical support areas;

(8) *medical records;*
(9) *waiting area;*
(10) *pre-operative area;*
(11) *operating rooms by type;*
(12) *recovery area; and*
(13) *observation area.*

-NA- The applicant is not proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program.

EXHIBIT F TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Original

March 3, 2010
Comments Submitted by Novant Health
Regarding the January 15, 2010
NCBH CON Application for a New $38 Million
Ambulatory Surgery Center with Seven New ORs
Pursuant to SMFP Policy AC-3
(Project I.D. # G-8460-10)

Received by the
CON Section

03 MAR 2010 03 : 0

NCBH Does Not Meet the Criteria to Qualify for Special Consideration and Exemption from the Forsyth County OR Need Determination Under SMFP Policy AC-3 "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects"

Overview

In its January 15, 2010 CON Application, NCBH is seeking the state's approval to add seven new ORs in Forsyth County, even though the 2010 SMFP shows for Forsyth County the need for no new ORs in Forsyth County in Table 6 C of the 2010 SMFP. In fact, the 2010 SMFP in Table 6B shows a projected surplus of 5.52 operating rooms in Forsyth County, more than half of which is associates with ORs that are part of the NCBH/Wake Forest Health Sciences (including the recent acquisition of Plastic Surgery Center of North Carolina) operating room inventory. NCBH/WFU Health Sciences did not address the 2.65 surplus ORs at Plastic Surgery Center of NC in seeking approval for seven new ORs in its 8-OR Ambulatory Surgery Center. NCBH proposes to spend $38.7 Million to construct a 72,300 Square Foot Ambulatory Surgery Center ("the West Campus Surgery Center") with:

- 8 operating rooms (7 new ORs and 1 relocated OR from NCBH's existing surgical suites)
- 2 procedure rooms
- 1 simulation operating room (to provide a safe and lifelike learning environment for medical students, residents, fellows, nurses, and faculty to acquire essential skills required in clinical care)[1]
- 1 robotics training operating room (to train surgeons interested in laparoscopic surgery and other minimally invasive procedures using the DaVinci robot)[2]
- Sterile Processing in the ASC
- 23 Prep/Recovery Bays plus one patient isolation room
- 10 PACU Bays NCBH .
- 8 Short-Stay Recovery Rooms, including one Isolation Recovery Room

Under the special status afforded only to Academic Medical Centers under SMFP Policy AC-3, the applicant has a especially important burden of showing the need for new ORs in a County where a surplus of existing ORs already exists. SMFP Policy AC-3: "Exemption From Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects" states:

"Projects for which certificates of need are sought by academic medical center teaching hospitals <u>may</u> qualify for exemption from the need determinations of this document. The Medical Facilities Planning Section shall designate as an Academic Medical Teaching

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[1] NCBH CON Application page 14.
[2] NCBH CON Application page 15.

Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate, and postgraduate education.

2. Houses extensive basic medical science and clinical research programs, patients, and equipment.

3. Serves the treatment needs of patients from a broad geographic area through multiple medical specialists.

Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January, 1, 1990 provided the projects comply with one of the following conditions:

1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school.*

2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*

3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*

A project submitted by an Academic Medical Center Teaching Hospital under this policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital." [Emphasis Added]

NCBH Provides Insufficient Documentation and Explanation Needed to Demonstrate Compliance with the SMFP Policy AC-3 Requirement for the Necessity to Support an Expansion of Students, Residents or Faculty

In its CON application for an 8-OR Ambulatory Surgery Center, with seven new ORs, NCBH is seeking to quality for Policy AC-3 Exemption from SMFP Provisions for New OR Need Determinations in Forsyth County, using Criterion #1 above: "*Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school.*"

At pages 66-67 in Section II of the 8-OR ASC CON Application, NCBH briefly addresses the provisions of SMFP Policy AC-3, under which it is seeking an exemption from the finite limits of an OR Need Determination in Forsyth County, where such exemption is only available to Academic Medical Centers. Since SMFP Policy AC-3 grants a unique privilege to a handful of North Carolina hospitals that are Academic Medical Centers, it is imperative that the Academic Medical Center is diligent and through in demonstrating compliance with all the requirements of SFMP Policy AC-3 in order to qualify for this exemption, which is a unique exception, available to a chosen few hospitals, in the standard SMFP Need Determination process.

In its Policy AC-3 documentation, NCBH relies on a letter included in CON Application Exhibit #8 from Dr. Applegate, President Wake Forest University Health Sciences & Dean, Wake Forest University School of Medicine. This letter notes as justification for the Policy AC-3 Exemption:

- WFUHS projects to add 39 clinical FTEs to the Division of Surgical Sciences by 2020 (over the next ten years);

The faculty recruiting plan represents the addition of approximately 3.9 FTE clinical staff per year for the Division of Surgical Sciences for each of the next ten years. This seems like a modest and manageable rate of growth in surgical faculty that may also be offset by future retirements of surgical faculty, which were not discussed as part of WFUHS Surgeon Recruiting Plan. However, it is unclear whether the projected 12 additional "research" FTEs in the Division of Surgical Sciences would require access to the proposed operating rooms in the West Campus ASC.[3]

- 2 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Cardiothoracic Surgery," so it is unlikely that these surgeons will perform surgical cases in the proposed West Campus 8-OR surgery center.

- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as "Emergency"; it is unclear whether these are "emergency" surgeons or whether these 6 FTEs are Emergency Department physicians; if these 6 FTEs are Emergency Room physicians it is very unlikely that they would be performing surgery in the proposed 8-OR West Campus ASC.

- 6 of the 39 new Clinical FTEs in the Division of Surgical Sciences are identified as Neurosurgeons. It is not likely that neurosurgeons would be performing surgical cases on a regular basis in the proposed West Campus 8-OR ASC.

If you assume that fourteen (2 Cardiothoracic Surgery, 6 Emergency, and 6 Neurosurgery) of the 39 Clinical FTEs to be recruited for the Division of Surgical Sciences during the next ten years (2010- 2020) will not use the West Campus Surgery Center ORs, then WFUHS is proposing to add only 25 clinical FTEs to the Division of

[3] See the table in Dr. Applegate's letter at page 2. See CON application Exhibit #8 for a copy of this letter.

Surgical Sciences over the next ten years who could be reasonably expected to use the eight ORs at the West Campus surgery center. This represents the modest addition of approximately 2.5 FTE clinical surgical staff per year added to the Division of Surgical Sciences, who would require access to the eight ORs of outpatient surgical capacity proposed at the West Campus ASC.

These 25 FTEs of new clinical surgery FTEs to be recruited to the Division of Surgical Sciences over the next ten years include surgeons specializing in: General Surgery, Ophthalmology, ENT, Plastic Surgery, Urology, and Vascular Surgery. The most recent Medical Group Mangers Association "Physician Compensation and Production Survey: Based on 2008 Data" shows that at the 75 Percentile of annual surgical case productivity:

- Each Plastic Surgeon performs 598 surgical cases per year
- Each General Surgeon performs 832 surgical cases per year
- Each Vascular Surgeon performs 685 surgical cases per year
- Each Urological Surgeon performs 2,043 cases per year
- Each ENT Surgeon performs 1,141 cases per year

In total, one each of these five types of surgeons, if working at the highly productive 75th percentile, would generate about 5,300 outpatient surgical cases per year.[4] The MGMA Table is provided as Attachment 1. Applying the SMFP OR Need Method Weighting Factor of 1.5 Hours Per Outpatient Surgery, would result in 7,949 hours of ambulatory surgery cases per year; dividing this by the SMFP defined capacity for annual OR hours per year per OR of 1,872, shows, at best, a need for only 4 ORs[5], rather than the 7, for which NCBH is seeking approval. With only 2.5 FTEs of surgeons added on average each year over the next ten years, if those surgeons are going to use only the West Campus surgery center (which seems unlikely), these 2.5 FTE new surgeons might add 2,650 outpatient OR cases per year. These 2,650 outpatient cases would occupy about two ORs during the course of a year[6], so an initial request for 7 new ORs seems to be overstated for the proposed West Campus ASC. This is not enough outpatient OR case volume to suggest that as many as eight ORs are needed right now.

If these surgeons, functioned at only the MGMA Median Percentile of annual surgical case productivity, due to the added complexity of Academic Medical Center patients as discussed in the NCBH CON application, then the annual cases for the above five surgeon types would total only 3,671. This level of annual outpatient OR volume would utilize the capacity of about 3 outpatient ORs[7], based on the elements of the SMFP OR Need Method. Again, seven new ORs for the NCBH West Campus ASC, seems excessive at this point in time.

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[4]Calculation: 598 + 832 + 685 + 2,043 + 1,141 = 5,299 cases per year

[5]Calculation: (5,299 outpt OR cases X 1.5 Hours/Case)/1,872 Hours Per OR Per Year = 4.2 ORs

[6]Calculation: 2.5 FTE Surgeons generate half the annual outpatient OR cases that 5 surgeons would = 5,299/2 = 2,650 outpatient OR cases/year. Estimate OR capacity utilized: (2,650 outpatient OR cases X 1.5 hours per OR case)/1,872 hours per OR per year = 2.1 ORs

[7] Calculation: (3,671 outpatient OR cases/year X 1.5 hours per OR case)/1,872 hours per OR per year = 2.99 ORs

A lesser number of ORs at the proposed ASC would meet the needs in the near-term and would not run the risk of saturating the OR inventory in Forsyth County that already shows a surplus of 5.5 operating rooms in the 2010 SMFP. Also, an affiliate of NCBH, Wake Forest University Health Sciences, has notified the Agency of the exempt acquisition of a 3-OR Plastic Surgery Center in Forsyth County (Plastic Surgery Center of NC), which is licensed for three ORs, 2.65 of which are currently identified in the 2010 SMFP as underutilized ORs. It is puzzling that NCBH did not seek to relocate one or two of these operating rooms to the proposed 8-OR ASC, in order to put them to better, more productive use. In addition, two more operating rooms may well be added to the OR inventory in Forsyth County pursuant to the Triad (Forsyth and Guilford) Need Determination for two new Demonstration Project single specialty ambulatory surgery ORs in the 2010 SMFP. The CON Application deadline for these Demonstration Project ASC ORs is March 15, 2010. Given the above factors, adding seven new ORs to the Forsyth County OR inventory, which are projected to be operational in 2012, would simply compound the surplus of OR capacity in Forsyth County now and for the foreseeable future. Unnecessary Duplication is a statutory Review Criterion[8] which the Agency will apply in its consideration of NCBH's 8-OR ASC CON application.

NCBH's Application Fails to Discuss the Mandatory SMFP Policy AC-3 Provision Requiring the Academic Medical Center to Show that its Teaching Need for the Project Cannot be Achieved at Any Non-AMC Currently Offering the Service and Located within 20 miles of NCBH

The above criterion, as stated in SMFP Policy AC-3 is a mandatory requirement *("shall also demonstrate")* which must be discussed by NCBH in its SMFP Policy AC-3 CON Application for the new 8-OR Ambulatory Surgery Center. Neither the CON application narrative nor the CON Application Exhibits provided by NCBH address this requirement. The NCBH application is silent on this point.

The Agency should note that there are other Non-Academic Medical Center providers of ambulatory surgical services within a twenty-mile radius of NCBH. These surgical services providers include:

- Forsyth Medical Center, Winston-Salem, NC (including FMC's Hawthorne Surgery Center, with 6 ORs)
- Medical Park Hospital, Winston-Salem, NC
- Kernersville Medical Center, Kernersville NC (under development and slated to open prior to the 2010 opening date for NCBH's proposed 8-OR ASC)
- Davie County Hospital Replacement Facility, Advance, NC
- Clemmons Medical Center, Clemmons, NC

NCBH's CON application is devoid of any discussion of these options and thus, fails to meet this mandatory requirement to qualify for an SMFP Policy AC-3 exemption from the OR Need Determination in Forsyth County, which is zero new ORs in the 2010

[8] North Carolina General Statutes Section 131E-183(a)(6).

SMFP. Thus, the Agency should find NCBH non-conforming under CON statutory Review Criterion (1)[9], which requires the applicant to demonstrate that "the project is consistent with applicable policies [including SMFP Policy AC-3]...in the State Medical Facilities Plan."

Simulation Operating Room and Robotics Training Operating Room

Novant does not oppose the portion of NCBH's proposal that seeks approval for one simulation operating room and one robotics training operating room. Novant would note that many area hospital facilities and surgeons already have in use DaVinci robotic surgical technology (to be addresses in the NCBH Robotics Training OR), which is in use today at operating rooms at Forsyth Medical Center, Medical Park Hospital, High Point Regional Medical Center, and Moses Cone Hospital. A few years ago NCBH announced an enhanced clinical training agreement between NCBH and MCH.

[9]North Carolina General Statutes Section 131E-183(a)(6).

NCBH Overstates the Need for Additional Operating Rooms in its Quantitative Need Method in CON Application Section III

Review of NCBH AC-3 OR Need Methodology

1. The following analysis reflects a review of only the need for **total** operating rooms at NCBH. The need methodology for the West Campus Outpatient Surgery Center was not analyzed, only NCBH's total need for ORs.

2. For FFY 2005-FFY 2009, the NCBH annual inpatient surgical growth rate of 0.8% and annual outpatient surgical growth rate of 3.9%, as calculated in the following table, are significantly less than the NCBH reported inpatient surgery growth rate of 5.52% and the outpatient surgery growth rate of 5.83% reflected on page 55, Section III of the Application for 2008 to 2009, based upon a July to June timeframe.

NCBH Annual Surgical Growth

NCBH	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	AGR FFY 2008-FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357	0.8%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%	
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693	3.9%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%	

Source: Table 2; LRAs

NCBH's narrative on CON Application page 55, is addressing the CON Application Question III.1(b), which requires the applicant to *"provide statistical data that substantiates the existence of an unmet need for each project component and the proposed services..."* This is the most basic threshold which every applicant must demonstrate in its Certificate of Need Application to establish the most fundamental level of "need" for the project: the applicant must first and foremost demonstrate the "quantitative need" for the 8-OR ambulatory surgery center as measured by the Agency under CON Statutory Review Criterion 3 ("Need").[10]

Two years of data, such as that used by NCBH on pages 46 and 55 of its application, is not typically enough to establish a trend or a reliable growth rate for use in estimating future surgical cases that justify 8 ORs at the proposed surgery center. It seems that the annual percent growth rates for NCBH OR cases may be overstated, which if applied to base year data would suggest a need for more new ORs than can be supported in the future.

3. The NCBH annual growth rate for the last fiscal year as reported on page 55, Section III of the Application, is inconsistent and overstated when compared to LRA[11] data

[10] NCGS Section 131E-183(a)(3).
[11] LRA = Annual Hospital Licensure Renewal Application

for the timeframe FFY 2008 to FFY 2009 as shown in the following table. Note that NCBH uses a July to June Fiscal Year in the Application, rather than an October to September Fiscal Year (timeframe in LRAs). The data reported in the 2010 LRA is the most current data available which NCBH elected not to consider in its projections of OR cases to demonstrate the need for its existing ORs and the seven proposed new ASC ORs.

Comparison NCBH Surgical Growth Rates

	Actual One Year Growth Rates 2008-2009	
	LRA Data FFY 2008 and FFY 2009 October 2007 – September 2009	NCBH Reported SFY 2008 and SFY 2009 July 2007 – June 2009 Page 55
Inpatient Cases	0.8%	5.52%
Ambulatory Cases	3.9%	5.83%

Source: Table 2; LRAs and page 55

4. Based upon NCBH's own data reported by NCBH in these two documents the only conclusion to be made is that the rate of inpatient surgical growth dropped precipitously in the last quarter of FFY 2009 (July 1, 2009 – Sept. 30, 2009). Annual growth for the twelve months from July 2008 to June of 2009 was 5.52% which decreased to 0.8% (less than 1%) for the twelve months from October 2008 to September 2009. Likewise, NCBH outpatient surgical growth dropped during the last quarter of FFY2009, from 5.83% for the twelve months from July 2008 to June of 2009, to 3.9% for the twelve months from October 2008 to September 2009. This rapid decrease in growth in only three months was not discussed by NCBH nor was it taken into consideration in the application when determining the projected growth rate used in calculating future surgical utilization to justify the need for all existing and new ORs.

5. The high growth rates utilized by NCBH in Step 3 of its Quantitative Need Method in Section III.1(b) of the application on page 56 were based upon the growth experience of NCBH referenced on page 55. However, the historical growth rates reflected in the NCBH Annual Surgical Growth table included in #2 above, which also are more current growth rates than those presented on page 55 of the Application, reflect a much lower growth rate than that which was used to in the projections.

6. The compound annual growth rates for NCBH as calculated: (a) using the LRA data (see table in #2 above); (b) as reported on page 55 of the application; and (c) those utilized in the projections are reflected in the following table.

NCBH Reported CAGRs (Compound Annual Growth Rates) For OR Cases

	NCBH Reported SFY 2005-SFY2009 July 2004-June2009 Page 55	NCBH Interim Growth Rates Page 56	NCBH Project Year Growth Rates Page 56
Inpatient Cases	2.1%	4.5%	5.0%
Ambulatory Cases	4.55%	5.0%	5.5%

Source: Table 2; 2010 LRA and page 55

7. As shown in the previous table, the 4.5% interim time period inpatient NCBH annual OR case growth rate and the 5.0% Project Year inpatient annual growth rate used in Step 4 on page 57 of the Application is over twice the actual CAGR rate reported by NCBH on page 55. The 5.0% interim period NCBH outpatient OR case annual growth rate and the 5.5% Project Year outpatient annual OR case growth rate used in Step 4 on page 57 of the Application are half of a percent to one percent greater than the actual CAGR rate reported by NCBH on page 55. Both annual OR case growth rates utilized by NCBH in its projections are significantly greater than the more current LRA annual growth rates discussed in #1 above.

8. The projected growth rates utilized in Step 4 of the application on page 57 are contradictory to the most current historical growth rates reported in LRA and the CAGR reflected on 55 of the Application. Overstated growth rates result in overstated utilization. Therefore, the projected need for new operating rooms is overstated.

9. NCBH fails to acknowledge the recent purchase of Plastic Surgery Center of North Carolina by Wake Forest University Health Sciences, which is the teaching/research arm of the organization. North Carolina Baptist Hospital and Wake Forest University Health Sciences are "related entities" as that term is defined in the CON Surgical Services and Operating Room Regulations at 10A NCAC 14C.2101((9)[12]. As a result of this recent acquisition, the teaching and research arm of the institution now has three operating rooms which can be utilized for teaching, so it is not clear why seven additional operation rooms, or 10 overall (7 + 3), are needed for teaching at NCBH and Wake Forest Health Sciences. The PSCNC operating rooms are chronically underutilized operating rooms as listed in Chapter 6 of the SMFP and should be relocated to the proposed West Campus ASC, as part of the project.

10. Novant calculated revised number of operating rooms need at NCBH using the LRA 2005-2009 CAGR included in Table 7. The result is a need for only four additional ORs at NCBH when the Plastic Surgery Center of North Carolina (PSCNC) surplus

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[12] The definition of "related entity" states: "...or a company that shares common ownership with the applicant (i.e., the applicant [NCBH] and another company [Wake Forest University Health Sciences] are owned by some of the same persons."

of 2.65 out of 3 ORs into consideration. In late 2009 Wake Forest University Health Sciences, a "related entity" and affiliate of NCBH sought and received confirmation from the CON Agency for the CON exemption acquisition of PSCNC. This is shown in the following table and in Table 7. Note that the following projections do not take into consideration any shift in NCBH surgical volume to the new Davie County Hospital, which was described in the Davie County Replacement Hospital CON Application filed in March 2008 by NCBH. This project was approved, a Certificate of Need was issued by the Agency following settlement, which projects the DCH ORs to become operational anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,764	14,183	14,615	15,059	15,518	15,990
Annual Growth Rate	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,291	42,548	43,844	45,178	46,554	47,971
Ambulatory Cases	19,540	20,426	21,351	22,319	23,331	24,388
Annual Growth Rate	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	29,310	30,639	32,027	33,479	34,996	36,582
Total Weighted Cases	70,601	73,187	75,871	78,657	81,550	84,553
Licensed ORs needed at 1,872 cases/year	38	39	41	42	44	45
Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0	-1	-3	-4	-6	-7
NCBH Deficit Less Surplus at PSCNC	3.0	1.7	0.2	-1.3	-2.8	**-4.4**

11. Novant also calculated revised operating room need at NCBH using a weighted population growth rate for 45+ population based upon NCBH discussion on CON Application page 49, Section III and current NCBH surgical patient origin as calculated in the attached Table 8. This methodology results in a need for only 1.5 or 2.0 additional ORs at NCBH (includes PSCNC surplus) as shown in the following table and in the attached Table 6. The result is a need for only four additional ORs at NCBH (taking the PSCNC surplus into consideration) as shown in the following table and in Table 6. Note that the following projections do not take into consideration any shift in surgical volume to the new Davie County Hospital operating rooms, which can open anytime between now and 2014.

	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015
Inpatient Cases	13,695	14,041	14,397	14,761	15,134	15,517
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	41,085	42,124	43,190	44,282	45,403	46,551
Ambulatory Cases	19,166	19,651	20,148	20,658	21,180	21,716
Annual Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Weighted Ambulatory Cases at 1.5 hrs/case	28,749	29,476	30,222	30,986	31,770	32,574
Total Weighted Cases	69,834	71,600	73,412	75,269	77,173	79,125
Licensed ORs needed at 1,872 cases/year	37	38	39	40	41	42
NCBH Planning Inventory	38	38	38	38	38	38
Surplus/Deficit	0.7	-0.2	-1.2	-2.2	-3.2	-4.3
NCBH Deficit Less Surplus at PSCNC	3.4	2.5	1.5	0.5	-0.5	-1.5

12. NCBH July 2008-June 2009 does not appear to subtract trauma/burn cases but does subtract trauma/burn ORs from planning inventory. This will cause the need for existing and new ORs to be overstated.

13. The 2010 SMFP does not indicate that NCBH's existing operating rooms are currently operating at capacity as suggested on page 44 of the NCBH CON Application. In fact, the 2010 SMFP shows only that NCBH's operating rooms are not projected to be at planning capacity (80% of total capacity) until 2012.

14. Based upon surgical data included in Table 6A of the 2010 SMFP, NCBH and Plastic Surgery Center of NC have a current surplus of 4.5 operating rooms in 2010. Based upon the projected growth rate in the 2010 SMFP, the projected surplus in 2012 for NCBH plus Plastic Surgery Center decreases to 2.0 operating rooms. The proposed additional seven operating rooms in this Application are projected to be operational in July 2012 as reflected in Section XII of the Application, which will result in a combined surplus of 9.0 operating rooms in 2012 if the proposed Application is approved.

Conclusion

In May 2003, NCBH has filed an SMFP Policy AC-3 CON Application that was ultimately successful, for one MRI Scanner and one PET/CT Scanner for placement in the NCBH Cancer Center (CON Project I.D. #G-6816-03). In that case the project involved medical equipment only and capital cost for the MRI scanner was $3.1Million and the capital cost for the PET/CT Scanner was $2.96 Million, for a total of $6 Million in projects exempt from the SMFP need determinations. By contrast, NCBH's Jan. 15, 2010 CON application, seeks approval to spend $38 Million for seven new ORs, the relocation of one existing OR, a simulation OR, and a robotics training OR, plus all

associated support space in a 72,600 Square Foot facility. Given the magnitude of the proposed capital expenditure and the large number of new ORs, requested over and above the existing surplus of operating rooms in Forsyth County per the 2010 SMFP OR Need Determination, the Agency should give careful consideration to the scope and capital intensity of this project under the requirements of SMFP Policy AC-3. Seven new ORs in a county that currently has 84 ORs (excluding dedicated c-section ORs) is a substantial, practical increase in operating room capacity (+8%) in a County that has consistently for the past five years of Forsyth County OR 2006-2010 SMPF data shown a surplus of operating rooms ranging from 5.5 to 10.3 ORs[13]. The FFY 2009 OR case data (10/1/2008-9/30/2009) that will populate the 2011 SMFP, will be the first data to reflect the time period when the effects of the economic downturn were in full force and perhaps reflected in hospital volumes, including OR cases. Taken in that context, including the historical pattern some ongoing excess OR capacity in Forsyth County, NCBH's request for seven new ORs is too much, too soon. A less costly project, with a significantly smaller compliment of new ORs and greater relocation of existing ORs seems the more reasonable course at this point in time.

File: NCBH AC-3 OR Application analysis 3 3 2010.FINAL.doc

[13] Forsyth County OR Surpluses in annual State Medical Facilities Plans, Chapter 6: 2006 SMFP = 8.7 ORs; 2007 SMFP = 8.47 ORs; 2008 SMFP = 10.3 ORs; 2009 SMFP = 8.42 ORs; and 2010 SMFP = 5.5 ORs.

e 53: Physician Surgery/Anesthesia Cases (NPP Excluded) (continued)

	Phys	Med Pracs	Mean	Std. Dev.	25th %tile	Median	75th %tile	90th %tile
hinolaryngology	203	69	801	649	301	755	1,141	1,478
hinolaryngology: Pediatric	3	3	*	*	*	*	*	*
n Management: Nonanesthesia	9	7	*	*	*	*	*	*
hology: Anatomic & Clinical	5	1	*	*	*	*	*	*
hology: Anatomic	1	1	*	*	*	*	*	*
hology: Clinical	0	*	*	*	*	*	*	*
iatrics: General	827	100	149	177	48	92	176	332
diatrics: Adolescent Medicine	7	3	*	*	*	*	*	*
ediatrics: Cardiology	8	3	*	*	*	*	*	*
ediatrics: Child Development	0	*	*	*	*	*	*	*
ediatrics: Critical Care/Intensivist	8	4	*	*	*	*	*	*
ediatrics: Emergency Medicine	1	1	*	*	*	*	*	*
ediatrics: Endocrinology	4	4	*	*	*	*	*	*
ediatrics: Gastroenterology	6	4	*	*	*	*	*	*
Pediatrics: Genetics	0	*	*	*	*	*	*	*
Pediatrics: Hematology/Oncology	7	3	*	*	*	*	*	*
Pediatrics: Infectious Disease	2	2	*	*	*	*	*	*
Pediatrics: Neonatal Medicine	25	8	19	20	6	8	20	64
Pediatrics: Nephrology	2	2	*	*	*	*	*	*
Pediatrics: Neurology	4	3	*	*	*	*	*	*
Pediatrics: Pulmonology	5	4	*	*	*	*	*	*
Pediatrics: Urgent Care	0	*	*	*	*	*	*	*
Physiatry (Phys Med & Rehab)	68	33	644	661	68	287	724	1,620
Podiatry: General	62	33	1,752	993	1,031	1,748	2,304	2,004
Podiatry: Surg-Foot & Ankle	40	15	1,012	794	238	916	1,651	2,034
Podiatry: Surg-Forefoot Only	2	2	*	*	*	*	*	*
Psychiatry: General	9	7	*	*	*	*	*	*
Psychiatry: Child & Adolescent	3	2	*	*	*	*	*	*
Pulmonary Medicine	82	40	180	163	76	135	228	362
Pulmonary Medicine: Critical Care	32	10	176	110	78	146	248	346
Pulmonary Med: Gen & Crit Care	45	11	224	165	64	132	390	519
Radiation Oncology	17	7	12	17	1	3	20	48
Radiology: Diagnostic-Invasive	44	12	494	375	170	396	768	1,124
Radiology: Diagnostic-Noninvasive	170	23	220	271	34	91	318	650
Radiology: Nuclear Medicine	1	1	*	*	*	*	*	*
Rheumatology	104	52	543	576	198	398	645	1,128
Sleep Medicine	3	3	*	*	*	*	*	*
Surgery: General	449	117	644	542	399	600	832	1,194
Surgery: Bariatric	11	8	660	189	446	634	753	777
Surgery: Cardiovascular	121	33	300	154	202	265	350	477
Surgery: Cardiovascular-Pediatric	0	*	*	*	*	*	*	*
Surgery: Colon & Rectal	25	14	1,249	694	624	1,336	1,695	1,099
Surgery: Neurological	108	35	346	272	184	274	408	608
Surgery: Oncology	9	7	*	*	*	*	*	*
Surgery: Oral	7	2	*	*	*	*	*	*
Surgery: Pediatric	10	6	462	223	257	470	683	747
Surgery: Plastic & Reconstruction	55	27	514	431	212	438	690	1,182
Surgery: Thoracic (primary)	12	8	402	240	225	383	670	836
Surgery: Transplant	2	2	*	*	*	*	*	*
Surgery: Trauma	31	9	412	583	146	233	340	1,609
Surgery: Vascular (primary)	71	29	532	239	358	466	685	876
Urgent Care	231	36	246	179	102	209	373	477
Urology	298	68	1,427	825	815	1,413	2,043	2,432
Urology: Pediatric	4	2	*	*	*	*	*	*

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53 Community Mental Health Facility
54 Intermediate Care Facility for Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
62 Comprehensive Outpatient Rehabilitation Facility
65 End-stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory

Important: If ambulatory encounters are reported in question 20, respondents must complete question 26.

Question 21 – Hospital encounters

Report the total number of encounters, using the previous definition, with the following CMS place of service codes:

21 Inpatient Hospital
25 Birthing Center
26 Military Treatment Facility
51 Inpatient Psychiatric Facility
61 Comprehensive Inpatient Rehabilitation Facility

Question 22 – Surgery/anesthesia cases

Report the total surgery/anesthesia cases performed annually by each provider. A surgery/anesthesia case is a case between a provider and a patient where at least one procedure performed is a procedure from the surgery chapter (CPT codes 10021-69979) or the anesthesia chapter (CPT codes 00100-01999) of the *Current Procedural Terminology, Fourth Edition*, copyrighted by the American Medical Association (AMA).

Note that the number of cases, not procedures, should be counted since a case may consist of multiple procedures. Surgery/anesthesia cases include cases performed on an inpatient or outpatient basis, regardless of facility or site. For anesthesia care teams or an anesthesiologist who supervises one or more CRNAs, include total care team cases.

Questions 23 and 24 – RVUs

Report the RVUs, as measured by the RBRVS, not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, nonphysician providers, and other health care professionals. The RVU system is explained in detail in the November 27, 2007 *Federal Register*, pages 66,222 to 66,578. Addendum B: Relative Value Units (RVUs) and Related Information presents a table of RVUs by CPT code. Your billing system vendor should be able to load these RVUs into your system if you are not yet using RVUs for management analysis. When answering this question, note the following:

- The RVUs published in the November 27, 2007, *Federal Register*, effective for calendar year 2008, should be used; and
- The total RVUs for a given procedure consist of three components:
  - Physician work RVUs;
  - Practice expense (PE) RVUs; and
  - Malpractice RVUs.

Thus, Total RVUs = Physician Work RVUs + Practice Expense RVUs + Malpractice RVUs.

For 2008, there were two different types of practice expense RVUs:

1. Fully implemented nonfacility practice expense RVUs; and
2. Fully implemented facility practice expense RVUs.

"Nonfacility" refers to RVUs associated with a medical practice that is not affiliated with a hospital and does not utilize a split billing system that itemizes facility (hospital) charges and professional charges. "Nonfacility" also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center. You should report total RVUs in question 23 that are a function of "nonfacility" practice expense RVUs.

"Facility" refers to RVUs associated with a hospital affiliated medical practice that utilizes a split billing fee schedule where facility (hospital) charges and professional charges are billed separately. "Facility" also refers to services performed in a hospital, skilled nursing facility, or ambulatory surgery center. Do not report total RVUs in question 23 that are a function of "facility" practice expense RVUs. If you are a hospital affiliated medical practice that utilizes a split billing fee schedule, you should report your total RVUs in question 23 as if you were a medical practice not affiliated with a hospital.

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Table 1: NCBH OR Inventory FFY 2007-FFY 2009

	OR Inventory
Inpatient	4
Shared	36
Ambulatory	0
Total	40
Excluded ORs (Trauma Burn)	-2
OR Planning Invenotry	38

Souce: 2008-2010 LRAs

Table 2: NCBH OR Utilization and Need FFY 2005 - FFY 2009

	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	CAGR FFY 2005-FFY 2009	AGR FFY 2008-FFY 2009
Inpatient Cases	11,847	11,900	12,208	13,251	13,357	3.0%	0.8%
Annual Growth Rate		0.4%	2.6%	8.5%	0.8%		
Weighted Inpatient Cases at 3 hrs/case	35,541	35,700	36,624	39,753	40,071		
Ambulatory Cases	15,656	15,842	16,717	17,999	18,693	4.5%	3.9%
Annual Growth Rate		1.2%	5.5%	7.7%	3.9%		
Weighted Ambulatory Cases at 1.5 hrs/case	23,484	23,763	25,076	26,999	28,040		
Total Weighted Cases	59,025	59,463	61,700	66,752	68,111		
Planning Inventory	38	38	38	38	38		
Licensed ORs needed at 1,872 cases/year	32	32	33	36	36		
Surplus/Deficit	6	6	5	2	2		

Souce: 2006-2010 LRAs

Table 3: NCBH OR Utilization

	FFY 2007	FFY 2008	FFY 2009
Inpatient Cases	12,208	13,251	13,357
Weighted Inpatient Cases	36,624	39,753	40,071
Ambulatory Cases	16,717	17,999	18,693
Weighted Ambulatory Cases	25,076	26,999	28,040
Total Weighted Cases	61,700	66,752	68,111
Licensed ORs needed at 1,872 cases/year	33	36	36
OR Planning Inventory	38	38	38
NCBH Surplus (+) / Deficit (-)	5.0	2.3	1.6

Source: Tables 2; SMFP OR Need Methodology

Table 4: Plastic Surgery Center of NC OR Utilization

	FFY 2007	FFY 2008	FFY 2009	Future Surplus Used in Tables 6, 7
Ambulatory Cases	447	411	148	
Weighted Cases at 1.5 hrs/case	670.5	616.5	222	
Ambulatory ORs needed at 1,872 cases/year	0.36	0.33	0.12	
Licensed Ambulatory ORs	3	3	3	
PSCNC Surplus (+) / Deficit (-)	2.64	2.67	2.88	2.75
Combined NCBH and PSCNC Surplus (+) / Deficit (-)	7.68	5.01	4.50	

Souce: 2008-2010 LRAs; SMFP OR Need Methodology

Note: On 6/5/2009, CON Section issued Exempt from Review letter approving the acquisition of Plastic Surgery Center of NC, Inc. by Wake Forest Health Sciences

Table 5: NCBH OR Utilization and Projected Need in CON Application

	SFY 2009	SFY 2010 Jul2009-Jun2010	SFY 2011	SFY 2012	PY1 SFY 2013	PY2 SFY 2014	PY3 SFY 2015
Inpatient Cases	13,446	14,051	14,683	15,344	16,111	16,917	17,763
Weighted Inpatient Cases at 3 hrs/case	40,338	42,153	44,049	46,032	48,333	50,751	53,289
Ambulatory Cases	18,683	19,617	20,598	20,482	20,894	22,043	23,256
Weighted Ambulatory Cases at 1.5 hrs/case	28,025	29,426	30,897	30,723	31,341	33,065	34,884
Total Weighted Cases	68,363	71,579	74,946	76,755	79,674	83,816	88,173
Licensed ORs needed at 1,872 cases/year	37	38	40	41	43	45	47
Planning Inventory	38	38	38	38	38	38	38
Surplus/Deficit	1	0	-2	-3	-5	-7	-9

Table 6: Revised Projections NCBH OR Utilization and Projected Need Using 2009-2015 Weighted Population Growth Rate (Table 8)

	Actual			Projected						Weighted Population 45+ Growth Rate
	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015	
Inpatient Cases	12,208	13,251	13,357	13,695	14,041	14,397	14,761	15,134	15,517	2.5%
Annual Growth Rate		8.5%	0.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,085	42,124	43,190	44,282	45,403	46,551	
Ambulatory Cases	16,717	17,999	18,693	19,166	19,651	20,148	20,658	21,180	21,716	2.5%
Annual Growth Rate		7.7%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Weighted Ambulatory Cases at 1.5 hrs/case	25,076	26,999	28,040	28,749	29,476	30,222	30,986	31,770	32,574	
Total Weighted Cases	61,700	66,752	68,111	69,834	71,600	73,412	75,269	77,173	79,125	
Licensed ORs needed at 1,872 cases/year	33	36	36	37	38	39	40	41	42	
NCBH Planning Inventory	38	38	38	38	38	38	38	38	38	
Surplus/Deficit	5.0	2.3	1.6	0.7	-0.2	-1.2	-2.2	-3.2	-4.3	
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.4	2.5	1.5	0.5	-0.5	-1.5	

Table 7: Revised Projections **NCBH OR Utilization and Projected Need Using NCBH CAGR 2005-2009**

	Actual			Projected						CAGR FFY 2005 - FFY 2009
	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	PY1 FFY 2013	PY2 FFY 2014	PY3 FFY 2015	
Inpatient Cases	12,208	13,251	13,357	13,764	14,183	14,615	15,059	15,518	15,990	3.0%
Annual Growth Rate		8.5%	0.8%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	
Weighted Inpatient Cases NCBH LRA 3.0 hrs/case	36,624	39,753	40,071	41,291	42,548	43,844	45,178	46,554	47,971	
Ambulatory Cases	16,717	17,999	18,693	19,540	20,426	21,351	22,319	23,331	24,388	4.5%
Annual Growth Rate		7.7%	3.9%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	
Weighted Ambulatory Cases at NCBH LRA 1.5 hrs/case	25,076	26,999	28,040	29,310	30,639	32,027	33,479	34,996	36,582	
Total Weighted Cases	61,700	66,752	68,111	70,601	73,187	75,871	78,657	81,550	84,553	
Licensed ORs needed at 1,872 cases/year	33	36	36	38	39	41	42	44	45	
Planning Inventory	38	38	38	38	38	38	38	38	38	
Surplus/Deficit	5	2	2	0	-1	-3	-4	-6	-7	
NCBH Deficit Less Surplus at PSCNC	7.8	5.1	4.4	3.0	1.7	0.2	-1.3	-2.8	-4.4	

Table 8. NCBH Surgical Weighted Population 45+ Growth Rate

County	45-54	55-59	60-64	65-74	75-84	85-94	95+	45+	Total
2009									
DAVIDSON	25,004	10,397	9,610	12,882	7,109	2,387	218	67,607	160,917
DAVIE	6,433	2,879	2,552	3,442	1,877	674	67	17,924	41,668
FORSYTH	52,052	22,364	18,984	24,287	14,854	5,282	581	138,404	349,405
GUILFORD	70,164	30,140	25,388	32,202	18,944	7,118	828	184,784	476,642
STATE	1,380,324	583,777	497,297	656,941	371,605	130,155	12,889	3,632,988	9,397,548
2015									
DAVIDSON	26,478	12,551	10,553	16,506	7,906	2,685	261	76,940	176,383
DAVIE	6,680	3,291	2,975	4,422	2,193	740	77	20,378	45,856
FORSYTH	54,791	26,069	22,713	32,355	15,542	6,064	670	158,204	383,608
GUILFORD	76,722	35,445	30,661	44,105	20,352	8,038	1,013	216,336	526,426
STATE	1,487,394	694,884	597,553	862,242	409,772	144,932	15,990	4,212,767	10,424,250

	Annual Growth		Patient Origin	Weighted Pop Growth Rate
DAVIDSON	2.3%		6%	0.14%
DAVIE	2.3%		3%	0.07%
FORSYTH	2.4%		42%	1.00%
GUILFORD	2.8%		10%	0.28%
STATE	2.7%		39%	1.04%
				2.53%

Table 9: Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP

NCBH		PSCNC		FMC		Medical Park		Total	
Inpatient Cases	13,357	Inpatient Cases	0	Inpatient Cases - C-Section	10,361	Inpatient Cases	1,085	Inpatient Cases	24,803
Weighted Inpatient Cases at 3 hrs/case	40,071	Weighted Inpatient Cases at 3 hrs/case	0	Weighted Inpatient Cases at 3 hrs/case	31,083	Weighted Inpatient Cases at 3 hrs/case	3,255	Weighted Inpatient Cases at 3 hrs/case	74,409
Ambulatory Cases	18,693	Ambulatory Cases	148	Ambulatory Cases	12,676	Ambulatory Cases	10,531	Ambulatory Cases	42,048
Weighted Ambulatory Cases at 1.5 hrs/case	28,040	Weighted Ambulatory Cases at 1.5 hrs/case	222	Weighted Ambulatory Cases at 1.5 hrs/case	19,014	Weighted Ambulatory Cases at 1.5 hrs/case	15,797	Weighted Ambulatory Cases at 1.5 hrs/case	63,072
Total Weighted Hours	68,111	Total Weighted Hours	222	Total Weighted Hours	50,097	Total Weighted Hours	19,052	Total Weighted Hours	137,481
OR Planning Inventory*	38	OR Planning Inventory	3	OR Planning Inventory**	32	OR Planning Inventory	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	36.4	Licensed ORs needed at 1,872 cases/year	0.1	Licensed ORs needed at 1,872 cases/year	26.8	Licensed ORs needed at 1,872 cases/year	10.2	Licensed ORs needed at 1,872 cases/year	73.4
Surplus/Deficit (-)	1.6	Surplus/Deficit (-)	2.9	Surplus/Deficit (-)	5.2	Surplus/Deficit (-)	2.8	Surplus/Deficit (-)	12.6

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 9: Forsyth County OR Utilization and OR Need FFY 2008 Data - 2010 SMFP - Combined System OR Surplus

NCBH + PSCNC		FMC + MPH		Total	
Inpatient Cases	13,357	Inpatient Cases	11,446	Inpatient Cases	24,803
Weighted Inpatient Cases at 3 hrs/case	40,071	Weighted Inpatient Cases at 3 hrs/case	34,338	Weighted Inpatient Cases at 3 hrs/case	74,409
Ambulatory Cases	18,841	Ambulatory Cases	23,207	Ambulatory Cases	42,048
Weighted Ambulatory Cases at 1.5 hrs/case	28,262	Weighted Ambulatory Cases at 1.5 hrs/case	34,811	Weighted Ambulatory Cases at 1.5 hrs/case	63,072
Total Weighted Hours	68,333	Total Weighted Hours	69,149	Total Weighted Hours	137,481
OR Planning Inventory*	41	OR Planning Inventory**	45	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	36.5	Licensed ORs needed at 1,872 cases/year	36.9	Licensed ORs needed at 1,872 cases/year	73.4
Surplus/Deficit (-)	4.5	Surplus/Deficit (-)	8.1	Surplus/Deficit (-)	12.6

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 11: Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP

NCBH		FSCNC		FMC		Medical Park		Total	
Inpatient Cases	14,256	Inpatient Cases	0	Inpatient Cases - C-Section	11,058	Inpatient Cases	1,158	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	Weighted Inpatient Cases at 3 hrs/case	0	Weighted Inpatient Cases at 3 hrs/case	33,175	Weighted Inpatient Cases at 3 hrs/case	3,474	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	19,951	Ambulatory Cases	158	Ambulatory Cases	13,529	Ambulatory Cases	11,240	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	29,927	Weighted Ambulatory Cases at 1.5 hrs/case	237	Weighted Ambulatory Cases at 1.5 hrs/case	20,294	Weighted Ambulatory Cases at 1.5 hrs/case	16,860	Weighted Ambulatory Cases at 1.5 hrs/case	67,317
Total Weighted Hours	72,694	Total Weighted Hours	237	Total Weighted Hours	53,469	Total Weighted Hours	20,334	Total Weighted Hours	146,733
OR Planning Inventory*	38	OR Planning Inventory	3	OR Planning Inventory**	32	OR Planning Inventory	13	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	38.8	Licensed ORs needed at 1,872 cases/year	0.1	Licensed ORs needed at 1,872 cases/year	28.6	Licensed ORs needed at 1,872 cases/year	10.9	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	-0.8	Surplus/Deficit (-)	2.9	Surplus/Deficit (-)	3.4	Surplus/Deficit (-)	2.1	Surplus/Deficit (-)	7.6

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

Table 12: Forsyth County OR Utilization and OR Need 2012 - 2010 SMFP - Combined System OR Surplus

NCBH+RSCNC		FMC+MPH		Total	
Inpatient Cases	14,256	Inpatient Cases	12,216	Inpatient Cases	26,472
Weighted Inpatient Cases at 3 hrs/case	42,768	Weighted Inpatient Cases at 3 hrs/case	36,649	Weighted Inpatient Cases at 3 hrs/case	79,417
Ambulatory Cases	20,109	Ambulatory Cases	24,769	Ambulatory Cases	44,878
Weighted Ambulatory Cases at 1.5 hrs/case	30,163	Weighted Ambulatory Cases at 1.5 hrs/case	37,153	Weighted Ambulatory Cases at 1.5 hrs/case	67,317
Total Weighted Hours	72,931	Total Weighted Hours	73,802	Total Weighted Hours	146,733
OR Planning Inventory*	41	OR Planning Inventory**	45	OR Planning Inventory	86
Licensed ORs needed at 1,872 cases/year	39.0	Licensed ORs needed at 1,872 cases/year	39.4	Licensed ORs needed at 1,872 cases/year	78.4
Surplus/Deficit (-)	2.0	Surplus/Deficit (-)	5.6	Surplus/Deficit (-)	7.6

Souce: 2010 LRA

**Excludes one trauma and one burn OR*

***Excludes two C-Section ORs*

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Certificate of Need Section
2704 Mail Service Center ▪ Raleigh, North Carolina 27699-2704

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

www.ncdhhs.gov/dhsr

Lee Hoffman, Section Chief
Phone: 919-855-3873
Fax: 919-733-8139

June 15, 2009

S. Todd Hemphill
Bode, Call & Stroupe, LLP
3105 Glenwood Avenue, Suite 300
Raleigh, NC 27612

RE: Exempt from Review / Acquisition of Plastic Surgery Center of North Carolina, Inc. by Wake Forest University Health Sciences (WFUHS) / Forsyth County
FID # 953413

Dear Mr. Hemphill:

In response to your letter of May 22, 2009, the above referenced proposal is exempt from certificate of need review in accordance with N.C.G.S 131E-184(a)(8). Therefore, Wake Forest University Health Sciences (WFUHS) may proceed to acquire the above referenced health service facility without first obtaining a certificate of need. However, you need to contact the Acute and Home Care Licensure and Certification Section of the Division of Health Service Regulation to obtain instructions for changing ownership of the existing facility. Note that pursuant to N.C.G.S. §131E-181(b): "*A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need.*"

It should be noted that this Agency's position is based solely on the facts represented by you and that any change in facts as represented would require further consideration by this Agency and a separate determination. If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Gebrette Miles
Project Analyst

Lee B. Hoffman, Chief
Certificate of Need Section

cc: Acute and Home Care Licensure and Certification Section, DHSR

Location: 701 Barbour Drive ▪ Dorothea Dix Hospital Campus ▪ Raleigh, N.C. 27603
An Equal Opportunity / Affirmative Action Employer

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RALEIGH, NORTH CAROLINA
27628-6338

Received by the
CON Section

22 MAY 2009 0 9 ... 0 1

May 22, 2009

Via Hand Delivery
Lee B. Hoffman, Chief
Gebrette Miles, Project Analyst
Certificate of Need Section
Division of Facility Services
701 Barbour Drive
Raleigh, North Carolina 27603

Re: Plastic Surgery Center of North Carolina, Inc. Ambulatory Surgical Facility / Acquisition by Wake Forest University Health Sciences / Winston-Salem, Forsyth County, North Carolina

Dear Ms. Hoffman and Ms. Miles:

This letter is submitted on behalf of our client, Wake Forest University Health Sciences ("WFUHS"). WFUHS intends to acquire from Plastic Surgery Center of North Carolina, Inc. ("PSCNC"), the ambulatory surgical facility, as that term is defined in G.S. §131E-176(1b), owned by PSCNC (hereinafter, the "Facility"). When the transaction is completed, PSCNC will have no interest in the Facility, and WFUHS will have no interest in PSCNC.

The Facility is located in the lower level of the medical building located at 2901 Maplewood Avenue, Winston-Salem, Forsyth County, North Carolina, and consists of three (3) ambulatory surgery operating rooms and support space, as identified in the 2009 SMFP. The parties have entered into a Purchase Agreement, which provides that the purchase is contingent upon our client obtaining confirmation from the CON Section that it does not need to obtain a certificate of need to acquire the Facility.

The medical office building in which PSCNC is located is owned by John Paul & Associates, LLC ("JPA"). PSCNC leases its space from JPA. WFUHS will enter into a new lease with JPA for the space which constitutes the Facility. WFUHS will not lease any other space in the building and will have no interest in JPA.

By this letter, we are providing notice to the CON Section, pursuant to G.S. §131E-184(a) of this transaction. Because this project involves the acquisition of an interest in an existing health service facility, we believe the acquisition of the Facility is exempt from CON review pursuant to G.S. §131E-184(a)(8). We would appreciate your office reviewing this information and advising us that our analysis is correct and that this acquisition is not subject to CON review.

The parties intend to close on this transaction by no later than the end of June, 2009, so your prompt attention to this request would be very much appreciated. Should you have any questions, please do not hesitate to contact me.

Very truly yours,

BODE, CALL & STROUPE, L.L.P.

S. Todd Hemphill

STH:sh
cc: Brian McGinn

EXHIBIT G TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/07 through 9/30/08 as reported on the 2009 Hospital and Ambulatory Surgical Facility License Renewal Applications.

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

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0015	Duke University Hospital	Durham	16,166	19,055	4	9	32	0	-1	4	0
	(In addition to a CON Adjustment for 4 ORs, Duke University Hospital has a CON for 16 additional ORs under Policy AC-3. These 16 ORs are not counted when determining OR need.)										
H0233	Durham Regional Hospital	Durham	4,276	3,238	3	0	12	-2	0	0	0
AS0041	James E. Davis Ambulatory Surgical Center	Durham	0	5,299	0	8	0	0	0	0	0
H0075	North Carolina Specialty Hospital	Durham	1,276	5,600	0	0	4	0	0	0	0
		Durham Total	21,718	33,192	7	17	48	-2	-1	4	0
H0209	Forsyth Medical Center	Forsyth	10,361	12,676	5	6	19	-2	0	10	0
H0229	Medical Park Hospital	Forsyth	1,085	10,531	0	0	13	0	0	-6	0
H0011	North Carolina Baptist Hospitals	Forsyth	13,251	17,999	4	0	36	0	-2	0	0
AS0021	Plastic Surgery Center Of North Carolina	Forsyth	0	411	0	3	0	0	0	0	0
		Forsyth Total	24,697	41,617	9	9	68	-2	-2	4	0
H0261	Franklin Regional Medical Center	Franklin	923	1,422	0	0	3	0	0	0	0
	2009 Franklin SMFP Need Determination	Franklin	0	0	0	0	0	0	0	1	
		Franklin Total	923	1,422	0	0	3	0	0	1	0
AS0037	CaroMont Specialty Surgery	Gaston	0	4,073	0	6	0	0	0	0	0
H0105	Gaston Memorial Hospital	Gaston	4,055	10,160	5	8	9	-4	0	0	0
		Gaston Total	4,055	14,233	5	14	9	-4	0	0	0
AS0015	Carolina Birth Center	Guilford	0	545	0	1	0	0	0	0	0
AS0009	HEALTHSOUTH Greensboro Specialty Surgical Center	Guilford	0	1,888	0	3	0	0	0	0	0
AS0018	HEALTHSOUTH Surgical Center of Greensboro	Guilford	0	13,984	0	13	0	0	0	0	0
H0052	High Point Regional Health System	Guilford	3,621	3,935	3	0	9	-1	0	-1	0
AS0047	High Point Surgery Center	Guilford	0	4,888	0	6	0	0	0	0	0
H0073	Kindred Hospital - Greensboro	Guilford	929	46	0	0	1	0	0	0	0
H0159	Moses Cone Health System	Guilford	13,723	20,083	4	13	37	0	-1	-2	0
	Triad Neurosurgery	Guilford	0	0	0	0	0	0	0	2	0
AS0063	Piedmont Surgical Center	Guilford	0	1,012	0	2	0	0	0	0	0
	Premier Surgery Center	Guilford	0	0	0	0	0	0	0	2	0
AS0033	Surgical Eye Center	Guilford	0	3,019	0	4	0	0	0	0	0
		Guilford Total	18,273	49,400	7	42	47	-1	-1	1	0

OR = Operating Room

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

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Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
H0153	Wilkes Regional Medical Center	Wilkes	1,005	1,933	1	0	4	-1	0	0	0
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes	0	442	0	1	0	0	0	0	0
		Wilkes Total	1,005	2,375	1	1	4	-1	0	0	0
AS0005	Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson	0	1,320	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,759	3,184	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	450	0	1	0	0	0	0	0
		Wilson Total	1,759	4,954	1	5	9	-1	0	0	0
		Grand Total	267,187	657,748	155	284	861	-84	-11	51	9

Underutilized Facilities:

Excluded from Need Determinations

Lic #	Facility Name	County
H0002	Pungo District Hospital Corporation	Beaufort
AS0062	Cleveland Ambulatory Services	Cleveland
AS0021	Plastic Surgery Center Of North Carolina	Forsyth
AS0050	Iredell Surgical Center	Iredell
H0193	Highlands-Cashiers Hospital	Macon
AS0098	Same Day Surgery Center at Ballantyne	Mecklenburg
AS0010	Chapel Hill Surgical Center	Orange
H0069	Swain County Hospital	Swain
AS0034	Raleigh Plastic Surgery Center	Wake
AS0048	Southern Eye Associates Ophthalmic Surgery Center	Wake
H0160	Blowing Rock Hospital	Watauga
AS0005	Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson
AS0007	Wilson OB-GYN	Wilson

OR = Operating Room

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
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	17	48	-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	2	5	-1	0	1	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	23	41	99	-13	-1	0	149	-19.63	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

EXHIBIT H TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/08 through 9/30/09 as reported on the 2010 Hospital and Ambulatory Surgical Facility License Renewal Applications.

Counties with one facility shown first, followed by counties with more than one facility.											
Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
		Cleveland Total	2,220	7,810	[illegible]	6	5	-1	0	0	0
H0213	Cape Fear Valley Medical Center	Cumberland	6,509	5,804	5	0	13	-3	0	1	0
AS0006	Fayetteville Ambulatory Surgery Center	Cumberland	0	14,210	0	11	0	0	0	0	0
H0275	Highsmith-Rainey Memorial Hospital	Cumberland	72	2,511	0	0	4	0	0	0	0
		Cumberland Total	6,581	22,525	5	11	17	-3	0	1	0
AS0053	RMS Surgery Center	Dare	0	559	0	2	0	0	0	0	0
H0273	The Outer Banks Hospital	Dare	243	917	1	0	2	-1	0	0	0
		Dare Total	243	1,476	1	2	2	-1	0	0	0
H0027	Lexington Memorial Hospital	Davidson	837	2,565	0	0	4	0	0	0	0
H0112	Thomasville Medical Center	Davidson	555	2,861	1	0	5	-1	0	0	0
		Davidson Total	1,392	5,426	1	0	9	-1	0	0	0
H0015	Duke University Hospital	Durham	16,766	19,343	4	9	32	0	-1	4	0
	(In addition to a CON Adjustment for 4 ORs, Duke University Hospital has a CON for 16 additional ORs under Policy AC-3. These 16 ORs are not counted when determining OR need.)										
H0233	Durham Regional Hospital	Durham	4,149	3,234	3	0	12	-2	0	0	0
AS0041	James E. Davis Ambulatory Surgical Center	Durham	0	4,477	0	8	0	0	0	0	0
H0075	North Carolina Specialty Hospital	Durham	1,395	6,285	0	0	4	0	0	0	0
		Durham Total	22,310	33,339	7	17	48	-2	-1	4	0
H0209	Forsyth Medical Center	Forsyth	10,431	12,968	5	6	19	-2	0	10	0
H0229	Medical Park Hospital	Forsyth	844	10,523	0	0	13	0	0	-6	0
H0011	North Carolina Baptist Hospitals	Forsyth	13,357	18,693	4	0	36	0	-2	0	0
AS0021	Plastic Surgery Center Of North Carolina	Forsyth	0	148	0	3	0	0	0	0	0
		Forsyth Total	24,632	42,332	9	9	68	-2	-2	4	0
H0261	Franklin Regional Medical Center	Franklin	151	834	0	0	3	0	0	0	0
	Same Day Surgery Center Franklin	Franklin	0	0	0	0	0	0	0	1	0
		Franklin Total	151	834	0	0	3	0	0	1	0

OR = Operating Room

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

Case Data for 10/01/08 through 9/30/09 as reported on the 2010 Hospital and Ambulatory Surgical Facility License Renewal Applications.

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

Lic #	Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded C-Section ORs	Excluded Trauma/Burn ORs	CON Adjustments	CON Adjustments for Dedicated C-Section OR
AS0005	Eastern Regional Surgical Center (formerly HealthSouth Surgecenter of Wilson)	Wilson	0	1,453	0	4	0	0	0	0	0
H0210	Wilson Medical Center	Wilson	1,551	2,764	1	0	9	-1	0	0	0
AS0007	Wilson OB-GYN	Wilson	0	400	0	1	0	0	0	0	0
		Wilson Total	1,551	4,617	1	5	9	-1	0	0	0
		Grand Total	263,195	653,627	[illegible]	160	289	862	89	[illegible]	59

Underutilized Facilities:		
Excluded from Need Determinations		
H0002	Pungo District Hospital Corporation	Beaufort
AS0082	Cleveland Ambulatory Services	Cleveland
AS0055	RMS Surgery Center	Dare
AS0121	Plastic Surgery Center of North Carolina	Forsyth
AS0050	Iredell Surgical Center	Iredell
H0034	Angel Medical Center	Macon
H0193	Highlands-Cashiers Hospital	Macon
AS0010	Chapel Hill Surgical Center	Orange
H0069	Swain County Hospital	Swain
AS0104	Raleigh Plastic Surgery Center	Wake
AS0048	Southern Eye Associates Ophthalmic Surgery Center	Wake
H0110	Blowing Rock Hospital	Watauga
AS0046	Wilkes Regional Medical Center Ambulatory Surgery Facility	Wilkes
AS0005	Surgecenter of Wilson (HealthSouth Surgecenter of Wilson)	Wilson
AS0007	Wilson OB-GYN	Wilson

OR = Operating Room

Table 6B: Projected Operating Room Need for 2013

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	0	12	-2.45	0
Alexander	0	0	2	0	0	0	2	-2.00	0
Alleghany	0	0	2	0	0	0	2	-1.71	0
Anson	0	0	2	0	0	0	2	-1.53	0
Ashe	0	0	2	0	0	0	2	-1.22	0
Avery	0	0	2	0	0	0	2	-1.40	0
Bertie	0	0	2	0	0	0	2	-1.35	0
Bladen	0	0	2	0	0	0	2	-1.22	0
Brunswick	1	0	5	-1	0	1	6	-0.02	0
Burke	1	2	9	-1	0	0	11	-2.92	0
Cabarrus	4	6	17	-2	0	0	25	-2.27	0
Caldwell	1	3	4	-1	0	0	7	-2.27	0
Carteret	1	2	5	-1	0	0	7	-0.72	0
Catawba	3	8	27	-1	0	0	37	-9.73	0
Chatham	0	0	2	0	0	0	2	-1.68	0
Cleveland	1	2	8	-1	0	0	10	-1.30	0
Columbus	1	0	4	-1	0	1	5	-0.15	1
Dare	1	0	2	-1	0	0	2	-0.90	0
Davidson	1	0	9	-1	0	0	9	-2.13	0
Davie	0	0	2	0	0	0	2	-1.83	0
Duplin	0	0	3	0	0	0	3	-1.07	0
Durham	7	17	48	-2	-1	4	73	-5.36	0
Edgecombe	1	0	5	-1	0	0	5	-2.80	0
Forsyth	9	6	68	-2	-2	4	83	-4.95	0
Franklin	0	0	3	0	0	1	4	-3.02	0
Gaston	5	14	9	-4	0	0	24	-5.81	0
Granville	0	0	3	0	0	0	3	-0.33	0
Guilford	7	42	47	-1	-1	1	95	-26.49	0
Harnett	0	0	4	0	0	6	10	-5.20	0
Haywood	0	0	7	0	0	0	7	-2.07	0
Henderson	0	0	16	0	0	0	16	-2.47	0
Hertford	1	0	5	-1	0	0	5	-2.32	0
Iredell	3	3	22	-3	0	0	25	-6.74	0
Johnston	1	2	5	-1	0	1	8	-0.80	0
Lee	1	0	5	-1	0	2	7	-2.76	0
Lenoir	1	0	9	-1	0	0	9	-3.85	0
Lincoln	1	0	4	-1	0	0	4	-1.20	0
Macon	0	0	0	0	0	0	0	0.00	0
Martin	0	0	2	0	0	0	2	-0.71	0
McDowell	1	0	3	-1	0	0	3	-1.03	0
Mecklenburg	23	44	99	-13	-1	-3	149	-23.31	0
Mitchell	0	0	3	0	0	0	3	-1.76	0
Montgomery	0	0	2	0	0	0	2	-1.83	0
Nash	1	0	13	-1	0	0	13	-3.15	0
New Hanover	5	16	20	-3	-1	4	41	-1.04	0
Onslow	1	4	5	-1	0	0	9	-3.46	0
Orange	6	4	29	-3	-2	4	38	-6.75	0
Pender	0	0	2	0	0	0	2	-1.58	0
Polk	0	0	3	0	0	0	3	-1.84	0
Randolph	1	0	5	-1	0	2	7	-2.42	0
Richmond	1	0	6	-1	0	0	6	-3.50	0
Robeson	1	0	9	0	0	0	10	-2.82	0
Rockingham	1	0	9	-1	0	0	9	-4.14	0
Rowan	2	3	8	-2	0	0	11	0.89	1
Rutherford	0	0	5	0	0	0	5	-0.86	0

EXHIBIT I TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

(Case Data for 10/01/06 through 9/30/07 as reported on the 2008 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpatient Cases (Dedicated C-Section OR Cases Excluded)	Ambulatory Cases	Inpatient Rooms	Ambulatory Rooms	Shared Rooms	Excluded C-Section Rooms	Excluded Trauma/Burn Rooms	Adjustments for CON Non Dedicated C-Section OR	Adjustments for CON Dedicated C-Section OR
Eastern Regional Surgical Center (X HealthSouth Surgecenter of Wilson)	Wilson	0	882	0	4	0	0	0	0	0
Wilson Medical Center	Wilson	2,075	3,464	1	0	9	-1	0	0	0
Wilson OB-GYN	Wilson	0	413	0	1	0	0	0	0	0
	Wilson Total	2,075	4,759	1	5	9	-1	0	0	0
Hoots Memorial Hospital	Yadkin	2	252	0	0	2	0	0	0	0
	Yadkin Total	2	252	0	0	2	0	0	0	0
	Grand Total	267,754	634,399	151	281	863	-82	-11	51	10

Underutilized Facilities - Excluded from Need Determinations

Facility	County
Pungo District Hospital Corporation	Beaufort
Cleveland Ambulatory Services	Cleveland
Plastic Surgery Center Of North Carolina	Forsyth
Piedmont Surgical Center	Guilford
Iredell Surgical Center	Iredell
Highlands-Cashiers Hospital	Macon
Carolina Center for Specialty Surgery	Mecklenburg
Chapel Hill Surgical Center	Orange
Swain County Hospital	Swain
Raleigh Plastic Surgery Center	Wake
Southern Eye Associates Ophthalmic Surgery	Wake
Blowing Rock Hospital	Watauga
Eastern Regional Surgical Center	Wilson

EXHIBIT J TO NOVANT HEALTH'S PETITION TO THE SHCC REGARDING POLICY AC-3

Table 6A: Operating Room Inventory (Combined Data for Hospitals and Ambulatory Surgical Facilities)

(Case Data for 10/01/05 through 9/30/06 as reported on the 2007 Hospital and Ambulatory Surgical Facility License Renewal Applications)

Facility Name	County	Inpt.- C-Sec.	Amb. Cases	Inpat. Rms.	Amb. Rms.	Shared Rms.	Exclu. C-Sec.	Exclu. Tra/Bur	Adj.CON
Murphy Medical Center, Inc.	Cherokee	358	1,873	0	0	4	0	0	0
Chowan Hospital	Chowan	614	1,117	0	0	3	0	0	0
Cleveland Ambulatory Services *	Cleveland		1,745		4				0
Cleveland Regional Medical Center	Cleveland	2,295	3,691	1	0	6	-1	-1	0
Eye Surgery Center of Shelby	Cleveland		1,711		2				0
Kings Mountain Hospital	Cleveland	271	1,212	0	0	2	0		0
Totals for:	**Cleveland**	**2,566**	**8,359**	**1**	**6**	**8**	**-1**	**-1**	**0**
Columbus Regional Healthcare System	Columbus	1,510	3,527	1	0	4	-1	0	0
Columbus Regional Same Day Surgery, LLC	Columbus		0		0				1
Totals for:	**Columbus**	**1,510**	**3,527**	**1**	**0**	**4**	**-1**	**0**	**1**
Craven Regional Medical Center	Craven	3,669	9,527	3	6	9	-1	0	0
Cape Fear Valley Medical Center	Cumberland	7,252	7,040	5	0	13	-3	0	0
Fayetteville Ambulatory Surgery Center	Cumberland		10,372		11				0
Highsmith-Rainey Memorial Hospital	Cumberland	171	2,895	0	0	4	0	0	0
2006 SMFP Need Determination	Cumberland								1
Totals for:	**Cumberland**	**7,423**	**20,307**	**5**	**11**	**17**	**-3**	**0**	**1**
RMS Surgery Center	Dare		2,308		2				0
The Outer Banks Hospital, Inc.	Dare	284	720	1	0	2	-1	0	0
Totals for:	**Dare**	**284**	**3,028**	**1**	**2**	**2**	**-1**	**0**	**0**
Lexington Memorial Hospital	Davidson	1,010	2,620	0	0	4	0	0	0
Thomasville Medical Center	Davidson	792	2,350	1	0	5	-1	0	0
Totals for:	**Davidson**	**1,802**	**4,970**	**1**	**0**	**9**	**-1**	**0**	**0**
Davie County Hospital	Davie	8	62	0	0	2	0	0	0
Duplin General Hospital, Inc.	Duplin	728	1,319	0	0	3	0	0	0
Duke University Hospital	Durham	15,281	18,216	4	8	33	0	-1	4
Durham Regional Hospital	Durham	4,619	3,546	3	0	12	-2	0	0
James E. Davis Ambulatory Surgical Center	Durham		7,575		8				0
North Carolina Specialty Hospital, LLC	Durham	810	4,557	0	0	4	0	0	0
Totals for:	**Durham**	**20,710**	**33,894**	**7**	**16**	**49**	**-2**	**-1**	**4**
Heritage Hospital	Edgecombe	664	1,441	1	0	5	-1	0	0
Forsyth Medical Center	Forsyth	10,153	6,109	5	2	19	-2	0	3
Hawthorne Surgical Center	Forsyth		6,933		4				2
Medical Park Hospital, Inc.	Forsyth	1,170	10,242	0	0	13	0	0	-1
North Carolina Baptist Hospitals, Inc.	Forsyth	11,900	15,842	4	0	36	0	-2	0
Plastic Surgery Center Of North Carolina, Inc. *	Forsyth		328		3				0
Totals for:	**Forsyth**	**23,223**	**39,454**	**9**	**9**	**68**	**-2**	**-2**	**4**

* Chronically underutilized facility; operating rooms in these facilities are excluded from Need Determination calculations.

COMMENTS BY NOVANT HEALTH, INC. ON THE PETITION FOR A CHANGE IN POLICY AC-3 SUBMITTED BY THE ACADEMIC MEDICAL CENTERS

Novant Health, Inc. ("Novant") submits these comments in opposition to the Petition submitted to the State Health Coordinating Council ("SHCC") on March 2, 2011 by the State's four academic medical centers ("AMCs"): Duke University Health System, Inc. d/b/a Duke University Hospital ("Duke"), North Carolina Baptist Hospital ("Baptist"), Pitt County Memorial Hospital ("Pitt"), and UNC Hospitals at Chapel Hill ("UNC").[1]

EXECUTIVE SUMMARY

The State Medical Facilities Plan ("SMFP") is the foundation of health planning in North Carolina. The SHCC, in conjunction with the Division of Health Service Regulation ("DHSR") Medical Facilities Planning Staff, spends countless hours every year studying data and analyzing important policy issues to ensure that all North Carolinians have access to health care. The process of developing the SMFP need determinations is a public process that is open and fair, and ensures that all stakeholders have an opportunity to participate.

Policy AC-3 undermines the foundation of health planning by allowing the AMCs to propose additional facilities and services that the SMFP says are not needed. Policy AC-3 ignores the SHCC's work and experience. Policy AC-3 is not a public process that allows everyone to participate. Rather, Policy AC-3 gives special benefits only to the AMCs based on the AMCs' self-determined needs. Policy AC-3 has been abused, and there is strong incentive for the AMCs to continue to abuse it. As discussed in Novant's Petition, and in these comments, the health planning process should be open and equitable. If a provider believes that there is a need for additional facilities and services, it should petition the SHCC, and if the

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[1]Novant also submitted a Petition to the SHCC on March 2, 2011, requesting the repeal or revision of Policy AC-3. Many of the same arguments contained in that Petition support Novant's opposition to the AMCs' Petition.

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SHCC, after reviewing the petition, comments and other relevant data, determines there is a need, the need should be placed in the next year's SMFP so that any interested provider can apply to meet the need. This process is open and fair and ultimately serves to protect the public interest.

The AMCs now propose dramatic expansion of Policy AC-3 to cover two more health care systems in this State, Carolinas Healthcare System ("CHS") and Mission Health System ("Mission"), because of the "changing academic landscape." *See* Petition, p. 3. Novant agrees that the "academic landscape" is vastly different from what it was in 1983, when Policy AC-3 was born, and that it is no longer workable in today's environment. For example:

- In 1983, CHS was required to completely comply with the SMFP. At that time, CHS was mainly providing regulated services in Mecklenburg County. Today, CHS employs nearly 2,000 physicians and controls, either through ownership or management, more than 6,300 licensed beds in 33 hospitals in two states. CHS is multi-billion dollar operation with operations throughout North Carolina.

- In 1983, Memorial Mission Hospital, as Mission was known in 1983, was required to comply completely with the SMFP. At that time, Mission was one of two acute care hospitals in Buncombe County. Today, it is a monopoly in Buncombe County through its merger with St. Joseph's in 1998. Mission is a major economic force in 17 counties in Western North Carolina.

- In 1983, Pitt was a county hospital only operating in one county. Today, Pitt is a major economic enterprise no longer controlled by Pitt County. Pitt's influence extends throughout eastern North Carolina.

- In 1983, UNC was focused on its academic mission from its campus in Chapel Hill. Since that time, it has used hundreds of millions of state funds to acquire other facilities, build new facilities off its academic campus, acquire private physician practices, and propose a community hospital in Hillsborough, near the Alamance County line.

- In 1983, Duke was focused on its academic mission from its campus in Durham. Since then, it has aggressively acquired private physician practices and other hospitals, and entered into a joint venture with a publicly-traded proprietary hospital company, LifePoint, so it can further

its competitive interests. Duke now operates in multiple North Carolina counties and is a major economic enterprise.

- In 1983, Baptist and its academic partner, Wake Forest University Health Sciences ("WFUHS"), focused on their academic mission from their campus on Hawthorne Hill in Winston-Salem. Since then, Baptist and WFUHS have acquired a number of private physician practices. Baptist owns one community hospital, Lexington Memorial Hospital and manages another community hospital, Davie County Hospital. Baptist is now using the Policy AC-3 exemption to build a freestanding ambulatory surgery center that does simple outpatient procedures that are done in hundreds of facilities in the State. Last week, the combined Baptist/WFUHS enterprise unveiled a new corporate identity, Wake Forest Baptist Health, at cost of $3.5 million, to promote its regional health care system in a 19-county service area.

In 1983, when Policy AC-3 was adopted, the four AMCs were only focused on four hospitals in four counties in North Carolina. They owned no other hospitals or private physician practices. The concept of a "clinical" faculty member did not exist. At that time, all faculty were devoted to the academic missions of teaching and research. There was minimal competition between the AMCs and the community hospitals back in the early 1980s, because their missions and their services were completely different.

Today, that is not at all the case. The AMCs' Petition would apply to multi-million (and in some cases, multi-billion) dollar corporations that provide billions of dollars of services, consuming a significant and ever growing part of our Medicaid budget, and providing services in all 100 counties of our State. They employ, or are affiliated with, hundreds of "clinical" faculty whose teaching and research activities are minimal and comparable to many private practice physicians in North Carolina.

Today's AMCs clearly are not the same institutions they were in 1983. Academic medicine and academic medical centers are big business, providing a major proportion of our health care economy and consuming billions of dollars in State funds and insurance costs for

the citizens of North Carolina. Hardly a week goes by without an announcement from the AMCs about their growth initiatives, be they hospital or physician practice acquisitions, joint ventures with for-profit companies to acquire or manage other providers, or multi-million dollar branding initiatives. As the recent experience with the Baptist Policy AC-3 ambulatory surgery center project shows, the AMCs have a powerful economic initiative to use their Policy AC-3 status to avoid health planning and achieve maximum return on investment.

As the SHCC reviews Policy AC-3, it needs to ask the following questions:

1. Why do six of the wealthiest, most economically sound health care corporations in our State need expanded exemption from health planning to compete unfairly with other hospitals, private practice physicians and surgery centers in the State?

2. Why are "clinical" faculty, who are compensated like private practice physicians, who perform research like private practice physicians, and who teach like private practice physicians, allowed to have outpatient surgery centers that are not needed in the SMFP, when their counterparts in private practice cannot apply for new operating rooms unless they are needed in the SMFP?

3. Why can't these major corporations, which employ dozens of staff planners, take the time to file special need petitions to adjust the SMFP when they perceive a need for additional facilities and services, just like their counterparts in the non-academic setting?

4. Does the SHCC believe that it is essential to use the existing planning process so that all health assets that generate costs for our State budget and employer health plans are regulated fairly and completely?

5. Why is North Carolina the only State in the country with a health planning process that allows such a massive exemption from health planning?

6. Why does the State of North Carolina spend hundreds, possibly thousands, of hours every year developing an SMFP, if some providers are not required to comply with it completely?

Novant strongly supports rational health planning because it helps reduce unnecessary duplication of services that drive up health care costs. But health planning only works when the State of North Carolina demands that all providers, regardless of title, comply completely with the SMFP. The current program, which gives certain providers the ability to opt out of health planning, without an empirical basis for doing so, is neither rational nor fair. Expanding that system to give two more providers special treatment jeopardizes health planning in North Carolina.

The AMCs' Petition should be denied. Instead, the SHCC should require all providers to comply completely with the SMFP, as recommended in the Novant Petition on Policy AC-3, also filed on March 2, 2011.

COMMENTS ON THE AMCS' PETITION

Attached to Novant's comments as Exhibit A is the Affidavit of Jay Wolfson, DrPH, JD. Dr. Wolfson is the Distinguished Service Professor of Public Health and Medicine and Associate Vice President of Health Law, Policy and Safety at the University of South Florida in Tampa, Florida and Professor of Health Law at Stetson University College of Law in Gulfport, Florida. Dr. Wolfson has over thirty years' experience in health policy and planning, and has served as a trustee and finance chair of a major university teaching hospital, Tampa General Hospital, in Tampa, Florida. He has advised federal and state legislators and judges on many health policy issues. Based on his training, education and experience, Dr. Wolfson concludes that the AMCs' proposal raises significant policy concerns, and he recommends that the SHCC not adopt the AMCs' recommendations. These comments will outline the reasons why the AMCs' recommendations should not be adopted, citing relevant portions of Dr. Wolfson's affidavit.

Novant notes that while the AMCs' Petition is replete with statistics, none of these statistics is particularly relevant to Policy AC-3 or to the precise issue before the SHCC, *i.e.*, should Policy AC-3 be repealed or modified. For example:

- Pages 6-7 of the Petition, which describe the number of "learners" that the AMCs teach: Numbers of medical students, residents, fellows and non-physician providers at these institutions do not explain why the AMCs need to be exempt from the "normal" planning process, which both Pitt and Duke have successfully used, or why Policy AC-3 needs to be expanded. In fact, no recent Policy AC-3 application has been premised on growing residency slots or adding medical school spaces.

- Page 7 of the Petition, which asserts that "[i]nserting teaching into the provision of these clinical services necessarily adds time and costs to the AMCs' operations" and that "AMCs must bear the costs for its additional trainees through other sources, including its clinical services revenue": Nothing in Policy AC-3 states or implies that its purpose was to help the AMCs make money or save time. Nor does the AMCs' assertion take into account that many non-AMCs train residents and students (*e.g.*, Forsyth Medical Center, Moses Cone, and WakeMed) and they also have costs (*e.g.*, resident salaries) associated with training.

- Page 7 of the Petition, which notes that according to a 2005 Sheps Center report, almost 40% of North Carolina medical school graduates practice in North Carolina, and more than 40% of those physicians who did their residency in North Carolina stay in State: There is no connection between these statistics and Policy AC-3. Indeed, one of Novant's major arguments for the reform of Policy AC-3 is that we do not know how, if at all, Policy AC-3 has actually benefitted any medical students or residents.

- Page 8 of the Petition, which lists various grants which the AMCs have been awarded: There is no explanation of how Policy AC-3 relates to this grant money. The award of these grants certainly could not have been premised on the AMCs' being able to take advantage of Policy AC-3, and there is also no evidence to suggest that the normal petitioning process could not be used by the AMCs for expansion purposes, if their grant obligations required them to pursue expansion opportunities.[2] As the Petition itself reveals, the recipients of these grants do not necessarily have to be AMCs. The Petition refers to New Hanover Regional Medical Center, a non-AMC, and its family medicine residency

[2]This section of the Petition also refers to a grant that Methodist University received for its physician assistant program. It is not clear why this is in the Petition, since there is no such institution in North Carolina.

program, as recipients of a grant. This also underscores the point Novant made in its Petition that non-AMCs play a vital role in training physicians.[3] These non-AMCs experience similar needs and costs as their AMC counterparts, but only the AMCs are eligible for the Policy AC-3 exemption. In fact, today in North Carolina, there are only four Policy AC-3 eligible AMCs, and about 120 non-AMCs that are not Policy AC-3 eligible. One could argue that the non-AMC hospitals, by their sheer number, have the ability to offer extensive training opportunities and venues beyond the finite capacity of the four AMCs. After all, the majority of physicians practicing in North Carolina are associated with non-AMC hospitals, and the majority of patients in North Carolina are cared for in non-AMC hospitals.

- Page 9 of the Petition, which states that Duke developed a protocol for whole body PET imaging, particularly for legs: There is no explanation about how Policy AC-3 relates to this protocol.

- Page 10 of the Petition, which states that cases at AMCs tend to take longer and are more complex, and that AMCs are the only providers of certain kinds of services: Case length and acuity levels are not discussed at all in Policy AC-3. If these factors were relevant to the drafters of Policy AC-3, they likely would have been included in Policy AC-3, but they are not. "Sole provider" status is also not discussed in Policy AC-3. Many non-AMCs are the sole providers of hospital and outpatient services in their home counties, but nobody has ever suggested that they be exempt from the SMFP because they are the only providers of services. Further, the Novant proposal would accommodate the AMCs' esoteric needs because they could petition the SHCC for a need determination and if the need determination is approved, they could later apply for it. If, as the AMCs suggest in their Petition, they are the "only" providers offering certain services, then it stands to reason that they would have a very good chance of being approved for the service, provided they demonstrate the need in their CON application.[4]

[3]For instance, during 2010, more than 100 residents from Baptist trained at Novant facilities in Winston-Salem in the following specialties: OB Anesthesia; Anesthesia/Pain Management (fellowship program); emergency medicine (doing an OB rotation); family medicine; general surgery; OB/GYN; ophthalmology (fellowship program); pathology; pediatric neonatology; pediatrics; and plastic surgery. Likewise, during the same period, more than 100 medical students from Baptist received training at Forsyth Medical Center.

[4]In the unlikely event that a genuine "emergency" occurred that required an AMC to develop an SMFP-regulated service in a time frame that would not accommodate the normal petitioning process (*e.g.*, the ACGME threatened an AMC with immediate loss of accreditation for a residency program unless it developed an SMFP-limited service), the State of North Carolina would undoubtedly come to the aid of the AMC to address the situation. This is shown by the flexibility the State has shown in similar situations. For example, a health service facility does not need to file a CON to address a life safety code issue. A health service facility can also apply for permission to exceed, on a temporary basis, its licensed bed capacity. The Governor was also able to eliminate, on short notice, a need determination in the 2011 SMFP for home health agencies, when it was discovered that there was a mistake in the 2011 SMFP need determination for additional home health agencies.

- Pages 11 and 12 of the Petition, which discusses that the AMCs "demonstrate a patient base dramatically different from even the most sophisticated non-academic facilities" and that AMCs tend to treat more patients from outside their home counties than do the tertiary-level non-AMCs: It is not clear why this should make any difference in determining who is subject to the SMFP and who is not subject to the SMFP. For example, according to its 2011 Hospital License Renewal Application, Forsyth Medical Center treated patients from 73 of North Carolina's 100 counties. Baptist served patients from 90 of North Carolina's 100 counties. There is no logical basis for asserting that a difference in 17 counties entitles Baptist to a broad-based exemption from the SMFP. Nor would there be a logical basis for asserting that the non-AMC provider that served 88 of the 100 counties should be required to follow the SMFP (Cape Fear Valley Medical Center in Fayetteville) while the AMC provider that served 90 out of 100 counties (Baptist) should be exempt from the SMFP.[5] And, if Policy AC-3 is really a contest to see who serves the most counties, then Baptist and Pitt would lose, because they only served 90 and 87 counties respectively, whereas Duke and UNC each served all 100 counties. Clearly, important health planning and policy decisions cannot be based on such arbitrary and minute distinctions. In fact, the SMFP gives providers "full credit" for every patient they serve, regardless of where the patient comes from, so the AMCs' contention about patient origin is irrelevant.

Thus, as the SHCC reviews the Novant Petition and the AMCs' Petition, the SHCC should not allow itself to be distracted by irrelevant points. Instead, the SHCC must remain focused on the core issues: should a policy that was first implemented in 1983, at a time when there was a vast difference between AMCs and community hospitals, remain in effect in 2012? And if it should remain in effect, are any changes necessary to ensure that all providers, regardless of their title, have an equal opportunity to compete? Novant respectfully submits that the changes the AMCs are seeking to Policy AC-3 would be even more damaging to North Carolina's health care planning process than present Policy AC-3 and should not be adopted.

[5]These statistics are taken from the hospitals' patient origin for general acute care services as stated in their 2011 Hospital License Renewal Applications. These are publicly-available documents.

I. THE SHCC SHOULD NOT ADOPT THE AMCS' REVISIONS TO POLICY AC-3.

The AMCs assert that Policy AC-3 should be expanded, under the guise of "fairness" to other providers who are not allowed to take advantage of the policy. *See* Petition, p. 2. Expansion of Policy AC-3 only exacerbates the inherent unfairness that exists today and further threatens the integrity of North Carolina's health planning process.

A. Expansion Of Policy AC-3 To New Medical Schools and Satellite Campuses of Medical Schools Is Unwarranted.

The AMCs have asked the SHCC to remove the date limitation in current Policy AC-3 (January 1, 1990) and expand the policy to facilities to "*any* designated Academic Medical Center Teaching Hospital which either 1) is under common ownership with a school of medicine, or 2) has the majority of the hospital's chiefs of service serving as medical school clinical department chair, or 3) which is the sole designated teaching site of a separate campus of an accredited North Carolina medical school which is determined adequate by the Liaison Committee on Medical Education, where such separate campus provides at least two years of clinical medical education to enrolled students." *See* Petition, p. 21 (emphasis added). This change is intended to benefit "new" medical schools, and satellite campuses of existing medical schools, specifically Carolinas Medical Center ("CMC") in Charlotte and Mission in Asheville. *See* Petition, p. 3. Thus, the AMCs would expand the reach of Policy AC-3 to two more institutions, including Novant's chief competitor in Mecklenburg County. The impact would be that Novant, which plays a significant role in training medical students and residents, but is excluded from Policy AC-3, would be operating in two markets (Winston-Salem and Charlotte) with AMC competitors that enjoy a competitive advantage that Novant does not. As Dr. Wolfson states:

> The proposed expansion of Policy AC-3's exemption to additional and new AMC related entities further erodes the integrity of the health planning process by permitting more wish lists and short term, often expensive and anti-competitive projects to escape the rational process of SMFP need determinations.
>
> Affording branch campuses and portions of AMC programs throughout communities in the state to arbitrarily trump the resources and needs of local, non-AMC hospitals and other providers creates a broader, state-sanctioned monopoly with reduced benefits to the community.

Exhibit A, pp. 11-12.

The stated reason for expansion of Policy AC-3 is to address a shortage of physicians, as stated by the President of the American Medical Association. No details are provided about the precise nature of the shortage, how North Carolina would be impacted by this shortage, or how expanding Policy AC-3 would help address the shortage. The AMCs do not indicate what additional resources in terms of SMFP-regulated assets are needed to meet the shortage. The AMCs do not explain why CMC and Mission, which have been involved in training residents for many years without the benefit of Policy AC-3 protection, suddenly need the unique benefits of Policy AC-3 protection. The AMCs do not explain why they and their satellite campuses could not use the normal petitioning process to meet the physician shortage, if additional SMFP-regulated assets are needed to help address the physician shortage. It is interesting to note that no Policy AC-3 CON application in recent times has proposed to add more medical school or residency slots. To do so would require verification from a third party and could not be done simply by obtaining a letter from the Dean of the AMC applying for the CON.

On page 13 of the Petition, the AMCs note that Duke successfully used the petitioning process in 1999 for an MRI scanner. The need determination was written in such a way that Duke was the only viable applicant. Duke was, in fact, the only applicant and its CON was

approved. The Petition states, however, that the petitioning process "delayed implementation by at least one year." This statement assumes that project implementation would have proceeded *exactly* according to the CON timetable, and would not have been affected by construction delays, funding issues or other organizational priorities. It is rare, at least in today's environment, for there to be no delays whatsoever in project implementation and for a project to come on line on the precise date identified in the CON timetable. The Petition also does not provide any details about how, if at all, the alleged delay affected Duke's ability to provide patient care. Thus, the reader cannot assume that the alleged delay of one year was meaningful.[6]

Moreover, it is important to put into context the one year delay that Duke says it experienced. The effects of health planning decisions made today can have effects decades into the future. For example, if a need is placed in the SMFP for additional beds, and the beds are ultimately approved and developed, one can reasonably expect those beds to remain in existence for decades. A one year delay, to make sure that the State of North Carolina gets it right and does not promote the unnecessary development of facilities and services that can drive up costs and put greater burdens on already-stressed payment systems like Medicaid for years to come, is not significant when considering the lasting effects of health planning decisions.

The Petition also neglects to mention Pitt's successful 2007 petition to add operating rooms, which is discussed in Novant's Petition. Clearly, the AMCs can and do use the normal

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[6]The fact that relatively few Policy AC-3 CON applications are filed would also suggest that Policy AC-3 is not the indispensible tool the AMCs imagine it to be, and that they do indeed have the time and the resources to go through the normal planning process.

petitioning process and there is no reason why they and their satellites cannot continue to do so.

The Petition also asserts, without any factual support, that following the normal petitioning process might cause an AMC to lose the ability to pursue research grants. *See* Petition, pp. 13-14. This statement seems to suggest that research grants are applied for on an "emergency basis" without time to go through the petitioning process. Dr. Wolfson has first-hand experience in academia and participates directly in grant-funded research himself. *See* Wolfson CV, attached as Exhibit 1 to Exhibit A. He disabuses the reader of the notion that grant opportunities and research are "emergency" situations that are ill-suited for the petitioning process:

> AMCs will not be forgoing grant opportunities if they are required to go through the petitioning process to obtain approval for projects. AMC-based research is a deliberate, incremental effort, built upon years of previously funded and published work and does not involve quick turnaround times or emergencies for faculty hiring decisions. This is especially true for NIH and major foundation grants. AMCs and their researchers are in a constant state of grant development and response to known requests for proposals. It is uncommon for a major, totally unexpected request for proposals to be issued by a granting agency, and for a researcher in an AMC to develop a cold response without having laid the groundwork with years of developmental research - much of it already funded by other sources. Clinical and basic research at AMCs is not a quick game - it is an incremental, deliberate and highly-competitive process.
>
> . . .
>
> There are few emergency resource decisions associated with bona fide grant, faculty recruitment and other institutional decisions that would not and should not be incorporated within a rational planning process and time frame.

Exhibit A, pp. 15-16.

The time involved in obtaining grants is illustrated by Baptist's experience in 2003, when it prematurely applied for a Policy AC-3 exemption for MRI and PET/CT scanners

before the grants were approved. *See* Exhibit B attached hereto, Findings on Project I.D. No. G-8616-03, page 7 ("Varian Medical Systems is funding current research performed by the Department of Radiation Oncology. However, the letter does not document that an expansion of this research has been approved by Varian Medical Systems and that the proposed equipment is needed for that expansion. Further, the applicant did not document that NIH or NCI have approved grants to fund any proposed research in this area. Therefore, the applicant did not adequately demonstrate that the proposed MRI and PET/CT scanners are '*[n]ecessary to accommodate patients, staff, or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research*' as required by Policy AC-3.")(emphasis added).

Given the lengthy and complex process involved in applying for grant money, the petitioning process does not unduly burden the AMCs or interfere with their research efforts. In fact, the alleged "delay" could be far less than even the year Duke says it experienced. A special needs petition could be filed in the August petitioning time frame, and depending on the nature of the service and the CON Sections' timetable, a review could be scheduled as early as the following winter. The time associated with the actual CON review would not be counted in determining the "delay" because, as the AMCs acknowledge, they would have to file CON applications anyway.

On page 13, the Petition notes that N.C. Gen. Stat. § 131E-184[7] provides an exemption for research projects, but the AMCs state this provision of the CON Law provides little value to them because they cannot charge for the services provided on the assets obtained through the

[7]The research exemption is found in N.C. Gen. Stat. § 131E-179, not N.C. Gen. Stat. § 131E-184, as stated in the AMCs' Petition.

research exemption.[8] The AMCs' complaint about the perceived shortcomings of the research exemption highlights why they zealously guard Policy AC-3: Policy AC-3 can be a tremendous money making opportunity for the AMCs.

This is perfectly illustrated by the recently-approved Baptist Policy AC-3 application proposing seven new operating rooms in Forsyth County. Forsyth County already has a surplus of almost six operating rooms. All of the counties adjacent to Forsyth also have a significant surplus of operating rooms. If developed, the Baptist project will cost Novant between $7 million to $11 million annually. *See* Novant Petition for further discussion. Novant appreciates that all not-for-profit health care providers must make money over and above their expenses to support their charitable missions and to reinvest in the continuous improvement of their facilities and services, but nothing in the plain language of Policy AC-3 states or suggests that it was intended to serve as a device to allow the AMCs to achieve the highest possible return on investment. Further, the AMCs' concerns about the statutory research exemption do not provide a basis for the expansion of Policy AC-3.

The AMCs' extensive discussion about research also implies, incorrectly, that they are the only health care providers doing any research. They fail to note that many community hospitals are also involved in research. For example, Novant Clinical Research Institute ("NCRI") was established in 2001 and has grown from a staff of 4 with a focus on cardiovascular studies to a staff of 14 who conduct and manage trials in a wide range of therapeutic indications. Forsyth Medical Center has an Institutional Review Board or IRB that reviews the research done by NCRI. *See* Exhibit C. WakeMed is another example of a non-

[8] N.C. Gen. Stat. § 131E-179(c) does allow the research exempted assets to be used for patient care provided on an occasional and irregular basis and not as part of the research program. The statute does not define "occasional and irregular basis." Baptist has been allowed to temporarily use equipment acquired pursuant to the research exemption for paying patients as a back-up while its non-research equipment was being replaced.

AMC with an IRB. *See* Exhibit D. The AMCs do not have a monopoly on research in North Carolina.

The Petition also asserts that "[r]equiring the SHCC as well as the CON Section to evaluate all academic projects also increases the administrative costs and the costs to the provider in seeking such an adjustment, with no benefit to patients." *See* Petition, p. 14. The AMCs do not describe the nature or amount of these "administrative" costs, or how these costs compare to the hundreds of thousands of dollars that are often spent on consulting fees, in addition to staff time, to provide the internal justification for a project, long before anyone even thinks of filing a petition or CON application. The AMCs do not discuss how the "administrative" costs compare to the revenues that will be realized from the development of Policy AC-3 project.

The AMCs' argument also fails to take into consideration the fact that the relatively small amount of "administrative" cost associated with filing a petition to the SHCC pales in comparison to the millions of dollars that are spent on the construction of Policy AC-3 projects. For example, the Baptist Policy AC-3 ambulatory surgery center project is reported to cost more than $38 million. Nor does the AMCs' argument take into consideration the cost to patients and payors of having to pay for unnecessary duplication of services, which can occur when the health planning process is not followed, and certain providers are allowed to bypass the SMFP.

The petitioning process protects patients, who are the ultimate beneficiaries of health planning and CON, to ensure that only those services and facilities that are actually needed are developed and deployed in an accessible and geographically dispersed manner. The benefit to

patients of following the health planning process far outweighs the relatively minor inconvenience and expense that the AMCs must "endure." As Dr. Wolfson observes:

> The benefits associated with reducing, rather than expanding exemptions and exceptions accrue to communities and patients and are consistent with the legislative intent of the health planning law.

Exhibit A, p. 15.

Novant is particularly concerned about an extension of Policy AC-3 to CMC, which directly competes with Novant's Presbyterian Hospital, in the greater Charlotte region, the most populous area of the State. This would mean that Novant would be competing in two major markets (Charlotte and Winston-Salem) with unfair regulation. It can propose SMFP-regulated services only when there is a need for them, and only if it prevails in a CON review that may be a competitive review with an AMC.[9] The AMCs, however, can file CON applications for SMFP-regulated assets whenever they wish, *and* they can also file CON applications in SMFP-regulated reviews. The assets that are at issue are not just "esoteric" forms of technology that only the AMCs use (*e.g.*, gamma knife). Rather, the assets include the building blocks of hospitals, such as beds, operating rooms, MRI scanners and cardiac catheterization units. One of the most recent Policy AC-3 applications, the Baptist ambulatory surgery center project, proposes to do relatively minor outpatient surgery, such as tonsillectomies and cataracts removal. These procedures are done every day in non-AMCs throughout this State and throughout this country.

Why should the State of North Carolina require Novant, or any non-AMC and private physician practice, to operate at such an extreme competitive disadvantage? This is not a hypothetical question. As discussed in Novant's Petition, the Baptist Policy AC-3 application

[9]The same is true for private physician practices. They can only apply for an SMFP-regulated service like operating rooms when there is a need in the SMFP.

will cost Novant $7 million to $11 million annually. Yet Novant, like every other provider, faces rising levels of indigent care every year, and has an obligation, like every other provider, to stay on top of technological developments and to maintain its facilities at optimum levels for patients. Novant is also the employer of more than 22,000 people in North Carolina. Many of the non-AMCs are, in fact, major employers in their respective communities, and are vitally important to the economy of North Carolina. The AMCs suggest that their proposal is really "fair" to everyone, but there is nothing fair about a system that gives some providers a distinct competitive advantage over others, when all providers are facing the same challenges. The AMCs' proposal to expand the reach of Policy AC-3 is doubly unfair to those providers, like Novant, that offer tertiary-level services, train residents, and perform clinical research, but are not deemed worthy of the Policy AC-3 exemption.

As discussed at length in Novant's Petition, the purpose of health planning and CON is to protect the community, not the interests of individual providers. The expansion of the two-tier system of health planning in North Carolina would suggest that North Carolina is less interested in health planning for community needs than it is in protecting and enhancing the bottom line of certain institutions. This not only disadvantages and discourages community physicians and private physicians that are providing services in North Carolina now, but also discourages potential future investment in North Carolina by health care companies and physicians that may perceive North Carolina's health planning process as inherently unfair and biased in favor of certain providers. This is not the message North Carolina should be sending at a time of extreme budget shortfalls.

As Dr. Wolfson notes:

> If anything, Policy AC-3 needs to be retracted, not expanded, and the State of North Carolina should take a long, hard look at the Policy and how it has been applied before it considers an expansion.
>
> As a health policy expert, I would suggest that North Carolina approach any possible expansion of Policy AC-3 with extreme caution. Otherwise, the integrity of the health planning process will be called into serious question and further concerns about inequities are likely to be created (*i.e.*, the AMCs and those who are 'aligned' with the AMCs being allowed to avoid the SMFP, but those who are not 'aligned' with the AMCs having to follow the SMFP.)
>
> In my opinion, health planning principles should be applied uniformly; otherwise, health planning will have failed its intended purpose. States should avoid creating or encouraging situations where some providers are treated or perceived as 'special' or 'more important' or 'better' than others, especially where such distinctions cannot be defended with empirical evidence.

Exhibit A, p. 17.

There is no demonstrable benefit to patients that flows from having a two-tier system of health planning in North Carolina. In fact, instead of benefitting patients, the two-tier system harms patients by creating an avenue for the unnecessary duplication of services that drive up health care costs. Accordingly, the SHCC should reject the AMCs' proposal to expand Policy AC-3.

B. Adding Adjectives To The 20 Mile Rule Is Unnecessary.

The AMCs also propose that the language of Policy AC-3 be changed, so that instead of being required to show that a project "cannot be achieved effectively" at a non-AMC within 20 miles of the AMC (the "20 Mile Rule"), the AMC will be required to demonstrate that it "cannot be met in a cost effective and clinically efficient manner." As Dr. Wolfson explains in his Affidavit, the problem is not the adjectives used in the Policy. The problem is the application and enforcement of the 20 Mile Rule, which is a mandatory provision in Policy AC-3. As the recent experience with the Baptist Policy AC-3 application shows, Baptist

simply did not address the 20 Mile Rule anywhere in its CON application, but its application was approved anyway by the CON Section. The 20 Mile Rule is meaningful because it serves as a further "check and balance" on the health planning process: to make sure that services and facilities are added only when they are genuinely needed, and not added simply because they can be added. If an existing provider is already doing what the AMC proposes to do in its Policy AC-3 application, and has existing capacity, the State must consider whether that resource can be used to meet a purported need.

There is no reason why an AMC, in answering the 20 Mile Rule as presently written, could not use the words "cost effective" and "clinically efficient." But the key is that the AMC must actually *answer* the 20 Mile Rule, not ignore it, as Baptist did. And the CON Section must deny those applicants that do not answer the 20-Mile Rule. As Dr. Wolfson observes:

> Lax or non-enforcement of the 20-mile requirement, along with presumptions about the completeness and validity of justifications included in exemption requests and Dean's letters, create incentives to exploit Policy AC-3.
>
> Regardless of whether the perverse incentive embodied in Policy AC-3 is ever used by an AMC, as a matter of sound health policy, it would be prudent to remove the incentive and its effects (that are manifestly contrary to the State's health planning law), if North Carolina intends to have a credible, consistent, and meaningful health planning process.

Exhibit A, pp. 10; 6.

The AMCs' proposed change does not address the fundamental problem of lax or non-enforcement of the 20 Mile Rule, and accordingly, the proposed change should be rejected.

C. The SMFP Inventory Should Reflect Assets and Utilization of All Assets Used to Provide Care.

The AMCs propose to exclude both the Policy AC-3 assets and the utilization of those assets from the SMFP. This simply does not make any sense from a health planning

perspective. *All* of these assets are available to be used by patients and their physicians. The State of North Carolina needs to have a complete inventory of all the health care assets available to serve people in this State, and it needs to know how well or how poorly these assets are being used, so that intelligent decisions about future planning needs can be made. The citizens of this State receive no benefit from the exclusion of these assets and the resulting utilization from official inventory. The AMCs, however, receive a major benefit, because exclusion of the assets and the related volumes makes it appear that the AMCs are busier and more efficient than they really are. An AMC can, in turn, leverage this in future competitive CON applications against a non-AMC to show that the AMC needs the CON more than the non-AMC. As Dr. Wolfson explains:

> The current exclusion of exempted resources artificially reduces the 'official' counts used by state agencies, and affords AMCs the illusion of doing more with less in future need determinations and CON competitions because their exempted projects never count.
>
> The AMCs state that expanding the exclusion on counting exempted services and projects will 'eliminate the risk of any *distortion* of the resulting need determination' (emphasis added), and 'prevents the delay in the demonstration of need that could result if the need determination reflected new services such as operating rooms that were approved, but not yet developed'. This is a hyperbolic spin that reflects exactly the opposite of its effect --- and implies that an exclusion in the counting of exempted projects is necessary to address some kind of emergency decision that must be made, rather than an integral part of the rational process of health planning, which the AMCs assiduously seek to avoid.
>
> Exempted projects/assets and those that have effectively traversed the reasonable hurdles of empirical health planning are all presumably available to treat patients. The State of North Carolina should reasonably want to count and know about the utilization of these assets, so that it has an accurate and complete picture of the health care resources available to serve citizens in their communities.

Exhibit A, pp. 12-13.

Instead, both Policy AC-3 facilities and their utilization should be *included* in the State's official health planning inventory. The reality is that these facilities exist, and they should not be ignored when the State takes inventory of what facilities are in the State and available to be used by patients and their physicians. Indeed, the AMCs' argument for exclusion contradicts their argument about why the research exemption in N.C. Gen. Stat. § 131E-179 is ineffective to meet their needs – they want to use their Policy AC-3 assets to treat patients and receive reimbursement for it. If so, the assets used to treat these patients, and the resulting volumes, need to be counted in the inventory so that the State and its citizens have a complete picture of health care assets available in this State.

This part of the Petition also contradicts the AMCs' offer to report the utilization of their Policy AC-3 assets in their annual Hospital License Renewal Applications. *See* Petition, p. 22. Data from the Hospital License Renewal Applications is in turn used to create some of the data tables in the SMFP. *See, e.g.*, Table 6A (operating rooms); Table 6E (endoscopy rooms); Table 9E (linear accelerators); Table 9I (PET Scanners); Table 9K (MRI scanners); and Table 9R (fixed cardiac catheterization units). There is no logical reason for including the data in one public document (the Hospital License Renewal Application) but excluding it from another document (the SMFP, which is the vehicle that actually uses the data reported in the Hospital License Renewal Application) that actually *uses* the data in the need formulas that specify the need for many types of healthcare assets in North Carolina. The data reporting needs to be consistent across all venues, and the data needs to be used, so that policy makers can make intelligent and well-informed planning decisions for the future.

D. The AMCs Need To Report More Data.

In the AMCs' Petition, they offer to report minimal data about their Policy AC-3 assets in the Hospital License Renewal Applications, but, as explained above, they do not want the data used for any health planning purposes in the SMFP. Further, the AMCs' minimalistic data reporting effort does not address key questions such as:

- Is the Policy AC-3 asset actually being used for research, or to train medical students or residents? Is the asset being used for other purposes?
- How many medical students and residents actually used the asset?
- Is the Policy AC-3 asset being used to provide care to medically underserved patients, and if so, how many medically underserved patients were served?

See also the data list proposed on pages 6 and 7 of Novant's Petition. Meaningful data should be reported, and it should be used to guide the health planning process in North Carolina.

E. The CON Process and Litigation Do Not Address The Fundamental Concerns About Policy AC-3.

On pages 14 and 15 of their Petition, the AMCs suggest that CON review and subsequent litigation are sufficient safeguards to ensure that Policy AC-3 "does not . . . provide a free pass to AMCs." *See* Petition, p. 14.[10] Unfortunately, it has been Novant's recent experience in the Baptist Policy AC-3 review that CON review does not always ensure that Policy AC-3 will be properly applied. As discussed in Novant's Petition, Baptist simply failed to answer the 20-Mile Rule, and the Agency approved the application anyway, despite the fact that: (a) the Agency knew, from prior reviews, that Novant provided the same services

[10]The AMCs also state that opposition to Policy AC-3 applications "has historically been very rare" and that in most cases in the past, "AMCs have faced no opposition from other providers to their Policy AC-3 projects." *See* Petition, p. 15. The relative lack of Policy AC-3 litigation should not be taken to mean that Policy AC-3 has been applied correctly in the past and that non-AMCs "agree" with the decisions reached on those applications. It should be noted that three of the four AMCs (UNC, Duke and Pitt) operate the only full-service acute care hospitals in their "home" counties and therefore, they do not face much competition in their "home" counties. Historically, the AMCs do not usually litigate against each other. Instead, they tend to work as a group, as evidenced by their joint Petition.

about three miles away from Baptist; (b) the Agency also knew, from prior reviews, that residents from Baptist train at Forsyth Medical Center; and (c) Novant explicitly pointed out in its comments that Baptist failed to answer the 20-Mile Rule. The matter is now in litigation, which is lengthy, expensive and uncertain.[11] Regardless of the outcome in the Baptist case, there is no guarantee that Policy AC-3 will not be abused in the future. Litigation is not a process that should be relied upon as a cogent and comprehensive health planning tool in North Carolina.

Further, the AMCs' discussion about the alleged "sufficiency" of CON review and litigation seems to assume that other agencies and the judicial system are better equipped than the SHCC to address health planning for the State of North Carolina. But it is the SHCC, not the CON Section and not the courts, that is charged with developing the SMFP. The SHCC represents a broad cross section of North Carolinians from all over the State. Many SHCC members work directly in the heath care industry, and have first-hand knowledge of health care delivery and the pressing needs that many North Carolina communities face. The SHCC members spend hundreds, possibly thousands, of hours working with the DHSR Medical Facilities Planning Staff developing the SMFP, which in turn presented to the Governor. CON review and litigation are in no way "substitutes" for the work of the SHCC.

Novant respectfully submits that the better approach is to prevent abuses before they happen and for the SHCC, which represents consumers, providers (including AMCs), physicians, insurers, and State and County government to address health policy issues that affect all North Carolinians, rather than leaving these issues for piecemeal litigation.

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[11]The SHCC should also consider that not every provider has the economic ability to undertake litigation because of the extreme expensive.

F. Changes in the Health Care Environment Do Not Support the AMCs' Proposed Changes to Policy AC-3.

The AMCs argue that changes in the health care environment will make Policy AC-3 even more critical. *See* Petition, p. 16. They suggest that if Policy AC-3 goes away, "the important process of discovering, developing, and perfecting new treatments may come to a halt, and North Carolina will fall behind other states in the arena of medical care." *See* Petition, p. 16.[12]

The AMCs' fears are unfounded. No one, least of all Novant, is trying to stand in the way of these institutions discovering, developing and perfecting new treatments.[13] Novant's proposal for the reform of Policy AC-3 recognizes that the AMCs may have unique needs, and so AMCs can file petitions to have need determinations included in future SMFPs to address their situations. As explained above, this process is not unduly burdensome and is not likely to have any material impact on the AMCs' teaching or research activities. Duke and Pitt have already successfully used the petitioning process, and there is no reason why they, and the other two AMCs, could not do so in the future.

In addition, the SHCC may also want to consider that on March 21, 2011, the Department of Health and Human Services ("DHHS") released the National Strategy for Quality Improvement in Health Care ("National Strategy") to Congress. *See* Exhibit E. This report was required by the health care reform law, the Affordable Care Act, in an effort to create national goals and strategies to improve the accessibility and quality of health care in the

[12] The AMCs also assert that losing Policy AC-3 may hinder faculty recruitment. They provide no evidence that any potential faculty member was ever informed of Policy AC-3 by a North Carolina AMC during the recruitment process; that any potential faculty member accepted an employment offer from a North Carolina AMC because of Policy AC-3; or that any potential faculty member declined an employment offer from a North Carolina AMC because of the concern that Policy AC-3 would be repealed or reformed.

[13] It remains to be seen, however, if Policy AC-3 has actually enabled any of the AMCs to discover, develop and perfect new treatments.

country. This National Strategy emphasizes the importance of coordination of care and communication among providers on a local level, to eliminate waste and unnecessary duplication that increase costs. It recognizes that while it is setting nationwide goals, it must rely on individual states' leadership to ensure that the national strategy reflects local needs. The goals in the National Strategy are consistent with the principles behind North Carolina's CON Law, but are contrary to Policy AC-3.

In pursuit of the goals of the National Strategy, DHHS has recognized that "all health care is local," and has made it a priority to promote effective communication and coordination of care among providers. *Id.* at p. 4. This emphasis on coordination indicates that *all* providers in a community, not just AMCs, are essential, and they must work together. "Collaborative efforts at the local level are also a vital resource for measuring, monitoring, and improving quality of care." *Id.* at p. 19. The National Strategy's focus on coordination is due in part to its finding that "too often, these improved models [of care delivery] are not known outside of the organization that created them." *Id.* at p. 21. The goal of achieving quality health care cannot be achieved by having silos of innovation; advances in care must be shared in communities for the benefit of the patient.

The AMCs' argument that only certain providers should remain entitled to the Policy AC-3 exemption, while other community providers are handicapped by it, contradicts the National Strategy's emphasis on coordination and collaboration among providers. Under the system envisioned by the National Strategy, which indicates the direction of health care nationwide, all providers have a critical role to play in providing quality health care to their communities.

The AMCs' argument that Policy AC-3 should be expanded further contradicts the goals of the National Strategy. Among the problems with the existing health care system, as cited by the National Strategy, is that the system is "characterized by unnecessary duplication of services and long waiting times and delays." *Id.* at p. 6. The National Strategy further faults the current system's overuse of services, which pose mores risks than potential benefits. *Id.* These problems are the same problems that North Carolina's CON Law seeks to prevent, by regulating new institutional health services in order to ensure that residents of North Carolina have access to the health care resources that are needed, while preventing unnecessary duplication of existing services.

As explained in Novant's Petition, Policy AC-3 is contrary to the premise of the CON Law, and would be at odds with the health care system identified in the National Strategy. It would allow the AMCs, and any new medical schools or satellite campuses that are entitled to use the policy, to circumvent the need determinations in the SMFP and essentially ignore the State's health planning process, without any evidence that the AMCs' use of the Policy provides measurable benefits to patients.

G. Other Flaws In The AMCs' Petition Need To Be Addressed.

In Exhibit A to their Petition, which is the AMCs' "new" version of Policy AC-3, the AMCs perpetuate a major problem with existing Policy AC -3: the self-serving, impossible to verify letter from the Dean of the Medical School, certifying that the project is "necessary." *See* Petitioner, p. 22. The Dean of the Medical School, who is employed or affiliated with the applicant applying for the Policy AC-3 exemption, will undoubtedly sign the letter presented to him or her by the AMC's staff. No external body is called upon to verify or validate that the proposed expansion of students, residents or faculty is needed. The CON Section does not do

any investigation to test the validity of any of the statements in the Dean's letter, but will instead accept the statements in the letter at face value. With hardly any effort, the AMC is able to avoid the need determinations in the SMFP.

The process that Novant is recommending (special needs petitions, which would involve public hearings and public comments where people debate issues and ask questions, and the SHCC ultimately decides whether there is a need), would eliminate this serious flaw in North Carolina's health planning process.

CONCLUSION

As stated by Dr. Wolfson:

> In the face of current and growing economic challenges facing all sectors of our communities - especially health and social services, rational health planning and a coordinated, community-oriented basis for determining need and approving the deployment of health care resources, is needed more than ever. Real health planning based on the sensible principles of North Carolina's legislatively articulated health policy principles is a public policy imperative.
>
> It is indeed imprudent in these challenging times to afford four entities in the state (the four academic medical centers) a relatively painless and easy way to achieve exemption from the rational and demanding process of health planning. North Carolina cannot afford to 'have it both ways'. . . .
>
> . . .
>
> At the very minimum, this health policy analyst strongly encourages modifications to Policy AC-3 policy to require a far greater degree of empirical justification by an academic medical center beyond a dean's letter - and far greater evidence that bona fide efforts have been made in advance to coordinate and collaborate with existing, local health care resources (*i.e.*, within the immediate 20 mile service area) that have like and similar services and resources. This, at the very least, would encourage the legislature's health planning policy intentions: coordinated planning and resource sharing to reduce waste and duplication, avoidance of geographic maldistribution and mitigation of costly, excess capacity. I believe that the suggestions made by Novant in its 2 March 2011 Petition seek to further these goals.

Exhibit A, pp. 16-17.

Accordingly, Novant respectfully submits that the SHCC reject the AMCs' proposed changes to Policy AC-3. Instead, the SHCC should adopt the changes proposed by Novant in its March 2, 2011 Petition and require all providers, including the AMCs, to comply completely with the SMFP.

This the 23rd day of March, 2011.

Denise M. Gunter
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Affidavit of Jay Wolfson, DrPH, JD
Regarding North Carolina State Health Coordinating Council
Policy AC-3 Rule

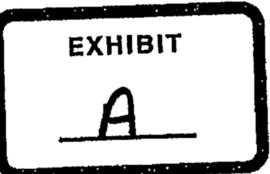
1. Statement of my name and position/title
    a. My name is Jay Wolfson.
    b. I am the Distinguished Service Professor of Public Health and Medicine and Associate Vice President of Health Law, Policy and Safety at the University of South Florida in Tampa, Florida, and Professor of Health Law at Stetson University College of Law, in Gulfport, Florida, and I have a private health law and policy legal and consulting practice.
    c. My address is P.O. Box 342548, Tampa, Florida 33694.
    d. A copy of my CV is attached to this affidavit as Exhibit 1.

2. The experiences and qualifications that afford me particular expertise in the immediate matter include:
    a. I have provided policy analysis and research consultation to local, state and federal agencies and government leaders regarding health policy, finance, planning and management for more than thirty years.

    b. I have been selected by federal and state legislators, executives and judges to serve on special tasks forces, panels or in unique advisory capacities on a panoply of health policy and finance issues. Examples include:
        i. Appointed as Special Guardian Ad Litem for Theresa Marie Schiavo, with report to Governor Bush and the Florida Courts (2003-2004);
        ii. Special Expert on Health Law, Finance and Policy to Florida Attorney General in matters relating to Dialysis Fraud and Abuse in Florida (2003 – 2009); and
        iii. Appointed to the Medicare Competitive Pricing Review Commission (1998-2004)

    c. I have conducted extensive funded research and published on matters of health policy and practice on topics directly related to health planning and certificate of need.

    d. I have participated personally and extensively in the health planning and CON processes as a trustee and finance chair of a major university (1,000 bed) teaching hospital, Tampa General Hospital, in Tampa, Florida, and



as a lead collaborator on CON projects between an academic medical center and community hospitals.

e. I have taught health care finance, health care financial policy and health policy and law for more than 30 years in graduate public health and law school venues.

3. Purpose of this Affidavit
    a. I have prepared this statement to reflect my findings and conclusions with respect to aspects of Policy AC-3 in the 2011 North Carolina State Medical Facilities Plan ("SMFP").
    b. I submit this affidavit to provide policy analysis and commentary relative to two petitions filed on 2 March 2011 with the North Carolina State Health Coordinating Council by Novant Health Inc., and by a consortium of four academic medical centers (AMCs) in North Carolina: Duke University Health System, Pitt County Memorial Hospital, North Carolina Baptist Hospital and University of North Carolina Hospitals.

4. Outline of approach taken and sources relied upon to reach conclusions proffered.
    a. In preparing this Affidavit, I relied upon the following:
        i. State laws and regulatory provisions in the 50 states regarding the health planning process and certificate of need guidelines, with an emphasis on existing and previous exceptions or exemptions afforded to academic medical centers;
        ii. North Carolina health planning statutory and regulatory provisions, with a particular emphasis on the history and application of the AC-3 exemption provision;
        iii. Select North Carolina Certificate of Need applications and State Agency decisions involving the application of the AC-3 exemption provision;
        iv. Novant's 2010 Policy AC-3 Petition and Responses to Novant's 2010 Petition from Pitt, UNC, Duke and NCBH;
        v. Novant's 2011 Petition to repeal or modify Policy AC-3;
        vi. Duke, UNC, Pitt and NCBH 2011 Petition to modify Policy AC-3 (the AMC Petition); and
        vii. More than 30 years of personal experience participating in, studying and writing about the history and practice of health planning and policy

making in the United States and the several states, including researching, teaching and participating in the health planning and policy making process, with a particular emphasis on the Certificate of Need process as it relates to academic medical centers.

5. Affiant statements:
   a. North Carolina's Policy AC-3 (a non-rule, agency policy) which affords an exemption to AMCs with respect to the need determinations in the State Medical Facilities Plan, does not comport with North Carolina statutory language regarding health planning or with the express statutory purpose of the Certificate of Need Law. Further, it is contrary to the evolving provisions of national health planning policies.

   b. The history of health planning in the United States includes a combination of federal and state statutory and regulatory initiatives to encourage and/or require formal planning and process initiatives. Since the 1970s, the intention of these efforts was to inject a greater degree of rationalization into the construction of health care facilities and the offering of complex and expensive health care services. Much has been learned since health planning and Certificate of Need programs were first deployed and as a consequence, many states have made many changes to their health planning processes – including Certificate of Need. These changes range from dropping various categories of care and services from CON review, increasing the dollar threshold for CON review, to eliminating entirely the CON process. Some states afforded exemptions or exceptions from health planning to AMCs in various forms.
      i. For example, Florida afforded AMCs an opportunity to intervene, by way of a special exemption, in competitors' CON-related projects. Unlike the broad-brush, far sweeping provisions of the North Carolina's Policy AC-3, Florida's provision was statutory. Florida, like some other states, offered AMCs the prerogative of intervening against any CON filed by any other entity if the AMC deemed that its research, education and service functions were compromised by the proposed CON. But even in those cases, there was no automatic veto – since the substantive

adverse effects on research, education and service had to be quantified and proved up. Florida eliminated its AMC-protectionist provision in 1994.

ii. Florida and other states have experienced a narrowing of the gap between the scope and quality of clinical services offered by AMCs and other health care providers in those same communities across the state – especially those community facilities that have established teaching and research affiliations with AMCs. As a consequence, Florida and other states have deemed pro-AMC health planning exemptions to be contrary to public policy, anti-competitive, and not supportive of cost containment and improved access to care.

c. It is my understanding that Policy AC-3 was intended to recognize that AMCs have certain unique needs, such as teaching and research obligations, and to assist AMCs in being able to fulfill their academic missions. But the policy language and the history of its application indicate that it is both out of step with health planning principles and practices and that it can be and has been misapplied in ways that are contrary to the North Carolina Legislature's express intent with respect to health planning and certificate of need.

   i. Based on my research, North Carolina appears to be standing alone among the states with a health planning process that employs AMC protection language that is as far reaching as Policy AC-3.
   ii. Policy AC-3 is unique in that the AMC must do very little to qualify for the exemption.
   iii. To benefit from the exemption, an AMC need only submit a letter from the Dean of its medical school and state that the teaching and research need for the project cannot be achieved effectively at any non-AMC that offers the same service within 20 miles of the AMC.
   iv. The Policy does not require that the petitioner afford any consideration to adverse impacts that may occur to patients, communities and other providers if the AMC is permitted to duplicate existing facilities and services.
   v. The Policy does not require any demonstration by the AMC that the exempt assets will provide tangible benefit to the state or the community, i.e.,

that they will be used to provide care to medically underserved populations.

vi. Most alarmingly, with an apparent blind eye toward being able to assess the impact and value of an exemption post approval and implementation, AMCs are not required to demonstrate that the exempted project was actually used for any academic purpose, such as teaching, research or expanded training opportunities for medical students and residents. Nor does Policy AC-3 require demonstration of the relative value of the purported academic purpose in terms of measurably improved quality, access, safety and costs. Rather, the current policy permits the fulfillment of what can amount to undocumented and quickly assembled "wish list" requests that are grounded in competition and market share goals - cloaked in academic regalia.

vii. Consequently, Policy AC-3 does not afford the policy makers or the people of North Carolina a rational means by which to know whether or to what extent Policy AC-3 fulfills its intended purpose.

d. It is with exceptional ease that AMCs can obtain a Policy AC-3 exemption. And there are no provisions to determine if the exempted projects were actually used for bona fide academic purposes (if at all). Therefore, the AMCs have a strong and natural incentive to exploit Policy AC-3 in order to avoid the reasonable planning and justification rigors of the SMFP.

    i. The malignant flaw in the current Policy AC-3 wording and use is that it is a license that permits AMCs to conveniently avoid the statutory premises of health planning in order to add services and facilities their competitors are precluded by law from adding, unless there is a need determination in the SMFP.

    ii. Contrary to reason, the AMCs, in their joint petition, actually seek to expand this flaw, further diluting the express legislative policy intentions that define the very purpose of health planning in North Carolina law for everybody else. And they shamelessly propose the expansion of Policy AC-3 to their greater benefit in the name of ensuring 'fairness' to other providers in the health planning

process." (AMC Petition, Page 2 'Reasons for Proposed Change')

e. Regardless of whether the perverse incentive embodied in Policy AC-3 is ever used by an AMC, as a matter of sound health policy, it would be prudent to remove the incentive and its effects (that are manifestly contrary to the State's health planning law), if North Carolina intends to have a credible, consistent, and meaningful health planning process.
   i. By affording some providers an option to avoid the SMFP, North Carolina's Policy AC-3 has fostered an inequitable health planning process and outcome.
   ii. Indeed, Policy AC-3 as written and implemented and the recent AMC petition for modification, underscore what has become an 'imperial' as opposed to an empirical health policy process.
   iii. This is indefensible, not only from a clear and unequivocal reading of the North Carolina health planning and CON statutes and their legislative intent, but also in terms of fundamental equity, fairness and good health policy practice.
   iv. The license afforded AMCs by the Policy AC-3 is particularly inappropriate, outdated and onerous given the leveled playing field in the health care marketplace. Non-AMCs are now also tertiary care providers; they conduct funded and unfunded clinical research; and they participate in the training of medical and nursing students and residents.

f. Acuity is not a legitimate basis upon which AMCs can distinguish themselves from non-AMCs according to the AC-3 policy.
   i. In their Petition for Change in Policy AC-3, the AMCs present data demonstrating differential acuity and severity for patients in AMCs versus non-AMCs as a basis for further justifying both the application and the expansion of Policy AC-3.
   ii. While AMCs generally provide a more complex, higher acuity level of care than the average community hospital, I can find no reference, directly or indirectly, to acuity levels serving as a basis for differential consideration in Policy AC-3.
   iii. This leads me to conclude that the AMCs' attempt to use claims of differential acuity levels is a sham

argument, not grounded in the policy, but used principally as an additional device to distract attention from a re-examination of Policy AC-3's substance and application.

iv. There is no reason why an AMC, even one with a very high acuity index, could not pursue the filing of a petition with the SMFP to meet the needs of its patient population. I understand that one of the AMCs, Pitt, actually did file a petition to add operating rooms a few years ago, that the petition was ultimately approved, and that Pitt applied for and received a CON for the operating rooms. Duke also states on page 13 of the AMC's Petition that it too has successfully used the "normal" health planning process. Certainly if they were able to follow the "normal" process with success, then other AMCs should also be able to follow the "normal" process.

v. Similarly, while the AMCs tend to serve patients from a broad geographic area, many non-AMCs, especially the tertiary providers, also serve patients from a broad geographic area. For example, Forsyth Medical Center routinely serves patients from more than 50 of North Carolina's 100 counties, and it also serves patients from other states. Likewise, other non-AMCs, such as Moses Cone, New Hanover and Presbyterian, also serve patients from a broad geographic region. In my opinion, patient origin is not a reason to exempt certain providers from the SMFP.

6. Policy AC-3 expressly contravenes and works against the legislative intent and principles of health policy and planning clearly articulated in North Carolina statutory law.

   a. Contrary to legislative intent, Policy AC-3 contravenes the express deliberative and planning process assigned to the State Health Coordinating Council, which devotes countless hours of voluntary time of appointed members who seek to meticulously and empirically craft rational health policy and plans for the state – efforts that can be undone with the stroke of a self-serving letter from the Dean of a medical school.

b. North Carolina's health planning policy is clearly and unambiguously articulated by the Legislature in its statutory findings of fact regarding the CON Law:

i. § 131E-175. Findings of fact (by the North Carolina General Assembly)

(1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed complements of these health service facilities.

(3) That if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have been medically underserved, would result.

(4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health services.

(6) That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities.

c. By this language, North Carolina health policy makers at the highest level have recognized and stated that costs, excess capacity, duplicated services, and geographic maldistribution were to be avoided by way of a rational and thoughtful process of planning and allocating resources at the community level, and with a clear eye toward coordination, collaboration and use of existing resources and opportunities. Only in the case of special research for distinctive services, were exceptions to be made, as set forth in N.C. Gen. Stat. § 131E-179.

7. Abuse of Policy AC-3 and the importance of the 20 mile provision

a. Policy AC-3 has gone far beyond the intention of the legislature, and affords a "back door" that allows certain providers to avoid the SMFP so that they can add services and facilities even when the SHCC has already said additional

services and facilities of the type being proposed are not needed. This "back door" becomes especially insidious and adverse to public policy if and when Policy AC-3 is not completely or consistently applied.

b. Based on my review of North Carolina Baptist Hospital's 2010 CON application to add seven new operating rooms in a county that already had a surplus of almost six operating rooms, and the CON Section's decision on that application, I am concerned that the Policy is being abused.

c. In that particular case, the applicant failed to address the express policy language requirement that it demonstrate that no other non-AMC within 20 miles could not effectively meet the purported teaching and research need for the project.

d. Despite the fact that objective data demonstrated that like and similar services already existed within three miles of the proposed project, the CON Section approved the application.

    i. The particular project involved an AC-3 exemption request for operating rooms be used for lower complexity procedures routinely performed at non-AMCs all over the country.

    ii. The justification proffered by the applicant included emphasis on a projected ten-year faculty recruitment plan. But there was no indication of when the faculty would arrive, the number of cases they would perform or even if they would use the proposed operating rooms.

    iii. Despite a well documented, long-standing teaching relationship with Forsyth Medical Center, an institution located only three miles from the proposed, exempted project – unambiguously within the '20 mile' directive of Policy AC-3, NCBH never mentioned either the relationship or Forsyth's identical services and resources in the exemption request, as if they did not exist.

    iv. Given that the proposed faculty recruitment was to occur over ten years, there was certainly nothing to indicate that this project was predicated on an emergency situation (such as the threatened loss of accreditation). There was

nothing in this application to afford the exemption applicant, NCBH, the special privilege of an exemption from the normal channel of petitioning the SMFP to add more operating rooms.

v. In another case I reviewed from 2003, the CON Section denied an NCBH application to add a PET/CT and MRI scanner under a Policy AC-3 application where NCBH also failed to address the 20-mile requirement. I do not understand how such different results could have been reached, considering that there was no change in the relevant language of Policy AC-3 between 2003 and 2010. It appears that somewhere between the two periods (2003-2010) there was an informal and unpromulgated decision to relax enforcement of the 20-mile requirement. Yet I am unaware of any evidence that the SHCC authorized the relaxation of the 20-mile rule. It is my understanding that only the SHCC has the authority to change Policy AC-3. Informal and unpromulgated relaxation of "controls" in Policy AC-3 is very dangerous from a health policy perspective. It not only leads to potential duplication of health services, but also erodes public confidence in the health planning process.

e. Given my reading and understanding of North Carolina's health planning statutory provisions, legislative intent and the clear and unambiguous language of the AC-3 policy, I believe that the 20-mile requirement speaks to a fundamental health policy and planning purpose of the Legislature: to reduce the possibility of unnecessary duplication of expensive community health services.
   i. This purpose is entirely consistent with, indeed, it is central to the stated purpose of the CON Law.
   ii. Lax or non-enforcement of the 20-mile requirement, along with presumptions about the completeness and validity of justifications included in exemption requests and Dean's letters, create incentives to exploit Policy AC-3. Such exploitations are evidenced in past applications, and in the current AMC petition for expansion of the fundamentally flawed Policy AC-3 language.
   iii. Unless the provisions of Policy AC-3 are eliminated or substantially revised, North Carolina's health planning process affords imperial privileges to a

select few without the empirical, legislatively intended obligations that affect the rest of the state's health care providers. Maintenance (or expansion) of the Policy AC-3 status quo relegates the health planning process to a relatively expensive sham process for non-AMC providers and the people of North Carolina.

8. Critique of The Petition filed by the AMCs on 2 March 2011 to Modify Policy AC-3
    a. The AMCs' 2 March 2011 Petition calls for expansion of Policy AC-3's currently flawed provisions, to include, among other things, endowment of the exemption privileges to other institutions with which the AMCs are or may become aligned, excluding more exempted projects from formal 'counts' of existing resources, modifying the 20 mile provision, and requiring certain reporting post award of an exemption.

    b. Premises and statements contained in the AMCs' petition are not always consistent with history, fact and state law, and warrant critical analysis presented herein.

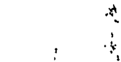
    c. Policy AC-3 is not, as the AMCs contend, "crucial to the ongoing teaching and research missions of the state's medical schools and by extension, the health care system of the state as a whole."
        i. The premise of a "crucial" character of Policy AC-3 is belied by the express legislative intent, statutory language, and history and use of the Policy AC-3.
        ii. As noted elsewhere in this analysis, Policy AC-3 has disproportionally benefited only AMCs, not the broader needs of the state, while avoiding, not ensuring 'fairness' to other providers.

    d. The proposed expansion of Policy AC-3's exemption to additional and new AMC related entities further erodes the integrity of the health planning process by permitting more wish lists and short term, often expensive and anti-competitive projects to escape the rational process of SMFP need determinations.
        i. Affording branch campuses and portions of AMC programs throughout communities in the state to arbitrarily trump the resources and needs of local, non-AMC hospitals and other providers creates a

broader, state-sanctioned monopoly with reduced benefits to the community.

e. Modifying the adjectives in the current Policy AC-3 from "achieved effectively" to "met in a cost effective and clinically efficient manner" treat the non-rule policy, AC-3, as if it were statutory, legislative intent language. It is not.
    i. If anything, stronger wording, highlighting the importance of health planning grounded in the health planning principles of coordination of community resources and the avoidance of costly duplication should be inserted.

f. The AMC petition proposes expanding the current perverse provision that excludes exempted resources from need determinations.
    i. The current exclusion of exempted resources artificially reduces the "official" counts used by state agencies, and affords AMCs the illusion of doing more with less in future need determinations and CON competitions because their exempted projects never count.
    ii. The AMCs state that expanding the exclusion on counting exempted services and projects will "eliminate the risk of any *distortion* of the resulting need determination" (emphasis added), and "prevents the delay in the demonstration of need that could result if the need determination reflected new services such as operating rooms that were approved, but not yet developed". This is a hyperbolic spin that reflects exactly the opposite of its effect --- and implies that an exclusion in the counting of exempted projects is necessary to address some kind of emergency decision that must be made, rather than an integral part of the rational process of health planning, which the AMCs assiduously seek to avoid.
    iii. Exempted projects/assets and those that have effectively traversed the reasonable hurdles of empirical health planning are all presumably available to treat patients. The State of North Carolina should reasonably want to count and know about the utilization of these assets, so that it has an accurate and complete picture of the



health care resources available to serve citizens in their communities.

g. The AMCs' petition also proposes changes to the 20-mile requirement in Policy AC-3. The language of the 20-mile requirement is not the problem; the problem is whether the 20-mile requirement is being applied within the application by the AMCs or by the State in its review of the Policy AC-3 application. The decision on the 2010 Baptist exemption application suggests that the 20-mile requirement – an essential concept clearly linked to the statutory goal of reducing unnecessary and costly duplication -- is not being honored.

h. The AMCs' petition suggests modifications in data reporting associated with AC-3 exemptions. Their proposal is a modest but insufficient step forward, and remains inconsistent with the principles of health planning and the intentions of the legislature.
    i. In addition to the few data points the AMCs suggest reporting, additional information should be reported, such as proposed in Novant's petition, regarding demonstration of how and the extent to which the exempted project actually met the teaching and research needs stated in the exemption request, along with data on outcome, quality, access, cost and the number of additional medical students and residents achieved expressly as a consequence of the exempted project.

i. The AMCs state confusingly in their Petition that expansion of Policy AC-3 is needed to reduce physician shortages by 2025. Correlating the exemption from the SMFP need determinations with physician shortage reduction is at best a curious slight of hand and distraction from the flaws inherent in the existing Policy AC-3. There is no relationship that has been shown between Policy AC-3 and physician shortage reduction per se.
    i. Addressing the shortage relates to increasing both the size of the undergraduate medical (UME) class, increasing the number of graduate medical education (GME) slots, and recognizing that nurse practitioners and physician extenders, not physicians, will be making up a significant portion of the care provider gap.

ii. Expansion of Policy AC-3 does not correlate with physician shortages – and any resources needed to address this matter could surely be applied for through the normal petitioning process by the AMCs and those who are aligned with them to seek to add more services and facilities.

iii. The claim within the AMCs' petition that an expansion of Policy AC-3 will "ensure fairness to other providers in the health planning process" is oxymoronic given the fact that such an expansion would only enhance a 2-class system at the explicit expense of the statutory health planning intentions of the Legislature.

j. The AMCs' petition to modify Policy AC-3 includes an extensive discussion about how research distinctly affects all AMC operations. The purpose of this argument is to support the contention that AMCs' research activities dramatically distinguish them from non-AMC facilities.

i. Research also substantially affects non-AMCs' operations.

ii. Non-AMCs have substantially leveled the playing field, not only in the scope and complexity of clinical services they provide (many are tertiary care facilities), but also with respect to the conduct of funded and unfunded research. Research also affects non-AMCs' operations in a substantial way.

iii. As an example, Novant, and other non-AMC institutions across the nation, have extensive clinical research programs, supported by public and private sources. Novant's Clinical Research Institute utilizes an formal, internal institutional review board (IRB) and has as its goal the improvement of the health of communities it serves through development of new therapies, treatments and clinical trials.

iv. Research needs are not and should not be short-term emergencies requiring sudden policy and practice exemptions. The AMCs put the cart well before the horse in proposing modifications to Policy AC-3 that would further bypass the legislature's intended rational planning process and guidelines in the name of improved research - in order to allow AMCs unobstructed benefits from

wish list, knee jerk, or prospective programmatic initiatives.

v. AMCs will not be forgoing grant opportunities if they are required to go through the petitioning process to obtain approval for projects. AMC-based research is a deliberate, incremental effort, built upon years of previously funded and published work and does not involve quick turnaround times or emergencies for faculty hiring decisions. This is especially true for NIH and major foundation grants. AMCs and their researchers are in a constant state of grant development and response to known requests for proposals. It is uncommon for a major, totally unexpected request for proposals to be issued by a granting agency, and for a researcher in an AMC to develop a cold response without having laid the groundwork with years of developmental research -- much of it already funded by other sources. Clinical and basic research at AMCs is not a quick game -- it is an incremental, deliberate and highly competitive process.

k. The AMCs claim that the current process of empirically-grounded, community-need based health planning and resource requests "can make it impossible for AMCs to pursue research grants, recruit faculty or meet accreditation standards." This is a distortion and misrepresentation – even of the current Policy AC-3 provisions.

i. The current Policy AC-3 provisions easily provide for accreditation and essential educational and research requests, and the statutory provision at N.C. Gen Stat Section 131E-179 makes special provisions for research requests;

ii. Educational and research "needs" are not and should not be short term emergencies UNLESS required by an accreditation body – in which case, AC-3 provides a clear and unambiguous vehicle. Yet it is my understanding that Policy AC-3 is rarely used because a third party, such as the ACGME, requires an AMC to do something. Rather, it appears that most Policy AC-3 applications are filed on a purely voluntary basis because the AMC wants to do something.

iii. The AMCs' example of Duke's use of the SMPF to obtain approval for an MRI (page 13 of AMC petition) is evidence that the process works. As noted above, Pitt has also used the "normal" petitioning process successfully.

iv. There are few emergency resource decisions associated with bona fide grant, faculty recruitment and other institutional decisions that would not and should not be incorporated within a rational planning process and time frame. The benefits associated with reducing, rather than expanding exemptions and exceptions accrue to communities and patients and are consistent with the legislative intent of the health planning law.

9. Conclusions

a. In the face of current and growing economic challenges facing all sectors of our communities – especially health and social services, rational health planning and a coordinated, community-oriented basis for determining need and approving the deployment of health care resources, is needed more than ever. Real health planning based on the sensible principles of North Carolina's legislatively articulated health policy principles is a public policy imperative.

b. It is indeed imprudent in these challenging times to afford four entities in the state (the four academic medical centers) a relatively painless and easy way to achieve exemption from the rational and demanding process of health planning. North Carolina cannot afford to 'have it both ways'. As a health policy analyst, researcher and expert, I believe that the current Policy AC-3 and application make no sense.

c. After nearly thirty years of experience with Policy AC-3 in the North Carolina health care arena, it is time for the State of North Carolina to ask whether the policy is rational and sensible and if the exemption, as it has been developed and used, is still warranted. And if it is still warranted, it is also important to ask whether changes need to be made to ensure that it is used for its intended purpose and is not exploited.

d. At the very minimum, this health policy analyst strongly encourages modifications to Policy AC-3 to require

a far greater degree of empirical justification by an academic medical center beyond a Dean's letter – and far greater evidence that bona fide efforts have been made in advance to coordinate and collaborate with existing, local health care resources (*i.e.,* within the immediate 20 mile service area) that have like and similar services and resources. This, at the very least, would encourage the legislature's health planning policy intentions: coordinated planning and resource sharing to reduce waste and duplication, avoidance of geographic maldistribution and mitigation of costly, excess capacity. I believe that the suggestions made by Novant in its 2 March 2011 Petition seek to further these goals.

e. If anything, Policy AC-3 needs to be retracted, not expanded, and the State of North Carolina should take a long, hard look at the Policy and how it has been applied before it considers an expansion.

f. As a health policy expert, I would suggest that North Carolina approach any possible expansion of Policy AC-3 with extreme caution. Otherwise, the integrity of the health planning process will be called into serious question and further concerns about inequities are likely to be created (*i.e.,* the AMCs and those who are "aligned" with the AMCs being allowed to avoid the SMFP, but those who are not "aligned" with the AMCs having to follow the SMFP.)

g. In my opinion, health planning principles should to be applied uniformly; otherwise, health planning will have failed its intended purpose. States should avoid creating or encouraging situations where some providers are treated or perceived as "special" or "more important" or "better" than others, especially where such distinctions cannot be defended with empirical evidence.

h. In my years of researching, practicing and teaching health policy, finance and planning, North Carolina has always been an example of careful, thoughtful, sensible health planning processes and policies. Historically, North Carolina's State Health Coordinating Council, in collaboration with the Medical Facilities Planning Section, have sought to produce a good faith, empirical and community based articulation of what is actually needed in health care at the community level. Policy AC-3, as

written and deployed, does not comport with that history and with sound health planning principles.

10. Attestation and notarization

Further, Affiant states nothing.

21 March 2011

Jay Wolfson, DrPH, JD

Notarization:

The foregoing was acknowledged before me this 21nd day of March 2011 by Jay Wolfson, who is personally known to me.

NANCY L. BEASLEY
MY COMMISSION # DD 753395
EXPIRES: May 21, 2012
Bonded Thru Notary Public Underwriters

Seal

My commission expires:

The above has been sworn to and signed in my presence.

CURRICULUM VITAE

DR. JAY WOLFSON

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PROFESSIONAL EXPERIENCE

Associate Vice President, Health Law, Policy and Safety, and Director of Outcomes, Center for Advanced Health Care, University of South Florida, 2005 -

Distinguished Service Professor of Public Health and Medicine, University of South Florida, 2005

Director, The Florida Health Information Center, College of Public Health University of South Florida, Tampa, 1990 -

Director, Suncoast Center for Patient Safety, Health Sciences Center (AHRQ funded), University of South Florida, Tampa 2001 - 2008

Professor, Health Law, Finance and Policy, and Internal Medicine, Colleges of Public Health and Medicine, University of South Florida, 1995, from Associate Professor, 1984 -

Professor of Health Law, Stetson University College of Law, 2000 -

Professor of Medicine, Florida State University College of Medicine, 2002 – 2010

General Counsel, American Board of Public Health Examiners, 2006 –

Governing Board Member, Florida Joint Medical Malpractice Underwriting Association (representing the Florida Bar), 2008 - 2010

Board Member (President 2009-2010), Health News Florida, 2007-

Executive Board Member, USA Africa Enterprise Foundation, 2008-

Associate Director, National Patient Safety Center of Inquiry, Veterans Health Administration, VISN 8, Florida and Puerto Rico 1999 – 2006

Member, Medicare Competitive Pricing Review Committee, Health Care Financing Administration, U.S. Dept. of Health and Human Services, 1998-2004

EXHIBIT
1

Board Member, Florida Health Sciences Center, Inc. (Tampa General Hospital), 1997-2000

President and Chairman, The Florida Kids Health Care Foundation, Inc., 1997-2005

President/CEO and Executive General Counsel, Care One, Inc., Tampa, Florida, 2002.

Vice Chair and Board Member, HealthEase Medicaid HMO, Tampa Florida, 1995-2000

Trustee, Vice Chair and Chair of Finance, Hillsborough County Hospital Authority (Tampa General), 1987-1999

General Counsel, American Board of Healthcare Risk Management, 1994–2000

Editorial Advisory Board, Men's Health magazine, 1998-2001

Acting Chairperson, Department of Health Policy and Management, College of Public Health, University of South Florida, Tampa, 1989-1991

Visiting Fulbright Professor, The University of Tokyo Medical School, and the National Institute of Public Health, Tokyo, Japan 1985.

Vice-President, Health Cost Management, Inc., Tampa, 1985 - 1993

Associate Professor of Health Administration, from Assistant Professor, College of Public Health, University of Oklahoma, Oklahoma City, 1981-1984

President, Jay Wolfson Associates, Houston and Oklahoma City, 1981-1984

Associate Director, Ideas, Inc., New York, Silver Spring, Columbia, Houston, 1976-1981

Faculty Associate, School of Public Health, The University of Texas, Houston, 1981

Assistant Professor of Health Services Administration and Program Evaluation, College of Public Health, University of South Carolina, Columbia, 1978-1980

SPECIAL ENGAGEMENTS

Appointed as Special Guardian Ad Litem for Theresa Marie Schiavo, with report to Governor Bush and the Florida Courts (2003-2004)

Special Expert on Health Law, Finance and Policy to Florida Attorney General in matters relating to Dialysis Fraud and Abuse in Florida (2003 – 2009)

EDUCATION

Doctor of Public Health, Health Services Organization and Administration, The University of Texas, School of Public Health, 1981

Juris Doctor, Stetson University, College of Law, 1993

Graduate Studies in Health and Hospital Administration, The University of Chicago, Graduate School of Business, Center for Health Administration Studies, 1976

Graduate Studies in Gerontology, The University of Southern California, Andrus Gerontology Center, 1975

Master of Public Health, cum laude, Community Health Organization and Administration, Indiana University, 1975

Master of Arts, European History and History of Thought, New York University, 1974

Bachelor or Arts, cum laude, History, The University of Illinois, Chicago, 1973

HONORS AND AWARDS

Distinguished Service Professor, University of South Florida, 2005
Faculty Scholar, U.S. Centers for Disease Control and Prevention, 1998-99
Licensed Health Care Risk Manager, Florida, 1995
Defense Research Institute, 1995
Admitted to the Florida Bar, 1994
Folmer Outstanding Service Award, Healthcare Financial Management
Association, 1993
Senior Fulbright Fellow, 1984-1985 (Japan)
W.K. Kellogg Fellow, 1982-1983 (Health Care Finance)
Sigma Xi, 1981
U.S. DHEW Public Health Service Traineeship, 1975-1977
Marcus and Theresa Levi Scholarship for Graduate Studies in Human Services,
1974-1975
New York City Department of Health, Health Research Fellowship, 1974

PUBLICATIONS

BOOKS

Wolfson, J., and P.J. Levin, Managing Employee Health Benefits: A Guide to Cost Control, Dow Jones-Irwin, Homewood, Il.,1985

CHAPTERS

Wolfson, J. "At the Bedside: A Guardian's Role and Reflections", in Ethics, Politics and Death in the 21st Century: The Strange, Sad Case of Terri Schiavo, ed. K Goodman, Oxford University Press, 2009.

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Wolfson, J., M. Choi and R Suggs, "Legal and Ethical Issues in Pharmacy Practice", in Pharmacy and Public Health, ed. B. Levin, 2007.

Wolfson, J. Morgan, R. "Health Decisions and Directives About the End of Life" in Handbook of Gerontology: Evidence-Based Approaches to Theory, Practice and Policy, ed. J. A. Blackburn and C.N. Dulmus, Wiley Publications, 2007

Wolfson. J., Foreword, in A. Caplan, J. McCartney and D. Sisti, ed., The Case of Terri Schiavo, Ethics at the End of Life. Prometheus Press, 2006.

N. Ikegami, **J. Wolfson**, and I. Ishi. "A Comparison of Administrative Cost Structures in Japanese and U.S. Hospitals" in N. Ikegmi et al, ed. Japanese Hospital and Health Care Systems, University of Michigan Press, 1996

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Wolfson, J, and Levin, P.J., "Who's Got the Money? Who's Got the Patients? - the Administrator's Response to PPOs and Self-Funding" in N. Goldfield and S.B. Goldsmith, eds., Alternative Delivery Systems, Aspen, Rockville, Md., 1987

Wolfson, J., "The CCD Cost-Sharing Case" (Case and teaching notes) in J. Suver, ed. Casebook on Health Care Financial Management, Health Administration Press, Ann Arbor, Mi, 1984. pgs. 245-261 of Text, and 20.1 -20.11 of Instructor's Manual

Wolfson, J. "Limits to Responsibility and Decision Making" in N.K Bell, Who Decides: Conflicts of Rights in Health Care. Human Press, Clifton, N.J., 1982

REFEREED JOURNALS

Wolfson, J. and Nir Menachemi. "Just Dating or Soul Mates? Patient Safety Meets Fraud and Abuse", Florida Journal of Health Law, February, 2010.

Wolfson, J. "When Patient Safety Meets Fraud and Abuse" Medical Ethics, October 2009.

Francois, R. M., G. Johnson, I. Hoare, **J. Wolfson**, C. Dziuban, R. Harbison. "Predicting Return to Work in Patients with Coronary Heart Disease" Journal of Medicine, Vol. 39 (1-6) (2008).

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Wolfson, J. "The Basis for Decisions to End Life: The Schiavo Dilemma". Clinical Interventions in Aging, January 2006.

Wolfson, J. "Schiavo's Lessons for Health Attorneys: When Good Law is All You Have", Journal of Health Law, Winter 2006.

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Spehar, M., Andrea, R.R. Campbell, C. Cherrie, P. Palacios, D. Scott, J. Baker, B. Bjornstad, **J. Wolfson,** "Seamless Care: Safe Patient Transitions from Hospital to Home" *Advances in Patient Safety: From Research to Implementation.* Volumes 1-4, AHRQ Publication Nos. 050021 (1-4). February 2005. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/advances/.

Hartman, R., **J. Wolfson**, and S. Yevich. "Military Deployment Health Surveillance Policy and its Application to Special Operations Forces" Journal of Military Medicine, February, 2004.

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Ikegami, N., **J. Wolfson**, and I. Ishi. "Comparison of Administrative Costs between U.S. and Japanese Hospitals" The Japanese Journal of Social Insurance, August, 1993, no. 1806, p 18.

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Levin, P.J. and **J. Wolfson**. "Health Care in the Balance: Japanese Eurythmy", Hospital and Health Services Administration, Sept. 1989, Vol 34, No. 3, pp 311 - 323.

Levin, P.J., **J. Wolfson**, L. Abberger and R.R. Campbell. "Quality and Financial Regulation of HMOs". Journal of Insurance Regulation, March, 1989, Vol 7, No. 3, pp 351 - 363.

Wolfson, J., P.J. Levin, and R.R. Campbell. "Beyond the Cost of Health Care: The New Era of Quality and Liability in Managed Care" Journal of the Florida Medical Association, March, 1988, Vol 75, No. 3, pp 165-169.

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Levin,P.J., **J. Wolfson**, and H. Akiyama. "The Role of Management in Japanese Hospitals". Hospital and Health Services Administration, May, 1987, Vol. 32, No.2, pp 249-261.

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Levin, P.J., and **J. Wolfson**. "Community Based Ambulatory Health Services Management: The Logic of the 1960s". Journal of Ambulatory Care Management" August, 1994, Vol 7, No. 3, pp 25-31.

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Glasser, J., and **J. Wolfson**. "Rocky Road: The Flavor of Health Services Research". Medical Care, September, 1983, Vol 21, No. 9, pp 939-942.

Wolfson, J., A. Kapadia, M. Decker, A. Sear, and L Roht. "Effects of Cost Sharing on Users of a State's Health Service Program". Medical Care, December, 1982, Vol. 20, No. 12, pp 1178 - 1187.

Wolfson, J., A. Sear, A. Kapadia, M. Decker, and L. Roht. "Cost-Sharing Effects". Medical Care, December, 1982, Vol. 20, No. 12, pp 1250 - 1251.

Levin, P.J., and **J. Wolfson**. "Health and American Business". New England Journal of Medicine, (letter) Vol. 307, No. 5, p. 320, July 29, 1982,

Wolfson, J. "Cost -Sharing Effects on Providers". Hospitals, Vol. 57, February 16, 1983, Vol. 57, p. 47.

PROCEEDINGS

Wolfson, J. "Linking Supreme Court Decisions on Abortion to End of Life Decisions: Legal Parameters and Guidelines for Neurological Decision Making" Proceedings of the American Academy of Neurology, Annual Meeting, April 2007, Boston, Massachusetts.

Wolfson, J., "Counseling Patients and Families about End of Life Decisions" Proceedings of the American Academy of Neurology, Annual Meeting, May 2007, Boston Massachusetts.

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Wolfson, J. "Personal Reflections from the Trenches: Are We Destined to Repeat the Tragedy of Terri Schiavo?" Proceedings of the American Academy of Neurology, Annual Meeting, April 2006, San Diego, California

NON REFEREED PUBLICATIONS

Wolfson, J. "The Courts and Our Rights" New York Times, Editorial, 9 October 2005.

Wolfson, J. "A Bond-Based Model to Finance Indigent Care" Modern Healthcare 8 January 1996, p. 37.

Wolfson, J. "Policy Making v Management on Public Boards" Tampa Bay Business Journal, 23 April, 1993

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Wolfson, J. "Financing Terminal and Catastrophic Health Care" Tampa Bay Business Journal, April, 1991

Wolfson, J. "A Growing Cry For National Health Insurance" Tampa Bay Business Journal, May, 1991

Wolfson, J. "Major Changes in the Financing of Health Care in the U.S, and the Implications of DRGs" Nikkei Medical (Japan), 14:7;. 119, 1985

Levin, P.J., and **J. Wolfson**. "Prescriptions for Medicare's Cost Spiral" The Wall Street Journal, October 13, 1982

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Wolfson, J. "Blues Jump on Bandwagon" Business Insurance, July 13,1981

SELECTED MAJOR TECHNICAL REPORTS (Sole author unless otherwise indicated)

Assessment of Progress Made by the Florida Patient Safety Corporation Toward Fulfilling Statutory Requirements, Senior Author, with Lisa Simpson, Nir Menachemi, Robert Weirs, Paul Barach, Lynn Glass, et al, The Florida Patient Safety Corporation, June 2006.

Recommendations for Implementation of the Florida Patient Safety Corporation, Senior Author with Paul Barach, Steven Stark, Lynn Glass, Deborah Zappa-Henley, et al, The Florida Agency for Health Care Administration, June 2004.

Litigation Alternatives and a No-Fault Demonstration for Medical Malpractice to Improve Patient Safety in Florida, Senior Author with Lynn Glass and Steven Stark. The Florida Agency for Health Care Administration/University of Miami Consortium, February 2004.

Medical Liability Reform: Study on the Establishment of a Patient Safety Authority, Pursuant to the requirements of S.B. 2 D (2003), with Paul Barach, Lynn Glass, Robert Weirs, James Howell, et. al, The Florida Agency for Health Care Administration, February 2004.

Medical Liability Reform: Quality Indicators for Consumers' Use in Selecting Hospitals, Pursuant to the requirements of S.B. 2 D (2003), with Paul Barach, Lynn Glass, Robert Weirs, James Howell, et. al, The Florida Agency for Health Care Administration, February 2004.

In Re: The Matter of Theresa Marie Schiavo, A Report to Governor Jeb Bush and the 6th Florida Judicial Circuit, Pursuant to the requirements of H.B. 35-E (Chapter 2003-418, Laws of Florida) and the Order of the Hon. David Demers, Chief Judge, Florida 6th Judicial Circuit regarding the appointment and duties of a Guardian Ad Litem in the matter of Theresa Marie Schiavo, Incapacitated, December 2003.

Dialysis Fraud and Abuse in Florida: Financial and Legal Relationships and Opportunities for Legislative and Regulator Action, Senior Author with Ronald P. Kaufman. The Florida Legislature and the Florida Agency for Health Care Administration, February 2001.

Recommendations to Preserve the Safety Net Health Care System in Florida, Senior Author with Michael Reid, Alan Friedlob, et al. The Florida Legislature and the Florida Agency for Health Care Administration, January 2001.

Preserving the Safety Net Health Care Provider System in Florida: Health Policy Analysis, Senior author with Michael Reid, Alan Friedlob, et al. The Florida Legislature and the Florida Agency for Health Care Administration, December 2000.

A Comparison of Utilization and Cost Patterns Between Services Provided to Injured Workers in Managed versus Unmanaged Care Environments in Florida's Mandatory Managed Care System. Senior Author with Stuart M. Brooks, Catherine Johnson, Yiliang Zhu, Andrea Spehar and Trevor Smith, State of Florida, Department of Labor, Division of Workers' Compensation, June 1998.

Implementation of Managed Care in Workers' Compensation at the Employer Level, Senior Author with Stuart M. Brooks, Catherine Johnson, Carl Newman and Trevor Smith, State of Florida, Department of Labor, Division of Workers' Compensation, October 1997

Evaluation of Florida's Mandatory Managed Care Workers' Compensation Initiative, Senior Author with Stuart M. Brooks and Cathy Johnson, State of Florida, Department of Labor, Division of Workers' Compensation, June 1997.

Validity of Cost and Utilization Estimates in Quality of Care Measures for Hospitals in Florida, The Employers Alliance, January 1997

Physician Perceptions of HMO Quality, The Hillsborough County Medical Association, May 1996

An Evaluation of the Full Service School: Working Toward Unity in the Community Project, with Barbara Clark-Alexander, The School Board of Manatee County, Florida, September 1995.

The Tax Exempt Status of Georgia Hospitals, Columbia Hospital Corporation, April 1994

The Tax Exempt Status of Florida Hospitals: What Does Not Get Paid; senior author, The Florida League of Hospitals, October 1993

The Appropriateness of Using Taxing Districts in Florida for the Support of Local Health Care Needs, senior author with S. Hopes, The Florida League of Hospitals, August 1993.

Feasibility Analysis for the Volusia County, Florida Indigent Health Care Plan, with S. Hopes. County of Volusia, Florida, August 1993.

Lessons Learned About How Health Care Institutions Can Prepare for a Hurricane or Other Worst Case Scenario, Wolfson, J., and G. Walker. American Hospital Association and Florida Hospital Association, July 1993

Comparison of Administrative Costs Between Japanese and U.S. Hospitals; Wolfson, J., N. Ikegami, and I. Ishi. Seminar on Comparative Health Care Costs, Ito, Japan, February 1993

The Florida Medicaid Managed Care Demonstration: Evaluation of Implementation, senior author with Gary Walker and Barbara Clark-Alexander, Florida Department of Health and Rehabilitative Services, January 1993

Comparative Admission and Service Use Patterns Between Physicians Who Have Equity Ownership Interests in Hospitals vs Those Who Do Not, with Scott Hopes, Columbia Health Care Corporation, February 1993

An Evaluation of the Drug Free Schools and Communities, (with Barbara Clark-Alexander, Robert McDermott, Gary Walker and Dino Contis) School Board of Manatee County, Florida, October 1992

Spiegel v University of South Florida: Property and Liberty Rights versus Service at Will for Department Chairs, Law and Higher Education National Conference, Stetson University College of Law, May, 1992

Cost and Quality Variations Between Free-Standing and Hospital-Based Ambulatory Surgery Centers (senior author with G. Walker) Ambulatory Surgery Centers, Inc., January 1992

Quality, Cost and Convenience: The Expanding Role of Freestanding Ambulatory Surgery (senior author with G. Walker) Medical Corporation International, October 1991

Strategic Plan for the Blake-Just Community Full-Service School Program in Hillsborough County, Florida, (senior author with D. Contis, B. Clark and G. Walker), Hillsborough County School District, July, 1991

Financial Viability of Adult Congregate Living Facilities in Florida. (contributing author, with J. Skinner and P.J. Levin) Florida Department of Health and Rehabilitative Services, September 1989

The Future of HMOs in Florida, (senior author with contributions of P.J. Levin, N. Fleming and R.R. Campbell) Florida Department or Insurance, July, 1989

Aging Access to Health Care in Florida, (with P.J. Levin and J. Skinner) Florida Office of the Governor and Florida Legislature, March 1989

Statutory and Regulatory Provisions Affecting Payment of Workers Compensation Claims in the U.S., Conservco, Inc., October 1988

The Florida Child Health Study (with Marti Coulter) Florida Department of Health and Rehabilitative Services, August, 1988

Cost Shifting and Florida Hospitals, Florida Office of the Public Counsel, September, 1987

HMO/Managed Care Legislative Recommendations for Florida, Florida Department of Insurance, March 1987, (senior author, with P.J. Levin and R. Campbell)

Report on HMO Quality and Financial Guidelines: A Legislative Summary, Florida Department of Insurance, February, 1987, (senior author, with P.J. Levin and R. Campbell

New Insurance Products in Japan and Coverage for Long Term Care, Beverly Enterprises, Rockville, Md., February 1987

Analysis of Claims Management and Financial Control Systems in Japan's Private Health Insurance Programs, Dun & Bradstreet, Plan Services, Tampa, Fl, January 1987

Costs of Health Care to Employees of Mitsubishi Companies, Mitsubishi Research Institute, Tokyo, November, 1986

Utilization-Cost Trends for Health Costs at the Nissan Corporation, Nissan Automobile Corporation, Tokyo, October 1986

Quality of Care and Financial Viability Measures for HMOs and PPOs in Florida, Florida Department of Insurance, September 1986, (senior author with P.J. Levin)

Appropriate Use of Detailed Case Mix Data in the Review and Analysis of Hospital Budgets by Florida's Hospital Cost Containment Board, Florida Office of the Public Counsel, July, 1986

The Application of the Main Penalty Rule by Florida's Hospital Cost Containment Board, Florida Office of the Public Counsel, June, 1986

Operating Margins, Deductions from Revenue and Other Indices of Financial Conditions of Florida's Public Hospitals Relative to Other Hospitals in Florida, Tampa General Hospital, June, 1986

Health Care Bond Issues in Florida and an Analysis of Capital and Working Capital Needs of Florida's Hospitals, Donaldson, Lufkin & Jenrette, New York, March, 1986, (senior author, with P.J. Levin).

Health Benefit Cost Control in Japan, U.S. Administrators, Los Angeles, January, 1986

Health Insurance Systems in Japan, U.S. Administrators, Los Angeles, October, 1985

The Japanese Health Benefits System Design, U.S. Administrators, Los Angeles, July, 1985

Employee Health Benefits Systems Design, Hospital Corporation of America, Tampa, February 1985 (senior author, with P.J. Levin).

Analysis of Options for Financing and Delivering Employee Health Benefits, Occidental Petroleum Corporation, Tulsa, September, 1983, (senior author, with P.J. Levin).

Alternative Health Cost Management Strategies in Insurance Companies vs Third Party Administrators, Cities Service Corporation, Tulsa, July, 1983, (senior author, with P.J. Levin).

A Utilization-Cost Trend Analysis of Health and Workers Compensation Costs, Anta Corporation, Oklahoma City, October, 1982

Cost Containment and Financing Arrangements Among Large, Houston Based Business Organizations, Houston Business Group on Health, October 1981

Data System Needs of the South Carolina Crippled Children's Division, South Carolina Department of Health and Environmental Control, November, 1980

Health Cost Management Systems in the Public Sector, CDP Corporation, Sliver Spring, MD, October, 1980

Harnessing Consumers to Improve Ambulatory Services, Bureau of Community Health Services, U.S. Department of Health and Human Services, August, 1980, (senior author, with J. Cahn)

Validity of Cost Estimates of Family Planning Services to Teenagers in the United States, Bureau of Community Health Services, U.S. Department of Health and Human Services, October, 1978, (with J. Cahn)

SELECTED GRANTS AND CONTRACTS

Principal Investigator, "PaperFree Florida Regional HIT Extension Center" Office of the National Coordinator for Health Information Technology, USDHHS, $5,884,132, 2010.

Principal Investigator, "Florida Family AIDS Network", U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2009-2010.

Principal Investigator, "Florida Family AIDS Network", U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2008-2009.

Co-Principal Investigator "The Tampa Bay Regional Health Information Organization Pilot System Development" Florida Agency for Health Care Administration, through the Tampa Bay Partnership, $235,000, 2007-2008.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2007-2008.

Co-Principal Investigator "The Tampa Bay Regional Health Information Organization Pilot System Development" Florida Agency for Health Care Administration, through the Tampa Bay Partnership, $330,000, 2006-2007.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2006-2007.

Principal Investigator, "Florida Patient Safety Initiative Advancement", Florida Patient Safety Corporation, $300,000, 2006.

Co-Principal Investigator, "The Tampa Bay Regional Health Information Organization Implementation Demonstration" Florida Agency for Health Care Administration, through the Tampa Bay Partnership Foundation, $467,000, 2006.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2005-2006.

Principal Investigator, "Incentives to Best Practices and Risk Management to Reduce Litigation in Medical Malpractice", Florida Agency for Health Care Administration, $106,400, 2004.

Principal Investigator, "The Role of Hospital Chief Executives and Board Members in Patient Safety Improvement", Subagreement with Florida State University College of Medicine, Florida Agency for Health Care Administration, $4,000, 2004.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2004-2005.

Principal Investigator, "Retraining Physician's Following Disciplinary Actions for Medical Negligence", Subagreement with University of Florida College of Medicine, Florida Agency for Health Care Administration, $10,000, 2004.

Principal Investigator, "Litigation Alternatives and a No-Fault Demonstration for Medical Malpractice in Florida", Subagreement with University of Miami College of Medicine, Florida Agency for Health Care Administration via University of Miami Consortium Agreement, $86,000, 2004.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2003-2004

Principal Investigator, Suncoast Developmental Center for Patient Safety Evaluation and Research, U.S. Agency for Healthcare Research and Quality, $198,000, 2003-2004

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2002-2003

Principal Investigator, Suncoast Developmental Center for Patient Safety Evaluation and Research, U.S. Agency for Healthcare Research and Quality, $198,000, 2002-2003

Co-Principal Investigator "Adolescent Clinical Trials for HIV/AIDS" National Institutes of Health, $700,000, 2000-2003.

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $1,228,090, 2001-2002

Principal Investigator, Suncoast Developmental Center for Patient Safety Evaluation and Research, U.S. Agency for Healthcare Research and Quality, $198,000, 2001-2002

Principal Investigator, "The Florida Dialysis Fraud Study" Florida Agency for Health Care Administration, $201,593, 2000-2001

Principal Investigator, "Managed Health Care Effects on Safety Net Providers in Florida", Florida Agency for Health Care Administration, $253,000, 2000-2001

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, 1,064,364, 2000-2001

Principal Investigator, "Targeted Outreach to Pregnant Woman with AIDS" (TOPWA), Florida State Department of Health, $100,000, 2000-2001

Principal Investigator, "The Impact of Implementing Telemedicine Technology in a Spinal Cord Injury Home Environment" American TeleCare, $36,000, 2000

Principal Investigator, "Florida Family AIDS Network" U.S. Department of Health and Human Services, Health Resources and Services Administration, $962,000, 1999-2000

Principal Investigator, "Congressional Black Caucus Grant for High Risk Populations Affected by HIV/AIDS", $80,000, 1999-2000

Principal Investigator, "Targeted Outreach to Pregnant Woman with AIDS" (TOPWA), Florida State Department of Health, $100,000, 1999-2000

Associate Project Director and Investigator, "Prevention and Management of Spinal Cord Injuries" U.S. Department of Veteran's Affairs, VISN 8, 180,000, 1999-2001

Principal Investigator, "Targeted Outreach to Pregnant Woman with AIDS" (TOPWA), Florida State Department of Health, $50,000, 1998-1999

Principal Investigator, "The Florida Family AIDS Network Program" U.S. Department of Health and Human Services, Health Resources and Services Administration, $880,000,1998-99

Principal Investigator, "The Tampa Bay Pediatric and Family AIDS Program" U.S. Department of Health and Human Services, Health Resources and Services Administration, $750,000, 1997-1998

Principal Investigator, "Creating a Healthy Kids Program in Tampa", Florida Healthy Kids Foundation, 18,000, 1997

Principal Investigator, "Tampa Bay Pediatric and Family AIDS Program" U.S. Health Resources and Services Administration, $428.900, 1996-1997.

Co-Principal Investigator, "Evaluation of Florida's Mandatory Managed Care Workers Compensation Initiative" Florida Department of Labor, Division of Workers Compensation, $150,000, 1996-1997,

Principal Investigator, "Physician's Perceptions of HMO Quality Issues" The Hillsborough County Medical Association, 1996, $1,000

Principal Investigator "Evaluation of Tobacco Use Education Project" Sarasota County Public Schools, 1996, $2,000

Principal Investigator, "The Tampa Bay Pediatric AIDS Project", U.S. Health Resources and Services Administration, $354,000, 1995-1996

Principal Investigator, "Evaluation of Manatee County Full Service School Program" 1995, $5,000

Principal Investigator, "Evaluation of the Full-Service School Program for Sarasota County Public Schools, 1994-1995, $14,000

Principal Investigator, "Evaluation of the Full-Service School Program for Sarasota County Public Schools, 1993-1994, $5,000

Principal Investigator, "Extension and Expansion of the Pediatric AIDS Project" 1994-1995", HRSA, USDHHS, $260,000

Principal Investigator, "The Ability of Health Care Organizations to Prepare and Respond to 'Worst Case Scenario' Natural Disasters – Follow Up to Hurricane Andrew in South Florida" 1993, The Florida Hospital Association and the American Hospital Association. $10,000

Principal Investigator, "Supplement to Tampa Bay Pediatric AIDS Project" 1992-1993, The All Children's Hospital Foundation. $14,000

Principal Investigator "The Tampa Bay Pediatrics AIDS Project" 1992-1995, Health Resources and Services Administration, USDHHS. $1,500,000.

Principal Investigator, "Evaluation of the Full-Service School Program for Manatee County Florida Schools, 1992-1993, $5,000

Principal Investigator, "Evaluation of the High Risk Drug Program for Manatee County Schools" 1991-1992, $5,000

Principal Investigator, "Evaluation of the Full Service School Program for Manatee County Schools" 1991, $5,000

Principal Investigator, "The Florida MediPass Program Evaluation: The Florida Medicaid, Managed Care Demonstration" 1991 through 1993, $101,000

Principal Investigator, "The Blake-Just Full-Service School Program Design and Evaluation Plan" Hillsborough County School District, 1991, $60,000

Investigator "Factors Associated with Viability in the Operation of Adult Congregate Care Facilities" Southmark Foundation on Gerontology, April 1989 through October, 1989, $75,000

Investigator "Project FAVA: ACLF Financial and Managerial Viability" Florida Department of Health and Rehabilitative Services, May 1989 through October 1989 $60,000

Principal Investigator "The Future Health of HMOs in Florida" STAR Grant, State of Florida, July 1988 through June 1989, $37,000

Co-Principal Investigator "Aging Access to Health Care in Florida" Florida State Legislature and Office of the Governor, September 1988 through December 1988, with P.J. Levin, $50,000

Co-Principal Investigator "Florida Child Health Study" Florida State Legislature, September 1988 through December 1988, with Martie Coulter, $67,000

Associate Principal Investigator and Associate Project Director "Healthy Beginnings: The Pregnancy Improvement Project for Florida" Florida Medicaid Program Office, DHRS, December 1988 - 1992, $325,000/year ($1,300,000)

Principal Investigator "The Japanese and U.S. Health Care Systems" The Associated Japan America Societies of America, November 1987 through April 1988, $12,000

Principal Investigator, "Updates on Health Insurance and Health Care Financing in Japan" Beverly Enterprises, Dun & Bradstreet Plan Services, U.S. Administrators, Inc., and Mitusi Mutual Life Insurance Company, 1986-1987 $30,000

Investigator "Long Term Industrial Hygiene Training Grant" The National Institutes of Health, 1984-88, $300,000.

Principal Investigator "The Financing of Japan's Health Care System" The Japanese Fulbright Commission, 1985, $60,000

Co-Principal Investigator "The Organization and Financing of Japanese Health Care" The Japan/U.S. Friendship Commission, 1985, with P.J. Levin, $20,000

Principal Investigator, "Use of Video Games to Stimulate Nursing Home Residents", Mattel Corporation, March 1983 through September 1984, $10,000

Principal Investigator, "Effects of Imposing Cost-Sharing on Users of a State's Health Service Program" South Carolina Department of Health and Environmental Control, 1981, $20,000.

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: October 28, 2003
FINDINGS DATE: October 29, 2003

PROJECT ANALYST: Martha J. Frisone
CHIEF: Lee B. Hoffman

PROJECT I.D. NUMBER: G-6816-03/ North Carolina Baptist Hospital/ Acquire one 3.0T MRI scanner and one PET/CT scanner pursuant to Policy AC-3 in the 2003 SMFP for radiation therapy treatment planning/ Forsyth County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

NC

North Carolina Baptist Hospital (Baptist) proposes to acquire a 3.0T MRI scanner and a PET/CT scanner pursuant to Policy AC-3 in the 2003 State Medical Facilities Plan (2003 SMFP) for radiation therapy (RT) treatment planning (i.e., simulation). In Section II.1, page 24, the applicant states

"NCBH proposes to purchase a General Electric Signa 3.0T magnetic resonance imaging scanner to be used primarily as a MRI-simulator for RT treatment planning. This system will include the following features:

EXHIBIT
B

- *3.0 Tesla system will perform whole body imaging using a wide variety of pulse sequences.*
- *Production of high resolution thin slices.*
- *Includes chemical-shift spectroscopy imaging.*
- *Radiation therapy simulation software, including CT-MRI fusion software and laser tracking system for MRI simulation.*

NCBH also proposes to purchase a General Electric Discovery ST PET/CT scanner to be used as a CT – simulator and PET/CT simulator for RT treatment planning. This system will include the following features:

- *High system sensitivity for both PET and CT.*
- *Large 70cm bore with short tunnel length (which is optimal for radiation therapy patient positioning).*
- *2-D and 3-D imaging capabilities.*
- *Four slice CT for thinner images also important for radiation therapy planning and rapid attenuation correction.*
- *Radiation therapy simulation software package, including PET / CT fusion software and laser tracking system for CT simulation.*

The proposed equipment will be located on the first floor of the Outpatient Comprehensive Cancer Center (OCCC), now under construction on the WFUBMC campus."

Construction of the outpatient cancer center was approved in Project I.D. #G-6376-01.

Policy AC-3 in the 2003 SMFP states

"Exemption from the provisions of need determinations of the State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 which projects comply with one of the following conditions:

> (i) *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*
>
> (ii) *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*
>
> (iii) *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*
>
> *A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Medical Center Teaching Hospital."*

By letter dated February 17, 1983, the Medical Facilities Planning Section, DFS, notified Baptist that it is designated as an Academic Medical Center Teaching Hospital.

Regarding a *"specified and approved"* expansion of the number or types of students, residents or faculty, in Section III.2, pages 65-68, the applicant states

> *"As a consequence of obtaining the proposed bioanatomic imaging devices (PET /CT and MRI scanners to be used for radiation therapy simulation devices), there will be an expansion of education and training programs in three areas: clinical oncology, radiation physics, and radiation biology.*

- *The Department of Radiation Oncology is submitting an application to the National Institutes of Health in response to PAR-03-083, 'Institutional Clinical Oncology Research Career Development Program'. ... The Program trains physicians (primarily recent graduates of radiation, medical, surgical or pediatric oncology residencies/fellowships) to perform clinical oncology research that develops and tests scientific hypotheses in specified areas of cancer research. ... The Program will be two to three years in length, and we anticipate recruiting two to three individuals per year for a maximum of 7 trainees at any given time. The Program Director will be W. Robert Lee, M.D., Vice-Chairman, Department of Radiation Oncology, and Director of the Radiation Oncology Residency Training Program.*
- *The Department of Radiation Oncology, Section of Radiation Physics ... and Section of Radiation Biology ... will be submitting an application this summer for a T32 Research Training Program Grant. ... The Grant will fund pre-doctoral graduate students ... and post-doctoral research fellows ... in basic cancer research, including translational research, (i.e., the movement of laboratory discoveries into patient and population research.) The main areas of training and research will be as follows:*

  - *Radiation Biology – two areas will be emphasized, the development of novel strategies to combat radiation resistance and the pathogenesis of radiation-induced brain injury. ...*
  - *Radiation Physics – four areas will be emphasized, including multimodality imaging, tumor volume determination, tumor control and normal tissue complication probabilities, and radiation dose distributions. ...*

Pre-doctoral training will be two to three years in length and post-doctoral training will be two to three years in length. We anticipate recruiting one to two individuals per year for a maximum of 6 trainees at any given time. ...

> *Please see the letter of support from William B. Applegate, M.D., M.P.H. Dean and Senior Vice President for Health Sciences attesting to the necessity of this project to complement a specified and approved expansion of the number or types of students, residents or faculty in Exhibit 9."*

Exhibit 9 includes an April 29, 2003 letter addressed to the President and CEO of Baptist from William B. Applegate, M.D., M.P.H, Dean and Senior Vice President for Health Sciences, Wake Forest University School of Medicine, which states

> *"Because the application is being submitted under the academic teaching hospital research exemption, I thought it would be of benefit to expand on the superb opportunities for oncology research and education that will be afforded to the School of Medicine with the acquisition of this technology.*
>
> *I have recently completed my annual review of all departments and sections in the School, including the Department of Radiation Oncology and the Sections of Radiation Physics and Radiation Biology. Dr. Robert Lee, Vice Chair of Radiation Oncology, is about to submit a K12 application to the National Institutes of Health and National Cancer Institute to support clinical fellows in oncology, most of whom will be in Radiation Oncology. The two (or three) year fellowships will be thematically structured with one of the major themes being bioanatomic radiation treatment planning and treatment delivery. The application has been motivated by the anticipation of the acquisition of the MRI-CT-PET simulators. Furthermore, Drs. Dan Bourland (Physics Section Head) and Mike Robbins (Radiation Biology Section Head) are going to submit a T32 training grant to the NIH/NCI later this summer to support graduate and post-graduate positions in Radiation Physics and Biology."*

Dr. Applegate is the *"head of the relevant associated professional school."* However, the letter does not demonstrate that any of the proposed expansions of the number of students, residents or faculty have actually been approved, as required by the policy. In particular, the letter states that funding for the proposed expansion of students has yet to be applied for, and thus has not been approved by the

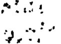
National Institute of Health (NIH) or the National Cancer Institute (NCI). Alternatively, the applicant does not demonstrate that an approval has been obtained to expand the number of students in the event that the grant approvals are not obtained. Therefore, the applicant failed to adequately demonstrate compliance with the first condition in the policy.

Regarding a *"specified and approved"* expansion of research activities, in Section III.2, pages 68-69, the applicant states

> *"As outlined in the discussion related to Criterion 1, each of the three areas of training program expansion revolves around research. Basic radiation biology and physics research will be translated into clinical trials of safety (Phase I studies) and efficacy (Phase II studies) as well as randomized Phase III studies in which bioanatomic treatment planning approaches are compared to standard methods. Conduct of these Phase I, II, and III clinical trials will be facilitated by the Clinical Research Program of the Comprehensive Cancer Center of Wake Forest University. ... At any given time, the Cancer Center has approximately 50 investigator-initiated studies open, which accrue approximately 600 patients year per year. ... Financial support for the clinical trials will come from the Cancer Center, grants from the National Cancer Institute and similar NIH funding agencies, non-profit associations, foundations, and societies, and industry .... For example, Varian now sponsors research in bioanatomic imaging and treatment with Dan Bourland, Ph.D. as principal investigator. A letter of support from Varian documenting their commitment to research sponsorship is included in Exhibit 17."*

Exhibit 17 includes a May 2, 2003 letter signed by the Manager, Research Partnerships, Varian Medical Systems, Oncology Systems, which states

> *"Varian Medical Systems enthusiastically and fully supports the CON application by North Carolina Baptist Hospital (NCBH) for two radiation treatment planning simulator devices that use advanced imaging: 1) an MR-Simulator and 2) a PET-CT-simulator. ...*



> *The acquisition and installation by NCBH/WFUHS of the MR-simulator and PET-CT-simulator is essential to the development of a strong and long-term collaboration in the area of bioanatomic imaging and treatment. In support of this promising educational and research initiative, Varian Medical systems currently sponsors the WFUHS Department of Radiation Oncology with a research grant of $150,000 per year. This grant, titled Bioanatomic Radiation Treatment for Brain and Lung, is directed by J. Daniel Bourland, PhD, Associate Professor and Head, Physics Section. ...*
>
> *Future funding of bioanatomic research at WFUHS is anticipated as subsequent research projects are proposed by Dr. Bourland and his faculty."*

Varian Medical Systems is funding current research performed by the Department of Radiation Oncology. However, the letter does not document that an <u>expansion</u> of this research has been <u>approved</u> by Varian Medical Systems and that the proposed equipment is needed for that expansion. Further, the applicant did not document that NIH or NCI have approved grants to fund any proposed research in this area. Therefore, the applicant did not adequately demonstrate that the proposed MRI and PET/CT scanners are "[n]*ecessary to accommodate patients, staff or equipment for a specified and <u>approved expansion</u> of research activities, as certified by the head of the entity sponsoring the research"* as required by Policy AC-3. (Emphasis added.)

With regard to the requirement to demonstrate the teaching or research need cannot be achieved at a non-academic medical center teaching hospital, in Section II.1, pages 25-26, the applicant states

> *"While MRI and PET scanners exist in non-teaching hospitals, appropriate and optimal use of the proposed MRI and PET/CT scanners as radiation therapy simulation and bioanatomic treatment planning devices is not possible in a non-teaching setting for the following reasons:*

- *Most non-teaching hospitals do not have PET or PET/CT scanners . The CT component of the PET / CT scanner is essential for image co-registration, that is, the precise superimposition of anatomic CT images with anatomic MRI and PET images and biologic MRI spectroscopic and PET images/information. The CT component also provides rapid attenuation correction.*
- *Most non-teaching hospitals do not have volume of patients or resources to justify the ancillary equipment and software necessary to perform MRI spectroscopy. Non-teaching hospitals with MRI spectroscopy, are limited to single-voxel spectroscopy, which is adequate for qualitative diagnostic information. The 2-dimensional and 3-dimensional quantitative biologic information needed for bioanatomic radiation therapy treatment planning are not currently provided in the non-teaching hospital setting.*
- *To perform the full range of bioanatomic imaging with PET, there must be a capability to synthesize a wide variety of radiopharmaceuticals other than standard FDG-18 (e.g., C-11 methionine and thymidine for proliferation imaging, F-18 misonidazole for hypoxia imaging, and others). To synthesize these specialized imaging agents, a cyclotron and radiochemicals to develop and implement safe processes for quality assurance is needed. There are no non-teaching hospitals in North Carolina that have a cyclotron. They rely on vendors or teaching hospitals like Wake Forest that have their own cyclotron to purchase FDG-18."*
- *A multidisciplinary team of physicists and physicians is necessary to utilize the anatomic and biologic information from MRI and PET/CT scanners for bioanatomic radiation therapy simulation, treatment, planning, and treatment delivery. This includes subspecialized physicists, including diagnostic radiology physicists specializing in MRI and PET physics, and radiation oncology physicists specializing in molecular imaging and treatment planning. It also includes subspecialized physicians, including disease-site oriented diagnostic radiologists (in CT, MRI), nuclear medicine radiologists (in PET), and radiation oncologists. ... The number and diversity of individuals involved and the*

> *integration of multiple disciplines would be difficult to recruit and maintain in a cost-effective manner in a non-teaching hospital."*

In addition, in Section III.2, page 64, the applicant states

> *"the project cannot be implemented through the use of MR and PET/CT scanners at other facilities within 20 miles of Winston-Salem. In fact, the proposed equipment with both the MRI and PET/CT simulation modules are not available anywhere in the State of North Carolina at the present time."*

There are no existing or approved PET or PET/CT scanners located within 20 miles of Baptist. Therefore, there is no other facility in the designated area that could meet the teaching or research need for the PET scanner at this time. However, the applicant makes only general and unsupported statements regarding the ability of other hospitals to meet the teaching or research need for the proposed MRI scanner. The applicant fails to identify the hospitals, located within 20 miles of Baptist, that currently offer MRI services. Further, the applicant fails to document that these hospitals cannot effectively meet the research need for the proposed MRI scanner. For example, the applicant fails to document that the research need for the proposed MRI scanner cannot be effectively met using the existing MRI scanner located at Forsyth Medical Center (FMC), which is located less than two miles from Baptist. Particularly since FMC currently serves as a clinical training site for Wake Forest University School of Medicine residents and is a tertiary hospital.

In summary, the applicant did not adequately demonstrate that the acquisition of the MRI or PET/CT scanner is consistent with Policy AC-3 in the 2003 SMFP. Therefore, the application is nonconforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

Baptist proposes to acquire a 3.0T MRI scanner and a PET/CT scanner for radiation therapy (RT) treatment planning (i.e., simulation). Baptist currently owns and operates one PET scanner, five MRI scanners, one CT simulator and one conventional simulator. The applicant proposes to replace the existing CT simulator with the proposed PET/CT scanner. Thus, upon completion of the project, Baptist would own and operate one PET scanner, six MRI scanners (one used for simulation), one PET/CT scanner (used for simulation) and one conventional simulator.

Population to be Served

In Section III.5(d), page 83, the applicant states

"NCBH currently has the capability to perform conventional and CT simulation procedures for treatment planning within its Department of Radiation Oncology. Projected patient origin for the proposed equipment is projected to be very similar to the existing patient origin."

The following table illustrates current patient origin for radiation oncology services and projected patient origin for the proposed MRI and PET/CT scanners, as reported by the applicant in Section III.4(b), pages 74-76, and Section III.5(c), pages 78-83.

COUNTY	% OF TOTAL PATIENTS	
	CURRENT RADIATION ONCOLOGY	PROJECTED PROPOSED MRI & PET/CT SCANNERS
Forsyth	24.5%	24.5%
Davidson	11.5%	11.5%
Surry	6.2%	6.2%
Guilford	5.8%	5.8%
Wilkes	4.6%	4.6%
Catawba	3.3%	3.3%
Iredell	2.8%	2.8%
Rowan	2.6%	2.6%
Stokes	2.6%	2.6%
Yadkin	2.5%	2.5%
Randolph	2.4%	2.4%
Davie	1.8%	1.8%
Carroll, VA	1.7%	1.7%
Henry, VA	1.6%	1.6%
Rockingham	1.4%	1.4%
Caldwell	1.3%	1.3%
Burke	0.8%	0.8%
Grayson, VA	0.8%	0.8%
Patrick, VA	0.8%	0.8%
Alleghany	0.7%	0.7%
Ashe	0.6%	0.6%
Gaston	0.4%	0.4%
Mecklenburg	0.3%	0.3%
Watauga	0.3%	0.3%
Alexander	0.2%	0.2%
Pittsylvania, VA	0.2%	0.2%
Other NC and VA Counties (1)	15.1%	15.1%
Other States	3.2%	3.2%
Total	100.0%	100.0%

(1) The applicant identifies the other North Carolina counties in Section III.4(b), pages 74-76, and Section III.5(c), pages 78-83. The percentage of total patients from any one of these counties is 1% or less.

The applicant adequately identifies the population it proposes to serve.

Need for the Proposed MRI and PET/CT Services

In Section II.1, pages 17-27, the applicant describes the proposal and explains why it believes the proposed MRI and PET/CT scanners are needed as follows.

"This application is for a GE Signa 3T magnetic resonance imaging (MRI) scanner and a GE Discovery ST-8 computed tomographic positron emission tomography (PET/CT) scanner to be used as radiation therapy (RT) simulation devices. Simulation is the initial step and most essential component of the treatment planning process necessary to accurately administer radiation therapy for cancer (and certain benign diseases). .... Therefore, accurate definition of the target volume, (i.e., the areas of gross and microscopic involvement of cancer), is essential to achieving local tumor control and a cure. Prior to CT and MRI scanners, target volume definition for RT was crude .... CT and MRI began the era of so-called anatomic RT treatment planning. CT has the advantages of being able to image the soft tissues of the neck, visceral structures and other soft tissues of the chest, abdomen, pelvis, and bone cortex with high resolution. MRI is complementary to CT and provides high resolution images of the brain, spinal cord, spine, muscles, and internal structure of the bones. ... CT scanners adapted specifically for the RT treatment process are called 'CT-simulators' and are now common place in most modern radiation therapy departments.

MRI-simulators are less common except in large radiation oncology departments in medical centers where high volumes of diseases best imaged by MRI are treated with radiation therapy. The application of MRI and PET/CT to simulation in treatment planning is relatively recent. ...

In 2000, the Duke University Medical Center Department of Radiation Oncology applied for and obtained an MRI scanner to be used as a MRI-simulator, the first and only known instance of this in North Carolina. The proposed project would introduce for the first time in North Carolina, an R/F (existing), MR and PET/CT simulator within the same Department of Radiation Oncology."

In Section III.1(a), pages 56-63, the applicant states

"NCBH has identified the following areas of unmet need that necessitate the inclusion of each of the proposed project components ....

__*Molecular and Biologic Imaging*__.

Advanced imaging modalities that better show tumor anatomy and demonstrate tumor biology are needed for radiation therapy treatment planning and delivery in order to improve the local tumor control rate, increase the cure rate, decrease treatment-related-side-effects, and reduce the overall burden of cancer. ... Molecular imaging provides three-dimensional information about cancer that cannot be provided by non-invasive methods like CT and MRI, or by invasive approaches such as histopathologic analysis such as biopsy or surgical resection. Examples of molecular imaging include magnetic resonance spectroscopy and positron emission tomography. ...

...

__*Current Imaging Modalities Do Not Adequately Image Tumor Anatomy*__

Magnetic resonance spectroscopy is a biochemical analysis of a region (called a voxel) of tissue otherwise imaged by a conventional MRI scan. ... Unlike MRI, which produces high resolution anatomic images, MRS generates chemical spectra that reflect the quantity of certain metabolites in normal and cancerous tissues. MRS can detect the presence of cancer in structures and tissues that appear anatomically normal on MRI, and conversely can disprove the presence of cancer of structures/tissues that are anatomically abnormal on a MRI scan. Therefore, MRS and MRI are complementary imaging modalities. ...

...

Positron emission tomography is a method of measuring metabolic, biochemical, and functional activity in living tissue via electronic detection of short-lived positron emitting radiopharmaceuticals. PET is able to detect the presence of cancer for nearly all human tumors ..., often when conventional anatomic CT or MRI images appear normal. PET and MRS are complementary imaging modalities, and both are emerging as important imaging technologies for radiation therapy treatment. ...

Current Imaging Modalities Do Not Image Tumor Biology

Presently, the radiation therapy treatment planning process is entirely anatomically based on either CT or MRI scans. Tumor biology is completely ignored. It has been known for nearly three decades that certain biologic characteristics of tumors, such as hypoxia, are associated with radiation resistance. The dose of radiation needed to kill a hypoxic cancer cell is three-fold greater than that needed to kill an oxic one. ... PET using the radiopharmaceutical F-18 misonidazole is one method of non-invasively imaging tumor hypoxia. ... Hypoxia is quite common in human tumors. ... The implication for radiation therapy is two-fold. First, areas of hypoxia should receive up to 3 times more radiation dose than non-hypoxic regions. Using the combination of PET and MRS, the degree of hypoxia for a given tumor can be defined, and radiation dose then administered in proportion to the degree of hypoxia. ... Second, patients with hypoxic tumors might benefit from the administration of drugs ... that increase the likelihood that a hypoxic cancer cell will be killed by a given dose of radiation.

Another method of intensifying radiation dose besides intensity modulated radiation therapy (IMRT) is with the use of Gamma Knife stereotactic radiosurgery (SRS). ...

Future Demand for Bioanatomic Radiation Therapy Treatment Planning

We believe the combination of anatomic and biologic imaging of cancer for radiation therapy treatment planning using MRI, MRS, and PET/CT will become the new standard of care for all patients with potentially curative cancer in whom radiation will play a role in their management. Bioanatomic imaging better defines the extent of gross and microscopic tumor, facilitates selective radiation dose escalation with techniques such as IMRT and SRS, and permits the selection of biologically specific drugs, all of which contributes to an individualized approach to the radiotherapeutic management of cancer, rather than the somewhat generic methods currently in use. This should translate into improved local tumor control, survival, and

quality of life. Furthermore, we envision that bioanatomic imaging will be of great value to other members of the oncology treatment team, including the surgeon, who will be better able to define the complete tumor volume of a given cancer for surgical resection, and the medical oncologist, who will be able to identify biologically specific targets for drug treatment.

Increased Accuracy of Treatment Planning Leads to Improved Patient Experience

As discussed previously, implementing MRI Simulation and PET/CT Simulation technology for treatment planning will allow physicians to locate tumors with pinpoint accuracy. The improved accuracy of tumor definition translates into improved focus of radiation oncology treatment delivery. NCBH anticipates that this will not only improve the outcomes of patients, but will also improve the quality of patient care and the patient's radiation oncology treatment experience. The side affects [sic] *often associated with radiation therapy will be greatly reduced because physicians will be able to reduce radiation exposure to healthy cells while increasing the strength of radiation to malignant cells. Destroying malignant tumor sooner and reducing the side effects of radiation exposure will allow patients to recover from treatment more rapidly."* (Emphasis in original.)

In Section III.1(b), pages 64-65, the applicant states

"Cancer is the second leading cause of death in the United States, following heart disease. ... At the North Carolina level, 39,600 new cancer cases and 16,500 cancer deaths are expected in 2003 .... It is anticipated that the cancer affliction on the population will only increase in the coming years with the aging of the baby boomer segment of the population. Estimates from the Solucient database indicate that 15,914 new cancer cases occurred in 2002 in the Medical Center's 26-county service area alone (21 North Carolina counties and 5 Virginia counties). Therefore, it is increasingly important that new technologies are discovered to treat and potentially cure this powerful disease.

The disease sites of focus for the new equipment will be primary and metastatic brain, breast, esophagus, head and neck, pancreas, prostrate, and lung cancer. Data on analytic cancer cases (newly diagnosed cancer cases) submitted to the Cancer Registry database indicates that NCBH is a leader in diagnosing these types of cancers. According to this database, NCBH diagnosed the following new cancer cases in 2001:

- *Lung: 293 cases*
- *Breast: 253 cases*
- *Prostate: 185 cases*
- *Central Nervous System (including brain): 141 cases*
- *Head and Neck: 96 cases*
- *Pancreas: 72 cases*
- *Esophagus: 20 cases"*

Further, in Section III.2, pages 65-69, the applicant states

"As a consequence of obtaining the proposed bioanatomic imaging devices (PET /CT and MRI scanners to be used for radiation therapy simulation devices), there will be an expansion of education and training programs in three areas: clinical oncology, radiation physics, and radiation biology.

...

As outlined in the discussion related to Criterion 1, each of the three areas of training program expansion revolves around research. Basic radiation biology and physics research will be translated into clinical trials of safety (Phase I studies) and efficacy (Phase II studies) as well as randomized Phase III studies in which bioanatomic treatment planning approaches are compared to standard methods. Conduct of these Phase I, II, and III clinical trials will be facilitated by the Clinical Research Program of the Comprehensive Cancer Center of Wake Forest University. ... At any given time, the Cancer Center has approximately 50 investigator-initiated studies open, which accrue approximately 600 patients year per year. ... Financial support for the clinical trials will come from the Cancer Center, grants from the National Cancer Institute

and similar NIH funding agencies, non-profit associations, foundations, and societies, and industry ..., For example, Varian now sponsors research in bioanatomic imaging and treatment with Dan Bourland, Ph.D. as principal investigator."

Baptist provides adequate arguments for the value of the clinical research anticipated to be performed on the proposed MRI and PET/CT scanners. However, the applicant fails to demonstrate that its plan to purchase new equipment, which results in increasing the number of units it operates, is less costly or more effective than relocating its existing PET scanner and one of its existing MRI scanners to the Outpatient Comprehensive Cancer Center. Further, the applicant fails to demonstrate that its plan to increase the number of MRI and PET scanners it owns is less costly or more effective than replacing its existing PET scanner with a PET/CT scanner and one of its existing MRI scanners with equipment configured to perform simulations.

In addition, the applicant does not adequately demonstrate that all of the persons it projects to serve need the proposed services because it did not demonstrate the reasonableness of the projected number of procedures to be performed, as discussed separately below for each item of equipment.

Projected Utilization of the Proposed PET/CT Scanner

The following table illustrates projected utilization of the proposed PET/CT scanner, as reported by the applicant in Exhibit 13.

PROPOSED PET/CT SCANNER

	YEAR ONE	YEAR TWO	YEAR THREE
"Radiation Volume"	397	433	472
"Surgical Volume"	193	232	258
Funded Research	78	104	130
Unfunded Research	78	104	130
"Radiology shift (PET only, not CT)"	76	152	230
Total	822	1,025	1,220

As shown in the above table, the applicant projects that the proposed PET/CT scanner will perform 1,220 procedures during Year Three. Regarding the assumptions and methodology used to project

utilization of the proposed PET/CT Scanner, in Section IV.3(a), page 89, the applicant states

> *"In order to develop both the MRI and PET/CT Simulator utilization projections, a detailed analysis occurred of the anticipated need for radiation oncology treatment planning, surgical oncology treatment planning, and funded and unfunded research. In addition, ... a small proportion of diagnostic procedures would be relocated from the Department of Radiology to relieve the capacity pressure on their existing machines. ...*
>
> *Please see the detailed tables in Exhibit 13. The inpatient/outpatient split is 8% inpatient and 92% outpatient for external beam procedures on both PET/CT and MRI Simulators and 20% inpatient and 80% outpatient for both PET/CT and MRI Simulations. Projections by type of procedure for each machine were based on NCBH's anticipated capacity and anticipated demand for the new technology."*

However, the applicant did not adequately document the reasonableness of its assumptions regarding the number of procedures to be performed by the proposed PET/CT scanner. In particular, the applicant did not provide the following:

- The detailed analysis which the applicant states is the basis for projected utilization of the proposed scanner.
- The specific assumptions, statistical data or methodology used to project the number of PET/CT procedures to be performed, such as:
  1) historical utilization data for the existing simulator(s);
  2) projected number of new cancer cases diagnosed and treated at Baptist through Year Three; and
  3) projected number of cancer patients who will need RT treatment planning through Year Three.

Further, the 1,220 procedures projected to be performed during Year Three includes 230 *"Radiology Shift (PET only, not CT)"* procedures currently being performed on the existing PET scanner. However, the applicant fails to document the basis for assuming these patients who are served on the existing PET scanner need the services offered on the proposed PET scanner.

Projected Utilization of the Proposed MRI Scanner

The following table illustrates projected utilization of the proposed MRI scanner, as reported by the applicant in Exhibit 13.

PROPOSED MRI SCANNER

	YEAR ONE	YEAR TWO	YEAR THREE
"MRI Sim Volume"	419	520	623
"Surgical Volume"	245	277	306
Funded Research	78	104	130
Unfunded Research	78	104	130
Gamma Knife® Tx Planning	300	300	300
"Radiology Diagnostic"	48	197	411
Total	1168	1,502	1,900

As shown in the above table, the applicant projects that the proposed MRI scanner will perform a total of 1,900 procedures during Year Three. Regarding the assumptions and methodology used to project utilization of the proposed MRI Scanner, in Section IV.3(a), page 89, the applicant states

> *"In order to develop both the MRI and PET/CT Simulator utilization projections, a detailed analysis occurred of the anticipated need for radiation oncology treatment planning, surgical oncology treatment planning, and funded and unfunded research. In addition, ... a small proportion of diagnostic procedures would be relocated from the Department of Radiology to relieve the capacity pressure on their existing machines. ...*
>
> *Please see the detailed tables in Exhibit 13. The inpatient/outpatient split is 8% inpatient and 92% outpatient for external beam procedures on both PET/CT and MRI Simulators and 20% inpatient and 80% outpatient for both PET/CT and MRI Simulations. Projections by type of procedure for each machine were based on NCBH's anticipated capacity and anticipated demand for the new technology."*

However, the applicant did not adequately document the reasonableness of its assumptions regarding the number of

procedures to be performed by the proposed MRI scanner. In particular, the applicant did not provide the following:

- The detailed analysis which the applicant states is the basis for projected utilization of the proposed scanner.
- The specific assumptions, statistical data or methodology used to project the number of MRI procedures to be performed, such as:
  1) historical utilization data for the existing simulator(s);
  2) projected number of new cancer cases diagnosed and treated at Baptist through Year Three; and
  3) projected number of cancer patients who will need RT treatment planning through Year Three.

Further, the 1,900 procedures projected to be performed during Year Three includes 411 *"Radiology Diagnostic"* procedures currently being performed by one of the five existing MRI scanners. However, the applicant fails to document that patients who are served by the existing MRI scanners need the services offered on the proposed MRI scanner.

In summary, Baptist provides adequate arguments for the value of the clinical research anticipated to be performed on the proposed MRI and PET/CT scanners. However, the applicant did not adequately document the reasonableness of the projected number of procedures to be performed with either scanner and therefore, failed to demonstrate that all persons proposed to be served need the services to be offered with the new equipment. Consequently, the application is nonconforming with this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Section II.5, pages 29-32, the applicant states that it considered the following alternatives:

Maintain the status quo – The applicant states

> *"Presently, bioanatomic imaging is not performed routinely for a number of reasons. First, the MRI and PET scanners are too busy with one to two week delays in scheduling procedures not being uncommon. Presently, in order for a patient to have bioanatomic imaging for RT simulation and treatment planning, they would first have to undergo CT simulation in the Department of Radiation Oncology, followed by an MRI scan in the MRI Center on a different day and then a PET scan in the PET Center on yet another separate day. This would come at great inconvenience to the patient whose conditions often leave them in a state of physical and emotional weakness, and the staff in Radiation Oncology who must be present at the time of the MRI and PET images to make sure the patient is properly set up. In this regard, conventional MRI and PET scanners that are not specifically radiation therapy simulation devices do not have the proper immobilization systems, laser light alignment systems, and the flatter and wider table tops that are necessary for a proper patient set-up. As a consequence, non-radiation therapy simulation devices increase the potential for image registration inaccuracies which may increase the potential for errors in the treatment planning and delivery process, perhaps necessitating the use of larger treatment volumes, irradiation of more normal tissue, and possibly greater side effects of treatment."*

Obtain only one type of simulator – The applicant states

> *"MRI and PET/CT are complementary rather than overlapping imaging modalities for radiation therapy treatment planning. These modalities are often used in concert to create a more complete picture, thus allowing for enhanced treatment of disease. As stated previously, there are certain situations in which MRI imaging has an*

advantage over CT (superior imaging of the brain, spine, spinal cord, muscles and internal structures of the bone). ...

... While PET does not have the same high degree of resolution as MRI, the range of tumor biology and physiology that can be imaged by PET radiopharmeceuticals is essentially endless .... The biologic information obtained from PET is displayed anatomically, unlike the biologic data from MRI spectroscopy, which requires further processing before it can be converted into anatomic data. Therefore, MRI and PET are both essential components of the bioanatomic imaging process, complementary for both the anatomic and biologic information they provide for RT simulation and treatment planning. Obtaining either the MRI or PET would allow for improved treatment planning over the status quo but would not achieve the goal of the proposed project which is to study and research the applications of conventional MRI and PET/CT simulation used in combination."

Obtain a 1.5T MRI scanner rather than a 3.0T scanner – The applicant states

"The proponents in the Department of Radiation Oncology have determined, in consultation with colleagues in the Department of Radiology and other institutions, that the 3.0T is most suited for the intended purpose in the proposed project for the following reasons: First, the higher magnet size in the 3.0T is believed to allow for greater MRI spectroscopic capabilities. Second, the 3.0T provides a more accurate image with a wider variety of chemical measures than is possible on the 1.5T. Third, it is believed that the 3.0T is quickly becoming the standard of care in all MRI applications and particularly in cancer diagnosis and management purposes. Finally, the relative cost of the 3.0T has dropped since its introduction."

Obtain a "conventional" PET scanner rather than a PET/CT scanner – The applicant states

"The proposed project with a PET/CT simulator will allow NCBH to remove its existing CT simulator from operation, thus increasing cost-efficiency of equipment and space by

> *obtaining a technology that will perform,* [sic] *PET/CT simulations and CT simulations. The PET/CT machine is necessary to achieve the goals of the project and allow the capability of performing PET/CT simulations that would not be possible with a conventional PET machine."*

However, the applicant fails to demonstrate that its plan to purchase new equipment, which results in increasing the number of units it owns and operates, is less costly or more effective than relocating its existing PET scanner and one of its an existing MRI scanners to the Outpatient Comprehensive Cancer Center. Further, the applicant fails to demonstrate that its plan to acquire additional equipment is less costly or more effective than replacing the existing PET scanner and one of its existing MRI scanners with equipment configured to perform simulations.

Further, the application is not conforming with all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (18a), 10A NCAC 14C .2700, and 10A NCAC 14C .3700. Therefore, the applicant did not adequately demonstrate that it proposed the least costly or most effective alternative. Consequently, the application is nonconforming with this criterion.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

NC

In Section VIII.1, pages 129-130, the applicant projects that the total capital cost of the project will be $6,080,546, including $585,025 for upfit costs, $5,272,321 for fixed equipment, $75,000 for movable equipment, $15,000 for furniture, $98,000 for consultant fees, and $35,200 for miscellaneous costs (CON filing fee, information systems and signage). In Section IX, page 137, the applicant states that there will be no start up or initial operating expenses because the project *"is an expansion of an existing service."* In Section VIII.3, page 132, the applicant states that 100% of the capital cost will be funded with Baptist's accumulated reserves. Exhibit 31 contains a May 7, 2003 letter signed by the chief financial officer for Baptist, which states

"The North Carolina Baptist Hospitals, Inc. agrees to make available from its accumulated reserves a total of $6,080,546 for the capital costs incurred in the acquisition of an MRI Simulator ($3,117,615) and PET/CT Simulator ($2,962,931) for Radiation Oncology Treatment Planning."

Exhibit 32 contains the audited financial statements for Baptist. As of June 30, 2002, Baptist had $57,634,000 in cash and cash equivalents, $59,221,000 in short-term investments, $252,840,000 in total assets, and $677,566,000 in net assets (total assets less total liabilities). The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In Section X.10, Form B-1, the applicant projects the following revenues and operating costs for the proposed MRI and PET/CT scanners during each of the first three years of operation following completion of the project, as illustrated in the following table.

	PROPOSED 3.0T MRI SCANNER			PROPOSED PET/CT SCANNER		
	YEAR ONE	YEAR TWO	YEAR THREE	YEAR ONE	YEAR TWO	YEAR THREE
Gross Revenues	$1,876,656	$2,299,338	$2,719,157	$2,601,226	$3,018,558	$3,410,038
Net Revenues	$1,137,757	$1,381,136	$1,622,644	$1,560,596	$1,781,226	$1,984,711
Operating Costs	$850,053	$1,270,034	$1,367,428	$1,140,136	$1,600,990	$1,709,426
Profit (Loss)	$287,704	$111,102	$255,216	$420,460	$180,236	$275,285

As shown in the above table, the applicant projects that revenues will exceed operating costs for each scanner during Years One, Two and Three. However, the applicant did not adequately document the reasonableness of the projected number of procedures to be performed by the proposed MRI and PET/CT scanners. See Criterion (3) for discussion. Consequently, revenues and operating costs, which are based on the projected number of procedures to be performed, are unsupported and unreliable.

Further, the applicant did not adequately demonstrate that all revenues and operating costs associated with the proposed MRI and PET/CT scanners are included in its projections. In Exhibit 13, the applicant projects that the proposed scanners, which will be located in the Department of Radiation Oncology, will perform some diagnostic MRI and PET procedures currently performed by existing MRI scanners and the PET scanner located in the Department of Radiology. These diagnostic procedures are in addition to the MRI

and PET/CT simulation procedures projected to be performed with the proposed scanners. In Section IV.3, page 89, the applicant states that these diagnostic procedures *"are excluded from the financial statements because these procedures currently are performed at NCBH, are a minority of the procedures in the utilization projection for this project and are an extended benefit and not a primary driver of the need in this application."* However, costs and revenues associated with the procedures to be "shifted" from the Department of Radiology should be included in Form B-1 and Form B-1a since they are proposed to be performed on the new equipment.

In summary, the applicant did not adequately demonstrate that the financial feasibility of the proposal is based on reasonable projections of revenues and operating costs for operation of the new equipment. Therefore, the application is nonconforming with this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

Baptist proposes to acquire a 3.0T MRI scanner and a PET/CT scanner pursuant to Policy AC-3 in the 2003 SMFP for radiation therapy treatment planning. However, the applicant did not adequately demonstrate the need the population projected to be served has for the proposed scanners. See Criteria (1), (3) and (4) for discussion. Therefore, the applicant did not adequately demonstrate that acquisition of the proposed MRI and PET/CT scanners would not result in an unnecessary duplication of existing MRI and PET services and the application is nonconforming with this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

The following tables illustrate the incremental staff for the proposed MRI and PET/CT scanners, as reported by the applicant in Section VII.2, page 119.

MRI SCANNER

POSITION	# OF FULL-TIME EQUIVALENT POSITIONS		
	YEAR ONE	YEAR TWO	YEAR THREE
Radiation Therapist	2	3	3
Staff Nurse	1	1	1
Scheduler	1	1	1
Total	4	5	5

PET/CT SCANNER

POSITION	# OF FULL-TIME EQUIVALENT POSITIONS		
	YEAR ONE	YEAR TWO	YEAR THREE
Radiation Therapist (1)	2	4	4
Radiation Onc. Engineer	1	1	1
Total	3	5	5

(1) In Section VII.2, page 120, the applicant states *"Present staff in the Radiation Oncology Department for the existing CT Simulator will be used for the PET/CT Simulator."* In Section I.13, page 11, the applicant states that the existing CT simulator *"will be replaced by the PET/CT Simulator."*

In Section VII.3, pages 120-121, the applicant states

> *"NCBH acknowledges that there is a national shortage of Imaging Technologists including Computerized Tomography (CT), Positron Emission Topography* [sic], *Nuclear Medicine, Magnetic Resonance Imaging (MRI) and Radiation Therapists. While NCBH has from time to time had one or two imaging technologist positions open due to natural turnover on* [sic] *in its diagnostic machines, as a regional tertiary and quaternary referral center, it has not experienced the shortages present in community hospitals. ... Nonetheless, for informational purposes, in the event that NCBH finds it necessary to recruit externally for any of the new positions, it will pursue the following strategies either individually or in concert. Traditionally, NCBH has made an effort to hire and train any needed FTE's that arises as the result of expanded or additional services. NCBH will continue this effort to hire from within the organization. NCBH is also actively involved with the 'Code Blue' area health care recruitment program and has recruiting relationships with Forsyth Technical Community College and other area schools. If these methods prove to be unsuccessful, the Department of Radiation Oncology at NCBH will use 'word of mouth' to advertise for the position and will also utilize area newspapers. If the above methods fail, NCBH will use a professional recruiting firm."*

In Section V.3(c), page 101, the applicant states

> *"The Medical Directors of the proposed MRI simulator and PET/CT simulator will be Dr. Edward Shaw, Chairman, Department of Radiation Oncology and Dr. Dan Bourland, Section Head, Radiation Physics, Department of Radiation Oncology. The medical directorship will be a shared responsibility because of the dual clinical and radiation physics/imaging expertise required to oversee the bioanatomic radiation therapy simulation, treatment planning, and treatment delivery process."*

Exhibit 2 contains curriculum vitae for Dr. Shaw and Dr. Bourland. Both are board certified and have training and experience in MRI and PET services. The applicant adequately documented the availability of sufficient health manpower and management personnel to provide the proposed services. Therefore, the application is conforming with this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section IV.5, page 95, the applicant states *"As a current provider of radiation oncology services, NCBH already provides all the necessary ancillary and support services, including registration, billing and medical records. The administrative services do not require expansion as a direct result of the proposed project."* Further, in Section II.8, page 42, the applicant states that Baptist already provides the support services required by 10A NCAC 14C .2704(a), including anesthesiology, radiology, oncology, neurology, internal medicine, orthopedics, neurosurgery, pathology and surgery. In addition, in Section II.8, pages 51-52, the applicant states that it will provide the support services required by 10A NCAC 14C .3704, including a system for responding to medical emergencies, a source for radioisotopes, and a clinical oversight committee for PET services.

In Section V.2, page 98, the applicant states *"As an academic medical center and a regional referral center for tertiary care, NCBH receives transfers from many providers throughout its 26 county service area and the Southeast."* Exhibit 23 contains a list of health care facilities with which Baptist has a transfer agreement. In Section V.3, page 99, the applicant states *"NCBH has developed strong referral relationships with the medical community, including physicians. As part of the planning process for the proposed project, NCBH has solicited and obtained support from WFUHS physicians who will refer patients to the MRI simulator and PET/CT simulator."* Exhibit 9 contains letters from WFUHS physicians supporting the proposed project.

In summary, the applicant adequately demonstrated that it will provide all necessary ancillary and support services and that the proposal will be coordinated with the existing health care system. Therefore, the application is conforming with this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

(a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

(b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;

(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

(iii) would cost no more than if the services were provided by the HMO; and

(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NA

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.2, page 108, the applicant states *"NCBH provides access to care to all patients including those listed above and does not discriminate based on age, race, national or ethnic origin, disability, sex, income, or ability to pay."* In Section VI.10, page 114, the applicant reports the following payor mix for the entire hospital.

FISCAL YEAR 2002 PAYOR MIX

PAYOR CATEGORY	% OF TOTAL
Self Pay, Indigent, Charity Care	3.2%
Medicare	39.5%
Medicaid	19.7%
Commercial Insurance (includes managed care contracts)	37.0%
Other	0.6%
TOTAL	100.0%

The applicant demonstrated that medically underserved populations currently have adequate access to Baptist's existing services.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

An examination of the licensure and certification files in the Division of Facility Services for North Carolina Baptist Hospital indicates there have been no civil rights access complaints filed against the facility.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Section VI.2, page 108, the applicant states *"NCBH provides access to care to all patients including those listed above and does not discriminate based on age, race, national or ethnic origin, disability, sex, income, or ability to pay. ... The NCBH policies and philosophy of access will extend to the proposed project."* In Section VI.12, pages 116-117, the applicant projects the following payor mix for the proposed MRI and PET/CT scanners.

PROPOSED MRI SCANNER
FISCAL YEAR 2006 PAYOR MIX

PAYOR CATEGORY	% OF TOTAL
Self Pay, Indigent, Charity Care	2.4%
Medicare	17.5%
Medicaid	5.9%
Commercial Insurance (includes managed care contracts)	73.2%
Other	1.0%
TOTAL	100.0%

PROPOSED PET/CT SCANNER
FISCAL YEAR 2006 PAYOR MIX

PAYOR CATEGORY	% OF TOTAL
Self Pay, Indigent, Charity Care	1.0%
Medicare	32.5%
Medicaid	8.5%
Commercial Insurance (includes managed care contracts)	56.3%
Other	1.7%
TOTAL	100.0%

The applicant demonstrated that medically underserved populations will have adequate access to the proposed health services.

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.7, page 111, the applicant states *"Physicians on the medical staff at the hospital currently refer patients to the existing radiation oncology services at NCBH. This will continue with both the MRI and PET/CT Simulators.... Please see Exhibit 26 for a list of the external and internal (WFUHS) physicians that most frequently refer patients to the Department of Radiation Oncology."* Exhibit 26 consists of two lists of physicians. One is identified as the *"Top Internal Referring Physicians for FY 2002"* and the other as the *"Top External Referring Physicians for FY 2002."* Further, in Section II.8, page 47, the applicant states *"As part of an NCI designated cancer center and one housed in an academic medical center teaching hospital, this service*

[PET/CT scanner] *will naturally serve as a regional resource."*

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Section V.1, page 97, the applicant states *"NCBH has established relationships with many clinical training programs in the Southeast and continues to provide teaching opportunities for these schools. With the proposed project, NCBH will be able to provide additional training support to the numerous clinical programs utilizing educational opportunities at the hospital."* Exhibit 22 contains a list of area health professional training programs with which Baptist has an existing relationship. The applicant adequately demonstrates that the proposed services will accommodate the clinical needs of area health professional training programs and the application is conforming with this criterion.

(15) Repealed effective July 1, 1987.

(16) Repealed effective July 1, 1987.

(17) Repealed effective July 1, 1987.

(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicant did not adequately demonstrate that the proposal will have a positive impact upon the cost effectiveness of the proposed services. See Criteria (3) and (5).

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

North Carolina Baptist Hospital is accredited by the Joint Commission of Accreditation of Health Care Organizations and certified for Medicare and Medicaid participation. According to the files in the Licensure and Certification Section, DFS, no incidents occurred, within the eighteen months immediately preceding the date of this decision, for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming with this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

In Section II.1, page 17, Baptist states that the proposed 3.0T MRI and PET/CT scanners will be used primarily for *"radiation therapy (RT) simulation."* However, the applicant also proposes to use the proposed MRI scanner and the proposed PET/CT Scanner for a significant number of routine diagnostic procedures. Thus, the Criteria and Standards for Magnetic Resonance Imaging Scanner, promulgated in 10A NCAC 14C .2700, and the Criteria and Standards for Positron Tomography Scanner, promulgated in 10A NCAC 14C .3700, are applicable to this review. The applicant does not propose to use the proposed PET/CT scanner to perform routine diagnostic CT scans and therefore, the Criteria and Standards for Computed Tomography Equipment are not applicable.

The application is not conforming with all applicable Criteria and Standards for Magnetic Resonance Imaging Scanner or Positron Tomography Scanner as discussed below.

CRITERIA AND STANDARDS FOR MAGNETIC RESONANCE IMAGING SCANNER

.2702 INFORMATION REQUIRED OF APPLICANT

.2702(a) This rule states *"An applicant proposing to acquire an MRI scanner, including a Mobile MRI scanner, shall use the Acute Care Facility/Medical Equipment application form."*

-C- The applicant used the Acute Care Facility/Medical Equipment application form.

.2702(b) This rule states *"Except for proposals to acquire mobile MRI scanners that serve two or more host facilities, both the applicant and the person billing the patients for the MRI service shall be named as co-applicants in the application form."*

-NC- The applicant fails to state whether or not it will be the entity billing the patients for the proposed MRI service.

.2702(c)(1) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: (1) documentation that the MRI scanner shall be available and staffed for use at least 66 hours per week, with the exception of a mobile MRI scanner."*

-NC- In Section II.8, page 37, the applicant states *"The proposed scanner will be staffed and available from 6:45 AM to 4:45 PM, Monday through Friday, for a total of 50 hours per week, with all other hours available and covered with on-call arrangements."* The applicant proposes to staff the MRI scanner for only 50 hours per week, the rule requires at least 66 hours per week. Therefore, the application is nonconforming with this rule.

.2702(c)(2) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: ... (2) projections of the annual number of*

procedures to be performed for each of the first three years of operation after completion of the project."

-C- The applicant provides projections of the annual number of procedures to be performed for each of the first three years of operation after completion of the project in Exhibit 13. However, see Criterion (3) for discussion of the reasonableness of these projections.

.2702(c)(3) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: ... (3) the average charge to the patient, regardless of who bills the patient, for each of the 20 most frequent MRI procedures to be performed for each of the first three years of operation after completion of the project and a description of items included in the charge; if the professional fee is included in the charge, provide the dollar amount for the professional fee."*

-NC- In Section X.2, page 147, the applicant provides the charge to the patient for the 20 most frequent MRI procedures to be performed on the proposed MRI scanner for only the first year of operation following completion of the project. However, the rule requires that the applicant provide charges for <u>each</u> of the first three years of operation following completion of the project, not just one year. Therefore, the application is nonconforming with this rule because the applicant did not provide each procedure charge for operating years two and three.

.2702(c)(4) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: ... (4) if the proposed MRI service will be provided pursuant to a service agreement, the dollar amount of the service contract fee billed by the applicant to the contracting party for each of the first three years of operation."*

-NA- The applicant does not propose that the MRI service will be provided pursuant to a service agreement.

.2702(c)(5) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: ... (5) documentation of the need for an additional MRI scanner in the proposed MRI service area and description of the methodology used to project need, including all assumptions regarding the population to be served."*

-NC- The applicant did not provide sufficient information to document the need for the proposed MRI scanner for the population it proposes to serve. Further, the applicant did not adequately describe the methodology used to project need, including all assumptions regarding the population to be served. See Criterion (3) for a detailed discussion. Therefore, the application is not conforming with this rule.

.2702(c)(6) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall also provide the following additional information: ... (6) letters from physicians indicating their intent to refer patients to the proposed magnetic resonance imaging scanner."*

-C- The applicant provides letters from area physicians indicating their intent to refer patients to the proposed MRI scanner in Exhibit 9.

.2702(d) This rule states *"An applicant proposing to acquire a mobile MRI scanner shall provide copies of letters of intent from, and proposed contracts with, all of the proposed host facilities of the new MRI scanner."*

-NA- The applicant does not propose to acquire a mobile MRI scanner.

.2702(e) This rule states *"An applicant proposing to acquire a dedicated fixed breast MRI scanner shall: (1) provide a copy of a contract or working agreement with a radiologist or practice group that has experience interpreting images and is trained to interpret images produced by an MRI scanner configured exclusively for mammographic studies; (2) document that the applicant performed mammograms*

continuously for the last year; and (3) document that the applicant's existing mammography equipment is in compliance with the U.S. Food and Drug Administration Mammography Quality Standards Act."

-NA- The applicant does not propose to acquire a dedicated fixed breast MRI scanner.

.2703 REQUIRED PERFORMANCE STANDARDS

.2703(a) This rule states *"An applicant proposing to acquire a mobile magnetic resonance imaging (MRI) scanner shall: (1) demonstrate that at least 2900 MRI procedures were performed in the last year on each of its existing mobile MRI scanners operating in the Health Service Area(s), (e.g., HSA I), in which the proposed mobile MRI scanner will be located [Note: This is not the average number of procedures performed on all of the applicant's mobile MRI scanners.]; (2) demonstrate annual utilization in the third year of operation is reasonably projected to be at least 2900 MRI procedures on each of its existing, approved and proposed mobile MRI scanners to be operated in the Health Service Area(s), (e.g., HSA I), in which the proposed equipment will be located [Note: This is not the average number of procedures performed on all of the applicant's mobile MRI scanners.]; and (3) document the assumptions and provide data supporting the methodology used for each projection required in this Rule."*

-NA- The applicant does not propose to acquire a mobile MRI scanner.

.2703(b) This rule states *"An applicant proposing to acquire a magnetic resonance imaging (MRI) scanner for which the need determination in the State Medical Facilities Plan was based on the utilization of fixed MRI scanners, shall: (1) demonstrate that its existing MRI scanners, except mobile MRI scanners, operating in the proposed MRI service area in which the proposed MRI scanner will be located performed an average of at least 2900 MRI procedures per scanner in the last year; (2) demonstrate annual utilization in the third year of operation is reasonably projected to be an average of 2900 procedures per scanner for all existing,*

approved and proposed MRI scanners or mobile MRI scanners to be operated by the applicant in the MRI service area(s) in which the proposed equipment will be located; and (3) document the assumptions and provide data supporting the methodology used for each projection required in this Rule."

-NA- The applicant did not apply pursuant to a need determination in the 2003 SMFP. Rather, the applicant applied pursuant to Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects.

.2703(c) This rule states *"An applicant proposing to acquire a magnetic resonance imaging (MRI) scanner for which the need determination in the State Medical Facilities Plan was based on utilization of mobile MRI scanners, shall: (1) if the applicant does not own or lease an MRI scanner or have an approved MRI scanner, demonstrate annual utilization in the third year of operation is reasonably projected to be at least 2080 MRI procedures per year for the proposed MRI scanner; (2) if the applicant already owns or leases an MRI scanner or has an approved MRI scanner, demonstrate annual utilization is reasonably projected to be an average of 2900 MRI procedures per scanner for all existing, approved and proposed MRI scanners or mobile MRI scanners to be operated by the applicant in the MRI service area(s) in which the proposed equipment will be located; and (3) document the assumptions and provide data supporting the methodology used for each projection required in this Rule."*

-NA- The applicant did not apply pursuant to a need determination in the 2003 SMFP. Rather, the applicant applied pursuant to Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects.

.2703(d) This rule states *"An applicant proposing to acquire a magnetic resonance imaging (MRI) scanner for which the need determination in the State Medical Facilities Plan was based on the absence of an existing or approved fixed MRI scanner in the MRI service area shall: (1) demonstrate*

annual utilization of the proposed MRI scanner in the third year of operation is reasonably projected to be at least 2080 MRI procedures per year; and, (2) document the assumptions and provide data supporting the methodology used for each projection required in this Rule."

-NA- The applicant did not apply pursuant to a need determination in the 2003 SMFP. Rather, the applicant applied pursuant to Policy AC-3: Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects.

.2704 REQUIRED SUPPORT SERVICES

.2704(a) This rule states *"An applicant proposing to acquire a magnetic resonance imaging scanner, including a mobile MRI scanner, shall make available through written affiliation or referral agreements the following services:*

(1) anesthesiology,
(2) radiology,
(3) oncology,
(4) neurology,
(5) internal medicine,
(6) orthopedics,
(7) neurosurgery,
(8) pathology, and
(9) surgery."

-C- In Section II.8, page 42, the applicant states that all of the services listed above are currently available at Baptist.

.2704(b) This rule states *"An applicant proposing to acquire a mobile MRI scanner shall provide referral agreements between each host site and at least one other provider of MRI services in the proposed MRI service area to document the availability of MRI services if patients require them when the mobile unit is not in service at that host site."*

-NA- The applicant does not propose to acquire a mobile MRI scanner.

.2705 REQUIRED STAFFING AND STAFF TRAINING

.2705(a) This rule states *"An applicant proposing to acquire an MRI scanner shall demonstrate that one board certified diagnostic radiologist shall be available to provide the proposed services who has had:*

(1) training in magnetic resonance imaging as an integral part of his or her residency training program; or
(2) six months of supervised MRI experience under the direction of a qualified diagnostic radiologist; or
(3) at least six months of fellowship training, or its equivalent, in MRI; or
(4) an appropriate combination of MRI experience and fellowship training equivalent to Subparagraph (a)(1), (2) or (3) of this Rule."

-C- In Section II.8, page 43, the applicant states *"Due to the unique application of the technology (for use in radiation oncology treatment planning), Dr. Ed Shaw and Dr. Dan Bourland will share the medical directorship. They will work in concert with the Medical Director of Magnetic Resonance Imaging, Dr. Kerry Michael Link and Dr. Allen Elster, Chair of the Department of Radiology."* Exhibit 2 contains curriculum vitae for Dr. Shaw, Dr. Link, and Dr. Elster. These physicians are board certified and have training and experience in MRI services.

.2705(b) This rule states *"An applicant proposing to acquire a dedicated fixed breast MRI scanner shall provide documentation that the radiologist is trained and has experience in interpreting images produced by an MRI scanner configured exclusively to perform mammographic studies."*

-NA- The applicant does not propose to acquire a dedicated fixed breast MRI scanner.

.2705(c) This rule states *"The applicant shall provide evidence of the availability of two full-time MRI technologist-radiographers and that one of these*

technologists shall be present during the hours of operation of the MRI scanner."

-C- In Section II.8, page 44, the applicant states *"Due to the unique application of the technology, NCBH proposes to train radiation therapists and require AART certification for each, making them in effect the equivalent to an 'MRI Technologists* [sic]. *At least one of these AART certified radiation therapist or "MRI technologist equivalents' will be present for the operation of the scanner."*

.2705(d)(1) This rule states *"An applicant proposing to acquire an MRI scanner shall demonstrate that the following staff training is provided: (1) certification in cardiopulmonary resuscitation (CPR) and basic cardiac life support."*

-C- In Section II.8, page 44, the applicant states *"All radiation therapists at NCBH are certified in CPR and basic cardiac life support (BCLS)."* Exhibit 10 contains a copy of the job description which documents that CPR and BCLS certification are required. Exhibit 11 contains copies of staff training policies for Baptist that document that training in CPR and BCLS is provided.

.2705(d)(2) This rule states *"An applicant proposing to acquire an MRI scanner shall demonstrate that the following staff training is provided: ... (2) an organized program of staff education and training which is integral to the services program and ensures improvement in technique and the proper training of new personnel."*

-C- Exhibit 11 contains copies of staff training policies for Baptist that document that the hospital has an organized program of staff education and training.

.2705(e) This rule states *"An applicant proposing to acquire a mobile MRI scanner shall document that the requirements in Paragraphs (a) and (c) of this Rule shall be met at each host facility."*

-NA- The applicant does not propose to acquire a mobile MRI scanner.

CRITERIA AND STANDARDS FOR POSITRON EMISSION TOMOGRAPHY SCANNER

.3702 INFORMATION REQUIRED OF APPLICANT

.3702(a) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall use the Acute Care Facility/Medical Equipment application form."*

-C- The applicant used the Acute Care Facility/Medical Equipment application form.

.3702(b)(1) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: (1) The projected number of procedures to be performed and the projected number of patients to be served for each of the first three years following completion of the proposed project. Projections shall be listed by clinical area (e.g., oncology, cardiology), and all methodologies and assumptions used in making the projections shall be provided."*

-NC- The applicant provides the projected number of procedures to be performed for each of the first three years of operation following completion of the project. However, the applicant failed to provide the projected number of patients for each of the first three years of operation as required by this rule. Further, the applicant did not provide all of the assumptions and methodology used in making its projections as required by this rule. See Criterion (3) for detailed discussion. Therefore, the application is nonconforming with this rule.

.3702(b)(2) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: .... (2) Documentation that all of the following services were provided, at each facility where the PET scanner will be operated, continuously throughout the 12 months immediately prior to the date on which the application is filed:*

(A) nuclear medicine imaging services;
(B) single photon emission computed tomography (including brain, bone, liver, gallium and thallium stress);
(C) magnetic resonance imaging scans;
(D) computerized tomography scans;
(E) cardiac angiography;
(F) cardiac ultrasound; and
(G) neuroangiography."

-C- In Section II.8, page 46, the applicant states that all of the services listed above were provided continuously throughout the 12 months immediately prior to the date on which the application was filed. See also the letter in Exhibit 7 which states that all of these services were provided continuously throughout the 12 months immediately prior to the date on which the application was filed.

.3702(b)(3)(A) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: ... (3) Documentation that the facility will: (A) establish the clinical PET unit, and any accompanying equipment used in the manufacture of positron-emitting radioisotopes, as a regional resource that will have no administrative, clinical or charge requirements that would impede physician referrals of patients for whom PET testing would be appropriate."*

-C- In Section II.8, page 47, the applicant states *"As part of an NCI* [National Cancer Institute] *designated cancer center and one housed in an academic medical center teaching hospital, this service will naturally serve as a regional resource. There are no known administrative, clinical or charge requirements planned that would impede physician referrals of patients for whom PET testing would be appropriate."*

.3702(b)(3)(B) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: ... (3) Documentation that the facility will: ... (B) provide scheduled hours of operation*

for the PET scanner of a minimum of 12 hours per day, six days a week, except for mobile scanners."

-NC- In Section II.8, page 47, the applicant states *"The PET/CT Simulator will operate from 6:45 AM – 9:00 PM (14.25 hours per day) from Monday – Friday. The PET/CT Simulator will be available during the non-scheduled hours on an on-call basis subject to patient need and demand."* The applicant proposes to staff the PET/CT scanner for scheduled hours of operation only five days per week. However, the rule requires that the applicant provide scheduled hours of operation for a minimum of six days per week. Therefore, the application is nonconforming with this rule.

.3702(b)(3)(C) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: ... (3) Documentation that the facility will: ... (C) implement a referral system which shall include a feedback mechanism of providing patient information to the referring physician and facility."*

-C- In Section II.8, page 47, the applicant states *"Referring physicians and facilities will receive a copy of the results report following completion of the procedure."*

.3702(b)(4) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall provide the following information for each facility where the PET scanner will be operated: ... (4) A description of the protocols that will be established to assure that all clinical PET procedures performed are medically necessary and cannot be performed using other, less expensive, established modalities."*

-C- In Section II.8, page 48, the applicant states *"The protocols that are currently utilized at NCBH will extend to these services and they are attached in Exhibit 12. In addition, the Clinical Oversight Committee will be charged with ensuring that appropriate policies are in place and adhered to and that clinical PET procedures performed are medically necessary and cannot be performed using other, less*

expensive, established modalities. The proposed Clinical Oversight Committee policy and the Admission policy for the PET Simulator are provided in Exhibit 12." Exhibit 12 contains a copy of the Positron Emission Tomography Center Procedure Manual for Clinical Patients.

.3702(c) This rule states *"An applicant proposing to acquire a mobile PET scanner shall provide copies of letters of intent from and proposed contracts with all of the proposed host facilities at which the mobile PET scanner will be operated."*

-NA- The applicant does not propose to acquire a mobile PET scanner.

.3702(d) This rule states *"An applicant proposing to acquire a mobile PET scanner shall demonstrate that each host facility offers or contracts with a hospital that offers comprehensive cancer services including radiation oncology, medical oncology, and surgical oncology."*

-NA- The applicant does not propose to acquire a mobile PET scanner.

.3702(e) This rule states *"An applicant shall document that all equipment, supplies and pharmaceuticals proposed for the service have been certified for use by the U.S. Food and Drug Administration or will be used under an institutional review board whose membership is consistent with U.S. Department of Health and Human Services' regulations."*

-C- Exhibit 8 contains a letter from the U.S. Food and Drug Administration notifying General Electric that the proposed PET/CT scanner has been certified for clinical use.

.3702(f)(1) This rule states *"An applicant shall document that each PET scanner and cyclotron shall be operated in a physical environment that conforms to federal standards, manufacturers specifications, and licensing requirements. The following shall be addressed: (1) quality control measures and assurance of radioisotope production of generator or cyclotron-produced agents."*

-C- In Section II.8, page 49, the applicant states *"NCBH owns a cyclotron that is operated by PET Net. Quality control measures and assurance production and testing are currently in place."*

.3702(f)(2) This rule states *"An applicant shall document that each PET scanner and cyclotron shall be operated in a physical environment that conforms to federal standards, manufacturers specifications, and licensing requirements. The following shall be addressed: ... (2) quality control measures and assurance of PET tomograph and associated instrumentation.*

-C- In Section II.8, page 49, the applicant states *"NCBH will conduct daily quality control measures of the equipment to include phantom studies, flooding of detectors and any other measures recommended by the equipment manufacturer."*

.3702(f)(3) This rule states *"An applicant shall document that each PET scanner and cyclotron shall be operated in a physical environment that conforms to federal standards, manufacturers specifications, and licensing requirements. The following shall be addressed: ... (3) radiation protection and shielding.*

-C- In Section II.8, page 49, the applicant states *"NCBH's/WFUHS's experience with FDG will assist in ensuring that proper radiation protection and shielding is in place for the proposed equipment. Patient waiting areas and open service areas will be located sufficiently far from the FDG so that there is no significant increase in radiation to individuals."*

.3702(f)(4) This rule states *"An applicant shall document that each PET scanner and cyclotron shall be operated in a physical environment that conforms to federal standards, manufacturers specifications, and licensing requirements. The following shall be addressed: ... (4) radioactive emission to the environment.*

-C- In Section II.8, page 49, the applicant states *"Handling of radioactive materials will be strictly adhered to as directed by North Carolina and federal codes."*

.3702(f)(5) This rule states *"An applicant shall document that each PET scanner and cyclotron shall be operated in a physical environment that conforms to federal standards, manufacturers specifications, and licensing requirements. The following shall be addressed: ... (5) radioactive waste disposal.*

-C- In Section II.8, page 50, the applicant states *"Syringes, needles, gloves and other contaminated articles will be stored in an appropriate lead container and allowed to decay for nine half-lives or until normal background levels are achieved, at which time they will be discarded as regular biologic waste."*

.3703 PERFORMANCE STANDARDS

.3703(a)(1) This rule states *"An applicant proposing to acquire a dedicated PET scanner, including a mobile dedicated PET scanner, shall demonstrate that: (1) the proposed dedicated PET scanner, including mobile dedicated PET scanners, shall be utilized at an annual rate of at least 1,220 PET procedures by the end of the third year following completion of the project."*

-NC- In Section II.8, page 50, and Exhibit 13, the applicant projects that the proposed PET/CT scanner will perform 1,220 procedures in Year Three. However, the applicant did not provide sufficient information to demonstrate that the proposed PET/CT scanner will perform at least 1,220 PET procedures in Year Three. See Criterion (3) for a detailed discussion. Therefore, the application is not conforming with this rule.

.3703(a)(2) This rule states *"An applicant proposing to acquire a dedicated PET scanner, including a mobile dedicated PET scanner, shall demonstrate that: ... (2) its existing dedicated PET scanners, excluding those used exclusively for research, performed an average of 1,220 PET procedures per PET scanner in the last year."*

-C- In Section II.8, page 50, the applicant states that the existing PET scanner performed 1,383 procedures during Fiscal Year

2002 (July 1, 2001 to June 30, 2002), which was the last full fiscal year of operation prior to submission of the application.

.3703(a)(3) This rule states *"An applicant proposing to acquire a dedicated PET scanner, including a mobile dedicated PET scanner, shall demonstrate that: ... (3) its existing and approved dedicated PET scanners shall perform an average of at least 1,220 PET procedures per PET scanner during the third year following completion of the project."*

-NC- In Fiscal Year 2002, the existing PET scanner performed 1,383 procedures and the applicant projects that it will perform 2,256 procedures in Year Three (FY 2007). Thus, the applicant projects that the number of procedures to be performed on the existing PET scanner will increase an average of 12.6% per year [2,256 – 1,383 = 873; 873 / 1,383 = 0.63; 63% / 5 years = 12.6% per year]. However, the applicant does not provide the assumptions or methodology used to project utilization of the existing PET scanner to demonstrate that the projected increases are reasonable. Particularly, given the additional procedures to be performed on the new PET scanner, including some existing routine diagnostic procedures that are proposed to be shifted to the new PET scanner. Therefore, the application is nonconforming with this rule.

.3703(b) This rule states *"The applicant shall describe the assumptions and provide data to support and document the assumptions and methodology used for each projection required in this Rule."*

-NC- The applicant did not adequately describe the assumptions or provide data to support and document the assumptions and methodology used for each projection required in this rule. See Criterion (3) for a detailed discussion. Therefore, the application is nonconforming with this rule.

.3704 SUPPORT SERVICES

.3704(a) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document how medical emergencies within the PET scanner unit will*

be managed at each facility where the PET scanner will be operated."

-C- In Section II.8, page 51, the applicant states *"A radiation therapist with specialized training as a technologist who is licensed by the State of North Carolina to handle radioisotopes will always be present at the PET Simulator. This radiation therapist will be immediately available to manage any medical emergency and activate the local hospital code procedures if necessary. An emergency crash cart appropriate to the Department of Radiation Oncology will be located within close proximity to the PET/CT Simulator."*

.3704(b) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that radioisotopes shall be acquired from one or more of the following sources and shall identify the sources which will be utilized by the applicant: (1) an off-site medical cyclotron and radioisotope production facility that is located within two hours transport time to each facility where the PET scanner will be operated; (2) an on-site rubidium-82 generator; or (3) an on-site medical cyclotron for radio nuclide production and a chemistry unit for labeling radioisotopes."*

-C- In Section II.8, page 51, the applicant states *"WFUBMC owns a cyclotron that is managed by PET.NET Pharmaceuticals. PET.Net has a national network of facilities and is able to supply NCBH with pharmaceutical radioisotopes in the unlikely event that the NCBH cyclotron is not operational."*

.3704(c) This rule states *"An applicant proposing to acquire an on-site cyclotron for radioisotope production shall document that these agents are not available or cannot be obtained in an economically cost effective manner from an off-site cyclotron located within 2 hours total transport time from the applicant's facility."*

-NA- The applicant does not propose to acquire an on-site cyclotron. There is already a cyclotron located on the campus of Wake Forest University Baptist Medical Center.

.3704(d) This rule states *"An applicant proposing to develop new PET scanner services, including mobile PET scanner services, shall establish a clinical oversight committee at each facility where the PET scanner will be operated before the proposed PET scanner is placed in service that shall: (1) develop screening criteria for appropriate PET scanner utilization; (2) review clinical protocols; (3) review appropriateness and quality of clinical procedures; (4) develop educational programs; and (5) oversee the data collection and evaluation activities of the PET scanning service."*

-NA- The applicant does not propose to develop new PET scanner services. PET scanner services have been provided at Baptist since 1990.

.3705 STAFFING AND STAFF TRAINING

.3705(a)(1) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that the scanner will be staffed by the following personnel: (1) One or more full-time nuclear medicine imaging physicians who:*

(A) are licensed by the State to handle medical radioisotopes;
(B) have specialized in the acquisition and interpretation of nuclear images, including tomographic studies, for at least one year;
(C) have acquired knowledge about PET through experience or postdoctoral education; and
(D) have had practical training with an operational PET scanner.

-C- In Section II.8, page 53, the applicant states *"Dr. Ed Shaw and Dr. Dan Bourland, will serve as co-medical Directors for the PET Simulator. ... In addition, Dr. Kathryn Morton, Section Chief for Nuclear Medicine/PET Services practices full-time for WFUHS and Medical Director for the fixed diagnostic PET, will support his project and possesses all the qualifications set forth in .3705 (A-D)."* Exhibit 2 contains curriculum vitae for each physician identified by

the applicant in response to this rule. These physicians are board certified and have training and experience in PET services.

.3705(a)(2) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that the scanner will be staffed by the following personnel: ... (2) Engineering and physics personnel with training and experience in the operation and maintenance of PET scanning equipment.*

-C- In Section II.8, page 53, the applicant states *"The purchase of the equipment includes vendor supplied maintenance of the PET scanning equipment for the first year. The radiation oncology engineer will have specified training to maintain the equipment after year one. Dr. Dan Bourland will be the lead physicist for the PET Simulator. In addition to Dan Bourland, Ph.D., WFUBMC employs three physicists who will be available to provide consultations and maintenance as needed for the PET/CT Simulator."* Exhibit 2 contains a copy of Dr. Bourland's curriculum vitae, which documents that he has training and experience in the operation of PET scanners.

.3705(a)(3) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that the scanner will be staffed by the following personnel: ... (3) Radiation safety personnel with training and experience in the handling of short-lived positron emitting nuclides.*

-C- In Section II.8, page 53, the applicant states *"All of the staff will be radiation therapists with training in nuclear medicine including specific training in the handling of short-lived positron emitting nuclides. All staff will be required to participate in continuing education related to the safe handling of radioactive materials and other safety considerations."*

.3705(a)(4) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that the scanner will be staffed by the following personnel: ... (4) Nuclear medicine technologists certified in this field*

by the Nuclear Medicine Technology Certification Board or the American Registry of Radiologic Technologists with training and experience in positron emission computed tomographic nuclear medicine imaging procedures."

-C- In Section II.8, page 54, the applicant states *"the radiation therapists who will administer the radioisotope and operate the machine will be certified or registry eligible with the American Registry Radiologic Technology (ARRT) which is the equivalent training of a nuclear medicine technologist."*

.3705(b) This rule states *"An applicant proposing to acquire a cyclotron shall document that the cyclotron shall be staffed by radiochemists or radiopharmacists who: (1) have at least one year of training and experience in the synthesis of short-lived positron emitting radioisotopes; and (2) have at least one year of training and experience in the testing of chemical, radiochemical, and radionuclidic purity of PET radiopharmaceutical synthesis."*

-NA- The applicant does not propose to acquire a cyclotron.

.3705(c) This rule states *"An applicant proposing to acquire a PET scanner, a mobile PET scanner, or a cyclotron, shall document that the personnel described in Paragraphs (a) and (b) of this Rule shall be available at all times that the scanner or cyclotron are operating."*

-C- In Section II.8, page 54, the applicant states *"The personnel described in Paragraph (a) will be available at all times that the scanner is operating."*

.3705(d) This rule states *"An applicant proposing to acquire a PET scanner, including a mobile PET scanner, shall document that a program of continuing staff education will be provided that will insure training of new personnel and the maintenance of staff competence as clinical PET applications, techniques and technology continue to develop and evolve."*

-C- In Section II.8, page 54, the applicant states *"all staff are subject to continuing staff education requirements. The NCBH PET department has established competencies as*

required by the Joint Commission on Health Care Accreditation. These competencies are reviewed within 30 days of initial employment, 90 days, and then annually thereafter." Exhibit 11 contains copies of staff training policies for Baptist that document that the hospital has an organized program of staff education and training.

Novant HEALTH
CLINICAL RESEARCH INSTITUTE

Sponsors

Novant Clinical Research Institute was established in 2001 and has grown from a staff of 4 with a focus on cardiovascular studies to a staff of 14 who conduct and manage trials in a wide range of therapeutic indications.

Staff

NCRI staff includes 7 CRCs, 2 regulatory professionals, as well as support and management professionals. Five of these are ACRP certified and all CRCs are either certified or on track to certification. The current Director, Bob Romanchuk holds certification as CCRC, CHRC (Certified in Health Research Compliance), CIP (Certified IRB Professional) and CRCP (Clinical Research Contract Professional) with 30 years of clinical experience as a Registered Respiratory Therapist.

Regulatory

The IRB of record for NCRI is Forsyth Medical Center IRB. This IRB meets monthly (first Thursday) with a submission deadline of 10 days prior and approval time of 5 days post for new studies. FMC-IRB will defer review to external IRBs on a case-by-case basis.

Contracts/Budgets

Contracts are negotiated directly with NCRI with a usual turnaround of one week. NCRI complies with Novant's Fair Market Value in Clinical Research Pricing policy to assure equitable pricing in compliance with AKS and Stark rules. A robust process of tracing clinical trial billing and coding assures compliance with CMS regulations governing billing for clinical trial participants.

Experience

NCRI's investigators have conducted over 200 phase II-IV drug and device studies in the following therapeutic areas:

- Hyperlipidemia
- Diabetes
- Hypertension
- Arrhythmia
- DVT/PE treatment and prophylaxis
- Infectious disease including
  - CAP, HAP
  - HIV
  - Bacteremia
  - Influenza
  - CSSI
- Stroke
- Cardiac/vascular including
  - ACS
  - STEMI/NSTEMI
  - DES
  - PFO
  - Cardiac CT and IVUS
  - CHF
- Carotid artery disease/occlusion
- PAD
- Long term sedation
- General Surgery

Amplatzer, Abbott, Invatec, Merck, Possis, Roche, Idev, Takeda, Trivascular, Abiomed, Medtronic, GSK, Astra-Zeneca, Baxter, Bayer, Berlex, Atrium, CVRx, J&J, GE Healthcare, Hospira, Lifecell, SJM, Eli Lilly, TriAciv, Volcano, Wyeth and others.

Previous CRO partners include: PPDI, Quintiles, Covance, Parexel, HCRI, DCRI, J Tyson, Global Research, Global Clinical Trial Operations, RCRI, Clinametrix, Weststat, Scimetrica, Symbios, TIMI, Paragon, MBS and other.

Contracts & Budgeting

The director, Bob Romanchuk facilitates negotiation of contracts and budgets and has signatory authority. A turnaround of two weeks is typical. Forward contracts to:

Director: Robert Romanchuk, BS, CIP, CCRC, CHRC
Novant Clinical Research Institute
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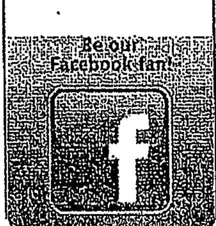

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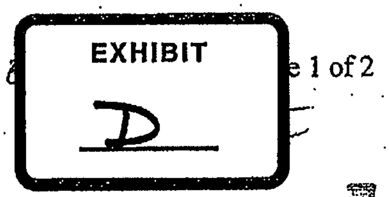

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Institutional Review Board (IRB)

The Institutional Review Board (IRB) is the appropriately constituted group at WakeMed designated to review research to assure the protection of the rights and welfare of the human subjects involved.

The IRB office is located at the WakeMed Raleigh Campus on the third floor, just before the beginning of C Hall. The phone number is (919) 350-8795 and the hours of operation are 8:00 a.m. until 4:30 p.m. Monday through Friday except on official holidays.

Contact Us

Email: wakemed_irb_office@wakemed.org
Phone: 919-350-8795

IRB Members

Investigators

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Consent Form Template
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Principal Investigators Checklist
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Investigator Agreement
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Waiver of Authorization Request Form
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Meetings

IRB meetings are held on every second and fourth Wednesday at 7:30 a.m. in Conference Dining at WakeMed Raleigh Campus except March and December when there will be only one IRB meeting.

Click here for a printable version of the WakeMed IRB Meeting Dates for 2011.

2011 IRB Meeting Dates	2011 Deadline for Submissions
	IRB submissions must be completely and accurately filled out, including all signatures.
January 12	December 22, 2010
January 26	January 5, 2011
February 9	January 19
February 23	February 2
March 9	February 16
April 13	March 23
April 27	April 6
May 11	April 20
May 25	May 4

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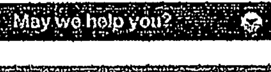

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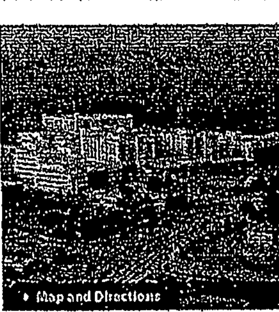

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Implementation Center

Report to Congress:

National Strategy for Quality Improvement in Health Care

March 2011

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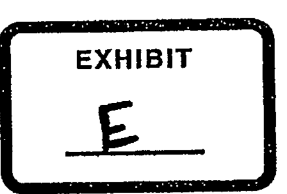

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Executive Summary

The Affordable Care Act seeks to increase access to high-quality, affordable health care for all Americans. To that end, the law requires the Secretary of the Department of Health and Human Services (HHS) to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it. This report describes the initial Strategy and plan for implementation.

The National Quality Strategy will promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care. It will incorporate the evidence-based results of the latest research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing their administrative burdens and helping them collaborate to improve care. It is guided by principles (available at www.ahrq.gov/workingforquality) that were developed with input by stakeholders across the health care system, including Federal and State agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. Most importantly, the implementation of this Strategy will lead to a measurable improvement in outcomes of care, and in the overall health of the American people.

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National Aims

The National Quality Strategy will pursue three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve the quality of health care.

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

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Setting Priorities

To advance these aims, we plan to initially focus on six priorities. These priorities are based on the latest research, input from a broad range of stakeholders, and examples from around the country. These priorities have great potential for rapidly improving health outcomes and increasing the effectiveness of care for all populations. As the National Quality Strategy is implemented in 2011 and beyond, we will work with stakeholders to create specific quantitative goals and measures for each of these priorities. They are:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities can only be achieved with the active engagement of clinicians, patients, provider organizations, and many others in local communities across the country, something the National Quality Strategy supports. Since different communities have different assets and needs, they will likely take different paths to achieving the six priorities. This Strategy will help to assure that these local efforts remain consistent with shared national aims and priorities.

Over time, our goal is to ensure that all patients receive the right care, at the right time, in the right setting, every time. The United States leads the world in discovering new approaches to prevent, diagnose, manage, and cure illness. Our institutions educate and train exceptional doctors, nurses, and other health care professionals. Yet Americans don't consistently receive a high level of care. Achieving optimal results every time requires an unyielding focus on eliminating patient harms from health care, reducing waste, and applying creativity and innovation to how care is delivered. That's what the National Quality Strategy will provide.

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Supporting Action to Address Priorities

The National Quality Strategy articulates broad aims and priorities that have been informed by extensive consultation with stakeholders across the country. At the same time, it explicitly recognizes that in the end, all health care is local.

Many stakeholders have important roles in promoting high quality care. It starts with clinicians and health professionals, but employers, government, advocates, and many others also have an interest in improving the quality of care. Employers and other private purchasers, for example, have been leaders in demanding better quality by pushing provider organizations to achieve new levels of excellence.

Until now, few of these efforts have been coordinated or aligned. The National Strategy will change that, outlining a common path forward that makes high quality, affordable care more available to

patients everywhere.

The Strategy will be updated annually and will provide an ongoing opportunity to identify and learn from those providers and communities that are ahead of the curve in delivering high quality, affordable care. It is our hope that this national strategy creates a new level of cooperation among all the stakeholders seeking to improve health and health care for all Americans.

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The Path Forward

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

The National Quality Strategy is designed to be an evolving guide for the Nation as we continue to move forward with efforts to measure and improve health and health care quality. As implementation proceeds, we will monitor our progress in achieving the Strategy's three aims along with other short- and long-term goals, and will refine the Strategy accordingly. We will provide updates annually to Congress and to the public.

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Section I. Introduction

The Affordable Care Act is improving the quality, affordability, and access to health care for all Americans. The law provides new protections for consumers in the private health insurance market, creates new coverage options for individuals and small business owners, and extends premium tax credits to moderate- and low-income Americans to make health care more affordable.

In addition, the Affordable Care Act has an array of provisions designed to enhance coordination, innovation, efficiency, and the quality of health care. These reforms build on progress that was already being made as a result of existing legislation such as the Children's Health Insurance Program Reauthorization Act of 2009 and the American Recovery and Reinvestment Act of 2009. Further, these provisions complement a wide range of State and local activities that also seek to make care more affordable, improve the quality of care, and promote better health.

To help guide and coordinate these public and private sector activities, the Affordable Care Act calls on the HHS Secretary to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it.

This report outlines the initial National Quality Strategy and plan. It identifies broad aims and priorities

for achieving better health and health care and describes examples of HHS initiatives that address the priorities. The Affordable Care Act also calls on the Secretary to establish a National Prevention and Health Promotion Strategy. The National Prevention and Health Promotion Strategy will align with the National Quality Strategy and will provide a more specific plan for improving population health.

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The Need for Improvement

The need to improve the quality and affordability of health care in the United States has been documented repeatedly. For example:

- In its groundbreaking 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine's Committee on Quality of Health Care wrote:

The performance of the health care system varies considerably. It may be exemplary, but often is not, and millions of Americans fail to receive effective care....The health care system as currently structured does not, as a whole, make the best use of its resources. There is little doubt that the aging population and increased patient demand for new services, technologies, and drugs are contributing to the steady increase in health care expenditures, but so, too, is waste. Many types of medical errors result in the subsequent need for additional health care services to treat patients who have been harmed. A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweigh the potential benefits. What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes.

- Researchers at the RAND Corporation have found that nearly half of all adult patients fail to receive recommended care.
- Since 2003, the Agency for Healthcare Research and Quality (AHRQ), together with its partners in HHS, has published annual National Healthcare Quality and Disparities Reports. (Available at http://www.ahrq.gov/qual/measurix.htm#quality). Overall, these reports find that while health care quality is improving, the pace of that improvement is slow.
- The Business Roundtable, in its *2010 Health System Value Comparability Study*, compared the United States with its five largest trading partners on both quality and cost of care. While noting potential for improvement on many fronts, it also noted that costs are far higher in the United States than in any other country. The report found that for every dollar spent on health care in the United States, other major competitors spent just 47 cents. Despite this increased spending, evidence suggests United States health care quality is no better, or in some cases worse, than other countries.

When looking at how our health care system works, these results are not surprising. The United States leads the world in developing new approaches to prevent, diagnose, manage, and cure illness, thereby improving health. Our academic institutions educate and train exceptional physicians, nurses, and other health care professionals. But while these advances have dramatically improved care for millions of people, they do not consistently reach all who would benefit.

That's because health care in the United States is often fragmented and disorganized. Patients,

caregivers, and families are forced to retell their stories to each new medical professional they encounter. Tests are duplicated because medical records are lost or unavailable. Doctors, nurses, and other health care professionals spend hours on paperwork. This fragmentation leaves both patients and clinicians dissatisfied, and adds significantly to the cost of care—and it's reinforced by payment systems that reward piecemeal care instead of care delivered in a seamless, coordinated manner.

The National Quality Strategy aims to change that by focusing on eliminating patient harms, reducing waste, and applying innovation in how care is delivered with the goal of ensuring that each patient receives the right care, at the right time, in the right setting, every time.

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Developing the National Quality Strategy

The Secretary developed this initial National Quality Strategy and plan through a participatory, transparent, and collaborative process that reached out to a range of stakeholders for comment. More than 300 groups, organizations, and individuals provided comments, representing all sectors of the health care industry and the general public. In addition, the Strategy incorporates input gathered at national meetings and from the National Priorities Partnership, a coalition of some 50 organizations committed to revamping the health care system. (See www.nationalprioritiespartnership.org.) These public comments led to revisions and enhancements to the Strategy and gathered support for the principles, aims, and priorities that form the foundation of this report. A full summary of the public comments made in the development of the National Quality Strategy is available at www.ahrq.gov/workingforquality. This dialogue will continue in 2011 and beyond, as the National Quality Strategy evolves and develops a sharper focus on specific goals, measures, and additional actions to be taken by the government and private sector partners.

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An Initial Outline of the Plan

The National Quality Strategy will focus national, State, and local efforts to improve health care quality on common aims, priorities and goals.

It will promote health and health care centered on the needs of patients, families, and communities. It will incorporate the evidence-based results of research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing their administrative burdens and helping them collaborate to improve care. It will be guided by a set of core aims and priorities that reflect shared values and best practices. Most importantly, the implementation of this Strategy will have a measurable impact on the experience and outcomes of care, and on the health of the American people.

The National Quality Strategy will pursue three broad aims that will be used to guide and assess local, State, and national efforts to improve health and the health care delivery system.

- **Better Care:** Improve the overall quality, by making health care more patient-centered, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in

addition to delivering higher-quality care.

- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

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Setting Priorities

To advance these aims, we plan to initially focus on six priorities. These priorities are based on research, input from a broad range of stakeholders, and examples from around the country, which suggest that we have great potential for rapidly improving health outcomes and increasing the value and effectiveness of care for all populations. As the National Quality Strategy is implemented in 2011 and beyond, we will work with stakeholders to create specific quantitative goals and measures for each of these priorities. They are:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities can only be achieved with the active engagement of clinicians, patients, provider organizations, and many others in local communities across the country, something the National Quality Strategy supports. Since different communities across the Nation have different assets and needs, they will likely take different paths to achieving the six priorities. This Strategy will help assure that these local efforts are consistent with shared national aims and priorities.

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Building on Work in Progress

The National Quality Strategy builds on the work, achievements, and recommendations of millions of concerned and committed clinicians and other stakeholders. Over the past two decades, these stakeholders have devoted enormous energy and enthusiasm to defining, measuring, and improving quality. Many of these efforts have occurred through partnerships between government, private organizations, and consumers. And while some of these have been nationwide efforts, many have been deeply rooted in local communities.

Communities and States have often served as laboratories for expanding health coverage, improving quality, and controlling costs. That will be even truer in the years to come as States take the lead in implementing key parts of the Affordable Care Act, such as new State-based Health Insurance Exchanges. State Exchanges will improve health care quality by providing transparent information for consumers and by creating quality standards for health plans. And as we move forward, State leadership will be crucial to ensuring that the National Quality Strategy continues to reflect local needs.

Notably, these State and local efforts to improve quality have often occurred in spite of payment systems

and incentives that do not reward value or improve quality. In addition, for many clinicians and provider organizations, these efforts have been undertaken in the midst of competing incentives, regulations, and administrative complexity that foster confusion and create barriers to improvement. The National Quality Strategy will help change this.

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The Path Forward

The National Quality Strategy is designed to be an adaptable and evolving guide for the Nation. It is a broad roadmap that will require the ongoing development of specific goals, measures, benchmarks, and initiatives, through a continued transparent collaborative process with all stakeholders. It will continue to draw from pockets of excellence from which others can learn and which could eventually be brought to scale. At the Federal level, the National Quality Strategy will guide the development of HHS programs, regulations, and strategic plans for new initiatives, in addition to serving as a critical tool for evaluating the full range of Federal health care efforts.

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

As implementation of the National Quality Strategy proceeds, it will be periodically refined, based on lessons learned in the public and private sectors, emerging best practices, new research findings, and the changing needs of the Nation. Updates on the Strategy and the Nation's progress in meeting the three aims of better care, improved health, and making quality care more affordable will be delivered annually to Congress and the American people.

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Section II. Aims, Priorities, and Goals for Improving Quality

As noted earlier, the National Quality Strategy is guided by three broad aims: better care, healthier people and communities, and affordable quality care for all. These aims are not separate, but are interrelated and mutually reinforcing. For example, by reducing gaps in patient support that raise the risk of avoidable complications or readmissions, better care coordination leads to better patient outcomes. In addition, care coordination can also make care more affordable by reducing duplication and preventing costly hospital admissions or readmissions and avoidable emergency department visits. Because of these connections, national priorities should contribute to the achievement of all three aims.

As the National Quality Strategy is implemented in 2011, the priorities and initiatives listed in this report will be refined, additional goals will be identified, and quality metrics and benchmarks will be

applied to ensure accountability for performance. (The Appendix to this report lists examples of measures that may be useful for monitoring the Nation's progress in achieving the Strategy's priorities. Actual targets and measures will be identified later in 2011. And the first update on the National Quality Strategy provided to Congress and the Nation in 2012 will include additional detail on how Federal agencies are addressing the priorities and goals in agency-specific strategic plans.)

In this first report to Congress and the Nation, we describe initiatives that are currently underway within HHS for each priority area. The initiatives described are not intended to be an exhaustive catalogue, but rather a sample of initiatives that are already addressing the priorities identified in this plan.

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1. Making Care Safer

Health care-related errors harm millions of American patients each year and needlessly add billions of dollars to health care costs. The Centers for Disease Control and Prevention (CDC) estimate that at least 1.7 million healthcare-associated infections occur each year and lead to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year—and the cost of treating patients who are harmed by these events is estimated to be as high as $5 billion annually.

Health care providers should be relentless in their efforts to reduce the risk for injury from care, aiming for zero harm whenever possible and striving to create a system that reliably provides high-quality health care for everyone. This isn't easy. Such a system requires, for example, the design of standard operating procedures, a workforce with diverse yet complementary skills, workloads that allow enough time for errors to be corrected or mitigated and leadership that promotes continuous improvement. But this kind of system can also make a big difference in improving care, whether it's by preventing serious medication events or eliminating healthcare associated infections and other preventable conditions.

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Examples of Federal Initiatives Making Care Safer

1. **Michigan Keystone Intensive Care Unit Project:** Nearly one in every 20 hospitalized patients in the United States each year acquires a healthcare-associated infection while receiving medical care. Central intravenous line associated blood-stream infections are one of the most deadly types, with a mortality rate of 12 to 25 percent. In this AHRQ-funded project, a research team at Johns Hopkins University partnered with the Michigan Health and Hospital Association to implement CDC recommendations to reduce central line blood stream infections in 100 intensive care units throughout the State. The initiative, known as the "Keystone Project," reduced the rate of these central line bloodstream infections by two-thirds within 3 months. Over 18 months, the program saved more than 1,500 lives and nearly $200 million. These dramatic improvements have been sustained for 5 years and the approach used is now being spread to all 50 States and the District of Columbia. For more information, go to www.ahrq.gov/about/annualmtg07/0928slides/goeschel/Goeschel.ppt.
2. **Safe Use Initiative:** Today, tens of millions of people in the United States depend on prescription and over-the-counter medications to sustain their health—with as many as 3 billion prescriptions written annually. Too many people, however, suffer unnecessary injuries, and even death, as a result of preventable medication errors. The U.S. Food and Drug Administration (FDA) has launched the Safe Use Initiative to create and facilitate public and private collaborations within the health care community with the goal of reducing this preventable harm. The Safe Use

Initiative will identify specific, preventable medication risks and then develop, implement, and evaluate cross-sector interventions to reduce these risks.For more information, go to http://www.fda.gov/Drugs/DrugSafety/ucm187806.htm.

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2. Ensuring Person- and Family-Centered Care

Health care delivery in the United States is often not designed around meeting the needs of the patient. Instead, clinical services are often organized around specific clinical conditions and designed with little input or direction from the patient. We need to change that.

Health care should give each individual patient and family an active role in their care. Care should adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds.

This kind of person-centered care, which sees a person as a multifaceted individual rather than the carrier of a particular symptom or illness, requires a partnership between the provider and the patient with shared power and responsibility in decision making and care management. It also requires giving the patient access to understandable information and decision support tools that help patients manage their health and navigate the health care delivery system. Person-centered care means defining success not just by the resolution of clinical syndromes but also by whether patients achieve their desired outcomes.

Some examples of person-centered care could be assuring that patients' feedback on their preferences, desired outcomes, and experiences of care is integrated into care delivery, integrating patient-generated data in electronic health records, and finding additional ways to involve patients and families in managing their care effectively.

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Examples of Federal Initiatives Fostering Person- and Family-Centered Care

1. **Building Patients' Perspectives Into All Performance Assessments:** The Federal government has taken the lead in assuring that the patient's perspective of care is a core measure of performance for providers and health plans. Starting with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare has used its purchasing power to get virtually all hospitals to publicly report standardized information on the perspective of all patients (including Medicare beneficiaries, Medicaid beneficiaries, and those with private insurance). This was the first large-scale initiative to include patient experience as a factor in quality reporting. In addition, the Affordable Care Act uses HCAHPS as one of the measures to calculate value-based incentive payments to hospitals beginning in 2012, and also calls on CMS to expand the use of patient experience information to assess physicians and other facilities, including nursing homes. For more information, go to https://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp.
2. **Establishing the Patient-Centered Outcomes Research Institute:** Established as an independent, nonprofit organization under the Affordable Care Act, the Patient-Centered Outcomes Research Institute (PCORI) will build on the current work of AHRQ and NIH to assist patients, clinicians, and policymakers in making informed health decisions. To do this, PCORI will identify research projects that provide quality, relevant evidence on how diseases and health conditions can be effectively diagnosed, prevented, treated, and managed. The Act requires that

initial priorities for PCORI be informed by the National Quality Strategy, and that consumer input influence all phases of sponsored research, starting with developing the questions researchers will try to answer. The 21 members of the PCORI Board of Governors are made up of 19 members appointed by the Comptroller General and the Directors of AHRQ and NIH. For more information, go to http://pcori.org/.

3. **AHRQ's Patient-Centered Care Improvement Guide:** AHRQ has developed a guide to help hospitals become more patient-centered. It outlines best practices and addresses common barriers to implementing patient-centered care. For more information, go to http://www.innovations.ahrq.gov/content.aspx?id=2383.

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3. Promoting Effective Communication and Coordination of Care

When all of a patient's health care providers coordinate their efforts, it helps ensure that the patient gets the care and support he needs and wants, when and how he needs and wants it. Effective care coordination models have begun to show that they can deliver better quality and lower costs in settings that range from small physician practices to large hospital centers.

Health care systems need to encourage coordination and help providers care for patients with chronic diseases so they get the kind of seamless care that is most effective. Gaps and duplication in patient care delivery can be reduced or eliminated through proven technologies such as electronic health records, e-prescribing, and telemedicine. Hospitals and long-term care and rehabilitation facilities, along with physicians, nurses, and other clinicians working together, are helping recently discharged patients avoid unnecessary rehospitalization. All too often, however, the way health care is paid for does not foster coordination but instead pays more to providers for doing more instead of working together. Policies advanced by the National Quality Strategy will help change that.

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Examples of Federal Initiatives Promoting More Effective Care Coordination

1. **Advancing Primary Care Services and Medical Homes:** The Federal government is promoting better care coordination through multiple programs. In November 2010, CMS announced: (1) the participation of eight States in the Multi-Payer Advanced Primary Care Practice Demonstration to evaluate the effectiveness of health professionals across care systems working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans. Ultimately this will provide advanced practice primary care for up to 1 million Medicare beneficiaries; (2) support to help States establish "health homes" to provide care to Medicaid beneficiaries with at least two chronic conditions; (3) the participation of up to 500 Federally Qualified Health Centers to test the effectiveness of health professionals working in teams to treat low-income patients at community health centers; and (4) the opportunity for States to apply for contracts to support development of new integrated care models aimed at improving care quality, care coordination, cost-effectiveness, and overall experiences of beneficiaries who are eligible for both Medicare and Medicaid, also known as "dual eligibles." For more information, go to http://innovations.cms.gov/news/pressreleases/pr110910.shtml.
2. **Developing Accountable Care Organizations:** As part of the Affordable Care Act, Congress directed CMS to establish a "shared savings program" to bring together groups of providers and

suppliers to deliver better quality and more cost-effective care for Medicare beneficiaries. CMS is currently engaging with physicians, hospitals, employers, and consumer groups to help plan this program, which the statute requires be established no later than January 2012. For more information, go to https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf.

3. **Improving Care Coordination Through Health Information Technology:** The Health Information Technology for Economic and Clinical Health (HITECH) Act allows HHS to establish programs to improve health care quality, safety, and efficiency through the adoption of health information technology, including electronic health records (EHRs) and private and secure electronic health information exchange. Eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives for improving care. Altogether, more than $27 billion in incentive payments is available to eligible providers and hospitals that meet these "meaningful use" objectives. A Federal regulation defining the first stage of meaningful use objectives was released in 2010. For more information, go to https://www.cms.gov/ehrincentiveprograms/. Meaningful use of health information technology improves quality by making needed clinical information accessible to all appropriate providers and in a more complete and timely fashion than paper records.

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4. Promoting the Most Effective Prevention and Treatment of the Leading Causes of Mortality, Starting With Cardiovascular Disease

More than 133 million Americans have at least one chronic illness, and many have several. As individuals and health systems feel the strain of this growing trend, we need to do a better job preventing and treating a number of leading causes of mortality and illness in adults and children including cardiovascular disease, cancer, diabetes, HIV/AIDS, premature births, and behavioral health conditions.

Among these, cardiovascular disease is the most deadly, accounting for one of every three deaths in the United States. Over $503 billion is spent annually on cardiovascular disease. And approximately 75 million Americans have high blood pressure, 18 million have a history of heart attack or angina, 6 million have a history of heart failure, and 6 million have a history of stroke. While mortality from cardiovascular disease has declined dramatically over the past forty years, current quality initiatives can help us do even better. For example, health plans with the best performance in managing cardiac risk factors (90th percentile) still only report effective care for 71 percent of patients.

Decades of research and practice have demonstrated that public health and clinical strategies can greatly reduce the risk of cardiovascular disease. The key interventions are referred to as the "ABCS": aspirin, blood pressure control, cholesterol reduction, and smoking cessation. Under this umbrella, activities that can improve heart health include reducing uncontrolled blood pressure and cholesterol, decreasing sodium and trans-fat intake, eliminating smoking and exposure to secondhand smoke, increasing aspirin use to prevent and reduce the severity of heart attacks and strokes, and lifestyle interventions to modify risk factors such as obesity.

By focusing on cardiovascular disease, we'll provide a model for how the Nation can make a dramatic and immediate impact on the health and health care of millions of Americans. And the lessons from this effort will inform complementary efforts addressing other conditions, including HIV/AIDS and other

chronic illnesses. Future initiatives will address a broad range of diseases and age ranges.

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Examples of Federal Initiatives Addressing the Leading Causes of Mortality

1. **CDC Community Transformation and Self Management Grants:** In 2011, the Affordable Care Act provides $750 million in prevention and public health funding to support a variety of activities to promote healthy living These grants represent a major commitment to promoting health in local communities, including reducing heart disease. Funding from CDC will support programs that reduce risk factors for chronic illnesses and discourage behaviors that increase risk.
2. **Focusing on Priority Conditions:** The National Quality Strategy highlights cardiovascular disease as a place to start, partially out of recognition of other important efforts already under way. For example:

- **The National HIV/AIDS Strategy:** On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the Nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015. In December 2010, HHS and five other lead agencies submitted NHAS operational plans to the White House, which were made public in February 2011. HHS is committed to NHAS priorities of preventing HIV infections, making more people aware of their HIV status, and giving people greater access to HIV care and treatment, using innovative, culturally appropriate means. For more information, go to http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/.
- **The Strategic Framework on Multiple Chronic Conditions:** In December 2010, HHS issued its new Strategic Framework on Multiple Chronic Conditions—an innovative, private-public sector collaboration. The new strategic framework will improve the overall health of individuals with multiple chronic conditions and reduce their risk of complications by providing more information and better tools to help health professionals—as well as patients—learn how to better coordinate and manage care and by facilitating research to improve care. For more information, go to http://www.hhs.gov/ash/initiatives/mcc/.

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5. Working With Communities to Promote Wide Use of Best Practices to Enable Healthy Living

Health is a state of physical, mental and social well-being and not merely the absence of disease or infirmity. Our health is affected by a range of factors such as individual behavior, access to health services, and the environment in which we live, in addition to biology and genetics.

The broad goal of promoting better health is one that is shared across the country, whether it's promoting healthy behaviors such as not using tobacco or fostering healthy environments that make it easier to exercise and get access to healthy foods. For that reason, successful efforts to improve these health factors rely on deploying evidence-based interventions through strong partnerships between local health care providers, public health professionals, and individuals.

One specific opportunity to improve health is by increasing the adoption of clinical preventive services for children and adults. When used correctly, these services can prevent illnesses and also identify them

at an earlier and more treatable stage. Clinical preventive services include such things as tobacco cessation services, screening for hypertension, high cholesterol, and depression and screening and counseling for risky alcohol behavior and other drug use. Another specific opportunity is to increase the adoption of evidence-based interventions to improve population health, such as those recommended by the CDC's Task Force on Community Preventive Services. The forthcoming National Prevention and Health Promotion Strategy will also align with the National Quality Strategy and will provide a more specific plan for improving population health.

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Examples of Federal Initiatives Supporting Better Health in Communities

1. **Putting Prevention to Work in Communities:** The American Recovery and Reinvestment Act of 2009 provided $650 million to carry out evidence-based clinical and community-based programs to prevent or delay chronic diseases and promote wellness in children and adults. Some of those funds went to "Communities Putting Prevention to Work," a program which supports policy and environmental changes at the local and State level that aim to increase levels of physical activity; improve nutrition; decrease obesity rates; and decrease smoking prevalence, teen smoking, and exposure to second-hand smoke. For more information, go to http://www.cdc.gov/CommunitiesPuttingPreventiontoWork/about/index.htm.
2. **First Lady's Let's Move! Campaign:** The Let's Move! campaign, started by First Lady Michelle Obama, has an ambitious national goal of addressing the challenge of childhood obesity within a generation so that children born today will reach adulthood at a healthy weight. Let's Move! is combating the epidemic of childhood obesity through a comprehensive approach that is engaging all the parties that affect the health of children, and providing schools, families, and communities with simple tools to help kids be more active, eat better, and get healthy. At the launch of the campaign, President Barack Obama signed a Presidential Memorandum creating the first-ever Task Force on Childhood Obesity to conduct a review of every single program and policy relating to child nutrition and physical activity, develop a national action plan to make the most of Federal resources, and set concrete benchmarks toward the First Lady's national goal. For more information, go to http://www.letsmove.gov/.
3. **Preventing Substance Abuse and Mental Illness in Tribal Communities:** Helping communities promote emotional health and reduce the likelihood of mental illness, substance abuse, and suicide is the goal of the Substance Abuse and Mental Health Services Administration's "Circles of Care" initiative. This initiative focuses on providing grants to Tribal communities to develop models of care, create new partnerships, and help community members to obtain comprehensive behavioral health services. Circles of Care currently support eight tribes and urban Indian organizations across the country. For more information, go to http://www.samhsa.gov/samhsaNewsletter/Volume_18_Number_6/CirclesOfCare.aspx.

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6. Making Quality Care More Affordable

For the past 30 years, health care spending has risen at a faster rate than the economy nearly every year. These rising costs have put a burden on America's families as patients, taxpayers, business owners, and employees who have seen a growing share of their paychecks go to pay for health care.

Yet there is good evidence that health care costs can be reduced while quality is improved. Making sure the right care is delivered to the right person at the right time every time can also make care more

affordable. The National Quality Strategy recognizes that while this will be a challenge, the goal of reducing costs is important to all because of the impact of increasing costs on families, employers, and State and Federal governments. Reducing costs must be considered hand-in-hand with the aims of expanding access, providing better care, and promoting population health.

For that reason, the National Quality Strategy will foster care strategies that reduce redundant and harmful care, for example, by reducing health care-acquired conditions; establish common measures that will help assess the cost impact of new programs and payment systems on families, employers, and the public sector, along with how well these programs support innovation and effective care; build measurement of cost and resource use—along with patient experience and outcomes—into the full range of public and private sector efforts to reform payment; reduce waste from undue administrative burdens; and make health care costs and quality more transparent to consumers and providers, so they can make better choices and decisions.

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Initiatives Making Care More Affordable

1. **Establishing Health Insurance Exchanges:** Today, individuals and small businesses looking to buy health insurance are often on their own, forced to choose between several undesirable options. Starting in 2014, State-based health insurance exchanges will lower costs and improve health care quality for individuals and small business owners by creating a more transparent and competitive marketplace. Exchanges will offer information on price and quality, so that insurers will compete on offering the best providers and services for the most affordable premium. By pooling people together, exchanges will also give individuals and small business owners purchasing power similar to that of large businesses. For more information, go to http://www.hhs.gov/news/press/2011pres/01/20110120b.html
2. **Fostering Innovations to Promote Quality and Reduce Cost:** The Affordable Care Act established a new Center for Medicare and Medicaid Innovation in CMS, charged with testing innovative payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) that improve care and save money. In 2011, the Innovation Center will begin testing additional models and engage clinicians, consumers, employers, and other stakeholders around the common pursuit of creating a health care system that delivers high-quality care while keeping costs down for Medicare, Medicaid, and CHIP beneficiaries. For more information, go to http://innovations.cms.gov/.
3. **Administrative Simplification:** The Affordable Care Act includes provisions to foster "administrative simplification." Under those provisions, new tools will be adopted to help doctors and other providers focus on patients instead of paperwork, such as a standard unique identifier for health plans, a new standard for electronic funds transfer, and operating rules that provide more specificity to existing transaction standards. These provisions are expected to generate significant savings. As electronic transactions become easier, more providers will use them in place of costly paper or telephone communication. As a result, providers and plans will save from reduced phone calls, reduced postage and check printing costs, fewer rejected transactions, and more automated processes.

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Section III. Policies and Infrastructure Needed to Support Priorities

The National Quality Strategy sets forth broad aims, initial priorities and goals, and maps out early initiatives. Reaching these goals will be the product of the actions of many individuals and groups across the Nation. At the forefront, are the millions of committed clinicians and health professionals seeking to partner with their patients in providing the best possible care. States, licensing organizations, health care professional specialty organizations, accrediting organizations, consumer advocates, and private sector purchasers will also contribute. A national strategy must build on and support these efforts and create a common path forward that results in high quality, affordable care everywhere.

To achieve its objective of improving health and health care for all Americans, the National Quality Strategy promotes collaboration among stakeholders in the Nation's health system around several initiatives, including the Healthcare Associated Infection Prevention Initiative, Accountable Care Organizations, and Communities Putting Prevention to Work. The strategy counts on the actions taken by doctors, nurses and other clinicians; better informed choices made by patients and family members; and systems of care put in place by health care providers and institutions to ensure high quality and reliable care.

The Federal government plays a vital role in supporting the delivery of safe, high quality care, including paying for care, monitoring quality, addressing disparities, providing technical assistance, supporting research, and directly providing care to veterans, members of the military, Native Americans, and others. Similarly, State, local, and tribal governments can support better care delivery in their communities.

At the same time the strategy provides an ongoing opportunity to identify and learn from those providers and communities that are ahead of the quality care curve. It is our hope that this National Quality Strategy launches a new level of cooperation that reflects the Nation's highest aspirations for health and health care for all Americans. With the appropriate modifications and enhancements, the current "building blocks" of the U.S. health care system can become a foundation for a system that provides better care, a healthier population, and lower health costs

This National Quality Strategy—and all efforts to improve health and health care delivery—must be guided by a core set of principles. We identify 10 principles (available at www.ahrq.gov/workingforquality) that can be used when designing specific initiatives to achieve the National Quality Strategy's three aims.

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1. Payment

Payment arrangements should offer incentives that foster better health; promote quality improvement and greater value while creating an environment that fosters innovation. Health care systems should be rewarded for working collaboratively to improve efficiency and adopt evidence-based practices across the spectrum of inpatient and outpatient services. Medicare, State Medicaid programs, and many private sector health plans and purchasers are moving rapidly to change payment systems to reward coordination and better outcomes. New payment incentives and delivery models that will be launched under the auspices of the Medicare, Medicaid, and private sector partnerships will provide the opportunity to evaluate and bring successful models to scale.

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2. Public Reporting

Public reporting initiatives offer consumers and payers vehicles to compare costs, review treatment outcomes, assess patient satisfaction, and hold providers accountable. This is done while ensuring the protection of personal health information and adjusting for factors beyond providers' control. Reporting also provides important resources and motivation for clinicians and other providers to improve performance. You can see examples of these initiatives—sponsored by health plans, States, nonprofit groups and community consortiums, employer coalitions, and individual firms—on a variety of scales. Many provide information that can help guide patients' decisions about their health care providers. This reporting should be further refined and expanded with broader use of commonly endorsed measures of performance. The new consumer focused web site, healthcare.gov will also improve transparency. The site allows all consumers to view the insurance plans in their area, compare them by price and benefits and pick the one that is best for them and their families. There will also be hospital pricing information, in addition to performance data, available online to help inform consumer decisions about where to obtain care.

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3. Quality Improvement/Technical Assistance

Public and private efforts to support providers' desire to deliver higher quality care are critically important. These include programs sponsored by provider organizations and clinical specialty groups and quality improvement organizations (QIOs) that work cooperatively with physicians, hospitals, nursing homes, home health agencies, and others to disseminate research evidence to the point of care, share best practices and technical assistance. HHS is contracting with QIOs to drive quality improvement through collaboratives at the State level. Collaborative efforts at the local level are also a vital resource for measuring, monitoring, and improving quality of care.

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4. Certification, Accreditation, and Regulation

State and Federal regulations create public standards for safe, reliable care. Certification by State, Federal, or federally-approved accrediting organizations lets public and private payers, consumers, and other stakeholders know that a clinician or organization meets certain quality standards for health services. Standards applied by accrediting entities should continue to draw on the expertise of provider organizations, clinicians, purchasers, health plans, consumers, and measurement experts and be mindful of the burden placed on providers. Through their regulatory authority, State and Federal agencies overseeing provider organizations and facilities should continue to monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement. For example, provider participation in public programs will be conditioned on more rigorous screening to ensure providers meet appropriate standards.

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5. Consumer Incentives and Benefit Designs

Consumer incentives, such as financial assistance for tobacco cessation programs, can help turn good

intentions into action. Some employers and private health plans already use the evidence-based programs to promote better health. Similar approaches can improve adherence to recommended medications, which many Americans fail to take, often due to cost. At the Federal level, HHS is promoting value-based insurance models. Value-based insurance provides incentives for consumers to choose high quality, efficient providers. In addition, clinicians and patients need information on the evidence supporting the care they give and receive.

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6. Measurement of Care Processes and Outcomes

Public and private stakeholders have worked hard to create accurate measurements for health care services quality. However, those efforts have relied largely on incomplete data generated from claims or patients' charts after an encounter with the health care system. Valid, reliable measures are the cornerstone of monitoring quality improvement efforts. In order to achieve the quality improvements envisioned by the National Quality Strategy, data on care delivery and outcomes should be measured using consistent, nationally-endorsed measures in order to provide information that is timely, actionable, and meaningful to both providers and patients. Across the country, there are efforts based in States and regional collaboratives that are at the cutting edge of measuring performance.

At the national level, HHS continues to help coordinate quality measurement efforts that address the National Quality Strategy's six priorities. The department will also develop national consensus on specific measures, data sources, and data collection procedures. Efforts will focus on aligning measurement efforts within value-based purchasing programs and will move toward measuring outcomes and patient experience. HHS will promote effective measurement while minimizing the burden of data collection by aligning measures across its programs, coordinating measurement with the private sector and developing a plan to integrate reporting on quality measures with the reporting requirements for meaningful use of electronic health records.

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7. Health Information Technology

Increased adoption of EHRs has the power to cut health care costs, reduce paperwork, improve outcomes, and give patients more control over their health care, while maintaining full protections on the privacy of individual health information. To promote adoption and improve the performance of the health care system, the HITECH Act was signed into law in 2009. The Act addresses obstacles to the adoption of EHRs and provides substantial financial incentives for the adoption and meaningful use of certified EHR technology. Meaningful use criteria include quality measurements that will be built on over the next several years. The goal is to build a system that supports clinical practice, research, public health, and the health of individual patients. The Office of the National Coordinator for Health Information Technology is focusing its efforts on engaging the private sector, including vendors, service companies, and insurers, to make health information exchange a reality. It is also working with health care providers through Beacon Community Programs, State Health Information Exchange Programs, and Regional Extension Centers to help expand the use of EHRs. At the same time, it builds on State and local efforts to promote better use of health information technology by engaging clinicians, employers, consumers, and others.

An increasing number of case studies demonstrate that health information technology improves quality.

A recent review published by AHRQ contained numerous examples of how health information technology can, for example, increase the likelihood that patients received life-saving treatment, or lower the frequency of a common type of hospital-acquired infection. (See *Using Health IT: Eight Quality Improvement Stories*, available at http://healthit.ahrq.gov/SuccessStoriesTHQIT.)

In one case, 15 nursing homes implemented an electronic documentation and clinical decision support system and subsequently observed a 34 percent decrease in high-risk pressure ulcers. In another case, a clinical decision support for emergency medical responders resulted in lower time-to-treatment for patients experiencing heart attacks. This increased the likelihood that patients received timely life-saving treatment. In a third example, use of clinical decision support through an EHR system in rural Iowa helped to reduce the rate of urinary tract infections after surgery. Using health information technology can also lead to improved efficiencies in health care delivery. One example from the AHRQ report is a continuity of care record that helped decrease the number of emergency room visits made by children who had experienced barriers to care. Another involved using formulary decision support to identify prescription drug savings for insurers and patients.

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8. Evaluation and Feedback

Clinicians and other providers need timely and actionable feedback in order to improve. Similarly, new innovations in delivery and payment need robust and rapid evaluation to support potential widespread implementation. One example of this can be found in patient safety organizations (PSOs). PSOs were created to provide feedback to health care organizations, on a voluntary basis, to improve patient safety and quality of care. These private organizations have expertise in identifying and analyzing confidential data reported to them by hospitals and physicians. They then provide feedback on ways to reduce or eliminate risks. Another example of useful feedback is the information provided to clinicians as part of their professional certification. Health plans also provide feedback to their contracted providers to identify gaps in care.

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9. Training, Professional Certification, and Workforce and Capacity Development

To achieve the aims and goals of the National Quality Strategy, health care professionals should be encouraged to maximize their training and skills through life-long learning that includes the application of quality improvement principles and patient safety systems concepts such as teamwork. At the same time, there is a need for a new generation of health care professionals. The Affordable Care Act provides $1.5 billion over 5 years to expand the National Health Service Corps (NHSC). This follows a $300 million investment that the American Recovery and Reinvestment Act of 2009 made in the program. As of September 30, 2010, the NHSC is a network of 7,500 primary health care professionals and 10,000 sites in underserved communities across the country providing valuable services to persons who would otherwise lack access to primary care. To support their service, the NHSC provides physicians, nurse practitioners, physician assistants, and other health professionals with financial support in the form of loan repayment and scholarships. The Health Resources and Services Administration's National Center for Health Workforce Analysis is working to identify workforce shortages and advise where resources might be best placed. At the same time, boards of medicine, nursing, and other providers enhance the quality of care that patients receive by requiring that practitioners continually demonstrate skills and

knowledge critical to their field. Promisingly, board policies are increasingly promoting a lifelong commitment to learning and the adoption of new evidence-based practices. Certification programs can also serve as a valuable tool for consumers to use as they choose a health care provider.

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10. Promoting Innovation and Rapid-Cycle Learning

Thanks to innovations in care, collaboration, and communication our health care system has made major strides in the detection and treatment of diseases and care delivery. But too often, these improved models are not known outside of the organization that created them. The Center for Medicare and Medicaid Innovation is part of a broad array of public and private sector efforts seeking to fix that problem. The Innovation Center is supporting new models of care and innovative practices for Medicare, Medicaid, and CHIP beneficiaries, with the goal, for example, of improving transitions from various health settings within a patient's community.

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Section IV. Next Steps

The National Quality Strategy is designed to adapt with the evolving health needs of the Nation. It is a broad roadmap that will require the ongoing development of specific goals and agreed-upon metrics. It will depend on initiatives launched through a public and private sector collaboration that builds on the successes already under way and respects the needs and priorities of local communities. This approach reflects the direction and support provided to the Secretary by the Affordable Care Act.

The National Quality Strategy will be shaped by recommendations and feedback from the private sector and with State engagement. Consumers, hospitals, clinicians, insurers, businesses, drug and device manufacturers, representatives of the health information technology industry, and other key stakeholders will be engaged to participate in improvement initiatives, identify the practical impact of public and private sector policies to improve quality, and guide public and private sector policymakers to expand or modify those policies as needed.

From the perspective of the Federal government, the National Quality Strategy will serve as a guide for HHS agencies as they develop programs, regulations, and new initiatives, as well as a vital tool in evaluating the full range of Federal health care efforts.

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

In addition, a Federal Interagency Working Group on Health Care Quality will begin working in 2011. It will be composed of senior-level members of Federal departments and agencies with jurisdiction over

health care quality and quality improvement. Their mission will be to collaborate, cooperate, and consult with departments and agencies that develop and disseminate the strategies, goals, models, and timetables that will advance the national priorities outlined in the National Quality Strategy. The main goals of this effort are to avoid duplication of efforts, assure accountability, and, where possible, develop a streamlined approach for quality reporting.

The National Quality Strategy will continue to be refined based on public and private sector experiences, best practices, research findings, and emerging health needs. Updates on the Strategy and the nation's progress in meeting the three aims of better care, improved health, and making care more affordable for all Americans will be reported annually to Congress and the public.

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APPENDIX: National Quality Strategy Priorities and Goals, With Illustrative Measures

The goals and illustrative measures described here are designed to begin a dialogue that will continue throughout 2011. The next version of the National Quality Strategy will reflect specific measures and include short-term and long-term goals. HHS will promote effective measurement while minimizing the burden of data collection by aligning measures across its programs, coordinating measurement with the private sector and developing a plan to integrate reporting on quality measures with the reporting requirements for meaningful use of electronic health records. All measures will be specifically assessed with the goal of making sure they can be included in electronic collection systems.

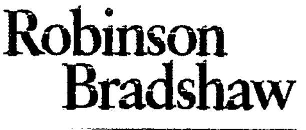
Appendix Table: National Quality Strategy Priorities and Goals, With Illustrative Measures

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
#1 **Safer Care**	**Goal:** Eliminate preventable health care-acquired conditions **Opportunities for success:** • Eliminate hospital-acquired infections • Reduce the number of serious adverse medication events **Illustrative measures:** • Standardized infection ratio for central line-associated blood stream infection as reported by CDC's National Healthcare Safety Network • Incidence of serious adverse medication events
#2 **Effective Care Coordination**	**Goal:** Create a delivery system that is less fragmented and more coordinated, where handoffs are clear, and patients and clinicians have the information they need to optimize the patient-clinician partnership **Opportunities for success:** • Reduce preventable hospital admissions and readmissions.

	• Prevent and manage chronic illness and disability • Ensure secure information exchange to facilitate efficient care delivery **Illustrative measures:** • All-cause readmissions within 30 days of discharge • Percentage of providers who provide a summary record of care for transitions and referrals
#3 **Person- and Family-Centered Care**	**Goal:** Build a system that has the capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with health care **Opportunities for success:** • Integrate patient feedback on preferences, functional outcomes, and experiences of care into all care settings and care delivery • Increase use of EHRs that capture the voice of the patient by integrating patient-generated data in EHRs • Routinely measure patient engagement and self-management, shared decision-making, and patient-reported outcomes **Illustrative measures:** • Percentage of patients asked for feedback
#4 **Prevention and Treatment of Leading Causes of Mortality**	**Goal:** Prevent and reduce the harm caused by cardiovascular disease **Opportunities for success:** • Increase blood pressure control in adults • Reduce high cholesterol levels in adults • Increase the use of aspirin to prevent cardiovascular disease • Decrease smoking among adults and adolescents **Illustrative measures:** • Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg • Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100 • Percentage of patients with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period • Percentage of patients who received evidence-based smoking cessation services (e.g., medications)
#5 **Supporting Better Health in**	**Goal:** Support every U.S. community as it pursues its local health priorities

Communities	**Opportunities for success:** • Increase the provision of clinical preventive services for children and adults • Increase the adoption of evidence-based interventions to improve health **Illustrative measures:** • Percentage of children and adults screened for depression and receiving a documented follow-up plan • Percentage of adults screened for risky alcohol use and if positive, received brief counseling • Percentage of children and adults who use the oral health care system each year • Proportion of U.S. population served by community water systems with optimally fluoridated water
#6 Making Care More Affordable	**Goal:** Identify and apply measures that can serve as effective indicators of progress in reducing costs **Opportunities for success:** • Build cost and resource use measurement into payment reforms • Establish common measures to assess the cost impacts of new programs and payment systems • Reduce amount of health care spending that goes to administrative burden • Make costs and quality more transparent to consumers **Illustrative measures:** • To be developed

U.S. Department of
Health and Human Services
March 2011



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November 1, 2011

Hon. Fred Steen, Chairman
Hon. John Torbett, Co-Chairman
N.C. House Select Committee on
Certificate of Need and Related Hospital Issues
c/o Viddia Torbett, Committee Clerk
537 Legislative Office Building
N.C. House of Representatives
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Your Committee's October 20, 2011 Hearing in Fletcher, North Carolina

Dear Rep. Steen and Rep. Torbett:

You will recall that during your Committee's hearing on October 20, 2011 in Fletcher, North Carolina, a speaker in behalf of Park Ridge Hospital submitted the chart that I've attached as Exhibit 1 for your committee's consideration. According to that chart our client, Mission Hospital's inpatient "market share" in Western North Carolina increased by 15% during the period between 2005 and 2010; and on that basis, the Park Ridge spokesman argued that your Committee should further regulate Mission, in order to contain its too-rapid growth, etc.

In fact, however, the chart and data submitted to you by Park Ridge were erroneous. According to correct data for that 5-year period of time – as shown on Exhibit 2, also attached – Mission's inpatient market share in Western North Carolina increased by only 4.7% (from 37.7% in 2005 to 42.4% in 2010, or less than 1/3 of the 15% inpatient market share growth claimed by Park Ridge!).

The reasons for Park Ridge's misinformation and Mission's more modest growth during that 5-year period are set forth in greater detail in Mission's "rebuttal" documents attached hereto as Exhibit 3.

Finally, and of equal significance is the data set forth on Exhibit 4, attached hereto. As we indicated in our presentation to your Committee on October 20, outpatient treatment is rapidly increasing at many hospitals throughout Western North Carolina (and indeed, nationwide), as efforts are made by hospitals to avoid the greater costs associated with inpatient care.

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In that regard, you will note on Exhibit 4 that Mission's outpatient market share increased by 2.4% between 2005 and 2010, and during that same period Park Ridge's outpatient market share increased by 142.1%.

Unlike Park Ridge, however, we do not contend that their rapid growth in outpatient market share is a cause for concern, or increased regulation by the State. Rather, we believe that their growth – and Mission's – are functions of the free market and competition and should be resolved in that manner, not by more government regulation.

I am enclosing 25 copies of this letter and its enclosures, and request that they be distributed to all members of your Committee for their consideration.

Thanks for your good work on this important subject; and please don't hesitate to contact me at your convenience if you have any questions about these enclosures, or the data contained therein.

Best regards.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Richard A. Vinroot

RAV:mt
Enclosures

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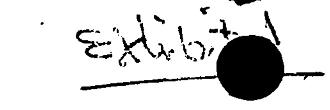


Mission Hospital County-Level Market Share over time in WNC

County	Patients (2009)	2005	2009	1st Half of 2010	Point Gain	% Gain
Buncombe	26,045	86.3%	89.6%	90.5%	4.2	5%
Henderson	12,740	22.1%	29.6%	36.4%	14.3	65%
Burke	10,548	5.3%	5.8%	5.8%	0.5	1%
Rutherford	8,613	5.9%	7.2%	7.2%	1.3	22%
Haywood	8,298	28.7%	33.5%	32.8%	4.1	14%
McDowell	5,131	31.5%	37.8%	35.8%	4.3	14%
Jackson	3,807	17.5%	27.3%	28.8%	11.3	65%
Macon	3,734	27.5%	29.3%	29.6%	1.8	7%
Transylvania	3,523	32.1%	34.6%	35.8%	3.7	12%
Cherokee	2,671	16.8%	18.5%	19.8%	1.0	5%
Swain	2,494	22.7%	26.8%	23.7%	1.0	4%
Yancey	2,329	45.5%	50.2%	49.5%	4.0	9%
Madison	2,172	88.9%	90.8%	91.2%	2.3	3%
Mitchell	2,138	27.4%	28.1%	29.6%	2.2	8%
Polk	1,790	11.9%	16.6%	18.0%	6.1	51%
Graham	1,116	22.3%	27.5%	29.2%	6.9	31%
Clay	916	20.8%	21.4%	21.6%	0.8	4%

15% Market Share Growth in WNC in the past 5 years

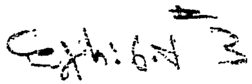
Thompson Reuters: Inpatient Data for North Carolina

Mission Hospitals | Carolina Hospitals | Other

State Inpatient PivotTable Report - Market Share by Hospital (Mission)
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))
Excludes Rehab Hospitals, Normal Newborns

	FY 2005	FY 2009	FY 2010	FY 2005	FY 2009	FY 2010	FY 2005	FY 2009	FY 2010	FY 2005 - FY 2010 Change
County	Total Mkt	Total Mkt	Total Mkt	Mission	Mission	Mission	Mkt Share	Mkt Share	Mkt Share	Point Gain/Loss
Avery County	1,980	1,721	1,679	147	145	130	7.4%	8.4%	7.7%	0.3%
Buncombe County	21,931	23,453	23,883	19,423	21,210	21,652	88.6%	90.4%	90.7%	2.1%
Burke County	10,714	10,067	9,357	588	595	580	5.5%	5.9%	6.2%	0.7%
Cherokee County	2,341	2,592	2,410	438	498	498	18.7%	19.2%	20.7%	2.0%
Clay County	737	840	813	150	182	184	20.4%	21.7%	22.6%	2.2%
Graham County	1,037	1,053	1,015	237	297	292	22.9%	28.2%	28.8%	5.9%
Haywood County	7,504	7,674	7,472	2,218	2,610	2,468	29.6%	34.0%	33.0%	3.5%
Henderson County	12,423	12,034	12,173	2,812	3,403	3,319	22.6%	28.3%	27.3%	4.0%
Jackson County	3,662	3,512	3,539	673	987	1,040	18.4%	28.1%	29.4%	11.0%
Macon County	3,198	3,393	3,391	872	1,075	1,061	27.3%	31.7%	31.3%	4.0%
Madison County	1,890	1,969	2,005	1,716	1,825	1,851	90.8%	92.7%	92.3%	1.5%
McDowell County	4,923	4,758	4,663	1,573	1,860	1,765	32.0%	39.1%	37.9%	5.9%
Mitchell County	2,083	2,051	2,111	584	570	622	28.0%	27.8%	29.5%	1.4%
Polk County	1,990	1,700	1,610	247	280	254	12.4%	16.5%	15.8%	3.4%
Rutherford County	8,058	7,962	8,490	486	612	671	6.0%	7.7%	7.9%	1.9%
Swain County	2,221	2,372	2,396	503	688	657	22.6%	29.0%	27.4%	4.8%
Transylvania County	3,235	3,406	3,589	1,048	1,190	1,220	32.4%	34.9%	34.0%	1.6%
Yancey County	2,051	2,152	2,140	953	1,081	1,074	46.5%	50.2%	50.2%	3.7%
Grand Total	91,978	92,709	92,736	34,668	39,108	39,338	37.7%	42.2%	42.4%	

State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))



Rebuttal to Erroneous Data on Market Share Presented by Jason Wells, Vice President of Park Ridge Health at 10/20/2011 Public Hearing

Overview

During a public hearing conducted by the North Carolina General Assembly House Select Committee on CON Process and Related Issues on October 20, 2011, Mr. Jason Wells, Vice President of Park Ridge Health presented certain data to the Committee and displayed a chart of market share trends for Mission Hospital. The data from this chart are in error and we respectfully request the corrections to these errors be included as part of the official record.

Data Set Errors

Attachment A is the data presented by Mr. Wells and attributed to Thompson Reuters: Inpatient Data for North Carolina. There are no corresponding notes as to whether proper exclusions (Psychiatry, Inpatient Rehabilitation, Long-term Care and Normal Newborns) were applied. Upon analysis, it appears that these exclusions were in fact not made in accordance with standard practice in the analysis of acute care market share.[1]

Attachment B is correspondence from Thompson Reuters dated August 16, 2011 describing significant discrepancies that resulted in the recent reissuance of 2010 data. In particular, Margaret Pardee Hospital incorrectly underreported its admissions from Henderson County by not submitting data in the first half of 2010 and again later in the year. The data supplied by Mr. Wells is from the flawed data set referenced in the correspondence.

Corrected Data Set and Mission Market Share

Attachment C is the market share and change for Mission Hospital drawn from the corrected database with proper exclusions. Comments by county are as follows:

> **Graham County** – Mission Hospital has been actively working to protect Graham County's only Primary Care practice from closing due to extraordinary financial challenges. Graham County is a rural county with high unemployment. Residents and practitioners began selecting Mission as their preferred hospital.
>
> **Haywood County** – In February 2008, Haywood Regional Hospital lost its Medicare Certification after repeated failures to achieve accreditation by CMS and The Joint Commission. As residents of Haywood County and their physicians lost access to the only acute care hospital in Haywood County, Mission Hospital began to have a significant influx of admissions, which have recently begun to decline as Haywood has come under a management agreement with Carolinas Health System.

1 Cecil G. Sheps Center for Health Services Research, University of North Carolina "Note: Discharges from Psychiatric, Rehabilitation, Long Term Care, and Substance Abuse Treatment Facilities are not included. Normal newborn discharges (DRG 795) excluded.

Henderson County - During the time period of 2005 to 2009, Henderson County residents and physicians increased their preference for Mission Hospital. As of 2010, this trend is changing as where Pardee's share of the market is increasing.

Jackson County - Jackson County and its only acute care Hospital, MedWest Harris, have experienced significant physician supply issues, especially in the surgical specialties. As a result, community members and referring physicians have chosen to utilize Mission. The majority of inpatient admissions increase from Jackson County to Mission relate directly to inpatient surgery

Mc Dowell County - Mission Hospital has experienced an increase in patients from McDowell County as the County has experienced physician shortage issues and the migration of several groups to the Grace Hospital staff. During this time, residents of Mc Dowell County and its physicians have chosen to seek services at Mission. Mission Hospital has undertaken successful recruiting to address physician shortages and expects to reverse this trend.

Mission's Inpatient Volume - For the past two years, Mission's patient volume has remained virtually constant reflecting increased competition and the decline of lower-level acuity admissions. Additionally, much of Mission's market share presence across the 18 county-area is ***due to services not offered by other regional providers such as Open-heart Surgery, Level II Trauma, Air Ambulance, Neonatal Intensive Care, Advanced Neurosurgery etc.***

Data Supplied on Hospital License Renewal Applications

Mr. Wells also attached selected statistics from the annual license renewals submitted to NC DHSR Licensure Section. He fails to include Outpatient Visits, a critical area of growth and competition. ***Attachment D*** details the visit volumes by provider for the 2005-2010 time periods and illustrates two key findings:

Mission's Outpatient Market Share of 27% is significantly lower than its corresponding acute care market share of 42.4%. During the five year time period, Mission's market share has grown 2.4%. Park Ridge has increased its market share of Outpatient Visits by 142% during the same time period. This increase includes a large ambulatory campus in Asheville treating orthopedic, sports and spine patients.

Conclusions

The data presented by Mr. Wells was inaccurate, and as a result, misleading. Mission has submitted corrected data and explained changes in market share due to loss of hospital accreditation, lack of primary care, loss of specialty physician, patient/physician preference and trends in the growing competitive arena of outpatient services.

Attachment A

Mission Hospital County-Level Market Share over time in WNC

County	Patients (2009)	2005	2009	1st Half of 2010	Point Gain	% Gain
Buncombe	26,045	86.3%	89.6%	90.5%	4.2	5%
Henderson	12,740	22.1%	29.6%	36.4%	14.3	65%
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Rutherford	8,613	5.9%	7.2%	7.2%	1.3	22%
Haywood	8,298	28.7%	33.5%	32.8%	4.1	14%
McDowell	5,131	31.5%	37.8%	35.8%	4.3	14%
Jackson	3,807	17.5%	27.3%	28.8%	11.3	65%
Macon	3,734	27.5%	29.3%	29.6%	1.8	7%
Transylvania	3,523	32.1%	34.6%	35.8%	3.7	12%
Cherokee	2,671	18.8%	18.5%	19.8%	1.0	5%
Swain	2,494	22.7%	25.8%	23.7%	1.0	4%
Yancey	2,329	45.5%	50.2%	49.5%	4.0	9%
Madison	2,172	88.9%	90.8%	91.2%	2.3	3%
Mitchell	2,138	27.4%	28.1%	29.6%	2.2	8%
Polk	1,790	11.9%	16.6%	18.0%	6.1	51%
Graham	1,116	22.3%	27.5%	29.2%	6.9	31%
Clay	916	20.8%	21.4%	21.6%	0.8	4%

Thompson Reuters: Inpatient Data for North Carolina

Mission Hospitals Carolina Hospitals Other

15% Market Share Growth in WNC in the past 5 years

Data supplied on hospital license renewal applications

Mission Hospital	2009	2010	2011
Total Beds	730	730	730
Total Admissions	37,221	38,104	38,559
ER Rooms	75	75	89
ER Visits	100,453	100,061	100,299
ER Admissions	18,122	19,554	20,421
OR Rooms	43	43	43
Endoscopy Rooms	6	6	6
Endoscopy Cases (GI)	7,064	6,741	6,563

ParkRidgeHealth	2009	2010	2011
Total Beds	103	103	103
Total Admissions	3,713	3,226	3,128
ER Rooms	12	12	12
ER Visits	16,191	17,409	19,486
ER Admissions	2,091	1,807	2,046
OR Rooms	6	6	6
Endoscopy Rooms	1	1	1
Endoscopy Cases (GI)	762	649	676

Pardee Hospital	2009	2010	2011
Total Beds	222	222	222
Total Admissions	6,649	6,369	6,557
ER Rooms	25	25	25
ER Visits	30,682	32,225	32,209
ER Admissions	5,606	5,837	5,695
OR Rooms	10	10	10
Endoscopy Rooms	3	3	3
Endoscopy Cases (GI)	3,891	3,344	2,444

Attachment B

From: Motter, Jamey (Professional)
Sent: Tuesday, August 16, 2011 9:00 AM
Subject: ATTENTION AND REPLY REQUIRED: Refresh for FY10 NC Statewide Databases

August 16, 2011

Dear NCHA Patient Data System Participant and Ad Hoc/Custom Database Recipient:

Due to the discrepancies identified by the State of North Carolina between information on their State of North Carolina Licensure Renewal Application and the inpatient submitted to the NCHA Patient Data System (NCHA PDS) database, the following hospitals' data have been updated for the fiscal year 2010. In the next week, Thomson Reuters will begin releasing the refreshed versions of the full fiscal year 2010 (October 1, 2009 – September 30, 2010) statewide North Carolina inpatient databases.

Hospital	Reason For Resubmission/Refresh
Albemarle Hospital	Resubmitted to include missing principal procedure codes
Beaufort County Hospital	Processed 231 INPATIENT claims not previously submitted for April – September 2010
Columbus Regional Healthcare System	Processed 219 INPATIENT claims not previously submitted
Johnston Memorial Hospital	Processed 708 INPATIENT claims not previously submitted
Lenoir Memorial Hospital	Processed 995 INPATIENT claims not previously submitted
Margaret R. Pardee Memorial Hospital	Processed 655 INPATIENT claims not previously submitted
Rutherford Hospital	Processed 14 INPATIENT claims not previously submitted
Sampson County Memorial Hospital	Processed 729 INPATIENT claims not previously submitted
Swain County Hospital	Omitted swing bed patients originally submitted incorrectly
Transylvania Regional Hospital	Processed 55 INPATIENT claims not previously submitted
WakeMed Rehabilitation Hospital	Corrected race and ethnicity codes
Washington County Hospital	Processed 91 INPATIENT claims not previously submitted for February and March 2010
Yadkin Valley Community Hospital	Processed 54 INPATIENT claims not previously submitted

As a recipient of this database, you are eligible to receive an updated version for FY10. **In order to receive a copy of the updated database, please reply to this email by next Tuesday, August 23rd. We will only produce a refreshed version of the database upon request.**

Please let us know of any questions concerning the refresh. We thank you for your time in assisting with the creation of a high quality statewide database.

Jamey Motter
Client Mgr

Thomson Reuters

Phone: 919-787-7160
Mobile: 919-612-6876
Fax: 303-804-2928
jamey.motter@thomsonreuters.com
thomsonreuters.com

Attachment C

State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))
Excludes Rehab Hospitals, Normal Newborns

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County	Total Mkt	Total Mkt	Total Mkt	Mission	Mission	Mission	Mkt Share	Mkt Share	Mkt Share	Point Gain/Loss	
Avery County	1,990	1,721	1,679	147	145	130	7.4%	8.4%	7.7%	0.3%	
Buncombe County	21,921	23,453	22,983	19,420	21,210	21,552	88.9%	90.4%	93.7%	2.1%	
Burke County	10,714	10,067	9,357	588	585	580	5.5%	5.8%	6.2%	0.7%	
Cherokee County	2,341	2,552	2,410	428	498	498	18.7%	19.2%	20.7%	2.0%	
Clay County	727	840	813	150	182	184	20.6%	21.7%	22.6%	2.3%	
Graham County	1,207	1,253	1,015	237	297	292	22.9%	23.2%	28.8%	5.9%	Mission rescues only primary care practice from closure
Haywood County	7,504	7,674	7,472	2,218	2,610	2,468	29.6%	34.0%	33.0%	3.5%	Share increase due to Haywood loss of Medicare, trend reversing with CHS mgmt arrangement
Henderson County	12,422	12,334	12,173	2,812	3,433	3,319	22.6%	28.0%	27.3%	4.6%	Share declining
Jackson County	3,602	3,512	3,529	670	987	1,040	18.6%	28.1%	29.6%	11.0%	Share increase due to loss of surgical coverage at Med-West harris
Macon County	3,198	3,380	3,391	872	1,075	1,061	27.3%	31.7%	31.3%	4.0%	
Madison County	1,990	1,967	2,005	1,716	1,825	1,851	90.8%	92.7%	92.3%	1.5%	
McDowell County	4,920	4,753	4,683	1,573	1,900	1,765	32.0%	39.1%	37.9%	5.9%	Cases shifting with locations within Mission Health System, not loss to Grace
Mitchell County	2,083	2,051	2,111	584	570	622	28.0%	27.8%	29.5%	1.4%	
Polk County	1,993	1,700	1,610	247	280	254	12.4%	16.5%	15.8%	3.4%	Share declining since CHS mgmt arrangement
Rutherford County	8,058	7,902	8,450	485	612	671	6.0%	7.7%	7.9%	1.9%	
Swain County	2,221	2,372	2,396	502	688	657	22.6%	29.0%	27.4%	4.8%	Share declining since CHS mgmt arrangement
Transylvania County	3,225	3,406	3,589	1,048	1,190	1,220	32.4%	34.9%	34.0%	1.6%	Transylvania converts to critical access, census capped at 25
Yancey County	2,351	2,152	2,140	953	1,081	1,074	26.5%	50.2%	50.2%	2.7%	
Grand Total	91,975	92,709	92,736	34,660	33,125	35,333	37.7%	42.2%	42.6%		Market cases not growing w population growth, higher % of tertiary

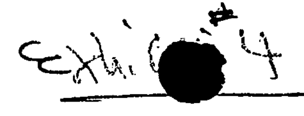
State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))

Attachment D

OP Visit Data For WNC Hospitals 2005 -2010

Source: NCDHSR Licensure Section

Hospital	2005 Visits	2005 Mkt Share	2010 Visits	2010 Mkt Share	2005-2010 % Change
Mission Hospital	227,648	26.6%	274,565	27.2%	2.4%
MedWest-Haywood	81,412	9.5%	107,269	10.6%	11.8%
Margaret R. Pardee Memorial	93,940	11.0%	97,366	9.6%	-12.0%
Park Ridge Hospital	26,940	3.1%	76,853	7.6%	142.1%
MedWest-Harris Regional	41,152	4.8%	59,784	5.9%	23.3%
Blue Ridge Regional Hospital	37,666	4.4%	50,625	5.0%	14.1%
Angel Community Hospital	40,839	4.8%	50,202	5.0%	4.3%
Rutherford Hospital	48,868	5.7%	49,884	4.9%	-13.4%
Murphy Medical Center	61,819	7.2%	49,735	4.9%	-31.7%
Valdese Hospital	31,516	3.7%	43,341	4.3%	16.7%
Grace Hospital	48,602	5.7%	43,331	4.3%	-24.3%
The McDowell Hospital	56,691	6.6%	42,564	4.2%	-36.3%
Transylvania Community Hospital	23,639	2.8%	35,862	3.6%	28.8%
St. Luke's Hospital	12,723	1.5%	14,243	1.4%	-5.0%
MedWest-Swain County Hospital	11,447	1.3%	9,670	1.0%	-28.3%
Highland-Cashiers Hospital	12,235	1.4%	4,647	0.5%	-67.8%
Total	857,137		1,009,941		17.8%



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Total	857,137		1,009,941		17.8%

Richard A. Vinroot
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rbh.com

November 2, 2011

Hon. Fred Steen, Chairman
Hon. John Torbett, Co-Chairman
N.C. House Select Committee on
Certificate of Need and Related Hospital Issues
c/o Viddia Torbett, Committee Clerk
537 Legislative Office Building
N.C. House of Representatives
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Your Committee's October 20, 2011 and November 1, 2011 Hearings in Fletcher and Mt. Holly, North Carolina, respectively

Dear Rep. Steen and Rep. Torbett:

Thank you for permitting me to speak briefly to your Committee last night in Mt. Holly in our client, Mission Health System's behalf. I did so in response to two speakers from Park Ridge Hospital, who essentially argued (as Park Ridge has before) that Mission should be subjected to "more COPA regulation," not less. My response (as it has been before) is, essentially, that (a) Mission is now the most-regulated hospital in North Carolina and the United States, (b) it has complied strictly with all of the State's requirements since its COPA agreement was approved by the State in 1996, and (c) as a result of the dramatically changed healthcare market conditions in Western North Carolina (and indeed, nationally), the time has come for the COPA agreement to end, thus permitting Mission to freely compete without the added restrictions imposed by the COPA. Mission expects to consult soon with the State regulatory agencies about a schedule and procedure for accomplishing this.

A full explanation of Mission's position is set forth in the white notebook we delivered to your Committee at your October 20, 2011 hearing in Fletcher, North Carolina. In addition, I also delivered a letter with enclosures to your Committee at your hearing in Mt. Holly last night (*i.e.*, in which I discussed misstatements made by Park Ridge concerning Mission's in-patient market share growth in their presentation in Fletcher), which is self-explanatory. I commend both to your Committee for further consideration in Mission's behalf.

Finally, when I spoke to you last night, I referred to a recent letter to your Committee from former State Senator Jack Stevens, in support of Mission's contention that the time has come for Mission's COPA agreement to end. As Chairman of Mission's board at the time the

---

COPA was initiated, former chairman of the board of the UNC Health Care System in Chapel Hill, and one who is quite knowledgeable and concerned about the healthcare needs of citizens throughout Western North Carolina, Jack speaks with considerable authority on this subject. Accordingly, I am enclosing herewith a copy of his October 18, 2011 letter for your consideration as well. In addition, I encourage you to review the further letters and commentary in support of Mission's position that we delivered to Shawn Parker yesterday.

As with my earlier correspondence, I'm enclosing 25 copies of this letter and its enclosure, and request that they be distributed to all members of your Committee for their consideration.

Best regards, and please contact me at your convenience if you have any other questions about this matter, and our contentions in Mission's behalf.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Richard A. Vinroot

RAV:mt
Enclosures

JOHN S. STEVENS
POST OFFICE BOX 7647 – ASHEVILLE, NORTH CAROLINA 28802

October 18, 2011

To: House Select Committee on the Certificates of Need Process
and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years on the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously complied with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived its usefulness and is it an impediment to the ability of Mission to continue as a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reasons no longer exist. There are now other large, well financed health care systems serving in Western North Carolina. When Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there are Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to

be freed from COPA restrictions to be able to compete. Mission is being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

John S. Stevens

R&S 878733-1

I. Committee Authorization, Powers , and Duties

1. Appointed by letter- requires a Q of 6 members be established prior to taking official action
2. Authorized to meet in the interim or between sessions
3. Meet in Raleigh or with approval elsewhere (public hearing)
4. Deemed a committee of the House
    a. Permanent House rules apply
    b. Limitation to matters contained in the authorization
5. Powers under Articles 5 and 5A
    a. Compel state agencies to provide all information and data in their possession or attainable from their records
    b. Call witnesses and compel testimony (under oath)
        i. Process for the committee to subpoena a witness if warranted

II. Matters properly before the committee:

1. Review concepts and provisions as provided in House Bill 743 and 812
    a. H743- Requires all rules, policies, and need determinations in the State Medical Facilities Plan apply equally to particular types of health services.
    b. H812 requires any hospital authority engaging in activities outside its territorial boundary obtain a Certificate of Public Advantage
2. Study the provisions of law relating to Certificate of Need
3. Roles of state-owned and publically owned hospitals and public hospital authorities to operate beyond the boundaries
4. Issues related inconsistencies in rules, policies, and limitations within each county that a hospital with a COPA operates
5. Business relationships among and between publically owned hospitals and entities that are operating under a CON or COPA.
6. Other matters reasonably related.

III. Reports required

1. Interim report is authorized to be submitted on or before May 1, 2012
2. Final report required by the convening of the 2013 General Assembly- Committee terminates upon filing.

Robinson Bradshaw

Richard A. Vinroot
Charlotte Office
704.377.8328 Direct Phone
704.373.3928 Direct Fax
rvinroot@rbh.com
rbh.com

November 2, 2011

Hon. Fred Steen, Chairman
Hon. John Torbett, Co-Chairman
N.C. House Select Committee on
Certificate of Need and Related Hospital Issues
c/o Viddia Torbett, Committee Clerk
537 Legislative Office Building
N.C. House of Representatives
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Your Committee's October 20, 2011 and November 1, 2011 Hearings in Fletcher and Mt. Holly, North Carolina, respectively

Dear Rep. Steen and Rep. Torbett:

Thank you for permitting me to speak briefly to your Committee last night in Mt. Holly in our client, Mission Health System's behalf. I did so in response to two speakers from Park Ridge Hospital, who essentially argued (as Park Ridge has before) that Mission should be subjected to "more COPA regulation," not less. My response (as it has been before) is, essentially, that (a) Mission is now the most-regulated hospital in North Carolina and the United States, (b) it has complied strictly with all of the State's requirements since its COPA agreement was approved by the State in 1996, and (c) as a result of the dramatically changed healthcare market conditions in Western North Carolina (and indeed, nationally), the time has come for the COPA agreement to end, thus permitting Mission to freely compete without the added restrictions imposed by the COPA. Mission expects to consult soon with the State regulatory agencies about a schedule and procedure for accomplishing this.

A full explanation of Mission's position is set forth in the white notebook we delivered to your Committee at your October 20, 2011 hearing in Fletcher, North Carolina. In addition, I also delivered a letter with enclosures to your Committee at your hearing in Mt. Holly last night (*i.e.*, in which I discussed misstatements made by Park Ridge concerning Mission's in-patient market share growth in their presentation in Fletcher), which is self-explanatory. I commend both to your Committee for further consideration in Mission's behalf.

Finally, when I spoke to you last night, I referred to a recent letter to your Committee from former State Senator Jack Stevens, in support of Mission's contention that the time has come for Mission's COPA agreement to end. As Chairman of Mission's board at the time the

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COPA was initiated, former chairman of the board of the UNC Health Care System in Chapel Hill, and one who is quite knowledgeable and concerned about the healthcare needs of citizens throughout Western North Carolina, Jack speaks with considerable authority on this subject. Accordingly, I am enclosing herewith a copy of his October 18, 2011 letter for your consideration as well. In addition, I encourage you to review the further letters and commentary in support of Mission's position that we delivered to Shawn Parker yesterday.

As with my earlier correspondence, I'm enclosing 25 copies of this letter and its enclosure, and request that they be distributed to all members of your Committee for their consideration.

Best regards, and please contact me at your convenience if you have any other questions about this matter, and our contentions in Mission's behalf.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Richard A. Vinroot

RAV:mt
Enclosures

JOHN S. STEVENS

POST OFFICE BOX 7647 – ASHEVILLE, NORTH CAROLINA 28802

October 18, 2011

To: House Select Committee on the Certificates of Need Process
and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years on the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously complied with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived its usefulness and is it an impediment to the ability of Mission to continue as a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reasons no longer exist. There are now other large, well financed health care systems serving in Western North Carolina. When Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there are Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to

be freed from COPA restrictions to be able to compete. Mission is being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

John S. Stevens

R&S 878733-1

Additional materials submitted to the Committee on behalf of Mission Health System, by Richard A. Vinroot, Esq. contains the following:

- 11/01/11 letter with enclosures to the Committee based on information presented by Park Ridge Hospital at the 10/20/11 hearing related to market growth.
- 11/02/11 letter with enclosure to the Committee supplementing comments made by Mr. Vinroot in Mt. Holly and a letter from former State Senator Jack Stevens
- 11/01/11 email from Everett Bowman to Committee staff including comments from people unable to speak at the Fletcher hearing
- 11/15/11 email from Everett Bowman to Committee staff with attached letter from the Ahseville Pediatrics Association
- Three (3) news articles from the Asheville Citizen times concerning the dispute between Mission and Park Ridge.

Richard A. Vinroot
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November 1, 2011

Hon. Fred Steen, Chairman
Hon. John Torbett, Co-Chairman
N.C. House Select Committee on
Certificate of Need and Related Hospital Issues
c/o Viddia Torbett, Committee Clerk
537 Legislative Office Building
N.C. House of Representatives
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Your Committee's October 20, 2011 Hearing in Fletcher, North Carolina

Dear Rep. Steen and Rep. Torbett:

You will recall that during your Committee's hearing on October 20, 2011 in Fletcher, North Carolina, a speaker in behalf of Park Ridge Hospital submitted the chart that I've attached as Exhibit 1 for your committee's consideration. According to that chart our client, Mission Hospital's inpatient "market share" in Western North Carolina increased by 15% during the period between 2005 and 2010; and on that basis, the Park Ridge spokesman argued that your Committee should further regulate Mission, in order to contain its too-rapid growth, etc.

In fact, however, the chart and data submitted to you by Park Ridge were erroneous. According to correct data for that 5-year period of time – as shown on Exhibit 2, also attached – Mission's inpatient market share in Western North Carolina increased by only 4.7% (from 37.7% in 2005 to 42.4% in 2010, or less than 1/3 of the 15% inpatient market share growth claimed by Park Ridge!).

The reasons for Park Ridge's misinformation and Mission's more modest growth during that 5-year period are set forth in greater detail in Mission's "rebuttal" documents attached hereto as Exhibit 3.

Finally, and of equal significance is the data set forth on Exhibit 4, attached hereto. As we indicated in our presentation to your Committee on October 20, outpatient treatment is rapidly increasing at many hospitals throughout Western North Carolina (and indeed, nationwide), as efforts are made by hospitals to avoid the greater costs associated with inpatient care.

3084241v1

In that regard, you will note on Exhibit 4 that Mission's outpatient market share increased by 2.4% between 2005 and 2010, and during that same period Park Ridge's outpatient market share increased by 142.1%.

Unlike Park Ridge, however, we do not contend that their rapid growth in outpatient market share is a cause for concern, or increased regulation by the State. Rather, we believe that their growth – and Mission's – are functions of the free market and competition and should be resolved in that manner, not by more government regulation.

I am enclosing 25 copies of this letter and its enclosures, and request that they be distributed to all members of your Committee for their consideration.

Thanks for your good work on this important subject; and please don't hesitate to contact me at your convenience if you have any questions about these enclosures, or the data contained therein.

Best regards.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Richard A. Vinroot

RAV:mt
Enclosures

Exhibit 1

Mission Hospital County-Level Market Share over time in WNC

County	Patients (2009)	2005	2009	1st Half of 2010	Point Gain	% Gain
Buncombe	26,045	86.3%	89.6%	90.5%	4.2	5%
Henderson	12,740	22.1%	29.6%	36.4%	14.3	65%
Burke	10,548	5.3%	5.8%	5.8%	0.5	1%
Rutherford	8,613	5.9%	7.2%	7.2%	1.3	22%
Haywood	8,298	28.7%	33.5%	32.8%	4.1	14%
McDowell	5,131	31.5%	37.8%	35.8%	4.3	14%
Jackson	3,807	17.5%	27.3%	28.8%	11.3	65%
Macon	3,734	27.5%	29.3%	29.6%	1.8	7%
Transylvania	3,523	32.1%	34.6%	35.8%	3.7	12%
Cherokee	2,671	18.8%	18.5%	19.8%	1.0	5%
Swain	2,494	22.7%	26.8%	23.7%	1.0	4%
Yancey	2,329	45.5%	50.2%	49.5%	4.0	9%
Madison	2,172	88.9%	90.8%	91.2%	2.3	3%
Mitchell	2,138	27.4%	28.1%	29.6%	2.2	8%
Polk	1,790	11.9%	16.6%	18.0%	6.1	51%
Graham	1,116	22.3%	27.5%	29.2%	6.9	31%
Clay	916	20.8%	21.4%	21.6%	0.8	4%

Thompson Reuters: Inpatient Data for North Carolina

Mission Hospitals | Carolina Hospitals | Other

15% Market Share Growth in WNC in the past 5 years

Exhibit #2

State Inpatient PivotTable Report - Market Share by Hospital (Mission)
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))
Excludes Rehab Hospitals, Normal Newborns

	FY 2005	FY 2009	FY 2010	FY 2005	FY 2009	FY 2010	FY 2005	FY 2009	FY 2010	FY 2005 - FY 2010 Change
County	Total Mkt	Total Mkt	Total Mkt	Mission	Mission	Mission	Mkt Share	Mkt Share	Mkt Share	Point Gain/Loss
Avery County	1,980	1,721	1,679	147	145	130	7.4%	8.4%	7.7%	0.3%
Buncombe County	21,931	23,453	23,883	19,423	21,210	21,652	88.6%	90.4%	90.7%	2.1%
Burke County	10,714	10,067	9,357	588	595	580	5.5%	5.9%	6.2%	0.7%
Cherokee County	2,341	2,592	2,410	438	498	498	18.7%	19.2%	20.7%	2.0%
Clay County	737	840	813	150	182	184	20.4%	21.7%	22.6%	2.2%
Graham County	1,037	1,053	1,015	237	297	292	22.9%	28.2%	28.8%	5.9%
Haywood County	7,504	7,674	7,472	2,218	2,610	2,468	29.6%	34.0%	33.0%	3.5%
Henderson County	12,423	12,034	12,173	2,812	3,403	3,319	22.6%	28.3%	27.3%	4.6%
Jackson County	3,662	3,512	3,539	673	987	1,040	18.4%	28.1%	29.4%	11.0%
Macon County	3,198	3,393	3,391	872	1,075	1,061	27.3%	31.7%	31.2%	4.0%
Madison County	1,890	1,969	2,005	1,716	1,825	1,851	90.8%	92.7%	92.3%	1.5%
McDowell County	4,923	4,758	4,663	1,573	1,860	1,765	32.0%	39.1%	37.9%	5.9%
Mitchell County	2,083	2,051	2,111	584	570	622	28.0%	27.8%	29.5%	1.4%
Polk County	1,990	1,700	1,610	247	280	254	12.4%	16.5%	15.8%	3.4%
Rutherford County	8,058	7,962	8,490	486	612	671	6.0%	7.7%	7.9%	1.9%
Swain County	2,221	2,372	2,396	503	688	657	22.6%	29.0%	27.4%	4.8%
Transylvania County	3,235	3,406	3,589	1,048	1,190	1,220	32.4%	34.9%	34.0%	1.6%
Yancey County	2,051	2,152	2,140	953	1,081	1,074	46.5%	50.2%	50.2%	3.7%
Grand Total	91,978	92,709	92,736	34,665	39,105	39,336	37.7%	42.2%	42.4%	

State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))

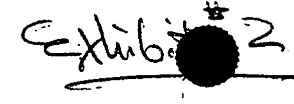

Exhibit 3

Rebuttal to Erroneous Data on Market Share Presented by Jason Wells, Vice President of Park Ridge Health at 10/20/2011 Public Hearing

Overview

During a public hearing conducted by the North Carolina General Assembly House Select Committee on CON Process and Related Issues on October 20, 2011, Mr. Jason Wells, Vice President of Park Ridge Health presented certain data to the Committee and displayed a chart of market share trends for Mission Hospital. The data from this chart are in error and we respectfully request the corrections to these errors be included as part of the official record.

Data Set Errors

Attachment A is the data presented by Mr. Wells and attributed to Thompson Reuters: Inpatient Data for North Carolina. There are no corresponding notes as to whether proper exclusions (Psychiatry, Inpatient Rehabilitation, Long-term Care and Normal Newborns) were applied. Upon analysis, it appears that these exclusions were in fact not made in accordance with standard practice in the analysis of acute care market share.[1]

Attachment B is correspondence from Thompson Reuters dated August 16, 2011 describing significant discrepancies that resulted in the recent reissuance of 2010 data. In particular, Margaret Pardee Hospital incorrectly underreported its admissions from Henderson County by not submitting data in the first half of 2010 and again later in the year. The data supplied by Mr. Wells is from the flawed data set referenced in the correspondence.

Corrected Data Set and Mission Market Share

Attachment C is the market share and change for Mission Hospital drawn from the corrected database with proper exclusions. Comments by county are as follows:

> **Graham County** – Mission Hospital has been actively working to protect Graham County's only Primary Care practice from closing due to extraordinary financial challenges. Graham County is a rural county with high unemployment. Residents and practitioners began selecting Mission as their preferred hospital.
>
> **Haywood County** – In February 2008, Haywood Regional Hospital lost its Medicare Certification after repeated failures to achieve accreditation by CMS and The Joint Commission. As residents of Haywood County and their physicians lost access to the only acute care hospital in Haywood County, Mission Hospital began to have a significant influx of admissions, which have recently begun to decline as Haywood has come under a management agreement with Carolinas Health System.

1 Cecil G. Sheps Center for Health Services Research, University of North Carolina "Note: Discharges from Psychiatric, Rehabilitation, Long Term Care, and Substance Abuse Treatment Facilities are not included. Normal newborn discharges (DRG 795) excluded.

Henderson County - During the time period of 2005 to 2009, Henderson County residents and physicians increased their preference for Mission Hospital. As of 2010, this trend is changing as where Pardee's share of the market is increasing.

Jackson County - Jackson County and its only acute care Hospital, MedWest Harris, have experienced significant physician supply issues, especially in the surgical specialties. As a result, community members and referring physicians have chosen to utilize Mission. The majority of inpatient admissions increase from Jackson County to Mission relate directly to inpatient surgery

Mc Dowell County - Mission Hospital has experienced an increase in patients from McDowell County as the County has experienced physician shortage issues and the migration of several groups to the Grace Hospital staff. During this time, residents of Mc Dowell County and its physicians have chosen to seek services at Mission. Mission Hospital has undertaken successful recruiting to address physician shortages and expects to reverse this trend.

Mission's Inpatient Volume - For the past two years, Mission's patient volume has remained virtually constant reflecting increased competition and the decline of lower-level acuity admissions. Additionally, much of Mission's market share presence across the 18 county-area is ***due to services not offered by other regional providers such as Open-heart Surgery, Level II Trauma, Air Ambulance, Neonatal Intensive Care, Advanced Neurosurgery etc.***

Data Supplied on Hospital License Renewal Applications

Mr. Wells also attached selected statistics from the annual license renewals submitted to NC DHSR Licensure Section. He fails to include Outpatient Visits, a critical area of growth and competition. ***Attachment D*** details the visit volumes by provider for the 2005-2010 time periods and illustrates two key findings:

Mission's Outpatient Market Share of 27% is significantly lower than its corresponding acute care market share of 42.4%. During the five year time period, Mission's market share has grown 2.4%. Park Ridge has increased its market share of Outpatient Visits by 142% during the same time period. This increase includes a large ambulatory campus in Asheville treating orthopedic, sports and spine patients.

Conclusions

The data presented by Mr. Wells was inaccurate, and as a result, misleading. Mission has submitted corrected data and explained changes in market share due to loss of hospital accreditation, lack of primary care, loss of specialty physician, patient/physician preference and trends in the growing competitive arena of outpatient services.

Attachment A

Mission Hospital County-Level Market Share over time in WNC

County	Patients (2009)	2005	2009	1st Half of 2010	Point Gain	% Gain
Buncombe	26,045	86.3%	89.6%	90.5%	4.2	5%
Henderson	12,740	22.1%	29.6%	36.4%	14.3	65%
Burke	10,548	5.3%	5.8%	5.8%	0.5	1%
Rutherford	8,613	5.9%	7.2%	7.2%	1.3	22%
Haywood	8,298	28.7%	33.5%	32.8%	4.1	14%
McDowell	5,131	31.5%	37.8%	35.8%	4.3	14%
Jackson	3,807	17.5%	27.3%	28.8%	11.3	65%
Macon	3,734	27.5%	29.3%	29.6%	1.8	7%
Transylvania	3,523	32.1%	34.6%	35.8%	3.7	12%
Cherokee	2,671	18.8%	18.5%	19.8%	1.0	5%
Swain	2,494	22.7%	26.8%	23.7%	1.0	4%
Yancey	2,329	45.5%	50.2%	49.5%	4.0	9%
Madison	2,172	88.9%	90.8%	91.2%	2.3	3%
Mitchell	2,138	27.4%	28.1%	29.6%	2.2	8%
Polk	1,790	11.9%	16.6%	18.0%	6.1	51%
Graham	1,116	22.3%	27.5%	29.2%	6.9	31%
Clay	916	20.8%	21.4%	21.6%	0.8	4%

Thompson Reuters: Inpatient Data for North Carolina

Mission Hospitals | Carolina Hospitals | Other

15%
Market Share Growth in WNC in the past 5 years

Data supplied on hospital license renewal applications

Mission Hospital	2009	2010	2011
Total Beds	730	730	730
Total Admissions	37,221	38,104	38,559
ER Rooms	75	75	89
ER Visits	100,453	100,061	100,299
ER Admissions	18,122	19,554	20,421
OR Rooms	43	43	43
Endoscopy Rooms	6	6	6
Endoscopy Cases (GI)	7,064	6,741	6,563

ParkRidgeHealth	2009	2010	2011
Total Beds	103	103	103
Total Admissions	3,713	3,226	3,128
ER Rooms	12	12	12
ER Visits	16,191	17,409	19,486
ER Admissions	2,091	1,807	2,046
OR Rooms	6	6	6
Endoscopy Rooms	1	1	1
Endoscopy Cases (GI)	762	649	676

Pardee Hospital	2009	2010	2011
Total Beds	222	222	222
Total Admissions	6,649	6,369	6,557
ER Rooms	25	25	25
ER Visits	30,682	32,225	32,209
ER Admissions	5,606	5,837	5,695
OR Rooms	10	10	10
Endoscopy Rooms	3	3	3
Endoscopy Cases (GI)	3,891	3,344	2,444

Attachment B

From: Motter, Jamey (Professional)
Sent: Tuesday, August 16, 2011 9:00 AM
Subject: ATTENTION AND REPLY REQUIRED: Refresh for FY10 NC Statewide Databases

August 16, 2011

Dear NCHA Patient Data System Participant and Ad Hoc/Custom Database Recipient:

Due to the discrepancies identified by the State of North Carolina between information on their State of North Carolina Licensure Renewal Application and the inpatient submitted to the NCHA Patient Data System (NCHA PDS) database, the following hospitals' data have been updated for the fiscal year 2010. In the next week, Thomson Reuters will begin releasing the refreshed versions of the full fiscal year 2010 (October 1, 2009 – September 30, 2010) statewide North Carolina inpatient databases.

Hospital	Reason For Resubmission/Refresh
Albemarle Hospital	Resubmitted to include missing principal procedure codes
Beaufort County Hospital	Processed 231 INPATIENT claims not previously submitted for April – September 2010
Columbus Regional Healthcare System	Processed 219 INPATIENT claims not previously submitted
Johnston Memorial Hospital	Processed 708 INPATIENT claims not previously submitted
Lenoir Memorial Hospital	Processed 995 INPATIENT claims not previously submitted
Margaret R. Pardee Memorial Hospital	Processed 655 INPATIENT claims not previously submitted
Rutherford Hospital	Processed 14 INPATIENT claims not previously submitted
Sampson County Memorial Hospital	Processed 729 INPATIENT claims not previously submitted
Swain County Hospital	Omitted swing bed patients originally submitted incorrectly
Transylvania Regional Hospital	Processed 55 INPATIENT claims not previously submitted
WakeMed Rehabilitation Hospital	Corrected race and ethnicity codes
Washington County Hospital	Processed 91 INPATIENT claims not previously submitted for February and March 2010
Yadkin Valley Community Hospital	Processed 54 INPATIENT claims not previously submitted

As a recipient of this database, you are eligible to receive an updated version for FY10. **In order to receive a copy of the updated database, please reply to this email by next Tuesday, August 23rd. We will only produce a refreshed version of the database upon request.**

Please let us know of any questions concerning the refresh. We thank you for your time in assisting with the creation of a high quality statewide database.

Jamey Motter
Client Mgr

Thomson Reuters

Phone: 919-787-7160
Mobile: 919-612-6876
Fax: 303-804-2928
jamey.motter@thomsonreuters.com
thomsonreuters.com

Attachment C

State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))
Excludes Rehab Hospitals, Normal Newborns

County	Total Mkt	Total Mkt	Total Mkt	Mission	Mission	Mission	Mkt Share	Mkt Share	Mkt Share	Point Gain/Loss	
Avery County	1,980	1,721	1,679	147	145	130	7.4%	8.4%	7.7%	0.3%	
Buncombe County	21,931	23,453	23,882	19,422	21,210	21,652	88.5%	90.4%	90.7%	2.1%	
Burke County	10,714	10,087	9,357	588	595	580	5.5%	5.9%	6.2%	0.7%	
Cherokee County	2,341	2,592	2,410	432	498	498	18.7%	19.2%	20.7%	2.0%	
Clay County	737	840	813	150	182	184	20.4%	21.7%	22.6%	2.2%	
Graham County	1,337	1,053	1,015	237	297	292	22.9%	28.2%	28.8%	5.9%	Mission rescues only primary care practice from closure
Haywood County	7,504	7,674	7,472	2,218	2,610	2,468	29.6%	34.0%	33.0%	3.5%	Share increase due to Haywood loss of Medicare, trend reversing with CHS mgmt arrangement
Henderson County	12,422	12,034	12,173	2,812	3,403	3,319	22.6%	28.3%	27.2%	4.6%	Share declining
Jackson County	3,662	3,512	3,539	673	987	1,040	18.4%	28.1%	29.4%	11.0%	Share increase due to loss of surgical coverage at Med-West harris
Macon County	3,198	3,393	3,391	872	1,075	1,061	27.3%	31.7%	31.3%	4.0%	
Madison County	1,890	1,969	2,005	1,716	1,825	1,851	90.8%	92.7%	92.3%	1.5%	
McDowell County	4,923	4,758	4,663	1,573	1,860	1,765	32.0%	39.1%	37.9%	5.9%	Cases shifting with locations within Mission Health System, net loss to Grace
Mitchell County	2,083	2,051	2,111	584	570	622	28.0%	27.8%	29.5%	1.4%	
Polk County	1,990	1,700	1,610	247	280	254	12.4%	16.5%	15.8%	3.4%	Share declining since CHS mgmt arragement
Rutherford County	8,058	7,962	8,490	486	612	671	6.0%	7.7%	7.9%	1.9%	
Swain County	2,221	2,372	2,396	503	688	657	22.6%	29.0%	27.4%	4.8%	Share declining since CHS mgmt arragement
Transylvania County	3,225	3,406	3,589	1,048	1,190	1,220	32.4%	34.9%	34.0%	1.6%	Transylvania converts to critical access, census capped at 25
Yancey County	2,051	2,152	2,140	953	1,081	1,074	46.5%	50.2%	50.2%	3.7%	
Grand Total	91,978	92,709	92,736	34,665	39,103	39,336	37.7%	42.2%	42.4%		Market cases not growing w population growth, higher % of tertiary

State Inpatient PivotTable Report - Market Share by Hospital
Database: Inpatient NC (DRG (2005) MS-DRG (2009-2010))

Attachment D

OP Visit Data For WNC Hospitals 2005 -2010

Source: NCDHSR Licensure Section

Hospital	2005 Visits	2005 Mkt Share	2010 Visits	2010 Mkt Share	2005-2010 % Change
Mission Hospital	227,648	26.6%	274,565	27.2%	2.4%
MedWest-Haywood	81,412	9.5%	107,269	10.6%	11.8%
Margaret R. Pardee Memorial	93,940	11.0%	97,366	9.6%	-12.0%
Park Ridge Hospital	26,940	3.1%	76,853	7.6%	142.1%
MedWest-Harris Regional	41,152	4.8%	59,784	5.9%	23.3%
Blue Ridge Regional Hospital	37,666	4.4%	50,625	5.0%	14.1%
Angel Community Hospital	40,839	4.8%	50,202	5.0%	4.3%
Rutherford Hospital	48,868	5.7%	49,884	4.9%	-13.4%
Murphy Medical Center	61,819	7.2%	49,735	4.9%	-31.7%
Valdese Hospital	31,516	3.7%	43,341	4.3%	16.7%
Grace Hospital	48,602	5.7%	43,331	4.3%	-24.3%
The McDowell Hospital	56,691	6.6%	42,564	4.2%	-36.3%
Transylvania Community Hospital	23,639	2.8%	35,862	3.6%	28.8%
St. Luke's Hospital	12,723	1.5%	14,243	1.4%	-5.0%
MedWest-Swain County Hospital	11,447	1.3%	9,670	1.0%	-28.3%
Highland-Cashiers Hospital	12,235	1.4%	4,647	0.5%	-67.8%
Total	857,137		1,009,941		17.8%

Exhibit #4

(continued)

OP Visit Data For WNC Hospitals 2005 -2010

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Robinson
Bradshaw

Richard A. Vinroot
Charlotte Office
704.377.8328 Direct Phone
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rvinroot@rbh.com
rbh.com

November 2, 2011

Hon. Fred Steen, Chairman
Hon. John Torbett, Co-Chairman
N.C. House Select Committee on
Certificate of Need and Related Hospital Issues
c/o Viddia Torbett, Committee Clerk
537 Legislative Office Building
N.C. House of Representatives
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Your Committee's October 20, 2011 and November 1, 2011 Hearings in Fletcher and Mt. Holly, North Carolina, respectively

Dear Rep. Steen and Rep. Torbett:

Thank you for permitting me to speak briefly to your Committee last night in Mt. Holly in our client, Mission Health System's behalf. I did so in response to two speakers from Park Ridge Hospital, who essentially argued (as Park Ridge has before) that Mission should be subjected to "more COPA regulation," not less. My response (as it has been before) is, essentially, that (a) Mission is now the most-regulated hospital in North Carolina and the United States, (b) it has complied strictly with all of the State's requirements since its COPA agreement was approved by the State in 1996, and (c) as a result of the dramatically changed healthcare market conditions in Western North Carolina (and indeed, nationally), the time has come for the COPA agreement to end, thus permitting Mission to freely compete without the added restrictions imposed by the COPA. Mission expects to consult soon with the State regulatory agencies about a schedule and procedure for accomplishing this.

A full explanation of Mission's position is set forth in the white notebook we delivered to your Committee at your October 20, 2011 hearing in Fletcher, North Carolina. In addition, I also delivered a letter with enclosures to your Committee at your hearing in Mt. Holly last night (*i.e.*, in which I discussed misstatements made by Park Ridge concerning Mission's in-patient market share growth in their presentation in Fletcher), which is self-explanatory. I commend both to your Committee for further consideration in Mission's behalf.

Finally, when I spoke to you last night, I referred to a recent letter to your Committee from former State Senator Jack Stevens, in support of Mission's contention that the time has come for Mission's COPA agreement to end. As Chairman of Mission's board at the time the

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COPA was initiated, former chairman of the board of the UNC Health Care System in Chapel Hill, and one who is quite knowledgeable and concerned about the healthcare needs of citizens throughout Western North Carolina, Jack speaks with considerable authority on this subject. Accordingly, I am enclosing herewith a copy of his October 18, 2011 letter for your consideration as well. In addition, I encourage you to review the further letters and commentary in support of Mission's position that we delivered to Shawn Parker yesterday.

As with my earlier correspondence, I'm enclosing 25 copies of this letter and its enclosure, and request that they be distributed to all members of your Committee for their consideration.

Best regards, and please contact me at your convenience if you have any other questions about this matter, and our contentions in Mission's behalf.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Richard A. Vinroot

RAV:mt
Enclosures

JOHN S. STEVENS
POST OFFICE BOX 7647 – ASHEVILLE, NORTH CAROLINA 28802

October 18, 2011

To: House Select Committee on the Certificates of Need Process
and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years on the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously complied with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived its usefulness and is it an impediment to the ability of Mission to continue as a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reasons no longer exist. There are now other large, well financed health care systems serving in Western North Carolina. When Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there are Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to

be freed from COPA restrictions to be able to compete. Mission is being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

[signature]

John S. Stevens

R&S 878733-1

COPA Talking Points

Thank you for allowing me to speak. My name is Keith Holtsclaw and I am the retired President and CEO of Blue Ridge Regional Hospital in Spruce Pine NC. I was in this position in 1997 when Mission became our "Sole Corporate Member" and the Hospital aligned with Mission. At that time the Hospital was doing very well financially, however, owing to previous financial history was not able to gain significant access to capital to improve the facility. Mission provided assurances so that BRRH could obtain bond funding to allow for the upgrade of the operating rooms. Mission also provided expertise that was difficult for a small rural hospital to obtain. This arrangement has served the citizens of Mitchell and Yancey Counties well as Mission's intent was to keep as much health care local as possible and be there for tertiary services. Mission again provided backing for financing of a $23 Million dollar clinical replacement and renovation project in 2006. BRRH now has a state-of-the-art facility to serve the citizens of Mitchell and Yancey Counties that would not have been possible without Mission's assistance.

I was also involved in working with The McDowell Hospital as Mission provided assistance at an extremely critical time when they were in jeopardy of maintaining ongoing operations. In effect, McDowell was in technical bankruptcy. Mission provided the needed cash infusion and management expertise to allow TMH to continue operations and provide services to the community. Mission stuck with them when a competing Provider hired the two OB/GYN's in the community and they stopped providing services at TMH, effectively decimating access to women's services. The competing Provider then enticed away and employed the largest Family Practice group in the community. Again, this had a devastating impact on the services provided at TMH. Mission again, added additional funds to ensure local access and assisted in recruiting new physicians and reinstituted services. I have been a Board Member of TMH for the past 6 years (since Mission added board members) and have personally observed the commitment that Mission has made to the community and to providing as many services locally as possible.

To vilify Mission by saying they are trying to move everything to their campuses is patently absurd. I have worked with and watched the organization provide help to smaller hospitals and do everything possible to have them maintain as many services locally as possible. In the case of Blue Ridge Regional Hospital, Mission's assistance helped the number of employees, during my tenure, increase from approximately 160 to over 400. As a current Mitchell County Commissioner I am certainly grateful for their help in growing the economic base for the County.

Thank you for allowing me to express my experience with Mission, and articulate my view of their commitment to providing the best possible health care for the Region.

JOHN S. STEVENS

POST OFFICE BOX 7647 – ASHEVILLE, NORTH CAROLINA 28802

October 18, 2011

To: House Select Committee on the Certificates of Need Process
and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years on the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

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be freed from COPA restrictions to be able to compete. Mission is being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

Jack Stevens

John S. Stevens

From: Jim Barrett [mailto:jim@pisgahlegal.org] **On Behalf Of** Jim Barrett
Sent: Friday, October 21, 2011 4:36 PM
To: 'torbettlu@ncleg.net'
Subject: Comments regarding Mission Hospital

Dear Representative Torbett:

Because of the volume of comments you are receiving regarding Mission Hospital, I will be brief with my points. Please let me know if you need more formal comments or comments in more detail.

1. As executive director of Pisgah Legal Services, I am extremely concerned about health care for people who lack the financial means to pay for it. (Pisgah Legal Services provides free legal assistance to help more than 12,000 people annually with their basic needs, including health care.) In the region served by Mission Hospitals, the number of those people who cannot afford health care exceeds 200,000. These neighbors are working for the most part in low-wage jobs without health insurance. Many are children, or are disabled, or are over 65, and thus have access to Medicaid. Many more people in the area with slightly higher incomes lack health insurance as you know. Rural county hospitals have been unable to serve these citizens and citizens benefiting from Medicare without running up deficits. Fortunately, Mission Hospitals has been able to step in and help by partnering with these hospitals. Mission Hospitals needs maximum flexibility to expand medical services for financially distressed citizens in western N.C.

2. Mission Hospitals can be trusted to accomplish its mission. I have served on the ethics committee for the hospital. I know many of the staff who serve on the hospital's leadership team, volunteer Board of Directors, and volunteer Board of Directors of the hospital foundation. At Pisgah Legal Services, we would know if there were problems with indigent patients receiving care at Mission Hospitals, and we never hear a complaint. I remain impressed with the commitment and dedication of the hospital to serve WNC residents, regardless of ability to pay. This commitment is exceptional and essential to the region. I do not believe that this commitment has anything to do with the COPA; it has everything to do with the dedication of the people who work with and for Mission Hospitals.

3. Mission Hospitals demonstrates its commitment to serve the region as the largest area non-profit in countless ways. Just a few that I am aware of are as follows:
   (a) Mission provides laundry service to the Room at the Inn ministry of area churches through the non-profit Homeward Bound at no charge. This ministry serves women who are homeless, who are working on formal plans to get back on their feet financially.
   (b) Mission provides the majority of the funding needed for the health clinic of Asheville Buncombe Community Christian Ministry to operate.
   (c) Mission partners with countless organizations in joint ventures to serve people who are economically disadvantaged. These include Project Access, the nationally recognized program that matches indigent patients with medical doctors for free care; Western N.C. Community Health Services, a large health care clinic that is serving more and more uninsured patients; Pisgah Legal Services' Health Education and Legal Support Project that provides free legal assistance to patients to help them meet basic needs so that their health care outcomes are enhanced.

4. As a community-based non-profit, Mission Hospitals is accountable to the people it serves. Mission is governed by a volunteer Board of Directors. We know who they are, what they care about, and where they live. Mission Hospitals has an exemplary track record and the drive to improve the health of area residents even more.

5. We have learned (again) that a healthy reserve fund is necessary in the modern world. It appears that Mission has a reserve fund equal to about six months operating costs. United Way requires our non-profit to have a three-month reserve, and we are not operating a tertiary care

hospital that depends on Medicare and Medicaid reimbursements to operate. It would be absurd to punish Mission for operating prudently in these uncertain times.

Thank you for considering this input,

Jim Barrett

Jim Barrett
Executive Director
Pisgah Legal Services
P.O. Box 2276
Asheville, N.C. 28802
828-210-3408
www.pisgahlegal.org

Providing free legal assistance to help people meet their basic needs.

Mission ForumMaxwell

Mission ForumI am Bob Maxwell, Board Chair of Transylvania Regional Hospital in Brevard, NC. We are 77 year old hospital and the cities largest employer.

AFFILIATION:

Affiliations have become a necessity for many hospitals of all sizes and our process began about 3 years ago. Without affiliation we would have had to reduce services and physicians and as a result, patients would be traveling to other communities for a lot more of their health care needs. Our Board has a fiduciary responsibility to consider various options of affiliation as we need to make the very best decisions we can for the benefit of our patients. After a lengthy due diligence process, Mission was chosen last December by a unanimous vote of the Board. We are even more confident a year later that we made the right decision.

If Mission were not an option for affiliation due to regulatory restrictions, we would have been unable to make the best decision for our community and patients. Other communities would be placed in this same position. Patients deserve better.

EMPLOYMENT OF PHYSICIANS

We employ 66% of our primary care physicians and 60% of our full time specialists and these %'s will likely grow. Who ever thought 15 years ago physicians would either want or need to be employed, but that is where we are today. Hospitals and physicians are just doing what is necessary in the climate we work in. Retention and hiring of new physicians necessitates the employment.

This issue is made more critical as our payor mix is 69% medicare and medicaid and you know the financial pressures that come from that mix as a result of their low reimbursement levels. Missions percentage is even higher and is actually the highest in the state.

Regulatory restrictions on the employment of physicians is wrong for the physicians, hospitals and most importantly the patients. Employment is part of our changing health care business.

OBLIGATIONS

As hospitals, we owe our patients the very best care with an exceptional experience. Patients should have a right to expect this kind of care from what ever hospital they choose.

By tieing a hospitals hands with restrictions in areas such as affiliation and employment of physicians can significantly lesson the hospital's ability to provide the very best care and services for their patients.

As Board members, regulators, policy makers, physicians, hospital employees, etc., we should always be doing what is in the best interest of the patient. Our communities, as the ultimate patients, do not deserve to have their care adveresly restricted and effected due to COPA restrictions.

CLOSING COMMENTS:

Regardless of what changes in health care come from North Carolina or Washington, we as an industry need to make significant progress and changes to improve population health and deliver more efficient health care. Providing health care with an excellent experience for the patient while doing so without waste, harm and delivering better outcomes is a goal we all need to reach. This will also improve population health at lower costs.

Being creative, innovative and able to make the changes appropriate for these goals will become necessary. Hospitals and physicians will need flexibility as it is not business as usual for the health care industry in the years ahead. Restrictions that might have made sense in the past will have to be put into the past to allow Mission the freedom it will need to be successful in a rapidly changing industry. With the leadership of Mission, all of us in Western North Carolina can set an example on how to accomplish these necessary goals.

Thank you for coming and listening to our comments.

Bob

Robert O. Maxwell
Board Chairman
Transylvania Regional Hospital
Brevard, NC
October 20, 2011

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 (828) 277-4800 WWW.CAREPARTNERS.ORG

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

Mission COPA-CON Hearing Thursday, October 20, 2011

Mr. Chairman and Honorable Committee Members of this North Carolina House Select Committee, I want to thank you for allowing me to address you this evening. My name is Alan Baumgarten and I am a family physician. I have been in active practice for the past 25 years. I am President of The Family Health Centers, a large, independent group of family physicians based in Buncombe County that provides primary care for more than 40,000 patients throughout Western North Carolina. Our group is made up of 21 board certified family physicians and four mid-level providers in 3 offices: Arden Family Health Center located in south Buncombe County very near to the site of the proposed Mission-Pardee joint ventured "south facility", Asheville Family Health Center, located in central Asheville very near to Mission Hospital and Hominy Valley Family Health Center located in western Buncombe County near to the Haywood County line. Many of our patients choose our practices for their primary health care services from out of Buncombe County specifically because they know that we are affiliated with Mission Health. In fact, The Family health Centers continues to "buck" the national trends providing our own inpatient hospital service at Mission Hospital, therefore providing 24/7 care to our patients both in and out of the hospital.

I also have the honored position of being the Project Director for a $2.6 million, three year Duke Endowment grant designed to assist other independent primary care practices towards their implementation of a new primary care model called the Patient Centered Medical Home (PCMH). In the end, this project will further enhance the quality, capacity and viability of primary practices. The project will assist at least 20 practices (75-100 physicians) throughout Western North Carolina achieve PCMH recognition status and practice re-design to the PCMH model. The project will provide the practices with much needed management and operational technical

assistance, Nurse Navigators to improve quality through case management and care coordination specifically during a patient's critical "transitions in care" and enhanced chronic disease care, management and education. The Mission Health Foundation holds this grant and Mission Health has been a huge supported of this project for all of Western North Carolina.

Lastly, I am Mission Hospital's immediate past Chief of Staff. In fact, I am the first primary care physician to serve as Mission's Chief of Staff since the COPA took effect in 1995. My role as Chief of Staff focused on improving medical staff (physician) – hospital relations and quality improvement. Mission Hospital has long been known as a high quality provider but I was concerned that Mission Hospital could begin to slip on its quality scores if we did not begin new initiatives with a specific focus on quality improvement. Thus, I spearheaded the medical staffs drive for quality improvement and forged a relationship between Mission Health and the Institute for Healthcare Improvement (IHI), the world's leading healthcare quality improvement organization. This collaboration has lead to several intentionally designed projects that the leaders of the IHI believed would lead to Mission's recognition as "the safest hospital in the United States".

Let me for a moment reflect back to December 1995, the time during which the COPA was being discussed. At that time, I was the President of our local independent physician's organization called Mountain Health Care (MHC). MHC represented more than 400 Buncombe and Madison County physicians in direct contract negotiations with payers, industry, hospitals and other healthcare organizations and providers. During the COPA investigation period, I was interviewed by the United States Justice Departments and went on record in opposition to the COPA believing that the merger of these two hospitals would stifle local competition in health care and compromise quality and access. I was wrong. In fact I could not have been more wrong. The COPA allowed for the safe and managed merger between then St.

Joseph's Hospital and Memorial Mission Hospital and could not have been better conceived nor could it have better served our community and Western North Carolina.

Let me explain.

Mission's role as Western North Carolina's most sophisticated secondary and tertiary health care center has been helped by the COPA and has served our region well. We have all needed and greatly benefited from the growth in stature, quality and market share of this organization.

The growth of Mission Health has been a great asset in the building of primary care capacity in Western North Caroline. I am a family physician who came to Western North Carolina and stayed in Western North Carolina after training in the MAHEC Family Practice Residency Program. The Mission based MAHEC Family Practice Residency Program (MAHEC FPRP) is nationally recognized for its quality in part due to its relationship with and the training opportunities provided at Mission Hospital. The MAHEC FPRP has for the last 33 years been the training ground for more than 300 family physicians, of which, like myself, more than 150 are in active primary care practice throughout Western North Carolina. Mission Hospital is a huge part of the success of the MAHEC FPRP by providing a super high quality secondary and tertiary hospital as part of this training program.

As mentioned earlier, Mission Hospital has helped to raise the quality bar for Western North Carolina. Mission Hospital has led the charge of regional quality that resulted in Western North Carolina's recent recognition for "high quality and low cost" health care. In June 2008, I led a Mission delegation at an IHI sponsored conference in Washington, DC titled "How Do they Do That?" During the heat of the healthcare reform debate, Western North Carolina along with 9 other regions in the United States were ask to present to White House representatives, Congressional

representatives the press and each other, how we were able to achieve the status where we were all identified in the top quartile of regions in the United States as providers of high quality-low cost healthcare. Mission Health is now recognized as the regional healthcare leader that has promoted Western North Carolina to national status for its high quality and low cost healthcare.

Please let me conclude by saying:

1. Through its history, the COPA has allowed Mission Health to achieve a status where it is now the region's premier provider of secondary care for Buncombe, Madison and the near surrounding counties and tertiary care for all of Western North Carolina. The COPA was the right solution at the time to promote improved access to high quality health care for all of Western North Carolina.
2. The national and the local healthcare environment is rapidly changing and becoming more competitive. We should not allow this new level of competition hamper the high quality of secondary and tertiary care that should remain available for the citizens of Western North Carolina. Now is the time to relinquish the COPA so that Mission Health can fairly compete and continue to lead healthcare in Western North Carolina.

Thank you for your attention and for allowing me to address your Committee.

Respectfully submitted,

Alan S. Baumgarten MD, MPH

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I have been in practice as an Emergency Physician of Transylvania Regional Hospital for the past 8 years. I have been in emergency practice for 20 years in a variety of settings and so I have the perspective of being able to compare a number of hospital systems. I am writing to give you my impression of how Mission, our primary referral source, has operated under the Certificate of Public Advantage, both before and after our recent affiliation with them. I also plan to attend the October 20 hearing at the Agricultural Center.

Over the years I have interacted with both physician staff and administration at Mission. They have been extremely helpful in providing free consultation and accepting patients in transfer for services we cannot provide at TRH. This is very important to me, since, as a small rural community, we do not have full coverage with specialist nor the specialized facilities needed to provide for all of our patients' emergency needs. They have worked hard at making their services easily accessible to me. Their approach has made these processes, oftentimes very time consuming elsewhere, quick and easy. Besides making my job easier, it allows for better and safer patient care in a sometime overwhelmingly busy ED.

Knowing that specialty care is readily available if needed, has translated into patients being satisfied and confident in the care I provide them and has vastly increased the efficiency of our health care delivery team. They have not only helped with tertiary care, but also with more basic needs in times when our specialists or inpatient beds were unavailable at TRH. Furthermore, they always seem willing to support our efforts to provide care for our own patients in a noncompetitive way. Attitudes such as this are uncommon and derive from a culture of excellence promulgated by the administration on down the line to physicians and staff. Other

hospitals in the region can and do provide some of the services, for which I utilize Mission's system. Yet, they do not provide the quality of care I have come to expect from Mission.

I have never been engaged politically in the process of determining the need for regulations in regards to health care delivery and as such, I don't fully understand the history of the COPA nor the recent allegations of noncompetitive behavior. However, I hope that you will take into account my experience as you decide what is best for our region and that you do not pass regulation that might dismantle the system that has allowed me to provide such excellent care for the folks of Transylvania County.

Sincerely,

Joseph A. Cohen, M.D.

Emergency Department

Transylvania Regional Hospital

Brevard, NC

(828)883-5330

joechenge@aol.com

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I, Veronica Els RN, am an employee of Transylvania Regional Hospital, a member of the Mission Health System. We are located in Brevard, North Carolina. I am unable to attend the October 20, 2011 hearing but wanted my opinion heard related to COPA and the Mission Health System.

I serve as the director of Surgical Services and clinical director of Brevard Cancer and Infusion Center. I consider it vitally important that community and regional hospitals remain a part of health care; in today's market, affiliation with Mission Health System has made it possible for Transylvania Regional hospital to remain not only a viable option, but an excellent option. Having the most advanced tertiary care in the region through Mission Health System in such close proximity allows us to care for sick patients with the comfort of knowing that we have support when needed. I was privileged to experience Mission Health System patient care first hand when a friend's child was hospitalized last summer after an equestrian accident at a summer camp and was impressed with the level of care and services.

We are all blessed to live in such a beautiful place. The desire to live here is tied not only to the beauty of the landscape but having life saving, high quality care in close proximity. Today's consumer savvy and knowledgeable patient value the importance of freedom of choice in health care including what facility best suites their needs.

It is vital the Mission Health System be allowed to continue to grow and improve delivery of health care so that Western North Carolina remains a desirable place to live.

Sincerely,

Veronica Els RN, CNOR

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I, Vickie Oliver, am an employee of Mission Hospital, Asheville NC, which is a member of Mission Health. I am writing you about how Mission has operated under the Certificate of Public Advantage. I can't attend the October 20 hearing, but wanted to make sure you heard my voice and opinion.

From my own experience as an employee and as a frequent patient, I would like to describe how Mission's services have made a difference in the lives of patients.

I am the assistant to the Director of Materials Management. We provide supplies to clinical and non clinical departments and facilities of Mission Hospital. Our department does the purchasing and contracting for all supplies. We work hard, fast, and efficiently to provide the highest quality supplies at the best possible cost to our patients.

I have a very close family member who was fatally wounded in a motorcycle accident and was revived by our flight team, brought to Mission via our medical air ambulance and is still with us today due to the skill and services that we are able to provide and due to the speed in which we can respond to a crisis.

It is vitally important that the Mission family, including our community hospitals in McDowell, Yancey, and Transylvania counties, remain close to home for people in rural communities. We need to be able to continue to provide the most advanced tertiary care for the whole region when it's needed – like trauma care, pediatric subspecialties, etc.

Mission has special meaning to me and my entire family going back to my ancestors that were born and raised in this region. My own child was born at this hospital and my grandchildren are being born here. I have had many serious health issues. Without Mission, particularly our cancer programs and services, ER, and our medical air ambulance, our family would be missing many family members, mef included. My father lived in Honduras and just passed away in Asheville in August from recurrent and metastatic cancer. He wanted to come to Asheville and be admitted to our Cancer Center because he is from here, born and raised. We got him back in Asheville, admitted through the ER, and to Oncology very quickly. This makes a huge statement to the extent of what Mission offers its community, its region, and speaks extremely highly of "our" confidence in the level of care we receive from Mission which is why the people of WNC deserve to have life-saving, high quality care close to home, just like every other region of N.C. and a right to chose where they wish to receive that care.

If we are not able to continue servicing WNC, the people of this region will not have life saving choices close to home. America is about freedom of choice to include where we spend our money for the medical care we need when we need it.

I am proud and honored to be employed with Mission for twenty years and don't know what I would have done over the past 30 years if Mission had not been my choice for medical care.

From: Adrian D Sandler, M.D.
Sent: Friday, October 28, 2011 2:24 PM
To: William R Hathaway, MD, Chief of Staff
Cc: Susan Mims, MD
Subject: RE: Submission of Comments to the State Commission looking at COPA and CON Issues

Bill,

I wanted to write a brief note regarding my experience as Medical Director of the Olson Huff Center at Mission Children's. The Olson Huff Center is a multi-disciplinary regional referral center providing diagnostic and treatment services for children with developmental disabilities and disorders, including autism, developmental delay, intellectual disabilities and cerebral palsy. It is the largest such center in North Carolina, receiving referrals from the entire Western region of NC, and many from neighboring states in the region. I have had the privilege of working in this capacity as a Mission-employed physician for 11 years. The Olson Huff Center loses money each year, while providing comprehensive exemplary care to children with special needs. We owe our existence and the opportunity to continue providing quality care to Mission Hospital's commitment to providing needed critical services to the region. I am concerned that unnecessary restrictions on Mission's freedom to serve would potentially impact the Hospital's ability to continue providing support for our Center. This would be a critical loss for the region's children with special needs and their families. Please convey these comments to the commission.

Best wishes,

Adrian Sandler MD
Medical Director
Olson Huff Center
828 213 1783

My name is Susan Mims. I have been a pediatrician in Asheville for over 11 years and have served as the Medical Director of Mission Children's Hospital for the past 5. Part of my role involves running a pediatric specialty practice. I would like to tell you about one of the large practices that Mission owns.

Mission employs 31 physicians and dentists who care for the children of WNC who need specialty care. Our doctors treat children with cancer, cystic fibrosis, diabetes, child abuse, autism, and many other problems. Mission hired these physicians in response to requests from families in the region who were struggling to get needed care for their children.

Prior to the development of Mission Children's Hospital, families with children needing weekly chemotherapy treatments or regular visits to a pediatric physical therapist had to travel several hours each way to get that care. And, as we have learned since we hired a pediatric orthopedist, some families could not travel and just went without the care their children needed.

Hayley is one such child and her parents gave me permission to share her story. She is an 8 year old quadriplegic with cerebral palsy living in foster care. Her family could not afford to drive Hayley to South Carolina regularly so she could not been seen as often as needed for her orthopedic care until Mission hired a pediatric orthopedist.

Prior to starting treatment this 8 year old child was wheel chair bound, crawled on the floor and was totally dependent on her foster parents for movement. Now, since receiving regular care over the past year at Mission Children's Hospital, Hayley is beginning to walk independently and you should see how proud she is!

I want to point out that the reason pediatric specialty services were not available before Mission hired these physicians is because they loose money, a lot of money. In fact, hiring these physicians who loose money has contributed to some of the market share gain referenced in earlier comments. Mission stepped up to offer this care for children because it was needed and <u>this</u> is who Mission is. Mission is here to create a healthier WNC and knew that could not be done if kids were left behind. This is just one example of the many ways Mission serves this region. Mission is here for the children and families of WNC. Mission is here for Hayley. Thank you.

Testimony to House Select Committee on Certificate of Need and Related Hospital Issues AMENDED

by John T. Ashley MD, MBA, FACPM October 20, 2011

NC CON law and regulations are designed to rationalize the distribution of health facilities and extraordinarily expensive medical technology in the face of an irrational financing system of third party payment that promotes and stimulates excess utilization of high cost procedures by patients, physicians and hospitals. A unique feature of the CON law and regulations is the application of the Certificate of Public Advantage (COPA) that is used to evaluate the results of an approved CON by Mission Hospitals.

The enormous value of COPA reporting has been demonstrated in Asheville-Buncombe by the work of the Asheville Chamber Healthcare Roundtable over the past 8 years. Based on data from the Mission Hospital's COPA Reports from the 1999 through 2008, the Roundtable developed and submitted, with the support of the leadership of the NC legislature, prominently lead by Rep Bruce Goforth and Sens Martin Nesbitt and Tom Apodoca, HB 212, The Health Insurance Pool Pilot Program, adopted in 2009.

This legislation was developed by the Roundtable with full participation by the major employers of the community, by all of the major private hospitals, by physicians represented by the Buncombe County Medical Society, by local governments, by organizations that procure health insurance for businesses, by small employers, by our local PPO organization of physicians and hospitals providing access to health care and the public. The legislation was vigorously and prominently opposed by the largest private insurers in the state in testimony to both houses of the legislature. The legislation received bi-partisan support during its thorough consideration in committees of the House and Senate. My observation was that the bi-partisan support grew as the largest insurers increased their opposition.

The content and language of HB 212 was developed based on data contained in the Mission Hospital COPA Annual Reports that were generously and thoroughly shared with the Roundtable each year during deliberations on how to address and resolve the twin conflicts of the EXCESS cost of Health Insurance premiums and GROWING number of Uninsured residents of Buncombe County. The data in the COPA Reports showed clearly that the merged hospital system incurs the millions of dollars of losses by caring for the uninsured and millions more of losses by less than full cost reimbursement from Medicare and Medicaid each year. The COPA Reports demonstrated that the hospital receives payment from private insurers representing the large employers and other privately insured groups and individuals that reimbursed all of the costs of care for their beneficiaries, PLUS the cost of losses from the uninsured and underinsured PLUS the margin that every hospital must generate to successfully serve their communities with needed services and to create the reserves for future growth.

The data from the MH COPA demonstrated explicitly the process of COST SHIFTING that occurs implicitly in every hospital market in NC and the U.S. to allow the uninsured to obtain medical care. The Roundtable membership, lead by representatives of large employers who pay for the cost shifting through their insurance payments and representatives of the professionals and institutions who receive the payments, recognized that the fundamental problem of the broken system must be addressed so that affordable health insurance was available to every resident and employer who had any ability to purchase health insurance rather than be uninsured.

In Buncombe County, the medical society with critical support from Mission Hospital and County government have developed and implemented Project Access, a national model of voluntary provision of specialty medical care, hospitalization, medications and support to the uninsured, poor residents of the community. But the number of uninsured has grown to almost 19 % of the adult population of the county and Project Access is rapidly exhausting the ability of physician specialists to donate their services to the poor because of the growing number of uninsured. Project Access does not provide access to Primary or Preventive Care. As a volunteer physician at our local free clinic, ABCCM Medical Ministry, we see an endless number of uninsured individuals, including some children, who suffer from preventable and treatable conditions like hypertension, hypercholesterolemia, diabetes, depression, obesity and smoking that lead to heart attacks, stroke and cancer resulting in catastrophic medical interventions, excess costs, excess morbidity and premature deaths. This is true in every community in NC and the nation and is the basic reason that the US has among the worst population health outcomes compared to other developed nations.

In Buncombe County, we have a national model of Disease Management called Project Asheville that is used to control many of the conditions that lead to excess hospitalization and costs for the insured. Project Asheville is not available to the uninsured but the costs of the care for their catastrophic health problems are borne by the privately insured who pay for their own beneficiaries care and the cost-shifted burden from the uninsured who receive hospital care. The hospital and insurers have become Unrecognized, Private Taxing Authorities that collects premiums and payments from the employed insured to care for employed and unemployed UNINSURED.

The Roundtable recognized the fundamental breakdown in our local financing system and the hidden burden of high cost health insurance premiums and the resulting uninsured in our community through their analysis of the local COPA data. The Roundtable employed health care and actuarial consultants who guided their deliberations and evaluation of approaches used in other communities in the US. The Roundtable wanted to make the system rational and fair by making insurance affordable to all employers and individuals by correcting the flaws that made insurance prohibitively expensive and resulted in unacceptable increases in the number of uninsured.

The Roundtable learned that US Health Insurance began as a community-rated product for limited benefits provided by a Not-for-Profit insurer with low overhead for all residents of communities with payments to providers at prices that reflected the actual costs of care. Private, For-Profit insurers entered the market after WW II and increased the covered benefits, segmented the market to identify the lowest risk groups, introduced reimbursement contracting with hospitals and physicians, implemented utilization controls and abandoned community rating to attract the lowest risk groups for increasingly expensive health insurance with higher overhead and significant profits. Large group insurance purchasers responded by self-insuring and negotiated for deeper discounts from providers. Hospitals and other Providers responded by increasing prices to cover the costs of uninsured losses and dramatically increased the volume of technology and specialty care procedures to offset their losses from primary care and catastrophic services.

The Roundtable, using COPA data, sought legislative authorization to undertake a demonstration project for pooling large and small employers into a unified community-rated purchasing group that would design and adopt proven packages of benefits that met the requirements of the NC Department of Insurance and the developing requirements of the national Accountable Care Act. The proposed four levels of benefits would cover the costs of uniform Primary and Preventive Care services and Catastrophic services in all packages and use proven actuarial processes to reduce the costs of premiums for discretionary, procedural services. Fundamentally the proposed pooling of insurance was to be designed to obtain low insurance overheard, less than 10% as achieved by the NC State employee health insurance program, optimum utilization of procedural services and full access to Primary Care to achieve best health outcomes for the combined group of insured from both large and small employers and potentially from insurable individuals. The proposed pooling of insured groups was designed to use market competition among insurers for the largest possible group in the community and potentially the region. The model is based on proven Prevention and Primary Care, full access to catastrophic care, and appropriate use of best technology without use of the most technology, managed by local systems of care supported by proven actuarial analysis and processes.

The Roundtable proposed legislation was adopted by the legislature and approved by the governor in 2009 and amended in 2010 to allow implementation of a model of a local health insurance program in NC. Without the data from the COPA Reports, this community approach could not have been developed and the authorizing legislation could not have been adopted. The authorization of HB 212 remains unfulfilled today because of the fluidity of the insurance market secondary to adoption of national health reform and the impending regulatory changes. The need for a local demonstration project to model the best benefit design with appropriate economic incentives for patients and providers has never been greater. The authorization of HB 212 remains available to Buncombe or other interested community because of the COPA data that demonstrates the potential value of changing our financing system in NC and the nation.

I recommend that COPA Reporting requirements be retained in the regulations even as other regulations are modified or reduced to relieve unnecessary burdens on Mission Hospital.

October 14, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am the Low Vision Technician at Mission's Low Vision Center in Asheville. As a Mission employee since 2003, I am writing them about how Mission has operated under the Certificate of Public Advantage. I cannot attend the meeting on October 20, because a co-worker and I will be doing a presentation educating professionals as to how to assist people with low vision when they come to their businesses.

The reason for me not being able to attend the Thursday meeting demonstrates one of the ways Mission serves Western North Carolina—educating the public. The main focus of my job is that I meet with patients who are facing the challenge of low vision, which can be devastating. I have low vision myself, and sharing my personal perspective of coping, as well as teaching them about techniques, resources, and aids makes a difference. I talk to them about the North Carolina Library for the Blind and Physically Handicapped from which they can receive for free-recorded books and magazines and large print books. My patients also learn about options they have to continue using computers using assistive technology that make things on the screen bigger and easier to see or programs that verbally read what is on the screen—which I use on my computers. My patients are not charged for the time I spend teaching them about these and other resources, and I spend anywhere from 20-75 minutes with them and any family or friends that may be with them. I encourage them to contact me with any questions they may have in the future. I also coordinate

Low Vision Center
50 Doctors Drive, Suite 403, Asheville, North Carolina 28801-4620
(828) 213-4370 Fax (828) 213-4376

the area low vision support group, which Mission sponsors. This takes me approximately eight hours a month, and again there is no charge for this community event. Please see the attached sample announcement that I sent out about these meetings. Additionally every week I prepare notices to send to interested people with low vision about movies showing with description in the area—see attached. I have also included an email exchange I had with a patient. All of these things help people dealing with low vision realize opportunities they have to regain independence! Mission helps people do this.

Low Vision Centers are rare, so we have patients come quite a distance to use our services. Our patients come here from all over WNC, and we often help patients from South Carolina. With the growing number of aging people in the area giving them options of having our Low Vision Center, as well as Mission's many other departments available for people in the area it is critical to let Mission grow, as well as provide existing services. Giving Mission this option to grow does not take away people's options to make choices as to where they can go for help. Mission needs the freedom to serve. We want to compete for patients based on outstanding care, without harm, without waste and with an exceptional experience. The region's patients – not government regulators -- should choose where they receive their care. Thank you.

Sincerely,

Judy L. Davis, MSLS

Low Vision Technician

Mercy, Excellence, Respect, Integrity, Trust/Teamwork

October 14, 2011

To the House Select Committee on the CON Process and Related Hospital Issues,

My name is Trent Ibbotson and I am an employee of Mission Health, residing here in Asheville, NC. I am relatively new to the region but lived in Charlotte for the last sixteen years and have been involved in healthcare that entire time. I remember when Mission Memorial and St. Joseph's merged fifteen years ago and the initial thought I had was that this newly merged entity would have a stranglehold on the western North Carolina market. After learning more about how Mission Health has had to operate under the Certificate of Public Advantage, COPA, I see why that original impression was probably accurate but has now become the furthest thing from the truth.

I am not a clinician but work diligently on ensuring that the community we serve has access to high quality care as close to home as possible. In my brief tenure here, I have had the opportunity to talk to some members of the community who have either had to use the health system's resources (including cancer care and outpatient surgery) or known someone who has. I am proud to say that the feedback has been overwhelmingly positive, which is a testament to the value and peace of mind that this institution brings to the region.

However, that sense of security is under continuous assault as changes in the regional and national market include a whole host of challenges that are only intensified in their complexity to overcome with the COPA still in place. Some of the issues to reflect on include:

- a mandate for higher quality at a lower cost,
- higher demand for provision of care in the outpatient arena,
- increasing competition from much larger systems who are not local to this region but obviously want to get bigger,
- decreasing reimbursement including payer mix challenges,
- increased regulations,
- national economic disarray,
- increasing desire by MDs to seek employment arrangements with hospitals/systems, and
- migration to an accountable care model

Predictably, there is increased pressure from our competitors to make the COPA even more restrictive. It is awfully convenient for them to lean on an outdated and burdensome regulation to ensure that we are only limited to advanced, tertiary care for the region. Meanwhile they deploy a strategy geared toward gobbling up the foundation of the healthcare future. Critical services like trauma and the NICU do not positively impact the margin nor is the provision of such services sustainable by itself. Despite that, we subsidize them because they are essential

and it is our mission to do so. Contributing to the financial challenges, we treat the highest percentage of Medicare and Medicaid patients in the state and bear a heavy financial burden to subsidize the services provided to those customers as well. Again, it is our mission to do so.

To continue providing the life-saving, high quality care that our whole region depends on and deserves, Mission needs the freedom to serve. We want to compete for patients based on outstanding care, without harm, without waste and with an exceptional experience. The region's patients – not government regulators -- should choose where they receive their care and we want to provide it to them as close to home as possible. Should they need more advanced tertiary or quaternary care, then Mission wants to be the destination hospital of their choice and we will earn that designation. I am convinced that rescinding the COPA can help pave the way for advancing healthcare not only in western North Carolina but the entire southeast.

Sincerely,

Trent Ibbotson
203 Blake Mountain Circle
Asheville, NC 28803

Bruce M. Burns
178 Stonehollow Rd
Fletcher, NC 28732
October 16, 2011

House Select Committee on Certificate of
Need Process and Related Hospital Issues

To whom it May Concern:

I was a patient of Mission Hospital in 2002 for a heart blockage. I was very grateful to have the services of one of the Top 100 Heart Hospitals in the country in my community.
I received three stints and that along with the Heart Path program have made a major improvement in my life.

I have been a participant in the Cardiac Maintenance program for almost 10 years now. While there are other places to "work out", this is by far the best available program for me to maintain and improve my heart health. This program is proactive,as I am, in maintaining and monitoring my heart health. It includes appropriate exercise programs, monthly rhythm strips, weekly educational programs and careful monitoring of my overall weight, blood pressure and other important factors. This is done by a professional and caring staff.

There are many reasons to live and retire in the Asheville area. On my list is the quality of the health care that I have had available from Mission Hospital. I feel it is important that Mission Hospital be able to serve the people like me in the Western North Carolina area. We are a community that is remote to a certain degree from larger metropolitan areas with many medical assets. I feel that we have a world-class hospital partner in Mission and we should all be able to have access to this level of care.

I am unable to attend your meeting but wanted to express my feelings to you.

Sincerely, Bruce M. Burns

Bruce M. Burns

October 16, 2011

To: House Select Committee on CON Process and other issues:

From: Jack A. Koontz, MD
FAAFP FACOEM

I am unable to attend the hearing scheduled for October 20, but I, as both a patient and physician, want to have input to the Select Committee on this vital subject.

During the afternoon of this past Labor Day, I sustained a myocardial infarction, aka: heart attack and was admitted to the Cardiac Service of Mission Hospital. To have the facilities provided by Mission, along with their superb staffs, medical, nursing and all support personnel, was life saving. I cannot adequately express my thanks for the timely manner in which I received treatment or for the courtesies extended to me and my family.

Having lived with coronary artery disease for sometime, I find great comfort in having Mission and its life saving, high quality care available to me and my fellow citizens here in western North Carolina. Illnesses by themselves create high level of anxiety and worry, but these complications are much reduced by having Mission and its capabilities here in our neighborhoods. We need to be able to do more than simply maintain what we have, we need to be able to plan for future needs and have them met here near our homes.

Sincerely,

Jack A. Koontz M.D.

Jack A. Koontz, MD
703 Crowfields Lane
Asheville, NC 28803

John A. Mills
32 Bucks Acres Dr.
Asheville, N.C. 28806

RE: Mission Hospital

I had a heart attack + a stroke one year apart. Thanks to Mission I'm still here. They have been great for my recovery.

John Mills

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

In 2006 my wife and I moved to Asheville seeking a good place to complete our retirement. It had to have the best in health care sevices. We found it here in Asheville.During my life of 82 years I have always heard and seen the conflict between the doctors anh hospitals.I did not want to become involved in the disputes , I only wanted the best medical service and I found it at Mission Hospital.My wife has had to use the hospital three times and all of the service was excellent.

I have become a volunteer at the hospital and my goal and the 600 volunteers is to help make Mission Hospital one of the best in our nation. We contribute over 100,000 hours and $300,000 cash each year. Let those who complain follow us to the top. There is always room for good competition.

Sincerely,

Douglas A. Young

Douglas A Young
16 Salisbury Dr. Apt 7313
Asheville NC 28803

House Select Committee

Certificate of Need Process and Related House Issues

As a current patient in the Mission Hospital healthcare system, who has and is still receiving care, I am concerned with the changes that may be imposed to the hospital under the Certificate of Public Advantage.

Since I cannot attend the October 20 meeting I'd like my opinion to be heard.

As a prostate and open heart surgery patient at Mission, I cannot express my complete satisfaction in the treatment I've received. I continue to be screened on a regular basis and am involved for the past six years in their Heart Path exercise program which has been extremely beneficial both physically and mentally.

I am very concerned that changes which may be imposed on the hospital will alter the high quality, life saving care they provide for me and other residents of Western North Carolina.

It would be greatly appreciated to allow the hospital to continue to operate as they currently do providing the best care in the region.

Sincerely,

Joseph Olita

332 Hemlock Springs Trl.

Weaverville, NC 28787

October 17, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am an employee of Mission Hospital in Asheville, NC. I am writing to you regarding the Certificate of Public Advantage (COPA). I am unable to attend the hearing on October 20th as I will be out of town, so I wanted to express my concerns to you by letter.

I am the Nurse Manager for the Women's Surgical Oncology Unit at Mission. More than thirty women come to us each week for surgical interventions for female cancers such as ovarian, uterine, cervical or breast cancer. Our nursing and medical staff provide care for these women as if they were our own family members. Some of them return after progression of their disease for symptom management and further treatment. Tender therapeutic relationships are formed at moments of crisis like these. These patients and their families deserve to have a choice about where they go for hospital care.

The people of western North Carolina deserve to have life-saving, high quality care close to home. Mission Health System needs to be free to serve the people of western North Carolina based on the people's choice. I urge you to release Mission Health from the burdensome regulation of the COPA. Allow us to do what we do best....care for our patients.

Sincerely,

Brenda Lee Smith

Brenda Lee Smith, BSN, RN, NE-BC
Nurse Manager, Mission Hospital

509 Biltmore Avenue, Asheville, North Carolina 28801 (828) 213-1111 www.missionhospitals.org

House Select Committee

Certificate of Need Process

Related Hospital Issues

I have been a very satisfied Mission Hospital patient since 1996. I will be unable to attend the hearing on October 20th.

I have been a Heart Patient at Mission since 1996 and the services that I have received at Mission have been excellent. The services have improved my heart functions and my outlook on life. One service that has been great for me is Heart Path Cardiac Rehabilitation. The friends that I have met in the program, the support from the Mission staff, and the educational information that has been given to me has been instrumental in improving my overall health. The exercise program has been especially good for me. Some of my heart issues have been discovered while at Heart Path, have been addressed, and have helped me avoid problems later on.

The people of WNC are very diverse including true "mountain people" and young entrepreneurs, to middle age working people and retirees. This diverse population needs all types of healthcare and Mission can provide this if the playing field is leveled for Mission. The level playing field is already in place in other regions of North Carolina. Why is not available in Western North Carolina?

My personal freedom to choose my healthcare is important to me because of my heart issues. Mission has a great national heart services rating in cardiac care. I'm very proud to be a patient of this program.

I'm also proud of Mission's being able to obtain this national recognition. I fully support Mission Hospital in their efforts to provide quality low cost healthcare to all of Western North Carolina. It is hard for people to understand healthcare who have not faced issues like I have. Mission Hospital has been there every step of the way, and I would not be here today without Mission Hospitals Systems and the Cardiac Rehab program.

Thank you very for allowing me to voice my opinion on this issue.

Sincerely,

Steven B. McElreath

10 Lynnette Drive

Fairview NC 28730

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

As a pharmacist that is employed by Mission Hospital in Asheville, North Carolina, I felt that it was very important for me to express to you the views that I have witnessed as to how Mission Health has operated under the Certificate of Public Advantage (COPA). It will be unlikely that I will be able to attend the public hearing on October 20th, thus I wanted to be sure to provide my perspective.

In my position with the outpatient Mission Hospital Medication Assistance Program, the impact of Mission services, that I have witnessed, on the community have been exponential. I feel that it is very important for you to know that the salary of myself, our other clinical pharmacist, our licensed clinical social worker, our pharmacy technician, and our two medication assistance specialists are all funded almost entirely by Mission without other significant revenue sources. Our program is completely free to qualifying patients. Providing services such as these are not required under the COPA (Mission provides millions of more in free care through charity care program that alone allows for non-profit status). To me, the ability to work for an organization that supports programs such as ours, along with other significant community benefit programs, has been phenomenal due to the large impact we are able to have on our patients. Patients do not have to see a Mission Health provider to have access to our services (there are other requirements, such as financial limitations). Many of our patients are disconnected from community services and have been unable to afford their medications when they are referred to us. It is extremely rewarding on my part to be able to not only provide many of these patients with their life-saving medications free of charge, but to also be able to spend significant amounts of time with them in clinical disease-state management visits (time fully supported financially for me to do so by Mission Health). It is a common occurrence to hear comments such as "I don't know what I would do without your program." It is during the clinical visits that I am able to identify and address a wide variety issues with their primary care providers, such as uncontrolled diabetes, elevated blood pressure, appropriate use of migraine medications etc. In spending this significant amount of time with patients, I am also able to connect our uninsured patients to other resources in the community. This includes programs such as Ladies Night Out (partially supported by Mission Health), which provides free mammograms to uninsured women. Other referrals can vary from food assistance to sliding scale counseling services to low-cost options for influenza vaccinations. My division participates in various community outreach activities, even including a healthfair event in the Craggy Jail for prisoners.

The dynamics in healthcare have significantly changed since the COPA was formed. There are multiple other competitors in our region, including the much larger Carolinas Healthcare System, the Adventist System, and the management of another hospital by UNC Hospitals. I do feel that competition is healthy. However, I think it is unfair to restrain one organization when other, larger organizations such as Carolinas do not have such restrictions. Mission is committed to quality (we receive emails all the time about the importance of high quality, which Mission is further improving in collaboration with

MISSION HOSPITALS

the Institute for Healthcare Improvement). From my perspective, Mission is proud to be in Western North Carolina and does not want to "run out" or "run over" competition, but instead compete without unfair restrictions, while at the same time providing the highest possible quality healthcare. Patients should be able to choose which hospital and physician services they receive based on that organization's quality, not based on federal and state regulations that unfairly limit the ability of one high quality organization to expand its services. With the changes in the healthcare environment, Mission does not have a choice but to expand in outpatient settings to be similar to other financially healthy systems around the country. Our challenges here in Western North Carolina, due to one of the highest Medicaid and Medicare populations in the state, (whose reimbursement does not cover our operating costs) are huge. However, the challenges are made larger by the COPA restrictions on physician hiring. As an employee, I have seen firsthand the commitment to quality and community enhancement in my time at Mission. Please consider advocating for the termination of the COPA agreement in order to allow Mission Health to continue this mission of serving the people of Western North Carolina. A mission that neither the state nor the people of Western North Carolina can afford, if it fails.

Sincerely,

Ben Smith, PharmD
Medication Assistance Program Clinical Pharmacist
PGY1 Pharmacy Residency in Ambulatory Care Coordinator
Mission Hospital Outpatient Clinical Pharmacy Services
501 Biltmore Ave
Asheville, NC 28801
828-213-5538 (phone)
828-213-1859 (fax)
ben.smith@msj.org
Ben Smith, PharmD

FULLERTON GENETICS CENTER

October 17, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Carolyn Wilson-Brackett and I have been a genetic counselor at Mission Hospital since 2003. I am very fortunate to have a wonderful career and colleagues, and I am so proud to be part of the Mission family. I am writing in regards to Mission Hospitals operating under the Certificate of Public Advantage. I am unable to attend the hearing on this on October 20th, but I would like to share with you some of my experiences at Mission.

Genetics is a unique specialty, and our patients generally have significant medical, cognitive, and physical challenges. We tend to follow patients over many years, which allow us to form close relationships. As a genetic counselor, my role is to help families understand the complexities of genetic conditions – not only the medical aspects, but the social and psychological ones as well. I assist the physicians in diagnosis, and help the families connect with support services. I do a lot of talking, and I do a lot of listening. Patients appreciate that they can reach me by phone, and I am on a number of speed dials. I am lucky that I have a position where I get to make a difference to a family every day.

Many of the families we work with have complicated medical needs and see multiple specialists. Finances are often tight, and travel can be a hardship. Our genetics physicians see patients at a number of satellite locations in the region to provide access to excellent care with the least amount of family hardship. When families do come to Asheville, their providers try to coordinate care to minimize family travel. Just this week we saw a patient for a genetics visit while he was receiving an infusion treatment for his rare genetic condition. Many of our families have been to see specialists throughout the state or county – and they invariably comment on the personal care they get at Mission as compared to other locations. That feeling that they are 'more than just a number' goes a long way with families who have complicated medical needs.

Western North Carolina is an amazing place to live. The people here are hard working, kind, and feel a strong sense of community. Access to high quality, life saving care in their community allows them to get well physically, without the stress and worry that comes from being far from their loved ones. Mission works hard to provide the best care, even in very difficult financial times. Mission employs wonderful people who truly care about their patients and neighbors. Mission has been a part of this community for generations, and has earned a reputation for excellent quality care. Our residents deserve to be able to choose where they get their care and I hope that Mission will be able to continue to serve its community in a way that puts patient's needs first.

Sincerely,

Carolyn Wilson-Brackett

Carolyn Wilson-Brackett, MS
Certified Genetic Counselor

Clinical Genetics Practice, 11 Vanderbilt Park Drive, Asheville, North Carolina 28803 (828) 213-0022 (888) 810-2800 Fax (828) 213-0030
Laboratory Operations, 267 McDowell Street, Asheville, North Carolina 28803 (828) 213-1015 Fax (828) 251-2808
www.missionhospitals.org/genetics

To: House Select on Certificate of Need Process and Related Hospital Issues:

My name is Gerald A. Kernick an employee of Mission Hospitals Asheville, NC. I feel certain that our hospital system has been more than transparent in regards to the Certificate of Needs Process and any other related hospital issues with the State of North Carolina now or over the last 15 years.

If more restrictions and regulation is placed on Mission Hospital systems with limited access to health care it will be a detriment to our community and state. By capping physician growth and hospital expansion in the South Buncombe and Hendersonville region access and quality of health care suffer. Would this CON be viewed any different if Carolina Health Care the intended provider in this region. I would think not.

Limiting services restricts choice for me and our community and would be a burden to get timely healthcare by having to go to another facility for services further away. Western Carolina is trying to attract other businesses to locate in this region but with this question about CON they might choose to locate elsewhere and our community is impacted even more.

I can speak personally about healthcare since I was a patient in 2010, and my outcome would have been worse if I had more than a 15 minute drive for the services I needed. Countless of patients have the same concern about health care as they consider Asheville and Western Carolina region for retirement.

10/18/2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Donna Borowski. I have worked at Mission Hospital for 21 years in Asheville N.C. I am writing about how Mission has operated under the Certificate of Public Advantage. I am unable to attend this meeting but want to be heard.

I work as Team Leader for the Nicotine Dependence Program. My Team and I see patients at the bedside, outpatients, employees, spouses and service as part of benefits to companies. All of the works we do at the bedside and as community patients are done for free. When someone is in this addiction to be provided support, education and follow up is very important for success. Mission gives our program to those that do not have a benefit. This is very important for our community and WNC.

I feel so strongly about the quality of care in our hospitals that I have brought both of my parents here from Georgia for treatment of health issues that could not be taken care of in their community. My parents have both had great outcomes from being cared for here. My husband has been very ill for the last 5 years and I have used our hospital because I trust the care here.

With the ever changing climate in health care and knowing that the smaller hospitals struggled. I am excited to have a larger system and help the care across WNC be of great quality. I know that many families are very grateful that they get quality care here in Asheville. I cannot imagine not having advanced tertiary care for WNC. We have a top trauma center, we excel at cardiac care, strokes, pediatrics, neonatal and the list goes on. I feel that we are blessed to have excellent this close to home for all in WNC.

Mission has been part of my family for a long time. I chose Mission to work at until retirement. I stand by that decision. We all should have the basic right to be cared for near our family and friends. We all deserve the best in our time of being the most vulnerable during illness. We all deserve to be able to choose where we receive our care.

It is important that Mission have the same privilege in this time of change to develop a stronger system through out WNC. It is important for the people of WNC and for a health system that has been providing care for 120 years.

Thanks for the opportunity to share.

Donna Borowski

10/14/11

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Julie Bowers and I am an employee at Mission Hospital located in Asheville, NC. I am writing you about how Mission has operated under the COPA, and I strongly feel it is time to free up Mission Health System from these constraints. I will not be able to attend the October 20, 2011 hearing, but I wanted to make sure you hear my opinion on this.

I work in Audit and Compliance Services, and although I do not provide patient care, my group strives to ensure compliance with all billing, coding and financial regulations. My dad who lived in Hayesville, NC, was a patient at Mission 2 years ago and overcame a serious infection that could not be addressed at the smaller hospital in Murphy, NC. Had he not gotten transferred to Mission, he would not have survived that illness. It is vital that Mission be able to affiliate with smaller hospitals in rural areas, and provide desperately needed care to those people.

I feel it is extremely important that Mission be free to serve the people of western N.C. without undue and unfair constraints. Mission provides the highest quality care and is a very important place of employment for 7,000 employees. People should have the freedom to choose where they go for hospital care, and my personal experiences have and will continue to cause me to choose Mission Hospital. I would like for my family, who lives west of Asheville, to be able to choose Mission also.

Respectfully,

Julie Bowers

Julie Bowers

October 14, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Rebecca Calloway and I am a member of Mission Health. I am the Administrative Director at Asheville Surgery Center, an outpatient surgery center in Asheville, NC. I am writing you about how Mission has operated under the Certificate of Public Advantage. I can't attend the October 20 hearing, but you wanted to make sure you heard from an employee.

From my own experience, Mission's services have made a tremendous difference in the lives of patients as well as my own personal life. In my role at Asheville Surgery Center, we see patients who are having elective surgery to improve their quality of life. Our center is designed to ensure patients who are at high risk receive the attention and quality of care they need to live a more comfortable life. Our staff provides a compassionate atmosphere where patients can come and know that they will be taken care of while they are with us. Our patients are so grateful to have a facility in Western North Carolina with such a highly respected reputation at their resource. They are comforted by the fact that they can be so close to home and know that their loved one is receiving the care they need and deserve.

As a Director, I look at our budget on a regular basis and see how COPA restrictions affect the services we can provide to our patients. In this market, everyone has to make cuts, but the COPA has definitely limited the quality and care our facility can provide to patients. For example, we perform a procedure in our center for patients with cerebral palsy to help them with nerve issues. Every time we perform this procedure, we lose approximately $10,000. We continue to do these types of procedures to help these patients live a more comfortable and better quality of life, but with even more cuts being made for the new fiscal year, we will be removing this procedure from our list. With the restrictions COPA has set for Mission Health, we definitely are limiting the services we can provide to our community. Not only is COPA affecting patients, it is reducing the number of staff we have available to serve our patients. With unemployment as high as it is in Western North Carolina, jobs are in high demand and COPA should look at the impact they are having on contributing to this figure. To remain competitive, COPA should remove the restrictions it has on Mission Health and look at bettering our community.

From a personal side, Mission Health has made a lasting impact on my life. Approximately a year ago, I was pregnant with my first child who was diagnosed with an incredibly rare chromosomal problem. My husband and I visited physicians in several states and none had ever seen a case like ours outside a textbook. We ultimately ended up using Dr. Ursula Harkness at MAHEC and Drs. Jim McGovern and Aaron Pulver at Asheville Cardiology and Dr. Ellen Boyd at Fullerton Genetics as our primary physicians

who helped us every step of the way. Our son was born as predicted three weeks early and weighed 3 lbs 12 oz. and was doing well under the loving care of the NICU staff. On the fifth day he caught an infection and died a few short hours later. Even in the midst of this tragedy, I left Mission Health feeling as though my family had received the best care possible under the unusual circumstances. I am thankful to these physicians and staff in the NICU for providing us the best care possible. Without Mission Health, we would have been required to travel to a different region to deliver our son and would not have been able for our family to meet our son in the short time span of his life. Mission Health was a tremendous resource for us and the love and care we received meant a lot to our family. When I accepted my current position at Asheville Surgery Center, I felt proud to be able to help serve the community in the way that my family was served just a year ago.

I ask that you reconsider the restrictions that COPA is placing on Mission Health and instead look at the good they are providing to our community in Western North Carolina. Thank you for your time and consideration to this very important matter.

Sincerely,

Rebecca Calloway
32 Memory Lane
Arden, NC 28704

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Elizabeth Pelletier and I have been employed at Transylvania Regional Hospital, a member of Mission Health, in Brevard, NC. I have worked as a nurse anesthetist for the past ten years here. I am writing to you about how the Mission system has operated under the Certificate of Public Advantage. I am hoping to attend the October 20 hearing but am unsure whether I will be able to speak and want to make sure that you hear from an employee.

I am involved in direct patient care and hear from patients on a daily basis how lucky they are to have such a great hospital close to home and yet have anesthesiologists from the Asheville Mission group practicing at our small hospital. Simply to be affiliated with Mission gives patients an added sense of comfort that the best medical technology and expertise are at their fingertips.

Being affiliated with Mission has already meant seeing a decreased cost in all the supplies used in patient care secondary to the stronger buying power of Mission. We will also soon see an increase in reimbursement from commercial insurance companies due to the greater bargaining power of the Mission system. All of this allows our smaller, critical access hospital to remain viable in these difficult financial times.

On a more personal note, a few years ago, my husband fell off a ladder and had a terrible fracture of his femur, a shattered heel bone, and a badly injured shoulder. Injuries of this type cannot be handled at our facility and we were lucky to have Mission so close. He was helicoptered there and was treated quickly and expertly by the staff and doctors there.

Because of the mountains here, we in Transylvania are fairly remote and deserve to have the high quality, life-saving care available close to home. We should be free to choose the expert care given at Mission and Mission should be free to serve the people of western North Carolina.

Thank you for your consideration...

Sincerely,

Elizabeth Pelletier

October 17, 2011

828-553-3644

TRANSYLVANIA
REGIONAL HOSPITAL

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am employed as the Director of Human Resources at Transylvania Regional Hospital in Brevard which is has a management agreement with Mission Health Systems. I am unable to attend the October 20th hearing but wanted to communicate with you concerning how Mission has operated under the Certificate of Public Advantage.

As the Human Resources Director at Transylvania Regional Hospital it very important that we have qualified staff to meet the needs of our patients. Mission has provided support to our efforts by helping us attract and retain great employees while allowing us the flexibility to meet the needs of a community hospital workforce. Mission Health is also an important part of our health plan's provider network which allows our employees to receive tertiary care that is a reasonable distance from their home. The inability to have high quality tertiary care close by would dramatically affect our ability to attract employees.

On a very personal note; my Mother and Father both have receive care on numerous occasions at Mission. The service has always been of high quality and delivered in a very compassionate way. Their ability to provide a personal touch in such a large organization has always been very impressive. For this and the other reasons it is vital that Mission be in a position to continue to provide care in Western North Carolina.

Sincerely,

Mark Emory, Director of Human Resources

My Name: Virginia Justice
22 Lilac St.
Asheville, NC 28806

I was a patient at Mission in 2006 I had
a heart attack and was told I was soon
to have another one, They got to work
right away and I had to have a stent.
I am so glad we have a hospital so
close, I was treated so good. I am so
glad we can choose where we go to
the hospital, I have been in Heart Path
since 06 and love it and all the staff
they are there to help in any way they
can.

Virginia Justice

My name is James McDonald and this letter is regarding Mission Hospital in Asheville, North Carolina, which operates under the Certificate of Public Advantage. I am a heart patient and unable to attend the October 20th hearing.

I have survived two heart attacks due to the availability of Mission Hospital's well-equipped and trained staff. I would like you to realize the important role Mission plays for the citizens of Western North Carolina.

It is very important to myself and my family to have the freedom to choose where you go for hospital care. It is also very important that Mission Hospital be free to serve all of the people here in Western North Carolina. We the people of Western North Carolina deserve to have life-saving, high quality care close to home just like every other region in North Carolina. They are both an integral part of the area they serve and a credit to the profession they are a part of.

Sincerely,

Mr. James C. McDonald
78 Queen Road
Candler, NC 28715

To the House Select Committee on the Certificate of Needs Process and Related Hospital Issues:

My name is Charles Koontz a current Heart Path patient with Mission Hospital. I could not attend the October 20 hearing in person due to my work schedule.

I became a patient with Mission Hospital on December 23, 2006. I was admitted with chest pains. After extensive testing it was determined that I needed coronary bypass surgery. Fortunately for me a heart attack was avoided and the surgery repaired the obstructed arteries. Heart Path rehab started in February of 2007. After completion of the cardiac rehab I was able to continue to this day with the maintenance program. The Heart Path program has completely changed my lifestyle involving regular exercise, better nutrition ideas and best of all new friends. Without the services provided by the Heart Path Staff my quality of life would not be what it is today. I am truly grateful for the staff's efforts and the mission of the Heart Path Program.

I'm proud of my mountain heritage and Mission Hospital has provided an improved quality of life for thousands of residents like me. That is why it is important for Mission Hospital to continue to serve the citizens of this region and continue to be leader in health care.

Sincerely,
Charles Koontz
Charles Koontz
800 South Mills River Road
Mills River, NC 28759

DRAFT

October 17, 2011

To: House Select Committee on the Certificates of Need Process and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years n the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously obeyed with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived it usefulness and is it an impediment to the ability of Mission to a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reason no longer exist. There are now other large, well financed health care systems serving in Western North Carolina who Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there is Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to be freed from COPA restrictions to be able to compete. Mission is

being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

ROBERTS & STEVENS, P.A.

John S. Stevens

JWM/paj

October 17, 2011

To: House Select Committee on the Certificate of Need Process and Related Hospital Issues

I am the President/CEO of Transylvania Health System based in Brevard, N.C., which includes Transylvania Regional Hospital. Transylvania Health System and our related entities entered a management agreement with Mission Health System on January 1, 2011. Currently, I am an employee of Mission Health System. I plan on attending the public hearing; however, I wanted to make sure that you hear from me as the lead executive of the not-for-profit healthcare system serving the residents of Transylvania County.

In 2009, our Board made a strategic decision that we needed to affiliate with a larger organization so that we could "maintain, enhance, and increase access to healthcare services for the people of Transylvania County." Our ability to reinvest in ourselves based on five-year financial projections, so that we could maintain our mission, was diminishing. After education on why hospitals were affiliating, we engaged a consultant group, Stroudwater and Associates, a national expert in affiliation matters.

Stroudwater lead our Board on an assessment of community need including short- and long-term needs. Based on that, we invited 15 different organizations, some local and some with a national presence, including not-for-profit and for-profit, to consider interest in an affiliation process. We received back seven active expressions of interests from which formal requests for proposals were sent. From the seven we received four meaningful proposals. These proposals included Mission Health System, another large dominant healthcare organization that provides management services to North and South Carolina hospitals, a large not-for-profit, religious health system with presence in Western North Carolina, and a for-profit firm. From these four our Board determined to pursue further due diligence with three. In the first quarter of 2010, we entered into a Memorandum of Understanding with Mission Health System, which lead to our Management Agreement.

Mission best fit the criteria for meeting both our community's and our organization's needs. The criteria included access to capital; assistance with third-party reimbursement; quality patient care and safety; physician recruitment and retention; quality-clinical integration; culture; ability to maintain/grow local services; local governance and management; branding; administrative assistance; long-term viability; and competitive risk. As our Board went through the process, Mission Health System substantially demonstrated better value for our local organization so that our community and hospital could "maintain, enhance, and increase access for the people that we serve."

After almost a year of affiliation we have experienced significant value from our management agreement with Mission. With the five-year financial plan based on our affiliation, we see our

260 Hospital Drive | Brevard, North Carolina 28712 | 828.884.9111 | trhospital.org

ability to be financial viable so that we can reinvest in maintaining services locally; having physicians to serve our local population; maintain a local healthcare team; purchase the necessary and needed clinical equipment for providing needed healthcare services locally; maintain and enhance our facilities so that they are current, meet code, and provide a safe environment for the patients that we serve.

Our affiliation will allow us as Transylvania Health System to be competitive in a rapidly changing healthcare environment in Western North Carolina. This environment is now dominated by large healthcare systems that are increasingly providing competition to Transylvania Regional Hospital. These include Greenville Health System from Greenville, S.C.; Carolinas Health System based in Charlotte, which now manages five hospitals in Western North Carolina; Park Ridge Hospital in Fletcher, a member of the Adventist Health System, one of the largest not-for-profit health systems in the country; and most recently UNC Hospitals, which has affiliated with Pardee Hospital in Hendersonville within recent months.

As the issue of the COPA has been discussed in our Legislature, our Board has unanimously adopted a resolution in support of the COPA. That resolution is attached. Our Board of County Commissioners also unanimously passed a resolution in support of the COPA. This is also attached.

In my professional judgment as the Chief Executive Officer of Transylvania Health System with 15 years of dedicated service and experience in leading this organization, without our affiliation with Mission Health System healthcare services by Transylvania Regional Hospital and its affiliates would be significantly diminished. In other words, our affiliation with Mission Health System is allowing our organization to continue to fulfill its mission locally which is that we "promote wellness and provide access to quality healthcare services for the people in our region."

Please understand that the COPA was the right solution at the time and Mission has complied fully. The competitive landscape in healthcare in Western North Carolina is changing dramatically. In order for us to meet the needs of people in our service area of Transylvania County and survive and thrive along the way, we must have the freedom to serve and compete in this new environment. Transylvania Health System as a managed member of Mission Health System wants our patients, not government regulators, to choose where they receive care.

Thank you for your attention to these matters and I encourage you to support Mission Health System, as a significant provider of healthcare delivery in a very competitive landscape of Western North Carolina.

Sincerely,

Robert J. Bednarek

Robert J. Bednarek
President/CEO

Attachments

RESOLUTION OF THE BOARD OF TRUSTEES OF TRANSYLVANIA HEALTH SYSTEM, INC.

The following resolution was adopted by the Board of Trustees of Transylvania Health System, Inc., a North Carolina nonprofit corporation, at a meeting of the Board duly called and held on April 28, 2011, at which a quorum was present.

We, the Board of Transylvania Health System, Inc, an affiliate of Mission Health System through a Management Services Agreement, would like to make the following points regarding proposed changes to the Certificate of Public Advantage (COPA).

1. Mission has been a good partner to community hospitals in our region. Mission has consistently come to the aid of struggling community and critical access hospitals in federally designated physician shortage areas, helping to add needed services, recruiting physicians, and updating facilities. Mission's significant investment in medical education, evidenced by partnerships with UNC-Chapel Hill's Schools of Medicine and Pharmacy, is important in helping us address the critical shortage of physicians and pharmacists in our region.
2. Mission is the region's safety net provider. Mission Hospital supports every community hospital in our region by serving as the region's tertiary care provider. As such, it offers specialty care to patients from all 18 counties of Western North Carolina. If these services were not available at Mission, our patients would have to drive four to six hours to receive them. These services include the region's only Children's Hospital, only Level III-c NICU, only high-risk OB program, and the region's largest community-based in-patient psychiatric facility for adults, geriatrics, adolescents and children. Mission also serves as the region's designated Trauma Center and offers one of the state's largest heart programs. All of these services make a significant difference in the health status of the people of Western North Carolina.
3. Since Mission Hospital voluntarily entered into the COPA agreement 15 years ago, competition has dramatically intensified in our region. Today, Mission competes with two significantly larger, multi-state health systems: The Adventist Health System, based in Orlando, FL, and Carolinas Healthcare, based in Charlotte, NC. We want our patients, our hospitals and our physicians to have choices when it comes to how and with whom we affiliate.
4. The Adventist and Carolinas systems have proposed changes to Mission's COPA in the hope of advantaging themselves directly. Those changes would take away the choices currently available to patients, their physicians and hospitals, thereby making it impossible for Mission to compete with larger health systems. To survive, Mission needs to have the flexibility to respond to whatever changes result from the implementation of health care reform, and it needs to be able to compete under the same rules that apply to these much larger, formidable competitors: The Adventist Health System and Carolinas Healthcare.

Taking all of these factors into consideration, we request our own changes to the COPA, revising it in the following ways:

1. Recognize that the competitive landscape in Western North Carolina has shifted dramatically, with Mission in direct, heated competition with much larger, out-of-area health systems; and
2. Remove the physician employment cap of 20%, which will allow Mission Health System to support the needs of its affiliate hospitals in rural counties and address the growing shortage of physicians in our region.

[signature]

President/CEO

BOARD OF COMMISSIONERS
Mike Hawkins, Chair
Kelvin Phillips, Vice-Chair
Larry Chapman
Jason Chappell
Daryle Hogsed

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3100
Fax 828-884-3119
828-884-3107
21 East Main Street
Brevard, NC 28712

Resolution 14-11
In Opposition to Senate Bill 698
Modify COPA Agreement /Mission Health

Whereas, Transylvania Regional Hospital (TRH) is a small rural hospital serving the citizens of Transylvania County and neighboring counties and has a management agreement with Mission Health System (MHS); and

Whereas, Senate Bill 698 could end or negatively impact the current management agreement between TRH and MHS; and

Whereas, this bill will severely restrict the number of physicians that can be employed by MHS and/or TRH which will put TRH at a significant disadvantage in recruiting new physicians to Transylvania County; and

Whereas, TRH will face significant financial pressure to maintain and enhance services in Transylvania County without the expertise and financial negotiating power of MHS; and

Whereas, as a small rural hospital TRH will be at a significant disadvantage to compete against much larger health systems already in our region including Carolinas Healthcare System and the Adventist Health System; and

Whereas, this bill circumvents an existing, well thought-out process of regulatory review of MHS and its competitiveness by the State of North Carolina; and

Whereas; no local input from TRH or local elected officials were sought regarding the impact this legislation would have on TRH's ability to serve the residents of Transylvania County;

Now therefore, the Board of Commissioners of Transylvania County does hereby oppose Senate Bill 698 and requests that it be withdrawn.

This the 9th day of May, 2011.

ATTEST:

Mike Hawkins, Chair
Transylvania County Board of Commissioners

Trisha M. Hogan
Clerk to the Board

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 Sweeten Creek Road Asheville, NC 28803 (828) 277-4800 www.carepartners.org

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

For Release Child Abuse Prevention Services

10-20-2011

50 S. French Broad Avenue
Asheville, NC 28801

Contact: Bill McGuire
O: 254-2000, ext 102

Child Abuse Prevention Services, Inc. of Asheville receives Counseling Grant from Community Benefits Program of Mission Hospital

Asheville: Child Abuse Prevention Services, Inc. (CAPS) of Asheville has received a $37,000 counseling grant from the Community Benefits Program of Mission Hospital.

"This grant will help us to provide immediate access to crisis intervention/counseling for children and families who have experienced abuse", said Bill McGuire, Director of CAPS. "It will give them the opportunity to stabilize, get through the devastating crisis and trauma, and develop new skills to cope with the abuse." We're very grateful to Mission's Community Benefits Program for helping us deliver these needed services to the community. Especially so, since we are seeing more and more younger children for counseling, and more hands are going up in our school-based prevention program (which reaches 8,000 children annually) to disclose abuse."

Child abuse is a preventable tragedy, yet over 5 million children a year are reported as abused or neglected, including over 100,000 in North Carolina, and over 4,000 in Buncombe County. One in every five children will be abused, half will be under six-years of age, and child abuse (physical, sexual and emotional) cuts across all lines and knows no boundaries. Behind each of these numbers is a face, a child, our future.

The cost of child abuse in the US is a quarter of a million dollars a day or $95 billion a year. This equates to $1,500 a year per family, yet we only spend a dollar a year a family on prevention.

Last year Child Abuse Prevention Services educated and empowered over 7,500 children with skills to protect themselves through prevention education; provided crisis intervention and counseling to 500 children and families, and helped several hundred parents acquire increased parenting skills.

Some success stories include the young girl who raised her hand in our child abuse prevention program at a local school to disclose abuse so horrific that DSS and law enforcement rushed to the scene to immediately remove her from the sexually abusing parents. In essence CAPS prevention program became an intervention in facilitating her disclosure and led to treatment as she came to us for counseling/therapy. She was later adopted by her foster parents and is doing well. And, the young brother and sister coming for counseling. The 8-year-old boy was put in a clothes dryer by the mother's boyfriend and witnessed the boyfriend blow his brains out. The 9-year-old girl was savagely sexually abused. They came in depressed, intimidated, sad, and now come in skipping in smiling, saying "Miss Shannon, what are we going to do in therapy today?" These kids have experienced something no child should have to experience,

but the hurt has stopped, the hope and healing has begun, and they have the opportunity to reach their potential.

For information or to become a donor or friend of Child Abuse Prevention Services, Inc., call 254-2000, write 50 S. French Board Avenue, Suite 152, Asheville, NC 28801 or email: caps@childabusepreventionservices.org, or go to www.childabusepreventionservices.org

William R. Hathaway, MD, FACC
Chief of Staff, Mission Hospital
509 Biltmore Avenue
Asheville, NC 28803

October 28, 2011

Chairman Steen, Chairman Torbett and Committee Members:

First and foremost, thank you for taking the time to meet with our community last week and to hear our views regarding CON and COPA issues as they pertain to Western North Carolina. As you no doubt discerned from the discussion, this is an emotionally charged issue. I hope that the facts will be clear and trust that they will lead the committee to decisions which will serve the best interests of our patients.

Mission has clearly and accurately conveyed that it has been fully compliant with the stipulations of the COPA, that the COPA has been appropriately overseen by the state and that the competitive landscape in Western North Carolina has dramatically changed obviating the need for a COPA. In my capacity as the elected Chief of the Medical Staff at Mission I wish to address issues related to patient access to care and quality of care. Please note that as the Chief of Staff I am not paid by Mission Hospital, but rather by the medical staff. I am certain that my views are representative of the vast majority of the physicians in our community.

Physician Employment

Any restriction on Mission's ability to employ beyond that which would be reasonable in a competitive market must be avoided. As greater numbers of graduates seek employment relationships with health care systems, any restrictions on such will limit the ability to recruit physicians to Western North Carolina. (Please see the appended article for details.) With fewer than 50% of physicians nationwide remaining independent at this time, and estimates indicating that fewer than one third will be independent in 2013, failure to allow Mission to employ physicians would not only be unfair with respect to competing against the other hospital systems that have come to our region, but would also limit the recruitment pool and in turn result in a critical shortage of both primary care and specialty physicians in the region. For a region that is already underserved, particularly with respect to primary care, *this would have a tremendously negative impact on access to care and community health.*

I will illustrate how employment/integration benefitted the region with an example from my cardiology practice. Despite repeated efforts, for many years we were unable to recruit cardiologists to the rural hospitals, of Harris Regional and Rutherford Hospital . Carolinas Medical Center eliminated the cardiology service at Rutherford Hospital and our practice's solo

cardiologist located in Sylva is retirement age and in need of a partner. Our independent business model provided us with little incentive to hire for the region; we were unable to offer adequate compensation for these positions which are in general less sought after by medical specialists interested in providing high tech care. We entered into our partnership with Mission Hospital in January of 2010 which allowed us to offer competitive pay and a relationship with our group. Almost instantly we found cardiologists for both of these hospitals. This would not have happened without the Mission Hospital employment relationship.

Moreover, and contrary to the misstatements offered repeatedly at the recent hearing, hiring these physicians strengthened the care at the local hospitals. Neither Harris Regional nor Rutherford Hospital is affiliated with Mission. The patient care that remains at these institutions is delivered in a safe and effective manner, locally and will continue to be delivered locally. *This has been a win for patients, a win for the hospitals and a win for the doctors. It is precisely this model that Mission seeks to leverage.*

Unreasonable limits on Mission's ability to hire will additionally restrict physician choice for those who already have practices in the region. At a time when external forces are driving physicians into employment relationships, limited choice with respect to with whom a physician can align will result in a physician exodus from the region with the attendant consequences of reduced access for patients and diminished health status for the region.

Patient Freedom to Choose

Much attention has been placed on the need for patients to have the ability to choose from whom they receive their healthcare and I couldn't agree more. Mission and the medical staff of Mission have taken great pride in the high quality and compassionate care that has been delivered to the patients of the region for many years. The quality of care is evidenced not only by the numerous quality awards Mission has received over the years, but also by the fact that patients have and will continue *to choose* Mission when they are critically ill. Limits that would hamper Mission's ability to fairly compete in the region would greatly impair its ability to maintain this superior quality and to care for those unable to pay or unable to receive the services in their local communities. We are the safety net provider and that cannot be emphasized enough. As the axiom goes, without margin, there is no mission and the mission remains to provide the highest quality of care for the entire region.

Finally, I would like to emphasize that contrary to what was expressed at the community hearing, Mission's alliance with regional hospitals has come at the request of those organizations and has truly served the best interests of the patient. Just as physician employment trends grow, small hospital affiliation with larger health systems is also a national

trend. Financial drivers are at the root of this movement. Being able to affiliate with a superior quality, locally owned and governed health system has saved these community hospitals and kept quality care close to home - no hostile takeovers, no loss of choice for patients.

I appreciate your time and attention to the matters at hand. There are numerous other compelling reasons to avoid limiting Mission's ability to fulfill its role as the regional safety net provider. I chose to focus my comments on just a few of the physician/patient issues, but would be happy to entertain questions from any of the committee members at any time. We, Mission Health, the hospitals in the region and the physicians in the region, have an obligation to the community that cannot go unfulfilled and hope that you will create a legislative environment that allows us to succeed. *The COPA has been paid in full, the competitive landscape has changed and Mission and the physicians of Western North Carolina must be given the freedom to serve as we have done so capably for the past 126 years.*

Sincerely,

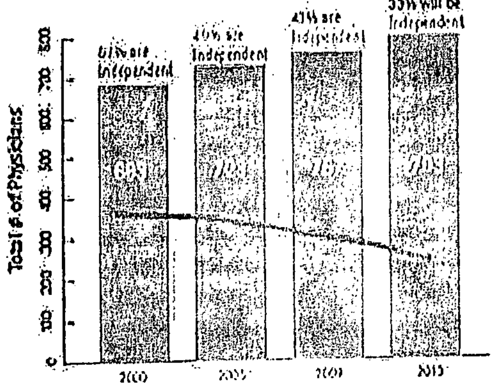
William R. Hathaway, MD, FACC

Chief of Staff, Mission Hospital

Physician Employment Trends Will Force Payers, Hospitals and Vendors to Revise Business Strategies, According to Accenture Survey

By 2013, less than one-third of physicians are expected to remain in private practice

NEW YORK; June 13,2011 – U.S. physicians continue to sell their private practices and seek employment with healthcare systems, according to a new survey from Accenture (NYSE:ACN). As physicians migrate from private practice to larger health systems, the new landscape will require healthcare IT, medical devicemanufacturers, pharmaceutical companies and payers to revise their business models and offerings. At the same time, hospitals will need to determine how to retain and recruit the correct mix of physicians, especially in high-growth service lines, including cardiovascular care, orthopedics, cancer care and radiology. Patients will increasingly move to large health systems, as opposed to the current trend of visiting doctors in private, small practice settings.



According to Accenture, the rate of independent physicians being employed by health systems will grow by an annual five percent over three years. By 2013, less than one-third of physicians are expected to remain truly independent.

"Health reform is challenging the entire system to deliver improved care through insight driven health," said Kristin Ficery, senior executive, Accenture Health. "We see an increasing number of physicians leaving private practice to join hospital systems, which will force all stakeholders to revise and refine their business models, product offerings and service strategies."

According to the survey, physicians are increasingly attracted to the benefits offered by hospital-based employment opportunities. These benefits include:

Relief from administrative responsibilities;

Greater access to leading-edge healthcare IT tools, facilities and equipment;

- A more manageable work week; and
- Stability in a business environment made uncertain by developments such as payment reforms.

Accenture's analysis suggests that complexities in the changing healthcare landscape may result in:

- Hospitals enhancing expertise and boosting patient volumes and revenues in high-growth service lines;
- Companies serving diverse markets will shift their sales force structure from national to regional;
- Payers encountering greater negotiating leverage, which must be factored into future business strategies, as physicians increasingly associate with larger groups and healthcare systems; and
- Companies working to reach the physician market will find their efforts more challenging.

Survey Methodology
Accenture's Physician Employment Report includes highlights from a survey and assessment of physicians and hospitals and business behaviors emerging from healthcare reform. The report highlights the impact to physician employment, care delivery and clinical coordination, which is relevant to policy makers, health systems and patient advocates. Accenture held in-person and phone interviews with c-

sulte hospital executives and industry stakeholdersbetween September to November 2010 and the analysis completed in 2011.
Learn more about Accenture Health.

MEDICAL ASSOCIATES
OF TRANSYLVANIA REGIONAL HOSPITAL

PRESENTATION TO THE SELECT COMMITTEE ON MISSION/ST. JOSEPH'S COPA
October 20, 2011

Good Evening Ladies & Gentlemen:

Welcome to Fall in the mountains. I am Ruffin Benton. I've been a family doc in Brevard for 35 years. I am Chief of Staff at Transylvania Regional Hospital, and serve on the Board of the Transylvania Health System. I will be 65 years old in two weeks, and another contributor to the medical care reimbursement problem in Western North Carolina.

Thanks for coming to help us care for the people of Western North Carolina.

Politics is the struggle for power. We are involved tonight in a political process to resolve the turf battle involving several outstanding health care systems. It is imperative to remember that our people--our patients--not our health care systems, need to be at the center of this hearing.

I came to Brevard 35 years ago to enjoy Western North Carolina and to care for the people here. The group I joined was small and grow over time. A few years ago, my group joined Transylvania Regional Hospital in order to deal with the economic and access problems of practicing medicine in Western North Carolina, and to enable us to attract and retain physicians for Brevard. More recently Transylvania Regional Hospital initiated and entered into a management agreement with Mission Health System for the same reasons: so that we might continue to provide high quality care to the people of Transylvania County through a formal agreement recognizing the longstanding collaboration with Mission Hospital. Before finalizing this agreement, we looked at several partners, all of whom had much to offer. Mission clearly offered our doctors and Transylvania Regional Hospital the best opportunity to take care of our patients and build a regional organization.

It is often said that the health care system is broken. I disagree with that statement for two reasons. First, doctors and hospitals offer primarily crisis and sick care, not health care. Second, there is no system, but many disparate and desperate groups who are struggling for power, dominance, and dollars. Transylvania Regional Hospital has joined with Blue Ridge, McDowell, Angel and Mission to build a health care system for the people of Western North Carolina. Limited reimbursement and mandates from the Forces of Darkness have made it impossible to move forward, or even exist as a community hospital or private medical practitioner in this challenging environment. Our management agreement with Mission Health System stresses cooperative efforts among all hospitals and doctors in the system we hope to build.

During my 35 years in practice and leadership positions, I have encountered many impasses. Imagine--doctors at an impasse! Faced with apparently insoluble problems, I remind myself that the patient must be paramount. The solution becomes much more clear at that point.

To best provide for the folks of Western North Carolina, we need to build a health care system. Transylvania, Blue Ridge, McDowell and Angel will work with Mission Health System to build an effective organization to serve the people of Western North Carolina. I will take the liberty to invite all of the practitioners and hospitals in Western North Carolina to be a part of our dream. I ask the Select Committee to recognize the needs of the people in Western North Carolina, and the legitimacy of our efforts. Legislative shackles should not be allowed to thwart our efforts to be patient advocates.

G. Ruffin Benton III, M.D.

377 Gallimore Road | Brevard, North Carolina 28712 | 828.884.9030 | www.matpaonline.com

My name is Michael LeCroy. I am an orthopaedic surgeon and the director of Mission's Orthopaedic Trauma Service. Eight years ago, I was recruited to come to Mission from the University of North Carolina to establish an orthopaedic trauma program. Since that time, our program has grown to one of the largest in the state, with over 1200 surgical procedures performed annually by our team. I never cease to be amazed and encouraged by the skill and dedication of my colleagues and the commitment by our trauma team at Mission to providing the highest quality care to all injured patients – care that I believe is second to none.

Of course, at Mission we readily accept and treat injured patients from all over Western North Carolina. Patients are accepted regardless of insurance status or their ability to pay. Many of these patients are initially seen in other hospitals. These hospitals in our region of the state, that otherwise view Mission as a competitor, rely on us to accept their patients, and they trust us to provide expert and often life-saving care. And that is exactly what we do – every day. We provide the opportunity for injured patients to receive the highest quality trauma care – right here in western North Carolina.

My colleagues and I at Mission remain committed to caring for injured patients throughout western North Carolina. We have dedicated our careers to this. However, Mission is facing significant challenges that threaten our ability to continue to provide expert trauma care to our region. Many of these challenges we have heard about in some detail tonight, including the fact that many services provided by Mission to the region, like trauma care, are money-losing endeavors. These essential services must be subsidized by other programs. Mission must have the freedom to survive and thrive in a healthcare environment that has changed drastically since the COPA was first established.

Just imagine for a moment what it would be like if Mission was not able to provide care for injured patients in our region? Just imagine if Mission was not able to provide this care for you, or for your loved ones? Isn't it obvious that we are all counting on Mission to be there when we need it to be?

Comments to State Special Committee on CON and COPA Issues:
In an effort to allow citizens of WNC to receive local, accessible, high quality care, Mission has actually helped small regional hospitals survive through system integration. Mission and its affiliates are actually the "home-grown" providers in the mountains; the Park Ridge/ Adventist system and the Carolinas Health System are just two of the outsiders threatening regional control and limiting options by skimming well insured patients from the already tenuous payer-mix. The Adventist system and Park Ridge will deny it, but they have committed a bottomless war chest of resources to the competition for patients in WNC, and have offered to buy Mission Health System in the process; a reversal of the David-Goliath myth. Mission is looking at national trends in the evolution of health systems and is trying to remain competitive through modern systems of organization and health care delivery. WNC and state legislators must avoid the reflexive rejection of everything that sounds like regulation or outside intervention, and should look at the big picture of what is required to maintain and improve a world-class system of high quality, safe, and cost-effective care in this region.

Stephen Hulkower, MD
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Public Hearing COPA Comments

- Hello, my name is Dr. Bryon Dickerson. I am a radiologist, and am the President and CEO of Asheville Radiology Associates, an independent radiology practice in Buncombe County. I have been practicing in this community for almost 10 years. My group has served the western North Carolina region since 1944.

- As a Radiologist it is my job to look inside the human body. I see miracles being performed at Mission daily. One example I'll share with you is a 20-year old trauma patient who presented to Mission's ED after falling from a construction site onto a vertical shaft of rebar. The rebar impaled him front to back, side to side from the upper right chest through to his upper left back. The EMS on the scene cut the rebar and transported him, rebar and all to the ED. It was the skill of Mission's ER and Trauma services that saved this person's life.

  Another example is of a seventy-year old man who was getting a CT for belly pain. He had a ruptured Abdominal Aortic Aneurysm and was actively bleeding into his belly. Most of these patients die and never make it to the hospital. He was emergently taken to the OR by the vascular surgeon where the bleeding was controlled, his aorta repaired, and his life saved.

  The third case I'll share is a 60 year-old man with dizziness who suddenly became unresponsive. He was intubated in the field and brought to the ED. He was then diagnosed with basilar artery thrombosis which has a death rate of 70-80%. Our doctors were able to guide a catheter into the brain, find the clot and treat the clot. This patient was discharged in 4 days with near complete return to function.

  These stories are real people - people who benefitted from the level of care provided at Mission Hospital. Stories like these happen every day at Mission because they are the tertiary care center for our region.

  Mission is the tertiary care resource in western North Carolina. Mission needs the freedom to serve this role without the restrictions the COPA places on Mission.

- But there is another aspect of freedom I would like to address, that is the personal freedom of choice.

- My group's choice right now is to remain independent. We know that there is a trend in healthcare for doctors to affiliate or be employed by hospitals. If, sometime in the future, we were to decide to affiliate with a hospital system we don't think it is appropriate that the government restrict our choices.

- Under the COPA, Mission is limited in the number of physicians it can employ. It is the only health system in North Carolina that is restricted in this way by the government. Meanwhile, other large health systems that operate here in Western North Carolina and compete vigorously with Mission are employing hundreds of physicians.

- It's clearly unfair to Mission because it handicaps them in trying to serve patients. But it's also unfair to me and other private practice doctors to have the government dictate which hospitals I may or may not choose to affiliate with.

- For now, I have decided that an independent practice is still the best option for me, for my family and my future. But if I should change my mind, I do not believe that the government should tell me to whom to align with in the region.

- To quote Thomas Jefferson, "...my reading of history convinces me that most bad government results from too much government."

- So please, I urge this committee: reevaluate the COPA and the restrictions it places on my choices as a professional in Buncombe County. Thank you.

Vinroot, Richard

From: Bowman, Everett
S[redacted] Tuesday, November 15, 2011 4:30 PM
To: Shawn Parker
Cc: 'Taylor, Chris'; 'Ksturgis@ncdoj.gov'; Vinroot, Richard; 'Brian D Moore'; 'Ann Young'
Subject: Physician letter regarding Mission's COPA
Attachments: 20111115145748257.pdf

Dear Shawn,
Attached is a letter dated November 3, 2011, from the physicians practicing with Asheville Pediatrics Associates concerning Mission's COPA. We would appreciate your circulating this letter to the members of the Legislative Study Committee, to be filed with the prior submissions by and on behalf of Mission.

We presume that the focus of the next public hearing, on November 17 in Wilmington, will be CON law, regulations, and procedures. We will not be surprised, however, if representatives of Park Ridge Hospital appear again before the Committee to criticize Mission, as they did at the end of the Mount Holly hearing. Therefore, Mission has asked that Richard Vinroot and I plan to attend the Wilmington hearing as well. We'll speak only if it appears necessary and appropriate to rebut any speaker who raises issues concerning Mission.

Richard and I look forward to seeing you in Wilmington (my home town). Best wishes. Everett

Everett J. Bowman
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Charlotte, North Carolina 28246
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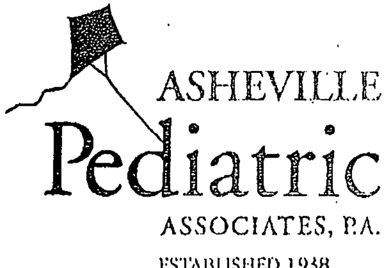

H. Wesley Garbee, M.D.
Susan R. Cohen, M.D.
Donna A. Page, M.D.
Leigh M. Dodson, M.D.
Eleanor A. Martin, M.D.
Calvin O. Tomkins, M.D.
Ellie M. McCormac, PA-C

Thursday, November 03, 2011

Chairman Torbett and Steen
North Carolina General Assembly

Dear Chairman Torbett and Steen,

We are pediatricians at Asheville Pediatric Associates, the oldest pediatric practice here in Asheville. We are writing to you because we feel strongly that Mission's COPA should be dissolved. The COPA was appropriate when first established, but as the health care economic landscape has changed, it's utility has waned. If Mission continues to be fettered by an antiquated COPA, it's solvency is at stake. Designed originally to protect patient's ability to choose health care services, the COPA now threatens to limit that ability by hindering Mission's capacity to evolve.

Mission's greatest asset is that it grew out of the western North Carolina community. Over the decades, it has responded and adapted to the specific needs of this community. Through patient satisfaction, Mission has cultivated a lasting trust.

As primary care physicians, we value the freedom to choose where we refer our patients. We have been very pleased with the care that Mission provides, and our patients feel the same way. We also value the freedom to affiliate with whichever hospital we choose. We believe that Mission should not be restricted in this regard.

Our patients deserve the excellent clinical care that Mission provides. Mission deserves a free market. We speak not out of "fear" as some have suggested, but out of concern for our patients.

Sincerely,

Susan Cohen, MD   Leigh Dodson, MD   Henry W Garbee, MD

Eleanor Martin, MD   Donna Page, MD   Calvin Tomkins, MD

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Bill would limit Asheville's Mission Health System growth

Written by

Nanci Bompey

9:57 PM, Apr. 21, 2011|

State legislation introduced this week would put limits on Mission Health System's ability to acquire hospitals and affiliate with physicians, a move the hospital said could [illegible] out of business.

The bill introduced by Sen. Jim Davis, R-Macon, would require that North Carolina amend Mission's certificate of public advantage agreement, or COPA. That agreement is intended to protect consumers against a loss of competition that followed the merger of Mission and St. Joseph's hospitals.

The legislation singles out Mission alone and would immediately place a moratorium on all of the health system's acquisitions, affiliations and joint ventures until the end of the year or a study is completed.

It would then place a 10 percent cap on physician employment by Mission in all counties in Western North Carolina and require Mission to provide notice to the state of any proposed new acquisition, affiliation or joint venture, which would be subject to public comment.

Davis, an orthodontist, said Mission has a "legal monopoly," giving it an unfair advantage in the health care field.

"The people I am really concerned about are the individual physician groups being bullied by Mission," he said. "They shouldn't have to make the choice between joining Mission and being crushed."

Mission is WNC's largest hospital, licensed for 730 beds. The health system is also the largest employer west of Charlotte, with about 7,000 employees.

Mission CEO Dr. Ron Paulus said the legislation is "detrimental and lacking in common sense".

Paulus said he doesn't believe the bill will pass and that it doesn't have broad support, but Mission is concerned about

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the potential impact. The hospital sent a r to employees about the legislation Wednesday.

The bill, Paulus said, would increase physician shortages in underserved areas and block the hospital's ability to complete an impending affiliation with Angel Medical Center in Franklin.

"If this legislation were in fact to be passed, it's only a matter of time, not a question of if, that Mission would ultimately not just be harmed, but shut its doors," Paulus said. "There is no health system that can operate in any kind of thoughtful, successful manner that would be restricted from all the things described in this bill."

Davis acknowledged that getting the bill passed is "going to be a struggle." He said ~el, which is in his district, should enter ... an affiliation with Mission willingly and if the deal falls through, Mission can find another partner.

"I am not trying to put Mission out of business, and their claim that it will put them out of business is widely exaggerated, if not totally untrue," Davis said. "They will survive but not be necessarily dominant in the area. ... They should have to compete like everyone else."

Mission's COPA

Mission has been operating under a COPA since the merger of Memorial Mission Hospital and St. Joseph's Hospital in 1995.

The COPA, issued by the state, is a way to ensure that the merger would not significantly increase Mission's market power. The agreement is designed to ensure consumers would not face higher prices or reduced quality although competition was being eliminated. Mission is the only hospital in North Carolina and one of only a handful in the country that operate under a COPA.

The recently introduced legislation is based on an economic analysis of the COPA completed in February and currently out for public comment. Mission said it commissioned the report to see if changes could be made to current caps on physician employment.

The report concluded that the agreement, and caps on the hospital's margins and costs, could allow the hospital to increase prices. It also said the cap on physician employment may be unnecessary.

It is up to the state to decide whether the current agreement will be modified with the

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recommendations.

Mission can accept the agreement, or it can exit the COPA.

"I don't disagree with any of the theoretical arguments made in the report," Paulus said. "I just don't think they are all necessarily apropos to how the real world functions and what we've done."

Increasing competition

The legislation and the report come amid increasing competition in health care in WNC.

In materials provided to the Citizen-Times, Mission claimed Charlotte-based Carolinas Healthcare, which manages MedWest, and Florida-based Adventist Health System, which owns Park Ridge Health, "are actively seeking to limit health care choices" in Western North Carolina.

MedWest officials were not available for comment Thursday.

Park Ridge Health said in a statement that "the analysis exposed many flaws in the COPA and raised significant red flags for our region."

"Additionally, the report confirmed that Mission continues to gain massive market share in neighboring counties as their efforts to directly compete with area community hospitals continue to intensify," the statement said. "Any action by the legislature is simply a response to the critical findings from the state ordered report."

Park Ridge has also been critical of Mission and Pardee Hospital's joint venture to build an outpatient center in Fletcher, saying it "exposes a continued desire on their part to further drive competition from this market".

Park Ridge would not comment on Thursday beyond the prepared statement.

Paulus said the need for the outpatient center is "undeniable." He said the COPA is complicated and has the potential to be misconstrued by people who have an agenda against what Mission is doing.

Davis said he has talked to a lot of stakeholders about the bill, including Mission. He said neither the state Hospital Association nor state Medical Board has an official position on the legislation.

"Park Ridge and Carolinas and Mission are big boys, and they can fight for

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themselves," he said.

I would never do anything to intentionally impede Mission's ability to provide quality health care in Western North Carolina, which they have done for many years," Davis said. "I am a free-market kind of guy, and this COPA, as prescribed, allows Mission to be predatory with practices in the western part of the state."

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Bill targeting Mission should quietly go away

:29 PM, Apr. 22, 2011|

The first order of medicine is to do no harm.

That would be a good prescription for our legislators down in Raleigh when they're tampering with health care for entire communities.

m Davis, R-Macon, introduced a bill last week that would drastically limit how Mission Health System grow to serve the region's medical needs in the increasingly competitive and complex health care market.

Davis is seeking a moratorium on Mission's talking with any hospitals or doctors about mergers, affiliations or joint ventures. The bill would also impose a 10 percent cap on the number of physicians in any county that could work fulltime for Mission, half of the 20 percent cap that Mission currently has in a certificate of public advantage agreement with the state.

Mission Health grew out of the 1995 merger between the century-old Mission Memorial Hospital and the Catholic-owned St. Joseph's Hospital. Leaders approached the state for a certificate of public advantage, which would allow the two hospitals to merge and save money from vendors without violating anti-trust laws.

Under that agreement, Mission has been the state's most regulated health system, officials said. Mission has the third lowest charges of any system in the state, despite having the highest percentage of Medicare and Medicaid patients. Those government programs offer less reimbursement for services the hospital and doctors provide than private insurers.

Mission recently asked for the state to review the certificate, possibly to raise the caps on physicians, but Davis's bill would short-circuit that review, effectively handcuffing Mission's efforts to compete in the market.

am a free market kind of guy," Davis said, but he worried that Mission's prominence in the region makes it predator that bullies physician groups.

on's CEO Ron Paulus was blunt about the potential fallout from the Davis bill. "If this legislation were in

fact to be passed, it's only a matter of time, not a question of if, that Mission would ultimately not just be harmed, but shut its doors," Paulus told the Citizen-Times editorial board.

That's a scary scenario for Mission Hospital, the region's largest with 730 licensed beds. The health system ˙ o the state's largest employer west of Charlotte with about 7,000 employees. Paulus has also alerted a.. .. Mission's employees by e-mail of the bill's potential.

It's not impossible to envision Mission Health becoming a prime target for a takeover by a larger entity, which would effectively end any local control of our primary health-care provider and the region's single largest employer.

Mission may seem like a 800-pound gorilla with $966 million in annual net revenues, but the nonprofit faces increased competition from other players in the region, namely the Carolina Heathcare in Charlotte ($6.5 billion annual net revenues), which operates MedWest with hospitals in Haywood, Swain and Jackson counties, and Adventist Health System of Orlando ($6.3 billion annual net revenues), which owns Park Ridge Health near Fletcher.

Davis's bill may, intentionally or not, nix the deal underway at his hometown hospital, Angel in Franklin, whose debt has been guaranteed by Mission Health. Smaller rural hospitals, in Spruce Pine, Marion and Brevard that have partnered with Mission for financial and clinical assistance may not be able to hire the specialists they need to serve their communities.

Without those local specialists, more people from smaller towns in Western North Carolina will have to drive a couple of hours to Asheville to get treatment.

Paulus said there seems to be little to no support for Davis's bill among other legislators, making it unlikely that Mission Hospital will be out of business any time soon.

We have to agree with Davis when he said "Park Ridge and Carolinas are big boys and they can fight for themselves."

We question why Raleigh needs to single out one hospital system, and not the largest by any means, effectively tying its hands in how it best serves the health needs of the region. The only potential benefit we can see from such heavy-handed government meddling would go to Mission's competitors.

The healthiest outcome for all of Western North Carolina would be for this particular bill to die a quiet death.

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Market should dictate hospital deal's viability

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... forces will determine whether Pardee Hospital and Mission Hospitals open a joint utpatient facility on the Henderson/Buncombe county line, regardless of the campaign waged y rival Park Ridge Health to halt the plan.

ardee and Mission have plans to build a $45 million, 130,000-square-foot outpatient facility on .S. Highway 25 straddling the county line. The medical complex would house rehabilitation rvices, a pharmacy, lab, imaging and doctors' offices, in addition to wellness and prevention ograms and an urgent care center.

ardee is looking to the joint venture to maintain its viability and appears headed toward nsummating the deal despite Park Ridge's protests that the facility will cut into its market are. The Fletcher Planning Board gave its approval last week.

enderson County has been blessed with two hospitals providing excellent care. But rapid anges in health care are prompting more and more mergers and joint operating agreements tween hospitals. As one local doctor put it, "There is a feeling that in order to survive, you've t to be bigger."

rdee last month entered into a managerial affiliation with UNC Health, which supports the int venture with Mission. Gary Park, president of UNC Hospitals, said the outpatient facility uld improve Pardee's market share.

is understandable that Park Ridge would oppose two rivals joining forces to open a competing cility 4 miles from its doorstep. Last year, Transylvania Community Hospital in Brevard came a Mission affiliate, joining McDowell Hospital in Marion and Blue Ridge Regional spital in Spruce Pine. But there is no evidence that the move would, as Park Ridge charged in ad that ran Tuesday in the Times-News, lead to Mission buying Pardee.

...tates the joint venture is "an attempt by Mission Health System to devalue one of our ...most important assets and acquire Pardee Hospital for well below fair market value, ile grossly duplicating services already available at the other community hospital — Park dge Health — and ultimately gaining an irrevocable hold on Henderson County."

It is important to note that the Henderson County Board of Commissioners is on record as stating that Pardee, which is owned by the county but does not receive tax dollars, is not for sale. It hard to see how opening a $45 million facility in conjunction with Mission will devalue Pardee.

The current Board of Commissioners reaffirmed the previous board's stance that Pardee not be sold following a public · last year over secretive talks involving Pardee's future. There would be another public outcry if Mission or any other entity attempted to buy Pardee.

As we have stated time and again, control over Pardee is a public matter, and Henderson County residents adamantly support the county maintaining ownership of the hospital.

The Park Ridge ad stated that the community faces "an important decision that will forever alter health care" locally. It also stated the joint venture between Mission and Pardee "threatens to weaken both of our community hospitals by ultimately drawing business, jobs and investment away from the county."

It is true that the joint venture may forever change health care in Henderson County. As letter writers to the Times-News have pointed out, it is not clear that two local hospitals can survive and compete in the changing health care environment. But no evidence has been presented to show that the proposed Pardee/Mission joint venture will suck business, jobs and investment out of Henderson County.

Park Ridge officials have lobbied hard against the joint venture but have gotten little traction in efforts to convince political leaders to nix the deal.

In April, State Sen. Jim Davis, a Republican from Macon County, introduced a bill to place an immediate moratorium on Mission acquiring hospitals or physician affiliations or entering into managerial agreements with other providers.

The bill was referred to the Senate Committee on Rules and Operations, where the committee chairman, Tom Apodaca, R-Hendersonville, predicted it would go nowhere.

"I don't want to restrict where doctors practice," Apodaca said. "That is not our job in the General Assembly."

It is also not the job of political leaders, either locally or in Raleigh, to weigh the scales in favor of one local hospital against the interests of another.

Elected leaders have a duty make sure Henderson County's interests are protected. The history of inter-local agreements with Asheville over water and the airport point to the need for diligence. It is also critical that discussions over the future of our hospitals be conducted in public to assure that the public's interests are protected.

[illegible] end, though, the health care needs of residents should determine the viability of affiliations such as the joint venture in Fletcher.

est Regards,

on

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Executive Summary of Comments Regarding
Mission Health System and COPA
Dr. Jeffrey Coston

October 21, 2011

I am sharing this short summary of my prepared comments for the Select Panel because I was unable to due to time constraints last night. Hopefully, members may find time to read my full comments.

1. Mission Health System is a monopoly. My first comment shares a story how that impacts my Anesthesiology group's practice.

2. Mission Health System is not only a monopoly but coercive and ruthless. Last night this was plainly shown. I share how this impacts me as a "non-affiliated" physician.

3. Last, but critically important to the COPA discussion, Mission has amassed its $550 million war chest because it's rate of reimbursement is based on a benchmarked value from large, urban, tertiary care centers in places "not around these here parts." Small players have been at a disadvantage from the very beginning of the COPA.

Quite by accident I found out that the Select Committee on Certificate of Need and other Related Hospital Issues would tour at Park Ridge Health today. The COPA impacts me as a health care provider, small businessman, and consumer. Because of the importance of this issue to our community I wanted to share my views. Please understand that I believe that it is not the physicians (who are providing compassionate and competent care) but the corporate mentality of Mission Health System that has created the current controversy that threatens my hospital and my very livelihood.

Thank you,

Jeffrey Coston, DO
President
Park Ridge Anesthesiology Services, PA

Comments regarding Mission Health System
Certificate Of Public Advantage
October 20, 2010
By
Dr. Jeffrey Coston

Thank you for the opportunity to share my observations with members of the Select Committee at this meeting. I am a clinically based physician, board certified in the specialty of Anesthesiology. I am the President of Park Ridge Anesthesiology Services, PA and thus also represent a small business with 11 employees. Finally, along with all of those here tonight, I am a consumer of health care services in western North Carolina. As a disclaimer, my comments are my own and have not been vetted by any other entity.

In the next three minutes I would like to share three observations with you.

1. One of the Anesthesiologists who participated in our practice a few years ago had a family member who needed surgery. After his five-year old son had surgery at a Mission Health System facility he shared the anesthesia billing information with me. We figured the reimbursement to be fully twenty dollars more per unit time than what our group could hope to get. There is only one reason why this could have been possible. There is a monopoly in health care in Buncombe County. The COPA, Certificate of Public Advantage, granted by the State, has created a situation that allows Mission and physicians who practice there a tremendous financial and tactical advantage over smaller hospitals like Pardee and Park Ridge Health. They are, quite simply, the only game in town. (Incidentally, our anesthesia group has yet to reach a contract with similar reimbursement from the same insurance carrier nine years later!). Is this an advantage for the public or for Mission?

2. As a physician I am concerned about the way Mission Health System has chosen to treat non-affiliated physicians and organizations. I sometimes need certain blood tests completed that only Mission Health System offers before I can do procedures for patients. Mission has recently told Park Ridge Health it will no longer accept blood drawn at Park Ridge because they are now only offering to do those tests for "affiliated" facilities. It seems to me that they are saying "give us what we want or we will take our toys and go home." If you take that reasoning to its conclusion it is frightening. For example, Mission wants to raise the hiring cap it currently has on employed physicians. What if they just happen to hire the only group of pathologists who serve our area. Suddenly, there would be no pathology service for Park Ridge Health. Think it's unlikely? The administration of Mission Health System has showed their hand with the testing issue. Does this attitude advantage the public or Mission?

3. Finally let me say I have read the majority of the Vistness and McCarthy reports. I say majority because it is the type of reading that for most of us makes your eyes glaze over and go into a coma. Mr. McCarthy argues in his report that Mission Health Systems should be reimbursed at a higher rate if it continues with a COPA because of its higher rate of Medicare and Medicaid patients compared to its benchmarked peers. I will say, based on my practice's numbers, that in Henderson County there is a higher rate of those patients. So, how would it be fair to increase Mission's reimbursement? The problem with the current COPA is that its benchmark for reimbursement is from a peer group comprised of large, urban based facilities in places like Charlotte, Raleigh, and Winston-Salem. So from the start Mission is able to bill at a higher rate than the smaller hospitals in the area. It comes as no surprise to me that Mission wants to do away with the COPA. They would like nothing more. There is no way for another hospital system to compete because it couldn't obtain a Certificate of Need because Mission has all the beds needed for Buncombe County. Is that an advantage to the public or to Mission Health System?

   Tonight we have heard an administrator from Mission say Mission is like a 500 pound gorilla. So, what is the answer to the question what does a 500 pound gorilla do? The answer is in your hands.

Oct. 20, 2011

I challenge this committee to find a better, more efficient, way to accomplish the task at hand. To jeopordize the health benefits to everyone in WNC is a step that will only bring our communities to their knees. If Memorial Mission loses critical care services, children's services, etc., Western North Carolina will suffer greatly. Look at the numbers; look how many lives have been saved, affected, and ultimately changed by the level of care provided by Mission Health Systems. Imagine for yourselves, what would you do if your loved one needed critical or traumatic care (your mother, child, grand-father), but to ~~res~~ ~~receive~~

recieve this care they have to be transported 4-5 hours away. How would you, as their loved one, support them? How could you be there for them each and everyday if you have to travel that far back and forth? Our people, here in Western North Carolina, need access to quality healthcare made available to us. So think about what you would do, if the only hospital you felt comfortable with, lost many of it's essential care needs.

I also challenge other healthcare sources in Western North Carolina to "raise the bar" so to speak. The people of our mountains trust Mission Health to provide for all of their needs.

challenge others to raise their level of care to the same standard of Memorial Mission. When others put in the effort and time to regain the trust of those they provide for, then their business will begin to improve. It isn't right to restrict or "punish" Memorial Mission for being trusted by the people of Western North Carolina.

① In addition, keep in mind that with critical and traumatic care, time is of the essence. In my case, and countless others, we could not have been taken to another healthcare facility.

We would not be here today if we had been sent 30 minutes or an hour away. Having Mission here for us is Life or Death! It comes down to that.

Thank you for your time.

Sincerely,

Jennifer Lawrence

Jennifer Lawrence
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My name is Scott Joslin, I am an Internal Medicine Physician with the Asheville Hospitalist Group and have been an active member on the Mission medical staff for just over 12 years. I am a former Army Medical officer and moved here from Washington DC with my wife and two daughters in 1999. I serve as the service line leader for the approximately 350 physicians on active or community affiliate medical staff membership status in primary and secondary care for adult medicine, I am the clinical director for my 37 physician hospital based Internal Medicine practice, work full time in the clinical schedule evaluating patients for hospital care in the Mission Emergency Room, provide medical care on the floors, and provide medical consultation to the surgeons and medical specialists at Mission. My 37 members provide a 24/7/365 in hospital presence to run an inpatient census of 175-200 patients a day, run a teaching service for the interns and residents for inpatient medicine, hospitalize between 40-50 patients a day (just over 14,500 patients a year) from our community and the region, and participate in a host of quality and safety projects within the Mission Health system to continually improve the service provided to the sick and injured in Western North Carolina.

In the last 12 years my practice has grown from 8 to 37 board certified Internal Medicine physicians with what I believe to be one of the best hospital based internal medicine hospitalist practices in the United States based on length of stay, costs of care, readmission rates, and patient satisfaction with their care. In an area of medical practice that has an 18-22% annual physician turnover rate we have achieved an annualized retention rate of 98%. This success has been the product of a partnership with Mission Hospital that remains productive and patient centered.

Mission hospital is a not for profit community and regional hospital held in trust for the citizens of Western North Carolina by a board of local citizen leaders. This locally controlled relationship with the community has attracted top flight physicians from across the country who continue to work on behalf of our patients to provide absolutely superior medical and surgical care in this region.

The certificate of public advantage created with the merger of Mission and St Josephs hospitals was created to provide additional safeguards to the public that such a joint entity would not abuse its position of trust to the detriment of quality medical care in the region. By every measure the Mission Health system has maintained the trust of the community as it regards patient centered care, as documented in the annual reviews of compliance with the certificate of public advantage. As a result of this local oversight Mission is the only physician led hospital in North Carolina, it is the busiest surgical hospital in the state, and supports through my medical practice and other outreach programs comprehensive medical care for the poor and the uninsured. As the current decade of care unfolds dramatic and difficult to predict changes in the community and in the national medical marketplace are taking place. As much larger and much better funded medical systems move into the area the safeguards to the public put in place with the certificate of public advantage have run their course and warrants removal to allow Mission the opportunity to recruit for the medical manpower needs of our community on a level playing field with these larger health systems ~~in my view.~~ The current constraints of the certificate of public advantage in my view threaten the ability of Mission to survive as a locally controlled medical system in Western North Carolina.

I am so sorry that I cannot be here in person to talk about my experience with Mission Hospital. I am travelling to Charlottesville, VA to visit my daughter at UVA.

In February I was faced with the potential of having a heart problem. I had been a patient with another heart care provider in Rutherfordton and saw the potential of having to go outside our local hospital to get treatment. I had recently had experience with Mission with both of my parents and had been very impressed with the care and atmosphere I sensed in Mission. My family also chooses to go to Asheville for shopping and entertainment rather than Charlotte, Spartanburg or Greenville because we are all more comfortable with its familiarity and proximity.

Asheville had just opened an office in Rutherfordton at Rutherford Regional and I thought I would give them a try because I would be sent to Asheville rather than Charlotte or Spartanburg. As it turned out they could do my cathiterization at Rutherford Regional (which was a surprise) and then only if I needed a further procedure would I be sent to Asheville.

I did ultimately need to go to Mission for a stent and my treatment and care was as good as I had experienced before with my parents. I truly appreciated the arrangement that existed with our local hospital and Mission because it gave me an option of excellent care and advanced medicine in what I consider to be my region and a place where my family and I felt more comfortable. Thank you!

October 19, 2011

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Testimony to House Select Committee on Certificate of Need and Related Hospital Issues

by John T. Ashley MD, MBA, FACPM October 20, 2011

NC CON law and regulations are designed to rationalize the distribution of health facilities and extraordinarily expensive medical technology in the face of an irrational financing system of third party payment that promotes and stimulates excess utilization of high cost procedures by patients, physicians and hospitals. A critical feature of the CON law and regulations is the application of the Certificate of Public Advantage (COPA) that is used to evaluate the results of approved CONs by the recipients.

The enormous value of the COPA had been demonstrated in Asheville-Buncombe by the work of the Asheville Chamber Healthcare Roundtable over the past 8 years. Based on data from the Mission Hospital's COPA Reports from the 1999 through 2008, the Roundtable developed and submitted, with the support of the leadership of the NC legislature, prominently lead by Rep Bruce Goforth and Sens Martin Nesbitt and Tom Apodoca, HB 212, The Health Insurance Pool Pilot Program, adopted in 2009.

This legislation was developed by the Roundtable with full participation by the major employers of the community, by all of the major private hospitals, by physicians represented by the Buncombe County Medical Society, by local governments, by organizations that procure health insurance for businesses, by small employers, by our local PPO organization of physicians and hospitals providing access to health care and the public. The legislation was vigorously and prominently opposed by the largest private insurers of the state in testimony to both houses of the legislature. The legislation received bi-partisan support during its thorough consideration in committees of the House and Senate. My observation was that the bi-partisan support grew as the largest insurers increased their opposition.

The content and language of HB 212 was developed based on data contained in the Mission Hospital COPA Annual Reports that were generously and thoroughly shared with the Roundtable each year during deliberations on how to address and resolve the twin conflicts of the Excess cost of Health Insurance premiums and Growing number of Uninsured residents of Buncombe County. The data in the COPA Reports showed clearly that the merged hospital system incurs the millions of dollars of losses by caring for the uninsured and millions more of losses by less than full cost reimbursement from Medicare and Medicaid each year. The COPA Reports demonstrated that the hospital receives payment from private insurers representing the large employers and other privately insured groups and individuals that reimbursed all of the costs of care for their beneficiaries, PLUS the cost of losses from the uninsured and underinsured PLUS the margin that every hospital must generate to successfully serve their communities with needed services and to create the reserves for future growth.

The data from the MH COPA demonstrated explicitly the process of Cost Shifting that occurs implicitly in every hospital market in NC and the U.S. to allow the uninsured to obtain medical care. The Roundtable membership, lead by representatives of large employers who pay for the cost shifting through their insurance payments and representatives of the professionals and institutions who receive the payments, recognized that the fundamental problem of the broken system must be addressed so that affordable health insurance was available to every resident and employer who had any ability to purchase health insurance rather than be uninsured.

In Buncombe County, the medical society with critical support from Mission Hospital and County government have developed and implemented Project Access, a national model of voluntary provision of specialty medical care, hospitalization, medications and support to the uninsured, poor residents of the community. But the number of uninsured has grown to almost 19 % of the adult population of the county and Project Access is rapidly exhausting the ability of physician specialists to donate their services to the poor because of the growing number of uninsured. Project Access does not provide access to Primary or Preventive Care. As a volunteer physician at our local free clinic, ABCCM Medical Ministry, we see an endless number of uninsured individuals, including some children, who suffer from preventable and treatable conditions like hypertension, hypercholesterolemia, diabetes, depression, obesity and smoking that lead to heart attacks, stroke and cancer resulting in catastrophic medical interventions, excess costs, excess morbidity and premature deaths. This is true in every community in NC and the nation and is the basic reason that the US has among the worst population health outcomes compared to other developed nations.

In Buncombe County, we have a national model of Disease Management called Project Asheville that is used to control many of the conditions that lead to excess hospitalization and costs for the insured. Project Asheville is not available to the uninsured but the costs of the care for their catastrophic health problems are borne by the private insurers who pay for their own beneficiaries care and the cost-shifted burden from the uninsured who receive hospital care. The hospital has become an Unrecognized, Private Taxing Authority that collects from the employed insured to care for employed and unemployed uninsured.

The Roundtable recognized the fundamental breakdown in our local financing system and the hidden burden of high cost health insurance premiums and the resulting uninsured in our community through their analysis of the local COPA data. The Roundtable employed health care and actuarial consultants who guided their deliberations and evaluation of approaches used in other communities in the US. The Roundtable wanted to make the system rational and fair by making insurance affordable to all employers and individuals by correcting the flaws that made insurance prohibitively expensive and resulted in unacceptable increases in the number of uninsured.

The Roundtable learned that US Health Insurance began as a Community-rated product for limited benefits provided by a Not-for-Profit insurer with low overhead for all residents of communities with payments to providers at prices that reflected the actual costs of care. Private, For-Profit insurers entered the market after WW II and increased the covered benefits, segmented the market to identify the lowest risk groups, introduced reimbursement contracting with hospitals and physicians, implemented utilization controls and abandoned community rating to attract the lowest risk groups for increasingly expensive health insurance with higher overhead and significant profits. Large group Insurance purchasers responded by self-insuring and negotiated for deeper discounts from providers. Hospitals and other Providers responded by increasing prices to cover the costs of uninsured losses and dramatically increased the volume of technology and specialty care procedures to offset their losses from primary care and catastrophic services.

The Roundtable, using COPA data, sought legislative authorization to undertake a demonstration project for pooling large and small employers into a unified community-rated purchasing group that would design and adopt proven packages of benefits that met the requirements of the NC Department of Insurance and the developing requirements of the national Accountable Care Act. The proposed four levels of benefits would cover the costs of uniform Primary and Preventive Care services and Catastrophic services in all packages and use proven actuarial processes to reduce the costs of premiums for discretionary, procedural services. Fundamentally the proposed pooling of insurance was to be designed to obtain low insurance overheard, less than 10% as achieved by the NC State employee health insurance program, optimum utilization of procedural services and full access to Primary Care to achieve best health outcomes for the combined group of insured from both large and small employers and potentially from insurable individuals. The proposed pooling of insured groups is designed to use market competition among insurers for the largest possible group in the community and potentially the region. The model is based on proven Prevention and Primary Care, full access to catastrophic care, and appropriate use of best technology without use of the most technology, managed by local systems of care supported by proven actuarial analysis and processes.

The Roundtable proposed legislation was adopted by the legislature and approved by the governor in 2009 and amended in 2010 to allow implementation of a model of a local health insurance program in NC. Without the data from the COPA Reports, this community approach could not have been developed and the authorizing legislation could not have been adopted. The authorization of HB 212 remains unfulfilled today because of the fluidity of the insurance market secondary to adoption of national health reform and the impending regulatory changes. The need for a local demonstration project to model the best benefit design with appropriate economic incentives for patients and providers has never been greater. The authorization of HB 212 remains available to Buncombe or other interested community because of the COPA data that demonstrates the potential value of changing our financing system in NC and the nation.

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Notes for COPA/CON meeting

1. Introduce myself
2. Thanks for holding this meeting in western NC so we can make comments directly to all of you
3. Appreciate the effort each of you make to help deliver excellent healthcare to people of NC
4. While MHS and PRH have made some excellent points tonight, we feel that the larger discussion should be about the CON rules in our state
5. While we understand the arguments that led to the creation of CON rules, we feel that CON rules regarding ambulatory surgery centers are currently expensive, anticompetitive, and outdated.
6. Over the last three decades Ambulatory Surgery Centers have demonstrated an exceptional ability to improve quality and patient satisfaction while concurrently reducing costs.
7. Physicians opened the first ASC in 1970 because of the frustrations they faced with local hospital operating suites, including scheduling delays, staffing inadequacies, limited OR availability and outdated or inadequate technology. Those same frustrations still exist today.
8. Since then, ASC growth has been exponential with the number of Medicare certified ASCs growing from 2786 in 1999 to over 4700 in 2007. ASC settings allow physicians to exercise professional autonomy over their work environment and allow them more control over the quality of surgical outcomes. Not only are they able to design these facilities to better accommodate their specialty, but they are also able to schedule procedures more conveniently, control technology and supplies that are suited to their specialties, and they are able to put together specially trained and highly skilled teams familiar with the surgical techniques being performed. The end result is high quality, convenient, more cost efficient care for the patient and substantial savings for the state and federal governments

9. A report by the National Conference of State Legislatures in November, 2007 shows that fourteen states have discontinued their CON programs and have opted to control costs through other measures. Of the 37 states with some form of CON regulation, only 27 states regulate ambulatory surgery services.

10. Just because the CON process has been in place in North Carolina for decades does not mean that the process is working for the people of North Carolina. In 2005, The John Locke Foundation, a North Carolina based nonprofit, nonpartisan public policy research institute, provided a compelling case for the repeal of CON laws in the state. In a series of reports called *"The Macon Series"* the author concludes that "The idea that in the area of health care services, free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence." While we are not suggesting a wholesale repeal of the CON laws, we are suggesting that the state consider these valid arguments for change.

11. The current outpatient surgical system serving our population is a poor value for the North Carolina consumer. We believe there is a large potential for reduced costs and overall health care savings if eye surgical procedures are done in a freestanding ASC vs. Hospital Outpatient Surgical Departments

12. Ophthalmology can provide improved quality of care for eye surgery, including outcomes, convenience and increased patient satisfaction through the delivery of surgical services in a single specialty ambulatory surgical environment.

13. Ophthalmology can provide improved access to care for patients through the delivery of services in a single specialty ambulatory surgical environment.

14. Ophthalmology can provide increased efficiency and improved utilization of facility and professional resources through the delivery of services in a single specialty ambulatory surgical environment.

15. Current North Carolina state health planning policies promote unfair competition between surgical practices. For example, at the current time, Asheville Eye Associates has an unfair competitive advantage because they have unfairly been granted a CON for 2 operating rooms in a stand-alone ASC

16. I urge you to consider reform of North Carolina's CON laws to allow the development of specialty specific ambulatory surgery centers that can compete to deliver the best care for our citizens. Imagine the kind of improved surgical care and financial savings that could be realized in our great state because of CON rule reform.

To: House Select Committee on the Certificate of Need process and Related Hospital Issues

Dear Representatives:

I am the retired CEO of Mission Health System, serving in that position from 1981 until 2005. Until the beginning of 2008, I assisted Mission as a fund raiser and consultant. I am continuing in a consultant role with other hospitals and medical groups and serve on the board of a large multi-hospital system in East TN and SW VA, Wellmont Health System.

My knowledge of the certificate of public advantage (COPA) is long standing and dates to the writing of the legislation. Mission submitted, in August 1994, the first application to the state of N.C. and the U.S. Justice Dept. for a COPA. After a 15+ month process the two hospitals, Mission and St. Jos. met the challenge of the States Attorney General and the U.S. Justice Dept. for a virtual merger. This very open process included but was not limited to thousands of pages from both hospitals' files and computers and interviews with hundreds of people in the region of W.N.C. Many requirements are included in the eventual document. Over the five year period of close monitoring, the hospitals met and exceeded all that was asked/directed in the COPA. This includes savings, margin limitation, cost control and appropriate managed care/insurance contracts. When Mission purchased St.Jos. in 1998, the new entity, Mission-St. Jos. Health System, again met and exceeded all new requirements. Having been personally involved in this, I know of the extensive scrutiny under which the hospitals were observed and monitored. I can only relate what happened from 1994 until my retirement in 2005.

The outcome of the merger has been overwhelmingly beneficial to WNC. Mission helped form a group of hospitals in the region that focuses on quality improvement, cost control and purchasing savings as well as operational enhancements. This organization, WNC Health Network is a model used in other regions of our state as well as other communities. Mission has gained many new awards for cost control, quality management...and outcomes, and expanded into new services for Asheville and the region. Many organizations have come to Asheville to model the methods of improving the delivery of care to patients.

While all of this has happened, other health organizations have come into and/or expanded their operations in WNC to pose major competition. This is good for all, especially the patients. However, those who are here now are from outside our region. They do not have the restrictions that Mission has voluntarily stayed under with the COPA. The Carolinas Health System is a governmental entity based in Charlotte with no limitation on margin, assets or employment of physicians. They currently manage West Care in Haywood, Swain and Jackson Counties, and Murphy Medical Ctr. The Adventist Health System from Orlando, FL, is an extremely large and financially profitable organization that owns ParkRidge Hospital and allows them to expand with no limitation in Buncombe Co. as well as Henderson Co. The UNC Health System now manages Pardee Hospital and has the state of N.C. as an asset.

Mission has only entered into relationships with hospitals that requested their assistant, including Spruce Pine, McDowell, Transylvania and Angel Community in Franklin, N.C. My personal knowledge only includes the first two since I retired before the latter were part of the MHS. Much assistance has been given and offered to many other institutions over the years.

Mission accepts all patients regardless of the ability to pay if the institution has the talent and services to care for them. Doing this means a very financially poor payer mix of patients and families. With 80% of the patients using either Medicare, Medicaid or self pay, the hospital must manage its costs very closely and the resultant numbers are exemplary, based on the severity of the patients. With the worse payer mix in N.C. and one of the worse in the nation, Mission cannot be encumbered with more regulations than the competition. This will force the hospital, a locally owned and operated organization begun in 1885, to limit its services and staff.

As a 30+ year resident of Asheville, I know the positive economic impact Mission has had on our region and state. With a workforce of over 7000, these valuable employees have put a huge return into our economy as well the most important service of quality cost effective care of the highest measure. As a past chair of the Chamber of Commerce, the United Way and many other organizations, I know how much the hospital and its physicians and employees mean to our community. New people in our community often talk about how important the great care at Mission has been for them, sometimes the major factor in relocating to our area. Our two new neighbors told me this, just last evening.

Many have told me that Mission is jewel and a model for how mergers should happen and how hospitals should be operated. With the board, medical staff and employee group, the community has that jewel and is constantly polishing it to great effectiveness.

Thank you for this opportunity to submit this and I welcome a chance to speak at the hearing on October 20th.
Thank you,
Robert F. Burgin
President Emeritus
Mission Health System

I worked as an RN at Mission Hospital for 14 years.

While in New Employee Orientation in 1982, I heard a young female employee speak about the greatness of Mission Hospital and the plans it had for its future growth. I was pleased to be going to work for a progressive medical facility where I could use the skills that I had acquired while working in Charlotte Memorial ICU. However, I was somewhat astounded by a statement that this speaker made which just didn't sound ethical. I didn't know exactly what this statement implied, but I have remembered it for over 28 years and have recalled it many times during those years as Mission Hospital has indeed lived up to its goal which she shared that day.

This statement which she made with pride was that **Mission Hospital was growing and would continue to do so and would eventually take over all the smaller hospitals in the area and put them out of business.** As an example, she name **specifically** one of the hospitals. This hospital that she named was **Fletcher Hospital**, the "little hospital out there" that "doesn't have a chance to survive."

As time went by, I was pleased to see that Fletcher Hospital not only survived, but grew and built a beautiful new facility and renamed it **Park Ridge Hospital**. I have had, and still have, great respect for the values of this hospital and the work they do to benefit the people of the area they serve.

My profession is that of a nurse. I am not a business professional or politician. However, I have discernment for honor, justice and right. I observed the first thing about which Mission was not entirely truthful and which was their first subtle step in taking was over St. Joseph's Hospital. They announced that the two hospitals would share a combined laundry facility. After this they announced several so-called "joint-ventures", each time reassuring in print that these changes were not a merger of the two hospitals at that time nor would they become so in the future.

History has proven their dishonesty as Mission not only merged with St. Joseph's but eventually took position of it. There is no longer a St. Joseph's Hospital in Asheville. Even the name they used to wean the public, Mission-St. Joseph's, has been changed to Mission Health System, leaving all memories of St. Joseph behind.

I have no doubt that Mission Health System has a plan to create a monopoly in this area. Their efforts to do so should have been recognized 28 years ago when Bob Burgin was making his frequent trips to Washington, DC, with his false presentations of reasons why Western North Carolina would be better served if Mission-St. Joseph's had a joint venture and became the only providers of health care in the area.

Certainly now, that all the facts are before us and Mission's plans to destroy any competition and to take complete control of health care in Western North Carolina are exposed, those who

have the authority to do so will put a stop to their selfish plans that do not benefit the people but somehow, in a way that is beyond my knowledge and understanding, benefits a few executives at the top. Unless this plan is halted Park Ridge Hospital will no longer be and will become forgotten in the same manner as St. Joseph's Asheville.

Mary Sloop, RN
Horse Shoe, NC

Hi, my name is Jennifer Bock. In the interest of full disclosure, my husband is a surgeon who works at Mission and is also a member of the board. That is not why I'm here. I am here as a cancer patient who wants to speak to the postive nature of Mission Hospital.

Recently, there was a fire in a medical building, NOT owned by Mission, where the Cancer Care of WNC was located. That building won't be open again for at least a year.

The fire happened three days before I was scheduled to begin my own chemotherapy treatment. Of course I was upset since I was sure that now I would have to go out of town, to Charlotte or Chapel Hill to get my chemo.

But in stepped Ron Paulus and Mission Hospital. Before the flames were out the plan was in place for Cancer Care to move over to the Mission campus. The amazing part for those of us who were so worried, was that the transition was seamless. The Cancer Care group only missed one half of one day of seeing patients. Chemotherapy was begun the next day, virtually uninterrupted. I started on schedule, which really made an already difficult situation much easier.

This story shows you what kind of organization Mission is, and the kind of people they are. Their number one priority is always the patient. We chose Mission, after going to Chapel Hill, researching both options and deciding that Mission is a great hospital, with the latest technology and treatment.

But even more importantly, Mission is my hometown hospital. I wanted my treatment to be here, with my family, my friends and my whole support system.

I was lucky. I was able to go to the hospital of my choice. I wanted to speak to you tonight to express the importance of a patient being able to choose their hospital. Whether the choice is based on quality, various services, or just location, it should be MY choice and no one else's.

I hope that through all the facts and figures that are being tossed around tonight,you hear the patient's voices. And I sincerely hope that Mission has the freedom to care for all of the patients who would choose Mission to treat us. Thank you.

My name is Kit Cramer and I'm the president and CEO of the Asheville Area Chamber of Commerce, the third largest chamber in the state. We have many members that are healthcare providers. So when there is a conflict among our members we're placed in a difficult position. It's at those times we fall back on the conviction that a market based economy in which entities can freely compete better sustains the economic growth on which we depend.

As the committee evaluates whether the certificate of public need process and the COPA agreement interfere with free-market expansion, we would ask you to keep a number of things in mind.

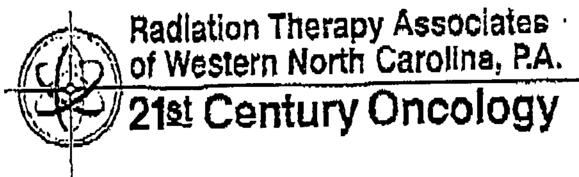
First, the Mission Health System is our region's safety net provider. They offer specialty care to patients from all 18 western counties. If we didn't have these services available at Mission, patients would have to drive four to six hours to receive them. Their role in serving children, pre-mature babies, high-risk pregnant mothers, heart patients, trauma patients and those who need psychiatric care is critical to our citizens.

Second, Mission is an economic engine for western North Carolina. They're our largest employer with nearly 13,000 jobs. They pay $335 million in direct wages and produce an overall economic impact of nearly $1 billion in the region. Their presence contributes $58 million in indirect <u>business</u> taxes to local governments and $12 million in state level <u>income</u> taxes. In a community largely composed of small businesses, their presence makes a huge difference to our quality of life.

Since Mission first entered the COPA agreement 15 years ago, the competitive landscape has changed. They now have two significantly larger, multi-state health systems with whom they compete. To survive, Mission needs the flexibility to respond to whatever changes result from the implementation of health care reform. They need the ability to compete under the <u>same</u> rules as their competitors.

The Asheville Chamber asks that you recognize that Mission's ability to reasonably compete is essential to the economic health of western North Carolina, as well as to the health of our citizens. Please give Mission the flexibility necessary to support the needs of its affiliate hospitals in rural counties and to address the growing shortage of physicians.

Thank you.



Board Certified in Medical Oncology

Board Certified in the Practice of Radiation Oncology

Accredited by the American College of Radiation Oncology

Medical Oncology

Barton R. Paschal, M.D.
Medical Degree: Emory University
Residency: Louisiana State University
Fellow: Wake Forest University Medical Center

Radiation Oncology

Charles C. Thomas II, M.D.
Medical Degree: University of North Carolina School of Medicine
Residency: Diagnostic Radiology Medical University of South Carolina
Radiation Oncology: Duke University Medical Center
Fellow American College Rad. Oncology

R. Lewis Royster, Jr., M.D.
Medical Degree: University of Virginia School of Medicine
Residency: Radiation Oncology Medical College of Virginia

Mary J. Puckett, MMS, Ph.D.
Physician Assistant
Degree MMS, Arcadia University
Ph D. University of Texas

Horacio F. Giraut, MS, DABR
Medical Physicist

David M. Strongosky, MMSc
Medical Physicist

S. Lynn Call, MS, DABR
Medical Physicist

March 25, 2011

To Whom it Concerns;

It has come to my attention that the business practices of Mission Hospitals have recently come under scrutiny. I submit this correspondence for informational purposes as it pertains to my personal experience with predatory tactics used by officials at Mission Hospitals. I moved my practice from Asheville to Clyde, North Carolina. In October 2009 as a direct result of harassment by hospital administrators at Mission Hospitals.

Around six years ago, my 25 year-old medical oncology practice moved to larger quarters in order to accommodate the addition of radiation oncology and imaging to our service line. At the time, there were no cancer centers in Asheville that were offering the advantages of medical oncology, radiation oncology, imaging, and laboratory services under one roof. My practice obtained a certificate of need (CON) exemption from the NC Department of Health and Human Services and began cancer center operations in earnest including the hiring of additional physicians and staff.

When Mission Hospitals sued my practice purportedly over concerns about our CON exemption, we continued all cancer center operations during the litigation; however, after Mission Hospitals communicated illegally with Mr. Fitzgerald, the head of the Department of Health and Human Services, an unexpected event happened. Mr. Fitzgerald vetoed the CON exemption that had been granted to my practice by his office staff. This turn of events forced the closure of our radiation oncology and imaging services while my practice litigated Mr Fitzgerald's veto. Mr. Fitzgerald's illegal communication with Mission Hospitals was eventually brought to light and his veto overturned. Mr Fitzgerald resigned his position and his replacement reinstated our practice's CON exemption. As before, our office hired new physicians and staff and returned our operations to full capacity.

In the end we prevailed, not only against Mr. Fitzgerald, but also against Mission Hospitals' litigation that resumed after Mr Fitzgerald's veto was vacated. Mission Hospitals then appealed the verdict to the NC Court of Appeals. Our practice won the appeal unanimously and for that reason, Mission Hospitals was not allowed to appeal to the NC Supreme Court.

The expense of litigation and the expense of leasing unused radiation oncology office space and equipment forced several members of my former practice, including me, to leave the practice. Mr. Fitzgerald took an early retirement. It is ironic that Mission Hospitals is now building a cancer center with multispecialty services under one roof, just as my practice planned to do several years ago. This episode resulted in unnecessary hardship for my practice. The expense of litigation may have benefited Mission Hospitals by causing more damage to a competitor than to themselves, but it was a disservice to the patients of Buncombe County as well as to my former colleagues, staff, employees and their families.

Please do not hesitate to contact me if you need any additional information about my

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21st Century Oncology, Inc.

March 25, 2011

RE:
Page 2

experience with the administration of Mission Hospitals.

Sincerely,

Electronically Signed by:
Barton R. Paschal, MD
Electronically signed by Barton R. Paschal, MD on 3/25/2011 6:48:46 PM

Barton R Paschal, MD

BRP/tk

DD: 3/25/2011
DT: 3/25/2011
cmn

My name is Paul Donahue and I live in the area of Henderson County where Mission Hospital is planning to locate a new medical facility.

Because Park Ridge Hospital is right in that area, I did not see any reason for building this new facility.

I became curious about why Mission Hospital would want to duplicate what Park Ridge Hospitsal was already doing – ---- and doing it so well!

This curiosity led me to educate myself about a Certificate of Public Advantage. In doing so, I did find out some interesting things about Mission Hospital's COPA.

Mission Hospital---in its apparent quest to get control of medical care here in Western North Carolina--- has found numerous ways to violate the letter and spirit of the 1995 COPA it signed when seeking permission to merge with St. JOSEPH HOSPITAL.

These violations have been clearly shown here tonight by the Park Ridge Hospital administrators.

They pointed out the consequences of Mission Hospital buying medical practices and merging with other hospitals here in Western North Carolina.

Study after study shows that medical monopolies lead to price increases that far outweigh any economy of scale cost reductions.

Further, a monopoly clearly lessens our citizens medical choices.

Thus, I do not need to waste you time by reiterating what has already been said.

Instead as a taxpayer, I would like to know why Mission Hospital's COPA was so unregulated by the State.

And also to know how Mission Hospital's market share and pricing increases were just allowed to happen over the past 16 years.

It is very clear to me that Mission Hospital's COPA benefited no one but Mission Hospital --- rather than the citizens of Western North Carolina --- which it was suppose to do!

I believe the State needs to do the following:

1. **Extend the COPA to cover all of Western North Carolina.**
2. **Stop all Mission Hospital expansion until the COPA issue is resolved.**

3. And most importantly, have the State begin to enforce the COPA.

Thank you for holding this pubic Hearing--- where we the citizens of Western North Carolina have the opportunity to share our concerns with you about our region's medical care.

Thank you members for coming to the beautiful western part of the state. My first comments are about the CON. CON's were required by the federal Health Planning Resources Development Act of 1974. This federal mandate was repealed in 1987..

2004. FTC and DOJ claimed CON programs actually contributed to rising prices because they inhibited competitive markets that should be able to control the costs of care and guarantee quality, plus access to treatment and services.

According to the NC CON website the fundamental premise of the CON law is that increasing health care costs may be controlled by government restrictions on unnecessary duplication of medical facilities.

One example of the potential failure of the law is in the 2011 State Medical Facilities Plan. The projection for 2013 is that Buncombe, Madison, and Yancey counties will have a projected bed deficit of 51 beds, yet adjacent Henderson County, which is in a separate planning area, has a surplus of 123 beds. My guess is that the population center would be closer to Henderson County than Madison and Yancey.

I wonder if the service area designations are created by a process similar to political districting.

Unfortunately, repealing the law would be anti-job, not only for state employees in the CON office, but the whole industry that the law has created. Lawyers, consultants and researchers would be without work. One wonders if the law does not cost more than it saves.

This debate rests on the same arguments as many other "Regulated Market" vs. "Open Market" discussions.

In regards to the COPA. Dr. Vistnes' of Charles River Associates report is more about costs than consumer choice. The report states that government payers prices are unlikely to depend significantly on hospital competition and each year government provides a higher percentage of hospital's revenue. Therefore competition is not about costs but about choice for the patient.

Competition is needed to provide the consumer with choices.

Statement from Buncombe County Resident

Good evening Reps. Torbett and Steen, and all members of this important committee to study the certificate of need held by Mission Hospital. My name is Elizabeth Davey and I live in South Asheville. Unlike many people here, I'm a relative newcomer to the region. During the past 18 months, I have made it a point to ask many people I've met about the doctors and hospitals that provide health care here. I've always believed strongly in being an educated consumer, so when I moved here, learning about my choices in doctors and hospitals was a top priority.

What I heard and what I've seen myself, is that Buncombe and Henderson counties offer its residents multiple and distinctive choices regarding hospitals. There is no doubt that we need the large institutions that can offer highly specialized care. But I would stress to you tonight, that we also need our smaller community hospitals where patients are not numbers and personalized care is the rule not the exception.

I am grateful that we have Mission Hospital in our community. But I am alarmed to see its Pac Man-styled expansion that is eliminating consumer choice and establishing itself as a virtual monopoly. We know from basic economics that monopolies stifle competition and drive up costs. As a healthcare consumer, that flies in the face of everything I believe in.

As I have done my health care research, I hear time after time that Park Ridge Health is a beloved organization. People have told me they will drive farther to Park Ridge's ER to

avoid long waits elsewhere. Neighbors have spoken glowingly of the people who work at Park Ridge. Frankly, I've heard of some pretty amazing stories of service that harkens back many decades when customers really were treated with importance.

I've been fortunate not to need hospital care since I've moved here. But if I do, my choice will be Park Ridge Health. I emphasize the word choice. I want to know I can choose this hospital or any other provider because our state has protected this fundamental American right. Competition is healthy and drives our entire economic system. With healthcare accounting for more than 17% of our national GDP, we certainly cannot afford to allow competition to be stifled.

A 500 pound gorilla is impressive in the wilds. It can beat its chest and claim the best bananas for itself. But when the gorilla is done stripping the tress bare and banishing the smaller prey, all that's left is an unfettered predator with no limits.

This scenario frightens me. I hope it frightens you as well.

If we allow Mission Hospital to continue monopolizing our health care system, we will be left with a gorilla that fears no one, uses its size to intimidate others, and set a dangerous and irreversible precedent. It's not too late. Please ensure that health care here avoids the perils of predatory practices and that choice stays alive and well in our region. Thank you for coming tonight and giving these important issues your thoughtful consideration.

Viddia Torbett (Rep. Torbett)

From:	Kathy Bryson <kmbryson@charter.net>
Sent:	Tuesday, November 01, 2011 6:32 PM
To:	Rep. Fred Steen
Cc:	Viddia Torbett (Rep. Torbett)
Subject:	Mission Hospital Hearing

Dear Representative Steen,

I was not able to attend the hearing regarding Mission Hospital in Asheville NC last week. I was also not on the list to speak. However, I was given your business card by a professional colleague and decided that I need to speak up. I have been a Registered Nurse for 28 years with all but 5 years of my work experience being in Asheville NC . I first worked at St. Joseph's Hospital, then Mission Hospital, then Mission St. Joseph's, and then Mission Health System. I am no longer an employee there, but still live in the geographic area. If I was an employee there, I would be afraid to speak up against them as a monopoly in fear of retribution on the job. I have seen the subtle ways that they add minor issues into employee's files, so that they can clear out workers when it comes time to cut the budget. I have also seen people who have been in their jobs for 20 or more years being told they all have to reapply for their jobs as Mission decides to restructure a department. These people have no job security even with their longevity and dedication. They often are the first to go as they have the higher percentage retirement match and cost the hospital more money (older workers getting higher wages). I believe if the employees there felt safe to tell you how they really feel, you would hear more staff than Mission Hospitals could ever believe say "We wish there was more competition in our area for health care". As the largest employer in WNC, Mission has extreme power over people's lives and can even cause an entire family to have to leave the region to find work if one or more of the wage earners are health care workers who for any reason leave Mission. As the major health care employer, they also have lots of control over wages and benefits because their workers really have hardly no place else to go that is not already affiliated with Mission.

With Mission's expansion into owning MD practices and other entities, I feel they have began to exercise their power in wrong ways. Among the work force there, it is common knowledge that MD practices are feeling they must cooperate (i.e., be bought or become a partner) or Mission will just go find themselves another group of doctors who are of the same specialty from another region and bring them to WNC to put the MDs here out of business. Besides buying specialty physician offices, Mission is also buying some family practice offices. As Mission becomes larger as a hospital and network of MD services, they can bargain better with insurance companies. Mission will put many family practice offices and small specialists out of business as they won't be the preferred providers for Blue Cross, United Health Care, etc.

Mission is also right on target to put smaller hospitals out of business unless they are owned by Carolinas Medical like Haywood County Medical Center. Why would they want to put an outpatient center right in the midst of Fletcher, when there are already two

hospitals with outpatient services in Henderson County? I respectfully think that it's not to better serve the community. It is to take over the entire area and become a power house. Maybe, they are that afraid of Carolinas Medical or larger hospitals in nearby Spartanburg and Greenville taking their business However, none of that makes them serve me or you any better. I believe that preserved competition actually keeps health care providers on their toes to provide the best care at the best price.

I sincerely appreciate you taking the time to read my email. I hope you will consider how Mission Hospitals as a monopoly (there is really no other word to describe what we have here in Asheville NC) will affect our community in years to come. Sure, they look slick with great positive advertising and health care awards, but there is also other quality health care going on in WNC not involving Mission. Sure, we need them for a Trauma Center and Neonatal Intensive Care Unit. However, they do not have to be the only entity providing many other services. If we don't do something now, they will be providing all the health care in WNC, have all the insurance contracts, have control over all the MDs, have control many wage earners here, and have control over me and you. We will not have a choice in our health care provider. It will be decided for us.

Kathy Bryson, RN
25 Ridgeview Way
Asheville, NC 28803

Viddia Torbett (Rep. Torbett)

From: David M Poorbaugh, M.D. <David.Poorbaugh@msj.org>
Sent: Wednesday, November 02, 2011 7:05 AM
To: Rep. John Torbett
Cc: Ronald A. Paulus, MD; William Hathaway, MD
Subject: Mission COPA / CON
Attachments: MH.CON..docx; MH.CON..docx

Dear Chairman Torbett,

Good morning. I hope you are well and happy this morning. I am an Emergency Medicine physician in Western North Carolina.

I attended the recent public hearing at the Airport in Asheville concerning the Mission CON application. Because of time contraints I did not deliver my enclosed prepared remarks orally. The evening was long indeed and I am sure you and the comittee were fatigued. Please accept my thanks for coming to Asheville to hear from local citizens concening the CON. I hope you will share my remarks with the rest of the committee. If you have need to discuss anything further please feel free to contact me. I was disappointed as I'm sure you were that the comments at the meeting from Park Ridge deteriorated into personal, out of context attacks. It caused a very valuable Mission leader that had been with the system for many years to tender her resignation. It has always been my approach that one should be hard on the issues but easy on the people.

I would very much appreciate your taking time to read my enclosed comments prepared for the meeting. I am in the unusual position of working both at Mission Hospital accepting patients from the region and at affiliate hospitals sending patients to Mission Hospital. I have also worked at and for the Adventist system at Park Ridge and hospitals that are part of the Carolinas Medical System since coming to Asheville in 1994.

I believe the Mission Hospital System is wearing the white hat in this drama. Everyone is interested in competing for patients in Western North Carolina at 10 AM on Tuesday after screening financially, but only Mission offers needed services to all patients of North Carolina either by their choice or because other systems do not find it profitable to offer services at certain times or to certain patients. Mission offers this night and day, holidays, weekends, and without question.

Warmest regards,

David M. Poorbaugh MD FACEP

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David M. Poorbaugh MD FACEP
12 Stonebridge Drive Asheville NC 28805
828.712.0689 devonsheaven@me.com

I am an Emergency Medicine physician currently practicing in Western North Carolina. I have been practicing at Mission Hospital in Asheville since 1994 and currently practice full time at Angel Hospital in Franklin, NC, about an hour west of Asheville.
I believe Mission has delivered on all promises made when the Mission and St. Joseph's systems merged a few years ago. Mission has delivered exceptional health care with charges to patients that are well below most hospitals. Medical outcomes are excellent at Mission and continue to improve. Mission is becoming a model for the country as to how to reduce harm to patients while they are hospitalized.

Competition in healthcare has increased dramatically in Western North Carolina in recent years. When I drive the major highways to the Mission affiliated hospital in Franklin, North Carolina to work I drive within a few hundred feet of two hospitals that are part of Carolinas Medical Center, a far larger hospital system than Mission. If I drive just a few miles south of the Airport in Asheville I pass within a few hundred feet of the Adventist Hospital system, an exponentially larger system than the Mission system.

For years I have accepted patients from all over WNC while working the Emergency Department at Mission in Asheville. This is done every day, 24 hours a day, 365 days a year without regard to the patient's ability to pay. Many times these patients need services that are not available at Community hospitals. Many times it is because there is no specialist available on call at the Community hospital on a particular day to provide a service offered at that hospital on other days. Patients are accepted without regard to whether the transfer originates from a Mission affiliated hospital or a hospital operated by other larger health care systems such as Park Ridge Hospital, MedWest Haywood Hospital, and MedWest Harris Regional Hospital. These acceptances occur at night, on weekends, and on holidays just as they have for decades. Very often Mission loses money on these transfers but that does not stop Mission from being the safety net tertiary hospital for Western North Carolina. When I am working in Franklin and need to transfer a patient to another hospital for a service not available at Angel, Mission is nearly always the only hospital that will accept the patient in transfer even if the services are available at a closer hospital operated by a large health system.

I can think of no reason why a hospital system providing such an invaluable safety net service to a region with many larger competing hospital systems should not be allowed to offer services or accept physicians who wish to be employed. Patients should be allowed to choose their health care provider near their home based on health care outcomes, price, and the overall experience provided to them rather than having their choices limited by legislation.

Mission is not a 700 lb gorilla stomping around over smaller systems in Western North Carolina. It is a local hospital system seeking to offer healthcare services based on providing excellent outcomes at low cost while providing the patients it serves with an

exceptional experience. It only seems fair to me to let the safety net tertiary hospital for Western North Carolina offer health care services throughout the region it serves to allow it to survive and continue offering those safety net services.

Viddia Torbett (Rep. Torbett)

From: Alan Verm <alverm@hotmail.com>
Sent: Friday, November 04, 2011 12:25 PM
To: Viddia Torbett (Rep. Torbett)
Subject: CON laws
Attachments: CON laws copy.rtf; ATT7574742.txt

Representative John Torbett,
I am an ophthalmologist in Hendersonville, NC, and met Rep. Jeff Collins at the COPA/CON meeting two weeks ago at the WNC Ag Center. He asked me to write him a letter regarding my thoughts on the CON laws. I have enclosed a copy.
Thanks you for including this information in your discussions regarding patient access to the best health care available.
With regards,
Alan Verm MD
Looking Glass Eye Center
Hendersonville, NC 28792

CON Committee
North Carolina

Dear Representative Jeff Collins,

My name is Dr. Alan Verm. I am an ophthalmologist with Looking Glass Eye Center with offices in Hendersonville and Brevard, North Carolina. I attended Davidson College in North Carolina, medical school at Baylor in Texas, an ophthalmology residency at Bascom Palmer Eye Institute in Miami, FL, and a fellowship in Minneapolis, MN. We spoke after the CON/COPA meeting held on October 20, 2011.

I appreciated your remarks concerning the challenge of providing choice and access for patients to the best health care available. While nearly everyone appreciates Mission Hospital and its excellent care, citizens do not want it to have a monopoly and want access to local hospitals like Park Ridge and Pardee, as well as their choice of physician in western North Carolina.

You said the last thing you want to do is to get between the patient and their doctor. I submit that changes to the CON laws can accomplish these goals.

My passion is taking care of the patients who choose me for their eye care whether they need cutting edge cataract surgery, laser treatment for glaucoma, an exam to monitor their macular degeneration, or just a check up and new glasses. After nine years my practice continues to grow because of a reputation for providing excellent care.

My dream is to build, help manage, and have ownership in a freestanding ASC (ambulatory surgery center) dedicated to providing the best eye surgery possible to the citizens of Hendersonville and Transylvania counties. I have been told that if my practice or a group of ophthalmologists applies for a CON that every hospital in the region will fight us and that your committee will likely deny the CON because of their influence.

Please consider the following. ASC's exist around the country in most states for good reasons. They provide a more efficient, less costly and better quality experience for patients. Medicare and Medicaid only pay an ASC about 61 cents on the dollar for cataract surgery compared to what they pay a hospital. Although this does not make much sense, this is the way ASC's are reimbursed. Considering that cataract surgery is the number one surgery performed in terms of volume across the country including North Carolina, allowing CONs for ophthalmology ASCs would save millions in our state alone. If an ASC can provide the same surgery, in less time, in a more pleasant environment, and do it for 61% of the cost at a hospital, then how can your committee uphold the current CON laws?

I think the current system perpetuates the <u>mini-monopolies that all the hospitals in North Carolina enjoy</u>. They own all the operating rooms regardless of surgical outcomes and efficiencies. If they are inefficient and have lower standards, the CON laws protect

them. And above all else they cost significantly more. You and I and every citizen pay for this through our taxes and our health insurance premiums. We can and should do better.

Every single day in the office when I counsel patients about cataract surgery, they all want to know if I do it in the office or if I have an ASC. Patients from out of state, especially Florida, tell me that is the care they want and expect. They do not want cataract surgery in a crowded inefficient hospital where they might get a serious infection. I have had patients tell me they are choosing to get cataract surgery in Florida when they go south for the winter.

This is just wrong and is bad policy. Health care dollars and therefore jobs will continue to go with the patients and their choices. Do we want patients to choose to have their elective surgery performed out of state? If I lived in Georgia, Tennessee, Texas, or Florida, I could easily have my own ASC, and my practice would grow even more.

When I need to recruit a new ophthalmologist to my practice, how do I convince him or her to come here? It is much harder to recruit the brightest and best surgeons to our state with the current CON laws. Is this what we want for each other? I have considered relocating my family and skills to another state for this reason alone, but I am loyal to North Carolina and the hope that the CON laws will eventually change.

We have these antiquated policies, and then we wonder why do other states have more growth, lower unemployment, more efficient systems with better outcomes.

My opinion is that the best way to ensure citizens have access to more affordable higher quality care is to lower barriers to competition and let the market work. One way to do this is to change the CON laws so that no one organization or entity controls patient access to operating rooms. Allow us to build an ASC in Henderson or Transylvania County if we want to put our capital at risk and provide less expensive and better quality surgery. This is a win-win-win situation for the patient, the taxpayer, and the health care providers. It would also create jobs in this depressed region. Allow another group to build a hospital or ASC in Buncombe County to compete with Mission hospital. Competition is good. So lower the barriers to more competition. Please.

Thanks for your time and dedication to the citizens and patients of our state,

Alan Verm, MD

JOHN S. STEVENS

POST OFFICE BOX 7647 – ASHEVILLE, NORTH CAROLINA 28802

October 18, 2011

To: House Select Committee on the Certificates of Need Process
and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years on the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously complied with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived its usefulness and is it an impediment to the ability of Mission to continue as a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reasons no longer exist. There are now other large, well financed health care systems serving in Western North Carolina. When Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there are Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to

be freed from COPA restrictions to be able to compete. Mission is being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

John S. Stevens

From: Jim Barrett [mailto:jim@pisgahlegal.org] **On Behalf Of** Jim Barrett
Sent: Friday, October 21, 2011 4:36 PM
To: 'torbettlu@ncleg.net'
Subject: Comments regarding Mission Hospital

Dear Representative Torbett:

Because of the volume of comments you are receiving regarding Mission Hospital, I will be brief with my points. Please let me know if you need more formal comments or comments in more detail.

1. As executive director of Pisgah Legal Services, I am extremely concerned about health care for people who lack the financial means to pay for it. (Pisgah Legal Services provides free legal assistance to help more than 12,000 people annually with their basic needs, including health care.) In the region served by Mission Hospitals, the number of those people who cannot afford health care exceeds 200,000. These neighbors are working for the most part in low-wage jobs without health insurance. Many are children, or are disabled, or are over 65, and thus have access to Medicaid. Many more people in the area with slightly higher incomes lack health insurance as you know. Rural county hospitals have been unable to serve these citizens and citizens benefiting from Medicare without running up deficits. Fortunately, Mission Hospitals has been able to step in and help by partnering with these hospitals. Mission Hospitals needs maximum flexibility to expand medical services for financially distressed citizens in western N.C.

2. Mission Hospitals can be trusted to accomplish its mission. I have served on the ethics committee for the hospital. I know many of the staff who serve on the hospital's leadership team, volunteer Board of Directors, and volunteer Board of Directors of the hospital foundation. At Pisgah Legal Services, we would know if there were problems with indigent patients receiving care at Mission Hospitals, and we never hear a complaint. I remain impressed with the commitment and dedication of the hospital to serve WNC residents, regardless of ability to pay. This commitment is exceptional and essential to the region. I do not believe that this commitment has anything to do with the COPA; it has everything to do with the dedication of the people who work with and for Mission Hospitals.

3. Mission Hospitals demonstrates its commitment to serve the region as the largest area non-profit in countless ways. Just a few that I am aware of are as follows:
   (a) Mission provides laundry service to the Room at the Inn ministry of area churches through the non-profit Homeward Bound at no charge. This ministry serves women who are homeless, who are working on formal plans to get back on their feet financially.
   (b) Mission provides the majority of the funding needed for the health clinic of Asheville Buncombe Community Christian Ministry to operate.
   (c) Mission partners with countless organizations in joint ventures to serve people who are economically disadvantaged. These include Project Access, the nationally recognized program that matches indigent patients with medical doctors for free care; Western N.C. Community Health Services, a large health care clinic that is serving more and more uninsured patients; Pisgah Legal Services' Health Education and Legal Support Project that provides free legal assistance to patients to help them meet basic needs so that their health care outcomes are enhanced.

4. As a community-based non-profit, Mission Hospitals is accountable to the people it serves. Mission is governed by a volunteer Board of Directors. We know who they are, what they care about, and where they live. Mission Hospitals has an exemplary track record and the drive to improve the health of area residents even more.

5. We have learned (again) that a healthy reserve fund is necessary in the modern world. It appears that Mission has a reserve fund equal to about six months operating costs. United Way requires our non-profit to have a three-month reserve, and we are not operating a tertiary care

hospital that depends on Medicare and Medicaid reimbursements to operate. It would be absurd to punish Mission for operating prudently in these uncertain times.

Thank you for considering this input,

Jim Barrett

Jim Barrett
Executive Director
Pisgah Legal Services
P.O. Box 2276
Asheville, N.C. 28802
828-210-3408
www.pisgahlegal.org

Providing free legal assistance to help people meet their basic needs.

Mission ForumMaxwell

Mission ForumI am Bob Maxwell, Board Chair of Transylvania Regional Hospital in Brevard, NC. We are 77 year old hospital and the cities largest employer.

AFFILIATION:

Affiliations have become a necessity for many hospitals of all sizes and our process began about 3 years ago. Without affiliation we would have had to reduce services and physicians and as a result, patients would be traveling to other communities for a lot more of their health care needs. Our Board has a fiduciary responsibility to consider various options of affiliation as we need to make the very best decisions we can for the benefit of our patients. After a lengthy due diligence process, Mission was chosen last December by a unanimous vote of the Board. We are even more confident a year later that we made the right decision.

If Mission were not an option for affiliation due to regulatory restrictions, we would have been unable to make the best decision for our community and patients. Other communities would be placed in this same position. Patients deserve better.

EMPLOYMENT OF PHYSICIANS

We employ 66% of our primary care physicians and 60% of our full time specialists and these %'s will likely grow. Who ever thought 15 years ago physicians would either want or need to be employed, but that is where we are today. Hospitals and physicians are just doing what is necessary in the climate we work in. Retention and hiring of new physicians necessitates the employment.

This issue is made more critical as our payor mix is 69% medicare and medicaid and you know the financial pressures that come from that mix as a result of their low reimbursement levels. Missions percentage is even higher and is actually the highest in the state.

Regulatory restrictions on the employment of physicians is wrong for the physicians, hospitals and most importantly the patients. Employment is part of our changing health care business.

OBLIGATIONS

As hospitals, we owe our patients the very best care with an exceptional experience. Patients should have a right to expect this kind of care from what ever hospital they choose.

By tieing a hospitals hands with restrictions in areas such as affiliation and employment of physicians can significantly lesson the hospital's ability to provide the very best care and services for their patients.

As Board members, regulators, policy makers, physicians, hospital employees, etc., we should always be doing what is in the best interest of the patient. Our communities, as the ultimate patients, do not deserve to have their care adveresly restricted and effected due to COPA restrictions.

CLOSING COMMENTS:

Regardless of what changes in health care come from North Carolina or Washington, we as an industry need to make significant progress and changes to improve population health and deliver more efficient health care. Providing health care with an excellent experience for the patient while doing so without waste, harm and delivering better outcomes is a goal we all need to reach. This will also improve population health at lower costs.

Being creative, innovative and able to make the changes appropriate for these goals will become necessary. Hospitals and physicians will need flexibility as it is not business as usual for the health care industry in the years ahead. Restrictions that might have made sense in the past will have to be put into the past to allow Mission the freedom it will need to be successful in a rapidly changing industry. With the leadership of Mission, all of us in Western North Carolina can set an example on how to accomplish these necessary goals.

Thank you for coming and listening to our comments.

Bob

Robert O. Maxwell
Board Chairman
Transylvania Regional Hospital
Brevard, NC
October 20, 2011

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 (828) 277-4800 WWW.CAREPARTNERS.ORG

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

Mission COPA-CON Hearing Thursday, October 20, 2011

Mr. Chairman and Honorable Committee Members of this North Carolina House Select Committee, I want to thank you for allowing me to address you this evening. My name is Alan Baumgarten and I am a family physician. I have been in active practice for the past 25 years. I am President of The Family Health Centers, a large, independent group of family physicians based in Buncombe County that provides primary care for more than 40,000 patients throughout Western North Carolina. Our group is made up of 21 board certified family physicians and four mid-level providers in 3 offices: Arden Family Health Center located in south Buncombe County very near to the site of the proposed Mission-Pardee joint ventured "south facility", Asheville Family Health Center, located in central Asheville very near to Mission Hospital and Hominy Valley Family Health Center located in western Buncombe County near to the Haywood County line. Many of our patients choose our practices for their primary health care services from out of Buncombe County specifically because they know that we are affiliated with Mission Health. In fact, The Family health Centers continues to "buck" the national trends providing our own inpatient hospital service at Mission Hospital, therefore providing 24/7 care to our patients both in and out of the hospital.

I also have the honored position of being the Project Director for a $2.6 million, three year Duke Endowment grant designed to assist other independent primary care practices towards their implementation of a new primary care model called the Patient Centered Medical Home (PCMH). In the end, this project will further enhance the quality, capacity and viability of primary practices. The project will assist at least 20 practices (75-100 physicians) throughout Western North Carolina achieve PCMH recognition status and practice re-design to the PCMH model. The project will provide the practices with much needed management and operational technical

assistance, Nurse Navigators to improve quality through case management and care coordination specifically during a patient's critical "transitions in care" and enhanced chronic disease care, management and education. The Mission Health Foundation holds this grant and Mission Health has been a huge supported of this project for all of Western North Carolina.

Lastly, I am Mission Hospital's immediate past Chief of Staff. In fact, I am the first primary care physician to serve as Mission's Chief of Staff since the COPA took effect in 1995. My role as Chief of Staff focused on improving medical staff (physician) – hospital relations and quality improvement. Mission Hospital has long been known as a high quality provider but I was concerned that Mission Hospital could begin to slip on its quality scores if we did not begin new initiatives with a specific focus on quality improvement. Thus, I spearheaded the medical staffs drive for quality improvement and forged a relationship between Mission Health and the Institute for Healthcare Improvement (IHI), the world's leading healthcare quality improvement organization. This collaboration has lead to several intentionally designed projects that the leaders of the IHI believed would lead to Mission's recognition as "the safest hospital in the United States".

Let me for a moment reflect back to December 1995, the time during which the COPA was being discussed. At that time, I was the President of our local independent physician's organization called Mountain Health Care (MHC). MHC represented more than 400 Buncombe and Madison County physicians in direct contract negotiations with payers, industry, hospitals and other healthcare organizations and providers. During the COPA investigation period, I was interviewed by the United States Justice Departments and went on record in opposition to the COPA believing that the merger of these two hospitals would stifle local competition in health care and compromise quality and access. I was wrong. In fact I could not have been more wrong. The COPA allowed for the safe and managed merger between then St.

Joseph's Hospital and Memorial Mission Hospital and could not have been better conceived nor could it have better served our community and Western North Carolina.

Let me explain.

Mission's role as Western North Carolina's most sophisticated secondary and tertiary health care center has been helped by the COPA and has served our region well. We have all needed and greatly benefited from the growth in stature, quality and market share of this organization.

The growth of Mission Health has been a great asset in the building of primary care capacity in Western North Caroline. I am a family physician who came to Western North Carolina and stayed in Western North Carolina after training in the MAHEC Family Practice Residency Program. The Mission based MAHEC Family Practice Residency Program (MAHEC FPRP) is nationally recognized for its quality in part due to its relationship with and the training opportunities provided at Mission Hospital. The MAHEC FPRP has for the last 33 years been the training ground for more than 300 family physicians, of which, like myself, more than 150 are in active primary care practice throughout Western North Carolina. Mission Hospital is a huge part of the success of the MAHEC FPRP by providing a super high quality secondary and tertiary hospital as part of this training program.

As mentioned earlier, Mission Hospital has helped to raise the quality bar for Western North Carolina. Mission Hospital has led the charge of regional quality that resulted in Western North Carolina's recent recognition for "high quality and low cost" health care. In June 2008, I led a Mission delegation at an IHI sponsored conference in Washington, DC titled "How Do they Do That?" During the heat of the healthcare reform debate, Western North Carolina along with 9 other regions in the United States were ask to present to White House representatives, Congressional

representatives the press and each other, how we were able to achieve the status where we were all identified in the top quartile of regions in the United States as providers of high quality-low cost healthcare. Mission Health is now recognized as the regional healthcare leader that has promoted Western North Carolina to national status for its high quality and low cost healthcare.

Please let me conclude by saying:

1. Through its history, the COPA has allowed Mission Health to achieve a status where it is now the region's premier provider of secondary care for Buncombe, Madison and the near surrounding counties and tertiary care for all of Western North Carolina. The COPA was the right solution at the time to promote improved access to high quality health care for all of Western North Carolina.
2. The national and the local healthcare environment is rapidly changing and becoming more competitive. We should not allow this new level of competition hamper the high quality of secondary and tertiary care that should remain available for the citizens of Western North Carolina. Now is the time to relinquish the COPA so that Mission Health can fairly compete and continue to lead healthcare in Western North Carolina.

Thank you for your attention and for allowing me to address your Committee.

Respectfully submitted,

Alan S. Baumgarten MD, MPH

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I have been in practice as an Emergency Physician of Transylvania Regional Hospital for the past 8 years. I have been in emergency practice for 20 years in a variety of settings and so I have the perspective of being able to compare a number of hospital systems. I am writing to give you my impression of how Mission, our primary referral source, has operated under the Certificate of Public Advantage, both before and after our recent affiliation with them. I also plan to attend the October 20 hearing at the Agricultural Center.

Over the years I have interacted with both physician staff and administration at Mission. They have been extremely helpful in providing free consultation and accepting patients in transfer for services we cannot provide at TRH. This is very important to me, since, as a small rural community, we do not have full coverage with specialist nor the specialized facilities needed to provide for all of our patients' emergency needs. They have worked hard at making their services easily accessible to me. Their approach has made these processes, oftentimes very time consuming elsewhere, quick and easy. Besides making my job easier, it allows for better and safer patient care in a sometime overwhelmingly busy ED.

Knowing that specialty care is readily available if needed, has translated into patients being satisfied and confident in the care I provide them and has vastly increased the efficiency of our health care delivery team. They have not only helped with tertiary care, but also with more basic needs in times when our specialists or inpatient beds were unavailable at TRH. Furthermore, they always seem willing to support our efforts to provide care for our own patients in a noncompetitive way. Attitudes such as this are uncommon and derive from a culture of excellence promulgated by the administration on down the line to physicians and staff. Other

hospitals in the region can and do provide some of the services, for which I utilize Mission's system. Yet, they do not provide the quality of care I have come to expect from Mission.

I have never been engaged politically in the process of determining the need for regulations in regards to health care delivery and as such, I don't fully understand the history of the COPA nor the recent allegations of noncompetitive behavior. However, I hope that you will take into account my experience as you decide what is best for our region and that you do not pass regulation that might dismantle the system that has allowed me to provide such excellent care for the folks of Transylvania County.

Sincerely,

Joseph A. Cohen, M.D.

Emergency Department

Transylvania Regional Hospital

Brevard, NC

(828)883-5330

joechenge@aol.com

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I, Veronica Els RN, am an employee of Transylvania Regional Hospital, a member of the Mission Health System. We are located in Brevard, North Carolina. I am unable to attend the October 20, 2011 hearing but wanted my opinion heard related to COPA and the Mission Health System.

I serve as the director of Surgical Services and clinical director of Brevard Cancer and Infusion Center. I consider it vitally important that community and regional hospitals remain a part of health care; in today's market, affiliation with Mission Health System has made it possible for Transylvania Regional hospital to remain not only a viable option, but an excellent option. Having the most advanced tertiary care in the region through Mission Health System in such close proximity allows us to care for sick patients with the comfort of knowing that we have support when needed. I was privileged to experience Mission Health System patient care first hand when a friend's child was hospitalized last summer after an equestrian accident at a summer camp and was impressed with the level of care and services.

We are all blessed to live in such a beautiful place. The desire to live here is tied not only to the beauty of the landscape but having life saving, high quality care in close proximity. Today's consumer savvy and knowledgeable patient value the importance of freedom of choice in health care including what facility best suites their needs.

It is vital the Mission Health System be allowed to continue to grow and improve delivery of health care so that Western North Carolina remains a desirable place to live.

Sincerely,

Veronica Els RN, CNOR

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I, Vickie Oliver, am an employee of Mission Hospital, Asheville NC, which is a member of Mission Health. I am writing you about how Mission has operated under the Certificate of Public Advantage. I can't attend the October 20 hearing, but wanted to make sure you heard my voice and opinion.

From my own experience as an employee and as a frequent patient, I would like to describe how Mission's services have made a difference in the lives of patients.

I am the assistant to the Director of Materials Management. We provide supplies to clinical and non clinical departments and facilities of Mission Hospital. Our department does the purchasing and contracting for all supplies. We work hard, fast, and efficiently to provide the highest quality supplies at the best possible cost to our patients.

I have a very close family member who was fatally wounded in a motorcycle accident and was revived by our flight team, brought to Mission via our medical air ambulance and is still with us today due to the skill and services that we are able to provide and due to the speed in which we can respond to a crisis.

It is vitally important that the Mission family, including our community hospitals in McDowell, Yancey, and Transylvania counties, remain close to home for people in rural communities. We need to be able to continue to provide the most advanced tertiary care for the whole region when it's needed – like trauma care, pediatric subspecialties, etc.

Mission has special meaning to me and my entire family going back to my ancestors that were born and raised in this region. My own child was born at this hospital and my grandchildren are being born here. I have had many serious health issues. Without Mission, particularly our cancer programs and services, ER, and our medical air ambulance, our family would be missing many family members, mef included. My father lived in Honduras and just passed away in Asheville in August from recurrent and metastatic cancer. He wanted to come to Asheville and be admitted to our Cancer Center because he is from here, born and raised. We got him back in Asheville, admitted through the ER, and to Oncology very quickly. This makes a huge statement to the extent of what Mission offers its community, its region, and speaks extremely highly of "our" confidence in the level of care we receive from Mission which is why the people of WNC deserve to have life-saving, high quality care close to home, just like every other region of N.C. and a right to chose where they wish to receive that care.

If we are not able to continue servicing WNC, the people of this region will not have life saving choices close to home. America is about freedom of choice to include where we spend our money for the medical care we need when we need it.

I am proud and honored to be employed with Mission for twenty years and don't know what I would have done over the past 30 years if Mission had not been my choice for medical care.

From: Adrian D Sandler, M.D.
Sent: Friday, October 28, 2011 2:24 PM
To: William R Hathaway, MD, Chief of Staff
Cc: Susan Mims, MD
Subject: RE: Submission of Comments to the State Commission looking at COPA and CON Issues

Bill,

I wanted to write a brief note regarding my experience as Medical Director of the Olson Huff Center at Mission Children's. The Olson Huff Center is a multi-disciplinary regional referral center providing diagnostic and treatment services for children with developmental disabilities and disorders, including autism, developmental delay, intellectual disabilities and cerebral palsy. It is the largest such center in North Carolina, receiving referrals from the entire Western region of NC, and many from neighboring states in the region. I have had the privilege of working in this capacity as a Mission-employed physician for 11 years. The Olson Huff Center loses money each year, while providing comprehensive exemplary care to children with special needs. We owe our existence and the opportunity to continue providing quality care to Mission Hospital's commitment to providing needed critical services to the region. I am concerned that unnecessary restrictions on Mission's freedom to serve would potentially impact the Hospital's ability to continue providing support for our Center. This would be a critical loss for the region's children with special needs and their families. Please convey these comments to the commission.

Best wishes,

Adrian Sandler MD
Medical Director
Olson Huff Center
828 213 1783

My name is Susan Mims. I have been a pediatrician in Asheville for over 11 years and have served as the Medical Director of Mission Children's Hospital for the past 5. Part of my role involves running a pediatric specialty practice. I would like to tell you about one of the large practices that Mission owns.

Mission employs 31 physicians and dentists who care for the children of WNC who need specialty care. Our doctors treat children with cancer, cystic fibrosis, diabetes, child abuse, autism, and many other problems. Mission hired these physicians in response to requests from families in the region who were struggling to get needed care for their children.

Prior to the development of Mission Children's Hospital, families with children needing weekly chemotherapy treatments or regular visits to a pediatric physical therapist had to travel several hours each way to get that care. And, as we have learned since we hired a pediatric orthopedist, some families could not travel and just went without the care their children needed.

Hayley is one such child and her parents gave me permission to share her story. She is an 8 year old quadriplegic with cerebral palsy living in foster care. Her family could not afford to drive Hayley to South Carolina regularly so she could not been seen as often as needed for her orthopedic care until Mission hired a pediatric orthopedist.

Prior to starting treatment this 8 year old child was wheel chair bound, crawled on the floor and was totally dependent on her foster parents for movement. Now, since receiving regular care over the past year at Mission Children's Hospital, Hayley is beginning to walk independently and you should see how proud she is!

I want to point out that the reason pediatric specialty services were not available before Mission hired these physicians is because they loose money, a lot of money. In fact, hiring these physicians who loose money has contributed to some of the market share gain referenced in earlier comments. Mission stepped up to offer this care for children because it was needed and <u>this</u> is who Mission is. Mission is here to create a healthier WNC and knew that could not be done if kids were left behind. This is just one example of the many ways Mission serves this region. Mission is here for the children and families of WNC. Mission is here for Hayley. Thank you.

Testimony to House Select Committee on Certificate of Need and Related Hospital Issues AMENDED

by John T. Ashley MD, MBA, FACPM October 20, 2011

NC CON law and regulations are designed to rationalize the distribution of health facilities and extraordinarily expensive medical technology in the face of an irrational financing system of third party payment that promotes and stimulates excess utilization of high cost procedures by patients, physicians and hospitals. A unique feature of the CON law and regulations is the application of the Certificate of Public Advantage (COPA) that is used to evaluate the results of an approved CON by Mission Hospitals.

The enormous value of COPA reporting has been demonstrated in Asheville-Buncombe by the work of the Asheville Chamber Healthcare Roundtable over the past 8 years. Based on data from the Mission Hospital's COPA Reports from the 1999 through 2008, the Roundtable developed and submitted, with the support of the leadership of the NC legislature, prominently lead by Rep Bruce Goforth and Sens Martin Nesbitt and Tom Apodoca, HB 212, The Health Insurance Pool Pilot Program, adopted in 2009.

This legislation was developed by the Roundtable with full participation by the major employers of the community, by all of the major private hospitals, by physicians represented by the Buncombe County Medical Society, by local governments, by organizations that procure health insurance for businesses, by small employers, by our local PPO organization of physicians and hospitals providing access to health care and the public. The legislation was vigorously and prominently opposed by the largest private insurers in the state in testimony to both houses of the legislature. The legislation received bi-partisan support during its thorough consideration in committees of the House and Senate. My observation was that the bi-partisan support grew as the largest insurers increased their opposition.

The content and language of HB 212 was developed based on data contained in the Mission Hospital COPA Annual Reports that were generously and thoroughly shared with the Roundtable each year during deliberations on how to address and resolve the twin conflicts of the EXCESS cost of Health Insurance premiums and GROWING number of Uninsured residents of Buncombe County. The data in the COPA Reports showed clearly that the merged hospital system incurs the millions of dollars of losses by caring for the uninsured and millions more of losses by less than full cost reimbursement from Medicare and Medicaid each year. The COPA Reports demonstrated that the hospital receives payment from private insurers representing the large employers and other privately insured groups and individuals that reimbursed all of the costs of care for their beneficiaries, PLUS the cost of losses from the uninsured and underinsured PLUS the margin that every hospital must generate to successfully serve their communities with needed services and to create the reserves for future growth.

The data from the MH COPA demonstrated explicitly the process of COST SHIFTING that occurs implicitly in every hospital market in NC and the U.S. to allow the uninsured to obtain medical care. The Roundtable membership, lead by representatives of large employers who pay for the cost shifting through their insurance payments and representatives of the professionals and institutions who receive the payments, recognized that the fundamental problem of the broken system must be addressed so that affordable health insurance was available to every resident and employer who had any ability to purchase health insurance rather than be uninsured.

In Buncombe County, the medical society with critical support from Mission Hospital and County government have developed and implemented Project Access, a national model of voluntary provision of specialty medical care, hospitalization, medications and support to the uninsured, poor residents of the community. But the number of uninsured has grown to almost 19 % of the adult population of the county and Project Access is rapidly exhausting the ability of physician specialists to donate their services to the poor because of the growing number of uninsured. Project Access does not provide access to Primary or Preventive Care. As a volunteer physician at our local free clinic, ABCCM Medical Ministry, we see an endless number of uninsured individuals, including some children, who suffer from preventable and treatable conditions like hypertension, hypercholesterolemia, diabetes, depression, obesity and smoking that lead to heart attacks, stroke and cancer resulting in catastrophic medical interventions, excess costs, excess morbidity and premature deaths. This is true in every community in NC and the nation and is the basic reason that the US has among the worst population health outcomes compared to other developed nations.

In Buncombe County, we have a national model of Disease Management called Project Asheville that is used to control many of the conditions that lead to excess hospitalization and costs for the insured. Project Asheville is not available to the uninsured but the costs of the care for their catastrophic health problems are borne by the privately insured who pay for their own beneficiaries care and the cost-shifted burden from the uninsured who receive hospital care. The hospital and Insurers have become Unrecognized, Private Taxing Authorities that collects premiums and payments from the employed insured to care for employed and unemployed UNINSURED.

The Roundtable recognized the fundamental breakdown in our local financing system and the hidden burden of high cost health insurance premiums and the resulting uninsured in our community through their analysis of the local COPA data. The Roundtable employed health care and actuarial consultants who guided their deliberations and evaluation of approaches used in other communities in the US. The Roundtable wanted to make the system rational and fair by making insurance affordable to all employers and individuals by correcting the flaws that made insurance prohibitively expensive and resulted in unacceptable increases in the number of uninsured.

The Roundtable learned that US Health Insurance began as a community-rated product for limited benefits provided by a Not-for-Profit insurer with low overhead for all residents of communities with payments to providers at prices that reflected the actual costs of care. Private, For-Profit insurers entered the market after WW II and increased the covered benefits, segmented the market to identify the lowest risk groups, introduced reimbursement contracting with hospitals and physicians, implemented utilization controls and abandoned community rating to attract the lowest risk groups for increasingly expensive health insurance with higher overhead and significant profits. Large group Insurance purchasers responded by self-insuring and negotiated for deeper discounts from providers. Hospitals and other Providers responded by increasing prices to cover the costs of uninsured losses and dramatically increased the volume of technology and specialty care procedures to offset their losses from primary care and catastrophic services.

The Roundtable, using COPA data, sought legislative authorization to undertake a demonstration project for pooling large and small employers into a unified community-rated purchasing group that would design and adopt proven packages of benefits that met the requirements of the NC Department of Insurance and the developing requirements of the national Accountable Care Act. The proposed four levels of benefits would cover the costs of uniform Primary and Preventive Care services and Catastrophic services in all packages and use proven actuarial processes to reduce the costs of premiums for discretionary, procedural services. Fundamentally the proposed pooling of insurance was to be designed to obtain low insurance overheard, less than 10% as achieved by the NC State employee health insurance program, optimum utilization of procedural services and full access to Primary Care to achieve best health outcomes for the combined group of insured from both large and small employers and potentially from insurable individuals. The proposed pooling of insured groups was designed to use market competition among insurers for the largest possible group in the community and potentially the region. The model is based on proven Prevention and Primary Care, full access to catastrophic care, and appropriate use of best technology without use of the most technology, managed by local systems of care supported by proven actuarial analysis and processes.

The Roundtable proposed legislation was adopted by the legislature and approved by the governor in 2009 and amended in 2010 to allow implementation of a model of a local health insurance program in NC. Without the data from the COPA Reports, this community approach could not have been developed and the authorizing legislation could not have been adopted. The authorization of HB 212 remains unfulfilled today because of the fluidity of the insurance market secondary to adoption of national health reform and the impending regulatory changes. The need for a local demonstration project to model the best benefit design with appropriate economic incentives for patients and providers has never been greater. The authorization of HB 212 remains available to Buncombe or other interested community because of the COPA data that demonstrates the potential value of changing our financing system in NC and the nation.

I recommend that COPA Reporting requirements be retained in the regulations even as other regulations are modified or reduced to relieve unnecessary burdens on Mission Hospital.

October 14, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am the Low Vision Technician at Mission's Low Vision Center in Asheville. As a Mission employee since 2003, I am writing them about how Mission has operated under the Certificate of Public Advantage. I cannot attend the meeting on October 20, because a co-worker and I will be doing a presentation educating professionals as to how to assist people with low vision when they come to their businesses.

The reason for me not being able to attend the Thursday meeting demonstrates one of the ways Mission serves Western North Carolina—educating the public. The main focus of my job is that I meet with patients who are facing the challenge of low vision, which can be devastating. I have low vision myself, and sharing my personal perspective of coping, as well as teaching them about techniques, resources, and aids makes a difference. I talk to them about the North Carolina Library for the Blind and Physically Handicapped from which they can receive for free-recorded books and magazines and large print books. My patients also learn about options they have to continue using computers using assistive technology that make things on the screen bigger and easier to see or programs that verbally read what is on the screen—which I use on my computers. My patients are not charged for the time I spend teaching them about these and other resources, and I spend anywhere from 20-75 minutes with them and any family or friends that may be with them. I encourage them to contact me with any questions they may have in the future. I also coordinate

the area low vision support group, which Mission sponsors. This takes me approximately eight hours a month, and again there is no charge for this community event. Please see the attached sample announcement that I sent out about these meetings. Additionally every week I prepare notices to send to interested people with low vision about movies showing with description in the area—see attached. I have also included an email exchange I had with a patient. All of these things help people dealing with low vision realize opportunities they have to regain independence! Mission helps people do this.

Low Vision Centers are rare, so we have patients come quite a distance to use our services. Our patients come here from all over WNC, and we often help patients from South Carolina. With the growing number of aging people in the area giving them options of having our Low Vision Center, as well as Mission's many other departments available for people in the area it is critical to let Mission grow, as well as provide existing services. Giving Mission this option to grow does not take away people's options to make choices as to where they can go for help. Mission needs the freedom to serve. We want to compete for patients based on outstanding care, without harm, without waste and with an exceptional experience. The region's patients – not government regulators -- should choose where they receive their care. Thank you.

Sincerely,

Judy L. Davis, MSLS

Low Vision Technician

Mercy, Excellence, Respect, Integrity, Trust/Teamwork

October 14, 2011

To the House Select Committee on the CON Process and Related Hospital Issues,

My name is Trent Ibbotson and I am an employee of Mission Health, residing here in Asheville, NC. I am relatively new to the region but lived in Charlotte for the last sixteen years and have been involved in healthcare that entire time. I remember when Mission Memorial and St. Joseph's merged fifteen years ago and the initial thought I had was that this newly merged entity would have a stranglehold on the western North Carolina market. After learning more about how Mission Health has had to operate under the Certificate of Public Advantage, COPA, I see why that original impression was probably accurate but has now become the furthest thing from the truth.

I am not a clinician but work diligently on ensuring that the community we serve has access to high quality care as close to home as possible. In my brief tenure here, I have had the opportunity to talk to some members of the community who have either had to use the health system's resources (including cancer care and outpatient surgery) or known someone who has. I am proud to say that the feedback has been overwhelmingly positive, which is a testament to the value and peace of mind that this institution brings to the region.

However, that sense of security is under continuous assault as changes in the regional and national market include a whole host of challenges that are only intensified in their complexity to overcome with the COPA still in place. Some of the issues to reflect on include:

- a mandate for higher quality at a lower cost,
- higher demand for provision of care in the outpatient arena,
- increasing competition from much larger systems who are not local to this region but obviously want to get bigger,
- decreasing reimbursement including payer mix challenges,
- increased regulations,
- national economic disarray,
- increasing desire by MDs to seek employment arrangements with hospitals/systems, and
- migration to an accountable care model

Predictably, there is increased pressure from our competitors to make the COPA even more restrictive. It is awfully convenient for them to lean on an outdated and burdensome regulation to ensure that we are only limited to advanced, tertiary care for the region. Meanwhile they deploy a strategy geared toward gobbling up the foundation of the healthcare future. Critical services like trauma and the NICU do not positively impact the margin nor is the provision of such services sustainable by itself. Despite that, we subsidize them because they are essential

and it is our mission to do so. Contributing to the financial challenges, we treat the highest percentage of Medicare and Medicaid patients in the state and bear a heavy financial burden to subsidize the services provided to those customers as well. Again, it is our mission to do so.

To continue providing the life-saving, high quality care that our whole region depends on and deserves, Mission needs the freedom to serve. We want to compete for patients based on outstanding care, without harm, without waste and with an exceptional experience. The region's patients – not government regulators -- should choose where they receive their care and we want to provide it to them as close to home as possible. Should they need more advanced tertiary or quaternary care, then Mission wants to be the destination hospital of their choice and we will earn that designation. I am convinced that rescinding the COPA can help pave the way for advancing healthcare not only in western North Carolina but the entire southeast.

Sincerely,

Trent Ibbotson
203 Blake Mountain Circle
Asheville, NC 28803

Bruce M. Burns
178 Stonehollow Rd
Fletcher, NC 28732
October 16, 2011

House Select Committee on Certificate of
Need Process and Related Hospital Issues

To whom it May Concern:

I was a patient of Mission Hospital in 2002 for a heart blockage. I was very grateful to have the services of one of the Top 100 Heart Hospitals in the country in my community.
I received three stints and that along with the Heart Path program have made a major improvement in my life.

I have been a participant in the Cardiac Maintenance program for almost 10 years now. While there are other places to "work out", this is by far the best available program for me to maintain and improve my heart health. This program is proactive,as I am, in maintaining and monitoring my heart health. It includes appropriate exercise programs, monthly rhythm strips, weekly educational programs and careful monitoring of my overall weight, blood pressure and other important factors. This is done by a professional and caring staff.

There are many reasons to live and retire in the Asheville area. On my list is the quality of the health care that I have had available from Mission Hospital. I feel it is important that Mission Hospital be able to serve the people like me in the Western North Carolina area. We are a community that is remote to a certain degree from larger metropolitan areas with many medical assets. I feel that we have a world-class hospital partner in Mission and we should all be able to have access to this level of care.

I am unable to attend your meeting but wanted to express my feelings to you.

Sincerely, Bruce M. Burns

Bruce M. Burns

October 16, 2011

To: House Select Committee on CON Process and other issues:

From: Jack A. Koontz, MD
FAAFP FACOEM

I am unable to attend the hearing scheduled for October 20, but I, as both a patient and physician, want to have input to the Select Committee on this vital subject.

During the afternoon of this past Labor Day, I sustained a myocardial infarction, aka: heart attack and was admitted to the Cardiac Service of Mission Hospital. To have the facilities provided by Mission, along with their superb staffs, medical, nursing and all support personnel, was life saving. I cannot adequately express my thanks for the timely manner in which I received treatment or for the courtesies extended to me and my family.

Having lived with coronary artery disease for sometime, I find great comfort in having Mission and its life saving, high quality care available to me and my fellow citizens here in western North Carolina. Illnesses by themselves create high level of anxiety and worry, but these complications are much reduced by having Mission and its capabilities here in our neighborhoods. We need to be able to do more than simply maintain what we have, we need to be able to plan for future needs and have them met here near our homes.

Sincerely,

Jack A. Koontz M.D.

Jack A. Koontz, MD
703 Crowfields Lane
Asheville, NC 28803

John A. Mills
32 Bucks Acres Dr.
Asheville, N.C. 28806

RE: Mission Hospital
I had a heart attack + a stroke one year apart. Thanks to Mission I'm still here. They have been great for my recovery.

John Mills

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

In 2006 my wife and I moved to Asheville seeking a good place to complete our retirement. It had to have the best in health care sevices. We found it here in Asheville.During my life of 82 years I have always heard and seen the conflict between the doctors anh hospitals.I did not want to become involved in the disputes , I only wanted the best medical service and I found it at Mission Hospital.My wife has had to use the hospital three times and all of the service was excellent.

I have become a volunteer at the hospital and my goal and the 600 volunteers is to help make Mission Hospital one of the best in our nation. We contribute over 100,000 hours and $300,000 cash each year. Let those who complain follow us to the top. There is always room for good competition.

Sincerely,

Douglas A. Young

Douglas A Young
16 Salisbury Dr. Apt 7313
Asheville NC 28803

House Select Committee

Certificate of Need Process and Related House Issues

As a current patient in the Mission Hospital healthcare system, who has and is still receiving care, I am concerned with the changes that may be imposed to the hospital under the Certificate of Public Advantage.

Since I cannot attend the October 20 meeting I'd like my opinion to be heard.

As a prostate and open heart surgery patient at Mission, I cannot express my complete satisfaction in the treatment I've received. I continue to be screened on a regular basis and am involved for the past six years in their Heart Path exercise program which has been extremely beneficial both physically and mentally.

I am very concerned that changes which may be imposed on the hospital will alter the high quality, life saving care they provide for me and other residents of Western North Carolina.

It would be greatly appreciated to allow the hospital to continue to operate as they currently do providing the best care in the region.

Sincerely,

Joseph Olita

332 Hemlock Springs Trl.

Weaverville, NC 28787

October 17, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am an employee of Mission Hospital in Asheville, NC. I am writing to you regarding the Certificate of Public Advantage (COPA). I am unable to attend the hearing on October 20th as I will be out of town, so I wanted to express my concerns to you by letter.

I am the Nurse Manager for the Women's Surgical Oncology Unit at Mission. More than thirty women come to us each week for surgical interventions for female cancers such as ovarian, uterine, cervical or breast cancer. Our nursing and medical staff provide care for these women as if they were our own family members. Some of them return after progression of their disease for symptom management and further treatment. Tender therapeutic relationships are formed at moments of crisis like these. These patients and their families deserve to have a choice about where they go for hospital care.

The people of western North Carolina deserve to have life-saving, high quality care close to home. Mission Health System needs to be free to serve the people of western North Carolina based on the people's choice. I urge you to release Mission Health from the burdensome regulation of the COPA. Allow us to do what we do best....care for our patients.

Sincerely,

Brenda Lee Smith

Brenda Lee Smith, BSN, RN, NE-BC
Nurse Manager, Mission Hospital

House Select Committee

Certificate of Need Process

Related Hospital Issues

I have been a very satisfied Mission Hospital patient since 1996. I will be unable to attend the hearing on October 20th.

I have been a Heart Patient at Mission since 1996 and the services that I have received at Mission have been excellent. The services have improved my heart functions and my outlook on life. One service that has been great for me is Heart Path Cardiac Rehabilitation. The friends that I have met in the program, the support from the Mission staff, and the educational information that has been given to me has been instrumental in improving my overall health. The exercise program has been especially good for me. Some of my heart issues have been discovered while at Heart Path, have been addressed, and have helped me avoid problems later on.

The people of WNC are very diverse including true "mountain people" and young entrepreneurs, to middle age working people and retirees. This diverse population needs all types of healthcare and Mission can provide this if the playing field is leveled for Mission. The level playing field is already in place in other regions of North Carolina. Why is not available in Western North Carolina?

My personal freedom to choose my healthcare is important to me because of my heart issues. Mission has a great national heart services rating in cardiac care. I'm very proud to be a patient of this program.

I'm also proud of Mission's being able to obtain this national recognition. I fully support Mission Hospital in their efforts to provide quality low cost healthcare to all of Western North Carolina. It is hard for people to understand healthcare who have not faced issues like I have. Mission Hospital has been there every step of the way, and I would not be here today without Mission Hospitals Systems and the Cardiac Rehab program.

Thank you very for allowing me to voice my opinion on this issue.

Sincerely,

Steven B. McElreath

10 Lynnette Drive

Fairview NC 28730

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

As a pharmacist that is employed by Mission Hospital in Asheville, North Carolina, I felt that it was very important for me to express to you the views that I have witnessed as to how Mission Health has operated under the Certificate of Public Advantage (COPA). It will be unlikely that I will be able to attend the public hearing on October 20th, thus I wanted to be sure to provide my perspective.

In my position with the outpatient Mission Hospital Medication Assistance Program, the impact of Mission services, that I have witnessed, on the community have been exponential. I feel that it is very important for you to know that the salary of myself, our other clinical pharmacist, our licensed clinical social worker, our pharmacy technician, and our two medication assistance specialists are all funded almost entirely by Mission without other significant revenue sources. Our program is completely free to qualifying patients. Providing services such as these are not required under the COPA (Mission provides millions of more in free care through charity care program that alone allows for non-profit status). To me, the ability to work for an organization that supports programs such as ours, along with other significant community benefit programs, has been phenomenal due to the large impact we are able to have on our patients. Patients do not have to see a Mission Health provider to have access to our services (there are other requirements, such as financial limitations). Many of our patients are disconnected from community services and have been unable to afford their medications when they are referred to us. It is extremely rewarding on my part to be able to not only provide many of these patients with their life-saving medications free of charge, but to also be able to spend significant amounts of time with them in clinical disease-state management visits (time fully supported financially for me to do so by Mission Health). It is a common occurrence to hear comments such as "I don't know what I would do without your program." It is during the clinical visits that I am able to identify and address a wide variety issues with their primary care providers, such as uncontrolled diabetes, elevated blood pressure, appropriate use of migraine medications etc. In spending this significant amount of time with patients, I am also able to connect our uninsured patients to other resources in the community. This includes programs such as Ladies Night Out (partially supported by Mission Health), which provides free mammograms to uninsured women. Other referrals can vary from food assistance to sliding scale counseling services to low-cost options for influenza vaccinations. My division participates in various community outreach activities, even including a healthfair event in the Craggy Jail for prisoners.

The dynamics in healthcare have significantly changed since the COPA was formed. There are multiple other competitors in our region, including the much larger Carolinas Healthcare System, the Adventist System, and the management of another hospital by UNC Hospitals. I do feel that competition is healthy. However, I think it is unfair to restrain one organization when other, larger organizations such as Carolinas do not have such restrictions. Mission is committed to quality (we receive emails all the time about the importance of high quality, which Mission is further improving in collaboration with

MISSION HOSPITALS

the Institute for Healthcare Improvement). From my perspective, Mission is proud to be in Western North Carolina and does not want to "run out" or "run over" competition, but instead compete without unfair restrictions, while at the same time providing the highest possible quality healthcare. Patients should be able to choose which hospital and physician services they receive based on that organization's quality, not based on federal and state regulations that unfairly limit the ability of one high quality organization to expand its services. With the changes in the healthcare environment, Mission does not have a choice but to expand in outpatient settings to be similar to other financially healthy systems around the country. Our challenges here in Western North Carolina, due to one of the highest Medicaid and Medicare populations in the state, (whose reimbursement does not cover our operating costs) are huge. However, the challenges are made larger by the COPA restrictions on physician hiring. As an employee, I have seen firsthand the commitment to quality and community enhancement in my time at Mission. Please consider advocating for the termination of the COPA agreement in order to allow Mission Health to continue this mission of serving the people of Western North Carolina. A mission that neither the state nor the people of Western North Carolina can afford, if it fails.

Sincerely,

Ben Smith, PharmD
Medication Assistance Program Clinical Pharmacist
PGY1 Pharmacy Residency in Ambulatory Care Coordinator
Mission Hospital Outpatient Clinical Pharmacy Services
501 Biltmore Ave
Asheville, NC 28801
828-213-5538 (phone)
828-213-1859 (fax)
ben.smith@msj.org
Ben Smith, PharmD

FULLERTON GENETICS CENTER

October 17, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Carolyn Wilson-Brackett and I have been a genetic counselor at Mission Hospital since 2003. I am very fortunate to have a wonderful career and colleagues, and I am so proud to be part of the Mission family. I am writing in regards to Mission Hospitals operating under the Certificate of Public Advantage. I am unable to attend the hearing on this on October 20th, but I would like to share with you some of my experiences at Mission.

Genetics is a unique specialty, and our patients generally have significant medical, cognitive, and physical challenges. We tend to follow patients over many years, which allow us to form close relationships. As a genetic counselor, my role is to help families understand the complexities of genetic conditions -- not only the medical aspects, but the social and psychological ones as well. I assist the physicians in diagnosis, and help the families connect with support services. I do a lot of talking, and I do a lot of listening. Patients appreciate that they can reach me by phone, and I am on a number of speed dials. I am lucky that I have a position where I get to make a difference to a family every day.

Many of the families we work with have complicated medical needs and see multiple specialists. Finances are often tight, and travel can be a hardship. Our genetics physicians see patients at a number of satellite locations in the region to provide access to excellent care with the least amount of family hardship. When families do come to Asheville, their providers try to coordinate care to minimize family travel. Just this week we saw a patient for a genetics visit while he was receiving an infusion treatment for his rare genetic condition. Many of our families have been to see specialists throughout the state or county – and they invariably comment on the personal care they get at Mission as compared to other locations. That feeling that they are 'more than just a number' goes a long way with families who have complicated medical needs.

Western North Carolina is an amazing place to live. The people here are hard working, kind, and feel a strong sense of community. Access to high quality, life saving care in their community allows them to get well physically, without the stress and worry that comes from being far from their loved ones. Mission works hard to provide the best care, even in very difficult financial times. Mission employs wonderful people who truly care about their patients and neighbors. Mission has been a part of this community for generations, and has earned a reputation for excellent quality care. Our residents deserve to be able to choose where they get their care and I hope that Mission will be able to continue to serve its community in a way that puts patient's needs first.

Sincerely,

Carolyn Wilson-Brackett

Carolyn Wilson-Brackett, MS
Certified Genetic Counselor

Clinical Genetics Practice, 11 Vanderbilt Park Drive, Asheville, North Carolina 28803 (828) 213-0022 (888) 810-2800 Fax (828) 213-0039
Laboratory Operations, 267 McDowell Street, Asheville, North Carolina 28803 (828) 213-1015 Fax (828) 251-2608
www.missionhospitals.org/genetics

To: House Select on Certificate of Need Process and Related Hospital Issues:

My name is Gerald A. Kernick an employee of Mission Hospitals Asheville, NC. I feel certain that our hospital system has been more than transparent in regards to the Certificate of Needs Process and any other related hospital issues with the State of North Carolina now or over the last 15 years.

If more restrictions and regulation is placed on Mission Hospital systems with limited access to health care it will be a detriment to our community and state. By capping physician growth and hospital expansion in the South Buncombe and Hendersonville region access and quality of health care suffer. Would this CON be viewed any different if Carolina Health Care the intended provider in this region. I would think not.

Limiting services restricts choice for me and our community and would be a burden to get timely healthcare by having to go to another facility for services further away. Western Carolina is trying to attract other businesses to locate in this region but with this question about CON they might choose to locate elsewhere and our community is impacted even more.

I can speak personally about healthcare since I was a patient in 2010, and my outcome would have been worse if I had more than a 15 minute drive for the services I needed. Countless of patients have the same concern about health care as they consider Asheville and Western Carolina region for retirement.

10/18/2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Donna Borowski. I have worked at Mission Hospital for 21 years in Asheville N.C. I am writing about how Mission has operated under the Certificate of Public Advantage. I am unable to attend this meeting but want to be heard.

I work as Team Leader for the Nicotine Dependence Program. My Team and I see patients at the bedside, outpatients, employees, spouses and service as part of benefits to companies. All of the works we do at the bedside and as community patients are done for free. When someone is in this addiction to be provided support, education and follow up is very important for success. Mission gives our program to those that do not have a benefit. This is very important for our community and WNC.

I feel so strongly about the quality of care in our hospitals that I have brought both of my parents here from Georgia for treatment of health issues that could not be taken care of in their community. My parents have both had great outcomes from being cared for here. My husband has been very ill for the last 5 years and I have used our hospital because I trust the care here.

With the ever changing climate in health care and knowing that the smaller hospitals struggled. I am excited to have a larger system and help the care across WNC be of great quality. I know that many families are very grateful that they get quality care here in Asheville. I cannot imagine not having advanced tertiary care for WNC. We have a top trauma center, we excel at cardiac care, strokes, pediatrics, neonatal and the list goes on. I feel that we are blessed to have excellent this close to home for all in WNC.

Mission has been part of my family for a long time. I chose Mission to work at until retirement. I stand by that decision. We all should have the basic right to be cared for near our family and friends. We all deserve the best in our time of being the most vulnerable during illness. We all deserve to be able to choose where we receive our care.

It is important that Mission have the same privilege in this time of change to develop a stronger system through out WNC. It is important for the people of WNC and for a health system that has been providing care for 120 years.

Thanks for the opportunity to share.

Donna Borowski

10/14/11

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Julie Bowers and I am an employee at Mission Hospital located in Asheville, NC. I am writing you about how Mission has operated under the COPA, and I strongly feel it is time to free up Mission Health System from these constraints. I will not be able to attend the October 20, 2011 hearing, but I wanted to make sure you hear my opinion on this.

I work in Audit and Compliance Services, and although I do not provide patient care, my group strives to ensure compliance with all billing, coding and financial regulations. My dad who lived in Hayesville, NC, was a patient at Mission 2 years ago and overcame a serious infection that could not be addressed at the smaller hospital in Murphy, NC. Had he not gotten transferred to Mission, he would not have survived that illness. It is vital that Mission be able to affiliate with smaller hospitals in rural areas, and provide desperately needed care to those people.

I feel it is extremely important that Mission be free to serve the people of western N.C. without undue and unfair constraints. Mission provides the highest quality care and is a very important place of employment for 7,000 employees. People should have the freedom to choose where they go for hospital care, and my personal experiences have and will continue to cause me to choose Mission Hospital. I would like for my family, who lives west of Asheville, to be able to choose Mission also.

Respectfully,

Julie Bowers

Julie Bowers

October 14, 2011

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Rebecca Calloway and I am a member of Mission Health. I am the Administrative Director at Asheville Surgery Center, an outpatient surgery center in Asheville, NC. I am writing you about how Mission has operated under the Certificate of Public Advantage. I can't attend the October 20 hearing, but you wanted to make sure you heard from an employee.

From my own experience, Mission's services have made a tremendous difference in the lives of patients as well as my own personal life. In my role at Asheville Surgery Center, we see patients who are having elective surgery to improve their quality of life. Our center is designed to ensure patients who are at high risk receive the attention and quality of care they need to live a more comfortable life. Our staff provides a compassionate atmosphere where patients can come and know that they will be taken care of while they are with us. Our patients are so grateful to have a facility in Western North Carolina with such a highly respected reputation at their resource. They are comforted by the fact that they can be so close to home and know that their loved one is receiving the care they need and deserve.

As a Director, I look at our budget on a regular basis and see how COPA restrictions affect the services we can provide to our patients. In this market, everyone has to make cuts, but the COPA has definitely limited the quality and care our facility can provide to patients. For example, we perform a procedure in our center for patients with cerebral palsy to help them with nerve issues. Every time we perform this procedure, we lose approximately $10,000. We continue to do these types of procedures to help these patients live a more comfortable and better quality of life, but with even more cuts being made for the new fiscal year, we will be removing this procedure from our list. With the restrictions COPA has set for Mission Health, we definitely are limiting the services we can provide to our community. Not only is COPA affecting patients, it is reducing the number of staff we have available to serve our patients. With unemployment as high as it is in Western North Carolina, jobs are in high demand and COPA should look at the impact they are having on contributing to this figure. To remain competitive, COPA should remove the restrictions it has on Mission Health and look at bettering our community.

From a personal side, Mission Health has made a lasting impact on my life. Approximately a year ago, I was pregnant with my first child who was diagnosed with an incredibly rare chromosomal problem. My husband and I visited physicians in several states and none had ever seen a case like ours outside a textbook. We ultimately ended up using Dr. Ursula Harkness at MAHEC and Drs. Jim McGovern and Aaron Pulver at Asheville Cardiology and Dr. Ellen Boyd at Fullerton Genetics as our primary physicians

who helped us every step of the way. Our son was born as predicted three weeks early and weighed 3 lbs 12 oz. and was doing well under the loving care of the NICU staff. On the fifth day he caught an infection and died a few short hours later. Even in the midst of this tragedy, I left Mission Health feeling as though my family had received the best care possible under the unusual circumstances. I am thankful to these physicians and staff in the NICU for providing us the best care possible. Without Mission Health, we would have been required to travel to a different region to deliver our son and would not have been able for our family to meet our son in the short time span of his life. Mission Health was a tremendous resource for us and the love and care we received meant a lot to our family. When I accepted my current position at Asheville Surgery Center, I felt proud to be able to help serve the community in the way that my family was served just a year ago.

I ask that you reconsider the restrictions that COPA is placing on Mission Health and instead look at the good they are providing to our community in Western North Carolina. Thank you for your time and consideration to this very important matter.

Sincerely,

Rebecca Calloway
32 Memory Lane
Arden, NC 28704

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

My name is Elizabeth Pelletier and I have been employed at Transylvania Regional Hospital, a member of Mission Health, in Brevard, NC. I have worked as a nurse anesthetist for the past ten years here. I am writing to you about how the Mission system has operated under the Certificate of Public Advantage. I am hoping to attend the October 20 hearing but am unsure whether I will be able to speak and want to make sure that you hear from an employee.

I am involved in direct patient care and hear from patients on a daily basis how lucky they are to have such a great hospital close to home and yet have anesthesiologists from the Asheville Mission group practicing at our small hospital. Simply to be affiliated with Mission gives patients an added sense of comfort that the best medical technology and expertise are at their fingertips.

Being affiliated with Mission has already meant seeing a decreased cost in all the supplies used in patient care secondary to the stronger buying power of Mission. We will also soon see an increase in reimbursement from commercial insurance companies due to the greater bargaining power of the Mission system. All of this allows our smaller, critical access hospital to remain viable in these difficult financial times.

On a more personal note, a few years ago, my husband fell off a ladder and had a terrible fracture of his femur, a shattered heel bone, and a badly injured shoulder. Injuries of this type cannot be handled at our facility and we were lucky to have Mission so close. He was helicoptered there and was treated quickly and expertly by the staff and doctors there.

Because of the mountains here, we in Transylvania are fairly remote and deserve to have the high quality, life-saving care available close to home. We should be free to choose the expert care given at Mission and Mission should be free to serve the people of western North Carolina.

Thank you for your consideration...

Sincerely,

Elizabeth Pelletier

October 17, 2011

828-553-3644

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am employed as the Director of Human Resources at Transylvania Regional Hospital in Brevard which is has a management agreement with Mission Health Systems. I am unable to attend the October 20th hearing but wanted to communicate with you concerning how Mission has operated under the Certificate of Public Advantage.

As the Human Resources Director at Transylvania Regional Hospital it very important that we have qualified staff to meet the needs of our patients. Mission has provided support to our efforts by helping us attract and retain great employees while allowing us the flexibility to meet the needs of a community hospital workforce. Mission Health is also an important part of our health plan's provider network which allows our employees to receive tertiary care that is a reasonable distance from their home. The inability to have high quality tertiary care close by would dramatically affect our ability to attract employees.

On a very personal note; my Mother and Father both have receive care on numerous occasions at Mission. The service has always been of high quality and delivered in a very compassionate way. Their ability to provide a personal touch in such a large organization has always been very impressive. For this and the other reasons it is vital that Mission be in a position to continue to provide care in Western North Carolina.

Sincerely,

Mark Emory, Director of Human Resources

My Name: Virginia Justice
22 Lilac St.
Gohauille, NC 28806

I was a patient at Mission in 2006 I had a heart attack and was told I was soon to have another one. They got to work right away and I had to have a stent. I am so glad we have a hospital so close, I was treated so good. I am so glad we can choose where we go to the hospital. I have been in Heart Path since 06 and love it and all the staff they are there to help in any way they can.

Virginia Justice

My name is James McDonald and this letter is regarding Mission Hospital in Asheville, North Carolina, which operates under the Certificate of Public Advantage. I am a heart patient and unable to attend the October 20th hearing.

I have survived two heart attacks due to the availability of Mission Hospital's well-equipped and trained staff. I would like you to realize the important role Mission plays for the citizens of Western North Carolina.

It is very important to myself and my family to have the freedom to choose where you go for hospital care. It is also very important that Mission Hospital be free to serve all of the people here in Western North Carolina. We the people of Western North Carolina deserve to have life-saving, high quality care close to home just like every other region in North Carolina. They are both an integral part of the area they serve and a credit to the profession they are a part of.

Sincerely,

Mr. James C. McDonald
78 Queen Road
Candler, NC 28715

To the House Select Committee on the Certificate of Needs Process and Related Hospital Issues:

My name is Charles Koontz a current Heart Path patient with Mission Hospital. I could not attend the October 20 hearing in person due to my work schedule.

I became a patient with Mission Hospital on December 23, 2006. I was admitted with chest pains. After extensive testing it was determined that I needed coronary bypass surgery. Fortunately for me a heart attack was avoided and the surgery repaired the obstructed arteries. Heart Path rehab started in February of 2007. After completion of the cardiac rehab I was able to continue to this day with the maintenance program. The Heart Path program has completely changed my lifestyle involving regular exercise, better nutrition ideas and best of all new friends. Without the services provided by the Heart Path Staff my quality of life would not be what it is today. I am truly grateful for the staff's efforts and the mission of the Heart Path Program.

I'm proud of my mountain heritage and Mission Hospital has provided an improved quality of life for thousands of residents like me. That is why it is important for Mission Hospital to continue to serve the citizens of this region and continue to be leader in health care.

Sincerely,

Charles Koontz
Charles Koontz
800 South Mills River Road
Mills River, NC 28759

DRAFT

October 17, 2011

To: House Select Committee on the Certificates of Need Process and Related Hospital Issues

I am a practicing Asheville attorney and in my capacity as attorney have represented health care entities and professionals in Certificate of Need ("CON") work. In addition, I was Board Chair of the Mission Hospital St. Joseph's Hospital collaborative partnership from its inception in the middle 1990's until November, 1998, when Mission Hospital bought St. Joseph's Hospital from the Sisters of Mercy in Belmont. Finally, I served for eight years n the Board, two as Board Chair, of the University of North Carolina Health Care System in Chapel Hill.

I am intimately aware of the Certificate of Public Advantage ("COPA") statute that enables private, non-profit health care providers to engage in certain collaborative undertakings provided those activities are overseen for fairness by the North Carolina Attorney General.

The COPA enabled our community to resolve issues of duplication and cost escalation and the cultural differences that existed with respect to Mission and St. Joseph's hospitals. It served our community well and Mission as the surviving hospital was able to achieve better and more affordable health care for our area. Importantly, Mission over the intervening 15 years has scrupulously obeyed with all of the COPA conditions placed on its operations.

The question now must be asked, has the COPA outlived it usefulness and is it an impediment to the ability of Mission to a quality tertiary care center properly serving the Asheville area as well as outlying, surrounding communities. Clearly, the COPA has outlived its utility and now constitutes serious restrictions that must be lifted.

There were reasons for the COPA when first used by Mission and St. Joseph's but those reason no longer exist. There are now other large, well financed health care systems serving in Western North Carolina who Mission and St. Joseph's were placed under the COPA those large systems did not exist. At that time there were a half dozen much smaller, regional hospitals. Now there is Westcare and Carolina Medical as well as the strongly financed and emerging Adventist Health System. Clearly, those systems do not need protection from Mission, to the contrary Mission needs to be freed from COPA restrictions to be able to compete. Mission is

being forced by COPA to enter the healthcare fray with one hand tied behind its back. Those restrictions must be removed.

Sincerely yours,

ROBERTS & STEVENS, P.A.

John S. Stevens

JWM/paj

October 17, 2011

To: House Select Committee on the Certificate of Need Process and Related Hospital Issues

I am the President/CEO of Transylvania Health System based in Brevard, N.C., which includes Transylvania Regional Hospital. Transylvania Health System and our related entities entered a management agreement with Mission Health System on January 1, 2011. Currently, I am an employee of Mission Health System. I plan on attending the public hearing; however, I wanted to make sure that you hear from me as the lead executive of the not-for-profit healthcare system serving the residents of Transylvania County.

In 2009, our Board made a strategic decision that we needed to affiliate with a larger organization so that we could "maintain, enhance, and increase access to healthcare services for the people of Transylvania County." Our ability to reinvest in ourselves based on five-year financial projections, so that we could maintain our mission, was diminishing. After education on why hospitals were affiliating, we engaged a consultant group, Stroudwater and Associates, a national expert in affiliation matters.

Stroudwater lead our Board on an assessment of community need including short- and long-term needs. Based on that, we invited 15 different organizations, some local and some with a national presence, including not-for-profit and for-profit, to consider interest in an affiliation process. We received back seven active expressions of interests from which formal requests for proposals were sent. From the seven we received four meaningful proposals. These proposals included Mission Health System, another large dominant healthcare organization that provides management services to North and South Carolina hospitals, a large not-for-profit, religious health system with presence in Western North Carolina, and a for-profit firm. From these four our Board determined to pursue further due diligence with three. In the first quarter of 2010, we entered into a Memorandum of Understanding with Mission Health System, which lead to our Management Agreement.

Mission best fit the criteria for meeting both our community's and our organization's needs. The criteria included access to capital; assistance with third-party reimbursement; quality patient care and safety; physician recruitment and retention; quality-clinical integration; culture; ability to maintain/grow local services; local governance and management; branding; administrative assistance; long-term viability; and competitive risk. As our Board went through the process, Mission Health System substantially demonstrated better value for our local organization so that our community and hospital could "maintain, enhance, and increase access for the people that we serve."

After almost a year of affiliation we have experienced significant value from our management agreement with Mission. With the five-year financial plan based on our affiliation, we see our

ability to be financial viable so that we can reinvest in maintaining services locally; having physicians to serve our local population; maintain a local healthcare team; purchase the necessary and needed clinical equipment for providing needed healthcare services locally; maintain and enhance our facilities so that they are current, meet code, and provide a safe environment for the patients that we serve.

Our affiliation will allow us as Transylvania Health System to be competitive in a rapidly changing healthcare environment in Western North Carolina. This environment is now dominated by large healthcare systems that are increasingly providing competition to Transylvania Regional Hospital. These include Greenville Health System from Greenville, S.C.; Carolinas Health System based in Charlotte, which now manages five hospitals in Western North Carolina; Park Ridge Hospital in Fletcher, a member of the Adventist Health System, one of the largest not-for-profit health systems in the country; and most recently UNC Hospitals, which has affiliated with Pardee Hospital in Hendersonville within recent months.

As the issue of the COPA has been discussed in our Legislature, our Board has unanimously adopted a resolution in support of the COPA. That resolution is attached. Our Board of County Commissioners also unanimously passed a resolution in support of the COPA. This is also attached.

In my professional judgment as the Chief Executive Officer of Transylvania Health System with 15 years of dedicated service and experience in leading this organization, without our affiliation with Mission Health System healthcare services by Transylvania Regional Hospital and its affiliates would be significantly diminished. In other words, our affiliation with Mission Health System is allowing our organization to continue to fulfill its mission locally which is that we "promote wellness and provide access to quality healthcare services for the people in our region."

Please understand that the COPA was the right solution at the time and Mission has complied fully. The competitive landscape in healthcare in Western North Carolina is changing dramatically. In order for us to meet the needs of people in our service area of Transylvania County and survive and thrive along the way, we must have the freedom to serve and compete in this new environment. Transylvania Health System as a managed member of Mission Health System wants our patients, not government regulators, to choose where they receive care.

Thank you for your attention to these matters and I encourage you to support Mission Health System, as a significant provider of healthcare delivery in a very competitive landscape of Western North Carolina.

Sincerely,

Robert J. Bednarek

Robert J. Bednarek
President/CEO

Attachments

RESOLUTION OF THE BOARD OF TRUSTEES OF TRANSYLVANIA HEALTH SYSTEM, INC.

The following resolution was adopted by the Board of Trustees of Transylvania Health System, Inc., a North Carolina nonprofit corporation, at a meeting of the Board duly called and held on April 28, 2011, at which a quorum was present.

We, the Board of Transylvania Health System, Inc, an affiliate of Mission Health System through a Management Services Agreement, would like to make the following points regarding proposed changes to the Certificate of Public Advantage (COPA).

1. **Mission has been a good partner to community hospitals in our region.** Mission has consistently come to the aid of struggling community and critical access hospitals in federally designated physician shortage areas, helping to add needed services, recruiting physicians, and updating facilities. Mission's significant investment in medical education, evidenced by partnerships with UNC-Chapel Hill's Schools of Medicine and Pharmacy, is important in helping us address the critical shortage of physicians and pharmacists in our region.
2. **Mission is the region's safety net provider.** Mission Hospital supports every community hospital in our region by serving as the region's tertiary care provider. As such, it offers specialty care to patients from all 18 counties of Western North Carolina. If these services were not available at Mission, our patients would have to drive four to six hours to receive them. These services include the region's only Children's Hospital, only Level III-c NICU, only high-risk OB program, and the region's largest community-based in-patient psychiatric facility for adults, geriatrics, adolescents and children. Mission also serves as the region's designated Trauma Center and offers one of the state's largest heart programs. All of these services make a significant difference in the health status of the people of Western North Carolina.
3. Since Mission Hospital voluntarily entered into the COPA agreement 15 years ago, competition has dramatically intensified in our region. Today, Mission competes with two significantly larger, multi-state health systems: The Adventist Health System, based in Orlando, FL, and Carolinas Healthcare, based in Charlotte, NC. **We want our patients, our hospitals and our physicians to have choices when it comes to how and with whom we affiliate.**
4. The Adventist and Carolinas systems have proposed changes to Mission's COPA in the hope of advantaging themselves directly. Those changes would take away the choices currently available to patients, their physicians and hospitals, thereby making it impossible for Mission to compete with larger health systems. **To survive, Mission needs to have the flexibility to respond to whatever changes result from the implementation of health care reform, and it needs to be able to compete under the same rules that apply to these much larger, formidable competitors: The Adventist Health System and Carolinas Healthcare.**

Taking all of these factors into consideration, we request our own changes to the COPA, revising it in the following ways:

1. **Recognize that the competitive landscape in Western North Carolina has shifted dramatically, with Mission in direct, heated competition with much larger, out-of-area health systems; and**
2. **Remove the physician employment cap of 20%, which will allow Mission Health System to support the needs of its affiliate hospitals in rural counties and address the growing shortage of physicians in our region.**

Robert J. Bednard [signature]

President/CEO

BOARD OF COMMISSIONERS
Mike Hawkins, Chair
Kelvin Phillips, Vice-Chair
Larry Chapman
Jason Chappell
Daryle Hogsed

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3100
Fax 828-884-3119
828-884-3107
21 East Main Street
Brevard, NC 28712

Resolution 14-11
In Opposition to Senate Bill 698
Modify COPA Agreement /Mission Health

Whereas, Transylvania Regional Hospital (TRH) is a small rural hospital serving the citizens of Transylvania County and neighboring counties and has a management agreement with Mission Health System (MHS); and

Whereas, Senate Bill 698 could end or negatively impact the current management agreement between TRH and MHS; and

Whereas, this bill will severely restrict the number of physicians that can be employed by MHS and/or TRH which will put TRH at a significant disadvantage in recruiting new physicians to Transylvania County; and

Whereas, TRH will face significant financial pressure to maintain and enhance services in Transylvania County without the expertise and financial negotiating power of MHS; and

Whereas, as a small rural hospital TRH will be at a significant disadvantage to compete against much larger health systems already in our region including Carolinas Healthcare System and the Adventist Health System; and

Whereas, this bill circumvents an existing, well thought-out process of regulatory review of MHS and its competitiveness by the State of North Carolina; and

Whereas; no local input from TRH or local elected officials were sought regarding the impact this legislation would have on TRH's ability to serve the residents of Transylvania County;

Now therefore, the Board of Commissioners of Transylvania County does hereby oppose Senate Bill 698 and requests that it be withdrawn.

This the 9th day of May, 2011.

ATTEST:

Mike Hawkins, Chair
Transylvania County Board of Commissioners

Trisha M. Hogan
Clerk to the Board

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 Sweeten Creek Road Asheville, NC 28803 (828) 277-4800 www.carepartners.org

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

For Release — Child Abuse Prevention Services

10-20-2011

50 S. French Broad Avenue
Asheville, NC 28801

Contact: Bill McGuire
O: 254-2000, ext 102

Child Abuse Prevention Services, Inc. of Asheville receives Counseling Grant from Community Benefits Program of Mission Hospital

Asheville: Child Abuse Prevention Services, Inc. (CAPS) of Asheville has received a $37,000 counseling grant from the Community Benefits Program of Mission Hospital.

"This grant will help us to provide immediate access to crisis intervention/counseling for children and families who have experienced abuse", said Bill McGuire, Director of CAPS. "It will give them the opportunity to stabilize, get through the devastating crisis and trauma, and develop new skills to cope with the abuse." We're very grateful to Mission's Community Benefits Program for helping us deliver these needed services to the community. Especially so, since we are seeing more and more younger children for counseling, and more hands are going up in our school-based prevention program (which reaches 8,000 children annually) to disclose abuse."

Child abuse is a preventable tragedy, yet over 5 million children a year are reported as abused or neglected, including over 100,000 in North Carolina, and over 4,000 in Buncombe County. One in every five children will be abused, half will be under six-years of age, and child abuse (physical, sexual and emotional) cuts across all lines and knows no boundaries. Behind each of these numbers is a face, a child, our future.

The cost of child abuse in the US is a quarter of a million dollars a day or $95 billion a year. This equates to $1,500 a year per family, yet we only spend a dollar a year a family on prevention.

Last year Child Abuse Prevention Services educated and empowered over 7,500 children with skills to protect themselves through prevention education; provided crisis intervention and counseling to 500 children and families, and helped several hundred parents acquire increased parenting skills.

Some success stories include the young girl who raised her hand in our child abuse prevention program at a local school to disclose abuse so horrific that DSS and law enforcement rushed to the scene to immediately remove her from the sexually abusing parents. In essence CAPS prevention program became an intervention in facilitating her disclosure and led to treatment as she came to us for counseling/therapy. She was later adopted by her foster parents and is doing well. And, the young brother and sister coming for counseling. The 8-year-old boy was put in a clothes dryer by the mother's boyfriend and witnessed the boyfriend blow his brains out. The 9-year-old girl was savagely sexually abused. They came in depressed, intimidated, sad, and now come in skipping in smiling, saying "Miss Shannon, what are we going to do in therapy today?" These kids have experienced something no child should have to experience,

but the hurt has stopped, the hope and healing has begun, and they have the opportunity to reach their potential.

For information or to become a donor or friend of Child Abuse Prevention Services, Inc., call 254-2000, write 50 S. French Board Avenue, Suite 152, Asheville, NC 28801 or email: caps@childabusepreventionservices.org, or go to www.childabusepreventionservices.org

-30-

William R. Hathaway, MD, FACC
Chief of Staff, Mission Hospital
509 Biltmore Avenue
Asheville, NC 28803

October 28, 2011

Chairman Steen, Chairman Torbett and Committee Members:

First and foremost, thank you for taking the time to meet with our community last week and to hear our views regarding CON and COPA issues as they pertain to Western North Carolina. As you no doubt discerned from the discussion, this is an emotionally charged issue. I hope that the facts will be clear and trust that they will lead the committee to decisions which will serve the best interests of our patients.

Mission has clearly and accurately conveyed that it has been fully compliant with the stipulations of the COPA, that the COPA has been appropriately overseen by the state and that the competitive landscape in Western North Carolina has dramatically changed obviating the need for a COPA. In my capacity as the elected Chief of the Medical Staff at Mission I wish to address issues related to patient access to care and quality of care. Please note that as the Chief of Staff I am not paid by Mission Hospital, but rather by the medical staff. I am certain that my views are representative of the vast majority of the physicians in our community.

Physician Employment

Any restriction on Mission's ability to employ beyond that which would be reasonable in a competitive market must be avoided. As greater numbers of graduates seek employment relationships with health care systems, any restrictions on such will limit the ability to recruit physicians to Western North Carolina. (Please see the appended article for details.) With fewer than 50% of physicians nationwide remaining independent at this time, and estimates indicating that fewer than one third will be independent in 2013, failure to allow Mission to employ physicians would not only be unfair with respect to competing against the other hospital systems that have come to our region, but would also limit the recruitment pool and in turn result in a critical shortage of both primary care and specialty physicians in the region. For a region that is already underserved, particularly with respect to primary care, *this would have a tremendously negative impact on access to care and community health.*

I will illustrate how employment/integration benefitted the region with an example from my cardiology practice. Despite repeated efforts, for many years we were unable to recruit cardiologists to the rural hospitals, ~~of~~ Harris Regional and Rutherford Hospital . Carolinas Medical Center eliminated the cardiology service at Rutherford Hospital and our practice's solo

cardiologist located in Sylva is retirement age and in need of a partner. Our independent business model provided us with little incentive to hire for the region; we were unable to offer adequate compensation for these positions which are in general less sought after by medical specialists interested in providing high tech care. We entered into our partnership with Mission Hospital in January of 2010 which allowed us to offer competitive pay and a relationship with our group. Almost instantly we found cardiologists for both of these hospitals. This would not have happened without the Mission Hospital employment relationship.

Moreover, and contrary to the misstatements offered repeatedly at the recent hearing, hiring these physicians strengthened the care at the local hospitals. Neither Harris Regional nor Rutherford Hospital is affiliated with Mission. The patient care that remains at these institutions is delivered in a safe and effective manner, locally and will continue to be delivered locally. *This has been a win for patients, a win for the hospitals and a win for the doctors. It is precisely this model that Mission seeks to leverage.*

Unreasonable limits on Mission's ability to hire will additionally restrict physician choice for those who already have practices in the region. At a time when external forces are driving physicians into employment relationships, limited choice with respect to with whom a physician can align will result in a physician exodus from the region with the attendant consequences of reduced access for patients and diminished health status for the region.

Patient Freedom to Choose

Much attention has been placed on the need for patients to have the ability to choose from whom they receive their healthcare and I couldn't agree more. Mission and the medical staff of Mission have taken great pride in the high quality and compassionate care that has been delivered to the patients of the region for many years. The quality of care is evidenced not only by the numerous quality awards Mission has received over the years, but also by the fact that patients have and will continue *to choose* Mission when they are critically ill. Limits that would hamper Mission's ability to fairly compete in the region would greatly impair its ability to maintain this superior quality and to care for those unable to pay or unable to receive the services in their local communities. We are the safety net provider and that cannot be emphasized enough. As the axiom goes, without margin, there is no mission and the mission remains to provide the highest quality of care for the entire region.

Finally, I would like to emphasize that contrary to what was expressed at the community hearing, Mission's alliance with regional hospitals has come at the request of those organizations and has truly served the best interests of the patient. Just as physician employment trends grow, small hospital affiliation with larger health systems is also a national

trend. Financial drivers are at the root of this movement. Being able to affiliate with a superior quality, locally owned and governed health system has saved these community hospitals and kept quality care close to home - no hostile takeovers, no loss of choice for patients.

I appreciate your time and attention to the matters at hand. There are numerous other compelling reasons to avoid limiting Mission's ability to fulfill its role as the regional safety net provider. I chose to focus my comments on just a few of the physician/patient issues, but would be happy to entertain questions from any of the committee members at any time. We, Mission Health, the hospitals in the region and the physicians in the region, have an obligation to the community that cannot go unfulfilled and hope that you will create a legislative environment that allows us to succeed. *The COPA has been paid in full, the competitive landscape has changed and Mission and the physicians of Western North Carolina must be given the freedom to serve as we have done so capably for the past 126 years.*

Sincerely,

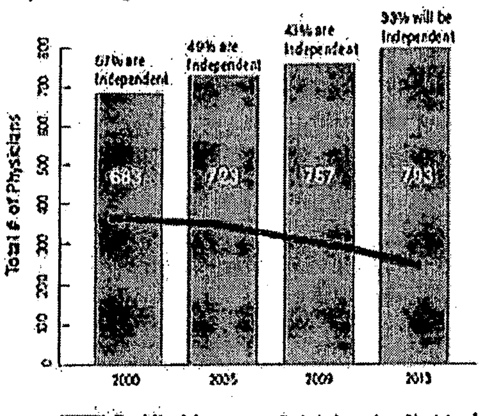
William R. Hathaway, MD, FACC

Chief of Staff, Mission Hospital

Physician Employment Trends Will Force Payers, Hospitals and Vendors to Revise Business Strategies, According to Accenture Survey

By 2013, less than one-third of physicians are expected to remain in private practice

NEW YORK; June 13,2011 – U.S. physicians continue to sell their private practices and seek employment with healthcare systems, according to a new survey from Accenture (NYSE:ACN). As physicians migrate from private practice to larger health systems, the new landscape will require healthcare IT, medical devicemanufacturers, pharmaceutical companies and payers to revise their business models and offerings. At the same time, hospitals will need to determine how to retain and recruit the correct mix of physicians, especially in high-growth service lines, including cardiovascular care, orthopedics, cancer care and radiology. Patients will increasingly move to large health systems, as opposed to the current trend of visiting doctors in private, small practice settings.



1 Estimated
Sources: Accenture Analysis, MGMA American Medical Association

According to Accenture, the rate of independent physicians being employed by health systems will grow by an annual five percent over three years. By 2013, less than one-third of physicians are expected to remain truly independent.

"Health reform is challenging the entire system to deliver improved care through insight driven health," said Kristin Ficery, senior executive, Accenture Health. "We see an increasing number of physicians leaving private practice to join hospital systems, which will force all stakeholders to revise and refine their business models, product offerings and service strategies."

According to the survey, physicians are increasingly attracted to the benefits offered by hospital-based employment opportunities. These benefits include:

Relief from administrative responsibilities;

Greater access to leading-edge healthcare IT tools, facilities and equipment;

- A more manageable work week; and
- Stability in a business environment made uncertain by developments such as payment reforms.

Accenture's analysis suggests that complexities in the changing healthcare landscape may result in:

- Hospitals enhancing expertise and boosting patient volumes and revenues in high-growth service lines;
- Companies serving diverse markets will shift their sales force structure from national to regional;
- Payers encountering greater negotiating leverage, which must be factored into future business strategies, as physicians increasingly associate with larger groups and healthcare systems; and
- Companies working to reach the physician market will find their efforts more challenging.

Survey Methodology
Accenture's Physician Employment Report includes highlights from a survey and assessment of physicians and hospitals and business behaviors emerging from healthcare reform. The report highlights the impact to physician employment, care delivery and clinical coordination, which is relevant to policy makers, health systems and patient advocates. Accenture held in-person and phone interviews with c-

suite hospital executives and industry stakeholdersbetween September to November 2010 and the analysis completed in 2011.
Learn more about Accenture Health.

PRESENTATION TO THE SELECT COMMITTEE ON MISSION/ST. JOSEPH'S COPA
October 20, 2011

Good Evening Ladies & Gentlemen:

Welcome to Fall in the mountains. I am Ruffin Benton. I've been a family doc in Brevard for 35 years. I am Chief of Staff at Transylvania Regional Hospital, and serve on the Board of the Transylvania Health System. I will be 65 years old in two weeks, and another contributor to the medical care reimbursement problem in Western North Carolina.

Thanks for coming to help us care for the people of Western North Carolina.

Politics is the struggle for power. We are involved tonight in a political process to resolve the turf battle involving several outstanding health care systems. It is imperative to remember that our people--our patients--not our health care systems, need to be at the center of this hearing.

I came to Brevard 35 years ago to enjoy Western North Carolina and to care for the people here. The group I joined was small and grew over time. A few years ago, my group joined Transylvania Regional Hospital in order to deal with the economic and access problems of practicing medicine in Western North Carolina, and to enable us to attract and retain physicians for Brevard. More recently Transylvania Regional Hospital initiated and entered into a management agreement with Mission Health System for the same reasons: so that we might continue to provide high quality care to the people of Transylvania County through a formal agreement recognizing the longstanding collaboration with Mission Hospital. Before finalizing this agreement, we looked at several partners, all of whom had much to offer. Mission clearly offered our doctors and Transylvania Regional Hospital the best opportunity to take care of our patients and build a regional organization.

It is often said that the health care system is broken. I disagree with that statement for two reasons. First, doctors and hospitals offer primarily crisis and sick care, not health care. Second, there is no system, but many disparate and desperate groups who are struggling for power, dominance, and dollars. Transylvania Regional Hospital has joined with Blue Ridge, McDowell, Angel and Mission to build a health care system for the people of Western North Carolina. Limited reimbursement and mandates from the Forces of Darkness have made it impossible to move forward, or even exist as a community hospital or private medical practitioner in this challenging environment. Our management agreement with Mission Health System stresses cooperative efforts among all hospitals and doctors in the system we hope to build.

During my 35 years in practice and leadership positions, I have encountered many impasses. Imagine--doctors at an impasse!. Faced with apparently insoluble problems, I remind myself that the patient must be paramount. The solution becomes much more clear at that point.

To best provide for the folks of Western North Carolina, we need to build a health care system. Transylvania, Blue Ridge, McDowell and Angel will work with Mission Health System to build an effective organization to serve the people of Western North Carolina. I will take the liberty to invite all of the practitioners and hospitals in Western North Carolina to be a part of our dream. I ask the Select Committee to recognize the needs of the people in Western North Carolina, and the legitimacy of our efforts. Legislative shackles should not be allowed to thwart our efforts to be patient advocates.

G. Ruffin Benton III, M.D.

377 Gallimore Road | Brevard, North Carolina 28712 | 828.884.9030 | www.matpaonline.com

My name is Michael LeCroy. I am an orthopaedic surgeon and the director of Mission's Orthopaedic Trauma Service. Eight years ago, I was recruited to come to Mission from the University of North Carolina to establish an orthopaedic trauma program. Since that time, our program has grown to one of the largest in the state, with over 1200 surgical procedures performed annually by our team. I never cease to be amazed and encouraged by the skill and dedication of my colleagues and the commitment by our trauma team at Mission to providing the highest quality care to all injured patients – care that I believe is second to none.

Of course, at Mission we readily accept and treat injured patients from all over Western North Carolina. Patients are accepted regardless of insurance status or their ability to pay. Many of these patients are initially seen in other hospitals. These hospitals in our region of the state, that otherwise view Mission as a competitor, rely on us to accept their patients, and they trust us to provide expert and often life-saving care. And that is exactly what we do – every day. We provide the opportunity for injured patients to receive the highest quality trauma care – right here in western North Carolina.

My colleagues and I at Mission remain committed to caring for injured patients throughout western North Carolina. We have dedicated our careers to this. However, Mission is facing significant challenges that threaten our ability to continue to provide expert trauma care to our region. Many of these challenges we have heard about in some detail tonight, including the fact that many services provided by Mission to the region, like trauma care, are money-losing endeavors. These essential services must be subsidized by other programs. Mission must have the freedom to survive and thrive in a healthcare environment that has changed drastically since the COPA was first established.

Just imagine for a moment what it would be like if Mission was not able to provide care for injured patients in our region? Just imagine if Mission was not able to provide this care for you, or for your loved ones? Isn't it obvious that we are all counting on Mission to be there when we need it to be?

Comments to State Special Committee on CON and COPA Issues:
In an effort to allow citizens of WNC to receive local, accessible, high quality care, Mission has actually helped small regional hospitals survive through system integration. Mission and its affiliates are actually the "home-grown" providers in the mountains; the Park Ridge/ Adventist system and the Carolinas Health System are just two of the outsiders threatening regional control and limiting options by skimming well insured patients from the already tenuous payer-mix. The Adventist system and Park Ridge will deny it, but they have committed a bottomless war chest of resources to the competition for patients in WNC, and have offered to buy Mission Health System in the process; a reversal of the David-Goliath myth. Mission is looking at national trends in the evolution of health systems and is trying to remain competitive through modern systems of organization and health care delivery. WNC and state legislators must avoid the reflexive rejection of everything that sounds like regulation or outside intervention, and should look at the big picture of what is required to maintain and improve a world-class system of high quality, safe, and cost-effective care in this region.

Stephen Hulkower, MD
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Viddia Torbett (Rep. Torbett)

From: Davis Allen, III MD <CAllen@ashevillehospitalist.com>
Sent: Wednesday, October 26, 2011 11:03 AM
To: Rep. John Torbett
Cc: Rep. Fred Steen
Subject: Mission and COPA

Dear congressmen,

I am a born and raised North Carolinian. I grew up in Elizabethtown. I went to medical school at East Carolina University because I loved its mission to provide health care for the citizens of this great state. I followed this with a residency in Internal Medicine at Duke University Medical Center. After residency, I became intrigued with Mission Health Systems due to the great care they provided overall. To me, Mission Health Systems is one of the greatest assests to western North Carolina. Anything to detract from its presence with respect to health care in the region, only hurts the citizens of North Carolina. Being a staunch advocate of patient care and also a physician, the COPA, with respect to Mission Health Systems, does nothing but weaken overall health care in western North Carolina. If the COPA continues, the patients of western North Carolina lose!

Sincerely,

C. Davis Allen, III, MD, PharmD

Mission COPA-CON Hearing Thursday, October 20, 2011

Mr. Chairman and Honorable Committee Members of this North Carolina House Select Committee, I want to thank you for allowing me to address you this evening. My name is Alan Baumgarten and I am a family physician. I have been in active practice for the past 25 years. I am President of The Family Health Centers, a large, independent group of family physicians based in Buncombe County that provides primary care for more than 40,000 patients throughout Western North Carolina. Our group is made up of 21 board certified family physicians and four mid-level providers in 3 offices: Arden Family Health Center located in south Buncombe County very near to the site of the proposed Mission-Pardee joint ventured "south facility", Asheville Family Health Center, located in central Asheville very near to Mission Hospital and Hominy Valley Family Health Center located in western Buncombe County near to the Haywood County line. Many of our patients choose our practices for their primary health care services from out of Buncombe County specifically because they know that we are affiliated with Mission Health. In fact, The Family health Centers continues to "buck" the national trends providing our own inpatient hospital service at Mission Hospital, therefore providing 24/7 care to our patients both in and out of the hospital.

I also have the honored position of being the Project Director for a $2.6 million, three year Duke Endowment grant designed to assist other independent primary care practices towards their implementation of a new primary care model called the Patient Centered Medical Home (PCMH). In the end, this project will further enhance the quality, capacity and viability of primary practices. The project will assist at least 20 practices (75-100 physicians) throughout Western North Carolina achieve PCMH recognition status and practice re-design to the PCMH model. The project will provide the practices with much needed management and operational technical

assistance, Nurse Navigators to improve quality through case management and care coordination specifically during a patient's critical "transitions in care" and enhanced chronic disease care, management and education. The Mission Health Foundation holds this grant and Mission Health has been a huge supported of this project for all of Western North Carolina.

Lastly, I am Mission Hospital's immediate past Chief of Staff. In fact, I am the first primary care physician to serve as Mission's Chief of Staff since the COPA took effect in 1995. My role as Chief of Staff focused on improving medical staff (physician) – hospital relations and quality improvement. Mission Hospital has long been known as a high quality provider but I was concerned that Mission Hospital could begin to slip on its quality scores if we did not begin new initiatives with a specific focus on quality improvement. Thus, I spearheaded the medical staffs drive for quality improvement and forged a relationship between Mission Health and the Institute for Healthcare Improvement (IHI), the world's leading healthcare quality improvement organization. This collaboration has lead to several intentionally designed projects that the leaders of the IHI believed would lead to Mission's recognition as "the safest hospital in the United States".

Let me for a moment reflect back to December 1995, the time during which the COPA was being discussed. At that time, I was the President of our local independent physician's organization called Mountain Health Care (MHC). MHC represented more than 400 Buncombe and Madison County physicians in direct contract negotiations with payers, industry, hospitals and other healthcare organizations and providers. During the COPA investigation period, I was interviewed by the United States Justice Departments and went on record in opposition to the COPA believing that the merger of these two hospitals would stifle local competition in health care and compromise quality and access. I was wrong. In fact I could not have been more wrong. The COPA allowed for the safe and managed merger between then St.

Joseph's Hospital and Memorial Mission Hospital and could not have been better conceived nor could it have better served our community and Western North Carolina.

Let me explain.

Mission's role as Western North Carolina's most sophisticated secondary and tertiary health care center has been helped by the COPA and has served our region well. We have all needed and greatly benefited from the growth in stature, quality and market share of this organization.

The growth of Mission Health has been a great asset in the building of primary care capacity in Western North Caroline. I am a family physician who came to Western North Carolina and stayed in Western North Carolina after training in the MAHEC Family Practice Residency Program. The Mission based MAHEC Family Practice Residency Program (MAHEC FPRP) is nationally recognized for its quality in part due to its relationship with and the training opportunities provided at Mission Hospital. The MAHEC FPRP has for the last 33 years been the training ground for more than 300 family physicians, of which, like myself, more than 150 are in active primary care practice throughout Western North Carolina. Mission Hospital is a huge part of the success of the MAHEC FPRP by providing a super high quality secondary and tertiary hospital as part of this training program.

As mentioned earlier, Mission Hospital has helped to raise the quality bar for Western North Carolina. Mission Hospital has led the charge of regional quality that resulted in Western North Carolina's recent recognition for "high quality and low cost" health care. In June 2008, I led a Mission delegation at an IHI sponsored conference in Washington, DC titled "How Do they Do That?" During the heat of the healthcare reform debate, Western North Carolina along with 9 other regions in the United States were ask to present to White House representatives, Congressional

representatives the press and each other, how we were able to achieve the status where we were all identified in the top quartile of regions in the United States as providers of high quality-low cost healthcare. Mission Health is now recognized as the regional healthcare leader that has promoted Western North Carolina to national status for its high quality and low cost healthcare.

Please let me conclude by saying:

1. Through its history, the COPA has allowed Mission Health to achieve a status where it is now the region's premier provider of secondary care for Buncombe, Madison and the near surrounding counties and tertiary care for all of Western North Carolina. The COPA was the right solution at the time to promote improved access to high quality health care for all of Western North Carolina.
2. The national and the local healthcare environment is rapidly changing and becoming more competitive. We should not allow this new level of competition hamper the high quality of secondary and tertiary care that should remain available for the citizens of Western North Carolina. Now is the time to relinquish the COPA so that Mission Health can fairly compete and continue to lead healthcare in Western North Carolina.

Thank you for your attention and for allowing me to address your Committee.

Respectfully submitted,

Alan S. Baumgarten MD, MPH

Viddia Torbett (Rep. Torbett)

From: Karen M Grogan <Karen.Grogan@msj.org>
Sent: Sunday, October 23, 2011 11:28 PM
To: Viddia Torbett (Rep. Torbett)
Subject: COPA/CON hearing in Asheville NC 10-20-2011

Mr. Torbett,
Please include these comments in your consideration of the Mission COPA and State CON regulations.

What if the Federal government dictated strict operational and financial limitations on the State of NC but did not impose those same operational and financial restrictions on Georgia, South Carolina, Tennessee or any other State? What if these restrictions limited the number of businesses that NC could recruit to create jobs, pay taxes and bring in revenue but there were no restrictions in our surrounding States?

Asking Mission to operate under unique restrictions when it comes to physicians or regional hospitals when other health care systems do have these same limitations is not equal treatment. The citizens of WNC deserve the same advantage for viable, strong, growing , and state of the art healthcare as the rest of the State.

You heard the Mission Cancer Center being mentioned several times at the hearing. Mission has been very behind on creating a comprehensive Cancer Center for the region. Cities like Spartanburg, Johnson City, Greenville, and Winston Salem have had comprehensive cancer centers for years. We diagnose and treat approximately 2600 new cancer cases every year and that number continues to grow as the population grows and ages. We have had services dispersed in 6 locations in Buncombe county alone. This is not efficient nor it is good for the patient. This Center is a resource for the region so that the vast majority of cancer patients can receive the same treatment regimens here as they would out of State or in our NCI centers. It wasn't built to compete with our community physicians. It was built to better serve the patients in collaboration with our community physicians. Cancer care takes a team and Mission's goal is to provide a healing environment, easily accessible for patients and the healthcare team.

Most physicians are struggling to practice medicine the way they know is best for the patient. Regulations and budget cuts have created the urgent need to reduce waste, to computerize the medical record and to meet tighter regulations. Some can do this alone, within their practice, but others need the coordination and assistance of the hospital system to be viable. Physicians should have the flexibility and choice to be employed or to partner with a hospital if it is the best for them , their patients and the hospital. Why should the State be the one to determine if this should be done? Mission should be able to partner or employee any physician who determines this to be a win-win for all involved.

Consider that a rural hospital was having financial difficulty and wanted Mission to buy or manage them but Mission had reached the "limit" imposed on them by the State and could not assist. How can that be good for patients, the physicians, nurses and other employees of that struggling hospital? How can that be good for the State who has a responsibility to support accessible health care, create jobs and meet the Federally mandated Healthy Initiatives?

Mission Is not requesting to be treated "special" but rather to have the flexibility to operate under the same principles/rules as all other NC health systems. It is time to eliminate the Mission COPA. Mission has proven it is a safety net, high quality, low cost hospital that is vital to the western region of the State. Let them operate in a viable, competitive manner to be successful in this economy.

Thank you for this opportunity to share my opinion.

Sincerely,

Karen Grogan

Karen Grogan, RN, MHA, OCN, CENP
Executive Director Cancer & Infusion Services
Mission Hospitals, 428 Biltmore Ave, Asheville, NC 28801
Tel: 828.213.5030/Fax: 828-213-5045
Email: Karen.grogan@msj.org

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Viddia Torbett (Rep. Torbett)

From: dantwalker <dantwalker@bellsouth.net>
Sent: Sunday, October 23, 2011 9:49 PM
To: Viddia Torbett (Rep. Torbett)
Subject: written comments for the House Select Committee on CON and Related Hospital Issues

Dear House Select Committee,

Below are written comments based on the public comments I made at the October 20 public hearing at the WNC Ag Center. Thank you for considering them in your deliberations:

My name is Daniel T. Walker and I have been a resident of Henderson County for 8 years. Just during that time period, independent hospitals have disappeared from the area. All of them are aligned with a major hospital system in one way or another. My opinion is that this is removing competition from Western North Carolina.

However, a basic rule of economics is that value is subjective. Value is not something that economists can measure on a graph. They cannot tell us whether or not Mission is in a competitive situation. Only patients and their families can decide that. Only they can decide what they value for their healthcare dollar.

Mission wants the COPA to be removed from them. Fine. Mission wants to build a hospital on the county line to threaten their closest competitor. Fine. Then the state needs to remove the barriers to competition – one of which is the CON laws. The CON laws prevent any competitor from building a hospital in Asheville.

Remove the CON and let UNC, or Carolinas, or Adventist open a hospital in Asheville. Then power would be back in the hands of patients and their families. Then they would decide what they value. Not economists with PhDs and graphs.

I ask the House Select Committee to do everything it can to allow freedom. Please allow patients and their families to decide what they value. Please remove the CON laws.

Sincerely,

Daniel T. Walker
http://www.makemenfree.com

October 20, 2011

I worked as an RN at Mission Hospital for 14 years.

While in New Employee Orientation in 1982, I heard a young female employee speak about the greatness of Mission Hospital and the plans it had for its future growth. I was pleased to be going to work for a progressive medical facility where I could use the skills that I had acquired while working in Charlotte Memorial ICU. However, I was somewhat astounded by a statement that this speaker made which just didn't sound ethical. I didn't know exactly what this statement implied, but I have remembered it for over 28 years and have recalled it many times during those years as Mission Hospital has indeed lived up to its goal which she shared that day.

This statement which she made with pride was that **Mission Hospital was growing and would continue to do so and would eventually take over all the smaller hospitals in the area and put them out of business.** As an example, she named **specifically** one of the hospitals. This hospital that she named was **Fletcher Hospital**, the "little hospital out there" that "doesn't have a chance to survive."

As time went by, I was pleased to see that Fletcher Hospital not only survived, but grew and built a beautiful new facility and renamed it **Park Ridge Hospital**. I have had, and still have, great respect for the values of this hospital and the work they do to benefit the people of the area they serve.

My profession is that of a nurse. I am not a business professional or politician. However, I have discernment for honor, justice and right. I observed the first thing about which Mission was not entirely truthful and which was their first subtle step in taking over St. Joseph's Hospital. It was when they announced that the two hospitals would share a combined laundry facility. After this they announced several so-called "joint-ventures", each time reassuring in print that these changes were not a merger of the two hospitals at that time nor would they become so in the future.

History has proven their dishonesty as Mission not only merged with St. Joseph's but eventually took position of it. There is no longer a St. Joseph's Hospital in Asheville. Even the name they used to wean the public, Mission-St. Joseph's, has been changed to Mission Health System, leaving all memories of St. Joseph's behind.

I have no doubt that Mission Health System has a plan to create a monopoly in this area. Their efforts to do so should have been recognized 28 years ago when Bob Burgin was making his frequent trips to Washington, DC, presenting his deceptive reasons why Western North Carolina would be better served if Mission was allowed an exemption from anti-trust laws. This exemption allowed a joint venture with St. Joseph's Hospital and was part of the Mission plan to become the only provider of health care in the area.

Certainly now, that all the facts are before us and Mission's plans to destroy any competition and to take complete control of health care in Western North Carolina have been exposed, those who have the authority to do so will put a stop to their selfish plans that do not benefit the people but somehow, in a way that is beyond my knowledge and understanding, benefits only a few money/power-hungry executives. Unless this plan is halted Pardee Hospital and Park Ridge Hospital will no longer exist. Pardee and Park Ridge will soon be forgotten in the same manner as St. Joseph's Asheville.

When making decisions concerning Mission, the "**employer monopoly**" should be the main concern. There are organizations that monitor health care to assure that providers give good care. There are incentives for doing so, such as loss of reimbursement if Joint Commission Standards are not met. Also, the present facilities when taken over by Mission are likely to remain open, making health care as accessible as it is now.

However, there are no laws in NC to protect employees. Mission Hospital prides itself in being the **largest employer** in Western NC. If allowed to move forward with their plans for a monopoly, they will be the **only** employer of health care workers in the area except for the Veterans Affairs Hospital. This will give Mission control of wages and allow them to treat their employees as they so desire, even harshly and unfairly. If an employee is dismissed from Mission, he will have nowhere else to seek employment in the area. This should be a concern for all health care workers in the area, even those who wear the stickers provided by their employer which state their support of Mission.

I support decisions that will keep Mission Hospital from taking possession of any more health care facilities in Western NC. This decision will support the present facilities, thereby giving patients and employees the choice to receive health care and employment somewhere other than Mission.

Mary Sloop, RN
44 Oakwood Drive
Ravenwood Forest
Horse Shoe, NC
waynesloop@att.net

Viddia Torbett (Rep. Torbett)

From: alan f huskins <alanh123@att.net>
Sent: Saturday, October 22, 2011 7:07 AM
To: Rep. John Torbett
Subject: Fwd: just another politician ??

Hi John,,

I think that COPA is in effect for a reason. In my opinion it secures freedom of choose. I appreciate your military service to this country,, but I do not like Dr. Ron Paulus likening that to phrases like " Freedom to Serve ". If COPA was not in place Mission would own them all. We as mountain people need COPA to stay in place.

Thanks

Alan

Begin forwarded message:

> **From:** alan f huskins <alanh123@att.net>
> **Date:** September 2, 2011 7:04:40 PM EDT
> **To:** "Rep. John Torbett" <John.Torbett@ncleg.net>
> **Subject: Re: just another politician ??**
>
> Sorry for the confusion,,
>
> I think you have led the way in investigating Mission Hospital and it's monopoly in healthcare .
>
> Thanks
>
> Alan
> On Sep 2, 2011, at 8:46 AM, Rep. John Torbett wrote:
>
>> Alan,
>>
>> I am unclear on your email below.
>>
>> Best,
>> John
>>
>> Hon. John A. Torbett
>> Representative
>> House District 108
>> North Carolina General Assembly
>>
>> Legislative Office
>> LOB 537

300 N. Salisbury St.
Raleigh, NC 27603-5925
O: 919-733-5868
F: 919-754-3612
John.Torbett@ncleg.net

Home Office
210 Blueridge Dr.
Stanley, NC 28164
H: 704-263-9282

-----Original Message-----
From: alan f huskins [mailto:alanh123@att.net]
Sent: Friday, September 02, 2011 6:50 AM
To: Rep. John Torbett
Subject: just another politician ??

Maybe so..

I know you are busy ,,you are on the right road ,,

Later

Alan

Viddia Torbett (Rep. Torbett)

From: Jim Barrett <jim@pisgahlegal.org>
Sent: Friday, October 21, 2011 4:36 PM
To: torbettlu@ncleg.net
Subject: Comments regarding Mission Hospital

Dear Representative Torbett:

Because of the volume of comments you are receiving regarding Mission Hospital, I will be brief with my points. Please let me know if you need more formal comments or comments in more detail.

1. As executive director of Pisgah Legal Services, I am extremely concerned about health care for people who lack the financial means to pay for it. (Pisgah Legal Services provides free legal assistance to help more than 12,000 people annually with their basic needs, including health care.) In the region served by Mission Hospitals, the number of those people who cannot afford health care exceeds 200,000. These neighbors are working for the most part in low-wage jobs without health insurance. Many are children, or are disabled, or are over 65, and thus have access to Medicaid. Many more people in the area with slightly higher incomes lack health insurance as you know. Rural county hospitals have been unable to serve these citizens and citizens benefiting from Medicare without running up deficits. Fortunately, Mission Hospitals has been able to step in and help by partnering with these hospitals. Mission Hospitals needs maximum flexibility to expand medical services for financially distressed citizens in western N.C.

2. Mission Hospitals can be trusted to accomplish its mission. I have served on the ethics committee for the hospital. I know many of the staff who serve on the hospital's leadership team, volunteer Board of Directors, and volunteer Board of Directors of the hospital foundation. At Pisgah Legal Services, we would know if there were problems with indigent patients receiving care at Mission Hospitals, and we never hear a complaint. I remain impressed with the commitment and dedication of the hospital to serve WNC residents, regardless of ability to pay. This commitment is exceptional and essential to the region. I do not believe that this commitment has anything to do with the COPA; it has everything to do with the dedication of the people who work with and for Mission Hospitals.

3. Mission Hospitals demonstrates its commitment to serve the region as the largest area non-profit in countless ways. Just a few that I am aware of are as follows:
   (a) Mission provides laundry service to the Room at the Inn ministry of area churches through the non-profit Homeward Bound at no charge. This ministry serves women who are homeless, who are working on formal plans to get back on their feet financially.
   (b) Mission provides the majority of the funding needed for the health clinic of Asheville Buncombe Community Christian Ministry to operate.
   (c) Mission partners with countless organizations in joint ventures to serve people who are economically disadvantaged. These include Project Access, the nationally recognized program that matches indigent patients with medical doctors for free care; Western N.C. Community Health Services, a large health care clinic that is serving more and more uninsured patients; Pisgah Legal Services' Health Education and Legal Support Project that provides free legal assistance to patients to help them meet basic needs so that their health care outcomes are enhanced.

4. As a community-based non-profit, Mission Hospitals is accountable to the people it serves. Mission is governed by a volunteer Board of Directors. We know who they are, what they care about, and where they live. Mission Hospitals has an exemplary track record and the drive to improve the health of area residents even more.

5. We have learned (again) that a healthy reserve fund is necessary in the modern world. It appears that Mission has a reserve fund equal to about six months operating costs. United Way requires our non-profit to have a three-month reserve, and we are not operating a tertiary care hospital that depends on Medicare and Medicaid reimbursements to operate. It would be absurd to punish Mission for operating prudently in these uncertain times.

Thank you for considering this input,

Jim Barrett

Jim Barrett
Executive Director
Pisgah Legal Services
P.O. Box 2276
Asheville, N.C. 28802
828-210-3408
www.pisgahlegal.org

Providing free legal assistance to help people meet their basic needs.

From: John Ashley <jtamdmba@charter.net>
Sent: Friday, October 21, 2011 6:34 AM
To: Rep. Fred Steen; Rep. John Torbett
Cc: jjg137@gmail.com; Tom.Apodoca@ncleg.net; Sen. Martin Nesbitt; 'Ronald A. Paulus, MD'; KCramer@ashevillechamber.org; LCopeland@ashevillechamber.org
Subject: Testimony to Select Committee on CON and Related Hospital Issues
Attachments: Testimony to House Select Committee on Certificate of Need and Related Hospital Issues.docx

Dear Representatives Steen and Torbett,
I was unable to make public comments during your hearing in Fletcher last evening. I submitted written comments that I wish to amend based on information I obtained from the hearing. My amended testimony is attached.
I am a physician living in Asheville. I am board certified in Preventive Medicine and Public Health, have served as a hospital CEO and managed care organization Medical Director. I have had the privilege of serving as a volunteer staff support person to the Asheville Chamber Healthcare Roundtable. My testimony is from me alone though I believe all of the facts in the comments are true. The opinion and recommendation expressed are mine alone.
Thank you for receiving all of the testimony at the hearing. Please accept the attached amended version and replace the written remarks that I left with your staff last evening.
Thank you for your service to the state and our community and region.

John T. Ashley MD, MBA, FACPM
81 Horizon Hill Road
Asheville, NC 28804-2429
Phone 828 251-2931
Cell 828 545-8876

Testimony to House Select Committee on Certificate of Need and Related Hospital Issues AMENDED

by John T. Ashley MD, MBA, FACPM October 20, 2011

NC CON law and regulations are designed to rationalize the distribution of health facilities and extraordinarily expensive medical technology in the face of an irrational financing system of third party payment that promotes and stimulates excess utilization of high cost procedures by patients, physicians and hospitals. A unique feature of the CON law and regulations is the application of the Certificate of Public Advantage (COPA) that is used to evaluate the results of an approved CON by Mission Hospitals.

The enormous value of COPA reporting has been demonstrated in Asheville-Buncombe by the work of the Asheville Chamber Healthcare Roundtable over the past 8 years. Based on data from the Mission Hospital's COPA Reports from the 1999 through 2008, the Roundtable developed and submitted, with the support of the leadership of the NC legislature, prominently lead by Rep Bruce Goforth and Sens Martin Nesbitt and Tom Apodoca, HB 212, The Health Insurance Pool Pilot Program, adopted in 2009.

This legislation was developed by the Roundtable with full participation by the major employers of the community, by all of the major private hospitals, by physicians represented by the Buncombe County Medical Society, by local governments, by organizations that procure health insurance for businesses, by small employers, by our local PPO organization of physicians and hospitals providing access to health care and the public. The legislation was vigorously and prominently opposed by the largest private insurers in the state in testimony to both houses of the legislature. The legislation received bi-partisan support during its thorough consideration in committees of the House and Senate. My observation was that the bi-partisan support grew as the largest insurers increased their opposition.

The content and language of HB 212 was developed based on data contained in the Mission Hospital COPA Annual Reports that were generously and thoroughly shared with the Roundtable each year during deliberations on how to address and resolve the twin conflicts of the EXCESS cost of Health Insurance premiums and GROWING number of Uninsured residents of Buncombe County. The data in the COPA Reports showed clearly that the merged hospital system incurs the millions of dollars of losses by caring for the uninsured and millions more of losses by less than full cost reimbursement from Medicare and Medicaid each year. The COPA Reports demonstrated that the hospital receives payment from private insurers representing the large employers and other privately insured groups and individuals that reimbursed all of the costs of care for their beneficiaries, PLUS the cost of losses from the uninsured and underinsured PLUS the margin that every hospital must generate to successfully serve their communities with needed services and to create the reserves for future growth.

The data from the MH COPA demonstrated explicitly the process of COST SHIFTING that occurs implicitly in every hospital market in NC and the U.S. to allow the uninsured to obtain medical care. The Roundtable membership, lead by representatives of large employers who pay for the cost shifting through their insurance payments and representatives of the professionals and institutions who receive the payments, recognized that the fundamental problem of the broken system must be addressed so that affordable health insurance was available to every resident and employer who had any ability to purchase health insurance rather than be uninsured.

In Buncombe County, the medical society with critical support from Mission Hospital and County government have developed and implemented Project Access, a national model of voluntary provision of specialty medical care, hospitalization, medications and support to the uninsured, poor residents of the community. But the number of uninsured has grown to almost 19 % of the adult population of the county and Project Access is rapidly exhausting the ability of physician specialists to donate their services to the poor because of the growing number of uninsured. Project Access does not provide access to Primary or Preventive Care. As a volunteer physician at our local free clinic, ABCCM Medical Ministry, we see an endless number of uninsured individuals, including some children, who suffer from preventable and treatable conditions like hypertension, hypercholesterolemia, diabetes, depression, obesity and smoking that lead to heart attacks, stroke and cancer resulting in catastrophic medical interventions, excess costs, excess morbidity and premature deaths. This is true in every community in NC and the nation and is the basic reason that the US has among the worst population health outcomes compared to other developed nations.

In Buncombe County, we have a national model of Disease Management called Project Asheville that is used to control many of the conditions that lead to excess hospitalization and costs for the insured. Project Asheville is not available to the uninsured but the costs of the care for their catastrophic health problems are borne by the privately insured who pay for their own beneficiaries care and the cost-shifted burden from the uninsured who receive hospital care. The hospital and Insurers have become Unrecognized, Private Taxing Authorities that collects premiums and payments from the employed insured to care for employed and unemployed UNINSURED.

The Roundtable recognized the fundamental breakdown in our local financing system and the hidden burden of high cost health insurance premiums and the resulting uninsured in our community through their analysis of the local COPA data. The Roundtable employed health care and actuarial consultants who guided their deliberations and evaluation of approaches used in other communities in the US. The Roundtable wanted to make the system rational and fair by making insurance affordable to all employers and individuals by correcting the flaws that made insurance prohibitively expensive and resulted in unacceptable increases in the number of uninsured.

The Roundtable learned that US Health Insurance began as a community-rated product for limited benefits provided by a Not-for-Profit insurer with low overhead for all residents of communities with payments to providers at prices that reflected the actual costs of care. Private, For-Profit insurers entered the market after WW II and increased the covered benefits, segmented the market to identify the lowest risk groups, introduced reimbursement contracting with hospitals and physicians, implemented utilization controls and abandoned community rating to attract the lowest risk groups for increasingly expensive health insurance with higher overhead and significant profits. Large group Insurance purchasers responded by self-insuring and negotiated for deeper discounts from providers. Hospitals and other Providers responded by increasing prices to cover the costs of uninsured losses and dramatically increased the volume of technology and specialty care procedures to offset their losses from primary care and catastrophic services.

The Roundtable, using COPA data, sought legislative authorization to undertake a demonstration project for pooling large and small employers into a unified community-rated purchasing group that would design and adopt proven packages of benefits that met the requirements of the NC Department of Insurance and the developing requirements of the national Accountable Care Act. The proposed four levels of benefits would cover the costs of uniform Primary and Preventive Care services and Catastrophic services in all packages and use proven actuarial processes to reduce the costs of premiums for discretionary, procedural services. Fundamentally the proposed pooling of insurance was to be designed to obtain low insurance overheard, less than 10% as achieved by the NC State employee health insurance program, optimum utilization of procedural services and full access to Primary Care to achieve best health outcomes for the combined group of insured from both large and small employers and potentially from insurable individuals. The proposed pooling of insured groups was designed to use market competition among insurers for the largest possible group in the community and potentially the region. The model is based on proven Prevention and Primary Care, full access to catastrophic care, and appropriate use of best technology without use of the most technology, managed by local systems of care supported by proven actuarial analysis and processes.

The Roundtable proposed legislation was adopted by the legislature and approved by the governor in 2009 and amended in 2010 to allow implementation of a model of a local health insurance program in NC. Without the data from the COPA Reports, this community approach could not have been developed and the authorizing legislation could not have been adopted. The authorization of HB 212 remains unfulfilled today because of the fluidity of the insurance market secondary to adoption of national health reform and the impending regulatory changes. The need for a local demonstration project to model the best benefit design with appropriate economic incentives for patients and providers has never been greater. The authorization of HB 212 remains available to Buncombe or other interested community because of the COPA data that demonstrates the potential value of changing our financing system in NC and the nation.

I recommend that COPA Reporting requirements be retained in the regulations even as other regulations are modified or reduced to relieve unnecessary burdens on Mission Hospital.

Viddia Torbett (Rep. Torbett)

From: True Morse <True.Morse@msj.org>
Sent: Thursday, October 20, 2011 11:24 PM
To: Viddia Torbett (Rep. Torbett)
Subject: 10/20 WNC Mission COPA public hearing

Thank you for the time and effort with the public hearing tonight. While as a long term Mission employee, as one would expect, my view is pro Mission. I worked hard tonight to step back from that and simply consider what I heard as facts. While I am not directly in the mix of COPA level discussions at Mission, I am familiar enough with some of the issues mentioned to know that there were many partial stories being told. Yes, the ultimately goal for all these organizations is to keep people well or get them well but none of these organizations can do this unless they make a reasonable profit to reinvest for the future. Here is what I came away with as key points that I would ask the committee to consider:

1. I see that the most central theme from those opposing Mission's business practices is that Mission is a monopoly so it limits choice for patients. That logic is so fundamentally flawed I am not sure how anyone can consider it for a moment. Lets explore that.
    a. From dictionary.com the definition of a monopoly is *1) exclusive control of a commodity or service in a particular market, or a control that makes possible the manipulation of prices. 2) an exclusive privilege to carry on a business, traffic, or service, granted by a government. 3) the exclusive possession or control of something. 4)something that is the subject of such control, as a commodity or service. 5) a company or group that has such control.*
    b. While by CON law, the state does limit certain health care resources to defined provider areas, Mission's market share in the 18 county region is in the 40% range. There are many other providers in the region. Almost all of these counties have one hospital in each county, just as Buncombe does. How does any of this come close to a monopoly?
    c. Pardee's chart on market share which showed large increases in certain areas by Mission, showed that there were equally large % changes by those hospitals managed by Carolina Health System. Looks like good solid competition to me rather than a monopoly.
2. While some speakers noted this distinction, each of the 4 regional hospitals that are part of the Mission system sought out Mission due to financial difficulties. They would have either closed, severely reduced their services to their community or affiliated with another health system. There is nothing predatory about this. In some of the cases where a hospital is aligned with Carolinas Health System, Mission lost the competition for that affiliation.
3. There were obviously some difficult competitive situations regarding the various CONs mentioned. In talking to my peers in other areas of NC, this is the rule, not the exception, in competitive markets. However, by the very nature of the CON law, it is designed to be competitive and has built in paths for opposing and appealing. What Park Ridge failed to mention is that they opposed what should have been a routine cost overrun CON on an inpatient project at Mission in 2008 that delayed that project and cost Mission over $3M in project delays only to have the administrative law judge dismiss the case only hours into the testimony. Their appeal was basically ruled as baseless. I am particularly familiar with this case as I was deposed for 10 hours on this given my role in managing the project and was due to testify.
4. While both sides initial presentations contained emotional references to patient care, as you would hope they would, there appeared to me a strong contrast between's Mission's presentation of well documented data regarding Mission's price and cost comparison to the COPA peer hospitals and the competitive landscape while Pardee largely used sensational quotes, much taken out of context. Seemed like a huge absence of data supporting their position.

Yours is a tough job but the bottom line is how best to ensure quality health care access for WNC. It appears to me that with the current competitive landscape in WNC there is no monopoly by any definition and the best way to ensure quality health care access is by what our nation does best – free market forces where the consumer chooses. Seems that is already going on and may be why MedWest and Carolinas Health System were conspicuously absent from the debate as they compete in the same manner as what Mission is asking to be able to do.

Thanks for your consideration.

True B. Morse
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Viddia Torbett (Rep. Torbett)

From:	RL Clark <rlpclark@charter.net>
Sent:	Wednesday, October 19, 2011 4:34 PM
To:	Rep. John Torbett
Cc:	moffitt@emoffitt.com; Sen. Tom Apodaca
Subject:	House select committee COPA Oct 20 WNC Agric. Ctr.

Honorable Representative Torbett:

A story in the local Asheville-Citizen Times Newspaper indicates your committee is holding a meeting Oct. 20 at the WNC Agricultural Center concerning Mission Hospitals. I have an interest since as a State Senator representing Buncombe County in 1995 it was with much reluctance on my part I voted for a consolidation of Mission and St. Joseph Hospitals. It didn't feel right at that time and what has unfolded during these past several years has tended to reinforce my doubts Of the 1990's. If possible I would appreciate being permitted to make some comments to the select committee.

R L Clark
N C State Senator
Buncombe, Madison, Yancey, McDowell, Burke (part)
1995-1998

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Rlpclark@charter.net

Public Hearing COPA Comments

- Hello, my name is Dr. Bryon Dickerson. I am a radiologist, and am the President and CEO of Asheville Radiology Associates, an independent radiology practice in Buncombe County. I have been practicing in this community for almost 10 years. My group has served the western North Carolina region since 1944.

- As a Radiologist it is my job to look inside the human body. I see miracles being performed at Mission daily. One example I'll share with you is a 20-year old trauma patient who presented to Mission's ED after falling from a construction site onto a vertical shaft of rebar. The rebar impaled him front to back, side to side from the upper right chest through to his upper left back. The EMS on the scene cut the rebar and transported him, rebar and all to the ED. It was the skill of Mission's ER and Trauma services that saved this person's life.

  Another example is of a seventy-year old man who was getting a CT for belly pain. He had a ruptured Abdominal Aortic Aneurysm and was actively bleeding into his belly. Most of these patients die and never make it to the hospital. He was emergently taken to the OR by the vascular surgeon where the bleeding was controlled, his aorta repaired, and his life saved.

  The third case I'll share is a 60 year-old man with dizziness who suddenly became unresponsive. He was intubated in the field and brought to the ED. He was then diagnosed with basilar artery thrombosis which has a death rate of 70-80%. Our doctors were able to guide a catheter into the brain, find the clot and treat the clot. This patient was discharged in 4 days with near complete return to function.

  These stories are real people - people who benefitted from the level of care provided at Mission Hospital. Stories like these happen every day at Mission because they are the tertiary care center for our region.

  Mission is the tertiary care resource in western North Carolina. Mission needs the **freedom** to serve this role without the restrictions the COPA places on Mission.

- But there is another aspect of **freedom** I would like to address, that is the personal freedom of choice.

- My group's choice right now is to remain independent. We know that there is a trend in healthcare for doctors to affiliate or be employed by hospitals. If, sometime in the future, we were to decide to affiliate with a hospital system we don't think it is appropriate that the government restrict our choices.

- Under the COPA, Mission is limited in the number of physicians it can employ. It is the only health system in North Carolina that is restricted in this way by the government. Meanwhile, other large health systems that operate here in Western North Carolina and compete vigorously with Mission are employing hundreds of physicians.

- It's clearly unfair to Mission because it handicaps them in trying to serve patients. But it's also unfair to me and other private practice doctors to have the government dictate which hospitals I may or may not choose to affiliate with.

- For now, I have decided that an independent practice is still the best option for me, for my family and my future. But if I should change my mind, I do not believe that the government should tell me to whom to align with in the region.

- To quote Thomas Jefferson, "...my reading of history convinces me that most bad government results from too much government."

- So please, I urge this committee: reevaluate the COPA and the restrictions it places on my choices as a professional in Buncombe County. Thank you.

COPA Talking Points

Thank you for allowing me to speak. My name is Keith Holtsclaw and I am the retired President and CEO of Blue Ridge Regional Hospital in Spruce Pine NC. I was in this position in 1997 when Mission became our "Sole Corporate Member" and the Hospital aligned with Mission. At that time the Hospital was doing very well financially, however, owing to previous financial history was not able to gain significant access to capital to improve the facility. Mission provided assurances so that BRRH could obtain bond funding to allow for the upgrade of the operating rooms. Mission also provided expertise that was difficult for a small rural hospital to obtain. This arrangement has served the citizens of Mitchell and Yancey Counties well as Mission's intent was to keep as much health care local as possible and be there for tertiary services. Mission again provided backing for financing of a $23 Million dollar clinical replacement and renovation project in 2006. BRRH now has a state-of-the-art facility to serve the citizens of Mitchell and Yancey Counties that would not have been possible without Mission's assistance.

I was also involved in working with The McDowell Hospital as Mission provided assistance at an extremely critical time when they were in jeopardy of maintaining ongoing operations. In effect, McDowell was in technical bankruptcy. Mission provided the needed cash infusion and management expertise to allow TMH to continue operations and provide services to the community. Mission stuck with them when a competing Provider hired the two OB/GYN's in the community and they stopped providing services at TMH, effectively decimating access to women's services. The competing Provider then enticed away and employed the largest Family Practice group in the community. Again, this had a devastating impact on the services provided at TMH. Mission again, added additional funds to ensure local access and assisted in recruiting new physicians and reinstituted services. I have been a Board Member of TMH for the past 6 years (since Mission added board members) and have personally observed the commitment that Mission has made to the community and to providing as many services locally as possible.

To vilify Mission by saying they are trying to move everything to their campuses is patently absurd. I have worked with and watched the organization provide help to smaller hospitals and do everything possible to have them maintain as many services locally as possible. In the case of Blue Ridge Regional Hospital, Mission's assistance helped the number of employees, during my tenure, increase from approximately 160 to over 400. As a current Mitchell County Commissioner I am certainly grateful for their help in growing the economic base for the County.

Thank you for allowing me to express my experience with Mission, and articulate my view of their commitment to providing the best possible health care for the Region.

Mark from Fletcher.

I recently moved to Fletcher from Chicago, IL. I moved to FL in July (bad decision) and moved to Chicago in January (another bad decision) and we moved here near the end of September (finally a good decision). My family loves this area and we can see ourselves staying in Western NC for a long time. I have a two year old and a two month old and as I've listened to this hearing, my concern is for them. I'm not particularly worried about tomorrow, next year or even ten years from now. I'm worried about the long-term impact, how this will impact my kids future and my grandkids, if this current trend continues. I find it particularly interesting in the new healthcare environment where I as the consumer wants to be more educated about our care, more informed of care options and have more provider choices that we would allow a giant to control a community. This hearing initially drew my interest because it is a clear contrast from the healthcare environment where I come from. In Chicago I had over 100 hospitals to choose from, all less than 50 miles from my home. I don't necessarily think this is all Mission's fault and I urge the state of NC to correct a bad COPA agreement and to hold hospitals accountable. Lastly, I want to thank this committee for being willing to take a serious look at this issue and I trust the committee will do what is best for the citizens of WNC.

Over the past few years Mission Health System has aggressively grown and become a monopolistic presence on healthcare in Western NC. Mission's aggressive practices with hospitals in Marion, Spruce Pine, Transylvania, Rutherfordton, Franklin and Hendersonville has lead our region into a dangerous territory.

- Why would Mission build a $45 million medical office building in a limited populated area of North Henderson County?
- Why would Mission work so hard and spend so much money for a building a few miles away from the only hospital in the region that isn't affiliated with them?

I would propose it is because Mission believes Western NC should be a single provider system.

I am not going go into detail about anti-trust laws, the justice department or the Federal Trade Commission and why anti-monopolistic laws are imperative to our country. In our history, we have had appropriate and necessary intervention from states to ensure citizens have choice and predatory practices are limited. Great companies such as AT&T and Microsoft have worked with the government to limit their monopolistic practices and as a result consumers benefited from these interventions. Our region must continue to have intervention from the state to ensure our healthcare is affordable and quality is delivered. On our current path with our lack of competition for healthcare services and very little substitution of services Western NC will continue to erode for our next generation.

Please look at the current Certificate of Public Advantage guidelines and honestly ask yourself what would this region look like if it the COPA didn't exist. I imagine it would look very similar because over the past few years Mission has become so aggressive and has ignored the COPA. Government intervention isn't unique to Mission – it happens all of the time throughout the country in the healthcare industry.

I am afraid this evening you may hear from Mission that they have a collaborative relationship with area hospitals and physicians, and as a result the citizens have benefited from their growth. However, as consumers of healthcare service and citizens of western NC we are left with limited choices. Small rural hospitals and physicians not affiliated with Mission provide excellent service, but as Mission continues it's aggressive growth it will limit our choice on hospitals and eventually limit and reduce physicians in our region.

My family, like most families should have the choice to choose a hospital or physician based on their clinical outcomes and cost. Mission's practice of eliminating competition will undermine the citizens of our region ability to select providers based on clinical outcomes and cost. The result of a monopoly is the ability for the enterprise to maximize their profit by providing fewer services and selling them at a higher prices. I have no doubt our health care cost will increase because Mission is building a $45 million dollar building that is not needed in our region. Mission isn't going to pay for that building – we are going to pay for that building with higher prices.

Over the past few years we have heard a lot about healthcare reform, which in some form or another most US citizen agreed was needed to control healthcare costs and improve clinical outcomes. However, what angered most people was the concept of a single payer system and limiting choice for insurance. I can only imagine what kind of outrage would have taken place if the debate included a single provider system, which is what Western North Carolina will be if Mission's practices aren't stopped. I believe our region needs health care reform – Reform that begins with current guidelines of the Certificate of Public Advantage. Please take a serious look at the current Certificate of Public Advantage guidelines. Our region needs a strong Mission Health System, but it is imperative we have other strong healthcare institutions and physicians. Please ensure the citizens of Western NC are able have the kind of healthcare that is provided throughout our fine state of NC. With so many of our citizens struggling, please do what you can to slow down the rapid increase of health care cost.

Thank you for your time and I am confident you will make the right choice for our citizens.

GOOD EVENING

WELCOME TO FALL IN THE MOUNTAINS.
THANKS FOR COMING TO HELP US CARE FOR THE PEOPLE OF WESTERN NC
I'M RUFFIN BENTON.

I'VE BEEN A FAMILY DOC IN BREVARD FOR 35 YEARS.

I'M CHIEF OF STAFF AT TRANSYLVANIA REGIONAL HOSPITAL.
I'LL BE 65 IN 2 WEEKS, A PARTICIPANT IN MEDICARE, AND APPARENTLY PART OF THE REIMBURSEMENT PROBLEM.
POLITICS IS THE STRUGGLE FOR POWER

WE ARE INVOLVED TONIGHT IN A POLITICAL PROCESS TO RESOLVE A TURF BATTLE INVOLVING SEVERAL OUTSTANDING HEALTH CARE ORGANIZATIONS.

IT IS IMPERATIVE TO REMEMBER THAT OUR PEOPLE, OUR PATIENTS NOT OUR HEALTH CARE ORGANIZATIONS, NEED TO BE AT THE CENTER OF THIS DISCUSSION.

I CAME TO BREVARD 35 YEARS AGO TO ENJOY WESTERN NC AND CARE FOR THE PEOPLE HERE.

THE GROUP I JOINED WAS SMALL, BUT GREW OVER TIME

A FEW YEARS AGO, MY GROUP JOINED TRANSYLVANIA REGIONAL HOSPITAL IN ORDER TO DEAL WITH THE ECONOMIC AND ACCESS ISSUES OF PRACTICING MEDICINE IN WESTERN NC, AND TO ENABLE US TO RETAIN AND ATTRACT PHYSIANS.

MORE RECENTLY, TRANSYLVANIA REGIONAL HOSPITAL INITIATED AND ENTERED INTO A MANAGEMENT AGREEMENT WITH MISSION HEALTH SYSTEM.

WE HOPE TO BE ABLE TO CONTINUE TO PROVIDE HIGH QUALITY CARE TO THE PEOPLE OF TRANSYLVANIA COUNTY, FORMALLY PERPETUATING THE LONG STANDING PRODUCTIVE COLLABORATION WITH MISSION HEALTH SYSTEM.

WE LOOKED AT SEVERAL POTENTIAL PARTNERS, ALL OF WHOM HAD MUCH TO OFFER.

MISSION OFFERED OUR DOCTORS AND OUR HOSPITAL THE BEST OPPORTUNITY TO CARE FOR OUR PEOPLE, OUR PATIENTS, AND BUILD A REGIONAL ORGANIZATION.

IT IS OFTEN SAID THAT THE HEALTH CARE SYSTEM IS BROKEN.
I CONTINUE TO DISAGREE WITH THAT STATEMENT FOR TWO REASONS.
FIRST, WE DO SICK CARE FAR MORE THAN HEALTH CARE
SECOND, THERE IS NO SYSTEM, BUT MANY DISPARATE AND DESPERATE GROUPS WHO ARE STRUGGLING FOR POWER.

TRANSYLVANIA HAS JOINED WITH BLUE RIDGE, MCDOWELL, AND ANGEL TO LEAD MISSION HEALTH SYSTEM FORWARD, AND BUILD AN OUTSTANDING HEALTH CARE SYSTEM FOR THE PEOPLE OF WESTERN N. C.

LIMITED REIMBURSEMENT AND MANDATES FROM THE FORCES OF DARKNESS HAVE MADE IT IMPOSSIBLE TO MOVE FORWARD OR EVEN EXIST AS A COMMUNITY HOSPITAL OR PRIVATE DOCTOR IN THIS CHALLENGING ENVIRONMENT.

OUR MANAGEMENT AGREEMENT WITH MISSION STRESSES COOPERATIVE EFFORTS AMONG ALL HOSPITALS IN THE SYSTEM WE HOPE TO BUILD.

DURING 38 YEARS IN PRACTICE AND LEADERSHIP POSITIONS I HAVE ENCOUNTERED MANY IMPASSES.

IMAGINE - DOCTORS AT AN IMPASSE.

ITS NOT ONLY POLITICIANS FOLKS.

WHEN FACED WITH INSOLUBLE PROBLEMS, I ALWAYS REMEMBER THAT THE PATIENT MUST BE PARAMOUNT.

TO BEST PROVIDE FOR THE FOLKS OF WESTERN NC, WE NEED TO BUILD A HEALTH CARE SYSTEM - TOGETHER.

TRANSYLVANIA, BLUE RIDGE, MCDOWELL, AND ANGEL PLAN TO WORK WITH MISSION TO BUILD THE SYSTEM.

WE INVITE ALL THE DOCTORS AND HOSPITALS IN WESTERN NC TO JOIN OUR EFFORTS.

LEGISLATIVE SHACKLES SHOULD NOT BE ALLOWED TO THWART OUR EFFORTS TO BE PATIENT ADVOCATES.

RUFFIN BENTON MD
377 Gallimore Rd
Brevard NC 28712
gruffinbenton@aim.com

I worked as an RN at Mission Hospital for 14 years.

While in New Employee Orientation in 1982, I heard a young female employee speak about the greatness of Mission Hospital and the plans it had for its future growth. I was pleased to be going to work for a progressive medical facility where I could use the skills that I had acquired while working in Charlotte Memorial ICU. However, I was somewhat astounded by a statement that this speaker made which just didn't sound ethical. I didn't know exactly what this statement implied, but I have remembered it for over 28 years and have recalled it many times during those years as Mission Hospital has indeed lived up to its goal which she shared that day.

This statement which she made with pride was that **Mission Hospital was growing and would continue to do so and would eventually take over all the smaller hospitals in the area and put them out of business.** As an example, she name **specifically** one of the hospitals. This hospital that she named was **Fletcher Hospital**, the "little hospital out there" that "doesn't have a chance to survive."

As time went by, I was pleased to see that Fletcher Hospital not only survived, but grew and built a beautiful new facility and renamed it **Park Ridge Hospital**. I have had, and still have, great respect for the values of this hospital and the work they do to benefit the people of the area they serve.

My profession is that of a nurse. I am not a business professional or politician. However, I have discernment for honor, justice and right. I observed the first thing about which Mission was not entirely truthful and which was their first subtle step in taking was over St. Joseph's Hospital. They announced that the two hospitals would share a combined laundry facility. After this they announced several so-called "joint-ventures", each time reassuring in print that these changes were not a merger of the two hospitals at that time nor would they become so in the future.

History has proven their dishonesty as Mission not only merged with St. Joseph's but eventually took position of it. There is no longer a St. Joseph's Hospital in Asheville. Even the name they used to wean the public, Mission-St. Joseph's, has been changed to Mission Health System, leaving all memories of St. Joseph behind.

I have no doubt that Mission Health System has a plan to create a monopoly in this area. Their efforts to do so should have been recognized 28 years ago when Bob Burgin was making his frequent trips to Washington, DC, with his false presentations of reasons why Western North Carolina would be better served if Mission-St. Joseph's had a joint venture and became the only providers of health care in the area.

Certainly now, that all the facts are before us and Mission's plans to destroy any competition and to take complete control of health care in Western North Carolina are exposed, those who

have the authority to do so will put a stop to their selfish plans that do not benefit the people but somehow, in a way that is beyond my knowledge and understanding, benefits a few executives at the top. Unless this plan is halted Park Ridge Hospital will no longer be and will become forgotten in the same manner as St. Joseph's Asheville.

Mary Sloop, RN
Horse Shoe, NC
44 Oakwood Drive

My name is Renae JOHNSON and I'm a resident of Henderson County. I am here to advocate for choice. My husband was born @ Pardee Hospital 38 years ago. My youngest son was born @ Park Ridge 9 years ago from this past Monday.

~~I am here to advocate for choice. I may never need to use any of the other hospitals in the area, but I still want them to be here just in case.~~ If my family needed services the hospitals in Henderson County could not provide, we would choose Mission.

I like Wal-Mart. They have ~~a good~~ an enormous selection and good prices, but I wouldn't want to shop there for the rest of my life.

I like ~~Applebee's~~ PF Changs but I wouldn't want to eat ~~every meal there.~~ at PF Changs everytime I wanted to eat out.

I believe there is a way that Mission can be strong and other hospitals can be protected. Maybe an updated COPA can do both?

I too echo the cancer patient who spoke earlier, however I am asking you to please ensure my family continues to have a choice in HENDERSON CO for our healthcare needs.

My name is Susan Mims. I have been a pediatrician in Asheville for over 11 years and have served as the Medical Director of Mission Children's Hospital for the past 5. Part of my role involves running a pediatric specialty practice. And I would like to tell you about one of the large practices that Mission owns
Mission employs 31 physicians and dentists who care for the children of WNC who need specialty care. Our doctors treat children with **cancer, cystic fibrosis, diabetes, child abuse, autism, and many other problems.** Mission hired these physicians in response to requests from families in the region who were struggling to get needed care for their children.

Prior to the development of Mission Children's Hospital, families with children needing weekly chemotherapy treatments or regular visits to a pediatric physical therapist had to travel several hours each way to get that care. And, as we have learned since we hired a pediatric orthopedist, some families could not travel and just went without the care their children needed.

Hayley is one such child and her parents gave me permission to share her story. She is an 8 year old quadriplegic with cerebral palsy living in foster care. Her family could not afford to drive Hayley to South Carolina regularly so she could not been seen as often as needed for her orthopedic care until Mission hired a pediatric orthopedist.

Prior to starting treatment this 8 year old child was wheel chair bound, crawled on the floor and was totally dependent on her foster parents for movement. Now, since receiving regular care over the past year at Mission Children's Hospital, Hayley is beginning to walk independently and you should see how proud she is!

I want to point out that the reason pediatric specialty services were not available before Mission hired these physicians is because they loose money, a lot of money.* Mission stepped up to offer this care for children because it was needed and <u>this</u> is who Mission is.

Mission is here to create a healthier WNC and knew that could not be done if kids were left behind. This is just one example of the many ways Mission serves this region. Mission is here for the children and families of WNC. Mission is here for Hayley. Thank you.

* In fact, these expanded services that loose money represent some of the market share growth outlined by Mr. Wells.

To the House Select Committee on the Certificate of Need Process and Related Hospital Issues:

I am an employee at Mission Hospital, in Asheville, North Carolina. I am writing to provide my observations on how Mission has operated under the Certificate of Public Advantage. I am not able to attend the hearing, but as an employee, I want to make sure that I express my support for Mission.

I have worked at Mission for over 20 years. Both my children were born at Mission Hospital and my husband received treatment for a serious mountain biking injury there.

While my role is not in patient care, I have been impressed with the stewardship principles that the board, senior management and the rest of the administrative staff apply in their management of the assets of the health care organization. Spending and revenue decisions are made after carefully reviewing many possible scenarios and outcomes. I have worked on measuring community benefits and it is amazing how many lives that Mission touches through community contributions and volunteer efforts of its employees.

When my husband was seriously injured in a mountain biking accident, he spent over a week at the hospital. Through God's grace and mercy we were able to get to the emergency room very quickly and get the care he needed. He has made a full recovery, but if that trauma care hadn't been available in our area, the result could have been very different.

During the credit crisis of 2008, and through the economic recovery still continuing, it has become very clear how difficult it is for small hospitals to be prepared to weather an economic crisis. Yet, those small hospitals are vital to their communities. Mission can provide a safety net to those hospitals while continuing its role to provide special services that the community hospitals do not have the resources to maintain. Since we all have the same goals of providing patient care for the people who live in our communities, why should Mission be hindered from providing that high quality care for the region?

I am proud to work for Mission Hospital. As long as I have worked here, there have been continuous awards for quality of care, yet the hospital has never been content to simply maintain. The quest for quality at Mission is never-ending, whether it is patient care, employee satisfaction, quality measured against its peers, the fine-tuning is continuous. From caring for children to trauma patients, I would not hesitate to choose Mission as my family's hospital of choice. This community needs Mission and Mission needs its community's support.

Sincerely,

Carol Goodrum, Manager of Tax Services

To: House Select Committee on the Certificate of Need process and Related Hospital Issues

Dear Representatives:

I am the retired CEO of Mission Health System, serving in that position from 1981 until 2005. Until the beginning of 2008, I assisted Mission as a fund raiser and consultant. I am continuing in a consultant role with other hospitals and medical groups and serve on the board of a large multi-hospital system in East TN and SW VA, Wellmont Health System.

My knowledge of the certificate of public advantage (COPA) is long standing and dates to the writing of the legislation. Mission submitted, in August 1994, the first application to the state of N.C. and the U.S. Justice Dept. for a COPA. After a 15+ month process the two hospitals, Mission and St. Jos. met the challenge of the States Attorney General and the U.S. Justice Dept. for a virtual merger. This very open process included but was not limited to thousands of pages from both hospitals' files and computers and interviews with hundreds of people in the region of W.N.C. Many requirements are included in the eventual document. Over the five year period of close monitoring, the hospitals met and exceeded all that was asked/directed in the COPA. This includes savings, margin limitation, cost control and appropriate managed care/insurance contracts. When Mission purchased St.Jos. in 1998, the new entity, Mission-St. Jos. Health System, again met and exceeded all new requirements. Having been personally involved in this, I know of the extensive scrutiny under which the hospitals were observed and monitored. I can only relate what happened from 1994 until my retirement in 2005.

The outcome of the merger has been overwhelmingly beneficial to WNC. Mission helped form a group of hospitals in the region that focuses on quality improvement, cost control and purchasing savings as well as operational enhancements. This organization, WNC Health Network is a model used in other regions of our state as well as other communities. Mission has gained many new awards for cost control, quality management...and outcomes, and expanded into new services for Asheville and the region. Many organizations have come to Asheville to model the methods of improving the delivery of care to patients.

While all of this has happened, other health organizations have come into and/or expanded their operations in WNC to pose major competition. This is good for all, especially the patients. However, those who are here now are from outside our region. They do not have the restrictions that Mission has voluntarily stayed under with the COPA. The Carolinas Health System is a governmental entity based in Charlotte with no limitation on margin, assets or employment of physicians. They currently manage West Care in Haywood, Swain and Jackson Counties, and Murphy Medical Ctr. The Adventist Health System from Orlando, FL, is an extremely large and financially profitable organization that owns ParkRidge Hospital and allows them to expand with no limitation in Buncombe Co. as well as Henderson Co. The UNC Health System now manages Pardee Hospital and has the state of N.C. as an asset.

Mission has only entered into relationships with hospitals that requested their assistant, including Spruce Pine, McDowell, Transylvania and Angel Community in Franklin, N.C. My personal knowledge only includes the first two since I retired before the latter were part of the MHS. Much assistance has been given and offered to many other institutions over the years.

Mission accepts all patients regardless of the ability to pay if the institution has the talent and services to care for them. Doing this means a very financially poor payer mix of patients and families. With 80% of the patients using either Medicare, Medicaid or self pay, the hospital must manage its costs very closely and the resultant numbers are exemplary, based on the severity of the patients. With the worse payer mix in N.C. and one of the worse in the nation, Mission cannot be encumbered with more regulations than the competition. This will force the hospital, a locally owned and operated organization begun in 1885, to limit its services and staff.

As a 30+ year resident of Asheville, I know the positive economic impact Mission has had on our region and state. With a workforce of over 7000, these valuable employees have put a huge return into our economy as well the most important service of quality cost effective care of the highest measure. As a past chair of the Chamber of Commerce, the United Way and many other organizations, I know how much the hospital and its physicians and employees mean to our community. New people in our community often talk about how important the great care at Mission has been for them, sometimes the major factor in relocating to our area. Our two new neighbors told me this, just last evening.

Many have told me that Mission is jewel and a model for how mergers should happen and how hospitals should be operated. With the board, medical staff and employee group, the community has that jewel and is constantly polishing it to great effectiveness.

Thank you for this opportunity to submit this and I welcome a chance to speak at the hearing on October 20th.
Thank you,
Robert F. Burgin
President Emeritus
Mission Health System

Matt Guffey

19 Springfield Way

Arden, NC 28704

DAD My father showed symptoms of some type of problem in February 2008. We were referred to Mission Hospital ~~and Carolina Spine & Neurology Center~~ by the physician in Rutherford County. My family wanted to stay in Western NC for ~~this~~. the procedures that followed.

The biopsy that he had was performed at Mission ~~by Dr. Fowler.~~ During this time of anxiousness my family was well cared for under all the circumstances and everyone whom we questioned was very patient in explaining any questions, procedures and results that were unclear to us. Everyone that was involved was very caring and showed extreme compassion when the diagnosis was a large inoperable brain tumor. My DAD made it almost a year from the time of that diagnosis. I am grateful for that precious time I had with him after that fateful day. I am also grateful that we had the opportunity to take him to Mission Hospital with its strong reputation and skilled doctors. I think that was instrumental in giving me the time we had before the cancer won. He would have been 67 years young today.

MOM My mother started developing some symptoms that were cause for alarm about a year after my Dad's death. Her Doctor in Rutherford County recommended testing and referred us ~~to [illegible]~~ Asheville Cardiology Associates. I don't believe there were adequate facilities and means to run these tests in Rutherford County at the time. The Dr. ~~[illegible]'s~~ recommendation was for a Heart Catheterization. All throughout this process we received the same professional and compassionate care we had experienced a year or so earlier with my Dad. The procedure was performed at Mission Hospital with all the expertise and care that ~~was~~ we expected.

The South end of Asheville has been growing fast. It only makes sense to have a facility that can offer more services for Southern Buncombe and Northern Henderson Counties in such an easily accessible location. This project would also create and foster employment for trained physicians and caregivers as well as the construction trades that have been hit so hard by this downturn in the economy. That money will in turn be put back into the local economy and help stimulate further growth.

This project is a positive in all aspects in my opinion!

Matt Guffey

8 Greenwood Rd

Asheville, NC. 28803

Mr. Christopher Taylor, CPA, Assistant Secretary

Carolina Medical Care Commission

2701 Mail Service Center

Raleigh, NC 27699-2701

Dear Mr. Taylor,

I have recently learned that some of the business practices of Mission Hospitals in Asheville, NC, have come under scrutiny. I am a medical oncologist—formerly a partner with Asheville Hematology/Oncology PA, later renamed Cancer Centers of North Carolina, Asheville. I am writing in reference to the manner in which Mission Hospitals in Asheville dealt with our Certificate of Need (CON) exemption to build a cancer center with medical oncology, radiation oncology, and imaging, all under one roof. This would have been the only such facility at that time in this region of state. Dr. Barton Paschal's letter has summarized the circumstances of the litigation and I refer the reader to that letter and the court records. This is my own summary given to the best of my knowledge and memory.

Having received our CON exemption we moved ahead with our cancer center construction. Missions Hospitals sued to reverse the CON exemption and stop construction but we won our case in a state administrative court and proceeded to open Cancer Centers of North Carolina. We had hired a superbly trained radiation oncologist and full supporting staff.

Unfortunately approximately ten weeks later (the day after we held an open house for the medical community) the State notified us that a certain Mr. Fitzgerald in the CON office had withdrawn our CON exemption clearly in defiance of the favorable court decision. This judgment came from the very office that had approved our project in the first place! None of this made any sense and we immediately appealed the decision (in this topsy-turvy legal system reason would have dictated that Mission Hospitals would be the party appealing). The Court of Appeals refused to issue a stay to allow us to continue operations until a formal appeal could be mounted. We shut down our radiation therapy department and fired virtually the entire radiation therapy staff we had just hired. Mr. Fitzgerald's actions seemed cruel and unjust.

Mr. Fitzgerald and his office would later issue Mission Hospitals a CON to build their own cancer center--one that is still under construction approximately five years since we opened the doors to our new office. Obviously, Mission perceived us as competition and wanted to make certain that we failed. I will point out that my practice did not formally oppose Mission's CON for their cancer center.

Approximately two years after we were forced to appeal our case, the Court of Appeals ruled in our favor based upon the fact that **Mission Hospitals' lawyers illegally met ex parte with Mr. Fitzgerald shortly before he rendered the decision to void our CON exemption—thus depriving us of due process of law.** This is clearly noted in the court records. We never dreamed someone would cheat like this.

To our utter amazement Mission Hospitals then appealed the court decision. There appeared to be no end in sight to the litigation, which had now all the trappings of a war of attrition.

In October 2009 I resigned from the practice choosing not to be a part of the continued litigation. I am currently employed at the Veterans Hospital in Asheville and have withdrawn my privileges at Mission Hospitals. Recently I learned that the Court of Appeals ruled unanimously in favor of my former practice thus ending the litigation that had dragged on for approximately five years. I also read that shortly after the Court rendered its favorable decision, Mr. Fitzgerald resigned/retired and the CON office fully restored the CON for Cancer Centers. Sometime shortly after that Mr. Joe Damore, Mission CEO and the author of our misery, was forced to resign for a variety of reasons. I have never learned if his ill-contrived lawsuit against us was a factor.

My former practice lost several million dollars because of a gross miscarriage of justice. The toll on me was not just financial but emotional and professional as well. I have lost faith in a health system that will allow one party to have so much autonomy as to deprive the very people who are its lifeblood of their legal rights. I have chosen to get on with my life and I can only hope that other doctors in this part of the state of North Carolina can be spared the type of experience we were forced to endure. Ours was at best a pyrrhic victory.

Sincerely,

James Butler Puckett, MD, FACP

To the House Select Committee on Certificate Of Need.

1. Having worked in many hospitals in the New York City region, I have been amazed at the level of care that Mission provides. Every step of the health care encounter is thought out thoroughly and each patient is given excellent care. In my experience, Mission is far beyond other hospitals of the same size. Furthermore, the quality initiatives are advanced and multiple. Mission is constantly working on new initiatives to make a better system.

2. Knowing this and having first hand experience, I am deeply saddened that Mission is not allowed to expand their excellent services to the region. As a small example of how money is wasted in a system that is not integrated (and is being prevented from being integrated), I had a patient (who happens to be an employee) voice her concerns that we repeated a lab test that had been done recently in the outpatient setting. (this was a HbA1c - monitoring the control of her diabetes). She ended up having to pay for this test because her insurance company wouldnt cover the repeated test. But we did not know that - we would have know that in an integrated system. In a system that is created to share EMRs.

3. It is my dream that Mission be allowed to care for the patients in this region without restriction. I find it absurd that we are being restricted from providing care to the people of this region. We have the resources to provide top quality care. We have the ~~resources~~ reputation to recruit the best physicians to one of the best hospitals in this nation. We have the resources to create jobs throughout Western North Carolina. In this volatile economic environment, we need to provide that security to this community. This regulation needs to be lifted.

Please lift the COPA so that Mission can provide the best possible primary care to WNC.

Thank you,

Rebecca Bernstein MD
Asheville Hospitalist Group
Mission Hospital

Rehabilitation Hospital
Outpatient Rehabilitation
Home Health
Hospice and Palliative Care
Adult Day
Private Duty

My name is Tracy Buchanan, President and CEO of CarePartners Health Services. I am unable to attend the October 20th hearing therefore I am submitting written comments in support of Mission's operation under the Certificate of Public Advantage.

CarePartners admits over 15,000 patients each year into our post-acute services which include Inpatient Rehabilitation, Home Health, Hospice, Palliative Care, Outpatient, Private Duty, and Adult Day. CarePartners was formed in 1996 as a private 501(c) 3 organization. Our founding members served the community for many years prior to the formation of CarePartners with Thoms Rehabilitation Hospital dating back to 1938.

Throughout our history, we have maintained a valuable and effective partnership with Mission Hospitals, working together to serve the needs of our community.

Through joint venture relationships we have developed programs providing needed services. Greentree Ridge Skilled Nursing Facility was originally developed through a joint venture between Thoms Rehabilitation Hospital, Mission Hospital and Saint Josephs Hospital. This effort was focused on providing top quality care and establishing a new benchmark in the community. The Asheville Specialty Hospital, a long term acute care hospital, is currently operated as a joint venture between CarePartners and Mission Hospital. Established in order to close a gap in care for patients who are acutely ill and require a longer length of stay in an acute care hospital setting, The Asheville Specialty Hospital has been in operation since 2003 and is an example of two partners using their combined strengths and expertise to meet the needs of this special population.

68 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 (828) 277-4800 WWW.CAREPARTNERS.ORG

CarePartners Home Health Services is recognized in the top 20% of the nation for the lowest number of readmissions to the hospital. This was accomplished only through a close, collaborative relationship with Mission working together with CarePartners to ensure a smooth transition to the community. It is also a reflection of the high quality care and discharge planning routinely provided by Mission.

While we work collaboratively on many levels, we also compete. Both Mission and CarePartners offer outpatient therapy services in Buncombe County. Through many years, we have found Mission to be a fair and ethical competitor. Our competition is founded on quality care provision, therefore improving patient outcomes overall in the community.

Mission serves a critical need within the Western North Carolina region. As the sole tertiary hospital in this region, more than 50% of their admissions come from outside Buncombe County. Many services are available in this region due to Mission's commitment to building a healthier community. Mission was instrumental in bringing the medical and pharmacy schools to our region which will have far reaching benefits to all healthcare providers.

Clearly, the healthcare environment is rapidly changing and becoming more competitive. Mission should have the ability and freedom to serve our community without undue restrictions.

Thank you for the opportunity to submit comments for your consideration.

Sincerely,

Tracy Buchanan
President & CEO

/lmw

12. I'm Kent Williams and I live in Henderson Co.

I'm worried about the future of healthcare in Western North Carolina. We all seem to be experiencing the consequences of a bad decision that took place 15 years ago. I can't imagine how any organization could work under the same business plan or mission statement as it did in the mid-1990s.

If the same merger happened today, what would that COPA look like? Listening to tonight's discussion, it seems that the best option for our community might be to change the COPA and make it more current.

Thomas

VHP

Advanced

Care partners

Hello. My name is Nancy Robinson and I have lived in Western North Carolina my whole life. I am 46 years old and was diagnosed with breast cancer at the age of 41. I had to go through chemotherapy treatment and 7 weeks of radiation treatments. I am a single parent and the sole supporter of myself and my daughter.

Being a young person with cancer presents challenges that an older person may not have. It was very important for me to be able to continue working during my treatments. I could not afford to miss time from work or have my paycheck reduced. I made the choice not to drive to Asheville. Even though I was sick I still had to get my daughter to and from school, continue to work and get cancer treatments. Cancer treatments closer to home allows us to get treatment without adding the burden of travel to an already difficult situation. I cannot tell you how important it is for cancer patients to have treatment centers in our local communities.

My treatment is finished but I want to ask you to be sure that the cancer patients who come after me have the same choices that I had. Since I am a younger cancer survivor at some point in my life the cancer may return. It upsets me to think I may not have the option of receiving treatments closer to home. When you are sick and have to rely on getting yourself to treatments you do not need the added stress of dealing with the distance, traffic and parking issues.

Mission does not need to be the only choice. I have driven by Mission's new cancer building and to be honest a big fancy building does not impress me. It scares me to think they will keep getting bigger and force the smaller treatment centers out of business. Just because it's a smaller community facility does not mean you are getting treatments that are less than what Mission can offer. From personal experience I received the same quality care that I would have received at a place like Duke. I did not pick my cancer doctors solely on distance but it was a major factor. It would be a tragedy for the cancer patients that come after me to not receive treatments closer to home and I am counting on you not to let that happen.

Thank you.

Robinson Bradshaw

Memorandum

TO: Members of the House Select Committee on Certificate of Need and Hospital-Related Issues.

FROM: Richard A. Vinroot and Everett J. Bowman

Robinson, Bradshaw & Hinson, P.A., Attorneys for Mission Health System, Inc.

DATE: September 14, 2011

RE: Background information regarding Mission Health System, Inc. and its Certificate of Public Advantage (COPA)

- Mission Health System, Inc. ("Mission") in Asheville, is the 7th largest hospital in North Carolina and the largest employer in the 18-county Western NC ("WNC") region. It was founded in 1885 and has always operated as a nonprofit organization. Its governing Board consists primarily of local businesspeople and other civic leaders who have an interest in high-quality, low-cost medical care and who have no ties to Mission. All of Mission's revenues are utilized for Mission and those served by Mission. Unlike many hospitals in North Carolina, Mission is private and receives no subsidies from either the State or any county. Mission competes with other regional and national hospital systems, including hospitals affiliated with Carolinas Healthcare System, UNC Health Care System, and Adventist Health System.

- For many years there were two acute care hospitals in Asheville, located literally across the street from each other: Mission and St. Joseph's, a Catholic hospital owned by the Sisters of Mercy. In the early 1990s, Asheville's business community began urging Mission and St. Joseph's to combine or merge. They were motivated by their desire to reduce health care costs while maintaining and increasing quality of care, and by the desire to streamline and simplify the process of contracting with the two hospitals. At the same time, Mission's board and management team were concerned that St. Joseph's financial performance appeared weak and seemed to be getting worse, and there was a risk that the hospital would fail unless it joined with Mission to save costs and increase efficiency.

- In March 1994, Mission and St. Joseph's announced that they had entered into a "letter of intent" to integrate their operations.

∂ Although there was no requirement that they do so, the two hospitals promptly notified the Antitrust Division of the U.S. Department of Justice of their proposed integration, or "virtual merger," so that the agency would have an early opportunity to evaluate any concerns about the hospitals' ceasing to compete with each other. The DOJ did choose to conduct a review, examining more than 200,000 of the two hospitals' documents—mainly business and financial records—and taking the depositions of members of management and boards of both hospitals.

∂ While still considering the proposed combination, the DOJ indicated that the agency would promptly end the review if the State of North Carolina: (1) concluded that the merger would, on balance, be beneficial to the people of North Carolina, and (2) provided sufficient and continuing oversight to Mission following the combination.

∂ Accordingly, in July 1995, Mission and St. Joseph's applied to the State to have their proposed transaction evaluated by the NC Department of Justice and Department of Health and Human Services under the State's newly-amended "Hospital Cooperation Act." That amendment was enacted in 1995 by the General Assembly expressly to cover mergers between competing hospitals. Essentially, the hospitals' application for a COPA under the Act asked those State agencies to weigh the "advantages" vs. "disadvantages" of the proposed combination of the two hospitals.

∂ The State then conducted the requested review, holding public hearings, as well as having access to all materials previously collected by the USDOJ.

∂ In December 1995, the State authorities, in a carefully written analysis, concluded that the benefits of the transaction would outweigh any disadvantages and therefore granted the requested COPA, permitting Mission and St. Joseph's to combine. Initially, the hospitals established a joint operating and organizational partnership (that is, a "virtual merger"). In October 1998, under the authority of a reconsidered and revised COPA, Mission purchased St. Joseph's outright from the Sisters of Mercy (a "full merger").

∂ The 1995 COPA legislation has worked well—and as intended. As the State regulatory agencies have repeatedly confirmed, Mission has achieved all aspects of the "advantages" that the original COPA envisioned. Mission is a low-cost hospital and has enhanced the quality of and access to healthcare in Buncombe County and the surrounding more-rural areas of WNC. As a result of the merger of the two hospitals, substantial savings have been generated, and those dollars have been pumped back into the community.

- As the COPA has required, Mission's board is composed primarily of local businesspeople and other local community leaders. As employers (and potential Mission patients) themselves, these board members have a keen interest in keeping down Mission's charges and costs, because their own businesses and personal interests would suffer from any unjustifiable increases in the expense of providing hospital care for employees.

- Mission has the 3rd lowest charges in NC—a direct testament to Mission's Board restricting the hospital to single-digit price increases during an extended period of double digit increases nationally. This is particularly remarkable in that 80% of its patients are covered by Medicare or Medicaid or are residents of relatively poor rural areas who are simply unable to pay. No other large hospital in the State has such a financially disadvantageous patient mix, without any financial support from governmental entities.

- Over the past couple of years, more and more physicians in Asheville, as well as all over the country, have sought to become hospital employees, giving up their private practices. Those physicians, who are facing ever-growing practice costs and complexity, wish to focus on caring for patients and to reduce costs by turning over to a well-managed, efficient hospital their administrative responsibilities (such as billing, hiring, accounting, electronic health records and all the other paperwork associated with providing healthcare services). Moreover, healthcare reform is pushing both doctors and hospitals to form integrated healthcare delivery systems because it is anticipated that these systems will be increasingly accountable for the care and outcomes of, and the per-capita costs for, their patients.

- The COPA put a cap on Mission's employment of or exclusive contracting with primary care physicians at a time when physician employment was very uncommon. In the fall of 2010 Mission requested that the State regulatory agencies modify the COPA so that Mission could employ more physicians and achieve cost savings in doing so, in order to compete with much larger regional hospitals. At the end of last month, the agencies did modify the COPA, making it less restrictive regarding Mission's hiring of physicians. In making that decision, the State was advised by one of the top health care antitrust economists in the country. Moreover, the NC regulatory agencies had both the USDOJ and FTC review and sign off on the COPA modification. In view of all that attention, and the continuing oversight of the State agencies, this Committee can rest assured that Mission's COPA is being properly administered and is pro-competitive.

- Mission—having volunteered to be supervised under the COPA legislation in 1995—is NC's most-regulated hospital: the only hospital in the state subject to a COPA, and is still subject to the Certificate of Need legislation. Despite that fact, others—such as Park Ridge, part of the much larger Orlando-based Adventist

Health system—continue to urge that the COPA be made more restrictive and Mission be subjected to "more regulation," in an effort to avoid completely appropriate competition from Mission. The State regulatory agencies have carefully considered and rejected those efforts.

- The position that the COPA be made more restrictive and that regulatory oversight be increased is particularly wrongheaded in view of the dramatically increased competition that Mission faces from other tertiary care hospital systems, such as Charlotte-based Carolinas Healthcare System ($6.5 billion in net revenues), which now manages and controls Haywood County's largest hospital (Haywood Regional Medical Center, in Waynesville and two other local hospitals), and UNC Health Care System ($1.86 billion in net revenues), which very recently contracted to manage and control the largest hospital in Henderson County (Pardee Hospital in Hendersonville), both almost on Mission's doorstep. Mission currently employs approximately 150 physicians, compared with 1,712 employed by Carolinas and 1,053 employed by Adventist ($6.7 billion in net revenues), both of which are better financed "competitors" of Mission in WNC.

- Mission doesn't object to or try to obstruct such free market competition, but would note that the rapid changes occurring in the health care marketplace, including growing competition from hospitals that are owned by large tertiary care systems, is likely soon to render the continuation of the COPA unnecessary. In any event, this increasing competition certainly makes any effort to change the COPA so as to clamp tighter "handcuffs" on Mission particularly inappropriate.

- In summary, the original goals of the COPA from 1995 to the present were that:

  (a) medical care be improved in WNC;
  (b) costs be contained;
  (c) access to quality care in rural areas be enhanced; and
  (d) smaller rural hospitals (such as Angel Hospital in Franklin, Transylvania Hospital in Brevard, Blue Ridge Regional Hospital in Spruce Pine, and McDowell County Hospital, through their association with Mission) be helped to survive.

- Consistently and repeatedly, and most recently in the exhaustive review in 2010-2011 that included the DOJ and FTC as well as the NC DHHS and the NC Attorney General, the regulatory authorities have determined that all of these goals have been met and that Mission has operated within the rules. The 1995 Mission COPA has worked well, and as planned. For that, the State—and this Legislature, which enacted the COPA law—should be very proud.

Talking Points about Mission and the COPA

1) ***The COPA was the right solution at the time and Mission has complied fully.***
   - Things have changed dramatically since the COPA was put in place 15 years ago. Back then, lawmakers and regulators wanted to make sure the newly merged Memorial Mission and St. Joseph's would not unfairly dominate the market.
   - Mission has done everything asked of the organization under the COPA – kept its margins and charges in line with peer hospitals and delivered more than ***$86 million in savings*** to the community. The COPA has been "paid in full."

2) ***The national healthcare environment and the competitive landscape in Western North Carolina have changed dramatically since 1995.***
   - Mission now vigorously competes in Western North Carolina with much larger and well-funded health systems based outside this region and outside our state.
   - Meanwhile, other national trends are shifting: more physicians are choosing employment instead of private practice, consumers are increasingly demanding outpatient over inpatient care, and hospitals are being called upon to deliver higher quality at a lower cost by integrating care more efficiently.

3) ***To meet the needs of Western North Carolinians for the next century and survive along the way, Mission must have the freedom to serve.***
   - To survive and thrive in this new environment, Mission must be freed from the outdated and burdensome regulation of the COPA.
     - Competitors are pushing to make the COPA even more restrictive; they argue that Mission should provide only advanced, tertiary care for the region. But these critical services like trauma and the NICU actually lose money – Mission subsidizes them because they are essential.
     - Because Mission treats the highest percentage of Medicare and Medicaid patients in the state, it also bears a heavy financial burden to subsidize those services.
   - To continue providing the life-saving, high quality care that our whole region depends on and deserves, Mission needs the freedom to serve.
     - Mission should be free to compete for patients based on outstanding care, without harm, without waste and with an exceptional experience.
     - The region's patients – not government regulators -- should choose where they receive their care.

My name is Susan Hoy and I Live in Hendersonville, NC.
I have been in Healthcare for over 30 yrs in North Carolina from Wilm, to Charl, to H'vlle.
I have always embraced competition as healthy and taught my children this.
This is not About competition, it is about choice.
I am here today because I genuinely feel the choice in healthcare for ~~me and~~ my family gets more limited every day Mission is allowed to continue to acquire more Local doctors and hospitals.
If what I hear on the news, read in papers and on internet is true, ~~we should~~ ~~all be~~ about Missions' control of western north Carolina, we should all be very concerned about the future of health care ~~here~~ choices here.
Please continue ~~doing~~ investigating this situation. I want to know that my family has choices for healthcare in the future.

Thank you,

Susan Hoy, Pharmacist
Hendersonville, N.C.

(1)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/01/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Lanier	Nelson Mullins
Allison Waller	Nelson Mullins
Mary Wilding	Novant
Matthew A. McConnell	Carolinas HealthCare System
[illegible]	Williams Mullen
Dari Caldwell	Rowan Regional - Novant
Barbara Freedy	Novant Health.
Jeff Horton	DHHS DHSR
Webb Cochran	Tenet Health
Noah Huffstetler	
Paul Vick	Duke Health

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/01/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Drexdal Pratt	DHHS / DHSR
Jesse Goodman	DHHS/DHSR
MARC HEWITT	WILLIAMS MULLEN
Connie Wilson	Novant
Richard Blackburn	CaroMont Health
JERRY LOVING	CAROMONT HEALTH
Greg Bass	Carolinas HealthCare System
David O'Connor	CaroMont Health
Maria Long	CaroMont Health
Doug Luckett	Caromont Health
Carol Lorin	Carolinas Healthcare

(3)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/01/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CRAIG SMITH	CON Section DHSR
Emily R. Coble	Interested Public
Elizabeth Kirkman	Carolinas HealthCare System
CRAIG DUNKER	CAROMONT HEALTH SYSTEM
DeeDee Murphy	HPS
Robin Warren	CaroMont Health
Gail Rosenberg	Carolinas HealthCare
Maureen Demarest Murray	Smith Moore Leatherwood LLP
Charlene Thomas	WNC CHT
ANDY LUTZ	PDA, INC.
MIKE JOHNSON	CAROMONT HEALTH

(4)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/01/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Moore	Mission Health
Nelma Sherrill	Mission Health
Jimm Bunch	Park Ridge Health
Ragan Robinson	Gaston Gazette
John Metcalf	Mission Hospital
Scott Farmer	Scott Farmer Properties Inc.
Hugh Tilson	NCHA
Mike Vicario	NCHA
April Byrd	Huntersville, NC

(5)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11/01/2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
IVAN BLAV	
Sen. Deb Clary	NC Gen. Assembly
Matt Wolfe	Parker Poe

SPEAKER SIGN-IN SHEET

	Name	Affiliation	Written Copy of Comments ? (Yes or No)
PASS	~~Richard Vinroot~~	Mission Hospital	No
PASS	~~Everett Bowman~~	ABH for Mission Hospital	No
PASS	~~Del Murphy~~	Carolinas HealthCare	No
	~~Carol Lovin~~ PRESENTER	Carolinas HealthCare	No - Powerpoint Provided
PASS	~~Greg Gombar~~	"	No
	~~DOUG LUCKETT~~ PRESENTER	CAROMONT HEALTH	PPT - YES
PASS	~~Maria Long~~ "	~~Caromont Health~~	
1. ✓	Bill Gary	CaroMont Health	
2. ✓	Scott Griffin	Interested public	NO
3. ✓	Todd Young	Citizen	nO
4. ✓	Graham Fields	Park Ridge Health	nO
PASS	IVAN BELOY	PERSONAL CARE OF NC	
5. ✓	JASON WELLS	PARK RIDGE HEALTH	NO
6. ✓	Jayne Kendall, MD	CaroMont Health	No
7.	RICHARD VINROOT		

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, January 19, 2012
TIME: 10:00 A.M.
LOCATION: 544 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **7 AM** o'clock on **December 06, 2011.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

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House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
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AGENDA

10:00 a.m. Thursday, January 19, 2012

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Committee Discussion

- *Review and consideration of items pertaining to Certificate of Need law*
- *Review and consideration of items pertaining to Certificate of Public Advantage*

MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Thursday, January 19, 2012
10:00 A.M.
Room 544 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, January 19, 2012 in Room 544 of the Legislative Office Building. Representatives Torbett, Steen, Alexander, Avila, Boles, Current, Glazier, Hollo, and Randleman attended.

Representative Torbett presided. He gave a brief recap of the previous travel meetings across the state. Today we will be going over the suggestions from the information received from these meetings and today we will only deliberate the CON recommendations. Representative Steen welcomed everyone and expressed that the committee has received a lot of input and it was very informative.

Representative Torbett asked for approval of the minutes for October 6, 2011, October 20, 2011, November 1, 2011, and November 17, 2011. Representative Glazier made a motion that the minutes be approved. No discussion. Minutes were approved unanimously.

Member from the DHSR were introduced by Representative Torbett including Drexdal Pratt, Jeff Horton, Jessie Goodman, Craig Smith, and Chris Taylor. Subject matter experts in the audience may be called upon also.

Amy Jo Johnson, staff council, presented the power point presentation based on chart (see attached and on committee website). Research staff has gone through the presentations and the comments and put together a chart.

Rep. Torbett opened the floor for discussion.

Rep. Alexander: Could she speak and explain the organ transplant program.

Jeff Horton: Federal government put in new requirements for quality of care for each type of organ. We don't believe it is any longer needed to be governed under CON.

Rep. Alexander: How many hospitals are doing organ transplants?

Jeff Horton: We have 5 hospitals that perform those.

Rep. Avila: List which hospitals those are?

Jeff Horton: Carolinas Medical Center, Wake Forest Baptist Medical Center, UNC, Duke, and East Carolina.

Rep. Torbett: Would it be the recommendation of this committee that we do suggest to remove air ambulances and organ transplant from the CON process.

Rep. Boles: How does the FAA cover air ambulance?

Drexdal Pratt: Federal court ruling where there was a pre-emptions lawsuit against North Carolina and the federal court decided that was an FAA responsibility. It is part of other state regulatory requirements in the licensing piece, just not in the regulation as indicated in CON.

Rep. Boles: If a hospital wanted to put an air ambulance in, they would first have to get FAA approval and then come back and meet the state?

Drexdal Pratt: The FAA is just the air worthiness of the craft, the medical aspects of it is still regulated under our office of emergency medical services. Still requires a license, still requires affiliation with the county and affiliation now with a trauma center. Those are the state requirements that were not affected by the federal ruling.

Rep. Torbett: Let's formally address as a committee, is it the committee's decision to also have air ambulances stricken from the CON requests.

Rep. Glazier: Do you want a motion for the record?

Rep. Torbett: We can take it by consensus, or if you would like to formalize it in the form of a motion that would be fine either way.

Rep. Glazier: I move that we adopt the first recommendation that CON process no longer needs to and contain services of the air ambulance and solid organ transplant.

Rep. Alexander: I don't know how it's going to be written up or established, but it seems to me like those are similar, but they are different and so I just think that if you made it like separate, I mean when it is written, I would just like to make it a suggestion as making them separate, so it's very clear.

Rep. Torbett: Wishes of committee? Hearing no objections, Rep. Glazier since I got you to change your motion, would you like to separate that?

Rep. Glazier: I will do it in two separate motions. First motion is that the CON process no longer is needed for air ambulance services.

Rep. Torbett: Shawn has informed me that we will take it formally, but will of course bring the language back for adoption. We have a motion to have air ambulance stricken from CON process. All in favor say aye. Any opposition? Hearing none.

Rep. Glazier: Second motion that we remove solid organ transplant services from the CON statute as well.

Rep. Torbett: We have a motion on the floor. Any discussion? All in favor by the sound of aye. Any opposition? Hearing none. Next in your chart the diagnostic service center requirements under CON are difficult to enforce and rarely reported. I'm sure that this may have some more dialogue engage, but some options would be eliminate the diagnostic service centers from CON, increase the threshold amount, and eliminate clinical laboratories from definition. Comments from the committee:

Rep. Avila: Clarification, when we refer to these entities, exactly what are they?

Craig Smith: Diagnostic Center is defined in statute as a free standing facility program or provider including and not limited to physician's offices, clinical laboratories, radiology centers, and mobile diagnostic programs in which the total cost allowing medical diagnostic equipment over ten thousand dollars exceeds five hundred thousand dollars.

Rep. Avila: In the discussion there is the proposal to eliminate a clinical laboratory, what was the rationale for eliminating that versus a radiology unit or something of that type.

Rep. Torbett: Pretty much a cost driver. As we go through here you'll see that we have levels for application and in some opinions some of those levels need to be increased and I'm supposing the reason for this request, is that those are your less applicable needs to go through the CON process, so it would save both the process time as well as dollars for people applying those services.

Rep. Alexander: What would be an example?

Craig Smith: A clinical laboratory would be something like LAB CORP, which takes specimens collected at various physician's office and hospitals and processes these specimens. It's more of an industrial approach as opposed to the other services which are dealing one on one with the patient.

Rep. Avila: My concern is that when we start separating these things out, I know that hospitals have a lot of these, for instance, radiology departments and things of that nature and now we're just going to open it up and they can just pop up anywhere regardless of any evaluation of actual need in a community?

Craig Smith: That would be the result if it were eliminated totally, if the threshold were raised, they would still be subject to review, but with a higher threshold.

Rep. Boles: If you could elaborate on that, I think what I am hearing you say, they would still have to apply with the state and that you will still inspect them or some type of standards that they would still have to meet for the accuracy or be responsible for their reporting and equipment.

Rep. Torbett: If you will look down in your three bullet points, if you did the total elimination, then they would not have to apply. If you went with your second bullet point where we increase the threshold, then of course they would, but the dollars would be set at a higher level.

Rep. Boles: I don't have a problem with private enterprise and the threshold, I guess what I am asking that there would still be some type of oversight or some accountability, and I guess they still would apply with you.

Craig Smith: No sir. Unless one of these diagnostic centers is operated by another licensed facility such as a hospital in which it would be subject to the hospital standards. Diagnostic centers are not licensed by the State of North Carolina in that within the division of prevue, the division of health service regulation. Those that utilize radiation are regulated by the radiation protection section. Other services such as ultrasound and MRI scanners are not regulated by the radiation protection section. MRI scanners would still be subject to CON review because MRI scanners are listed in the statue specifically.

Jeff Horton: In clinical laboratories, if they were removed, our agency actually regulates clinical laboratories in terms of quality care and standards and we do that on behalf of the federal government. There would be regulatory oversight in terms of what they do in their performance and the tests they do and quality control measures in place. We're just talking about if they were removed from CON, that doesn't mean they just operate without any oversight. There would still be oversight from a quality of care perspective.

Rep. Alexander: So that includes the private facilities?

Jeff Horton: All laboratories in the state are covered under the clinical laboratory improvement amendments, which is a federal law. They have to have certificates and inspections by our agency.

Rep. Current: I received a letter of concern and I would like to have some of these experts speak to it for my own personal clarification. If a not for profit hospital is supposed to accept people whether they have any means of paying for their services or not, therefore, that hospital that has to treat than patient would use these diagnostic services to appropriately treat the patient. The concern that I've had raised to me is that if this were done, then a facility could come set up next door to the hospital and if the patients that showed up for their diagnostic services didn't have resources to pay, they would be rejected and sent to the hospital who would see them. This would, according to the people that contacted me, act adversely on the

diagnostic facilities of the hospital, in that they would end up primarily with the non-pay patients.

Craig Smith: Hospitals in the United States, if they are certified to participate in a Medicare program, they are covered under a law called the emergency medical treatment and labor act. Which means if you show up a hospital that is certified for Medicare, the hospital must screen you to see if you have an emergency medical condition and if you do, they must stabilize that condition? If you had a place that was not a hospital, such as a diagnostic center. The center could say we are not going to do any services for you here.

Rep. Current: The cost of healthcare is what we are all concerned about, we want quality healthcare at a cost that we can afford and it's pretty obvious that under the present scenario, the costs are increasing so that we are going to have a problem providing it. If we eliminate this CON of the diagnostic centers, what would end up in the cost of healthcare, as reflected, say in hospitals and so forth. Is there some way to get a grasp on that, and I think more importantly, the quality of care that ends up being delivered to the people.

Rep. Torbett: Rep. Current we are going to go on hold with your question, they have not been forgotten.

Rep. Avila: It's going to be obvious that what happens in a hospital, when they are losing money on diagnostic, they are going to have to up the price somewhere else in order not to go bankrupt. When you don't have a level playing field between one group and another group we've got to do some controlling and field leveling.

Rep. Glazier: I concur completely. The first option is not an option, it simply codifies cherry picking and I think that becomes a huge problem. I don't know enough about the second option and what the sort of variations of threshold options might be. I wonder if we could talk a little bit about that.

Rep. Boles: CONs are difficult to enforce and rarely reported. Does that mean that a lot of labs ask for permission to open?

Jeff Horton: A lot of little small labs would not be subject to the law, and again we regulate those. They have to have a CLIA certificate from us. We're all in the same division, we could call CON and say, did they get a CON for this big lab they just opened up and if they didn't, then the CON would stay stop it until you get a CON. The real problem comes with diagnostic centers, because we really don't have much regulatory oversight of those in terms of quality of care if they do just primarily imaging and some medical treatments. Those are the ones we don't know, there could be some out there that are operating that could be skirting the law and unless somebody in the community calls us up and says, I think this building exceeds the threshold for CON, we don't get many of those calls, we kind of figure there may be some out there, it's very difficult to regulate.

Rep. Hollo: How long has the $500,000 threshold been in effect and is there a recommendation to what it should be raised to.

Craig Smith: The threshold has been in place since March, 1993. Increasing cap to $1,000,000 would be reasonable.

Rep. Avila: Do we do any indexing to inflation, where they are evaluated on a regular basis or do we just have to statutorily look at them as legislature whenever somebody thinks about it and changes it.

Jeff Horton: For CON it is just set and there are not adjustments for inflationary increases.

Rep. Glazier: I wonder if staff could tell us, in other areas of the law, how we do indexing?

Amy Jo Johnson: There are other areas in the statute that discuss inflation.

Shawn Parker: There are statutory fees that are adjusted through the consumer price index.

Drexdal Pratt: In recent years we've seen the index drop and now it's rebounded, so that would add a bit of uncertainty.

Rep. Torbett: I understand those are annually under review, when the SHCC goes through their process.

Jeff Horton: It's under the prevue of the general assembly.

Rep. Glazier: I wonder if we could have any stakeholder's reaction to the suggestion of increasing the threshold.

Noah Huffstetler: The real problem here is the current definition of the way the threshold is calculated. If you are a physician's office, you might have $490,000 worth of major medical equipment as defined in the law that you have acquired over the last 20 years. You might buy a $12,000 microscope that would put you over the threshold to be a diagnostic and unwittingly you would therefore violate the law. There are numerous physician's offices around the state of North Carolina that have more than $500,000 in equipment that are in violation of the law right now and they don't know it. The way these things come to the attention of the government is when a member of the group gets dissatisfied or there is a disgruntled employee, they go and report the group to the CON section and say these people are violating the CON law. Change the way the threshold is calculated so that people can know they are subject to it or not and bring some clarity to it.

Rep. Glazier: How do bring clarity?

Rep. Avila: Any loosening of this, we may be adversely burdening hospitals. I'd like to hear from the hospitals if there is an issue with this or if they some suggestions.

Rep. Torbett: I would like to pull this for further review and bring it back at a later date.

Rep. Boles: Talking about clarity does depreciation or anything built in over time.

Drexdal Pratt: The depreciated value of the equipment is not accounted for; it's the purchase price of the equipment.

Rep. Torbett: For staff, let's look at the cumulative cost of articles in an office and calendar time for that cost.

Rep. Avila: Could I have staff explain what effect of what deadlines would change or not change?

Craig Smith: Facilities write us from time to time, for determination that their project is not subject to review. Some of those are complicated, they are very close to thresholds and we want to evaluate whether anything has been left out of the proposal, also there are times that competitors comments on the veracity and legitimacy of the request. Right now there is no requirement in the law that the facility makes this request. If the facility honestly believes that it is not subject to CON, it can proceed with the development of a project, however, some prefer to get assurances that they may proceed, administratively and they submit requests. It is an informal process, the only time it is formalized is if the facility has a proposal, it has a certified cost estimate that the proposal is under $2,000,000 and upon initiating the proposal, finds out that they made an honest mistake and in that case the law provides that they can be forgiven and not penalized for proceeding with that project, providing they notify the agency. Exemptions in the statute 131.184 on require prior written notice; they do not require response from the agency as long as they meet the requirements in the notice. We do give them a response, but the response is not required for them to proceed. Material compliance requests can be complicated, where a project is being amended in some fashion, can still be developed without filing an amended CON application and because depending on the detail and the complexity of their request, it can take almost as long as reviewing an application, except this is done in an informal rather than formal basis, without a filing fee, without validity of a public hearing, and without a formal set of findings being developed.

Rep. Avila: Asking for forgiveness rather than permission?

Craig Smith: That is not the case.

Rep. Avila: Since it is on here, I'm assuming it is a problem for somebody.

Rep. Torbett: We will put this on hold and find out where this originated and bring it up at our next discussion.

Rep. Glazier: Move that we adopt the recommendation that we direct the agency to accept or to require electronic forms and make appropriate modifications to the statute for electronic submission, I say that just to know if there is opposition to that, what it is?

Rep. Torbett: I agree, but I would like to see cost associated with implementation.

Rep. Avila: I would like to second that, with caveat that we look at cost.

Rep. Boles: When the hard copy is submitted now, it still has to be put on line for review?

Drexdal Pratt: The applications that we receive a voluminous. We have had much discussion about this and we are in the process of putting in a new electronic system that handles some of our processes. There is going to be cost associated with this, because there are so many attachments and you are getting into file size issues.

Rep. Boles: When they do make the application, do you put it on line?

Craig Smith: No it is not. It is made available for inspection. It would consume a lot of staff time for us to scan all the applications. There was a recent review in Wake County for nursing home beds. We received 16 applications. All the applications and attachments fill up two carts, stacked more than a foot high on both top and bottom layer.

Rep. Torbett: It is probably going to go on our list to look at refinement and reducing the amount of information needed.

Rep. Avila: You receive it in paper format. There are no electronic submission capabilities for your department?

Craig Smith: We have accepted an additional copy on CD of the application. We do need a paper copy to work with.

Drexdal Pratt: We are having discussions about that, because when you are talking about limiting the size of the fields if we do an online application, we would have to limit the characters that people could enter the data, and all sorts of things. This one is rather unique and will take some time to do if directed to do that.

Rep. Avila: Maybe we should defer to the department and let them finish their study. Streamlining applications might be something that we could look at.

Rep. Torbett: I concur and I just add that with an official recommendation from this committee addressing their advancements in this, specifying for directing it to the CON process for application, I think would be appropriate language coming from this committee. Even though

they are working on it, but in all specificity it says, you will look also at the CON submission process, which is also a great Segway in our second one on page 2.

Rep. Glazier: I agree with what the chairman and Rep. Avila are saying and understand the cost and time. By the same token, when the section is looking at moving this way, I think it would very helpful for us to have a recommendation in the report that indicates they ought to be talking as well to the applicants about what their needs are on the input side of this.

Rep. Torbett: Would it be the feeling of this committee that applications being submitted would be a recommendation?

Rep. Alexander: They have to have some in print, what are their needs.

Rep. Torbett: Mr. Pratt, was it in your scope in bringing some of this in electronic form, is that in your current list of to dos?

Drexdal Pratt: We have had discussions and we are in the process of having a system wide electronic processing program put together now.

Rep. Torbett: No time line has been determined, would be appropriate that we recommend a time line.

Drexdal Pratt: We have discussed posting our decision on line.

Rep. Glazier: What is the logistic or downside to posting the decision on the website?

Craig Smith: We have one person who is our web person and they do other jobs as well. Do we have the staff time and resources? I don't think we actually need statutory direction.

Rep. Glazier: Because I view a decision as a legal document that may be numbers of pages in your case, I've had to read long CON decisions, but still it is a typed document of decision, so not a hard document to transfer. How many on average, a month, decisions are issued?

Craig Smith: Last year we received 144 applications. On average it would be 12 decisions a month.

Rep. Glazer: I just think from a public point of view and transparency point of view, the one thing we ought to make sure is on the website is the final decision by the agency and to the extent that more resources are needed to assist in doing that, I would think that would be something we would want to do.

Rep. Avila: They are typing this up and it is a word document that you can convert into a PDF and download pretty quickly, I wouldn't think there is a significant additional necessary time fact that would be impacted.

Rep. Torbett: We would recommend that they require electronic submissions of applications, they require all application determine requests, requests for review, as well as agency decisions to be posted on the website.

Rep. Glazier: I was focusing only on the decision.

Rep. Torbett: Recommend that the final decision is posted on the website? No opposition. Recommendation that they would bring back costs associated with application requests be online?

Rep. Glazier: Recommend as to applications is to move with all deliberate speed to develop a system for being able to post online.

Rep. Avila: Some of these requests are complicated; would we have to be a little judicious in those as well?

Craig Smith: There are not as long as applications in most cases. A short application is close to 100 pages.

Rep. Torbett: I am going to pull this and hopefully by meeting in February can you give more specifics on going online and bring costs.

Rep. Avila: Could there be a consideration of having public comments to be posted as well.

Craig Smith: We post the comments that are submitted during the comment period to the website now.

Rep. Avila: I talking about letting people post to your website, comments, if they are unable to attend in person.

Craig Smith: We will have to look into logistics of that.

Drexdal Pratt: They have to send it in, we don't have the ability to have an online update by the individual, but we do take those comments, scan them, and put them on the web.

Craig Smith: The law specifies written comments are to be made within the first 30 days of the review period. Then it specifies the public hearing will be held 20 days after the comment period.

Craig Smith: We looked at the cost, we went to the federal department of labor statistics and looked at the cost of the increasing construction since 1993 and the cost of medical and hospital and one had gone up 71% higher, the other was 76% higher. We multiplied that out and took into consideration that if there were going to be a statutory change, the statutory

change might not take place for approximately 6 months, so we felt that doubling the cost of $2,000,000 to $4,000,000 was reasonable and on the next issue the $750,000, I believe we raised that the 1.5 million for major medical equipment. The expedited review we felt the threshold of $5,000,000 should be raised to at least $10,000,000 if not eliminated entirely. Replacement equipment threshold is now $2,000,000 and we had talked about raising that to $3,000,000, $5,000,000 or possibly eliminating it entirely.

Rep. Torbett: What impact do you think these changes would have on the department by reducing CON requests?

Craig Smith: There were 20 applications over the last three years solely based on cost, we looked at the fees that would have been foregone, that would have been about $70,000 or so a year. It would reduce the applications by about 7 a year.

Rep. Avila: Does this just affect the process or does this affect the people in terms of what kind of issues may be raised when the threshold changes.

Jeff Horton: Some of your larger hospitals, if you were to double it to 4 million, many times when they do a major renovation, they are going to be over the 4 million anyway, so I doubt if it really would affect them. Some of the smaller providers, the law was changed a couple of years ago to allow nursing homes, adult care homes, and intermediate care facilities of the mentally retarded to be exempt from this threshold if they are doing a replacement facility or renovation to improve the quality of life or quality of care for the resident, so it really wouldn't affect them. There could be some smaller providers that might be exempt. For the big providers, it probably would have little effect, for the medium size providers it probably would have an effect where they would not have to file a CON application. From our workload standpoint, we would see a little reduced revenue.

Rep. Avila: Are they restricted in what they can do if they do not exceed the threshold?

Jeff Horton: Depends on what they wanted to add. They would not be able to add beds, some major medical equipment they would not be able to add.

Rep. Torbett: When was the current threshold put in place?

Craig Smith: March 1993.

Rep. Glazier: I was curious since this recommendation is coming from the agency; is there any objection by any stakeholders?

Rep. Torbett: Any objection from any stakeholders here?

Rep. Glazier: I would make a motion to increase the monetary threshold for projects requiring a CON under 131.176 to 4 million dollars and make confirmatory changes to section 176.16 and section 131.184.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Rep. Torbett: Monetary threshold for expedited review, why does the department feel it could be eliminated?

Craig Smith: Expedited review as defined in the statute includes reviews which are non - competitive, reviews in which the public has not requested a public hearing, or reviews in which the agency has determined a public hearing is not in the public interest. The other threshold is monetary. The expedited review in addition to focusing on a quicker turn around also focuses on the ability of the department to work with the proponent of the project to modify the application in such a fashion that it could be approved. These tend to be non –controversial projects. The only down side would be if we get overwhelmed by requests then scheduling does become a bit more problematic because we can only extend the review if we need substantive information. For many projects, such as the one the gentleman from South Port spoke about, where it is over 10 million dollars and it is a renovation of a hospital. We have to hold a public hearing. If we were to raise the threshold, it would still be covered by the threshold, but it would allow us to work with somebody if there were insufficient documentation in one area. The other alternative is to deny the application, have the party appeal, and then work out a negotiated settlement, which takes more time and puts more burdens on the applicant.

Rep. Avila: When it talks about request for a public hearing is not received in a specific time frame, are expedited reviews published so that people know that they are out there to make a request for public hearing.

Craig Smith: All applications received, we publish legal notice.

Rep. Glazier: Any stakeholders can let us know if there is opposition and why?

Rep. Torbett: Anyone in the audience wishing to speak? No one.

Rep. Glazier: I move that we adopt the recommendation to eliminate the monetary threshold for expedited review and make conforming changes to 131.176 7BB and 131.181A12.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Craig Smith: Major Medical equipment threshold from $750,000 to 1.5 million.

Rep. Glazier: Any objection by stakeholders to raise the threshold?

Chip Baggett from NC Medical Society: We're paying close attention to your recommendations, but you are asking a lot of very fair questions, Rep. Glazier and we're not prepared to answer those questions today. Just because we are silent doesn't mean we don't want to come back and have a further conversation with you later on.

Rep. Avila: I would like to make the motion that we raise the monetary threshold to 1.5 million dollars and make conforming changes to 131.176 14O.

Rep. Torbett: Committee in favor? All in favor, no opposition.

Rep. Alexander: I believe I heard 3 or 5 threshold for replacement equipment?

Craig Smith: 3 million would be a 50% increase, somewhat less than inflation, but it would be double the cost of major medical equipment, that was the rationale. 5 million was to make it more open ended, given that the facility had already been operating the equipment for some time and in most cases demonstrated a need for it. We also discussed the possibility of eliminating the threshold altogether, I'm a little dubious on that because I am not sure if someone who has a 2 million dollar piece of equipment and they come out with a 15 million dollar piece of equipment that can do the same thing but with a little bit more, is it worth someone getting it without review.

Rep. Hollo: Technology is changing rapidly in the medical field. A machine you buy today could be obsolete two years from now. Since they had a CON for the original equipment and are using that type of equipment, why would you ask them to go back and get a CON for the same equipment just because they are replacing that piece of machinery? I would be more in favor of eliminating it.

Rep. Glazier: I would go with the 5 million. What is the definition in the statute of replacement?

Amy Jo Johnson: It is defined as equipment that costs less than 2 million dollars and it is purchased for the sole purpose of replacing comparable medical equipment currently in use, which will be sold or otherwise disposed of when replaced.

Rep. Glazier: Any objections by stakeholders to raise threshold?

Rep. Avila: Due to technology, the machine could be doing other things than what it was originally intended for. Opens an area of expansion potential.

Amy Jo Johnson: It just uses the word equipment.

Rep. Hollo: Technology changes continuously. Example of CT scanner, its measured on slices and how good of a picture they can get and that is constantly changing. I would like to put the Hospital Association on the spot and hear from them.

Hugh Tilson, NC Hospital Association: I would like to reserve the right to come back with further information after we have seen the specific things that you are talking about. Many CON regulated items occur in the State Medical Facilities Plan, and therefore, there is a need determined for those and there is a competitive process for which they would be awarded. Some aren't. So the only concern that pops into my mind about having a threshold is that if it is a CT scanner or something like that you get under the threshold right now and then come back later for an upgrade, then it is not necessarily potentially subject to the same degree of scrutiny that something like a linear accelerator would be under.

Rep. Glazier: Would you be willing to put this one on hold and get the comments back and make a decision at the February meeting?

Rep. Torbett: We will hold this back with the other ones. If you have additions or questions on upcoming meeting please forward to chairs or staff.

Rep. Avila: In terms of the COPA, it is different from the CON, currently there is a lot of flexibility for what can happen under the COPA, we're talking about making changes and modifying it, would we be prudent in saying ok let's not do anything going forward, until the recommendations are in place, because something may happen that goes beyond what we want to recommend and turning back the clock or moving backwards in action may be more difficult than we can handle.

Shawn Parker: The work you did today was giving direction on what recommendations you may make. In a House Select Committee their step one would be to identify recommendations that the committee is comfortable with and then make a recommendation to the body as a whole, so as far as step one, even today's action will require follow up action from this committee to actually approve a report to the general assembly, which can contain legislation or other recommendations that may not have direction, that are just recommendations to set what the intent of this committee was, so I think that would still be the case, if you have discussion in the next meeting on COPA in the similar manner as this, it does not bind this body or even this committee as to what actions it is going to take or recommend as a final product of your work and your direction.

Rep. Boles: When we meet next, with the COPA, I understand the Attorney General's Office has concerns, will that be addressed?

Rep. Torbett: I have not heard from them specifically, but by all means there concerns are brought forward.

Rep. Current: This information may be already available, but it seems I'm getting conflicting things from here to there, could you or staff get me a report that demonstrates, unequivocally, the states that have CON, their percentage increases in the cost of health care versus the states that do not support a CON and their increases or decreases in the cost of health care.

Shawn Parker: We have access to Kiser Family, there are state data reports, and unfortunately, sometime beyond the time frame they have had to collect the information may be from 2005, but there are other definitions when you measure health care costs, so we are limited as to what they have identified as far as in ratings. The more sources we seek, and then there is a possibility that there is some conflicting date, just as how it was measured and analyzed from the different sources.

Rep. Steen: One clarification. This committee does have subpoena power if we do need that, is that correct staff.

Shawn Parker: Yes, that is part of this committee's powers.

Rep. Steen: As far as the COPA, I think we would like to be fair to both medical facilities there in the western part of the state, the COPA is a very complex issue and I think we want to take it very diligently and look at all sides of this thing. One question that I think we are getting on the committee is what happens if the COPA goes away. What does that mean to Mission, what does that mean to Park Ridge and other facilities in the area? I think we should go slowly and have appropriate staff here with DHSR and maybe someone from the Attorney General's office. We will make sure we hear from both sides and all sides.

Rep. Boles: In getting back to the IT issues, if I'm correct there are 39 states that have CON, or 37, I don't think we are going to invent a new wheel about the IT issues. It would be interested to see if other states are more online.

The Committee adjourned at 12:00 p.m.

Representative John Torbett, Co-Chair Presiding

Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair

CON APPLICATION PROCESS & GENERAL PROCEDURES

Concern	Options	Changes required	Misc.
CON process is no longer needed for certain services: • Air Ambulance • Solid Organ Transplant	No longer require CON for air ambulances or solid organ transplant services.	• Remove air ambulance from CON statute. • Remove Solid Organ Transplant services from CON statute.	• *Med-Trans Corp. v. Benton,* 591 F.Supp.2d 812, (E.D.N.C., 2008) indicates that air ambulances are under the purview of the FAA, not state regulation. • CMS has tightened regulations for solid organ transplants: Medicare Conditions of Participation for organ transplant programs were established in 2007.
The diagnostic service center requirements under CON are difficult to enforce and rarely reported.	• Eliminate diagnostic service centers from CON requirements. • Increase the threshold amount. • Eliminate "clinical laboratories" from definition	• Delete all references to diagnostic service centers. • Make conforming changes to 131E-176(7a).	Currently a diagnostic service center must obtain a CON when the total cost of all medical diagnostic equipment utilized by the facility that cost $10,000 or more exceeds $500,000.
No statutory requirement deadline for letters of review, CON Exemption requests or Material Compliance Requests.	• Create a deadlines • Require fee for such determinations.	• Codify for letters of review and create deadline. • Add deadlines for other requests. • Add authorization for to charge fees for such requests.	• Letters of review are not currently statutorily required.

CON APPLICATION PROCESS & GENERAL PROCEDURES			
Concern	**Options**	**Changes required**	**Misc.**
Applications are required to be submitted in hard copy.	Allow for or require electronic submissions of applications.	• Direction to Agency to accept or to require electronic forms. • Make modifications to 131E-182(b) requiring or allowing for electronic submission.	Consider technological ability of current system.
More transparency is needed in the CON process.	Require all applications/determination requests/requests for review as well as Agency decisions to be posted on website.	• Direction to Agency to post all applications, determination requests, decisions, responses, etc. on their website. • Add statutory language to 131E-185 directing Agency to post this information on website. • Add statutory language indicating all information submitted to CON/DHSR is public information.	
Monetary threshold for projects requiring a CON under 131E-176 of 2 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(16) and 131E-184(e).	
Monetary threshold for expedited review of less than 5 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(7b)(b) and 131E-185(a1)(2).	
Monetary threshold for major medical equipment requiring a CON is too low at $750,000.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(14o).	
Monetary threshold for replacement equipment is too low at 2 million dollars.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(22a).	

APPEALS PROCESS			
Concern	**Options**	**Changes required**	**Misc.**
Appeals cause delays in provision of needed facilities and or services.	Eliminate stays. A CON issued by the State takes effect immediately upon issuance. Mississippi model: The filing of an appeal from a final order of the statutorily specified body or tribunal shall not stop the purchase of medical equipment or development or offering of institutional health services granted in a CON issued by the State.	Create new section declaring that no stay shall be granted upon a party's appeal from a final agency decision or order.	
Bond requirements are inadequate.	• Increase the threshold amount of required appeal bond. • Account for inflation. • Amount of bond in discretion of board or court, with requirement that any appeal of a final order in a CON proceeding requires the giving of a bond sufficient to secure the appellee against the loss of costs, fees, expenses and attorney's fees incurred in defense of the appeal, approved by the appellate court within five (5) days of the date of filing the appeal. • Require a separate bond for each petition filed.	Make conforming change to 131E-(a1) and 131E-(b1)(1).	

APPEALS PROCESS			
Concern	**Options**	**Changes required**	**Misc.**
Frivolous appeals cause unnecessary delays.	• Prevailing party gets costs and attorneys' fees. • Increase penalties for frivolous appeals. • Stricter enforcement of imposed penalties.	Make conforming change to 131E-188(a1).	
Too many parties have the ability to file an appeal.	Redefine and limit "affected person" and "aggrieved party" for purposes of standing to file an appeal.	Make conforming changes to 131E-188 and Chapter 150B.	Give only the applicant standing to appeal. Eliminate intervenors from the appeals process.
The appeals process is too lengthy.	• Appeal from a final order or decision of the Department in a CON denial case goes to a contested case hearing before OAH and from there, directly to the Supreme Court. • Time limits for appeals decisions. e.g., Georgia model: Certificate of Need Appeal Panel consists of independent hearing officers appointed by the Governor in order to review the Dept's initial decisions to grant or deny a Certificate of Need. The decision of the appeals panel hearing officer is final unless objection is filed with the Commissioner within 60 days. Commr reviews and can award attorneys' fees and expenses if determines appeal was made for purposes of delay or harassment. Commr's Decision final unless appealed to Superior Court. However, if the Court does not hear the case within one hundred and twenty (120) days of the date of docketing in the Superior Court, the decision of the Dept. shall be considered affirmed by operation of law unless a hearing originally scheduled to be heard within the 120 days has been continued to a date certain by order of the Court.	• Make conforming changes to 131E-187, 131E-188. • Make conforming changes to 7A-29(a)and (b).	

STATE HEALTH COORDINATING COUNCIL			
Concern	**Options**	**Changes required**	**Misc.**
State Ethics Act should apply to SHCC members.	Require Council to be subject to all or part of the Act.	Statutory change would be required. By current definition the SEC does not have the authority to subject SHCC to the Act.	Potential conflicts between current Executive Order and Chapter 138A exist.
Appointments should be made by legislature and Governor.	Divide membership appointments among Governor, Senate, and House of Representatives	Likely would need to codify SHCC and then in its establishment set appointing mechanism.	Consider role of Advisory Committees within the Executive Branch.
SHCC members may have an affiliation with or be employed by providers applying for CON.	Extend prohibition in 131E-191.1 to include persons employed or affiliated with XXXX.	Statutory change would be required.	Consider desired knowledge base of Advisory Committee.
Determinations of need made by the SHCC are "outcome determinative" with respect to any CON application.	Make need determinations presumptively correct and rebuttable by evidence of specific circumstances involved in a CON application.	Amend G.S. 131E-183(a)(1) to conform.	

STATE MEDICAL FACILITIES PLAN			
Concern	**Options**	**Changes required**	**Misc.**
Policies adopted in the SMFP are not considered rules under the APA.	• Include under the APA. • Direct that certain portions of APA apply. • Establish SHCC by law.	Statutory change would be required.	• Consider timing requirements under the APA. • Consider Rules Review Commission's impact on policy.
The SMFP contains exceptions.	• Recommend language from H743. • Eliminate/limit certain plan exemptions (AC-3). • Develop non-subjective criteria to qualify for exemptions.	Legislative direction.	
Current target occupancy tiers result in difficulties for small hospitals.	• Create occupancy tiers for hospitals with 100 beds or less and tiers for hospitals with greater than 100 beds	Legislative direction.	
No recognition for beds that play dual roles of observation/inpatient care that is more prevalent in small hospitals.	• Count the dual beds in the census count for hospitals with 100 beds or less. • Create a new system of classifying beds that accounts for dual purpose beds.	Legislative direction.	

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 01-19-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Kouba	CompassNC
BRIAN MOORE	MISSION HEALTH SYSTEM
Nelson Sherrill	" " "
Jimm Bunch	Park Ridge Health
GRAHAM FIELDS	PARK RIDGE HEALTH
Charlene Thomas	WNC Community Healthcare Initiative
Laurie Onorio	Jason Deans + Assoc.
Tina Shanahan	CompassNC
Joe Lanier	NELSON MULLINS
Dana Simpson	Smith Anderson
Richard Vinroot	Robinson Bradshaw + Hinson (representing Mission Health System)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 01-19-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	CSS
Michelle Brooks	Vidant Health (formerly University Health Systems)
David Barnes	PS
Chip Baggett	NCMS
Kristi Huff	NCHCFA
Sim Harrell	Harrell + Assoc
Marc Wilder	Novant
[illegible]	[illegible]
Andrew Lutz	PDA
Evelyn Hawthorne	EHER
Connie Wilson	NCSEPS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 01-19-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Vick	Duke U.
Catharine Cummer	Duke U.
David Meyer	Keystone Planning Group
Robbie Roberts	WakeMed
Jason Deans	Jason Deans & Assoc.
Kathleen Besson	CaroMont Health
Tracey Colvard	AHHC
Matt Wolfe	PPAB
David Miner	TRG
Kristen Laster	Fetzer Strategic
David Stone	The Carolinas Center for Hospice and End Care

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 01-19-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison Waller	NMRS
Noah Huffstetler	NMRS
[illegible]	TSS
DeDe Murphy	HPS
[illegible]	LINCH
MARC HEWITT	WILLIAMS MULLEN
JIM SWANN	FRESENIUS MEDICAL CARE
BILL HYLAND	DAVITA INC
Barbara Freedy	Novant Health Inc.
Tom West	Poyner Spruill LLP
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Freedy	Novant Health
Nancy Bres Martin	NBM HPA
Rob Lamme	RLA
Jim Roberts	CDI NanoBiotech, Durham
Bo Heath	MWC
JOEL MAYNARD	GPM & ASSOC

SPEAKER SIGN-IN SHEET 01-19-2012

Name	Affiliation	Written Copy of Comments ? (Yes or No)
Noah Huffstetler	NMRS	No
HUGH TILSON	NCHA	NO

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Viddia Torbett (Rep. Torbett)

From: NCGA Committee Notices <noreply@ncleg.net>
Sent: Monday, January 23, 2012 9:46 AM
Subject: <NCGA> House Select Committee on Certificate of Need Process and Related Hospital Issues Committee Meeting Notice for Wed, 02-15-2012 at 9:00 A.M.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Wednesday, February 15, 2012
TIME: 9:00 A.M.
LOCATION: 421 LOB
COMMENTS: PLEASE NOTE TIME AND ROOM CHANGE FROM PREVIOUS MEETINGS

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **9 AM** o'clock on **January 23, 2011**.

Principal Clerk
Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

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This message was sent to you by Viddia Torbett (Rep. Torbett) (torbettla@ncleg.net) because you signed up to receive NC General Assembly Committee Notices by email. To unsubscribe, visit http://www.ncleg.net/gascripts/Committees/Committees.asp?sAction=ViewDLForm&sActionDetails=House%20Standing

General Assembly of North Carolina

House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
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REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

AGENDA
9:00 AM, Wednesday, February 15, 2012
Room 421 LOB

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Committee Discussion

Review and consideration of items pertaining to Certificate of Public Advantage
Review and consideration of items pertaining to Certificate of Need law

Next meeting:
10:00 AM, Thursday, March 15, 2012, Room 544 LOB

MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Wednesday, February 15, 2012
9:00 A.M.
Room 421 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Wednesday, February 15, 2012 in Room 421 of the Legislative Office Building. Representatives Steen, Torbett, Avila, Boles, Brandon, Collins, Current, Hollo, and Randleman attended.

Representative Steen presided. Today we are going to have a quick review of some of the questions that were asked at the last meeting.

Members from the DHSR present were Drexdal Pratt, Craig Smith, Jeff Horton, Jesse Goodman, and Chris Taylor. Kip Sturgis from the Office of The Attorney General was present.

Representative Steen asked for approval of the minutes for Thursday, January 19, 2012. Minutes were unanimously accepted.

Shawn Parker, staff council, gave a presentation (see attached and on committee website) of the questions we indicated we would provide a follow up response to. He asked if Jeff Horton, Chief Operation Officer DHSR, wanted to add anything.

Jeff Horton: When the electronic database that is currently being developed for our agency is completed in 2013, we should be able to have more information.

Rep. Steen: We will now go on to the certificate of public advantage and have a briefing on this.

Shawn Parker, staff council: We were directed to cull the different recommendations that were presented. These are not intended to be vetted recommendations, so there are quite possibly are recommendations that were offered from the public, that are already existing in current law policy or practice. To the same extent, these were not intended to be your recommendations for consideration, more just topics so you can give us direction when you come back in the next month or so to take action on a committee report. It will help expedite the process, we will not be drafting legislation or working on backgrounds on things that this committee does not have interest in pursuing, so that is the intent of this. (See attached and on committee website). We did contact both larger stakeholders in this group to get clarifications on things they have presented.

Rep. Avila: Has there ever been an impartial third party study done?

Kip Sturgis: Last year we engaged an expert to give a recommendation, he came back with a report, and we made that a public process. Mission submitted its own expert report. We got a lot of public comment. It is not required by law to make that a public process but we did and we have an en depth report by a nationally known expert.

Rep. Avila: Where is that study?

Kip Sturgis: We will make it available.

Chris Taylor: Every year we have an independent CPA firm give the analysis of whether Mission's financial criteria, if they fall within the basket that is set forth in the COPA, we do annually, in addition to what Kip talked about, have an independent firm do that analysis.

Rep. Avila: Do you do any kind of performance reviews?

Drexdal Pratt: Mission is required to maintain certain certifications.

Rep. Collins: Is that designed to show whether the hospital is abiding by the terms of the COPA?

Kip Sturgis: That study was not an audit. It was an economic analysis of the competitive impact including review of the payers.

Rep. Torbett: As we go through this, I would remind committee that we have two meetings before May and that we need to starting buttoning things up and get the language prepared and get it to drafting.

Rep. Steen: We will now go through the topics for discussion. (See chart) What impact would this have?

Kip Sturgis: My understanding is that it would have no effect on Mission or Park Ridge; it would have an effect on Carolinas Healthcare Systems.

Rep. Torbett: Upon originally drafting HB 812, it listed the Hospital Authorities as a lone entity and that was not the intent. The language will probably be changed to remove any mention of public advantage. The only gest of that bill would be to remove the ten mile extra territorial jurisdiction, in the hopes this would provide better relationships between these entities and drive down litigation costs, which was the initial intent of this bill.

Shawn Parker, staff council: What this committee would want to do is to recommend concept and it would be a completely new bill draft under your current adjournment resolution would not be eligible, so whatever contents you want in it, it would be new legislation.

Rep. Avila: What type of review would there be?

Rep. Torbett: We'll get that bill to everyone and come back.

Rep. Boles: How many hospital authorities do we have?

Rep. Torbett: Five.

Rep. Avila: If they have all these abilities to engage, why are they suing each other so much?

Rep. Steen: Statutory change to ten year COPA.

Kip Sturgis: We don't have a position. Whether the COPA is terminated by ten year, at that point they are in position in having to deal with the feds in whether they are a monopoly. We are not for or against.

Rep. Steen: What happens to Mission if the COPA goes away?

Kip Sturgis: Mission acquired St. Joe's Hospital under the COPA as a means of giving it immunity from federal prosecution for forming a monopoly.

Rep. Torbett: If the COPA went away it would increase the probability of lawsuits against Mission Hospital.

Kip Sturgis: It would not have immunity, what the FTC or USDOJ would do about that, we don't know.

Rep. Steen: Do we want to take action?

Rep. Avila: We don't want to open them up to anything, if requirements or restrictions don't really apply.

Rep. Torbett: Could we ask the CEO of Mission to address this.

Ron Paulus: Our position on the COPA and its elimination really came down to how rapidly and how significantly healthcare, one only has to look at federal legislation, look at the trend and healthcare consolidation. At the time of the Copa's creation, there was only one hospital in all of Western North Carolina that was part of the system. Today there is only one hospital that is not part of the system. The competitive landscape has shifted dramatically and from our perspective, what we have requested was the option to formally terminate the COPA at such time as we believe that that was necessary and helpful to us to continue to provide and serve our mission. We're the safety net hospital for all of Western North Carolina, we have 75% plus of our patients either on Medicare/Medicaid or can't pay anything at all and it is not hard for me to envision recently likely circumstances where some of the activities we are currently constrained from and the amount of litigation that we are subjected to, the time and energy for

these kind of meetings and the distraction from the core mission of trying to improve care and make quality better and to make it more efficient. It wasn't clear to us as to what the mechanism is, should a time come when that is necessary to actually end. Our goal is not to say let's end it today, but to have a formal process where we can work with our state colleagues to unwind it at some point.

Shawn Parker, staff council: If you are the entity with a COPA, their council would be the ones to make a business decision on what might be their outcome.

Richard Vinroot: Rep. Avila, your point seemed to be that we shouldn't have an option out, because that would somehow endanger the protection that we've got. Our concern is that we've been in this thing now for 17 years. We've met every standard that has been applied to us. We're the third lowest cost hospital in this state. We're one of the 15 best service hospitals in the nation, recently so acclaimed. One of 5 in our class in the nation. We are now under this bureaucracy that the corner of Ron Paulus's office has millions of dollars of records and reports that have taken place over those 17 years and at some point this regulation needs to end. We may choose not to opt out, because of the risk that you are concerned about. It is fascinating to me that there are folks in this room that want us to stay under it for their purposes, not our purposes. What Ron said was the whole map has changed. Carolinas out of Charlotte is now in 7 locations in Western North Carolina, they are all over the place. There is competition from big hospitals out of Orlando Florida, the owner of this hospital has been picking at us for various issues. We're now in a different atmosphere. There is a day that is going to come when we say enough of this regulation, let us go out and take our chances in the marketplace like everyone else. We think that day may have come. All we are saying is give us the option. There are only 2 COPA agreements in the whole country, out of 50 states, 11 have laws and 2 have COPAs, one in Columbia, SC and one in Asheville, NC. We're not the only ones that are instep and the others are out of step. We think there out to be a provision like Montana, that lets us in some point in time say, let us out of this regulatory harassment.

Rep. Steen: If that is what this committee wanted to do, I still think there is that fear of what can happen out there from the federal standpoint.

Richard Vinroot: We have that fear worse than you do and we're not about to jump into that if we think it is something we shouldn't be doing.

Denise Gunter: I'm here this morning on behalf of Western North Carolina Community Healthcare, which is an organization of hospitals, healthcare providers and individuals from Western North Carolina with an interest in the certificate of public advantage. WNC CHI does not support termination of the COPA. I did see a draft proposal that Mission has circulated to Mr. Parker as to how they propose to terminate the COPA and we do not support that. This termination provision would require or simply allow Mission to terminate on 90 day's notice to DHSR. As I read the proposal, it did not even require Mission to notify DHSR in writing. They could simply call. There was not opportunity for DHSR to comment on that or for members of the public. I frankly don't understand why Mission would want to get out of the COPA. I have

been involved in the COPA process now along with Mr. Sturgis, their council for 17 years. I sat in the room in Asheville in August of 1995 listening to Mission and many of the other community participants talk about how badly they wanted this COPA and how badly they needed to merge with St. Joseph's Hospital. Mission has gotten everything that it wanted over the last 17 years under this COPA. They have been able to expand their footprint throughout Western North Carolina. Today they have a 90+% market share in Buncombe County. Their market share in outlying counties in Western North Carolina is in the 40's right now, if I got my numbers correct. It is growing every day. COPA has not prevented Mission from expanding or from being a very financially solid organization. I frankly don't understand why Mission would want to get out of it. The other thing that I noted in Mission's proposal for termination is that it wanted to keep the immunity that it receives, but it doesn't want the COPA. The two things do not go together. You cannot have freedom and regulation and get immunity. In response to what I heard Rep. Avila say, there is a report offered by PhD healthcare antitrust economist named Gregory Vistnes that was turned into the state around February 2011. That was an objective, unbiased review of the competition situation in Western North Carolina. Dr. Vistnes found that there are significant and serious problems and he recommended changes. When the third amended COPA was published in August of 2011, there was not record of Dr. Vistnes' report and why DHSR and the AG's office apparently dejected Dr. Vistnes' recommendations. I would suggest that if this committee is inclined to do anything, what it needs to do is first step, read the Vistnes report and then ask the question why didn't they follow this report and then after that if the committee deems it appropriate, I think what has to happen is reinvigoration of the active state supervision that is absolutely required under U.S. Supreme Court precedent in order for Mission to receive the antitrust immunity.

Rep. Avila: You referred to the constraint and to being sued.

Ron Paulus: There were a series of factual inaccuracies in the prior set of comments. Park Ridge and the Adventist system from Orlando, one of the larger health systems in the United States has for years been actively antagonistic towards Mission Health. They sued us numerous times and raise objections and concerns at each and every turn as it relates to reporting and requests for any changes. That is part of the landscape that we find ourselves in today. The constraints that we faced, to some extent, were modestly ambiguities, relates that transformation of care that I alluded to earlier. So if you look back to the time when the COPA was originally created, one of the constraints that were placed on Mission Health related to the employment of physicians. Primary care physicians were kept at 20%. At that time that was a cap like you can't spend a trillion dollars and now we overspend by a trillion dollars every year at the federal level. It didn't seem conceivable back then, but today it is. If you look nationally at physicians and whether they are employed or not, now I'm a physician, I'm not a big fan of physician employment. I really believe medicine an infection and it's a disappointment we all come as a calling, but at the end of the day that model is being transformed. It's not my choice, it's not their choice, it's the choice of the market around us and the question is how we can respond to those market changes. So the 20% cap on physician employment in primary care was something that was so out of step with the market, nationally, on average, it is approaching 70% of physicians that are employed. Those coming out of training are

overwhelmingly seeking employment and have no interest, for better or worse, in setting up their own practices. That is the kind of constraint I was referring to and the litigation has been a series of issues that relate to each and every possibility and as I was told directly by the leadership of the Adventist system that they would fund any amount of legal bills that Park Ridge desired.

Rep Avila: I'm assuming they are suing you under the possibility of issues regarding specifically to how you execute the conditioning with the COPA.

Ron Paulus: It's a mix. It's a generic set of suits. They are not specific to the COPA. It's CON, it's issues related to the concerns that they raised about our request that relaxed some of these constraints, it's the process that we are hearing today, which they haven't really originated, and so it's a constant form of harassment and it's not surprising, for example, that they have asked for a sort of competition free zone, a 10 mile radius around them to which there would be not activity, kind of like asking a running back, a defensive defender on a football field, can't actually get close enough to tackle someone, so it's a series of those issues, and unfortunately I think it describes both Park Ridge, and I can't speak for them, and us from getting about the business of transforming. It's got to be better quality; it's got to be more efficient. The fact that we were recognized as one of the top 15 health systems in America, based on mortality, complication rates, length of stay, 21% less chance of dying in our hospital. That's good, but it's not good enough. Because the people of Western North Carolina deserve to have the best there possibly can be and this is just, unfortunately, a distraction.

Rep. Avila: From somebody that doesn't live in Western North Carolina, does a hospital like Park Ridge that has slightly over a hundred beds? And you are in 90% of Buncombe and 40% in surrounding counties?

Ron Paulus: The 40% number is one of the inaccuracies in that statement. The 40% number would give blended market share, when you take the Buncombe County amounts, but when you look at the other counties, we're not typically in the 40% in those counties. Some of that is in part because some services, for example, we had 2 patients just this past week, an 85 year old and a 91 year old, who were able to receive new aortic valves without having surgery. What's referred to as the TAVI procedure, the catheter goes in through the groin and without having to open up the chest, the patients would otherwise live a completely challenged life, difficulty breathing, unable to move, they were able to receive new heart valves and go home in 3 days. We're the only organization that does that. So is it surprising we have a 100% market share of those patients? No it's not, so the market share numbers, while they are significant are inflated by the fact that it's not an equal amount of services and that reflects patient choice. When patient's drive from Henderson County, I see here today, someone who drove from Henderson County to bring his baby. So we know that people should be able to assert choice.

Rep. Avila: I understand you are doing something that nobody else is doing. What does the COPA have to do with that, limiting services that you are providing and you're the only one in

Western North Carolina, it's obvious. That's like people driving the DUKE, because there are only things that they do there. I don't understand why the COPA is so onerous that you need it.

Ron Paulus: So in part, I haven't been arguing, I'm not trying to argue that it has kept us from being successful to date. I think we have that success and I think the testament to that is in patient's exertion of choice in coming to seek services at Mission and I think it has been evidenced by numerous national and other rankings that place us in the upper decile in care nationally, but I referred to our testament, though I may not have done it well, was to say that the world is transforming and one could have argued 15 years ago, that record stores were very successful, but today digital downloads of music have transformed that model to where record stores no longer exist. That is why we are not saying end the COPA today, we're saying let's have a mechanism whereby we could end it if we face a circumstance that that would make our business plan a problem. The state in response to our request did grant some degrees of freedom on the position of relationships, so instead of 20%, that was increased to 30% and we appreciated that, it extended the 30% cap to a much broader swap of positions than just primary care, again, I would ask that relative to the national average, it's not that national averages are right, but that 30% threshold is far lower than what the normal market is. That's why we ask that over time, I can easily envision a circumstance where that might be in doubt.

Rep. Torbett: I believe I heard that there is an opt out for a 30 day notice?

Drexdal Pratt: That is in the proposed legislation.

Shawn Parker: I do have in the current record keeping that any party to a cooperative agreement who terminates an agreement shall file a notice of termination with the department within 30 days after the termination. So whether that must apply at the end of the 2 year agreement period, so perhaps it is unclear as to what the termination mechanism is.

Rep. Torbett: I would ask that we need to address that in a PED study, if there is a way to get into a process, there needs to be a way to get out of that process. It seems to me that doesn't exist with full clarity and that we address that in perhaps an evaluation.

Drexdal Pratt: Let me call your attention to a provision within the existing statute. Any person aggrieved by a decision to continue the COPA can file a petition saying, for instance, we don't want to continue, they can bring in a factual showing and through the record to show why they should be relieved of that. That is in the existing statute.

Rep. Torbett: Every 2 years there is an option in place for those entities to say we either want to stay in or get out, they have that option?

Drexdal Pratt: At a minimum, every 2 years. I'd have to look back at the statute to see is it's possible more often than that.

Rep. Steen: We're back on 812 now. What's the pleasure of the committee on HB 812?

Rep. Torbett: I'd like to address Rep. Avila's question. You were correct. The current language in 131E-20 provides may engage in healthcare activity outside boundary pursuant to and then lists 3 options and I defer to her question, is there some way we can get to the amount of litigation.

Rep. Avila: My question is, with the flexibility, why is everybody suing everybody?

Joe Lanier: We represent several hospitals who have spoken in support of this legislation. To answer your question, Rep. Avila, we believe that the key issue here is the extraterritorial jurisdiction, the 10 mile boundary extension, and that area, 10 miles outside of the county creating the authority, is where you will see most of the additional litigation. A hospital authority created inside counties that operate outside of that county as if they were in their own county. That was the issue that we were looking at.

Martha Ann McConnell: The only status if conflict in this state that is regulated by territorial jurisdiction, other than Asheville with the COPA and I'm not going to weigh in on that. Our hospital authorities, there are 4 or 5 of those in the state; Charlotte Mecklenburg Hospital Authority is one of those. If the attempt is to limit the amount of litigation, you would have to subject all hospitals to that limitation, because the only thing you are limiting is that litigation that involves hospital authorities, and really this language would regulate our ability to compete, so no other hospital in the state, other than hospital authorities are subject to the 3 regulations that you've got up there now that are going outside of the territorial boundary. Not public hospitals, not not-for-profit, and not for profits. So what you would be able to do then is the only limit the ability of a hospital authority to compete.

Rep. Steen: Is that the intent of the bill sponsor?

Rep. Torbett: That is not the intent of the bill sponsor.

Martha Ann McConnell: The hospitals that Mr. Lanier represents in Mecklenburg County, you are not limiting any competition, except for hospital authorities.

Rep. Torbett: When we are going out of the territorial jurisdiction, are all 3 of these being met?

Martha Ann McConnell: It's 1 of the three.

Joe Lanier: It is our understanding that 1 of those 3 does not have to be met in the extraterritorial jurisdiction granted by the statute. So what we are really talking about is we will compete. The hospitals that I represent and the hospitals that Martha Ann represent will compete, it is just a question of whether or not that that extra 10 mile extraterritorial jurisdiction, a public hospital authority can act as if it were in its own county.

Martha Ann McConnell: So we would not, under the proposed legislation, as I understand it to be revised, we wouldn't be able to go outside of Mecklenburg County.

Joe Lanier: Unless 1 of the 3 conditions was met. All this would do is change the territorial jurisdiction of the hospital authority.

Martha Ann McConnell: And then hospital authorities would be the only hospitals in the state that would be under that limitation.

Rep. Avila: Give me an illustration of what you sue over?

Craig Smith: The catalyst in this case was the incident in Gaston County, where Gaston Memorial Hospital proposed a satellite emergency department in Mount Holly and the same time Carolinas Medical Center proposed a satellite emergency department in Belmont, both are in the eastern part of Gaston County. This resulted in the pull of the Mount Holly proposal, the denial of the Belmont proposal and it was a contested case. The certificate has been issued to the Mount Holly facility. During the course of the initial appeal, Gaston filed a modified proposal that would address some perceived deficiencies in the original proposal. There was legislation enacted subsequent to the initial application, CMC appealed the 2nd Mount Holly proposal and that is still a contested case.

Rep. Avila: That opens up another issue that we aren't talking about today and that is one of the problems with our CON.

Rep. Boles: Do they have a facility today, is anybody being serviced.

Rep. Current: My understanding is that we won the certificate of need battle. Aren't they taking it to court?

Craig Smith: The competitive review that has been initiated in this issue and Gaston may proceed to develop the Mount Holly facility. It will take it some time to complete the facility, but it has the authority to proceed.

Rep. Current: It's more of a broader situation, when this thing first started in Mount Holly, I said what we'll end up doing is spending a lot of money on legal funds and probably end up with 2 emergency rooms, but we probably don't need either one of them. We all know it's about patients to try to come to your facility, which directly refers to money. And as I've said on many occasions, money is driving all the decisions in healthcare. It would seem to me that our job on this committee is to try and do that which is in the best interest of the quality of care of the people of North Carolina. If that involves doing away with CON and just opening the flood gates for competition at every level, so be it. That's where we need to go. In making that statement, it would seem to me that we need to determine where this group agrees with that group, where there is common ground on how we can best bring the highest quality and make it accessible to serving the needs of sick people and trying to keep them from getting sick.

Unless we are about that, we are playing games here trying to come down on one side so they can hire more doctors or whatever will bring more revenue to their system. What we've got in this country is a system out of control that nobody can afford if it continues to go up. We need to be looking for areas where we agree. In interest to the group that is opposed to doing away with this COPA, said they would prefer to see CON go away and my question to Mr. Vinroot would be do you support doing that?

Richard Vinroot: No, I don't think so. There are instances out there where you need to tell people there is room for 1 of these, not 2 of these in this geographical are. That doesn't have anything to do with what's going on with the COPA issue. What's going on with the COPA issue frankly is, a little bit like the old briar patch story. Please don't throw me in the briar patch, when in fact you really want to be in the briar patch. These folks want to keep the COPA for their own benefit. We'll run the risk of doing away with the COPA when we think we can afford to do away with the COPA. We don't need to be protected from what's happened in the past. We have been protected. We'd like to be out there to be free to compete and do the things we do in the way it's happening in the industry now, not restrained by some artificial articles on argument that was made 17 years ago about the position of whatever the issue may be.

Rep. Current: What I'm saying to you sir is what you and your hospital thinks is in their best interest may not necessarily be in the interest of the people of North Carolina and that's our job.

Richard Vinroot: I'm a believer in free enterprise and I believe that is what is great about America. A whole lot about what's going on in this COPA argument is anti-free enterprise. It's about please don't complete with us, please don't come into our territory, please draw a line around us. We ought to be about getting the best medical services to as many people as we can and not draw a line to keep those services away from those people. Interestingly enough, the Vistnes report was mentioned. It made no analysis about that we were meeting our responsibilities under the COPA rules. Another report by Dr. McCarthy came in and answered all those questions and said this hospital has consistently for 17 done all the things we were supposed to do. Are we going to regulate this system for another 17 years, because somebody doesn't want competition anywhere near them? That's wrong.

Barbara Riley: I thought I heard Dr. Current say that this group supports abolition of certificate of need and is not correct.

Rep. Torbett: I want to get with the friends that spoke on 812 and bring that back to committee at a later date.

Rep. Steen: I would ask that you get with Rep. Torbett and try to work this 812 out; I think there is some common ground we can get to. COPA modification oversight. Standard measures of empirical data direct the rule making, time other state resources. Rep. Torbett you pointed out the fact that we may could send this to a study through the PED program, would you like to speak on that?

Rep Torbett: Perhaps we need a fresh look at it.

Rep. Steen: Wishes of committee? We need to get communication at federal level to see what happens when we do come out of this COPA.

Rep. Avila: Has anybody from Mission talked with DOJ or spoke with federal in terms of how they review change?

Kip Sturgis: We work with the DOJ on a number of things; I have alerted their people this may be coming down the pipe.

Rep. Steen: The annual or semi-annual review of changes to public review. Wishes of the committee?

Rep. Torbett: I believe the intent of this was to have an unbiased independent agency do an audit every year. Ron, does Mission provide its own audit to DHSR or do they do an independent audit?

Craig Smith: They provide a report to us. They prepare the periodic report. That's not subject to the separate independent audit as is done on financial material.

Rep. Torbett: Every 2 years there is an independent financial audit taken and the collection of that data are not brought to you by Mission?

Craig Smith: There are 2 reports. The periodic report is done every 2 years and Mission prepares and we sit down and have discussion. Every year Dixon-Hughes, an independent CPA firm does annual work for us based on a basket of hospitals which we have selected that are hospitals we have determined to be similar to Mission. They get financial information from their audits and their cost reports and determine if Mission is falling within the parameters of the financial criteria in the COPA. Dixon-Hughes does that for the department. We selected them. Mission pays for it. It is done at our direction and under our control and while I do have the floor, the item about an additional audit, if it is the desire of this committee to have that done, I would suggest that it would be more efficient to employ Dixon-Hughes to do that work. They do financial and operational audits for more hospitals than any other.

Rep. Torbett: So if they did 1 audit, you are suggesting they do the 2nd audit too?

Craig Smith: Yes.

Rep. Torbett: What would they be auditing the 2nd time?

Craig Smith: They would be auditing the criteria such as the percentage of physicians that are employed. There seems to be a question.

Rep. Torbett: Currently that information is brought to you every 2 years by Mission. So they would audit the non-financial data?

Craig Smith: They would do a compliance audit.

Rep. Avila: Has there ever been an independent audit?

Craig Smith: There has not been a separate independent compliance audit. That information is provided to us by Mission and we have had no reason to doubt that they were providing us correct information.

Rep. Torbett: Would that reduce the paperwork they have to go through every 2 years?

Ann Young: We do file a report on an annual basis. One year is called an annual report and the next year it is called a periodic report, but the content is essentially the same and on an annual basis, Dixon-Hughes provides the audit of compliance with the various financial parameters of the COPA.

Richard Vinroot: Will the 2nd audit cost more money? You are dern right and the question ought to be who ought to pay for that? I don't suggest the state does it; I don't suggest we do it. If somebody else wants to come in and do a separate audit, fine, have at it, but you pay for it, don't ask us to keep paying millions of dollars for all of this.

Rep. Torbett: My concern was that it maybe helps you cost less for the paperwork that you currently do. If you are performing that audit internally now, that has to come at some kind of cost and if you didn't need to do that audit because someone was doing that audit.

Richard Vinroot: We are required to under the current COPA. That is why we are doing it.

Rep. Boles: The audit that is required is both financial and compliance?

Jeff Horton: The statute doesn't use the word audit; the statute uses the work review. The work that is done by Dixon-Hughes for us we consider it's actually an agreed upon procedure from what we have said, we want you to look at A, B, C, and D.

Rep. Boles: They are only reporting one, based on an audit that they pay for and does it have both the financial and compliance component? Are both required by the general statute?

Jeff Horton: We made the decision to have an independent firm do the work as to whether or not they met the criteria, because we do not have the resources to do it ourselves and that was something which was agreed on by Mission in working to expedite the process.

Rep. Boles: But the 2nd component, the compliance, is it statutory that it be audited?

Jeff Horton: No, it says that you will review it.

Rep. Steen: Please of committee?

Rep. Avila: Considering there is so much at stake, in terms of government transparency and what's going on and all this other stuff, a financial audit says you are not embezzling money and you are spending it the right way. It doesn't say whether you are spending it on the right things and how it is being done. I think that with COPA, that is one of the issues we've got to determine in what they are doing and how they are doing it. I don't think we can recommend because we don't know enough in terms of is it, has it worked the way it is, can you modify it, is it archaic?

Rep. Steen: So would you like to see a more in depth or annual report or every 2 years?

Rep. Avila: I've questioned a lot of people out there about what's been done the last 17 years and I think get it cleared up, so with this transformation of medical care taking place, and then we can use under this direction or is there something different that we need to pursue.

Rep. Steen: Is this a consensus? Is there anybody opposed to this?

Rep. Avila: We need a more in depth financial audit. Also a PED study about what a COPA is in the state of North Carolina.

Rep. Steen: So we'll send this to PED if this is something we can do as a study committee. COPA modification activities, it mentions a moratorium on projects, the committee action would be non-codified and there may be some constitutional limits on this. Does anyone want to see us go forward with that? Shawn, you may want to discuss that.

Shawn Parker: This committee probably could not direct the PED study; we could recommend legislation to direct the PED study. As Rep. Avila brought up at the end of the last meeting. I just would very broadly speak to concerns that anytime you have government taking a retroactive impairment of a current contract. By all bounds of the constitution, when you are directing actions towards a contract that would already be in place, the general assembly as enacted moratoriums on activities, in that same sense, I would advise as your council, that you leave that moratorium to a broad class, you would not want to individualize a moratorium directed at a specific entity.

Rep. Steen: I don't see anyone saying we need to go in that direction. Restrictions on activity for COPA recipients.

Shawn Parker: The proponents of that measure, they can go into a little more detail on what specific activity restrictions. Again with the earlier round, if it would broadly apply to any party to a COPA, you would have more leeway than trying to assert that to a current COPA, with the

exception, just on the reporting process, there could be direction as part of the department's purview on what this general assembly would believe as appropriate. For those who brought this up, if they could say which activities or what type of restrictions, I think they would be better suited to speak.

Rep. Avila: Are there things that can take place, that at some point in time, we do things that some of the issues get settled, that something can be done that we can't undo and it totally defeat the purpose.

Rep. Steen: We do not want to do any damage to anyone.

Graham Fields: What you are seeing is acceleration on the part of the only entity in North Carolina operating under a COPA. I think there is a recognition and understanding this committee is getting to the bottom of some of their activities and as this information begins to come out, it is clear that there is an acceleration on their part with aggressive projects and projects that probably wouldn't get any new standards with this discussion, so I believe that that is the effort to sort of footlight them, that just as you said, these projects will be done, they will have all the agreements and essentially by the time anything comes out and we find out, it will be too late for those types of projects and the big thing is, the patients will be effected. My question to you would be if there is a way; at least until the study is complete, to just pause things.

Richard Vinroot: This is strike 3. These folks don't like a joint venture project between the party of the largest hospital in Henderson County and our hospital on the county line. So they asked these folks 2 years ago to stop that project. They said there is no basis for that. They then had a representative, who incidentally is a member of the Adventist Church in the Senate, to submit a bill that would have stopped the project. The bill went nowhere. Now this is the 3rd effort. We want you in this process to somehow stop that project. This is not about free enterprise, this is about stopping competition between another 2 hospitals creating an inpatient facility, beg your pardon, just the reverse, an outpatient facility that they think is too close to their facility. That's what this is. An extra effort to try to get your committee to get into the CON process.

Rep. Avila: Under the circumstances, if Mission is doing what they are supposed to be doing and in the interest of medicine and everything and there is no problem at pausing to getting all the truth on the table. If your provision is what it is it would prove out one way or the other? You've got nothing to lose.

Rep. Steen: Any projects that are being done are these projects that would be happening anyway, if they weren't under the COPA in your opinion.

Graham Fields: I believe that they are only possible because of the protection afforded to market position under that, they are only possible. Just as a point, they are not finished, there's

no building, there's nothing there and frankly the CON itself for the first part of that project was denied by the state.

Rep. Avila: Goes back to Shawn in the terms of what we legally can do.

Rep. Boles: As far as the moratorium, this process still has to go before a CON committee?

Craig Smith: The project is a medical office building and does not have to go before CON. If there are other proponents to go into this building that fall under CON, they would have to submitted and reviewed.

Shawn Parker: I would fall back to my general interprets on concerns, it will be fact specific, you are speaking to this one individual circumstance and that is how the committee requests the draft. I could do a better analysis based on how much of a restriction or what type of moratorium to do, that's the type of direction I would need. But in general, I would caution just the concern of when you speak to doing a moratorium or restriction on activity.

Rep. Avila: You said that there is some operation in this particular facility, are there any that would not require a CON based on any benefits. That there would be a way to get the footing for this?

Craig Smith: They are working on a medical office building. Unless the project is subject to a CON law such as an endoscopy, they have discussed with us a satellite emergency department, anything of that nature, which would require a CON.

Chris Taylor: The facility that Mission is proposing, that is not part of the COPA.

Ron Paulus: I just want to emphasize a couple of points that I think that have been distorted. This building project, literally, has nothing in any way, shape, or form to do with COPA. Except that in the extent that those representing the Adventist and Park Ridge would like to bundle that somehow to confuse the issue and distract from what the actual activities are. I can think of no reason that makes any sense, whatsoever, that whatever this committee chooses or not chooses to do in its wisdom, auditing or what have you in respect to that, why it would relate to anything completely and independent and separate from the COPA and specifically to which there is not CON requirements of any kind. That to me is just part of the whole interesting phenomenon that we have. The second thing is on the proposal to doing an extra audit. Just to be clear, it's not as if, we have reported every year for 17 years and it has always been audited from an outside entity, Dixon-Hughes, supervised and selected by the state, paid for by us, we've paid for a lot of those things and the whole purpose of the COPA was to try to create protection and ensure that the merger would not create anti-competitive pricing. That's what those audits are all about. The other components, in terms of conformance with the percentage of physicians employed, etc., etc., those were additional compliance restrictions and we've provided the information and can attest to that as well. I just want to make sure the committee understands, it's not like we haven't been audited or reviewed over the course of 17

years, in fact, we have been audited and reviewed every single year by an independent separate certified public accountant firm that does the most of those audits in any such firm in all of North Carolina.

Graham Fields: This project is estimated from 80 to 130,000 square feet. We've heard a variety from outpatient surgery to ER, so forth, for a medical office building 4 miles from a hospital in a community of about 6,500 people. So I guess the question is, is this project is in the spirit of the COPA. It's interesting in the Vistnes report that monopolies are mentioned. It is amazing that that report is not implementing, discussed, and even talked about.

Rep. Torbett: I want to ask when a COPA is developed and you are working on the guidelines, does it dictate that it has to be within a geographical or territorial boundary or can it be described as the entity with no boundaries?

Kip Sturgis: I think the law allows for both possibilities, typically yielding to the reality of the situation, county lines don't define the geographic area in which a business operates, whether it's a car dealership or whatever, they are going to draw people from all over. So I think to say within this particular geographic area you should or shouldn't do whatever, I think that is artificial at this time.

Rep. Torbett: COPA is based more on the entity acquiring the COPA than any territorial lines?

Kip Sturgis: I think that's the way an economist would view a competitor's position in the marketplace, you look at their own geographic market area, however, and that is defined. It's not specifically being city lines or county lines; it's going to be where they draw their customers from.

Dr. T.J. Pulliam: I am the lone G.I. doctor for Wilkes County, currently serving as the vice-chair of the SHCC and personally I absolutely appreciate the time, energy, and efforts that all of you are putting into this process. We have to continue to look and relook at we are doing here in North Carolina when it comes down to healthcare. We are a state that is resource rich in healthcare. Rep. Current is absolutely right, there is a lot of money out there and a lot of what comes before the SHCC, we are trying to make sense of how to distribute healthcare around the state with an eye on quality, access, and value. As far as this whole COPA thing, I didn't know much about it and I've come here to try to understand about it and I think the more I've learned, the less I really know. The one thing that I would suggest is "first do no harm". I appreciate the folks that have tried to bring the discussion back around to the patient's concern, because ultimately that is what this is all about. That's why I drive to Raleigh several times a year; the thing that I think is relevant today is that Mission is able to keep their doors open serving 75% of patients with government payers. I want to know how you are doing that, because as we move ahead in healthcare reform, every hospital in the state is going to be overwhelmed with government payer patients. The best news is this: all of you doing this important work, all of those who sit at the table of the state health coordinating council, are all well intentioned people.

Rep. Collins: What is the recommendation to authorizing the COPA recipient to terminate the agreement 10 years after?

Rep. Steen: We are going to put into PED study or study further.

Rep. Current: All of that was cleared up in Mount Holly?

Jeff Horton: They are building that. No one has filed a CON to develop a second satellite ED.

Rep. Steen: We do have the Vistnes report and the McCarthy report. They will make that available electronically to all the committee members. The COPA is a very complex issue as our folks on the committee can attest. The more we learn the more confused we do get. We do not want to do any harm, so doctor I appreciate you bringing that up. Did the COPA give one side too much advantage or has it restricted them as it's progressed to today's time. We are trying to get to the bottom of and we are trying to do it objectively and we are in the middle and we appreciate all the comments we heard today. Our biggest concern is if COPA goes away, what will the feds do? As we send this to PED, we'll have some other follow up later on COPA. Rep. Steen adjourned the meeting at 11:45 a.m.

Fred F. Steen II

Representative Fred Steen, presiding chair

Viddia Torbett

Viddia Torbett, committee clerk

John J. Torbett

Representative John Torbett, co-chair

Repurpose COPA

Recommendation	Committee Action	Considerations
• Support House Bill 812- Hospital Authority Territorial Jurisdiction	- Statutory change to 131E-20 - Possible changes to Article 9A	Purpose and scope of Article 9A of Chapter 131E Eligibility per Adjournment Resolution

Statutory Mechanism to Terminate COPA agreements

Recommendation	Committee Action	Considerations
• Authorize COPA recipient by statute to terminate agreement ten years after a period of time in compliance	-Statutory change	Necessity- voluntary agreement Length of time v. Scope of activity Deemed compliant v. at the option applicability

COPA Modification –Oversight

Recommendation	Committee Action	Considerations
• Standard measures of empirical data • Direct a study through Program Evaluation Division NCGA • Additional audit by Office of State Auditor • Annual or semi-annual review • Changes to public review- DHSR publish response to comments	- Direct through rule making - Direct Program Evaluation to complete Study - Direction/Statutory change - Statutory change - Statutory change	Time and other State resources

COPA Modification –Activity

Recommendation	Committee Action	Considerations
• Moratorium on projects • Restriction on activity for COPA recipients • Specify territorial limitations of protections	- Non-codified - Statutory change/Direction to modify - Direction to modify	Constitutional limits Applicability

Follow-up Questions from the Previous CON Meeting

Question 1: How many States allow for online submission of Certificate of Need (CON) applications?

Currently there are two states that accept CON applications online: Michigan and New York.

Michigan	**http://www.michigan.gov/con**
New York	**http://www.health.state.ny.us/nysdoh/cons/index.htm**

More information can be found on NCSL's website: http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx.

Question 2: What can North Carolina do to make our CON website more user-friendly?

In response to inquiries from the House Select Committee on CON, Jeff Horton, Chief Operating Officer, Division of Health Service Regulation (DHSR), provided the following information. DHSR has updated its website to include more CON information (http://www.ncdhhs.gov/dhsr/coneed/index.html). The changes are as follows:

Two new web pages that contain information we believe the public will find useful:

- Decisions and Findings: http://www.ncdhhs.gov/dhsr/coneed/decisions/index.html
- No Reviews and Exemptions: http://www.ncdhhs.gov/dhsr/coneed/reviews/index.html

There are also two web pages that have been revised for easier navigation and use:

- Overview of CON: http://www.ncdhhs.gov/dhsr/coneed/overview.html
- Staff: http://www.ncdhhs.gov/dhsr/coneed/staff.html

Question 3: What is the cost of health care in states with CON programs compared to states without current CON programs?

Research Division Staff have compiled a chart showing the health care expenditures* per capita for all 50 states in five year increments from 1994-2009 (see Attachment I). The chart ranks all 50 states by year from most expensive to least expensive. States that do not have CON programs currently are shaded in gray. The expenditure information was provided by:

Centers for Medicare & Medicaid Services (2011). Health Expenditures by State of Residence. Retrieved (December 2011) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.

*Health Care Expenditures measure spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence. Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total. For more information on definitions, sources, and methods, please see http://www.cms.gov/NationalHealthExpendData/downloads/dsm-09.pdf.

Health Care Expenditures per Capita

(States without CON programs are shaded in gray)

State	2009	State	2004	State	1999	State	1994
District of Columbia	$10,349	DC	$8,296	DC	$6,429	DC	$5,546
Massachusetts	$9,278	MA	$6,988	CT	$4,908	MA	$3,963
Alaska	$9,128	CT	$6,824	MA	$4,865	NY	$3,838
Connecticut	$8,654	NY	$6,709	NY	$4,860	CT	$3,835
Maine	$8,521	DE	$6,611	DE	$4,606	NJ	$3,591
Delaware	$8,480	ME	$6,590	RI	$4,469	DE	$3,503
New York	$8,341	AK	$6,528	PA	$4,429	PA	$3,495
Rhode Island	$8,309	RI	$6,487	NJ	$4,400	FL	$3,465
New Hampshire	$7,839	VT	$6,237	ME	$4,375	RI	$3,430
North Dakota	$7,749	PA	$6,148	WV	$4,227	MD	$3,292
Pennsylvania	$7,730	WV	$6,055	FL	$4,188	WV	$3,243
West Virginia	$7,667	NJ	$6,054	ND	$4,184	IL	$3,200
Vermont	$7,635	ND	$5,956	AK	$4,176	LA	$3,196
New Jersey	$7,583	MN	$5,930	MN	$4,143	OH	$3,168
Maryland	$7,492	OH	$5,766	NH	$4,037	HI	$3,165
Minnesota	$7,409	WI	$5,752	WI	$4,026	ND	$3,162
Wisconsin	$7,233	MD	$5,737	MD	$3,993	MN	$3,146
Florida	$7,156	NH	$5,722	IA	$3,991	US	$3,128
Ohio	$7,076	FL	$5,709	SD	$3,973	MI	$3,092
South Dakota	$7,056	NE	$5,602	OH	$3,972	TN	$3,080
Nebraska	$7,048	TN	$5,499	VT	$3,960	MO	$3,079
Wyoming	$7,040	SD	$5,457	IL	$3,940	KS	$3,034
Missouri	$6,967	IA	$5,445	KS	$3,915	WI	$3,020
Iowa	$6,921	MO	$5,437	US	$3,902	AL	$3,019
Hawaii	$6,856	KS	$5,420	MO	$3,901	CA	$3,008
United States	$6,815	US	$5,411	LA	$3,900	IN	$3,005
Louisiana	$6,795	IN	$5,401	TN	$3,868	IA	$2,996
Washington	$6,782	KY	$5,392	KY	$3,851	ME	$2,972
Kansas	$6,782	IL	$5,323	MI	$3,839	GA	$2,945
Illinois	$6,756	WY	$5,316	NE	$3,813	AK	$2,899
Indiana	$6,666	LA	$5,309	HI	$3,803	NH	$2,897
New Mexico	$6,651	AL	$5,272	IN	$3,790	WA	$2,874
Montana	$6,640	NC	$5,260	AL	$3,741	SD	$2,870
Michigan	$6,618	SC	$5,197	WA	$3,691	NE	$2,842
Kentucky	$6,596	MI	$5,138	SC	$3,676	KY	$2,813
Oregon	$6,580	WA	$5,125	NC	$3,669	OK	$2,802
Mississippi	$6,571	HI	$5,122	WY	$3,630	NC	$2,795
Oklahoma	$6,532	MS	$5,110	MT	$3,608	VT	$2,793
North Carolina	$6,444	MT	$5,085	OR	$3,578	SC	$2,777
Tennessee	$6,411	OR	$5,059	OK	$3,569	CO	$2,777
South Carolina	$6,323	OK	$4,970	AR	$3,567	NV	$2,775
Virginia	$6,286	AR	$4,892	TX	$3,512	TX	$2,749
Alabama	$6,272	VA	$4,891	GA	$3,510	AR	$2,735
California	$6,238	NM	$4,843	CO	$3,487	AZ	$2,695
Arkansas	$6,167	CO	$4,837	CA	$3,486	VA	$2,694
Colorado	$5,994	CA	$4,777	MS	$3,483	OR	$2,692
Texas	$5,924	NV	$4,759	VA	$3,426	MT	$2,660
Nevada	$5,735	GA	$4,714	NM	$3,381	MS	$2,657
Idaho	$5,658	TX	$4,675	NV	$3,273	WY	$2,626
Georgia	$5,467	ID	$4,485	ID	$3,183	NM	$2,601
Arizona	$5,434	AZ	$4,304	AZ	$3,131	ID	$2,420
Utah	$5,031	UT	$4,087	UT	$2,794	UT	$2,231

Robinson
Bradshaw

Everett J. Bowman
Charlotte Office
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704.373.3929 Direct Fax
ebowman@rbh.com
rbh.com

January 11, 2012

Email - shawn.parker@ncleg.net

Mr. Shawn Parker
Counsel to the North Carolina General Assembly
North Carolina General Assembly
Suite 545
300 North Salisbury Street
Raleigh, NC 27603

Re: COPA Study Committee

Dear Shawn:

On behalf of our firm's client Mission Health System, Inc. ("Mission"), we are pleased to respond to your request that Mission identify any legislative action that it would recommend the Committee consider with regard to the Certificate of Public Advantage ("COPA") statute (the Hospital Cooperation Act).

We preface this recommendation by observing that the evidence presented at the meetings and hearings of the Committee demonstrate that Mission has fully complied with the COPA that has been in place since 1995. As the State regulatory agencies have repeatedly confirmed, Mission has achieved all of the benefits or advantages that the original COPA envisioned: Mission has operated as a low-cost hospital, and has enhanced the quality of and access to healthcare in Buncombe County and the surrounding areas of Western North Carolina. Mission has the third lowest charges in NC, despite the fact that more than 75% of its patients are covered by Medicare or Medicaid or are residents of relatively poor rural areas who are simply unable to pay. No other large hospital in the State has such a financially disadvantageous patient mix, which Mission serves without any financial support from governmental entities.

Since the COPA was issued in 1995, Western North Carolina has become significantly more competitive, as additional tertiary care hospital systems have entered the market. Charlotte-based Carolinas Healthcare System now manages and controls Haywood County's largest hospital (Haywood Regional Medical Center, in Waynesville) and two other WNC hospitals. Carolinas has $6.5 billion in net revenues and employs 1,712 physicians. UNC Health Care System ($1.86 billion in net revenues, employing 1,485 physicians) has contracted to manage and control the largest hospital in Henderson

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County (Pardee Hospital in Hendersonville). Park Ridge Hospital in Hendersonville is part of the Adventist Health system, which has $6.7 billion in net revenues and employs 1,053 physicians. For your convenience, we are attaching a fuller treatment of these subjects from our September 1, 2010 letter to the State Regulators, Messrs. Sturgis and Taylor [Attachment 2], and the Memorandum dated September 14, 2011 that we provided to the Committee [Attachment 3] at its first meeting.

Mission's success in competing under these conditions provides no justification for making the COPA more burdensome or restrictive, as Mission's competitor Park Ridge has requested. Mission should not be penalized, as it would be under the further COPA restrictions that Park Ridge previously has unsuccessfully proposed to the NC DHHS and NC DOJ, for Mission's success in delivering high quality, cost-effective care, or for growing, innovating, and attracting patients and payers. To the contrary, while the COPA regulatory regime has been appropriate and useful, its administration imposes costs on both Mission and the State. As competition in Western North Carolina increases, the need for the COPA diminishes—but the costs of regulation only increase. Eventually, the costs of regulation come to outweigh the benefits. Accordingly, some type of termination provision is appropriate.

The State of Montana addressed the same problem not long ago: A 1996 COPA governed the merger of Great Falls' Montana Deaconess Medical Center and Columbus Hospital. In 2007, the Montana Legislature amended its COPA statute to provide that a certificate of public advantage is to terminate 10 years from the date on which it was issued, although the reporting requirement would continue for another two years. As the Montana Department of Justice website explains, "These amendments were applied retroactively to the Great Falls Hospital merger, thereby terminating the 1996 COPA on July 9, 2006."

We agree with Montana's determination that ten years is a reasonable estimate of the length of time within which the costs of a COPA regulatory regime begin to outweigh its benefits. Recognizing, however, that circumstances may be different and that a COPA may be useful for a longer period of time, our request is that a COPA recipient have the *option* to terminate it no sooner than ten years after it is awarded (rather than an automatic termination following ten years, as the Montana amendment provides). We have drafted the attached proposed amendment to the COPA statute [Attachment 1] accordingly.

Both we and Mission appreciate the thoughtful and constructive consideration the Committee has given and continues to give to this matter.

Sincerely,

ROBINSON BRADSHAW & HINSON, P.A.

Everett J. Bowman

EJB:rhk

cc: Mr. Kip D. Sturgis ksturgis@ncdoj.com
Mr. Christopher B. Taylor chris.taylor@ncmail.net

Attachments:

1 – Proposed amendment
2 – Letter dated September 1, 2010
3 – Memorandum dated September 14, 2011

The WNC Community Healthcare Initiative would first like to thank the committee and staff for the time, effort and expertise they have devoted to this issue. We are truly grateful for the opportunity to be part of this process.

Acknowledging that Mission Health System's COPA must continue to legally exist, the WNC Community Healthcare Initiative, a consortium of concerned physicians and healthcare providers in the region, respectfully makes the following recommendations to the House Select Committee:

1.) **Pause:** Prohibit Mission Health System's current and proposed predatory projects against existing healthcare providers, for example, the "county-line" project, a proposed 130,000 sq. ft "mini-hospital" in Fletcher, four miles from Park Ridge Health.

   Legislation should effectively limit any entity that operates under a COPA or an entity owned or managed by an entity that operates under a COPA from constructing, developing, operating or otherwise owning interest in any outpatient facility or service or new institutional service within a ten mile radius of an existing healthcare facility or service within the eighteen counties of Western North Carolina.

2.) **Audit:** Request the NC State Auditor or a qualified third party to conduct a through independent audit of Mission Health System's compliance with the COPA since its inception in 1995. The empirical data should be thoroughly analyzed to determine if Mission's activities have met the specific requirements of the COPA law.

   For example, Mission has never provided empirical data to the State to prove it has met the 20%—and now 30%—limitation on employment of the physician categories outlined in the COPA.

3.) **Revise:** Update Mission Health System's COPA to better reflect the region's healthcare landscape and Mission's dramatically expanded market dominance since 1995. In addition to a 90% market share in Buncombe County, Mission, according to its own data, now controls a market share of 43% in the 18 counties it claims as its service area.

   For example, by applying COPA protection to Mission's stated current service area, the committee would ensure maximal healthcare choices and access to the citizens of Western North Carolina allowing current and future healthcare providers to remain in the marketplace.

Questions for DHSR

- Are there any services/facilities/equipment that require a CON that the Division may see as outdated or for which an application is never submitted?
- Is there any reason a CON application or request for a determination of whether a project requires a CON could not be submitted electronically?
- What is a reasonable time frame for making a decision on whether a proposed project is a new institutional health service (i.e. requires a CON)?
- If the 2 million threshold for projects was to be increased, what would a reasonable amount be? In other words, is there a number at which the amount of applications to the Division would be affected?
- Same question as above regarding the $750,000 threshold for major medical equipment
- If there was not an exemption under the plan AC-3, is there another avenue to receive special permission...Currently could an academic center petition DHSR and receive permission to act similarly to what they are allowed to do in AC-3?

Suggestions for CON Reform

1) Enactment of H743, Equal Treatment Under SMFP *

2) Enactment of HB 812, Hospital Authority Territorial Jurisdiction *

3) Require that CON Applications and Application Exhibits be filed electronically and that the CON Agency post the applications and exhibits, on line. In addition, require that CON Agency CON Application decisions and findings (which are produced electronically today in Word Software) and are public documents, be posted on the CON Agency web site.

   Rationale: This would be analogous to what the DHSR Director currently does in terms of posting DHSR Declaratory Ruling Request decisions on the DHSR web site. Also require that Material Compliance and CON exemption requests filed by providers and the related CON Agency decisions on Material Compliance and CON Exemptions be posted by the CON Agency on their web site. This would be similar to what the DHSR Medical Facilities Planning Section currently does in posting on its web site SHCC, SHCC Committee, and SHCC Work Group minutes, drafts of the annual SMFPs, and SMFP provider petitions and staff responses related to the annual SMFP.

   This has the potential to save significant manpower hours at the CON Agency related to checking in and storing 1000s of pages of CON Applications and Exhibits; faxing copies of CON Applications and Exhibits, decisions, and findings; and responding to phone calls from providers and the media regarding CON Agency decisions, etc. It also serves to make public documents more readily available to the public, providers, and the media.

4) Establish statutory decision deadlines for CON Exemption Requests and Material Compliance Requests sent to the CON Agency for review and decision.

   Rationale: There are no dates specified by the state as to specific dates when a Material Compliance or Exemption Request can be filed by a provider. Currently, the law specifies a CON decision deadline for only CON Applications sent to the CON Section and for Declaratory Ruling Requests sent to the DHSR/Division of Health Service Regulation Director's office. The current timeline for a CON decision is either within 90 calendar days from the first day of the month following the CON Application deadline submission (always mid-month, ~ the 15th day of the month) or the Agency may extend the CON decision deadline for up to 150 days from the first day of the month following the CON Application deadline submission. Thus, today CON decisions are made between 4 ½ and 6 ½ months after the CON Application is submitted by the provider. The Certificate of Need is issued about 1 month after the CON decision (if no appeal is filed).

Given that Material Compliance Requests and Exemption Requests are much less lengthy and complex than a CON Application + Exhibits, it would be reasonable to expect that the CON Agency staff could issue and post on its web site a Material Compliance or Exemption CON decision no later than 45-60 days after the Exemption or Material Compliance Request is filed with the CON Office. In addition, Material Compliance and Exemption Requests most often pertain to projects which have been previously reviewed by the CON Agency as part of a CON Application process. These Material Compliance and Exemption Request process also allows CON Agency staff to have a direct discussion with the provider during the review of the Material Compliance or Exemption Request, so that the provider can supply the CON Agency staff with additional clarifying information.

5) Expand the definition of CON Application projects which qualify for expedited 90-day review by the CON Agency.

Rationale: Today, a CON Application is only eligible to be considered for expedited review if the total capital cost of the project is less than $5 Million. See the current CON statute at NCGS Section 131E-185(a1)(2) and (a2). The dollar cap of $5 Million should be raised and even indexed for annual increases. This would permit more CON Applications to qualify to have their CON Application decision within 90 days (from the start of the state's CON review period). The standard CON review period is typically 150 days, so the expedited review and CON decision process saves 60 days or 2 months of regulatory review. This puts the provider is better position to implement the proposed project sooner. The Committee can consider updating the language in NCGS 131E-185 to reflect that an applicant can request expedited review for any CON Application project with a total capital cost (as stated in the CON Application) of less than $10 million, indexed for inflation.

Nelson Mullins Riley & Scarborough LLP

Memorandum

To: Amy Jo Johnson

From: Noah H. Huffstetler III

Date: December 21, 2011

Re: Further Information Regarding CON Suggested Improvements

At your request, the following are specific recommendations that we would make for the Committee's consideration to address the five (5) issues identified in your communication to me on December 15, 2011.

Reduce Delays in the Provision of Needed Facilities and Services:

1. Currently, there is no statutory deadline for the Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section (the "Agency") to respond to inquiries concerning whether a proposed project is within the definition of "new institutional health services" and therefore reviewable, whether a project is exempt from review under one of the provisions of N.C. Gen. Stat. § 131E-184, or whether a proposed modification of an approved project violates the requirement that a project be developed in material compliance with the representations made in the application, as provided in N.C. Gen. Stat. § 131E-181(b). Consequently, the response to such inquiries and the development of projects that are ultimately determined not to require a CON is often delayed for many months. There should be a 60-day deadline for the Agency to respond to a request for such a determination, and the Agency's decision on such a request should be reviewable in the same manner as a decision to approve or disapprove a CON application. To offset any additional cost to the Agency to process such requests more quickly, the Agency should be permitted to charge a reasonable user fee for such a determination, as it presently does for a CON application.

2. At present, all CON applications, which typically run to several hundred pages, must be submitted in hard copy to the Agency in Raleigh. Applicants should be given the option to submit their applications electronically, in a format prescribed by the Agency, and the Agency's decisions on all applications and requests for determinations should be required to be posted on its website.

Bond Requirements Should Be Adequate to Deter Unmeritorious Appeals:

1. Now, the bond required to be posted under N.C. Gen. Stat. § 131E-188(a1) and (b1) by a petitioner to appeal the approval of a CON application is in an amount equal to five percent (5%) of the projected cost of the project that is the subject of the petition, but is capped at a maximum of Fifty Thousand Dollars ($50,000.00). The Court of

Appeals, in its discretion, can raise the amount of this cap in a pending appeal to Three Hundred Thousand Dollars ($300,000.00). This amount is nominal, compared to the cost of delaying a multi-million dollar project, and the cap should be eliminated.

2. Since the bond requirements were first imposed in 1993, there is no recorded instance of a bond posted under the foregoing statutes being forfeited. Likely, this results from the extremely difficult standard to recover against such a bond, under which the court must find that the petition to appeal a project "was frivolous or filed to delay the applicant." To discourage unmeritorious appeals, which are frequently filed by existing providers which simply wish to delay the entrance of a potential competitor into their market, the bond posted under the foregoing statutes should be forfeited to the approved applicant if it is found that the Agency decision was not erroneous or did not substantially prejudice the petitioner.

Outdated or Unenforceable Requirements Should Be Eliminated:

1. The monetary threshold for projects requiring a CON under N.C. Gen. Stat. § 131E-176(16), which were established decades ago and not modified in recent years, should be raised to currently reasonable amounts, and indexed for inflation going forward.

2. Currently, many physician offices inadvertently violate the requirement to obtain a CON for a "diagnostic center" when the value of the diagnostic equipment they have acquired over the years exceeds Five Hundred Thousand Dollars ($500,000.00). This requirement is virtually unenforceable and a violation of the Five Hundred Thousand Dollars ($500,000.00) threshold is almost never reported to the Agency unless there is a dispute among the members of a physician practice or a request is made by a disgruntled former employee. This requirement, contained in N.C. Gen. Stat. § 131E-176(7a), (9b), and (16), should be eliminated.

All CON Applicants Should Be Subject to the Same Requirements:

1. House Bill 743, entitled "Equal Treatment Under SMFP," amending N.C. Gen. Stat. § 131E-183(b) should be adopted. A copy is attached to this memorandum.

2. House Bill 812, entitled "Hospital Authority Territorial Jurisdiction," amending N.C. Gen. Stat. § 131E-20(a) should be adopted. A copy is attached to this memorandum

Decisions of the State Health Coordinating Council ("SHCC") Should Be Made More Transparent and Accountable:

1. All members of the SHCC are currently appointed by the Governor. Appointments should be divided equally among the Speaker of the House of Representatives, the President Pro Tem of the Senate, and the Governor.

2. Members of the SHCC are currently not subject to the State Ethics Act, and therefore are not required to make the types of financial disclosures required of members of other state boards and commissions which make decisions having similar economic impacts. The SHCC should be made subject to the State Ethics Act.

3. Currently N.C. Gen. Stat. § 131E-183(a)(1) and a rule of the Agency adopted pursuant to that statutory authority make determinations of need made by the SHCC "outcome determinative" with respect to any CON application. This statute should be amended to provide that those need determinations are presumptively correct, but can be rebutted by evidence of the specific circumstances involved in a CON application or appeal.

Please let me know if you need any further information concerning these recommendations, or we can of any further assistance to the Committee in its important work.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H **1**

HOUSE BILL 743*

Short Title:	Equal Treatment Under SMFP.	(Public)
Sponsors:	Representatives Steen, Current, Glazier, and Torbett (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO ENSURE EQUAL TREATMENT OF HEALTH SERVICE APPLICANTS UNDER THE STATE MEDICAL FACILITIES PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-183(b) reads as rewritten:

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. ~~No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.~~ All such rules, and all policies and need determinations in the State Medical Facilities Plan, shall apply equally to all applications for a particular type of health service."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 1

HOUSE BILL 812

Short Title:	Hospital Authority Territorial Jurisdiction.	(Public)
Sponsors:	Representative Torbett (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO DEFINE THE BOUNDARIES OF A HOSPITAL AUTHORITY AS THE TERRITORIAL BOUNDARIES OF THE CITY OR COUNTY CREATING THE AUTHORITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-20 reads as rewritten:

"**§ 131E-20. Boundaries of the authority.**

(a) The territorial boundaries of a hospital authority shall include the territorial boundaries of the city or county creating the~~ authority and the area within 10 miles from the territorial boundaries of that city or county.~~ authority. However, a hospital authority may engage in health care activities in a county outside its territorial boundaries pursuant to:

(1) An agreement with a hospital facility if only one hospital currently exists in that county;

(2) An agreement with any hospital if more than one hospital currently exists in that county; or

(3) An agreement with any health care agency if no hospital currently exists in that county.

Provided, however, that if a hospital authority enters into an agreement under subdivision (1), (2), or (3) of this subsection, the hospital authority shall first apply for and obtain a certificate of public advantage pursuant to G.S. 131E-192.1, et seq.

(a1) In no event shall the territorial boundaries of a hospital authority include, in whole or in part, the area of any previously existing hospital authority. All priorities shall be determined on the basis of the time of issuance of the certificates of incorporation by the Secretary of State.

(b) After the creation of an authority, the subsequent existence within its territorial boundaries of more than one city or county shall in no way affect the territorial boundaries of the authority."

SECTION 2. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 02-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Catharine Cummer	Duke University Health System
Amy Whited	NC Medical Society
Andy Lutz	PDA, Inc.
Jim Swann	Fresenius Medical Care
Tina Shanahan	Compass NC
John Cooper	Compass NC
Stephen Korra	Compass NC
Nadine Pfeiffer	DHSR - Medical Facilities Planning Branch
TJ Pulliam MD	Wilkes Regional GI (Vice Chair NC SHCC)
David Miner	TRG Inc
Abby Emanuelson	NMSS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 02-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lauren Bumgardner	Jason Deans + Assoc.
Laurie Onorio	Jason Deans + Assoc.
Justin Puleo	Smith Moore Leatherwood
N. Shmitt	Mission Health Systems
Kris Horton	DHHS
Ann Young	Mission Health
[illegible]	Robinson Bradshaw (for Mission)
Ron Paulus	Mission Health
Richard Vinroot	Robinson, Bradshaw + Hinson Law firm (representing Mission Health System)
John Merritt	Policy Group (Mission)
BRIAN MOORE	MISSION HEALTH

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 02-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bode	BCS
Rob Lamme	RLA
David O'Connor	Coromont Health
Joe Lanier	Nelson Mullins
Allison Waller	NMRS
[illegible]	Duke
Hugh Tilson	NCHA
Deidra Murphy	HPS
Max Mason	Principle Long Term Care
Nancy Bres Martin	NBM HPA

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 02-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Meyer	Keystone Planning Group
MARC HEWITT	WILLIAMS MULLEN
Martha A. McConnell	CHS
Sandy Sands	UNC
[illegible]	[illegible]. Mission Health.
Neal Inman	Civitas

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, March 15, 2012
TIME: 10:00 A.M.
LOCATION: 544 LOB LOB
COMMENTS: THE AGENDA FOR THIS MEETING IS ON THE COMMITTEE WEBSITE

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **6 AM** o'clock on **March 08, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

AGENDA

10:00 a.m.- 3:00 p.m.
Thursday, March 15, 2012
Room 544 Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. CON Law - Ophthalmic Procedure Rooms in Licensed Health Service Facilities
Jonathan D Christenbury, M.D., F.A.C.S

III. Committee Discussion – Cont. of Certificate of Need Discussion (10:00 – 12:00)
Research Staff

IV. Lunch (12:00 – 1:00)

V. Presentation to the Committee- (1:00 - 1:30)
CON law- Impacts on health care, economy, and overall well-being of the citizens of Harnett County
Pat Cameron, Good Hope Hospital, Inc.
Jim Burgin, Harnett County Commissioner
Dr. Linda Robinson, Family Practitioner
Pasty Carson, Mayor of Erwin

VI. Committee Discussion- Direction for the Interim Report (1:30 – 3:00)
Representative Fred Steen and Representative John Torbett

Next meeting:
10:00 a.m., April 19, 2012,
544 Legislative Office Building

MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Thursday, March 15, 2012
10:00 A.M.
Room 544 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, March 15, 2012 in Room 544 of the Legislative Office Building. Representatives Steen, Torbett, Alexander, Boles, Collins, Current, Glazier, Hollo, and Randleman attended. Representative Torbett presided.

Dr. Jonathan Christenbury made a presentation on Ophthalmic Procedure Rooms in Licensed Health Service Facilities (see attached and on committee website)

Rep. Collins: I'm all for lowering government intervention in your profession and every other profession and business, as well, if we exempted existing facilities from the CON procedures, but required of new ones, would that not, in effect, doesn't it favor the people who are already in the practice versus newer graduates and all, coming in from establishing their own facility.

Dr. Christenbury: You have to start somewhere, and if you want to extend that grandfather clause to allow more ophthalmologists, you are welcome to do that. I think that is wise to open more access to physicians using facilities or having them and also maybe decrease the number of procedures per room that are required to be certified.

Rep. Current: Let me take this opportunity to thank your profession, you have done some amazing things. I'm sitting here with 2 cornea grafts and I'm glad to be able to see you.

Dr. Christenbury: Was that outpatient.

Rep. Current: No this was inpatient at Presbyterian Hospital. Will this result in any type of cost shift in any way that would affect adversely the fact that hospitals are required to see anybody, does this play out in this are or not?

Dr. Christenbury: 20% of the procedures performed in North Carolina per year would just be the increase in the utilization of the services of the growth.

Rep. Current: When you get a letter from a hospital saying please keep CON, we don't want a free standing clinic to do diagnostic procedures because they will only see people with means and send the other people to the hospital. Is this a factor here?

Dr. Christenbury: I don't think so, because in my presentation I mentioned that we would take all payer schedules.

Rep. Boles: Even if they had no insurance could they come in and you give them the surgery?

Dr. Christenbury: Oh sure. That's why for several years now, I've performed 1000s of eye procedures in my office because people have no insurance, whether they are immigrants, legal or illegal aliens, they have such a high deductible, they would rather come to the office than go to the hospital or surgery center, that is why I started doing these procedures in the office several years ago. Some patients won't schedule the surgery if they have to go to the hospital because the copay is too high, 400 and something dollars so, there needs to be more access, either we do it in the office like the G.I. physicians some years ago, or pay more at different facilities or have less access.

Jan Paul, staff council gave presentation on Topics of Discussion (See attached and on committee website)

Drexdal Pratt: Effective January 1, 2012 the final agency decision portion of that has been removed as a result of Senate Bill 781.

Rep. Glazier: It seems to me that the expedited procedure sort of creates the fail safe mechanism where you need it and I'm wondering how often that expedited procedure is used, if it's not being used sufficiently, it would seem that if there is a time problem, the statute already creates an opportunity to expedite and can't see a need to change if that is not being utilized.

Craig Smith: Within the CON review, there is an expedited review process, that we try to get decisions out in 90 days and can extend to the additional 60 days as a regular where you can be extended only if we need substantial information. We use that procedure quite a bit. Often end up extending projects, but the extension of projects for substantial information avoids a denial of a project and then a contested case hearing to resolve the matter through settlement. I think it is a much more efficient process and that is one reason why we suggested broadening the scope of who is eligible for an expedited review. As far as any expedited process through OAH, none of our cases have gone through that process that I am aware. Probably because most of the cases that are on a settlement track will get resolved, if not quite as quickly, they will still get it resolved fairly straight forward and if it is a highly contested case, the parties are probably not willing to participate in such a procedure.

Rep. Torbett: Is there some way you could give us some type of rationality, is it effective, is it 1 out of 10 that go through that process is it 9 out of 10?

Craig Smith: It really varies. A lot of applications can get reviewed if they are fairly simple and straightforward in 90 days anyway. Part of it is a matter of workload. Some months we've had 1/3 to ½ requests it, most of which are granted. Once it gets above that, it gets a little difficult because the nature of our review calendar it can back up. A lot of folks don't request, but they hope they would get a decision sooner.

Rep. Torbett: Have you all prepared a list of what the department would recommend that would add to the people that are applicable to that process.

Craig Smith: We have just proposed either eliminating or raising the threshold, therefore allowing other facilities. We would still have the ability to schedule public hearings if we believed it was in the public interest or the public could request a hearing and right now those things keep us from having expedited reviews.

Rep. Torbett: Committee recommendations?

Rep. Glazier: I have a real problem with the elimination of stays, without a discussion of what the downside of doing that is.

Rep. Torbett: The committee did make a determination on raising the ceilings.

Jeff Horton: The law was changed to create stays a couple of years ago. We had a case where the CON was issued, a hospital actually was built, and by the time it came around to the court, the judge said, this case is kind of moot, because the place is already built. That is probably what would happen if you were to eliminate stays.

Craig Smith: That was not just the CON docket, we don't have that many appeals, I think she was saying that was the total appellate docket.

Rep. Glazier: Court of appeals issue ought to stay where it is headed. The Supreme Court likely would not be happy with getting a new charge of a direct appeal from the administrative process. We're the only state in the country that doesn't have a certification process, because our supreme court doesn't want the additional case load, so I don't think they would be happy with this. You've developed an expertise at the court of appeals level and you really would have to in these cases develop another sort of expertise.

Rep. Torbett: Is it the wish of the committee to put this on hold and get more study.

Rep. Alexander: Why don't we just leave it and not to anything to it?

Rep. Torbett: Recommendation of the committee? All agree.

Rep. Torbett: Bond requirements are the next issue.

Rep. Glazier: The bond originally gets set when the appeal is noted and really the appellate court has the capacity to raise or lower that bond at any time?

Jan Paul: The appeal bond is going to be set in the trial court. I don't know if they have the authority to modify a bond that was set by a separate tribunal.

Rep. Glazier: I would think it could be modified and they would know a whole lot more about it than we do, but if they don't have any authority, it may be a different issue.

Rep. Torbett: Can we get that answer?

Craig Smith: The specific point that your staff mentioned was that we had hoped that the language in 131E-188A1 talks about the proposed bond, and we just wanted the word each proposed project as opposed to the proposed project, there was a particular case in which one party filed one bond and was appealing for approvals. There are 2 different levels of bond, the bond for the OAH is set in that provision and then later on in B1-1, the same limits apply to the court of appeals, but the court of appeals does have the ability to raise the bond from a $50,000 maximum to a $300,000 maximum right now.

Rep. Glazier: A recommendation is that the bond requirement be made so that it applies to each proposed new institutional health service that is the subject of the petition.

Rep. Torbett: Unanimous by committee.

Rep. Collins: Having been involved in our legal system against my will in an estate case where multiple people kept trying to file suit to become beneficiaries of the estate and in effect those of us that won all the way up through the supreme court had to end up paying all the costs. I would like to see number one take place and also wonder if that wouldn't find of necessitate doing bullet point 3 under the section we just looked out.

Rep. Glazier: Do we have a sense of how many times it has been ruled that the appeal made in these cases has been deemed frivolous?

Craig Smith: I'm not aware of any.

Jeff Horton: Basically the issue comes as to the definition of affected persons and it is so broad in the current appeal language that I think a judge would be hard pressed to say a case is frivolous.

Rep. Collins: I would actually be for number one for that being the case for non-frivolous law suits.

Rep. Glazier: I think this creates a whole different economics of how you do these cases and whether cases would settle and how they would settle. I would get real concerned without getting some input from all the parties about opening that Pandora's Box.

Dr. Current: If an attorney was asked to handle it and he says I don't have any chance to win this and if I don't I'm going to have to pick up the tab, he would deem it frivolous, would he not.

Rep. Glazier: If there is a determination there has been a frivolous suit, that when a penalty is done, the provisions of the statute makes sure that that penalty is going to be strictly enforced, that would make sense to me.

Rep. Torbett: We are going to be looking at that in an effort to reduce that appeal process. We will put a hold on this. Too many parties have the ability to file an appeal.

Jeff Horton: The definition for appeals for effected persons. Effected persons can file appeals, the definition is very broad. If you were to narrow the definition of who can file an appeal, you probably would have fewer interveners and fewer parties to litigation which we think may be a move in a positive direction.

Drexdal Pratt: There are delays being created which fall back to this effected person definition.

Rep. Alexander: Too many parties, can you give a ball park number?

Jeff Horton: You have a party that didn't even apply for the need, and they'll file as an intervener. It has the appearance of just being a delay tactic.

Rep. Torbett: I'm going to ask Shawn that we get with the department for some language and bring it back to us. The appeals process is too lengthy.

Rep. Glazier: This applies to the ALJ process and the court of appeals. It would be a mistake to bypass the court of appeals without talking to the court and ALC about those issues. The ALJ can expedite?

Craig Smith: That is part of it. There will be 30-60 day cut out of going to the court of appeals. The other thing is, there are a number of cases, because of the complexity, that actually get pulled within the 270 day and get refiled. So the 270 day period can become a 540 day period.

Rep. Glazier: If the parties want it delayed, I don't know that it is our job to get mixed in with all of the parties' views.

Drexdal Pratt: We make the decision and it goes beyond that, we do receive a lot of complaints about that, but it is really in 150B and out of our jurisdiction.

Rep. Glazer: Could we have chief of ALJs over to talk about that.

Rep. Torbett: We will bump to back and get someone from ALJ to discuss. State Health Coordinating Council should be under state ethics.

Drexdal Pratt: The SHCC is an advisory group in development of this plan.

Rep. Glazier: When we were looking at legislation 2 years ago we brought up the issue of whether the SHCC and several other advisory groups ought to be added in. There are some real issues whether that could fundamentally alter not only the SHCC, but potentially take out people you want on the SHCC with expertise and knowledge just because the act doesn't neatly fit into how that group is selected.

Rep. Boles: Are these advisory boards compensated?

Drexdal Pratt: Just for expenses.

Rep. Alexander: They may be employed by a provider applying for CON. Do they remove themselves to not be a conflict of interest or is it really more generic.

Drexdal Pratt: Executive order 10 is read at every meeting. They do recuse themselves in those situations.

Rep. Torbett: When you were discussing these groups fall under the ethics act, was there any discussion of having a different layer within ethics that they would fall in?

Rep. Glazier: I don't recall we did the layer discussion. We did talk about the recusal rule.

Rep. Torbett: Recommendations from committee? We would have to bring in governor's liaison.

Rep. Alexander: You wouldn't just want to make the changes. There are numerous advisory committees. It wouldn't be fair just to site one council when others may have a different topic, but they act in the same.

Rep. Torbett: The difficulty is the expertise required to sit on such a board. Is this a leave alone?

Rep. Collins: My concern is if my institution is in a CON process, it's not really good enough for me just not to vote.

Rep. Current: I had the privilege of serving on the SHCC under Governor Martin. I don't know how he asked me to serve; I think it was because I worked for him politically. The question I would pose is, members of the SHCC, and if you wanted to get a room full of people with conflict of interest, you go to one of those meetings and you can find it. These different modalities that need beds appropriated, these organizations know who the good folk people are, and would it be appropriate to consider recommendations coming from, say if they need a dentist on there, that that recommendation would come from the medical board or dental society?

Rep. Glazier: We are talking about multiple things, it is important to keep the expertise but to make sure of the recusal process.

Rep. Boles: Do all the advisory boards take the basic ethics training?

Rep. Glazier: Any of the appointees on any board that are under the act do have the requirement for the training component.

Drexdal Pratt: We will get a copy of the provision that is given to the SHCC at each meeting for the next meeting.

Rep. Torbett: Appointing mechanism? We will leave until after we get further information.

Rep. Glazier: Don't understand determination of need made by the SHCC is outcome determinative?

Shawn Parker: We would need a proponent of this to explain the differences. It lays out the process in statute. There would be a need to change how they are to weigh their consideration.

Drexdal Pratt: The state medical facilities was under rules previously. That was changed in 1996. Those rules have remained on the books and as part of Executive Order 70 and SB 781, we've been cleaning up those things, and actually this morning at 10:00 a.m. those rules went before the rules review commission to be repealed. The reasons they were being repealed and the reason we stopped being a part of that, is that the process for getting rules in place, if you make the plan as part of the APA process, there is just not enough time to do an annual plan. It takes 4 ½ months to get a temporary rule in place.

Rep. Glazier: My recommendation would be that we don't go there, that we don't attempt to put this under the APA.

Rep. Torbett: Consensus on Rep. Glazier's recommendations? Yes.

Shawn Parker: There are a number of policy exceptions that are in the state medical facilities plan.

Drexdal Pratt: The AC3 allows them certain exemptions for equipment and things as part of research and part of their academic responsibilities. The hospital association working with the department and the SHCC worked through those issues and has come to an acceptable agreement that was actually in the 2012 plan. That resolution is in there; all parties were in agreement as far as I know. There is not an issue around AC3 as far as we are concerned.

Craig Smith: Most of the policies in the medical facilities plan are exemptions for specific types of facilities.

Rep. Collins: Does ECU get an exception to allow for that or make it easier for them to buy up hospitals than it would for an independent hospital group?

Drexdal Pratt: I personally don't think it has anything to do with who they purchase or develop management agreements with.

Craig Smith: The policy only applies to the actual teaching campus in Greenville and the policy is limited to what used to be called Pitt County Memorial Hospital, UNC Hospitals, Duke University Medical Center, and North Carolina Baptist Hospital in its current name.

Rep. Current: If you had a CON for a number of operating rooms for cardiovascular surgery, it the institution that has that commitment, does it have the authority to transfer those to some other entity at its own discretion or does it have to get approval to do that?

Craig Smith: No, relocation of operating rooms to another healthcare facility would require a CON.

Rep. Current: Has it always been that way?

Craig Smith: It has not always been that way and the development of open heart surgery was regulated specifically through the capitol cost as well as through the purchase of heart lung bypass machines, but the amendments adopted in the past decade have provided for stricter operating room regulation and the CON requirements that if you are moving it off campus other than across the street, then you need a CON.

Rep. Torbett: When was the last time the department reviewed?

Drexdal Pratt: The medical facilities plan is reviewed annually and we have several subcommittees as part of the SHCC that is part of the responsibilities for reviewing and getting feedback if we get petitions.

Rep. Steen: I think we need to keep this issue alive and keep it in the sunshine and keep it open.

Recess until 1:00 p.m.

Presentation on **CON law- Impacts on health care, economy, and overall well-being of the citizens of Harnett County**
Pat Cameron, Good Hope Hospital, Inc.
Jim Burgin, Harnett County Commissioner
Dr. Linda Robinson, Family Practitioner
Patsy Carson, Mayor of Erwin

(See attached and on committee website)

Rep. Torbett: I don't have any easy answers for you today. What I can promise you is that this committee will take your information and we'll get the questions you asked answered and we will definitely ask the department in charge of that and try to get down to some answers and perhaps even stumble upon a remedy.

Rep. Current: Since my legislative assistant is from Erwin, I've heard a little bit about this from time to time. You just about would be in favor of doing away with the whole CON process.

Jim Burgin: Based on our experience, there might be a value of the CON, but the rules need to be fair and have what I would say some common sense. Is it improving healthcare or is it protecting the people that already have their CON or have a service and that is the way it is being used.

Rep. Steen: I do have some information and I would like to ask that, I don't if we have got our handouts yet(See attached and on committee website), but I do have some things that we talked about from the COPA last time and it's just recommendations, they are not anything hard and fast, it's just some things that are out there and I want the committee to have that. They'll be some copies available to you soon. I would like to say as we move forward with the COPA issue, I know that we have made some type of advancement, I'll go over the quick recommendations and you all will get copies of these very soon. We talked about the buffer zone, I would like to continue to look at that and give us some input before our next meeting on that. The future CON applications and see how that would dove tail into the COPA issue. Extend physician caps- I think we need to talk about that a little bit more and see what we can come up with there with retired physicians and those kind of things. Recommend that COPA compliance reports be made annually to DHSR, if Chris Taylor is in the room, if we could get an update, I think there is some update on that, if he would let the committee know what's happened on that point, and I think it is a good thing.

Chris Taylor: We being the department and the department of justice are currently in discussions with Dixon-Hughes-Goodman to conduct a 5 year compliance audit on Mission's operations under the COPA. We have just initiated those discussions with Dixon-Hughes, so beyond saying that we have started the process, I can't report anything beyond that. Once the audit is done, obviously, it will be a public document and the reason we have selected Dixon-Hughes is they have been doing the independent work for us on the financial part of it for a number of years, so they are familiar with the COPA and familiar with Mission. They also do the audit on more healthcare facilities than any other accounting firm in the state and they have a significant healthcare practice. So we believe they would be the best firm to do that kind of work for us.

Rep. Steen: The COPA transition, I think we had talked earlier about PED looking at this. This is something I think we have to make sure that that is a scope of what PED can do. I hope it is

something they can do; just to make sure the audit process itself is proper in the way DHSR is doing that. I think that we will find out some things there. But we want to make sure from staff that that is a recommendation that this committee can make for PED to go in that direction. Typically they look at governmental operations, we want to make sure that this does tie into some type of governmental operation as they go forward and I think it does. A couple of other things, I would like to ask that both sides try to get together as far as Mission and Park Ridge, try to find, what is your common ground? I'm sure there is some common ground out there that you have. Try to find out what those are. Make a list, I know you've got differences, we've been there and seen that and we've taken a lot of input from both sides and I'd like to hear what you think the differences are moving forward. We do not want to do any harm to either side. We want to make sure that coming out of this COPA, if there is an exit strategy, how does that impact the other folks in that area, other than Mission. I think those are critical and I would like to see us work together if we can. It would be nice if you had a united front, and I know that is asking a lot, but if you had a united front coming back to us saying we disagree on these issues, how can we work them out? We may be able to work them out. We've been sitting here as judge and jury and it's kind of tough to do that and we'd like to go forward and I think with your input we can do that and I trust that you will make a best effort to do just that. So if that's ok with the committee, that's what I would like to recommend and you will get a list of these recommendations, like I say, nothing is in stone, but give us more input, give us more input as we try to wrap this thing up in the next meeting. I appreciate your attendance, comments, and notes and all the things that you have been providing so far and I hope that we can continue to work in a direction that will be beneficial for everybody.

Rep. Torbett: Wise words, the meeting was adjourned at 3:00 p.m.

Representative John Torbett, presiding chair

Viddia Torbett, committee clerk

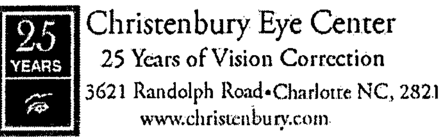
Representative Fred Steen, co-chair

AMEND CON LAW TO ALLOW OPHTHALMIC PROCEDURE ROOMS IN LICENSED HEALTH SERVICE FACILITIES

March 15, 2012 Raleigh, NC

Jonathan Christenbury, MD

Presented to NC House Select Committee on CON Process & Related Hospital Issues



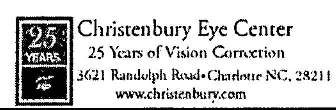
Change CON Law to Allow Ophthalmic Procedure Rooms in a Licensed Health Service Facility

1) Provide opportunities to submit CON applications to develop new ophthalmic procedure rooms in licensed ambulatory surgical facilities with no need determinations or need methodology in the State Medical Facilities Plan ("SMFP")

2) Allow a specified time for existing ophthalmic procedure rooms in physician offices to seek licensure as ambulatory surgical centers without having to obtain CON approval

3) Develop definitions and facility standards for ophthalmic procedure rooms

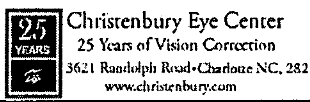
4) Remedy the CON appeals process to eliminate / reduce appeals



Previous Change in CON Law

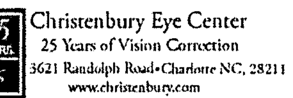
In August of 2005, the General Assembly amended N.C.G.S. § 131E-178(a) to allow:

1) CON applications for gastroenterology procedure rooms based on specific requirements
2) No need methodology and no need determinations for gastroenterology procedure rooms in the SMFP
3) Gastrointestinal endoscopy rooms located in a nonlicensed setting could, for a limited time period, seek to obtain a license without having to obtain CON approval



Allow ophthalmic procedure rooms in licensed facilities in the similar manner as CON law allows gastrointestinal procedure rooms in licensed ambulatory surgical centers

- No CON required to provide ophthalmic procedures in existing office settings
- No need formula in future years' State Medical Facilities Plans
- CON applications for new ophthalmic rooms have to meet specific criteria:
  - Obtain accreditation
  - Provide access to Medicaid, Medicare and charity care patients
  - Meet a utilization standard of 1500 procedures per room per year
  - Provide quality assurance and surgical safety standard policies
  - Provide written medical staff credentialing standards
  - Commit to reporting procedure volumes in the annual facility license reports



Rationale for Change:

- **Ophthalmic surgeons should receive the same treatment under CON law as gastroenterologists because the procedures performed by both specialists are ideally suited to ambulatory surgical facilities (high volume, minimally invasive, low risk, short duration, minimal anesthesia / sedation)**
- **Under the current regulations there are no CON opportunities for physicians to develop ophthalmic ambulatory surgery centers in North Carolina**
- **Ophthalmic surgery can safely be performed in procedure rooms as this is already standard practice at some hospitals**
- **Ophthalmic procedures are 99.8 percent outpatient as compared to 86.1 percent for GI endoscopy procedures**
- **Rates of adverse events for ophthalmic procedures are extremely low**

Christenbury Eye Center
25 Years of Vision Correction
3621 Randolph Road•Charlotte NC, 28211
www.christenbury.com

Rationale for Change:

- Medicare (national data) reported ASC procedures

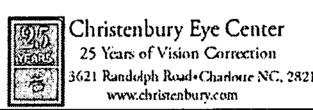
  2008 Cataract 18.3% GI 7.9%

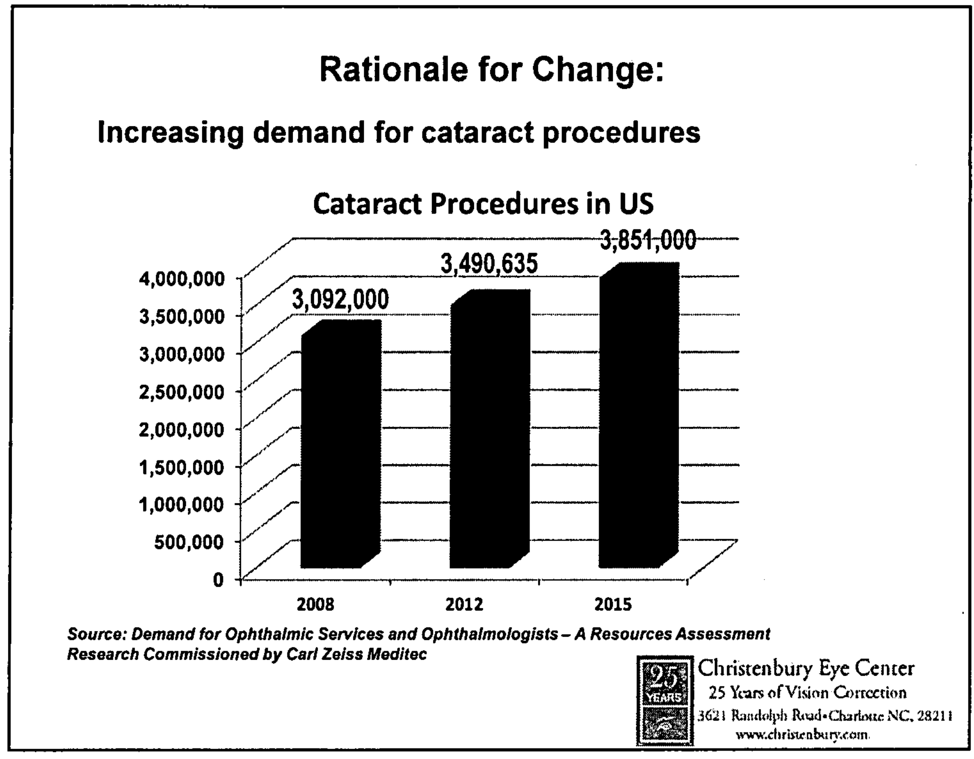
  2009 Cataract 20.6% GI 7.9%

  Source: US Dept of HHS Report Congress, 2011
  www.cms.gov/ASCPayment/...

- Incidence of Cataract *
  - Affects 22 million Americans > 40 (17.2%)
  - Will increase to 30.1 million by 2020
  - By age 80 > 50% will have diagnosis of cataract
  - Estimated cost $6.8 billion annually

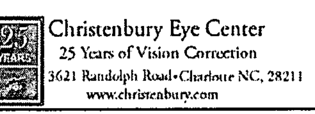
  Source: Prevent Blindness America, NIH, CDC





Rationale for Change:

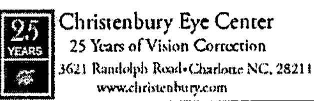
- **A shortfall in the number of ophthalmologists compared to demand for services will occur in the next 7 years due to retiring ophthalmologists, fewer trainees and increased demand for services**
- **Increasing productivity by at least 17.3% is needed to respond to this shortfall of resources** ***(Demand for Ophthalmic Services and Ophthalmologists – A Resources Assessment; 2009 Research Commissioned by Carl Zeiss Meditech)***
- **Changing the CON law to allow ophthalmic procedure rooms will improve physician productivity and help recruit more ophthalmologists in future years**



Additional Justification:

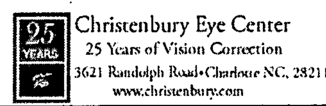
- **High volume of ophthalmic procedures combined with growing demand as the population ages (top procedure: cataract extraction with IOL)**
- **Patient charges and reimbursement for ophthalmic procedures in ambulatory surgery centers are much lower than in hospitals**

	Charlotte Area - Average List Price	
Compare Average Facilty Charges	ASCs	Hospitals
Cataract Surgery with IOL	$3,500-$3,600	$4,500-$8,500
www.newchoicehealth.com		
Compare Medicare Reimbursement	ASCs	Hospitals
Cataract Surgery with IOL	$952.83	$1,667.18
Compare Medicare Copayment	ASCs	Hospitals
Cataract Surgery with IOL	$190.57	$488.94



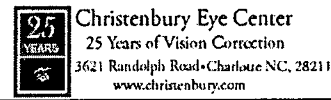
Benefits to North Carolina Citizens:

- **Cost savings of at least $300 per patient due to lower copayments**
- **Cost savings of $700 to $1500 per procedure ($1100 average) for Medicaid, Medicare, State Employees Health Plan and Commercial Insurance as more patients will have the option of obtaining ophthalmic procedures in a licensed ambulatory surgical center instead of the higher cost hospital setting**



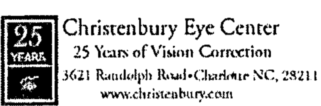
Estimated Savings to the Healthcare System:

- The use rate for ophthalmic surgery of approximately 237.6 procedures / 10,000 population based on the 2006 National Ambulatory Surgery Survey which includes hospitals and freestanding ASCs.
- 235,000 procedures / year in NC for the 2012 population
  302,000 procedures / year in NC for the 2020 based on 2 percent increase in use rate and population growth
- 30 ophthalmic procedure rooms operating at 1500 annual procedures can serve 45,000 procedures annually which is less than 20% of the 2012 total utilization
- **$49,500,000** annual cost savings based on the $1,100 savings per procedure



Additional Benefits:

- Eight operating rooms located in ASCs in Mecklenburg were recently converted to the more costly hospital-based outpatient ORs; some of these rooms were used for ophthalmic surgery
- The proposed change would help reverse the trend of hospitals acquiring existing ambulatory surgery centers and converting these operating rooms from freestanding ASC rooms with lower charges and reimbursement to become hospital-based operating rooms with unreasonably high charges
- Improve patient access due to greater availability of ophthalmic surgery procedure rooms
- Enhance competition and patient choice
- Allow ophthalmology procedures to be performed in a highly specialized patient-centered and physician-directed licensed facility



Thank you

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Topics for Discussion

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues
March 15, 2012

APPEALS PROCESS

Concerns:

- Appeals cause delays in provision of needed facilities and or services.
- Bond requirements are inadequate.
- Frivolous appeals cause unnecessary delays.
- Too many parties have the ability to file an appeal.
- The appeals process is too lengthy.

STATE HEALTH COORDINATING COUNCIL

Concerns:

- State Ethics Act should apply to SHCC members.
- Appointments should be made by legislature and Governor.
- SHCC members may have an affiliation with or be employed by providers applying for CON.
- Determinations of need made by the SHCC are "outcome determinative" with respect to any CON application.

STATE MEDICAL FACILITIES PLAN

Concerns:

- Policies adopted in the SMFP are not considered rules under the APA.
- The SMFP contains exceptions.
- Current target occupancy tiers result in difficulties for small hospitals.
- No recognition for beds that play dual roles of observation/inpatient care that is more prevalent in small hospitals.

PULLED FOR FURTHER DISCUSSION

Concerns:

- The diagnostic service center requirements under CON are difficult to enforce and rarely reported.
- No statutory requirement deadline for letters of review, CON Exemption requests or Material Compliance Requests
- Monetary threshold for replacement equipment is too low at 2 million dollars.

CON APPLICATION PROCESS & GENERAL PROCEDURES			
Concern	**Options**	**Changes required**	**Decision**
CON process is no longer needed for certain services: • Air Ambulance • Solid Organ Transplant	No longer require CON for air ambulances or solid organ transplant services.	• Remove air ambulance from CON statute. • Remove Solid Organ Transplant services from CON statute.	**Recommendation**: Divide into two separate recommendations: • **Recommendation #1 -** Remove air ambulance from CON statute. • **Recommendation #2 -** Remove Solid Organ Transplant services from CON statute.
Applications are required to be submitted in hard copy.	Allow for or require electronic submissions of applications.	• Direction to Agency to accept or to require electronic forms. • Make modifications to 131E-182(b) requiring or allowing for electronic submission.	**Recommendation:** • DHSR to study CON submission process.
More transparency is needed in the CON process.	Require all applications/determination requests/requests for review as well as Agency decisions to be posted on website.	• Direction to Agency to post all applications, determination requests, decisions, responses, etc. on their website. • Add statutory language to 131E-185 directing Agency to post this information on website. • Add statutory language indicating all information submitted to CON/DHSR is public information.	**Recommendation:** • DHSR to move with all deliberate speed with posting materials to website.

CON APPLICATION PROCESS & GENERAL PROCEDURES			
Concern	**Options**	**Changes required**	**Decision**
Monetary threshold for projects requiring a CON under 131E-176 of 2 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(16) and 131E-184(e).	**Recommendation:** • Increase threshold amount to 4 million dollars.
Monetary threshold for expedited review of less than 5 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(7b)(b) and 131E-185(a1)(2).	**Recommendation:** • Eliminate threshold.
Monetary threshold for major medical equipment requiring a CON is too low at $750,000.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(14o).	**Recommendation:** • Increase threshold amount to 1.5 million dollars.

APPEALS PROCESS			
Concern	**Options**	**Changes required**	**Misc.**
Appeals cause delays in provision of needed facilities and or services.	Eliminate stays. A CON issued by the State takes effect immediately upon issuance. Mississippi model: The filing of an appeal from a final order of the statutorily specified body or tribunal shall not stop the purchase of medical equipment or development or offering of institutional health services granted in a CON issued by the State.	Create new section declaring that no stay shall be granted upon a party's appeal from a final agency decision or order.	
Bond requirements are inadequate.	• Increase the threshold amount of required appeal bond. • Account for inflation. • Amount of bond in discretion of board or court, with requirement that any appeal of a final order in a CON proceeding requires the giving of a bond sufficient to secure the appellee against the loss of costs, fees, expenses and attorney's fees incurred in defense of the appeal, approved by the appellate court within five (5) days of the date of filing the appeal. • Require a separate bond for each petition filed.	Make conforming change to 131E-(a1) and 131E-(b1)(1).	

APPEALS PROCESS

Concern	Options	Changes required	Misc.
Frivolous appeals cause unnecessary delays.	• Prevailing party gets costs and attorneys' fees. • Increase penalties for frivolous appeals. • Stricter enforcement of imposed penalties.	Make conforming change to 131E-188(a1).	
Too many parties have the ability to file an appeal.	Redefine and limit "affected person" and "aggrieved party" for purposes of standing to file an appeal.	Make conforming changes to 131E-188 and Chapter 150B.	Give only the applicant standing to appeal. Eliminate intervenors from the appeals process.
The appeals process is too lengthy.	• Appeal from a final order or decision of the Department in a CON denial case goes to a contested case hearing before OAH and from there, directly to the Supreme Court. • Time limits for appeals decisions. e.g., Georgia model: Certificate of Need Appeal Panel consists of independent hearing officers appointed by the Governor in order to review the Dept's initial decisions to grant or deny a Certificate of Need. The decision of the appeals panel hearing officer is final unless objection is filed with the Commissioner within 60 days. Commr reviews and can award attorneys' fees and expenses if determines appeal was made for purposes of delay or harassment. Commr's Decision final unless appealed to Superior Court. However, if the Court does not hear the case within one hundred and twenty (120) days of the date of docketing in the Superior Court, the decision of the Dept. shall be considered affirmed by operation of law unless a hearing originally scheduled to be heard within the 120 days has been continued to a date certain by order of the Court.	• Make conforming changes to 131E-187, 131E-188. • Make conforming changes to 7A-29(a)and (b).	

STATE HEALTH COORDINATING COUNCIL			
Concern	**Options**	**Changes required**	**Misc.**
State Ethics Act should apply to SHCC members.	Require Council to be subject to all or part of the Act.	Statutory change would be required. By current definition the SEC does not have the authority to subject SHCC to the Act.	Potential conflicts between current Executive Order and Chapter 138A exist.
Appointments should be made by legislature and Governor.	Divide membership appointments among Governor, Senate, and House of Representatives	Likely would need to codify SHCC and then in its establishment set appointing mechanism.	Consider role of Advisory Committees within the Executive Branch.
SHCC members may have an affiliation with or be employed by providers applying for CON.	Extend prohibition in 131E-191.1 to include persons employed or affiliated with XXXX.	Statutory change would be required.	Consider desired knowledge base of Advisory Committee.
Determinations of need made by the SHCC are "outcome determinative" with respect to any CON application.	Make need determinations presumptively correct and rebuttable by evidence of specific circumstances involved in a CON application.	Amend G.S. 131E-183(a)(1) to conform.	

STATE MEDICAL FACILITIES PLAN			
Concern	**Options**	**Changes required**	**Misc.**
Policies adopted in the SMFP are not considered rules under the APA.	• Include under the APA. • Direct that certain portions of APA apply. • Establish SHCC by law.	Statutory change would be required.	• Consider timing requirements under the APA. • Consider Rules Review Commission's impact on policy.
The SMFP contains exceptions.	• Recommend language from H743. • Eliminate/limit certain plan exemptions (AC-3). • Develop non-subjective criteria to qualify for exemptions.	Legislative direction.	
Current target occupancy tiers result in difficulties for small hospitals.	• Create occupancy tiers for hospitals with 100 beds or less and tiers for hospitals with greater than 100 beds	Legislative direction.	
No recognition for beds that play dual roles of observation/inpatient care that is more prevalent in small hospitals.	• Count the dual beds in the census count for hospitals with 100 beds or less. • Create a new system of classifying beds that accounts for dual purpose beds.	Legislative direction.	

PULLED FOR FURTHER DISCUSSION

CON APPLICATION PROCESS & GENERAL PROCEDURES			
Concern	**Options**	**Changes required**	**Misc.**
The diagnostic service center requirements under CON are difficult to enforce and rarely reported.	• Eliminate diagnostic service centers from CON requirements. • Increase the threshold amount. • Eliminate "clinical laboratories" from definition	• Delete all references to diagnostic service centers. • Make conforming changes to 131E-176(7a).	Currently a diagnostic service center must obtain a CON when the total cost of all medical diagnostic equipment utilized by the facility that cost $10,000 or more exceeds $500,000.
No statutory requirement deadline for letters of review, CON Exemption requests or Material Compliance Requests.	• Create a deadlines • Require fee for such determinations.	• Codify for letters of review and create deadline. • Add deadlines for other requests. • Add authorization for to charge fees for such requests.	• Letters of review are not currently statutorily required.
Monetary threshold for replacement equipment is too low at 2 million dollars.	• Increase the threshold amount. • Account for inflation.	Make conforming change to 131E-176(22a).	

House Select Committee on Certificate of Need Process
Timeline of Good Hope Hospital, Inc.'s Efforts to Rebuild Hospital
March 15, 2012

- Spring of 2001, Good Hope Hospital, Inc. (Good Hope) applied for a CON to replace its existing Hospital. CON was issued after Health Regulation Services (HRS) staff commented that it was one of the best applications they had ever reviewed.

- As a condition of HUD financing for Good Hope's replacement hospital, Good Hope was required to obtain approval from the North Carolina Medical Care Commission (NCMCC). NCMCC staff recommended approval. Betsy Johnson Hospital (BJH) representatives were allowed to speak in opposition to Good Hope, stating that Harnett County did not need two hospitals. (Note: Harnett County already had two hospitals, Good Hope operated for decades before Betsy Johnson, the second hospital, was built.)

- Reversing its staff recommendation, NCMCC ruled against Good Hope, but made no findings that the plan was not financially feasible. The Vice Chairman of NCMCC stated that if Good Hope wished to replace its hospital, it should find other financing. (Notes: 1. At the next quarterly NCNCC meeting, Good Hope was denied the right to speak when the NCNCC approved Betsy Johnson's right to obtain HUD financing for its project. 2. Betsy Johnson consultant's notes (obtained later through discovery) disclosed that Robert Fitzgerald, a NCNCC member and then Director of the Division of Facility Services, expressed concern to Betsy Johnson representatives that if Good Hope received HUD financing, Betsy Johnson might not be able to do so. 3. During this process, NCMCC provided confidential Good Hope documents to Betsy Johnson.)

- As a result of NCMCC's Vice Chairman's comment, Good Hope entered into a partnership with Triad Hospital Corporation (Triad). Triad agreed to provide <u>cash</u> to build Good Hope's replacement facility so financing was no longer needed. This partnership would have protected the 225 jobs at Good Hope, provided an immediate increase of more than $35 million to Harnett County's tax base, with a projected increase to more than $100 million, and provided access to improved health care services.

- Good Hope and Triad filed a Declaratory Ruling Request to approve the Good Hope/Triad partnership, increase the project size by 6,000 square feet, allow a modest increase in the cost of the project, and move the site of hospital approximately 6 miles, on the same highway as originally approved by the State but more centrally located in the county.

North Carolina General Assembly
16 West Jones Street
Raleigh, NC 27601

March 14, 2012

Re: North Carolina Sportsmen and Sportswomen Urge Your Support for Land and Water Investments

Dear North Carolina General Assembly Member,

We are hundreds of thousands of dedicated sportsmen and women from North Carolina. We span political parties and ideologies. We are bird hunters and waterfowlers, trout and bass anglers, hunters and trappers. What we share is a deep-rooted passion and concern for conservation and our sporting heritage.

State natural resource funds are essential to protecting critical habitat for fish and game, conserving wetlands and watersheds essential to clean water supplies, and ensuring public access for hunting and fishing.

The country's original conservationists, hunters and anglers, are still on the forefront of conservation. Our dollars spent on licenses, gear, and associated expenditures such as travel, bait and tackle, meals, and lodging has a tremendous impact on the state's economy. According to the most recent survey of the USFWS about the economic value of fish and wildlife based recreational activities, we contributed $4.3 billion to the state's economy while supporting over 46,000 jobs.

For years, the General Assembly has recognized sportsmen's economic input and commitment to fish and wildlife resources by fully funding the state's four conservation trust funds. Now conservation funding has been cut by a disproportionate 90 percent. Fiscal responsibility is important, but it doesn't mean abandoning successful programs that have protected tens of thousands of acres of game lands, wetlands, fishing habitat and farmland across the state.

In order to effectively safeguard key components of our economy, the sports and traditions that North Carolinians enjoy, and the health and integrity of some of our most important natural resources, it is essential that you restore a portion of these critical funds for the wild places that sustain our sporting heritage and economic impact.

This request comes to less than a half percent of the state budget, but the payoff is enormous. For every dollar invested the state receives at least $4 of natural goods and services such as drinking water protection, flood control and cleaner air. When you add in the associated benefits for our $22 billion a year travel and tourism and $32 billion agricultural industries, it is clear that conservation is crucial to our economy. Please support this major economic driver by:

- **Restoring funding for the Clean Water Management Trust Fund (CWMTF) to $40 million, still well below historic levels.**
- **Removing the general prohibition on the use of CWMTF funds for land acquisition.**
- **Maintaining the dedicated revenue source for the Natural Heritage Trust Fund and Parks and Recreation Trust Fund, and oppose any diversion of those funds.**
- **Funding the Agricultural Development and Farmland Preservation Trust Fund at $2 million.**

Thank you for your consideration.

Sincerely,
The below signed groups.

Albemarle Conservation & Wildlife Chapter
Blue Ridge Branch of QDMA
Blue Ridge Chapter of Trout Unlimited
Blue Ridge NWTF Chapter
Broad River NWTF Chapter
Brunswick County Longbeards NWTF Chapter
Cabarrus Golden Cutters NWTF Chapter
Cape Fear River Branch of QDMA
Carolina Fly Fishing Club
Carteret County Wildlife Club
Cataloochee Chapter of Trout Unlimited
Catawba River NWTF Chapter
Chatham County NWTF Chapter
Coastal Plains NWTF Chapter
Colonial Callers NWTF Chapter
Crossroads NWTF Chapter
Daniel Boone Bear Club
Davidson County Longbeards NWTF Chapter
Downeast Gobblers NWTF Chapter
East Carolina NWTF Chapter
Ed Andrews NWTF Chapter
Five County Bassmasters
Flat River NWTF Chapter
Foothills NWTF Chapter
Forsyth Full Strutters NWTF Chapter
Fort Bragg Branch of QDMA
Franklin County Longbeards NWTF Chapter
French Broad NWTF Chapter
Friends of Pocosin Lakes National Wildlife Refuge
Gaston County Piedmont Area Wildlife Stewards
Greater Pee Dee NWTF Chapter
Greater Raleigh Outdoors and Wildlife
Habitat and Wildlife Keepers
Hanging Rock NWTF Chapter
Hardcore Kayak Fishing Team
Harnett County Strutters NWTF Chapter
Hawks Ridge Gun Club
Headwaters, Ltd.
High Country Sportsmen Coalition
Hyde County Longbeards NWTF Chapter
Johnston County Longbeards NWTF Chapter
Johnston County Wildlife Association
L.A. Dixon NWTF Chapter
Lake James Area Wildlife and Nature Society
Lake Norman NWTF Chapter
Lake Norman Wildlife Conservationists
Lake Norman Rod & Gun Club
Land O'Sky Chapter of Trout Unlimited
Lee County NWTF Chapter
Lincolnton Sportsman Club, Inc.
Lumber River NWTF Chapter
Moore County Wildlife & Conservation Club
Mountain Island Lake Wildlife Stewards
Mountain WILD!
Mount Jefferson NWTF Chapter
Nantahala NWTF Chapter
Nat Greene Fly Fishers
Neuse NWTF Chapter
New River Longbeards NWTF Chapter
NC Bowhunters Association
NC Camouflage Coalition
NC Catfish Association Tournament Series
NC Chapter National Wild Turkey Federation (NWTF)
NC Ducks Unlimited
NC Falconers Guild
NC Handicapped Sportsmen, Inc
NC Hunters for the Hungry
NC State Chapter of Quality Deer Management Association (QDMA)
NC State Council Quail and Upland Wildlife Federation
NC Trappers Association
NC Trout Unlimited State Council
NC Wildlife Federation
NC Wildlife Habitat Foundation
North Central Longbeards NWTF Chapter
Northwestern NWTF Chapter
Pender County Longbeards NWTF Chapter
Pisgah Chapter, Trout Unlimited
Protecting, Advocating, and Conserving Together (PACT) in the High Country
Randleman Longbeards NWTF Chapter
Red Clay Longbeards NWTF Chapter
Roanoke-Albermarle NWTF Chapter
Rocky River Chapter, Trout Unlimited
Rowan County Wildlife Association
Ruffed Grouse Society Eastern NC Chapter
Sandhills NWTF Chapter
Sandhills Rod & Gun Club
Smoky Mountain NWTF Chapter
South Fork Limbhangers NWTF Chapter
Southern Appalachian Branch of QDMA
Southern Piedmont NWTF Chapter
Southern Strutters NWTF Chapter
Stanly County NWTF Chapter
State College NWTF Chapter
Stone Mountain Chapter, Trout Unlimited
Surry Longspurs NWTF Chapter
Table Rock Chapter, Trout Unlimited
Tar River NWTF Chapter
Triangle Fly Fishers
Tri-County Chapter NWTF Chapter
Union County NWTF Chapter
Wake County NWTF Chapter
Warren County Double Beards NWTF Chapter
White Store Branch of QDMA
Wilson County Spurs NWTF Chapter

For more information contact Tim Gestwicki, North Carolina Wildlife Federation Executive Director, tim@ncwf.org, 704-332-5696

- After further opposition by Betsy Johnson, Good Hope was denied its Request for Declaratory Ruling by HRS. HRS stated that Good Hope's requests should be addressed by filing for a new CON.

- Good Hope/Triad then filed for a new CON. The 2003 CON public hearing lasted over five and a half hours with overwhelming support expressed by the public and Harnett Medical providers for the hospital planned by Good Hope/Triad. A public survey showed 84% support of the Good Hope/Triad hospital.

- The Good Hope/Triad CON request was denied by HRS.

- Good Hope/Triad filed an appeal of its CON denial. The appeal was heard by Senior Administrative Law Judge Fred Morrison. Judge Morrison ruled in favor of Good Hope on all issues and found that the State acted with bias against Good Hope. HRS rejected Judge Morrison's decision and refused to grant the 2003 CON. (Note: Fortunately, the law now provides that an Administrative Law Judge's decision is binding on the State as opposed to a recommended decision.)

- Good Hope also requested permission from the State to build a replacement hospital based on the law that allows an exemption to the CON laws when health and safety standards place patients at risk. HRS used this request as a basis to demand immediate repairs at Good Hope exceeding $300,000 under threat of suspending Good Hope's license. HRS then denied Good Hope's exemption request.

- Former Governor Easley amended the State Health Facilities Plan, determining that there was a need for a fifty (50) bed hospital in Lillington.

- Good Hope/Triad applied for this new CON. Harnett Health System, consisting of Betsy Johnston Hospital with WakeMed as its manager, filed a competing CON application. (Note: This action represented a tacit admission by Betsy Johnson that Harnett Co. could support more than one hospital.)

- The State awarded the 2005 CON to Harnett Health. (Notes: 1. During the review process, Harnett County Commissioner Tim McNeill repeatedly stated in public that he was informed by a high ranking state official that Good Hope would not be granted the 2005 CON 2. Good Hope learned years later that Senior Analyst Michael B. McKillip's original finding was to award the 2005 CON to Good Hope/Triad, but his recommendation was overturned by senior management, and the 2005 CON was awarded to Harnett Health. Mr. McKillip testified that to his knowledge, such an original finding had never been overturned before. No record of Mr. McKillip's decision was ever given to Good Hope in the discovery process.

- Good Hope Trustees determined that Harnett Health has no interest in inpatient mental health services and requested the State to grant Good Hope permission to reopen 16 inpatient mental health beds at Good Hope's former campus.

- After five (5) years of discussions, and with the assistance of Rep. David Lewis, the State granted Good Hope permission to use 12 beds from its 2001 CON and the State transferred 4 additional beds from Dix to Good Hope. This action was accomplished by administrative action by HRS Director.

- Representatives from Good Hope, Rex Healthcare and FirstHealth met with the HRS staff and its attorney to discuss a proposal to open an Ambulatory Surgery Center (ASC) based on 2001 CON and 2009 Settlement Agreement. The attorney for HRS expressed no legal concerns about the proposed request. The main question asked by the staff concerned whether or not Good Hope expected opposition from WakeMed/Harnett Health.

- Rex and FirstHealth attorney filed a Declaratory Ruling Request to reestablish Good Hope's outpatient surgery services by establishing an Ambulatory Surgery Center (ASC). WakeMed/Harnett Health filed objections.

- Rex and FirstHealth's declaratory ruling request to establish an ASC with Good Hope is denied. The denial mirrors objections listed by WakeMed/Harnett Health.

- Good Hope met with Representative David Lewis regarding the denial of Rex and FirstHealth's request to build an ASC with Good Hope.

- Good Hope was informed by Rep. Lewis that HRS Director Pratt recommended that Good Hope resubmit the Request for Declaratory Ruling and that Rep. Lewis should confer with WakeMed CEO Bill Atkinson about the Good Hope ASC.

- After WakeMed/Harnett Health filed objections, HRS Director denied Good Hope's request. (Note: There is precedent in earlier Declaratory Rulings that support approval of Good Hope's request.)

March 15, 2012

- The State is well aware that the clock is running on Good Hope's 2009 Settlement Agreement and nearly one year has elapsed since Good Hope began following the State's suggested path for achieving the ASC modification of the 2009 Settlement Agreement. Nevertheless, not only has the State denied permission to build said ASC, it has also denied any extension of time for the Settlement Agreement.

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

Name of Committee

03-15-2012

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Griffin	Novant Health, Inc. Winston-Salem, NC
Jill Rosenblum	NBM Health Planning Associates Durham, NC
Laurie Onorio	Jason Deans & Assoc.
Jason Deans	Jason Deans Assoc.
Charlene Thomas	Strategic Healthcare Advisors
Denise Gunter	Nelson Mullins
Jimm Bunch	Park Ridge Health
Jerry Parks	North Carolina Association of Local Health Directors
Nadine Pfeiffer	NC Division of Health Service Regulation, Medical Facilities Planning Branch Raleigh, NC
Stephen Kouba	Compass NC
Tina Shanahan	CompassNC
John Cooper	CompassNC

(2)

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 03-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Colvard	AHHC
Max Mason	Principle Long Term Care
T.J. Pulliam	1105 Fawnbrook Rd Lewisville NC 27023
Duncan Yaggy	3512 Ridge Road Durham NC 27705
Catharine Cummer	Duke University Health System
Sandra Greene	UNC - Chapel Hill
David O'Connor	CaroMont Health
Greg Bass	Carolinas HealthCare System
Debbie Murphy	HPS
Trey Adams	PDA
David Meyer	Keystone Planning

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES 03-15-2012

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
C S Hollis	TSS
Connie Wilson	NCOA/NCSERS
Kris Horton	DHHS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 03-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Metcalf	Mission Health
Ronald B. Timms	Mission Health
Ann Young	Mission Health
Al J. Zerman	UNCHCS
[illegible]	K&L Gates
[illegible]	[illegible]
[illegible]	Duke
MARC HEWITT	WILLIAMS MULLEN
[illegible]	Mission Health
BRIAN MOORE	MISSION HEALTH
[illegible]	NEWS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 03-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Tilson	NCHA
Kristen Laster	Acclaim Strat.
Allison Waller	Nelson Mullins
Joe Lanier	Nelson Mullins
Gretchen Kelly	First Health
John Bode	BCS
Angie Harris	Williams Mullen
Eric Snider	Smith Moore Leatherwood
Kathleen Worrell	PDC
Tom West	Poyner Spruill
Ken Melton	K.M.A.

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 03-15-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matthew Eisley	Smith Anderson
[illegible]	NMRS
ROSE HOBAN	NC HEALTHNEWS

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, April 19, 2012
TIME: 10:00 A.M.
LOCATION: 544 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **9 AM** o'clock on **April 10, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee On the Certificate of Need Process and Related Hospital Issues

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

State Legislative Building
Raleigh, North Carolina

AGENDA
10:00 a.m.
Thursday, April 19, 2012
Room 544 Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Committee Discussion
- *Interim Committee Report Document*
- *Accompanying Proposed Legislation*
- *Future Committee Focus and Direction for the Fall interim*

III. Adjourn

MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Thursday, April 19, 2012
10:00 A.M.
Room 544 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, April 19, 2012 in room 544 LOB. Representatives Alexander, Avila, Boles, Current, Collins, Glazier, Hollo, and Randleman attended. Representative Steen presided. He called the meeting to order and welcomed everyone.

Rep. Steen: We appreciate the work the staff has done on this committee through this process. It has been a very intense process and we appreciate all the patience and hard work on everybody's behalf. We are getting ready to hear the draft report from staff. I will turn the meeting over to Shawn Parker, who will give us some of the findings of the committee.

Shawn Parker, Staff Council: Interim Draft Report(see attached and on committee website)

Rep. Torbett: Committee approval of two preceding meetings minutes. The minutes were approved. Seek approval of the recommended report. The report was approved.

Rep. Steen: We appreciate all the patience and hard work from all the committee members. We will continue this study after session and we appreciate all the staff and all their input.

Rep. Torbett: We need to let the members of the committee know that this Select Committee will stand adjourned until after the short session when we can reconvene.

Rep. Steen adjourned the meeting at 10:25 a.m.

Rep. Fred Steen, Presiding Chair

Viddia Torbett, Committee Clerk

Rep. John Torbett, Co-Chair

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MARC HEWITT	WILLIAMS MULLEN
Heather Barnett	WM
Jason Deans	Jason Deans & Assoc.
JOHN COOPER	COMPASS NC
Charlene Thomas	Strategic Healthcare Advisors
GRAHAM FIELDS	PARK RIDGE HEALTH
Jimm Bunch	PARK RIDGE HEALTH
Denise Gunter	Nelson Mullins
Marie Wilding	Novant
Barb Freedy	Novant
Candace Friel	Nelson Mullins

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Melanie Lewis	HealthSouth
Tina Shanahan	Compass NC
Shelley Anderson	PDA
Lori Ann Harris	LAHA
Stephen Kouba	Compass NC
[illegible]	[illegible]
Linda Henning	UNC Hosp
Justin Puleo	Smith Moore
Ron Paulus	[illegible]
Scott Foreman	Robinson Bradshaw
William Hathaway	Mission Health
Rowena Buffett Timms	Mission Health

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Duncan Yaggy	Retired
[illegible]	Individual
Daniel Carter	Health Planning Source 324 Blackwell St. Ste 1100 Durham, NC 27701
Carol Jones	K&L Gates
[illegible]	Mission Health
[illegible]	Mission Health
Robert K. Skaddow, MD	Pardee Hospital
Pam Scott	Poyner Spruill
Jim Jones	DHHS
David Barnes	PS
Christine Craig	WakeMed

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jill Rosenblum	NBM Health Planning Associates / Durham
Stephanie Soucheray	Reporter Carolina Public Press
Jim Swann	FRESENIUS MEDICAL CARE
MAX MASON	PRINCIPLE LONGTERM CARE, INC.
David Meyer	Keystone Planning.com
Robbie Roberts	WakeMed
Joy Heath	Heath Law Firm, PLLC 514 Daniels St #182 Raleigh NC 27605
Ruth Levy	Heath Law Firm, PLLC
Tom Novinc	A&C Comm
JOE LANIER	NELSON MULLINS
Paul Vick	Duke

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gretchen Kelly	FirstHealth of the Carolinas
[illegible]	[illegible]
Kris Horton	DHHS
Connie Wilson	NCOA/NCSEPS
BJ Miller	Cone Health
Daniel Baum	Troutman Sanders
David Miner	TRG Inc

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 04-19-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chip Baggett	NCMS
Ann Miller Wilson	NCMS
Kathleen Worrell	PDC
Breeden Blackwell	Cape Fear Valley Health
Allison Waller	Nelson Mullins
[illegible]	GSK
John Thompson	CCNC

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, September 13, 2012
TIME: 1:00pm - 3:00pm
LOCATION: 544 LOB LOB
COMMENTS: Review and Recap

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **9 AM** o'clock on **August 24, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

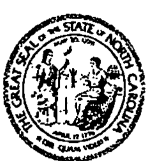
REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868



AGENDA
1:00 p.m.
Thursday, September 13, 2012
Room 545, Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Review of Previous Topics Before the Committee
Amy Jo Johnson and Jan Paul, Research Division

III. Update from the Division of Health Service Regulation
Drexdal Pratt, Director, Division of Health Service Regulation, DHHS

IV. Committee Discussion

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, September 13, 2012

1:00 p.m.

Room 544, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, September 13, 2012 in Room 544, LOB at 1:00 p.m. Representatives Avila, Collins, Current, Glazier, and Torbett were present.

Representative Torbett presided.

Amy Jo Johnson and Jan Paul presented a review of topics before the committee (please see attached and on committee website).

Drexdal Pratt gave an update from the Division of Health Service Regulation (please see attached and on committee website).

Representative Avila: Has the department looked at new E-forms that the controller's office is implementing?

Drexdal Pratt: We have not, but are looking at a new processing system for our division, and would be happy to get with the controller's office about this.

Representative Glazier: Is there a selective comparison in the Dixon Hughes report?

Chris Taylor: There are six reports and that is included.

Representative Current: The Simpson Bowles report says that the number one issue is cost of healthcare for economic recovery, has this been studied, at what degree, do they get into the CON and getting a handle on it?

Craig Smith: A former SHCC member noted that healthcare costs in North Carolina compare very favorably as it relates to California, Florida, and Texas.

Representative Current: I would question a full evaluation of the Simpson Bowles report and if Certificate of Need comes into it.

Representative Avila: Why not a comparison of South Carolina, Virginia, Georgia, neighboring states?

Craig Smith: We will have that at next meeting (please see attached 2009 healthcare expenditure comparison provided to members, attached and on committee website).

Glazier: The data is limited by variables it excludes; I would expect that there are hundreds of variables.

Representative Collins: Do we have unintended consequences by diagnostic centers not being under CON of people who have been affected?

Craig Smith: We have no comment from them.

Representative Avila: What would happen if diagnostic centers were removed from CON?

Craig Smith: If we remove, existing diagnostic centers who met all requirements would be at a disadvantage.

Representative Collins: What if clinical labs were removed?

Craig Smith: It might be ok with not the same consequences as diagnostic centers.

Representative Torbett: We have a large subject to cover and Representative Steen and I have discussed that perhaps it would be appropriate to provide an opportunity for committee members to drill down by specific interests and come back to the committee by the end of October with their findings. For an example I plan to drill down further into adding doctors and the total time for a CON application to the opening of doors for a new facility.

Representative Avila: I would like to look more at COPA.

Representative Glazier: I would like to focus on appeals process issue about the timing and discuss with OAH and AOC about ways to streamline the appellate process.

Representative Torbett: I will be requesting your help with this. Our overall goal is cost, access, and availability. Are there any members of the audience that would like to speak?

Representative Torbett adjourned the meeting.

Representative John Torbett, Co-Chair, Presiding

Viddia Torbett, Committee Clerk

Representative Fred Steen, Co-Chair

CON APPLICATION PROCESS & GENERAL PROCEDURES		
Concern	**Options**	**Discussion**
CON process is no longer needed for certain services: • Air Ambulance • Solid Organ Transplant	No longer require CON for air ambulances or solid organ transplant services.	**Recommendation**: Divide into two separate recommendations: • **Recommendation #1 -** Remove air ambulance from CON statute. • **Recommendation #2 -** Remove Solid Organ Transplant services from CON statute.
The diagnostic service center requirements under CON are difficult to enforce and rarely reported.	• Eliminate diagnostic service centers from CON requirements. • Increase the threshold amount. • Eliminate "clinical laboratories" from definition.	Held – with request for further details from DHSR.
Ophthalmic procedure rooms in licensed ambulatory facilities should be regulated by CON.	Amend CON law to allow Ophthalmic procedure rooms in licensed ambulatory surgical facilities – similar to that for gastroenterology.	Presentation by Dr. Christenbury – limited discussion.
Applications are required to be submitted in hard copy.	Allow for or require electronic submissions of applications.	**Recommendation:** DHSR to look into possibilities for CON submission process.
More transparency is needed in the CON process.	Require all applications/ determination requests/requests for review as well as Agency decisions to be posted on website.	**Recommendation**: DHSR to move with all deliberate speed with posting materials to website.
Monetary threshold for projects requiring a CON under 131E-176 of 2 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	**Recommendation:** Increase threshold amount to 4 million dollars.
Monetary threshold for expedited review of less than 5 million dollars is too low.	• Increase the threshold amount. • Account for inflation.	**Recommendation:** Eliminate threshold.

CON APPLICATION PROCESS & GENERAL PROCEDURES		
Concern	**Options**	**Discussion**
Monetary threshold for major medical equipment requiring a CON is too low at $750,000.	• Increase the threshold amount. • Account for inflation.	**Recommendation:** Increase threshold amount to 1.5 million dollars.
Monetary threshold for replacement equipment is too low at 2 million dollars.	• Increase the threshold amount. • Account for inflation.	Held.
Modification/changing a CON is too difficult.	• No longer require approval for CON changes under all or special circumstances. • Change Scope of CON	Presentation by Harnett County, using example of experience with Good Hope Hospital – limited discussion.
No statutory requirement deadline for letters of review, CON Exemption requests or Material Compliance Requests.	• Create a deadline. • Require fee for such determinations.	Held.

STATE HEALTH COORDINATING COUNCIL		
Concern	**Options**	**Discussion**
State Ethics Act should apply to SHCC members.	Require Council to be subject to all or part of the Act.	• Discussion of potential conflicts between current Executive Order and Chapter 138A. • Discussion that the issue has already been looked at by Ethics Committee. • Held.
Appointments should be made by legislature and Governor.	Divide membership appointments among Governor, Senate, and House of Representatives	Held.
SHCC members may have an affiliation with or be employed by providers applying for CON.	Extend prohibition in 131E-191.1 to include persons employed or affiliated with XXXX.	Provision on conflict of interest requested from DHSR – Held.
Determinations of need made by the SHCC are "outcome determinative" with respect to any CON application.	Make need determinations presumptively correct & rebuttable by evidence of specific circumstances involved in a CON application.	Held.

STATE MEDICAL FACILITIES PLAN		
Concern	**Options**	**Discussion**
Policies adopted in the SMFP are not considered rules under the APA.	• Include under the APA. • Direct that certain portions of APA apply. • Establish SHCC by law.	**Recommendation:** Do not put under APA.
The SMFP contains exceptions.	• Eliminate/limit certain plan exemptions (AC-3). • Develop non-subjective criteria to qualify for exemptions.	**Recommendation**: Continue to keep topic open.
SMFP does not address differences between hospitals of varying size.	• Create occupancy tiers for hospitals with 100 beds or less and tiers for hospitals with greater than 100 beds.	Held.
	• Count the dual beds in the census count for hospitals with 100 beds or less. • Create a new system of classifying beds that accounts for dual purpose beds.	Held.

APPEALS PROCESS		
Concern	**Options**	**Discussion**
Frivolous appeals cause unnecessary delays.	• Prevailing party gets costs and attorneys' fees. • Increase penalties for frivolous appeals. • Stricter enforcement of imposed penalties.	Held.
Appeals cause delays in provision of needed facilities and/or services.	Eliminate stays. A CON issued by the State takes effect immediately upon issuance. Mississippi model: The filing of an appeal from a final order of the statutorily specified body or tribunal shall not stop the purchase of medical equipment or development or offering of institutional health services granted in a CON issued by the State.	Concerns that cases become moot. – Held.

APPEALS PROCESS		
Concern	**Options**	**Discussion**
Bond requirements are inadequate.	• Increase the threshold amount of required appeal bond. • Account for inflation. • Amount of bond in discretion of board or court, with requirement that any appeal of a final order in a CON proceeding requires the giving of a bond sufficient to secure the appellee against the loss of costs, fees, expenses and attorney's fees incurred in defense of the appeal, approved by the appellate court within five (5) days of the date of filing the appeal. • Require a separate bond for each petition filed.	Discussion surrounding separate bonds for each petition – Held.
Too many parties have the ability to file an appeal.	Redefine and limit "affected person" and "aggrieved party" for purposes of standing to file an appeal.	Suggestion to obtain proposed language from DHSR. – Held.
The appeals process is too lengthy.	• Appeal from a final order or decision of the Department in a CON denial case goes to a contested case hearing before OAH and from there, directly to the Supreme Court. • Time limits for appeals decisions. e.g., Georgia model: Certificate of Need Appeal Panel consists of independent hearing officers appointed by the Governor in order to review the Dept's initial decisions to grant or deny a Certificate of Need. The decision of the appeals panel hearing officer is final unless objection is filed with the Commissioner within 60 days. Commr reviews and can award attorneys' fees and expenses if determines appeal was made for purposes of delay or harassment. Commr's Decision final unless appealed to Superior Court. However, if the Court does not hear the case within one hundred and twenty (120) days of the date of docketing in the Superior Court, the decision of the Dept. shall be considered affirmed by operation of law unless a hearing originally scheduled to be heard within the 120 days has been continued to a date certain by order of the Court.	Suggestion to consult with OAH and AOC. – Held.

COPA		
Concern	**Options**	**Discussion**
Purpose and scope of COPA needs to be changed.	• Statutory change to 131E-20 • Possible changes to Article 9A	Held.
No means by which to terminate COPA.	Statutory change - Authorize COPA recipient by statute to terminate agreement ten years after a period of time in compliance	Held.
Oversight of COPA should be modified.	• Direct through rule making. • Direct Program Evaluation to complete Study. • Direct audit by Office of State Auditor. • Annual or semi-annual review. • Changes to public review- DHSR publish response to comments.	Discussion of independent compliance audit by Dixon Hughes. – Held. **Recommendation:** a more in-depth audit is needed.
COPA activity should be modified.	• Moratorium on projects. • Restriction on activity for COPA recipients. • Specify territorial limitations of protections.	Held.

Division of Health Service Regulation
Update on activities
September 13, 2012

<u>Certificate of Public Advantage (COPA)</u>

Since the last meeting of the Subcommittee we have had Dixon-Hughes Goodman as an independent third party prepare:

<u>(A) Hospital Market Basket Report for FY 2011</u>

The Report along with other information will be used in determining:

(1) If Mission's operating margin exceeds mean of the selected other comparable institutions over three year period.

(2) If the cost per adjusted discharge meets the requirements of the COPA.

<u>(B) The Five Year Compliance Report on the COPA.</u>

(1) The report was designed to determine if Mission was in compliance with terms of the COPA

(2) The report will be discussed at the next meeting of the Subcommittee at which meeting Dixon Hughes Goodman will be present.

The Reports are being furnished to the members of the Subcommittee today and are available on the Reports Section of the DHSR Web Site as of 1:00 pm today.

<u>Diagnostic Centers</u>

During our discussions with the Committee and its staff in the fall, we suggested that it might be possible to remove diagnostic centers from the definition of health service facilities that require certificate of need approval as a new institutional health service. However, since those discussions, we have researched that issue and realize there are possible unintended consequences.

Transparency

There have been several updates to our web site and internal processes.

Certificate of Need (CON)

- Decisions and Findings posted monthly;
- Letters of no review and exemptions posted monthly;
- The monthly report has been broken down from one report into 7 separate reports;
- The seven reports include:
  - Appeals from the previous month
  - Certificates issued in the previous month
  - Decisions during the previous month
  - Expedited review petitions approved in the previous month
  - Reviews extended in the previous month
  - Written comments and public hearings for the upcoming review cycle
  - Application log of the current month

We have the ability to accommodate the uploading of a CD or DVD of a CON application to the website and are in the planning stages for this to begin soon.

State Health Coordinating Council (SHCC)

- Held six public hearings on the Proposed 2013 State Medical Facilities Plan
  - Greensboro, Asheville, Charlotte, Greenville, Wilmington and Raleigh

- Posted revised general information on public hearings to website for each public hearing listing

- Beginning with the summer petitions the petitions and comments page was revised to be more user friendly and for clarity on searching for specific petitions and comments filed

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-13-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Wolfe	McGuireWoods Consulting
John Cooper	Compass NC
GRAHAM FIELDS	PARK RIDGE HEALTH
Jimm Bunch	" " "
Stephen Kouba	Compass NC
Tina Shanahan	Compass NC
Elise Quick	Troutman Sanders
Cheryl Ouimet	DHHS-DHSR
Martha Frisone	DHHS-DHSR
Nadine Pfeiffer	DHHS-DHSR
HUGH TILSON	NCHA
Barbara Freedy	Novant Health

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-13-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Catharine Cummer	DHHS
Earl Jones	Good Hope Hospital, Inc.
Pat Cameron	Good Hope Hospital, Inc.
Jim Burgin	Harnett County Commission / Good Hope Hosp
Max Mason	Principle Long Term Care, Inc.
Roger Balmer	Concerned Citizen
Jason Deans	Jason Deans + Assoc.
Gary Qualls	K&L Gates
Dawn Carter	Ascendient

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-13-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Jill Rosenblum	NBM Health Planning
Alex Mullineaux	Carolinas Mont Health
Bill Forstner	Smith Moore
David Meyer	Keystone Planning Group.
Mike Vicario	NCHA
[illegible]	Mission Health
John Metcalf	Mission Health.
[illegible] Scott	Poyner Spruill
Trey Adams	PDA, Inc.
Doug Heron	DUKE

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-13-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison Walter	Nelson Mullins
Gretchen Kelly	FirstHealth of the Carolinas
Andrew Blackburn	Southern Strategy Group
Jacob Parson	Civitas Institute
Clark Riemer	Civitas
Kathleen Worrell	PDC

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, September 27, 2012
TIME: 10:00 a.m.
LOCATION: 544 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **5 PM** o'clock on **September 17, 2011.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
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House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
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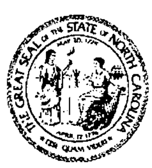


AGENDA
Thursday, September 27, 2012
10:00 am
Room 544, Legislative Office Building

I. Welcome and Opening Remarks
Representative John Torbett and Representative Fred Steen

II. Scope of Certificate of Need
Craig Smith, Chief, Certificate of Need Section, Division of Health Services Regulation, NCDHHS

III. 2005 Change in the CON Law for GI Endoscopy Procedure Rooms
Dave French, MBA, MHA, President, Strategic Healthcare Consultants

IV. North Carolina CON Regulation of Diagnostic Centers
Dave French, MBA, MHA, President, Strategic Healthcare Consultants

V. Hospital Quality Improvements Activities
Hugh Tilson, Senior Vice President, North Carolina Hospital Association

VI. Committee Discussion

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, September 27, 2012

10:00 a.m.

Room 544, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, September 27, 2012 in Room 544, LOB at 10:00 a.m. Representatives Alexander, Boles, Brandon, Collins, Current, Hollo, Randleman, Steen, and Torbett were present.

Representative Torbett presided.

Craig Smith, Chief, Certificate of Need Section, Division of Health Services Regulation, NCDHHS gave a presentation on the scope of certificate of need (see attached and on committee website).

Questions from committee members Representatives Boles, Collins, and Current regarding endoscopy, methodology, duplication, Simpson-Bowles concluding healthcare cost number one issue, and letters of support for MRI were answered by Craig Smith, Chief, Certificate of Need Section, Division of Health Services Regulation, NCDHHS.

Dave French, MBA, MHA, President, Strategic Healthcare Consultants gave a presentation on 2005 change in the CON law for GI endoscopy procedure rooms (see attached and on committee website).

Questions from committee members Representatives Alexander, Boles, Collins, Current, and Steen regarding Medicaid, annual CON report, privilege in case of emergency, diagnostic centers, disproportion of non-paying patients, licenses the same, patient choice, financial obligation, increased utilization, data projections, exemptions, depreciation andexempt or update number were answered by Dave French, MBA, MHA, President, Strategic Healthcare Consultants.

Hugh Tilson, Senior Vice President, North Carolina Hospital Association gave a presentation on hospital quality improvement activities (see attached and on committee website).

Questions from committee members Representatives Collins and Current regarding cancer drug costs and who decides where the costs are increased were answered by Hugh Tilson, Senior Vice President, North Carolina Hospital Association.

Representative Torbett adjourned the meeting.

Representative John Torbett, Co-Chair Presiding

Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair

OVERVIEW OF CERTIFICATE OF NEED

Health Service Facilities Regulated by the CON Law [N.C.G.S. §131E-176(9b)]

1. Acute Care Hospitals. [N.C.G.S. 131E-176(13)]
2. Inpatient Psychiatric Hospitals. [N.C.G.S. 131E-176(21)]
3. Inpatient Rehabilitation Hospitals. [N.C.G.S. 131E-176(22)]
4. Nursing Homes. [N.C.G.S. 131E-176(17b)]
5. Kidney Disease Treatment Centers (i.e., Certified End-Stage Renal Disease Facilities). [N.C.G.S. 131E-176(14e)]
6. Intermediate Care Facilities for Individuals with Intellectual Disabilities. [N.C.G.S. 131E-176(14a)]
7. Certified Home Health Agency Offices. [N.C.G.S. 131E-176(12)]
8. Chemical Dependency Treatment Facilities (inpatient & residential). [N.C.G.S. 131E-176(5a)]
9. Diagnostic Centers. [N.C.G.S. 131E-176(7a)]
10. Hospice Programs and Offices. [N.C.G.S. 131E-176(13a)]
11. Hospice Inpatient Facilities. [N.C.G.S. 131E-176(13b)]
12. Hospice Residential Care Facilities. [N.C.G.S. 131E-176(13c)]
13. Ambulatory Surgical Facilities. [N.C.G.S. 131E-176(1b)]
14. Adult Care Homes. [N.C.G.S. 131E-176(1)]
15. Long-Term Care Hospitals. [N.C.G.S. 131E-176(14k)]

Activities Requiring Certificate of Need Review [N.C.G.S. §131E-176(16)]

1. Establishment of a new health service facility (See 1 through 15 above). [N.C.G.S. 131E-176(16a)]
2. Capital expenditure by any person for a health service in excess of $2 million dollars. [N.C.G.S. 131E-176(16b)]
3. Change in bed capacity. [N.C.G.S. 131E 176(16c), 176(5) and 176(9c)]
   - (i) Relocation of health service facility beds or dialysis stations. [N.C.G.S. 131E-176(5)(i)]
   - (ii) Change of health service facility beds from one category to another. [N.C.G.S. 131E-176(5)(ii)]
   - (iii) Increase in dialysis stations or health service facility beds. [N.C.G.S. 131E-176(5)(iii)]

   Health service facility beds are defined in N.C.G.S. 131E-176(9c) to include:
   - a. acute care beds;
   - b. inpatient psychiatric beds;
   - c. inpatient rehabilitation beds;
   - d. nursing home beds;
   - e. intermediate care beds for Individuals with Intellectual Disabilities;
   - f. chemical dependency treatment beds (inpatient and residential);
   - g. hospice inpatient facility beds;
   - h. hospice residential care facility beds;
   - i. adult care home beds; and
   - j. long-term care hospital beds.
4. Establishment of new dialysis services or home health services. [N.C.G.S. 131E-176(16d)]
5. Change in an approved CON project that includes cost overrun of 15% or the addition of a health service. [N.C.G.S. 131E-176(16e)]
6. The offering of any of the following services [N.C.G.S. 131E-176(16f)]:
   - a. Bone marrow transplantation;

  b. Burn intensive care services;
  c. Neonatal intensive care services (NICU);
  d. Open-heart surgery services;
  e. Solid organ transplantation services; and
  f. Cardiac catheterization services.

7. The acquisition of any of the following equipment [N.C.G.S. 131E-176(16f1)]:
   a. Air ambulance;*[not enforced subject to a federal court order]*
   b. Cardiac catheterization equipment;
   c. Gamma knife equipment;
   d. Heart-lung bypass machine;
   e. Linear Accelerator for Radiation Therapy Treatments;
   f. Lithotriptor;
   g. Magnetic Resonance Imaging (MRI) scanner;
   h. Positron Emission Tomography (PET) scanner; and
   i. Radiation Therapy Treatment Simulator.
8. The acquisition of a health service facility from an HMO. [N.C.G.S. 131E-176(16l)]
9. Conversion of non-health care beds to health care beds. [N.C.G.S. 131E-176(16m)]
10. Construction or establishment of a hospice, hospice inpatient facility, or hospice residential care facility. [N.C.G.S. 131E-176(16n)]
11. Opening of an additional office by an existing home health agency or hospice. [N.C.G.S. 131E-176(16o)]
12. Acquisition of major medical equipment ($750,000 including costs of studies, design, construction, renovation and installation). [N.C.G.S. 131E-176(14o)]
13. Relocation of a health service facility from one service area to another. [N.C.G.S. 131E-176(16q) and 176(24a)]
14. Conversion of specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program. [N.C.G.S. 131E-176(16r), 176(15a) and 176(24c)]
15. Furnishing mobile medical equipment to any person in North Carolina if equipment was not in use in North Carolina prior to March 18, 1993. [N.C.G.S. 131E-176(16s)]
16. Development or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than relocation within the same building, on the same grounds, or across a public right of way from the existing location. [N.C.G.S. 131E-176(16u)]
17. The change in designation of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room. [N.C.G.S. 131E-176(16v)]

OVERVIEW OF CERTIFICATE OF NEED

Health Service Facilities Regulated by the CON Law [N.C.G.S. §131E-176(9b)]

1. Acute Care Hospitals. [N.C.G.S. 131E-176(13)]
2. Inpatient Psychiatric Hospitals. [N.C.G.S. 131E-176(21)]
3. Inpatient Rehabilitation Hospitals. [N.C.G.S. 131E-176(22)]
4. Nursing Homes. [N.C.G.S. 131E-176(17b)]
5. Adult Care Homes. [N.C.G.S. 131E-176(1)]
6. Long-Term Care Hospitals. [N.C.G.S. 131E-176(14k)]
7. Intermediate Care Facilities for Individuals with Intellectual Disabilities. [N.C.G.S. 131E-176(14a)]
8. Chemical Dependency Treatment Facilities (inpatient & residential). [N.C.G.S. 131E-176(5a)]
9. Hospice Inpatient Facilities. [N.C.G.S. 131E-176(13b)]
10. Hospice Residential Care Facilities. [N.C.G.S. 131E-176(13c)]

Health Service Facilities Regulated by the CON Law (continued)

11. Kidney Disease Treatment Centers (i.e., Certified End-Stage Renal Disease Facilities). [N.C.G.S. 131E-176(14e)]

12. Certified Home Health Agency Offices. [N.C.G.S. 131E-176(12)]

13. Diagnostic Centers. [N.C.G.S. 131E-176(7a)]

14. Hospice Programs and Offices. [N.C.G.S. 131E-176(13a)]

15. Ambulatory Surgical Facilities. [N.C.G.S. 131E-176(1b)]

Activities Requiring Certificate of Need Review [N.C.G.S. §131E-176(16)]

1. Establishment of a new health service facility. [N.C.G.S. 131E-176(16a)] (See Health Service Facilities Regulated by the CON Law [N.C.G.S. 131E-176(9b)]).

2. Capital expenditure by any person for a health service in excess of $2 million dollars. [N.C.G.S. 131E-176(16b)]

Activities Requiring Certificate of Need Review (continued)

3. Change in bed capacity. [N.C.G.S. 131E 176(16)c, 176(5) and 176(9c)]

   (i) Relocation of health service facility beds or dialysis stations. [N.C.G.S. 131E-176(5)(i)]

   (ii) Change of health service facility beds from one category to another. [N.C.G.S. 131E-176(5)(ii)]

   (iii) Increase in dialysis stations or health service facility beds. [N.C.G.S. 131E-176(5)(iii)]

Health service facility beds are defined in N.C.G.S. 131E-176(9c) to include:

a. acute care beds;
b. inpatient psychiatric beds;
c. inpatient rehabilitation beds;
d. nursing home beds;
e. intermediate care beds for Individuals with Intellectual Disabilities;
f. chemical dependency treatment beds (inpatient and residential);
g. hospice inpatient facility beds;
h. hospice residential care facility beds;
i. adult care home beds; and
j. long-term care hospital beds.

Activities Requiring Certificate of Need Review (continued)

4. Establishment of new dialysis services or home health services. [N.C.G.S. 131E-176(16d)]

5. Change in an approved CON project that includes cost overrun of 15% or the addition of a health service. [N.C.G.S. 131E-176(16e)]

Activities Requiring Certificate of Need Review (continued)

6. The offering of any of the following services [N.C.G.S. 131E-176(16f)]:

   a. Bone marrow transplantation;
   b. Burn intensive care services;
   c. Neonatal intensive care services (NICU);
   d. Open-heart surgery services;
   e. Solid organ transplantation services; and
   f. Cardiac catheterization services.

Activities Requiring Certificate of Need Review (continued)

7. The acquisition of any of the following equipment [N.C.G.S. 131E-176(16fl)]:

   a. Air ambulance; *[not enforced subject to a federal court order]*
   b. Cardiac catheterization equipment;
   c. Gamma knife equipment;
   d. Heart-lung bypass machine;
   e. Linear Accelerator for Radiation Therapy Treatments;
   f. Lithotriptor;
   g. Magnetic Resonance Imaging (MRI) scanner;
   h. Positron Emission Tomography (PET) scanner; and
   i. Radiation Therapy Treatment Simulator.

Activities Requiring Certificate of Need Review (continued)

8. The acquisition of a health service facility from an HMO. [N.C.G.S. 131E-176(16l)]

9. Conversion of non-health care beds to health care beds. [N.C.G.S. 131E-176(16m)]

10. Construction or establishment of a hospice, hospice inpatient facility, or hospice residential care facility. [N.C.G.S. 131E-176(16n)]

11. Opening of an additional office by an existing home health agency or hospice. [N.C.G.S. 131E-176(16o)]

12. Acquisition of major medical equipment ($750,000 including costs of studies, design, construction, renovation and installation). [N.C.G.S. 131E-176(14o)]

Activities Requiring Certificate of Need Review (continued)

13. Relocation of a health service facility from one service area to another. [N.C.G.S. 131E-176(16q) and 176(24a)]

14. Conversion of specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program. [N.C.G.S. 131E-176(16r), 176(15a) and 176(24c)]

15. Furnishing mobile medical equipment to any person in North Carolina if equipment was not in use in North Carolina prior to March 18, 1993. [N.C.G.S. 131E-176(16s)]

Activities Requiring Certificate of Need Review (concluded)

16. Development or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than relocation within the same building, on the same grounds, or across a public right of way from the existing location. [N.C.G.S. 131E-176(16u)]

17. The change in designation of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room. [N.C.G.S. 131E-176(16v)]

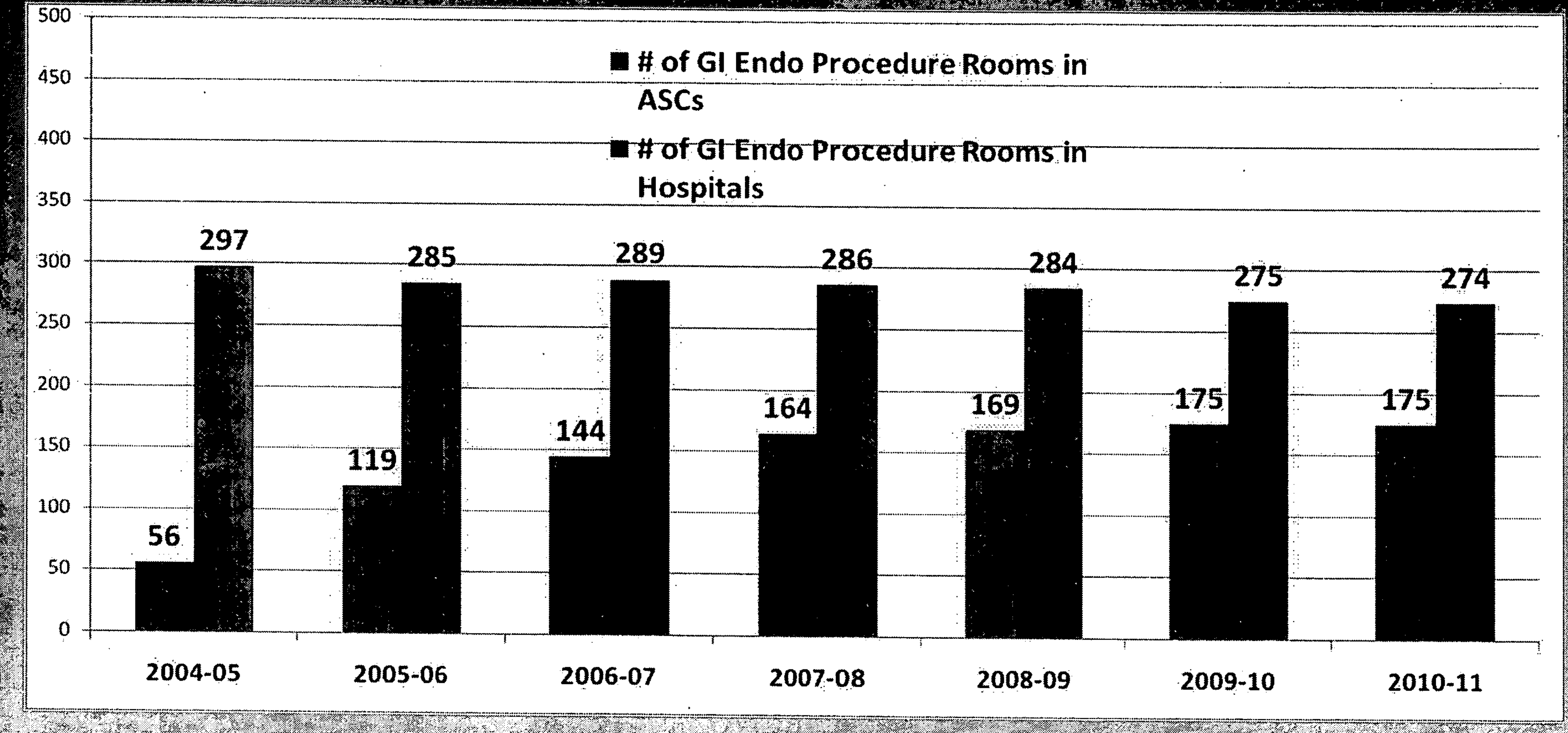
2005 Change in CON Law for GI Endoscopy Procedure Rooms

Cost Savings and Justification for Changes to CON Law to Allow Single-Specialty Ambulatory Surgery Centers

David J. French MBA, MHA
Strategic Healthcare Consultants

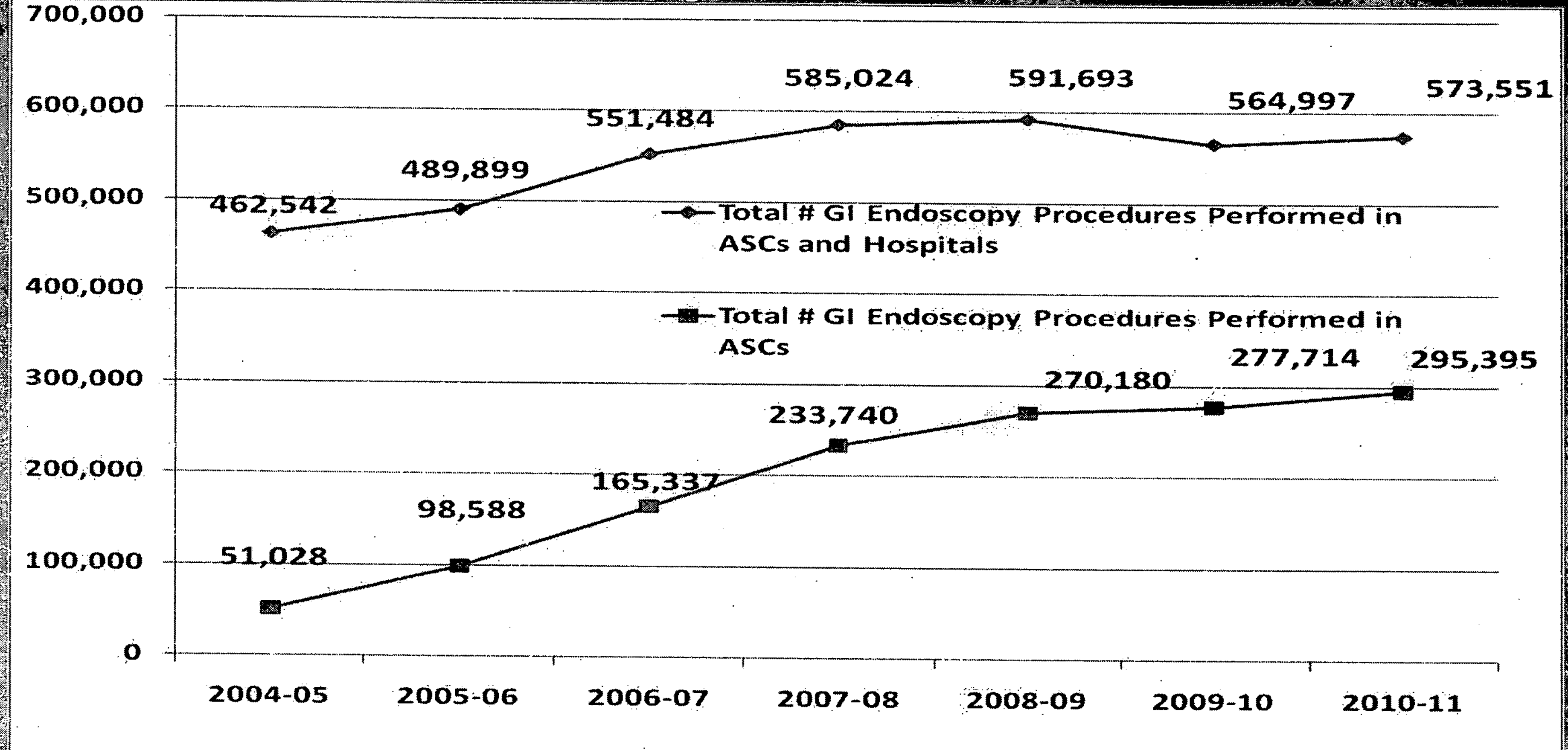
North Carolina Orthopaedic Association

2005 Change in CON Law for GI Endoscopy Procedure Rooms



During the six years following the 2005 change in the CON law, 47 new ASC facilities were developed. GI endoscopy procedure rooms in ASCs increased from 56 to 175.

GI Endoscopy Procedure Volumes



Total utilization for GI endoscopy procedures increased by 28 percent over the four years following the change in the CON law. Some of this increase is "normal growth" due to the aging population. Utilization declined in the most recent two years, due to the downturn in the economy.

Total savings related to the shift from hospitals to ASCs far exceeded the increase in expenditures for facility reimbursement. The total net savings over 6 years is estimated at $224,605,748.

Calculate Additional Endoscopy Volumes and Facility Reimbursements that Resulted from Additional Endoscopic ASCs Following the 2005 Change in CON Law

	A	B	C	D
North Carolina	Normal Expected Growth Due to Population Growth and Aging (3.0% Annual Increase for Population Over 45 years)	Actual Utilization for ASCs and Hospitals	Additional Procedures Attibuted to ASCs (B minus A)	Reimbursement of Additional ASC Procedures Based on $445 per Procedure for Facility Fees (C times $445)
2004-05	462,542	462,542	0	
2005-06	476,418	489,899	13,481	$ 5,998,929
2006-07	490,711	551,484	60,773	$ 27,044,071
2007-08	505,432	585,024	79,592	$ 35,418,381
2008-09	520,595	591,693	71,098	$ 31,638,567
2009-10	536,213	564,997	28,784	$ 12,808,903
2011-12	552,299	573,551	21,252	$ 9,456,990
	3,544,211	3,819,190	274,979	$ 122,365,841

Even without the change in the CON law in 2005, growth in GI endoscopy would occur due to population growth and aging. Between 2000 and 2010 the NC population over 45 years of age had a compound annual growth rate of over 3 percent.

Increased availability of endoscopy procedure rooms in ASCs supported greater access, higher efficiency and increased physician productivity.

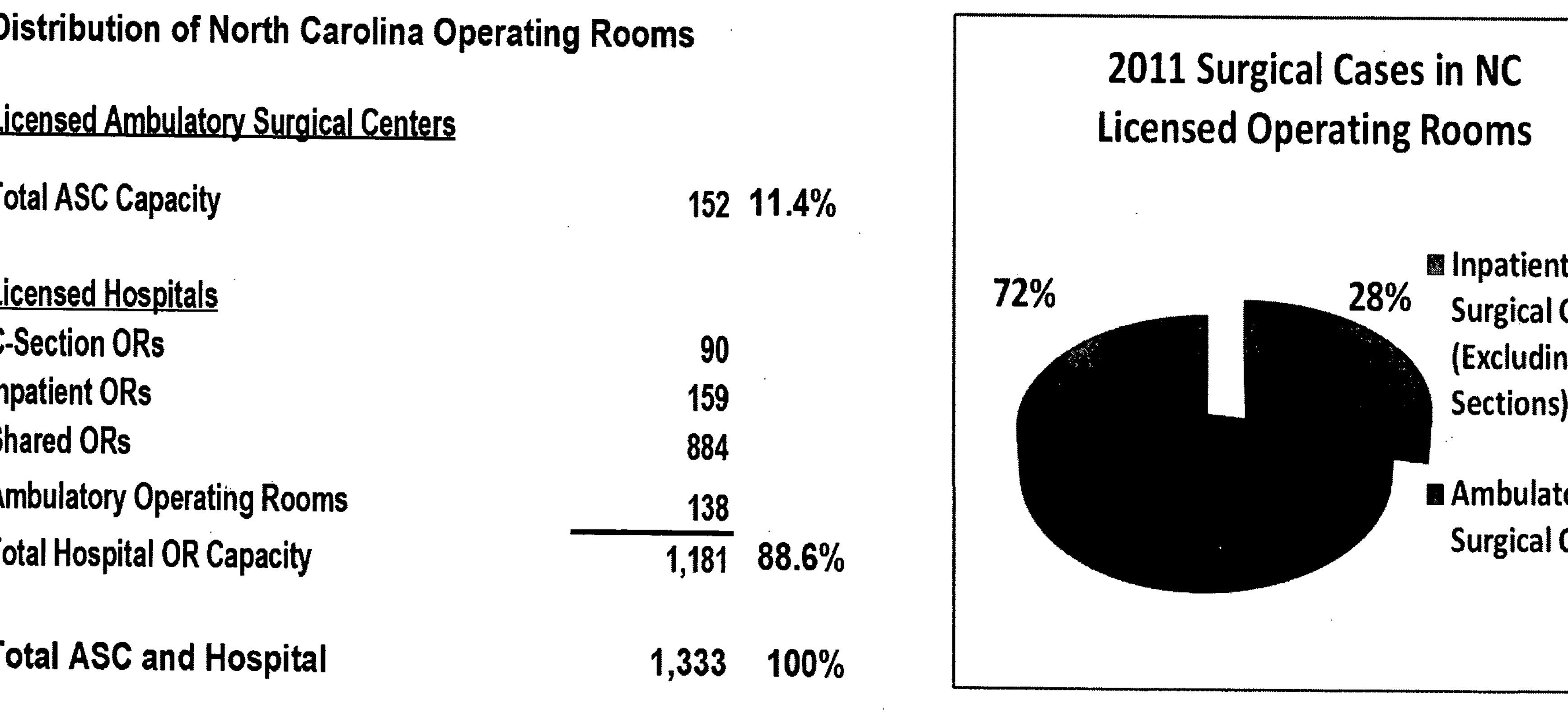
Calculate Cost Savings for Endoscopy Procedures Performed in ASCs instead of Hospitals

	A	B	C	D
North Carolina	Actual Procedures Performed in ASCs	Procedures Shifted to ASCs from Hospitals (75% Estimate X A)*	Average Cost Savings Per Procedure (Facility Rates Only)**	Total Estimated Savings for ASC Procedures All Payors + Patients
2004-05	51,028	0	NA	NA
2005-06	98,588	73,941	345	$25,509,645
2006-07	165,337	124,003	345	$42,780,949
2007-08	233,740	175,305	345	$60,480,225
2008-09	270,180	202,635	345	$69,909,075
2009-10	277,714	208,286	345	$71,858,498
2011-12	295,394	221,546	345	$76,433,198
	1,391,981	1,005,715		$346,971,589

* On average, 75 percent of the volume growth in colonoscopy and endoscopic GI procedures was due to a shift in site of service. From "An Analysis of Recent Growth of Ambulatory Surgery Centers" by KNG Consulting.

** Average savings per endoscopy procedure are estimated based on a broad range of endoscopy procedures with ASC paid 56% of the rates paid to hospitals.

Operating room capacity in North Carolina is dominated by hospitals even though the majority of surgical cases are ambulatory.

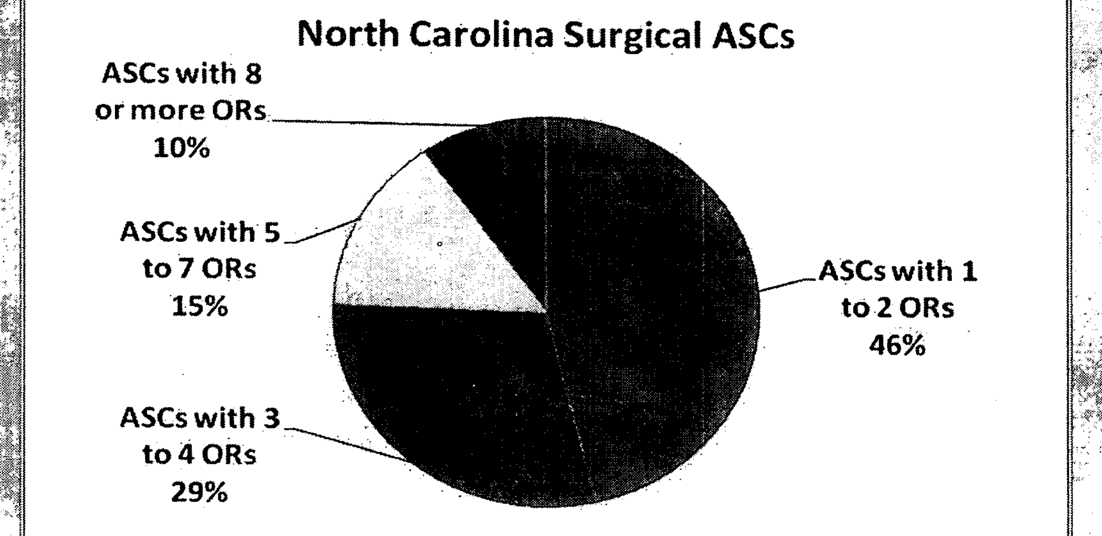


Distribution of North Carolina Operating Rooms

Licensed Ambulatory Surgical Centers		
Total ASC Capacity	152	11.4%
Licensed Hospitals		
C-Section ORs	90	
Inpatient ORs	159	
Shared ORs	884	
Ambulatory Operating Rooms	138	
Total Hospital OR Capacity	1,181	88.6%
Total ASC and Hospital	1,333	100%

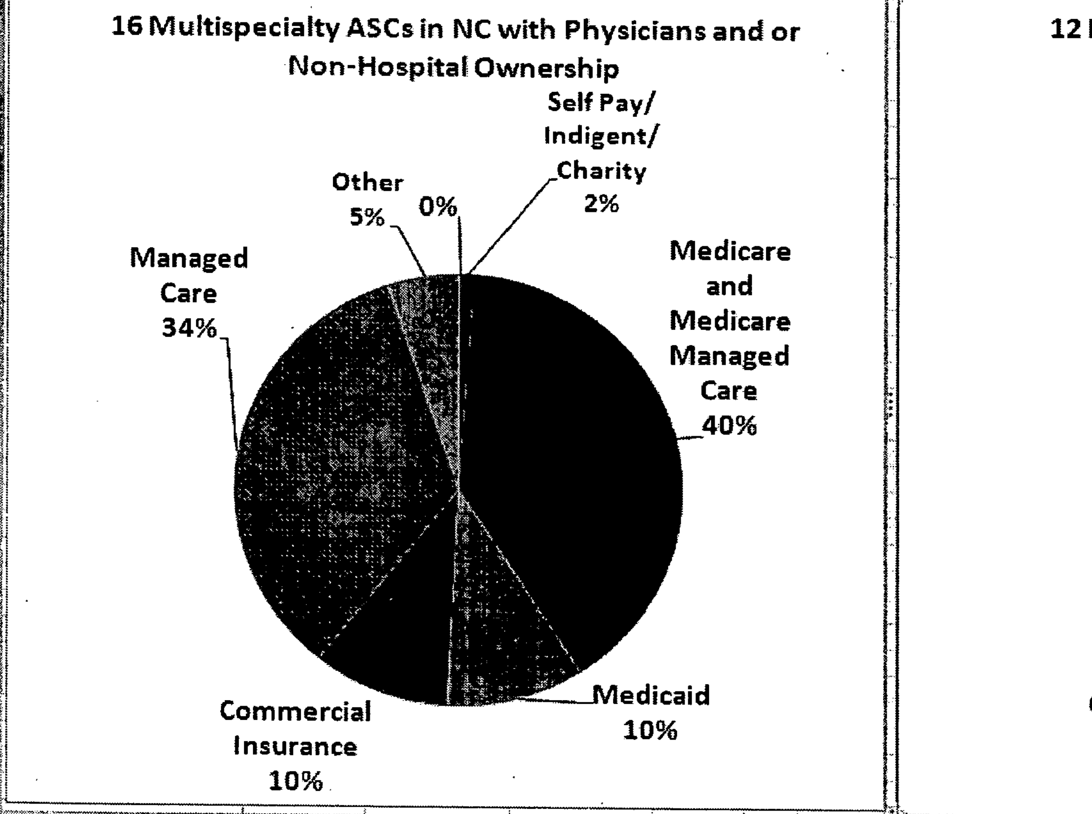
Surgical cases performed in ASC's are reimbursed at 56% of the rates paid to hospitals for the same procedures.

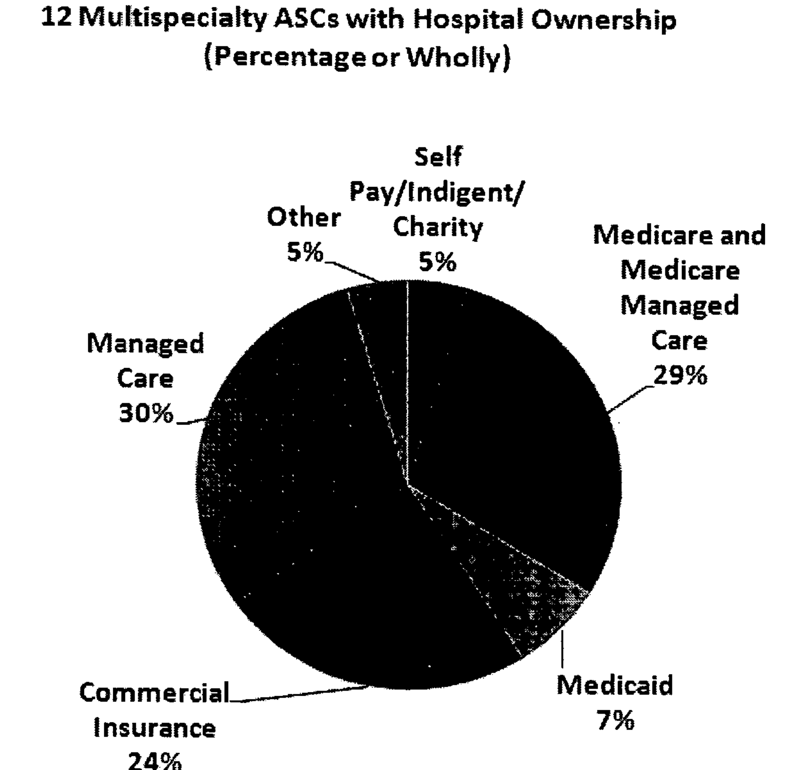
Types of Existing and Approved Ambulatory Surgical Facilities



2012 Licensed Surgical ASCs (Excludes ASCs Having Only GI Endoscopy Rooms)	Totals ASCs	Multi-specialty ASCs	Ophthalmic ASCs	Obstetrics ASCs	Plastic ASCs	Orthopaedic ASCs	ENT ASC
ASCs with Physician Ownership w/o Hospitals	30	16	8	4	2	0	0
ASCs with Hospital Ownership (wholly or percentage)	12	12	0	0	0	0	0
Totals	42	28	8	4	2	0	0
ASC Facilities in Development	13	9	0	0	0	3	1

Comparison of Percentages of Cases by Payor Category for Multispecialty ASCs Physician Owned as compared to Hospital Owned





Physician owned multispecialty ASCs serve higher percentages of Medicaid and Medicare patients.

Multispecialty ASCs owned by hospitals provide higher Commercial Insurance and Self Pay / Indigent / Charity.

2011 Procedure Volumes and Top Physician Specialties on ASC Medical Staff

Highest Procedure Volumes by Specialty Performed in NC Surgical ASCs	
Ophthalmology	57,345
Orthopaedics	32,134
Otolaryngology	24,381
General Surgery	8,597
Obstetrics and GYN	6,626
Plastic Surgery	2,746

Highest Volumes of Non-Surgical Procedures Performed in NC Surgical ASCs	
Pain Management	20,760
Yag Lasers	5,563

Top 6 Physician Specialties on ASC Medical Staff (This is not a measure of physician ownership)	
Anesthesia	294
Orthopaedic Surgeon	338
Gynecologist	244
Ophtalmologist	246
Otolaryngologist	182
General Surgeons	178

North Carolinians Have Limited Access to ASCs

	2012 North Carolina	2010 US Totals
Total Licensed ASCs (Surgical and Endoscopy)	96	5,316
Population	9,781,022	308,745,538
ASCs per 100,000 Population	0.98	1.72

States	CON Status	2012 Licensed ASCs	2012 Population	ASCs per 100,000 Population
Virginia	CON Required	51	8,001,024	0.64
North Carolina	CON Required	96	9,781,022	0.98
South Carolina	CON Required	75	4,625,364	1.62
Tenessee	CON Required	162	6,346,105	2.55
Georgia	Exemptions for Single Specialty and JV ASC with $ Thresholds	333	9,687,653	3.44
Florida	No CON required for ASC	422	18,801,310	2.24

Rationale for Changing CON Law to Allow CON Applications for Single-Specialty ASCs

Ambulatory surgical centers (ASCs) provide tremendous cost savings to patients, insurance companies and government payors

Proposals can be submitted by physicians, hospital-owned physician groups or other legal entities including joint ventures

This change will increase competition and patient access

ASCs will be required to provide specific levels of care to Medicaid and Charity patients and to provide annual reports

This change in the CON law will support the future recruitment of physician specialists to North Carolina

This change will increase investment in facilities, create jobs and expand the tax base

CON Regulation of Diagnostic Centers

CON regulation of "diagnostic centers" should be eliminated because the rule is poorly defined, often misinterpreted or ignored by providers, and rarely enforced. The following definition is provided in the CON statute:

***§ 131E-176. Definitions.** (7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.*

This definition requires non-hospital providers to obtain CON approval if the total cost to acquire diagnostic equipment exceeds $500,000. The Certificate of Need Section interprets the $500,000 threshold to be the cumulative cost based on the original equipment purchase price.

Consider the following scenario: A large physician group obtained three radiography units and installed these in their office in 1998 with the total equipment purchase cost of $375,000 plus the design, installation, inspections and construction cost of $75,000. This was not subject to CON review because the total capital cost was $450,000. Now the physician group wants to spend $400,000 to replace two of these radiography units with digital radiography equipment so that the images can be obtained digitally and transmitted to the hospital or other physician specialists without the use of film. This would cause the cumulative cost of the diagnostic equipment at the physician office to exceed $500,000 because the original purchase price of the one remaining radiography unit was $125,000 plus the design and installation costs. Thus, the physicians would be required to obtain CON approval as a diagnostic center.

This aspect of the CON law is often misunderstood because most physicians and practice managers do not recognize that the threshold is based on cumulative costs. Furthermore, the CON law regarding diagnostic centers is deficient because it contains no definition of diagnostic equipment. Therefore many people do not comprehend that the diagnostic center regulations apply to a vast array of equipment including ultrasound equipment in obstetricians' offices, stress test machines in cardiologists' offices, and the many types of ophthalmic and optometric equipment.

Thousands of physician practices in North Carolina have various modalities of diagnostic equipment. There is no single database that reports the inventory all of the various types of equipment. The North Carolina Division of Health Service Regulation Radiation Protection Section regulates X-ray equipment and mammography equipment and it licenses providers with equipment that use radioactive materials. This agency does not regulate many other types of diagnostic equipment that are commonly used in physician offices including ultrasound equipment, EKG machines, holter monitors, stress test machines, pulmonary function systems and ophthalmic / optometry equipment..

Having a $500,000 threshold for a diagnostic center makes it difficult and burdensome for non-hospital providers to obtain digital radiography, digital mammography equipment, ultrasound

units, and other diagnostic equipment that are not specifically regulated by CON law. A CON application to acquire replacement or additional diagnostic equipment can cost $20,000 or more to prepare; if it is challenged by the hospital or other providers the legal costs could be hundreds of thousands of dollars. Consequently, the current CON regulation of diagnostic centers discourages physicians and non-hospital providers from replacing outdated equipment with safer, digital equipment that can transmit images and greatly reduce the need for a patient to have repeated diagnostic tests.

Certificate of Need officials do not have the resources to provide comprehensive enforcement of the diagnostic center CON regulations. If the agency receives a complaint or a request for investigation, the CON staff does investigate and send letters to providers requesting information regarding the diagnostic equipment at the specified location. The outcome of these investigations may require the provider to submit a CON application or pay a fine.

If the CON law is changed to eliminate future regulation of diagnostic centers, those facilities that are currently designated by the DHSR, CON Section as diagnostic centers should be granted the option of either maintaining their present status as a "health service facility" or voluntarily relinquishing this status. In this way, the change in the CON law would not cause unintended consequences or hardship for healthcare providers that may be acquired in the future. Another option to minimize unintended consequences would be to add an exemption to the CON law that permits the acquisition of existing diagnostic centers without CON approval.

North Carolina CON Regulation of Diagnostic Centers

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North Carolina CON Regulation of Diagnostic Centers

CON regulation of “diagnostic centers” should be eliminated because the rule is poorly defined, often misinterpreted or ignored by providers, and rarely enforced.

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The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

CON Regulation of Diagnostic Centers

Having a $500,000 threshold for a diagnostic center makes it difficult and burdensome for non-hospital providers to obtain digital radiography equipment, digital mammography equipment, ultrasound units, and other diagnostic equipment that are not specifically regulated by CON law.

A CON application to acquire replacement or additional diagnostic equipment can cost $20,000 or more to prepare.

If it is challenged by a hospital or other providers the legal costs could be hundreds of thousands of dollars.

Consequently, the current CON regulation of a diagnostic center Restricts the replacement outdated equipment with safer, digital equipment that can transmit images and greatly reduces the need for a patient to have repeated diagnostic tests.

CON Regulation of Diagnostic Centers

Eliminating CON regulation of diagnostic centers should not create any unintended consequences because:

Existing centers can be given the choice of maintaining their status as institutional health service facilities.

The CON law can be easily amended to include exemptions to allow the change in ownership of the equipment that is owned by CON-approved diagnostic centers.

OVERVIEW OF CERTIFICATE OF NEED

Health Service Facilities Regulated by the CON Law [N.C.G.S. §131E-176(9b)]

1. Acute Care Hospitals. [N.C.G.S. 131E-176(13)]
2. Inpatient Psychiatric Hospitals. [N.C.G.S. 131E-176(21)]
3. Inpatient Rehabilitation Hospitals. [N.C.G.S. 131E-176(22)]
4. Nursing Homes. [N.C.G.S. 131E-176(17b)]
5. Kidney Disease Treatment Centers (i.e., Certified End-Stage Renal Disease Facilities). [N.C.G.S. 131E-176(14e)]
6. Intermediate Care Facilities for Individuals with Intellectual Disabilities. [N.C.G.S. 131E-176(14a)]
7. Certified Home Health Agency Offices. [N.C.G.S. 131E-176(12)]
8. Chemical Dependency Treatment Facilities (inpatient & residential). [N.C.G.S. 131E-176(5a)]
9. Diagnostic Centers. [N.C.G.S. 131E-176(7a)]
10. Hospice Programs and Offices. [N.C.G.S. 131E-176(13a)]
11. Hospice Inpatient Facilities. [N.C.G.S. 131E-176(13b)]
12. Hospice Residential Care Facilities. [N.C.G.S. 131E-176(13c)]
13. Ambulatory Surgical Facilities. [N.C.G.S. 131E-176(1b)]
14. Adult Care Homes. [N.C.G.S. 131E-176(1)]
15. Long-Term Care Hospitals. [N.C.G.S. 131E-176(14k)]

Activities Requiring Certificate of Need Review [N.C.G.S. §131E-176(16)]

1. Establishment of a new health service facility (See 1 through 15 above). [N.C.G.S. 131E-176(16a)]
2. Capital expenditure by any person for a health service in excess of $2 million dollars. [N.C.G.S. 131E-176(16b)]
3. Change in bed capacity. [N.C.G.S. 131E 176(16c), 176(5) and 176(9c)]
   - (i) Relocation of health service facility beds or dialysis stations. [N.C.G.S. 131E-176(5)(i)]
   - (ii) Change of health service facility beds from one category to another. [N.C.G.S. 131E-176(5)(ii)]
   - (iii) Increase in dialysis stations or health service facility beds. [N.C.G.S. 131E-176(5)(iii)]

   Health service facility beds are defined in N.C.G.S. 131E-176(9c) to include:
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   - g. hospice inpatient facility beds;
   - h. hospice residential care facility beds;
   - i. adult care home beds; and
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4. Establishment of new dialysis services or home health services. [N.C.G.S. 131E-176(16d)]
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b. Burn intensive care services;
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   b. Cardiac catheterization equipment;
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   f. Lithotriptor;
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8. The acquisition of a health service facility from an HMO. [N.C.G.S. 131E-176(16l)]
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17. The change in designation of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room. [N.C.G.S. 131E-176(16v)]

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-27-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Heron	Duke
Elizabeth Bise	Brooks Pierce
Jeff Barnhart	McGuire Woods

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-27-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	SEANC
Allison Waller	Nelson Mullins
Stephen Korba	Compass NC
DAVID BARNES	PS
JAY PETERS	CSS
Sarah Wolfe	MWC
GRAHAM FIELDS	PARK RIDGE HEALTH
Elise Quick	Troutman Sanders
Laurie Onorio	Jason Deans & Assoc.
[illegible signature]	[illegible]
George Smith	Nexsen Pruet

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 09-27-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	MH
Cody Hand	NCHA
Kathleen Worrell	PDC
Catharine Cummer	Duke
Jason Deans	JD+A
[illegible]	UNC
[illegible]	KLG
Erica Nelson	NCHA
Karl Stein	Raleigh Orthopaedic Clinic
Tracy Colvard	AHHC
Max Mason	Principle Long Term Care

VISITOR REGISTRATION SHEET

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Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Metcalf	Mission
Rudine Jones	Mission
DeDe Murphy	Ascendient
Mike Vicario	NCHA
David Meyer	Keystone
Trey Adams	PDA
Susan Kelley	Poyner Spruill
Robbie Roberts	WakeMed
Julie Rodm	SML
Hugh Tilson	NCHA
Chip Baggett	NCMS

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, October 11, 2012
TIME: **10:00 A.M.**
LOCATION: 643 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **9 AM** o'clock on **October 03, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee
On
the Certificate of Need Process
and Related Hospital Issues

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

State Legislative Building
Raleigh, North Carolina

AGENDA
THURSDAY, OCTOBER 11, 2012
10:00 a.m.
Room 643, Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Planning for the Future of Healthcare in North Carolina
Lanier Cansler, President, Cansler Collaborative Resources, Inc., Former Secretary, North Carolina Department of Health and Human Resources.

III. Supply and Demand of Physicians in North Carolina
Dr. Thomas Ricketts, Professor, Health Policy and Administration, Deputy Director, Cecil G. Sheps Center for Health Services Research

IV. CON Law and the Impact on the Citizens of Harnett County (Update from March 2012 Committee Presentation)
Earl Jones, Chairman, Good Hope Hospital
Pat Cameron, Chairman, Good Hope Mental Health
Patsy Carson, Mayor of Erwin
Jim Burgin, Commissioner, Harnett County

V. Committee Discussion

Next Meeting: Thursday, October 25, 2012

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, October 11, 2012

10:00 a.m.

Room 643 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 11, 2012 in Room 643, LOB at 10:00 a.m. Representatives Avila, Brandon, Randleman, Steen, and Torbett were present.

Representative Torbett presided.

Hugh Tilson, Senior Vice President, North Carolina Hospital Association gave a presentation on an update on the NCHA website (see attached and on committee website).

Lanier Cansler, President, Cansler Collaborative Resources, Inc., Former Secretary, North Carolina Department of Health and Human Resources gave a presentation on planning for the future of healthcare in North Carolina (see attached and on committee website).

There were questions from Representatives Avila, Brandon, and Steen regarding a single payor , how are we going to plan when we have two different philosophies and certificate of need or not, creating two tiers, and has certificate of need reform been included in the vision. Mr. Cansler answered the questions including if a single payor was put in place, research would go away, the future and vision of healthcare needs to studies by outside entities and bring their findings to government.

Dr. Thomas Ricketts, Professor, Health Policy and Administration, Deputy Director, Cecil G Sheps Center for Health Services Research gave a presentation on supply and demand of physicians in North Carolina.

There were questions from Representatives Randleman and Torbett regarding if the med mal reform impacted the supply and why we were losing doctors. Dr. Ricketts explained that the med mal reform had little impact and that North Carolina sits second from the bottom for high school students going into medicine.

Earl Jones, Chairman, Good Hope Hospital, Pat Cameron, Chairman, Good Hope Mental Health, Patsy Caron, Mayor of Erwin, and Jim Burgin, Commissioner, Harnett County gave an updated presentation on CON law and the impact on the citizens of Harnett County.

Representative Torbett adjourned the meeting.

John A. Torbett

Representative John Torbett, Co-Chair, Presiding

Viddia Torbett

Viddia Torbett, Committee Clerk

Representative Fred Steen, Co-Chair

Hugh Tilson Presentation 10-11-12

At the last committee meeting I presented on information related to hospital quality measures that is publicly available on NCHA's website.

It occurred to me afterward that the NCHA website also has publicly available information about two additional areas that may be of interest to the Committee.

State law requires hospitals to report their volumes and charges for the top 35 'diagnosis-related groups' or inpatient care. That information is available by hospital on the NCHA website.
https://www.ncha.org/issues/finance/top-35-drgs

Hospitals voluntarily report their Community Benefits, a description of the unreimbursed costs of caring for patients and serving the community. That information is also available by hospital on the NCHA website.
https://www.ncha.org/issues/community-benefit

Physicians in North Carolina: Sufficiency, Shortage or "Stress"

Thomas C. Ricketts, Ph.D. MPH, Erin Fraher, PhD MPP
Katie Gaul, M.A.

University of North Carolina at Chapel Hill

The Current Policy Context

- **Demand side**: aging population, increase in chronic disease, insurance expansions, rising patient expectations
- **Supply Side**: health workforce overall is growing, professions operate in silos, turf wars abound, and productivity is lagging

With, or without health reform, cost and quality pressures will change the physician workforce

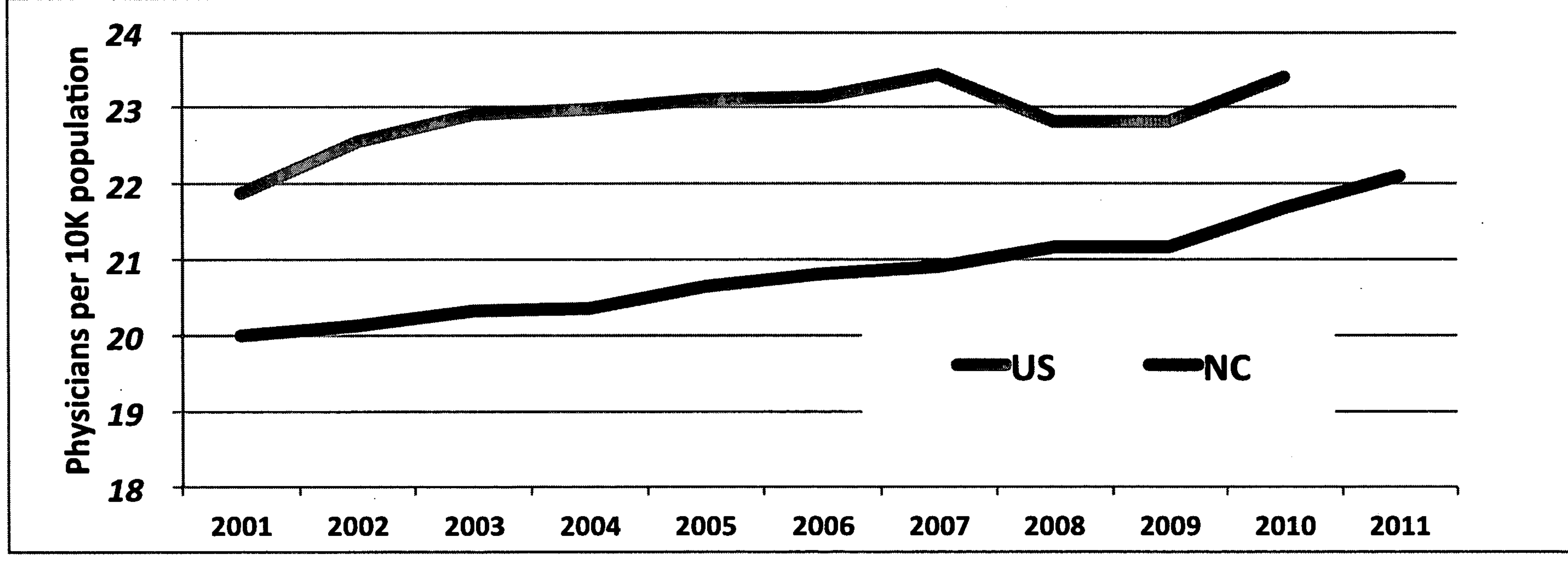
Questions

- Can we trust the numbers?
  - **YES**, North Carolina has the most accurate and trustworthy inventory of physician data
- What is a shortage of physicians?
  - Economic: When the prices of service rises because there is less of it available
  - Clinical: When people cannot get needed care because there aren't enough doctors
- How can we know a shortage exists?
  - Sick people get sicker? People take more time to get to a doctor?

The State of the State:
Let's Drown (or Swim) in a lot of Data

NC Lags US in Physicians per Population

NC 22 per 10,000



NC Doctor Supply has grown faster than NC Population

Doctor Supply is Dynamic: 2002-2009

Supply	New Actives	Left File	Total
2002 Supply 16,734	New Actives 1,568 (returned to active 511 newly licensed 1,057)	Left File 1,212	2003 total 17,090 Net gain 356
2003 Supply 17,090	New Actives 1,430 (returned to active 487 newly licensed 943)	Left File 1,171	2004 total 17,349 Net gain 259
2004 Supply 17,349	New Actives 1,550 (returned to active 667 newly licensed 883)	Left File 1,004	2005 total 17,895 Net gain 546
2005 Supply 17,895	New Actives 1,951 (returned to active 630 newly licensed 1,321)	Left File 1,450	2006 total 18,396 Net gain 501
2006 Supply 18,396	New Actives 1,659 (returned to active 569 newly licensed 1,090)	Left File 1,142	2007 total 18,913 Net gain 533
2007 Supply 18,913	New Actives 1,822 (returned to active 461 newly licensed 1,361)	Left File 1,193	2008 total 19,542 Net gain 629
2008 Supply 19,542	New Actives 1,808 (returned to active 499 newly licensed 1,309)	Left File 1,449	2009 total 19,901 Net gain 359

Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2002-2009. Prepared 6/16/2010. Counts

Doctor Supply is Older Males and Younger Females

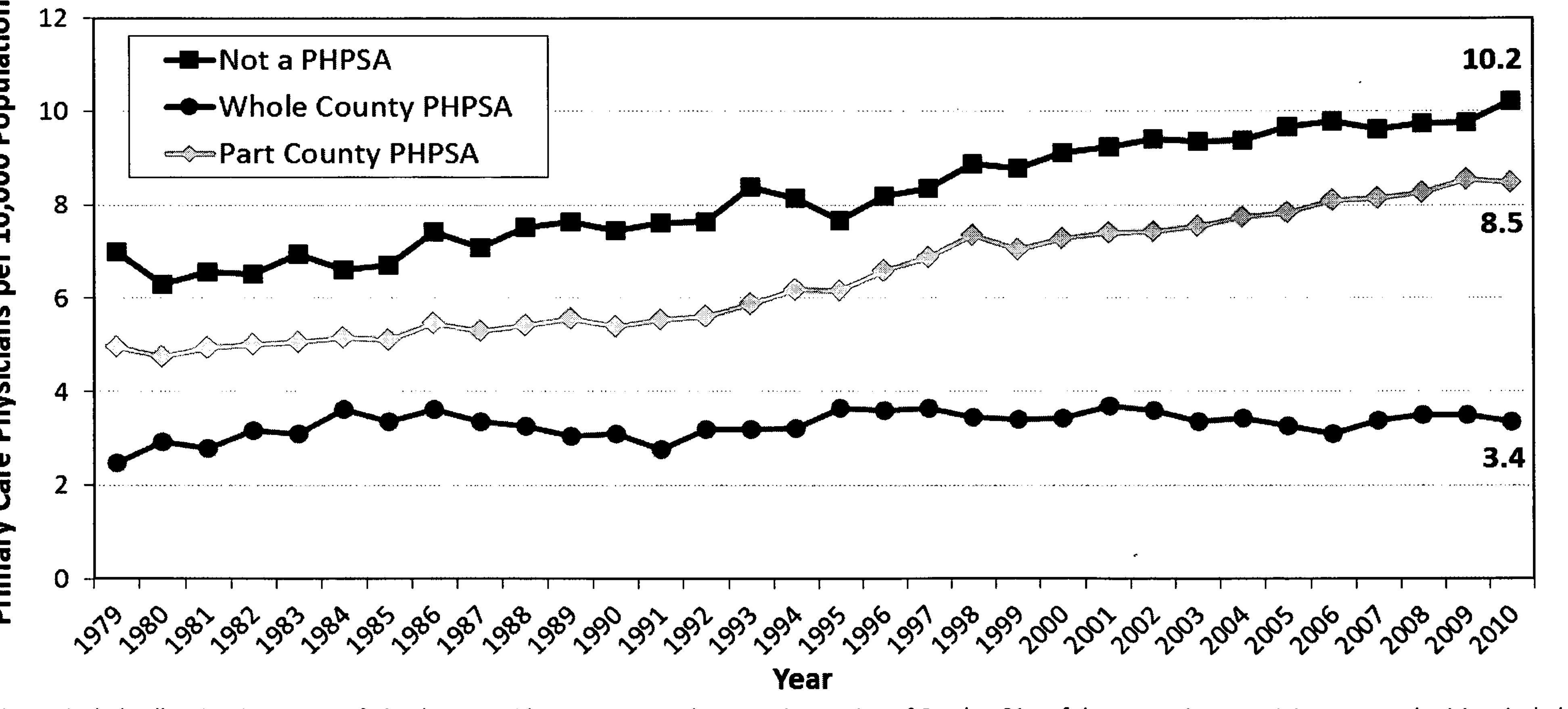
Figures include active, instate, nonfederal, non-resident-in-training physicians licensed in North Carolina as of October 31, 2009.

NC Bucks National Trend: More Rapid Increase in Primary Care Physicians

Percentage Growth Since 1990 of Physicians and Primary Care Physicians per 10,000 Population, North Carolina, 1991-2009

Sources: North Carolina Health Professions Data System with data derived from the North Carolina Medical Board ,1979 to 2009; North Carolina Office of State Planning. Figures include all licensed, active, instate, non-federal, non-resident-in-training physicians.

And Despite Overall Growth, Persistent Maldistribution



Notes: Figures include all active, instate, nonfederal, non-resident-in-training physicians licensed as of October 31st of the respective year. Primary care physicians include those indicating a primary specialty of family practice, general practice, internal medicine, Ob/Gyn or pediatrics. Persistent HPSAs are those designated as HPSAs by HRSA from 1999 through 2005, or in 6 of the last 7 releases of HPSA definitions.

Sources: North Carolina Health Professions Data System, 1979 to 2010; HRSA, Bureau of Health Professions; Area Resource File; US Census Bureau; North Ca[illegible]ina Office of State Planning. Figures include all licensed, active, insta[illegible] non-federal, non-resident-in-training physicians.

Primary Care Health Professional Shortage Areas (HPSAs)
North Carolina, 2012

HPSA Status, 2012
(# of Counties)

Status	Counties
Not a HPSA	(55)
Special Population or Part County HPSA	(35)
Single County HPSA	(10)

Source: Bureau of Health Professions, Shortage Designation Branch, HRSA, August 2012.
Produced by the North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

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WHERE DO DOCTORS IN NORTH CAROLINA COME FROM?

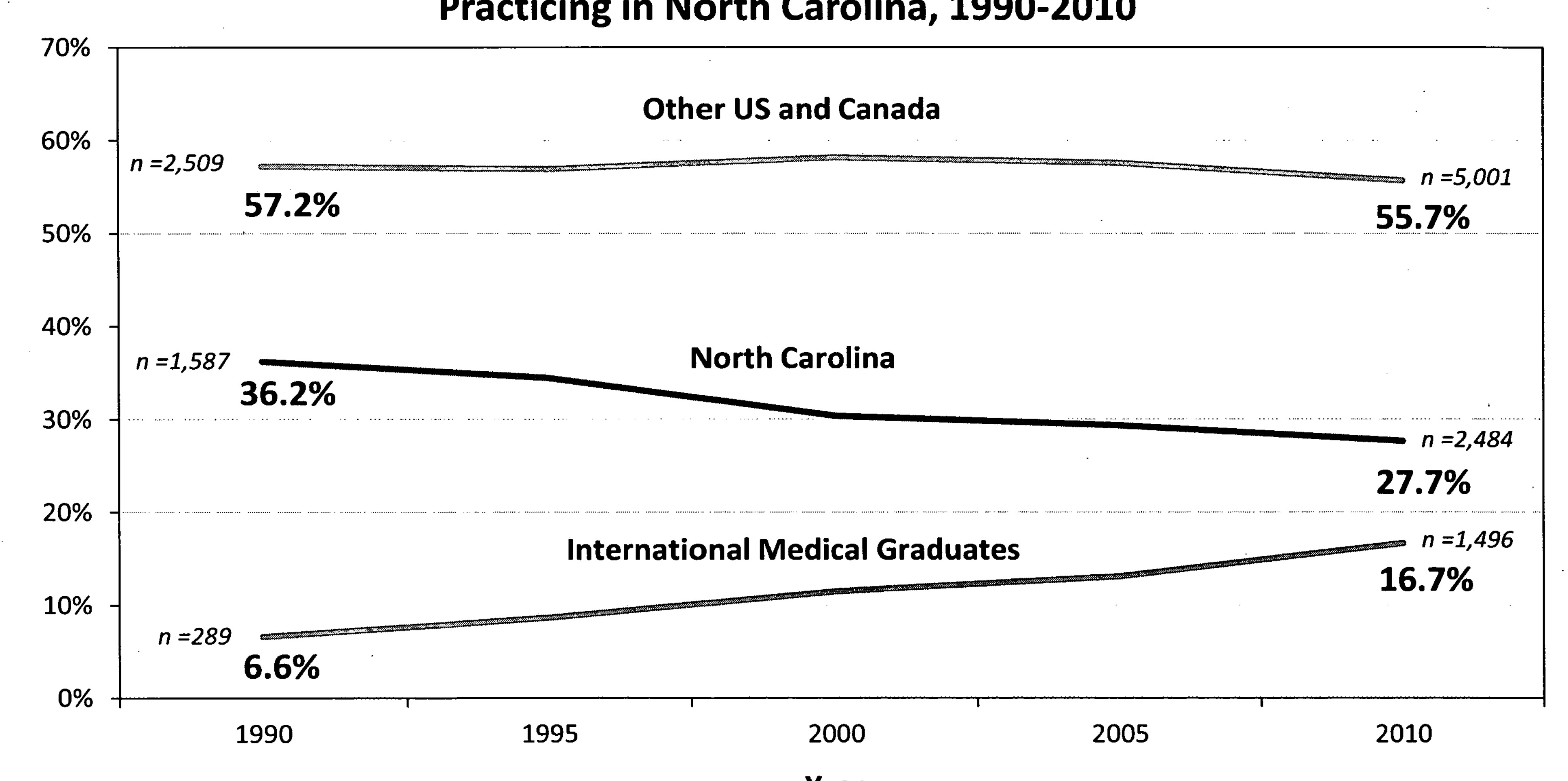
Total Enrollment and Residency Status of First Year Students North Carolina and Neighboring States' Medical Schools, 2010-2011

Source: Campbell University, 2012; Barzansky B, Etzel SI. 2011. Medical Schools in the United States, 2010-2011. *JAMA*. 306(9): 1007-1014. Accessed 10/8/12.
Produced by the North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University o f North Carolina at Chapel Hill.

Post Graduate Residency Programs: AKA "Teaching Hospitals"

- 10 programs in North Carolina. 2,681 residents in training
  - UNC Hospitals 714
  - Duke Hospitals 709
  - Wake Forest Baptist 506
  - ECU Pitt County 294
  - Charlotte AHEC 254
  - Other AHECs 204
- Nationally 8,750 programs with 109,000 Trainees

North Carolina's Physicians Come from Outside the State



Sources: North Carolina Health Professions Data System with data derived from the North Carolina Medical Board, 1990 to 2010; Figures include all licensed, active, instate, non-federal, non-resident-in-training physicians.

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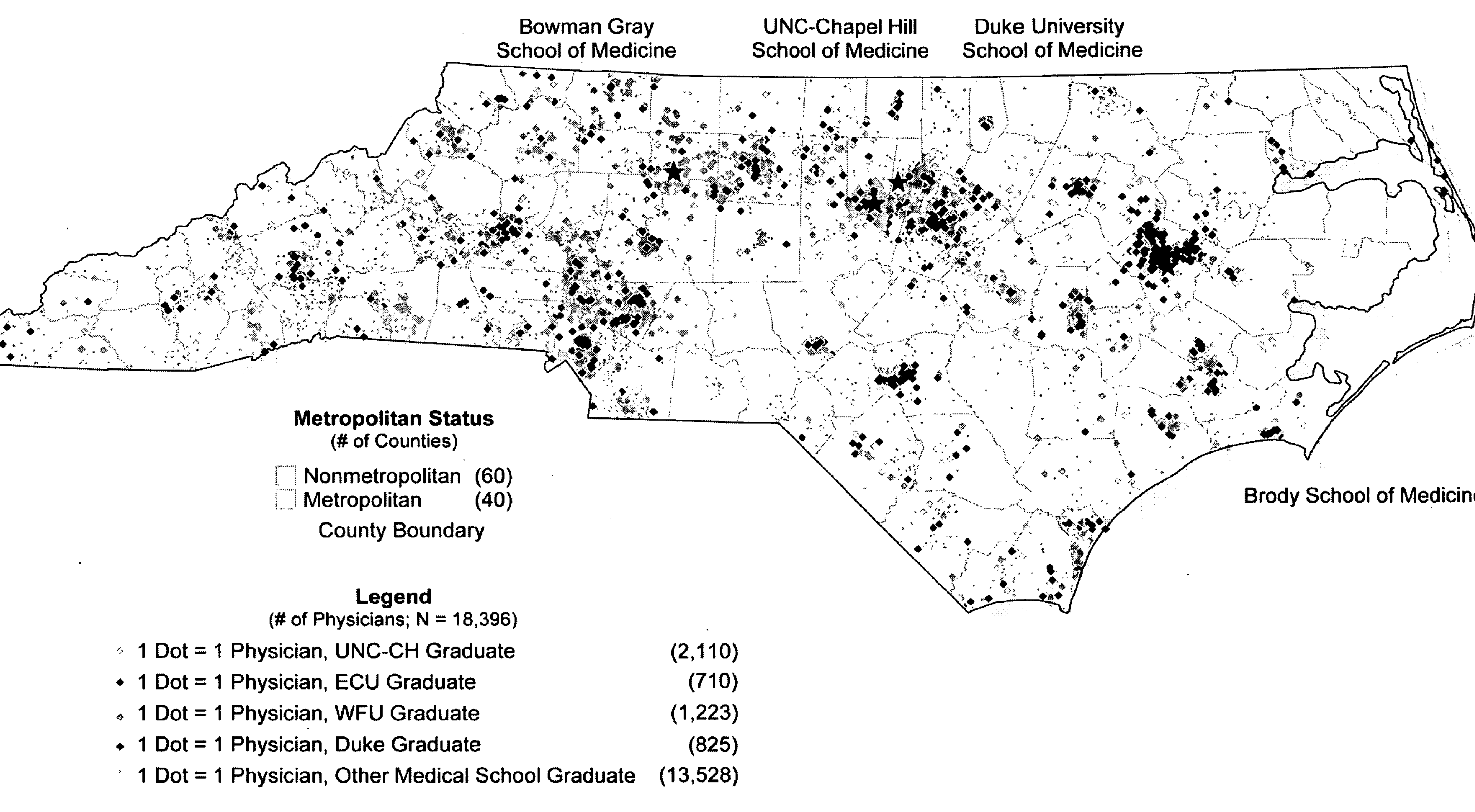
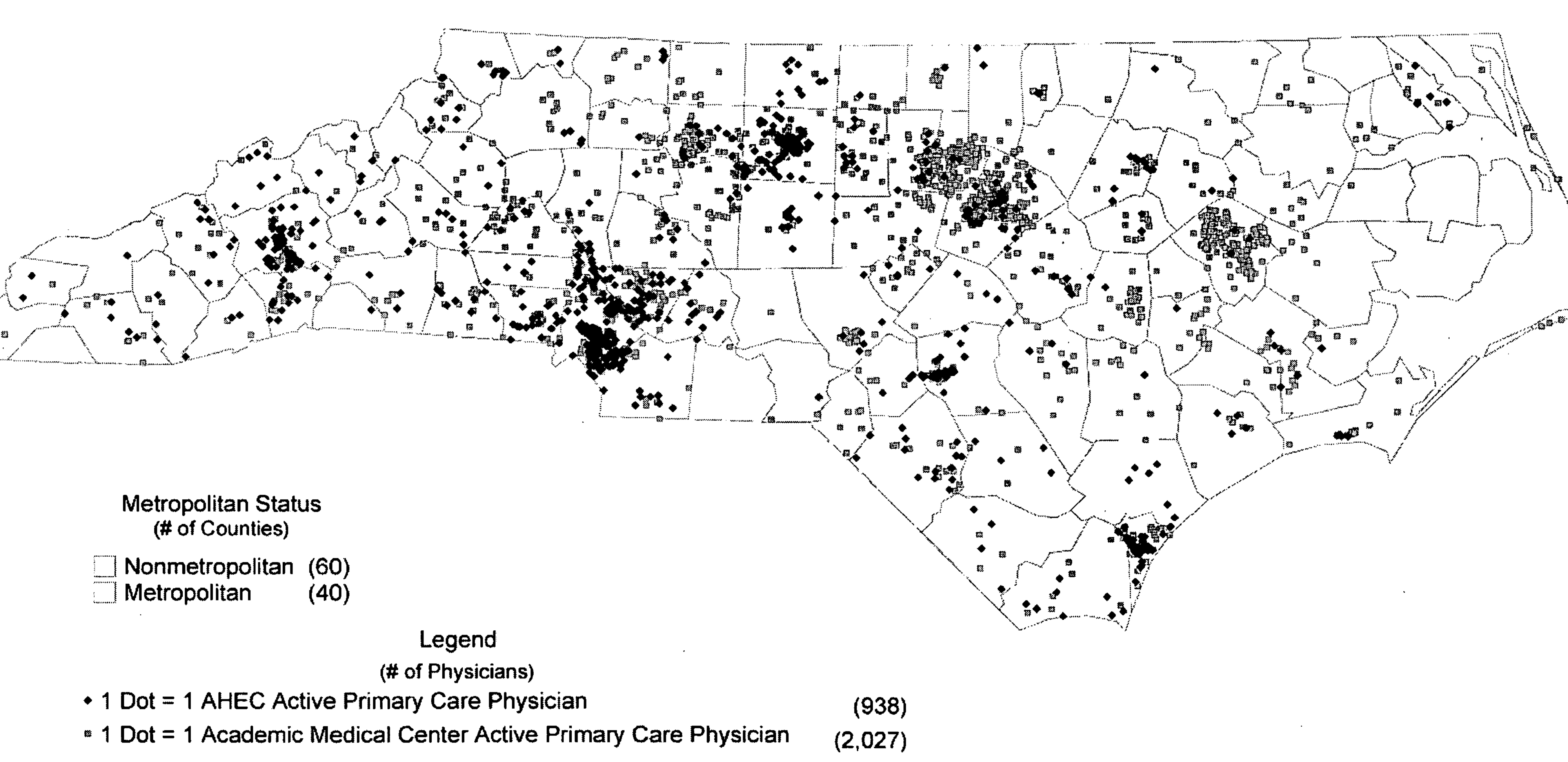
Distribution of Physicians Active in 2006 Who Graduated from a North Carolina Medical School



Source: NC Health Professions Data System with data derived from the NC Medical Board, 2006; AMA Masterfile, 2005; US Census Bureau, 2006.
Notes: Data are for active, in-state, non-federal, non-resident-in-training physicians who were licensed as of October 2006. Training data were missing for 55 physicians. Dots are scattered randomly within the zip code area (ZCTA). Different colored dots may overlap. One dot represents one physician.
Produced by: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Distribution of Active Primary Care Physicians Who Graduated from a North Carolina Residency Program AHEC and Academic Medical Center Programs, North Carolina, 2006



Metropolitan Status
(# of Counties)

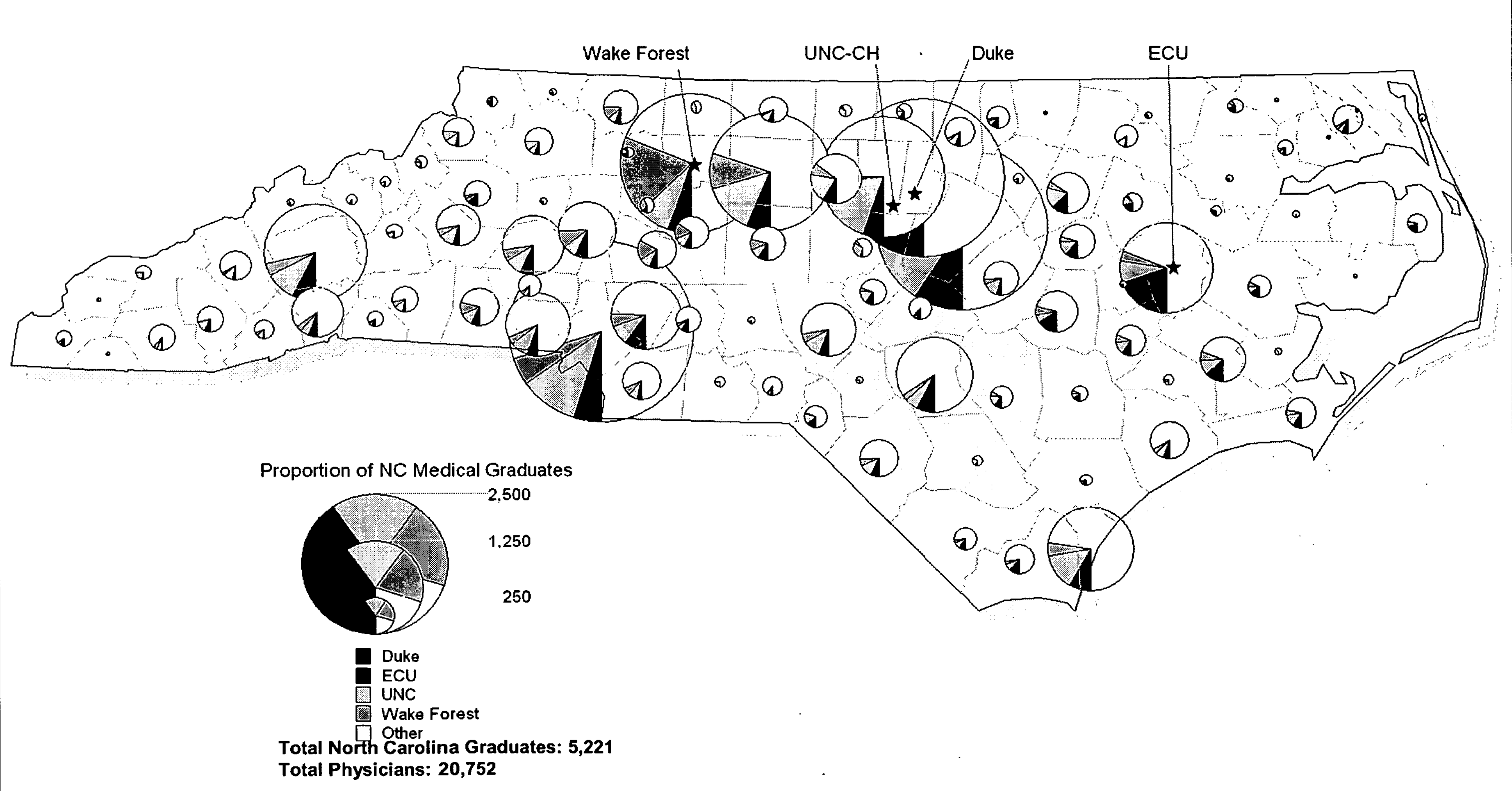
- Nonmetropolitan (60)
- Metropolitan (40)

Legend
(# of Physicians)

- 1 Dot = 1 AHEC Active Primary Care Physician (938)
- 1 Dot = 1 Academic Medical Center Active Primary Care Physician (2,027)

Produced by: North Carolina Health Professions Data System,
Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: NC Health Professions Data System; NC Area Health Education Centers Program, 2006; US Census Bureau, 2007.
Data are for active, in-state, non-federal, non-resident-in-training physicians indicating primary care specialties of FP, GP, IM, Ob/Gyn or Pediatrics, who were licensed as of October 2006 with residency graduation dates from 1972 and later. Internship data were used if residency data were missing.
*Note: Core Based Statistical Areas are current as of the December 2006 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

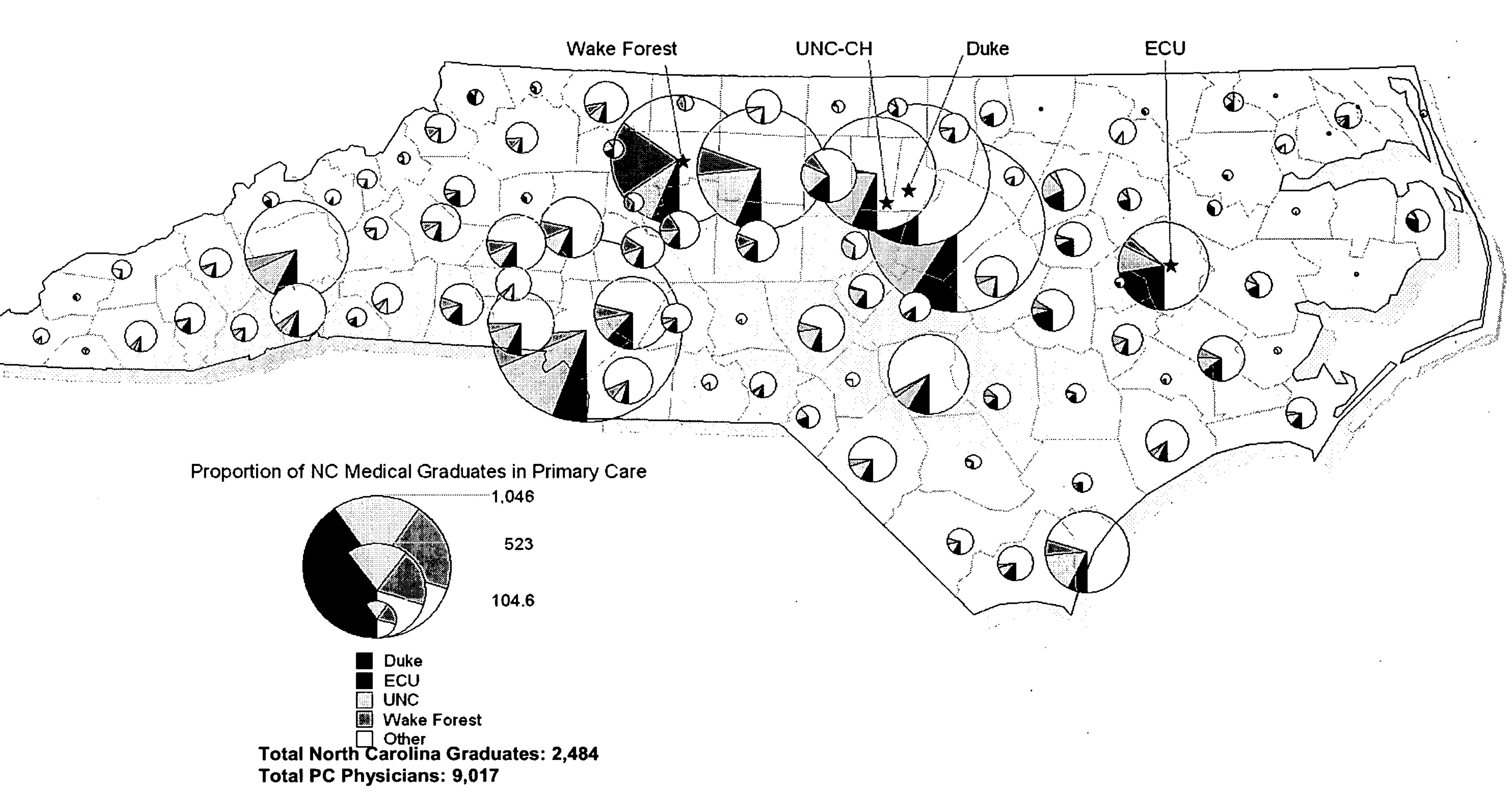
Percent of All Active Physicians* in 2010 who Graduated from a School of Medicine in North Carolina



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2010.

*Counts include active, instate, nonfederal, non-resident-in-training MDs and DOs currently practicing in North Carolina who graduated from ECU, Duke, UNC-CH or Wake Forest University Schools of Medicine. Graduates from schools outside of North Carolina are counted as "other."

Percent of All Active Primary Care Physicians* in 2010 who Graduated from a School of Medicine in North Carolina

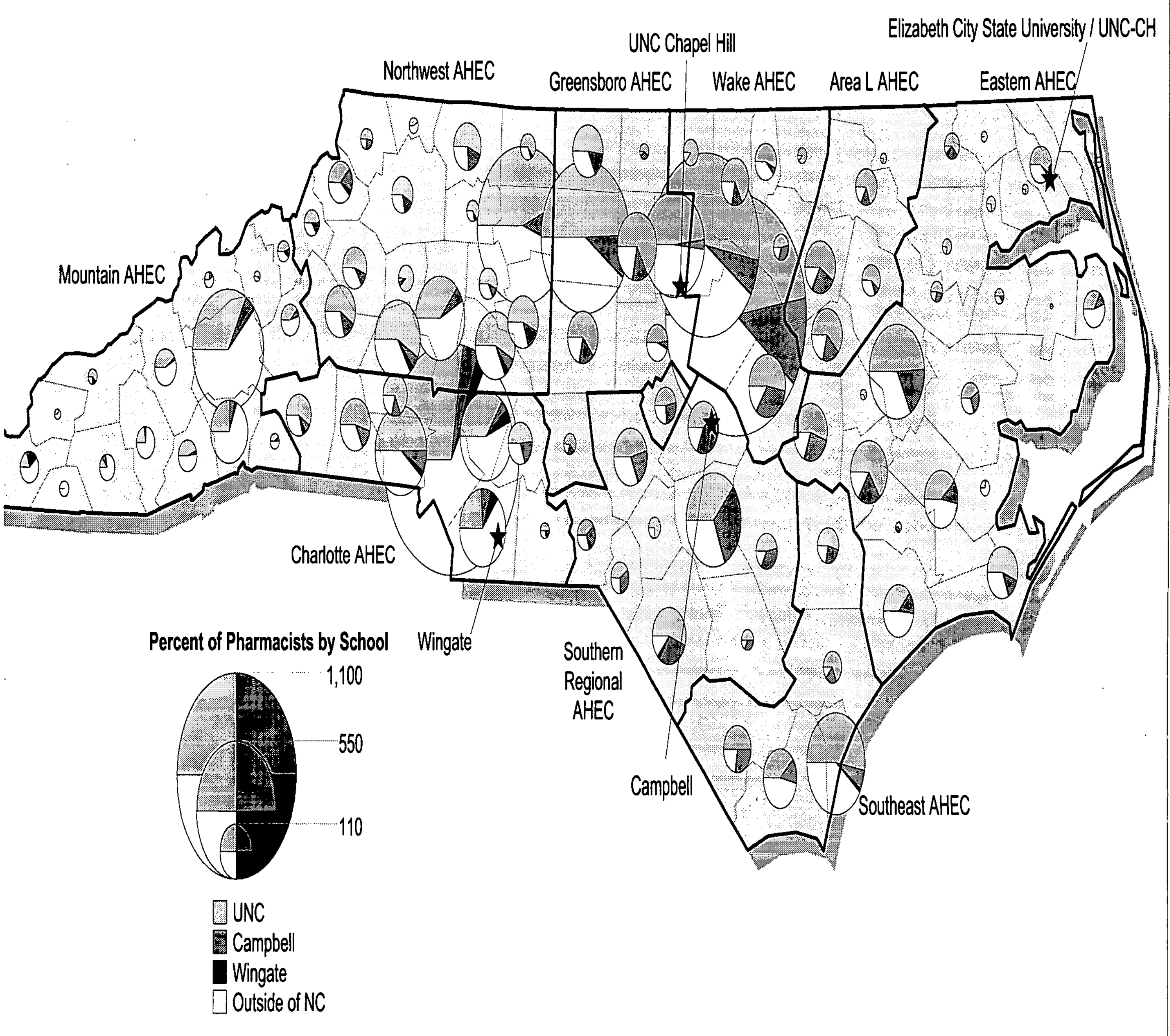


Total North Carolina Graduates: 2,484
Total PC Physicians: 9,017

Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2010.

*Counts include active, instate, nonfederal, non-resident-in-training MDs and DOs currently practicing in North Carolina who graduated from ECU, Duke, UNC-CH or Wake Forest University Schools of Medicine. Graduates from schools outside of North Carolina are counted as "other." Primary care physicians include physicians indicating a primary specialty of family practice, general practice, internal medicine, ob-gyn or pediatrics.

Percent of Active Pharmacists in 2008 Graduating from a School of Pharmacy in North Carolina



Size of circle represents total number of active pharmacists in the county.
Size of slices indicates percent of those pharmacists by school.

ıarmacists included are active or have unknown activity status.
ırce: North Carolina Health Professions Data System, with data derived from the North Carolina Board of Pharmacy, 2008.
ıduced by: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of N orth Carolina at Chapel Hill.

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NC's Trade Surplus/Deficit: Medical Students

Blue: Import more than we export
Orange: Export more than we import

Data Source: AMA 2009 Physician Masterfile.

Notes: Includes only clinically active, non-federal, non-resident in training, non-locum tenens physicians. One physician practicing in North Carolina was missing medical school state.

Produced by: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

NC's Trade Surplus/Deficit: Resident Physicians

Blue: Import more than we export
Orange: Export more than we import

-53 WA
-75 OR
109 CA
-53 NV
-51 AZ
-48 ID
-30 MT
-3 WY
-41 UT
-48 CO
-16 NM
-5 ND
-15 SD
-5 NE
-12 KS
-19 OK
0 TX
98 MN
22 IA
90 MO
-29 AR
117 LA
-32 WI
177 IL
-24 MS
295 MI
-6 IN
38 KY
16 TN
24 AL
435 OH
61 WV
-131 GA
-160 FL
61 SC
113 VA
NC
677 PA
1,145 NY
-11 VT
-23 NH
-14 ME
275 MA
40 RI
111 CT
150 NJ
11 DE
114 MD
317 DC
-24 HI
-30 AK

NC imports 3,589 more residents than it exports

Net importer of residents from 23 states & DC

Net Import/Export

Net exporter of residents to 25 states

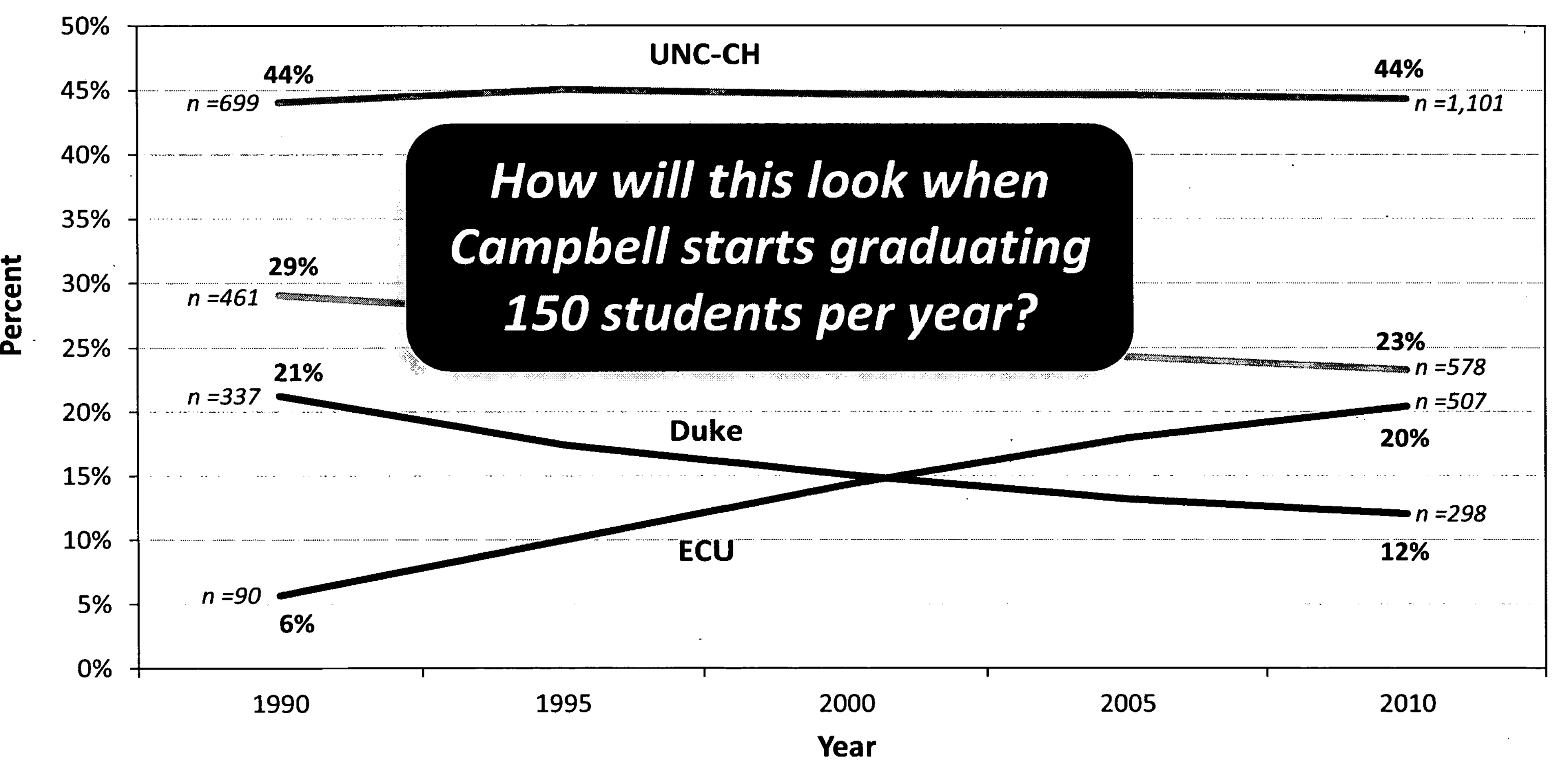
Up to 1,145 Gained

0 - No Gain/Loss

Up to 160 Lost

Data Source: AMA 2009 Physician Masterfile.
Notes: Includes only clinically active, non-federal, non-resident in training, non-locum tenens physicians.
Three physicians were missing practice state; 570 physicians practicing in North Carolina were missing residency state.
Produced by: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Contribution of NC Medical Schools to NC Supply



Sources: North Carolina Health Professions Data System with data derived from the North Carolina Medical Board, 1990 to 2010; Figures include all licensed, active, instate, non-federal, non-resident-in-training physicians.

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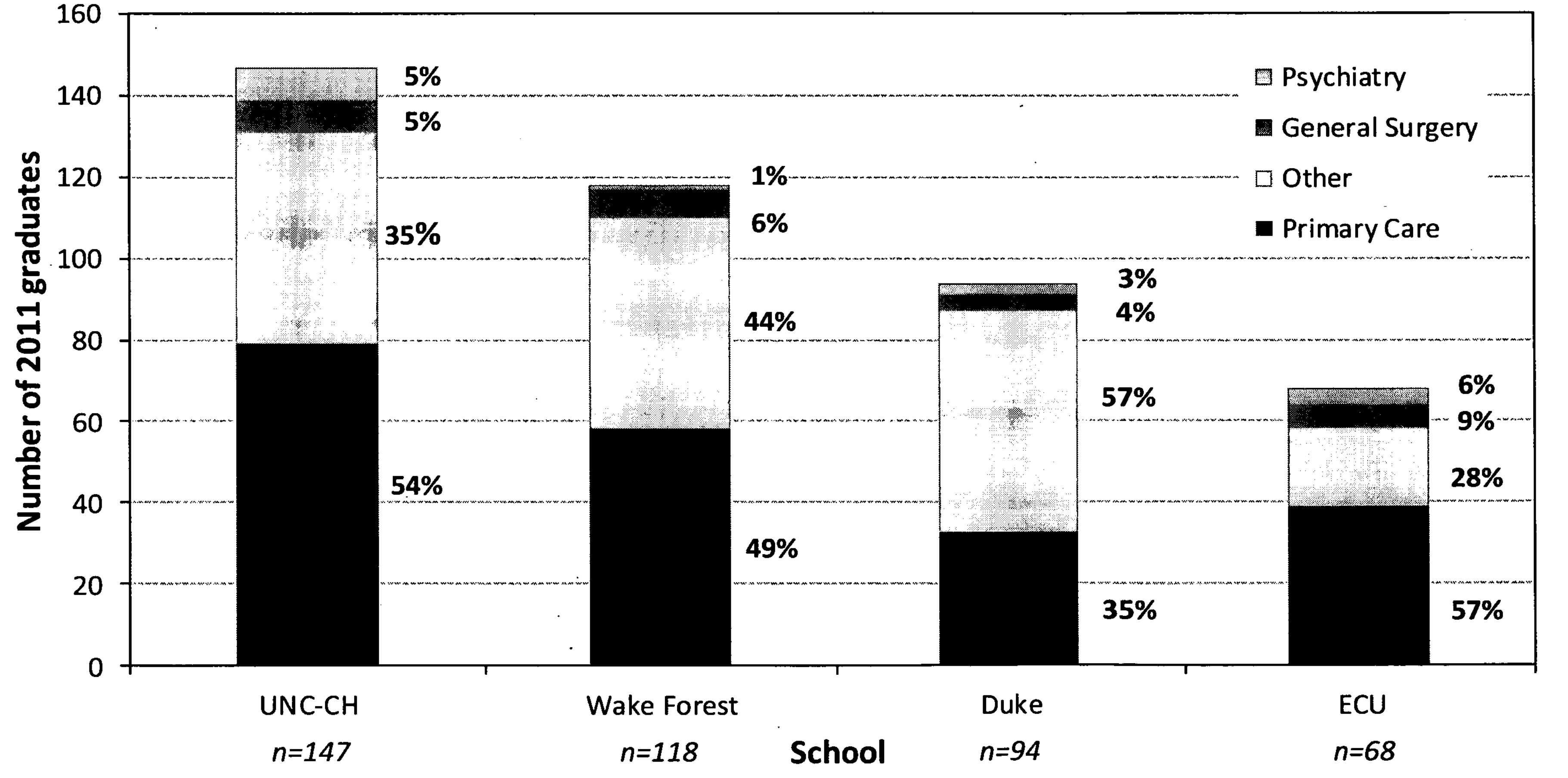
Graduate Training by Med School Affiliated Hospitals



Prepared by the North Carolina Health Professions Data System and the North Carolina AHEC Program.

Source: Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest Ur[illegible]rsity SOM Office of Student Affairs, Association of American Medical C[illegible]eges, and the NC Medical Board.

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Why Do We Care Where Physicians Trained?

Because it affects specialty choice, practice location and workforce diversity

NC Medical Students: Retention of Graduates in Primary Care After Five Years

School	2005 Graduates	% Initially Selecting PC Specialty	2010: % in Primary Care (Anywhere in US)	2010: % in Primary Care (in NC)
Duke	78	60%	23%	8%
ECU	73	82%	59%	41%
UNC	152	60%	38%	21%
Wake Forest	105	60%	37%	17%
Total	**408**	**64%**	**38%**	**21%**

Prepared by the North Carolina Health Professions Data System and the North Carolina AHEC Program.

Source: Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest Ur[illegible]sity SOM Office of Student Affairs, Association of American Medical C[illegible]eges, and the NC Medical Board.

Retention in North Carolina of Class of 2005 in 2010: Primary Care

NC Medical Students: Retention in Primary Care in NC's Rural Areas

Total Number of 2005 NC med school graduates in training or practice as of 2010:

408

Initial residency in primary care

261 (64%)

In training/practice in primary care in 2010:

155 (38%)

In primary care in NC in 2010:

86 (21%)

In PC in rural NC:

10 (2%)

Class of 2005
(N=422 graduates)

Source: North Carolina Health Professions Data System with data derived from the Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest University SOM Office of Student Affairs, Association of American Medical Colleges, and the NC Medical Board, 2011.

Declining Interest in and "Leakage" from Primary Care Over Time

Source: North Carolina Health Professions Data System with data derived from the Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest University SOM Office of Student Affairs, Association of American Medical Colleges, and the NC Medical Board, 2011.

And Where Physician Completed a Residency Even More Important Predictor of Retention in NC

- 46% of physicians who complete an NC AHEC residency stay in North Carolina to practice

compared to

- 31% of physicians who complete a non-AHEC residency stay in North Carolina to practice

AHEC

Non-AHEC

Source: NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the American Medical Association Masterfile, 2011. "Active" includes federal, as well as non-patient care activities such as teaching, research, administration, etc.

AHEC-Trained Residents More Likely to Practice in Rural Areas

Specialty	Residency Type	Practicing in NC, 2011	
		% in Metro Area	% in Nonmetro Area
ALL	AHEC	85%	15%
	Non-AHEC	88%	12%
Primary Care	AHEC	85%	15%
	Non-AHEC	85%	15%
General Surg	AHEC	70%	**30%**
	Non-AHEC	81%	**19%**

Of the active and practicing physicians who completed a NC AHEC residency, 1,491 (46%) are practicing in NC and 1,739 (54%) are practicing outside of NC.
Of the active and practicing physicians who completed a NC Non-AHEC residency, 6,092 (31%) are practicing in NC and 13,639 (69%) are practicing outside of NC.
Note: Primary Care includes the following specialties: Family Medicine, Internal Medicine, Obstetrics and Gynecology, and Pediatrics.

Source: NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the American Medical Associatic asterfile, 2011. "Active" includes federal, as well as non-patient care activities such as ching, research, administration, etc.

And More Likely to Choose Primary Care

Source: NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the American Medical Association Masterfile, 2011. "Active" includes federal, as well as non-patient care activities such as teaching, research, administration, etc.

But Who Counts as “Primary Care”?

Who does Primary Care?

Percentage of Total Clinical Care Hours Spent in Primary Care
North Carolina, 1999-2008

Source: NC Health Professions Data System with data derived from the North Carolina Medical Board. Data are for active, in-state, non-federal, non-resident-in-training physicians licensed by the NC Medical Board as of October of each year. Data are self-reported at time of initial licensure and subsequent renewal.

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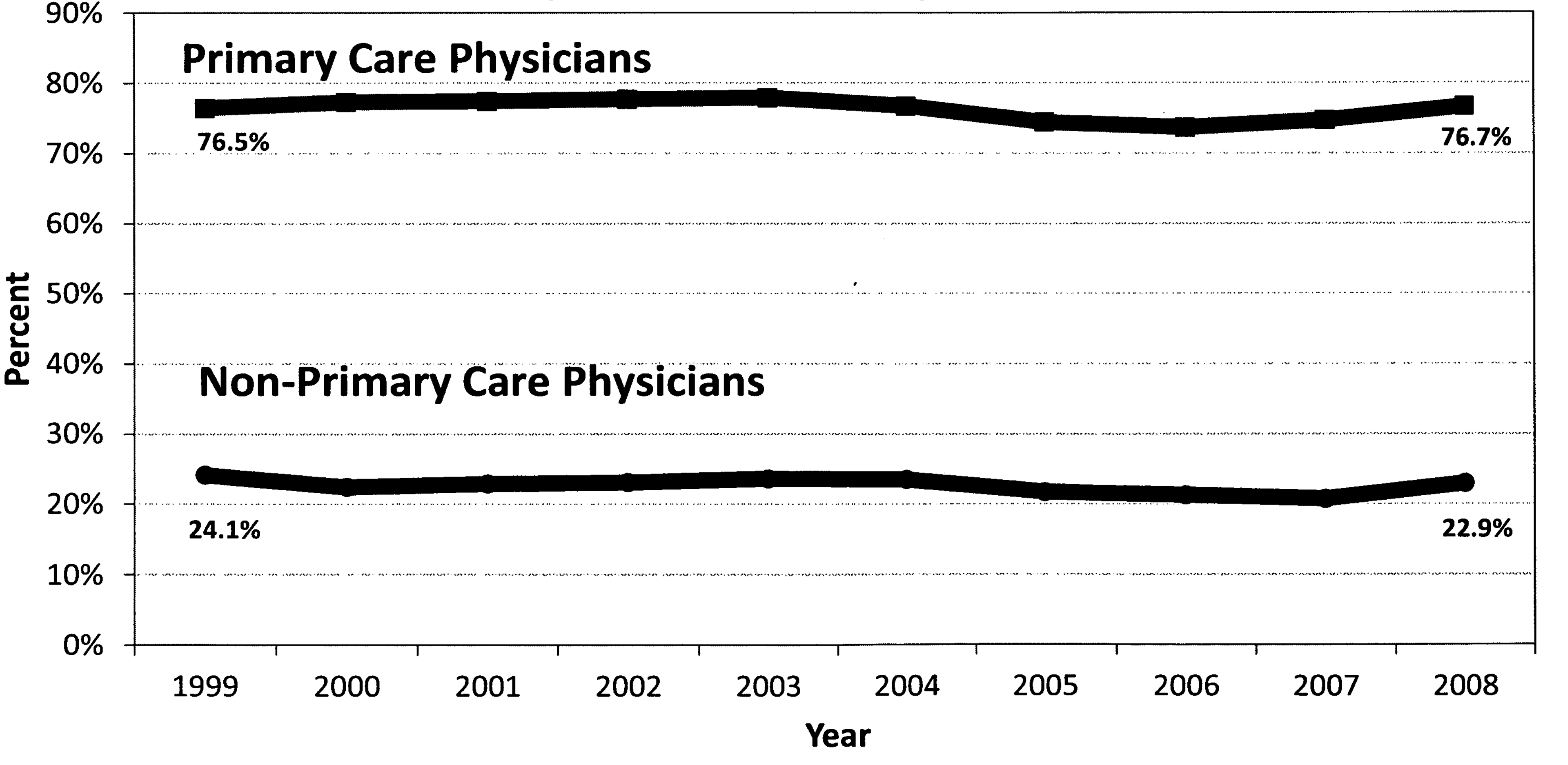
But, Specialists Also Provide Primary Care



Source: NC Health Professions Data System with data derived from the North Carolina Medical Board. Data are for active, in-state, non-federal, non-resident-in-training physician[illegible]ensed by the NC Medical Board as of October of each year. Data are self-report[illegible]t time of initial licensure and subsequent renewal.

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Are NPs and PAs the Answer to Physician Supply Stress?

Percentage Growth Since 1990 of Physicians, PAs and NPs per 10,000 Population, North Carolina, 1991-2009

Source: NC Health Professions Data System with data derived from the North Carolina Medical Board. Data are for active, in-state, non-federal, non-resident-in-training physicians licensed by the NC Medical Board as of October of each year. Data are self-reported at time of initial licensure and subsequent renewal.

How Many NPs are in Primary Care? Depends on Definitions

Defining Primary Care Nurse Practitioner Specialty, NC, 1997-2010: Comparison of Certification and Supervisory Definitions

Notes: Data for primary specialty ("supervisory") include active, in-state NPs indicating a primary specialty of family practice, general practice, internal medicine, Ob/Gyn, or pediatrics, who were licensed in NC as of October 31 of the respective year. Data for physician extender type ("certification") include active-instate NPs indicating a physician extender type of family nurse practitioner, adult nurse practitioner, ob/gyn nurse or pediatric nurse practitioner who were licensed as of October 31 of the respective year.

Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, Univers' ɔf North Carolina at Chapel Hill, with data derived from the NC Medical Board.

And PAs are Increasingly Specializing

Physician Assistants in Specialty vs. Primary Care, North Carolina, 1996-2009

Notes: Data include active, instate physician assistants licensed in NC as of October 31 of the respective year.
Primary care includes family practice, general practice, internal medicine, Ob/Gyn, or pediatrics.

Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the NC Medical Board.

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General Surgery has both supply and distribution issues

Percent Change in Ratio of General Surgeons to Population 1997 - 2008
North Carolina

% Change per 100,000 Population

Category	Count
Gained More than 50%	(3)
Gained Less than 50%	(17)
Decline in Ratio	(54)
Lost All Surgeons	(5)
None in 1997, at least 1 in 2008	(1)
No Surgeons Either Year	(20)

Notes: General Surgery includes Abdominal Surgery, Bariatric Surgery, Critical Care Surgery, General Surgery, Hand Surgery, Maxillofacial Surgery, Oral Surgery, Pediatric Surgery, Oncology Surgery, Traumatic Surgery, Abdominal Organ Transplantation, Vascular Surgery, and Cardiovascular Surgery.

Source: North Carolina Medical Board physician licensure data, 1997 - 2008; and 2010 Area Resource File for population data.

Produced by the Cecil G. Sheps Center for Health Services Research, UNC-CH, August 3, 2010.

Half of NC's Counties Qualify as *Mental* Health Professional Shortage Areas

Psychiatrist Full-Time Equivalents per 10,000 Population North Carolina, 2008

Central Regional Hospital - Butner

Central Regional Hospital - Raleigh

Broughton Hospital

Cherry Hospital

Psychiatry FTEs per 10,000 Population (# of Counties)

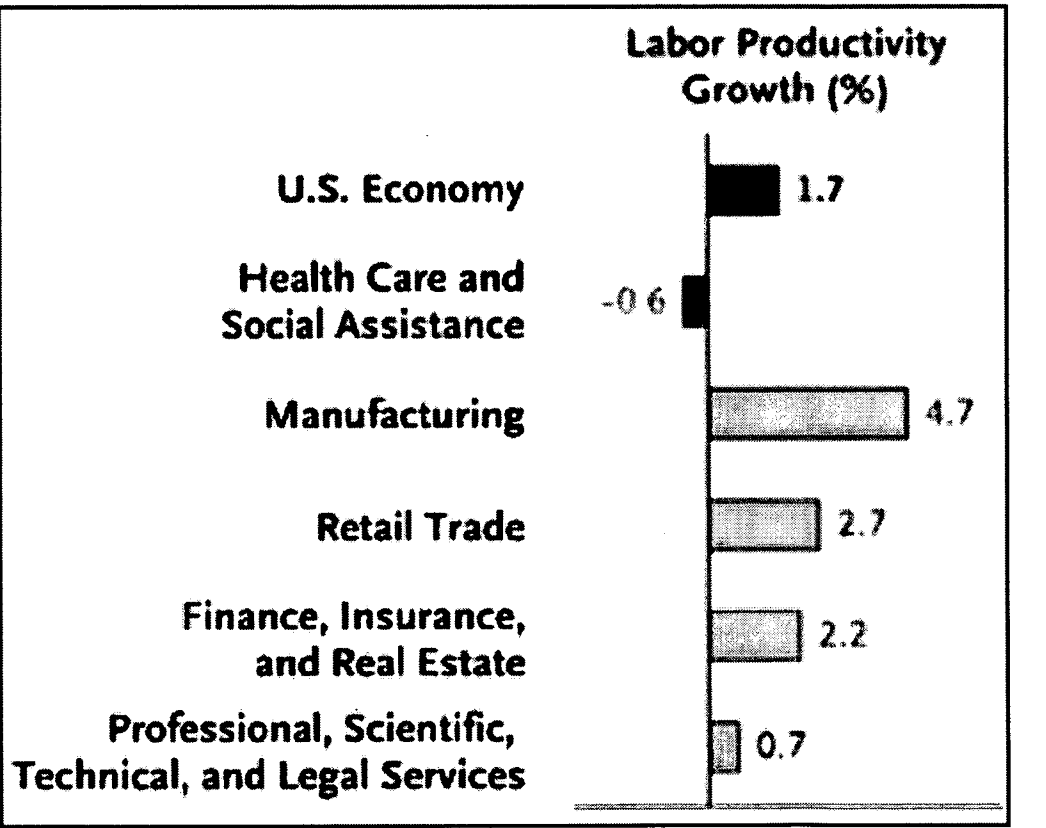
- 0.99 to 9.91 (20)
- 0.60 to 0.98 (15)
- 0.33 to 0.59 (26)
- 0.01 to 0.32 (26)
- No Psychiatrists (13)

● One Psychiatric Hospital

Produced by: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. **Source**: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2008; LINC, 2010; NC DHHS, MHDDSAS, 2010. **Note**: Psychiatrists include active, instate, nonfederal, non-resident-in-training physicians who indicate a primary specialty of psychiatry, child psychiatry, psychoanalysis, psychosomatic Medicine, addiction/chemical dependency, forensic psychiatry, or geriatric psychiatry, and secondary specialties in psychiatry, child psychiatry and forensic psychiatry.

Work Harder? More Health Worker are Doing Less

- Of $2.6 trillion spent nationally on health care, 56% is wages for health workers
- Workforce is LESS productive now than it was 20 years ago…



Kocher and Sahni, "Rethinking Health Care Labor", *NEJM*, October 13, 2011.

IF WE NEED MORE PEOPLE, WHAT KINDS OF PEOPLE?

Diversity and Workforce Needs

In context of emerging workforce shortfalls and maldistribution:

- Are we adequately accessing a talented pool of workers?
- Is there access to education and upward job mobility?

A transformed health care system will emphasize population health, reducing health disparities, and community-based models of care.

Can we accomplish this system without increasing workforce diversity?

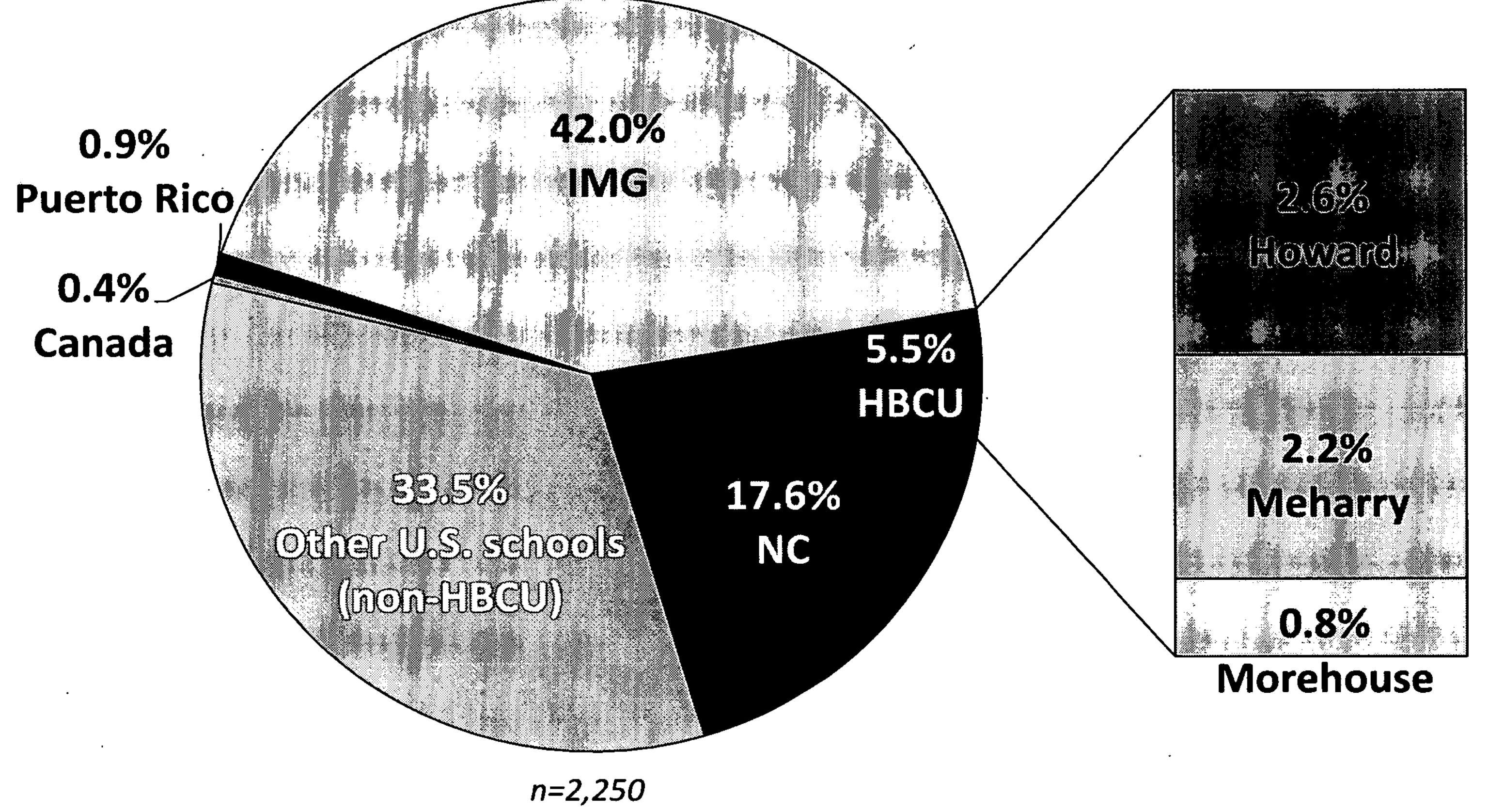
Race/Ethnicity of Practitioners Falls Short of Matching Population Diversity

Diversity of North Carolina's Population vs. Diversity of Selected Health Professions, 2009

Health Professions are Diversifying Over Time at Different Rates

Change in Non-White Diversity of Selected Health Professions, North Carolina: 1994-2009

Majority of NC's Non-White Primary Care Physicians Educated in Other States and Countries



North Carolina does “planning” for workforce

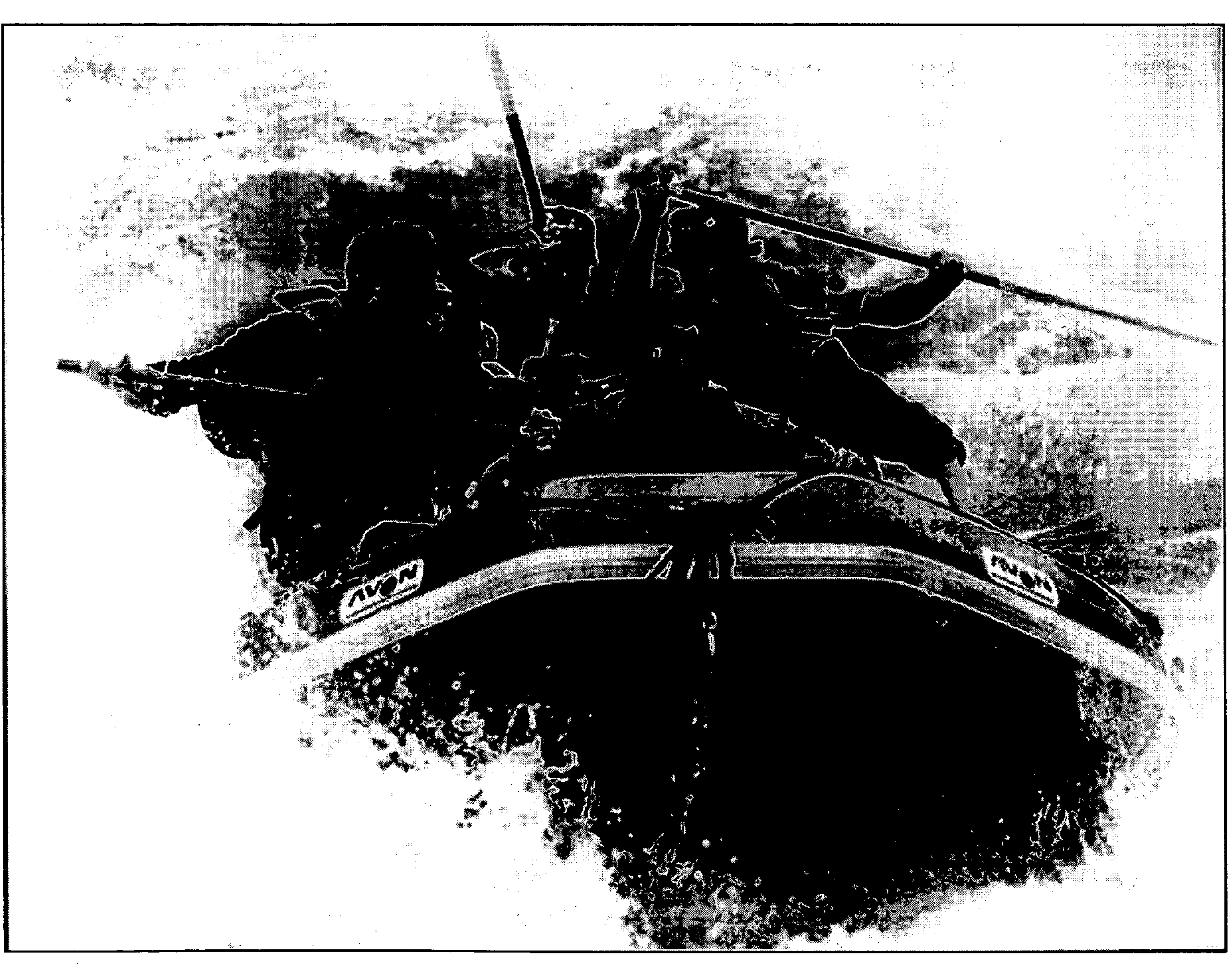
State has long history of workforce planning:

- Well-established AHEC
- Strong public community college and university system
- History of collaboration and trust
- Better data and analytical capacity than most states
- Strong base from which to move forward

North Carolina's Workforce Planning: The Critique

- Starts from professional, **silo-based** perspective
- Little accountability for matching workforce to population health needs
- Limited employer involvement
- Generally not interdisciplinary
- Reactive, heavy reliance on market
- Lacks coordination

Health Workforce Planning in North Carolina the Traditional Way



Result is a "Compromised" Workforce Planning System

- Resembles "a version of Goldilocks written by Albert Camus" with approaches that are either "too hot, or too cold, but never just right"
  (Grumbach, *Health Affairs* 2002; 21(5): 13-27)
- Often lurches from oversupply to shortage
- Generates "vigorous" disagreements about what constitutes an adequate supply, distribution and "right" mix of health providers
- Data not linked to policy action

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10-11-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Deidre Murphy	Ascendient
Will Pittman	Rex Healthcare
[illegible]	NP
Jeanne Foley	Smith Moore Leatherwood LLP
Earl Jones	Good Hope Hospital, Inc.
Patsy Carson	Mayor of Erwin
Pat Cameron	Good Hope Hospital, Inc.
Jim Burgin	Harnett County / Good Hope Hosp
Matt Wolfe	PIAB
DAVID FRENCH	STRATEGIC HEALTHCARE CONSULTANTS
Trey Adams	PDA, Inc.

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Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Kip Sturgis	NC DOJ
Chris Taylor	NCMCC
Drexdal Pratt	DHHS/DHSR
Jesse Goodman	DHHS/DHSR
Kelly Nicholson	UNC Health Care
Pam Scott	Poyner Spruill
David Meyer	Keystone Planning
Catharine Cummer	DUHS
Kathleen Worrell	PDC
Doug Heron	DUHS

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NAME	FIRM OR AGENCY AND ADDRESS
Hugh Tilson	NCHA
Christine Craig	WakeMed
Andi Curtis	WakeMed
Heather Barnett	Ward & Smith
Tracy Colvard	AHHC
Jill Rosenblum	NBM Health Planning
Sandy Godwin	CFVHS
Elise Quick	Troutman Sanders
Andrew Blackburn	Southern Strategy Group
Laurie Onorio	Jason Roano & Assoc.
Tom Ricketts	UNC-CH

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Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Fitzgerald	[illegible]
Cody Hand	NCHA
Erica Nelson	NCHA
JOE LANIER	NELSON MULLINS
JEFF BARNHART	McGUIREWOODS
Julia Adams	The Arc of NC
Connie Wilson	NCHA
Kris Horton	DHHS
Sarah Wolfe	McGuireWoods
John Cooper	Compass NC
GRAHAM FIELDS	PARK RIDGE HEALTH

VISITOR REGISTRATION SHEET

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Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Kouba	CompassNC
Estherine Davis	Estherine Davis & Assoc.
Rowena Timms	Mission Health
Alex Mullineaux	Caromont Health

COMMITTEE MEETING NOTICE

2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, October 25, 2012

TIME: 1:00 p.m.

LOCATION: 544 LOB

COMMENTS: FUTURE MEETINGS FOR PLANNING PURPOSES

11-15-2012 643LOB 10:00 a.m. - 3:00 p.m.

12-08-2012 544 LOB 10:00 a.m. - 3:00 p.m. INCORRECT DATE SHOULD BE:

12-06-2012 544 LOB 10:00 a.m. - 3:00 p.m.

Respectfully,

Representative Steen, Chair

Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at

8 AM o'clock on **October 13, 2011**.

Principal Clerk

Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

AGENDA
Thursday, October 25th
1:00 pm
Room 544, Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

I. North Carolina Certificate of Need Law in the 21st Century Revisited.
Noah H. Huffstetler III, Partner, Nelson Mullins

II. Cost Savings and Justification for Changes to CON Law to Allow Single-Specialty Ambulatory Surgery Centers.
Dave French, MBA, MHA, President, Strategic Healthcare Consultants

III. Ambulatory Surgery and Certificate of Need: A Hospital Perspective.
Hugh Tilson, Sr. Vice-President, North Carolina Hospital Association

IV. Committee Discussion

Upcoming Meetings
November 15th – 10:00 am
December 6th – 10:00 am

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, October 25, 2012

1:00 p.m.

Room 544, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 25, 2012 in Room 544, LOB at 1:00 p.m. Representatives Avila, Hollo, Steen, and Torbett were present.

Representative Steen presidéd.

Noah Huffstetler, Partner, Nelson Mullins gave a presentation on North Carolina Certificate of Need Law in the 21st Century Revisited. (Please see presentation attached and on committee web site.)

Question from committee member Representative Torbett requested that the ethics rules for the State Health Care Council be revised possibly to the same standards as MPO's and TAC's and that the structure of how the members are appointed is changed.

Dave French, MBA, MHA, President, Strategic Healthcare Consultants gave a presentation on Cost Savings and Justification for Changes to CON Law to Allow Single-Specialty Ambulatory Surgery Centers.(Please see attached and on committee web site.)

Questions from committee members Representatives Avila, Hollo, and Steen regarding projection of how many, impact to existing hospitals, reimbursements, hospital/doctor partnership, provide all data for applications dealing with charity care and if projections were lived up to, diagnostics versus surgery and the unintended consequences, progress in hospital's sake of not undermining them and not create a monster, surgeons in ambulatory surgery centers having coverage in emergency room with a transfer in place.

Hugh Tilson, Senior Vice President, North Carolina Hospital Association gave a presentation on Ambulatory Surgery and Certificate of Need: A Hospital Perspective. (Please see attached and on committee web site.)

There was a question from committee member Representative Steen regarding suggestions for modification.

Representative Steen advised the members of the next two meetings and that the next meeting would be to start developing a consensus of the final report.

Representative Steen adjourned the meeting.

Representative Fred Steen, Co-Chair Presiding

Viddia Torbett, Clerk

Representative John Torbett, Co-Chair

North Carolina's Certificate of Need Law in the 21st Century Revisited: What Have We Learned?

October 25, 2012

Noah H. Huffstetler, III

Presented to the House Select Committee on Certificate of Need and Related Hospital Issues

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP

Nelson Mullins

Outline

- Reasons to retain CON regulation
- Opportunities for CON law improvement

Nelson Mullins

Reasons to retain CON regulation

Ensures continued strength and credit-worthiness of North Carolina's health care market

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NC Medical Care Commission

Hospitals with Outstanding Debt as of June 2012

Loss from Operations at FYE 2011

OUTSTANDING DEBT

As of June 30, 2012, the Commission has closed 423 revenue bonds, notes and leases. The total authorized principal amount of all such financings was $18,805,396,052 and the total outstanding principal amount of all such financings as of June 30, 2012 was $7,456,353,735 excluding financings that have been refunded.

NC Medical Care Commission

"Health Care Facilities Finance Act Annual Report," June 30, 2012

Health Care providers in these states and geographic regions benefit from a combination of strong demographic and economic trends, favorable payer environments, and the presence of strong Certificate of Need regulation. Two states in particular, Virginia and North Carolina, stand out when comparing their characteristics and hospital ratings to other states in the country.

Moody's Investors Service, 2004

Nelson Mullins

Reasons to retain CON regulation

Regardless of election outcome, health care providers continue to operate under tremendous uncertainty with ACA implications

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Cuts Anticipated over Next 10 Years

Programs / Actions Causing Cuts	Statewide 10-Year Impact
Hospital Acquired Conditions	($72,266,014)
Value-Based Purchasing	$ 2,985,917*
Readmissions Reduction Program	($ 208,627,000)
ACA / CMS Medicare Payment Reductions	($ 4,593,501,000)
Deficit Reduction Sequestration Requirement (2% Medicare Reduction Resulting from Lack of Super Committee Action)	($ 1,259,248,500)
ACA Medicare DSH Reductions	($ 847,659,000)
Effect of Massachusetts' Manipulation of Medicare "rural floor" wage index calculation (stemming from national budget neutrality)	($ 218,000,000)
Bad Debt Reimbursement Restrictions	($ 125,452,600)
Total Known Cuts (June 19, 2012)	($7,196,314,597)

*Single year impact only. Ten-year projection not possible. Sources: American Hospital Association, DataGen

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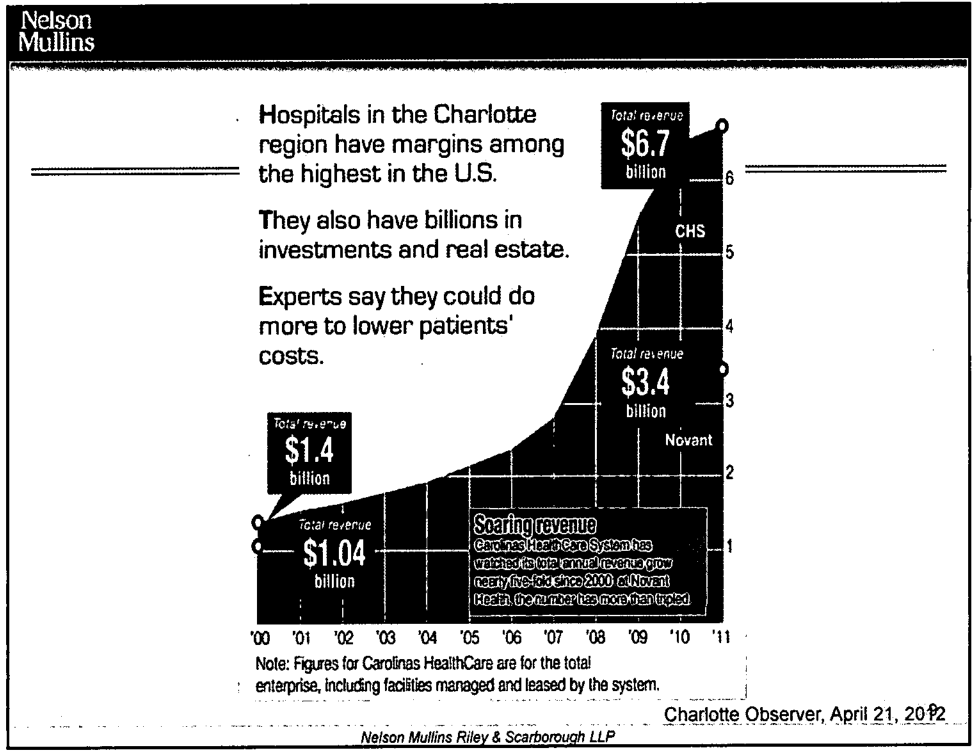

Charlotte Observer, April 21, 2012

Nelson Mullins Riley & Scarborough LLP

Nelson Mullins

Reasons to retain CON regulation: Access to Care

- **Example:**
- **In a May 15, 2012 CON application, Forsyth Medical Center (FMC) in Winston-Salem showed the following about FMC in response to Question 8:**

(a) **What amount of charity care did the facility provide to patients during the last full fiscal year?**

$79,663,814 in Charity Care which was 12.48% of net revenue

(a) **Does this amount include bad debt? No. If so, what amount is bad debt? $19,294,332 in bad debt, which was 3.02% of net revenue**

(b) **Provide an estimate of the amount of charity care that will be provided in each of the first two fiscal years of operation for the project.**

In Project Year 1, $92,379,006 in Charity Care, which is 12.25% of net revenue

In Project Year 2, $97,053,384 in Charity Care, which is 12.48% of net revenue

(c) **Does this amount include bad debt? No. If so, what amount is bad debt?**

In Project Year 1, $22,373,913 in bad debt, which is 3.02% of net revenue

In Project Year 2, $23,506,033 in bad debt, which is 3.02% of net revenue

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Opportunities for CON law improvement

Reduce delays in provision of needed facilities and services.

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Opportunities for CON law improvement
Example: Gaston Memorial Hospital

Mount Holly Emergency Room Expansion

- Proposed in 2008
- Argued in Court of Appeals, September 2011
- CON Awarded May 2012

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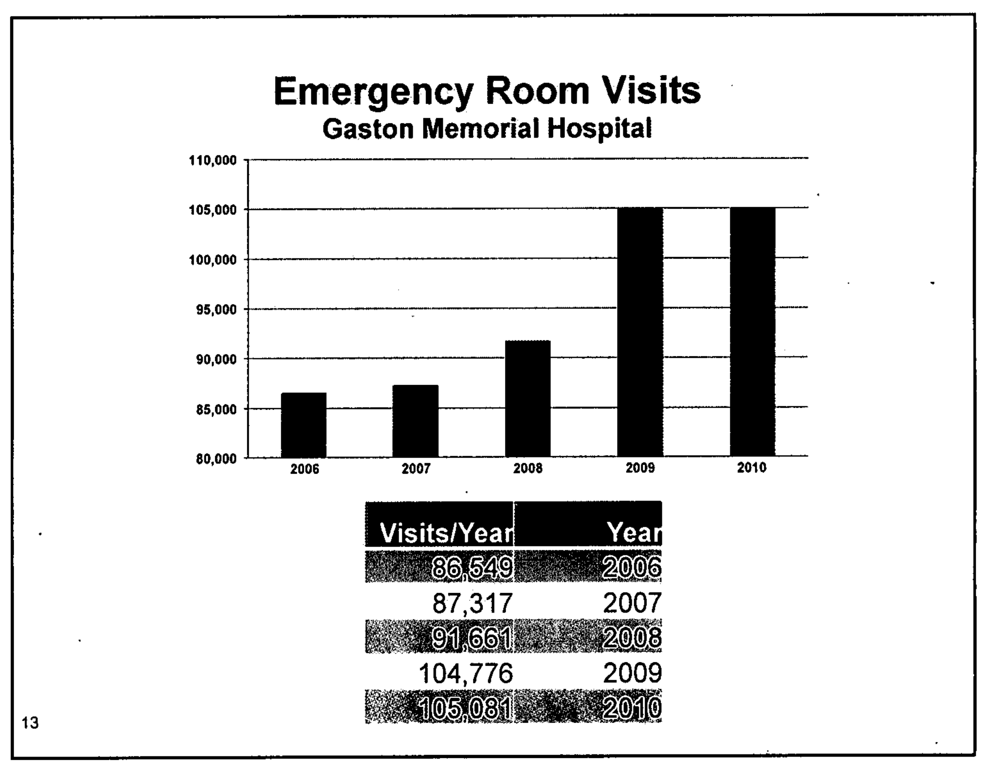

Visits/Year	Year
86,549	2006
87,317	2007
91,661	2008
104,776	2009
105,081	2010

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"In short, CMHA simply has no 'right' to be free of competition, and, as a result, it is not possible that any such right has been prejudiced by the Agency's approval of the CaroMont 2010 Application.

CMHA's contested case in OAH appealing such approval...was frivolous.

CMHA's contested case in OAH appealing such approval...was filed for purposes of delay, to prevent CaroMont, the approved applicant, from moving forward with its development of a freestanding emergency department in Mount Holly"

Order Granting Motion for Recovery of Bond; Hon. Nathanial J. Poovey, 13 July 2012

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"Each RME room that CaroMont developed and was unneeded would result in additional capacity for Caromont to attempt to take away volume from CHS, at a rate of approximately 1,333 annual visits and $346,000 in annual net revenue per room"

Affidavit of Dawn Carter

20 June 2012

Annual net revenue loss

$6,228,000

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Improvements Implemented Since 2011

- **NCHA facilitated agreed-upon clarification of CON exemption for Academic Medical Centers**
- **2012 SMFP includes that clarification for Policy AC-3**

CHAPTER 4
STATEMENT OF POLICIES

Summary of Policy Changes for 2012

There is one substantive policy change incorporated into the North Carolina 2012 State Medical Facilities Plan. POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS has been revised to clarify the existing language and to strengthen the focus on "...unique academic medical needs."

- **Opportunity for statutory action**

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Improvements Implemented Since 2011

- CON Section technological advances

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Opportunities for CON law improvement

Bond requirement inadequate to deter frivolous appeals.

Impossible to estimate lost revenues, jobs, higher contribution costs resulting from delays, not to mention delay in needed services.

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Opportunities for CON Law Improvement

Eliminate outdated, unenforceable requirements.

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"Diagnostic Center" means a freestanding facility, program or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

N.C.G.S. 131E-176 (7a)

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Mullins

Opportunities for CON Law Reform

Make all applicants subject to the same requirements.

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Mullins

What reforms should be considered?

Make all applicants subject to the same requirements

- ❖ UNC, NC Baptist Hospitals, Duke University Medical Center, Pitt County Memorial Hospital

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Opportunities for CON Law Reform

Make certain decisions of the State Health Coordinating Council more transparent and accountable

- All members appointed by Governor – not General Assembly
- In recent litigation, at least 22 of 29 members were recognized to be employed by or affiliated with providers regulated under the SMFP

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Opportunities for CON Law Reform

SHCC's decisions not subject to scrutiny by the Rules Review Commission.

Not subject to review on appeal.

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The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health offices that may be approved.

N.C.G.S. 131E-83(a)(1)

The correctness, adequacy, or appropriateness of criteria, plans, and standards shall not be an issue in a contested case hearing.

10A NCAC 14C .0402

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Opportunities for CON Law Reform

SHCC members not subject to State Ethics Act.

Questions?

Noah H. Huffstetler, III

October 25, 2012

Presented to the House Select Committee on Certificate of Need and Related Hospital Issues

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP

Cost Savings and Justification for Changes to CON Law to Allow Single-Specialty Ambulatory Surgery Centers

October 25, 2012

David J. French MBA, MHA
Strategic Healthcare Consultants

North Carolina Orthopaedic Association

2005 Change in CON Law for GI Endoscopy Procedure Rooms

During the six years following the 2005 change in the CON law, 47 new GI Endoscopy ASC facilities were developed. GI endoscopy cases performed in ASCs are reimbursed by Medicare at 57% of the rates paid to hospitals for the same procedures.

A recent study published in the New England Journal of Medicine verifies that colonoscopy procedures save lives.

Total net savings related to the shift of GI endoscopy cases from hospitals to ASCs over the past six years is estimated at $224,605,748.

Changes to the NC CON law to allow additional single-specialty ASCs would provide tremendous cost savings in future years.

North Carolinians Have Limited Access to ASCs

	2012 North Carolina	2010 US Totals
Total Licensed ASCs (Surgical and Endoscopy)	96	5,316
Population	9,781,022	308,745,538
ASCs per 100,000 Population	0.98	1.72

States	CON Status	2012 Licensed ASCs	2012 Population	ASCs per 100,000 Population
Virginia	CON Required	51	8,001,024	0.64
North Carolina	CON Required	96	9,781,022	0.98
South Carolina	CON Required	75	4,625,364	1.62
Tenessee	CON Required	162	6,346,105	2.55
Georgia	Exemptions for Single Specialty and JV ASCs with $ Thresholds	333	9,687,653	3.44
Florida	No CON Required for ASCs	422	18,801,310	2.24

2011 Procedure Volumes and Top Physician Specialties At ASCs

Highest Procedure Volumes by Specialty Performed in NC Surgical ASCs

Specialty	Volume
Ophthalmology	57,345
Orthopaedic Surgery	32,134
Otolaryngology	24,381
General Surgery	8,597
Obstetrics and GYN	6,626
Plastic Surgery	2,746

Highest Volumes of Non-Surgical Procedures Performed in NC Surgical ASCs

Procedure	Volume
Pain Management	20,760
Yag Lasers	5,563

Top 6 Physician Specialties on ASC Medical Staff (This is not a measure of physician ownership)

Specialty	Count
Orthopaedic Surgery	338
Anesthesia	294
Ophtalmology	246
Obstetrics and GYN	244
Otolaryngology	182
General Surgery	178

Rationale for Changing CON Law to Allow CON Applications for Single-Specialty ASCs

- ✓ Ambulatory surgical centers provide tremendous cost savings to patients, insurance companies and government payors
- ✓ ASCs enable surgeons to be more efficient
- ✓ Proposals can be submitted by physicians, hospital-owned physician groups or other legal entities including joint ventures
- ✓ This change will increase competition and patient access
- ✓ ASCs will be required to provide specific levels of care to Medicaid and Charity patients and to provide annual reports
- ✓ This change in the CON law will support the future recruitment of physician specialists to North Carolina
- ✓ This change will increase investment in facilities, create jobs and expand the tax base

NC Medicaid Ambulatory Surgery
Actual Cases and Amounts Paid

	2011	2012
Hospital Medicaid Ambulatory Surgery Paid Amounts	$74,799,293	$85,191,372
Hospital Medicaid Ambulatory Surgery Cases	164,489	172,673
Average $ Paid per Case	$454.74	$493.37
ASC Medicaid Ambulatory Surgery Paid Amounts	$13,597,774	$14,589,820
ASC Medicaid Ambulatory Surgery Cases	46,951	43,895
Average $ Paid per Case	$289.62	$332.38
Combined ASC and Hospital Paid Amounts	$88,397,067	$99,781,192
Combined ASC and Hospital Ambulatory Cases	211,440	216,568
Average $ Paid per Case	$418.07	$460.74
Variance between Hospital and ASC per Case Paid Amount	$165.12	$160.99
Percentage Variance of Hospital and ASC Paid Amount	36.31%	32.63%

Projections of Future Years' Cases and Amounts Paid With No Changes in CON Law

Project Future Medicaid Total Cases and Amounts Paid

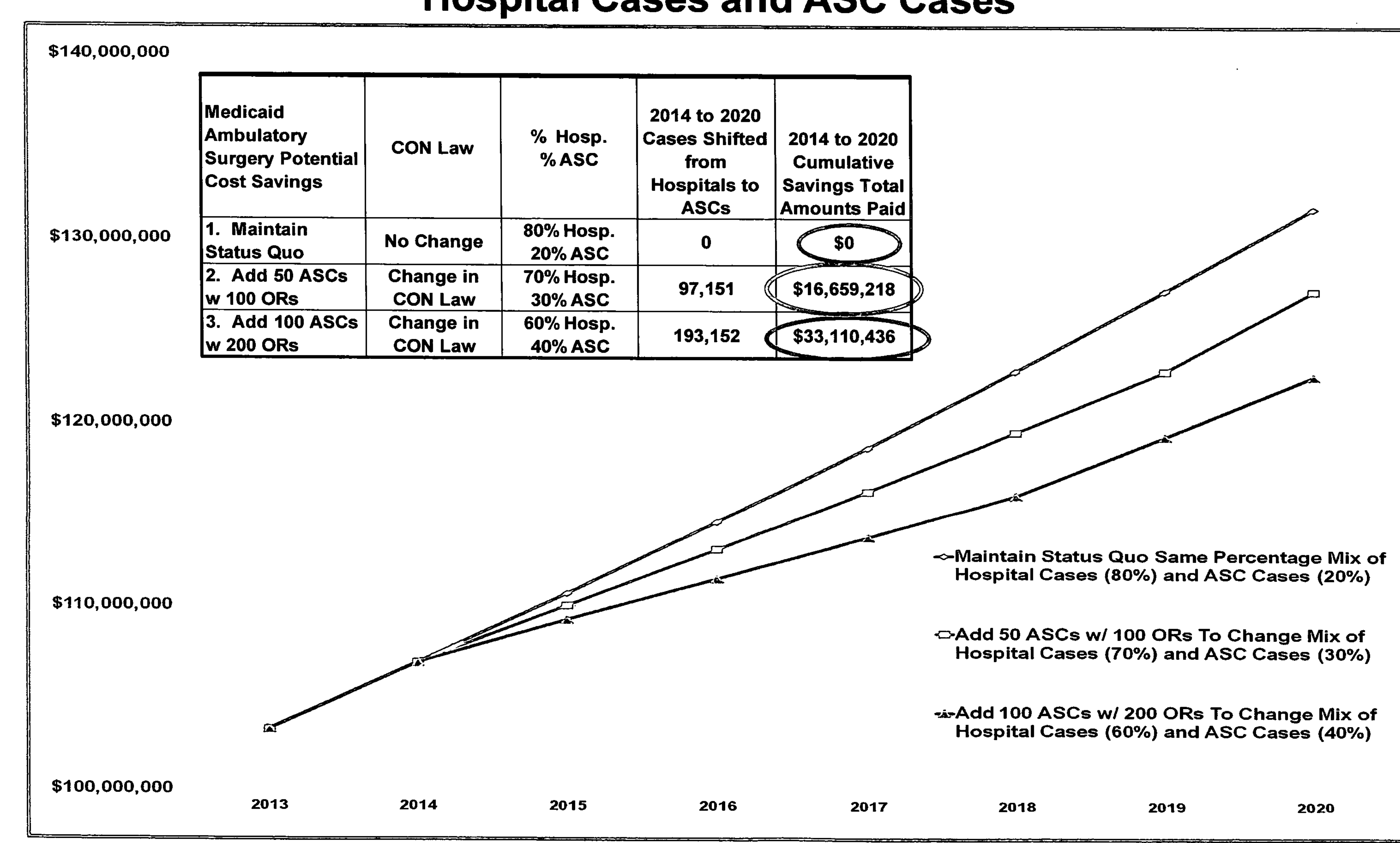
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Combined # ASC and Hospital Ambulatory Cases	211,440	216,568	221,982	227,532	233,220	239,051	245,027	251,152	257,431	263,867
Average $ Paid per Case	$418.07	$460.74	$465.35	$470.00	$474.70	$479.45	$484.24	$489.08	$493.97	$498.91
Combined ASC and Hospital Paid Amounts in Millions	$88.4	$99.8	$103.3	$106.9	$110.7	$114.6	$118.7	$122.8	$127.2	$131.6

Assumptions 2013 to 2020:

Combined ASC and Hospital Cases Increase 2.5% Annuallly

Average Paid per Case Increases 1% Annually

Medicaid Ambulatory Surgery Projections; Three Scenarios for Total Combined Annual Paid Amounts for Hospital Cases and ASC Cases



Medicaid Ambulatory Surgery Potential Cost Savings	CON Law	% Hosp. % ASC	2014 to 2020 Cases Shifted from Hospitals to ASCs	2014 to 2020 Cumulative Savings Total Amounts Paid
1. Maintain Status Quo	No Change	80% Hosp. 20% ASC	0	$0
2. Add 50 ASCs w 100 ORs	Change in CON Law	70% Hosp. 30% ASC	97,151	$16,659,218
3. Add 100 ASCs w 200 ORs	Change in CON Law	60% Hosp. 40% ASC	193,152	$33,110,436

NC State Health Plan Ambulatory Surgery Cases and Amounts Paid (SHP Enrollment 663,000 Persons)

	2011	2012
Hospital SHP Ambulatory Surgery Paid Amounts	$186,272,164	$186,586,774
Hospital SHP Ambulatory Surgery Cases	60,847	58,383
Average $ Paid per Case	$3,061.32	$3,195.91
ASC SHP Ambulatory Surgery Paid Amounts	$14,216,247	$15,714,905
ASC SHP Ambulatory Surgery Cases	14,798	13,485
Average $ Paid per Case	$960.69	$1,165.36
Combined ASC and Hospital Paid Amounts	$200,488,411	$202,301,679
Combined ASC and Hospital Ambulatory Cases	75,645	71,868
Average $ Paid per Case	$2,650.39	$2,814.91
Variance between Hospital and ASC per Case Paid Amounts	$2,100.63	$2,030.55
Percentage Variance of Hospital and ASC Paid Amounts	68.62%	63.54%

NC SHP Surgery Utilization Mix of ASC and Hospital Cases	2012	% Mix
Hospital SHP Ambulatory Surgery Cases	58,383	81%
ASC SHP Ambulatory Surgery Cases	13,485	19%
Total Combined SHP Ambulatory Surgery Cases	71,868	

State Health Plan Ambulatory Surgery
Projections of Future Years' Cases and Amounts Paid
With No Changes in CON Law

Project Future State Health Plan Total Cases and Amounts Paid

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Combined # ASC and Hospital Ambulatory Cases	90,443	85,353	87,487	89,674	91,916	94,214	96,569	98,983	101,458	103,994
Average $ Paid per Case	$2,373.92	$2,554.29	$2,579.84	$2,605.63	$2,631.69	$2,658.01	$2,684.59	$2,711.43	$2,738.55	$2,765.93
Combined ASC and Hospital Paid Amounts in Millions	$214.7	$218.0	$225.7	$233.6	$241.9	$250.4	$259.2	$268.4	$277.8	$287.6

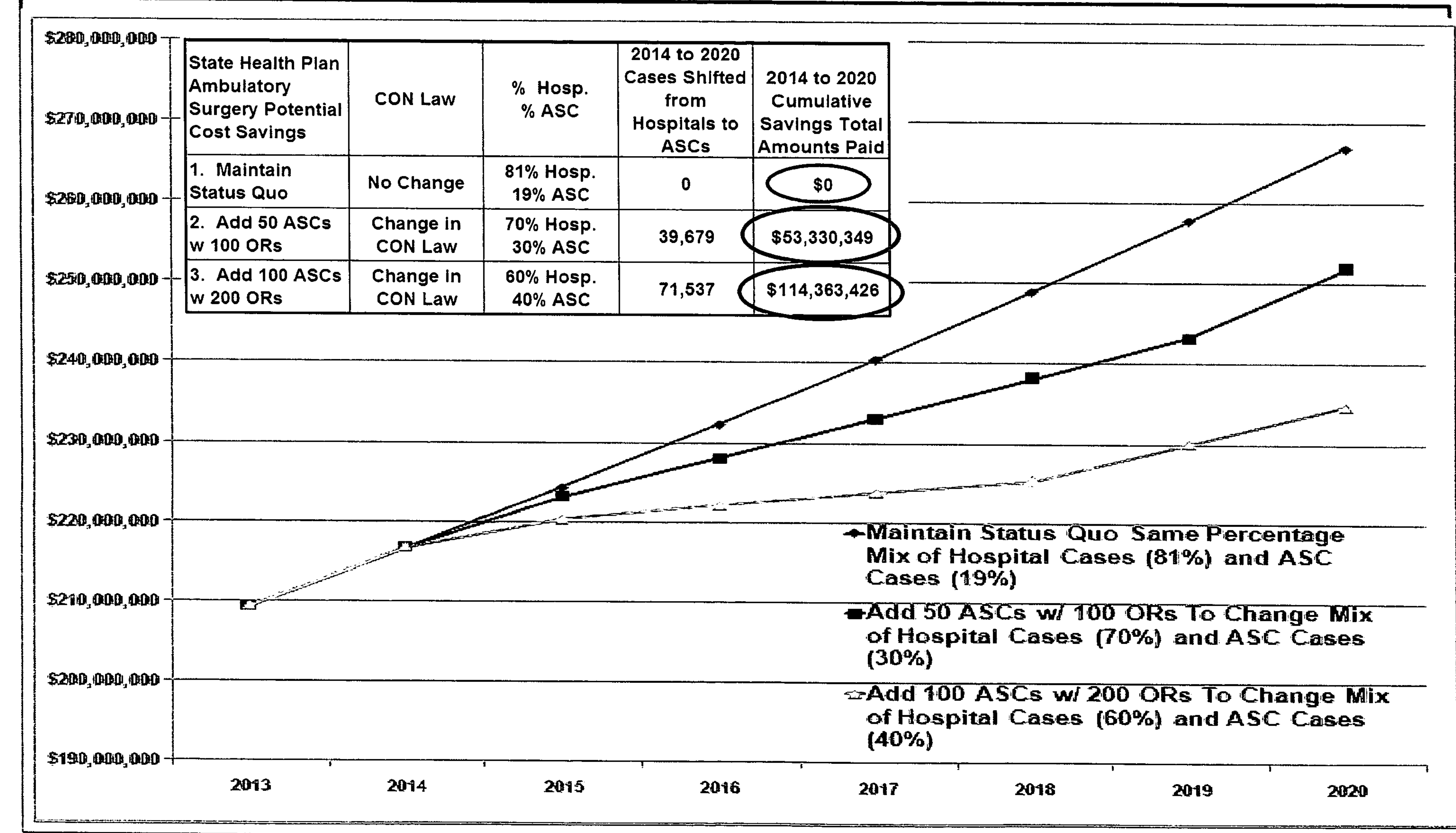
Assumptions for 2013 to 2020:

Combined ASC and Hospital Cases Increase 2.5% Annuallly

Average Paid per Case Increases 1% Annually

State Health Plan Ambulatory Surgery Projections; Three Scenarios for Total Combined Annual Paid Amounts for Hospital Cases and ASC Cases

State Health Plan Ambulatory Surgery Potential Cost Savings	CON Law	% Hosp. % ASC	2014 to 2020 Cases Shifted from Hospitals to ASCs	2014 to 2020 Cumulative Savings Total Amounts Paid
1. Maintain Status Quo	No Change	81% Hosp. 19% ASC	0	$0
2. Add 50 ASCs w 100 ORs	Change in CON Law	70% Hosp. 30% ASC	39,679	$53,330,349
3. Add 100 ASCs w 200 ORs	Change in CON Law	60% Hosp. 40% ASC	71,537	$114,363,426



Medicaid and State Health Plan
Estimated Savings Following Change in CON Law

	2014 to 2020
Scenario 1 - No Changes to CON Law , Ambulatory Cases Remain at 80% Hospitals and 20% ASCs	Scenario 1
Total Medicaid + SHP Amounts Paid	Cumulative $2,520,532.219
Savings	**$0**
Scenario 2 - Add 50 ASCs w 100 ORs (2 per ASC) Changes Ambulatory Cases to 70% Hospitals and 30% ASC	Scenario 2
Total Medicaid + SHP Amounts Paid	Cumlative $2,450,542,562
Savings	**$69,989,568**
Scenario 3 - Add 100 ASCs with 200 ORs (2 per ASC) Changes Ambulatory Cases to 60% Hospitals and 40% ASCs	Scenario 3
Total Medicaid + SHP Amounts Paid	Cumlative $2,172,694,165
Savings	**$147,473,862**

Cumulative Cost Savings Range Between $70 Million and $147 Million Depending on the Number of ASCs and the Shift of Cases

Key Factors Regarding Changes To CON Law

Single Specialty ASCs:

Must meet all licensure and accreditation standards and Medicare Conditions of Participation

Must establish transfer agreements with local hospitals

Will be required to provide access for Charity Care and Medicaid patients on par with existing hospitals and ASCs and consistent with written policies

Must submit annual reports of Charity Care and Medicaid utilization

Will not be permitted to be developed in the 23 rural counties with a Critical Access Hospital

Key Factors Regarding Changes To CON Law

Single-specialty ASCs should not be permitted to be developed in the 23 rural counties with a Critical Access Hospital

	Hospital	City	County
1	Swain County Hospital	Bryson City	Swain
2	Our Community Hospital	Scotland Neck	Halifax
3	Montgomery Memorial Hospital	Troy	Montgomery
4	Vidant Bertie Hospital	Windsor	Bertie
5	Bladen County Hospital	Elizabethtown	Bladen
6	Hoots Memorial Hospital	Yadkinville	Yadkin
7	St. Lukes Hospital	Columbus	Columbus
8	Chatham Hospital	Siler City	Chatham
9	Davie County Hospital	Mocksville	Davie
10	Pender Memorial Hospital	Burgaw	Pender
11	Washington County Hospital	Plymouth	Washington
12	Vidant Pungo District Hospital	Belhaven	Beaufort
13	Alleghany Memorial Hospital	Sparta	Alleghany
14	Stokes-Reynolds Memorial	Danbury	Stokes
15	J. Arthur Dosher Hospital	Southport	Brunswick
16	Blowing Rock Hospital	Blowing Rock	Watauga
17	Highlands-Cashiers Hospital	Highlands	Macon
18	Vidant Chowan Hospital	Edenton	Chowan
19	Transylvania Hospital	Brevard	Transylvania
20	Charles A. Cannon Jr. Memorial	Linville	Avery
21	Outer Banks Hospital	Nags Head	Dare
22	Ashe Memorial Hospital *	Jefferson	Ashe
23	Angel Medical Center	Franklin	Franklin

Concerns Regarding Current CON Law

Hospitals can file CON applications to relocate existing hospital licensed ORs to new outpatient facility locations and obtain the higher reimbursement as hospital-based ORs. In addition, hospitals currently can acquire freestanding ASCs and file CON applications to convert these ORs into hospital-based ORs to maximize reimbursement. Converting freestanding ASC ORs into hospital-based ORs unfairly increases costs and charges to patients, insurance companies and government payors.

The NC CON law could be changed to define hospital-based ORs as only those that are located within the same facility location as the existing emergency department and licensed inpatient acute care beds. Furthermore hospital-based ORs should not be movable unless the entire hospital is relocated or a new hospital is established with CON approval.

Additional Points

There is no guarantee that a CON application for a single-specialty ASC will be approved. The CON process gives applicants the opportunity to demonstrate how their project will conform to all the rules and benefit the community. Anyone can submit comments during the CON process. Also, the CON Section has the authority to impose conditions on the applicant.

Hospitals will have the option of submitting CONs for single-specialty ASCs in collaboration with surgeons.

ASCs provide normal competition and patient choice - - why should NC citizens have less access to ASCs than citizens of most other states?

Alamance Regional Medical Center • Albemarle Health • Alleghany Memorial Hospital • Angel Medical Center • Annie Penn Hospital • Anson Community Hospital • Ashe Memorial Hospital, Inc. • Betsy Johnson Regional Hospital • Blowing Rock Hospital • Blue Ridge Regional Hospital • Broughton Hospital • Brunswick Community Hospital • Caldwell Memorial Hospital, Inc. • Cape Fear Valley - Bladen County Hospital • Cape Fear Valley Health System • CarePartners Rehabilitation Hospital • CarolinaEast Health System • Carolinas Medical Center • Carolinas Medical Center - Lincoln • Carolinas Medical Center - Mercy • Carolinas Medical Center - Northeast • Carolinas Medical Center - Pineville • Carolinas Medical Center - Union • Carolinas Medical Center - University • Carolinas Rehabilitation • Carteret County General Hospital • CaroMont Health, Inc. • Catawba Valley Medical Center • Central Carolina Hospital • Central Regional Hospital • Charles A Cannon, Jr. Memorial Hospital • Chatham Hospital • Cherokee Indian Hospital • Cherry Hospital • Cleveland Regional Medical Center • Coastal Plain Hospital • Columbus Regional Healthcare System • Cone Health Behavioral Health • Davie County Hospital • Davis Regional Medical Center • Department of Veterans Affairs Medical Center Asheville • Department of Veterans Affairs Medical Center Durham • Dorothea Dix Hospital • Duke Raleigh Hospital • Duke University Hospital • Durham Regional Hospital • FirstHealth Montgomery Memorial Hospital • FirstHealth Moore Regional Hospital • FirstHealth Richmond Memorial Hospital • Forsyth Medical Center • Franklin Regional Medical C ... tal • Granville Health System • Halifax Regional Medical Center • High Point Regional Hea ... Rainey Specialty Hospital • Holly Hill Hospital • Hugh Chatham Memorial Hospital • ... hnston Medical Center - Smithfield • Kindred Hospital • Kings Mountain Hosp ... Hospital, Inc. • Lexington Memorial Hospital, Inc. • LifeCare Hospitals of ... Medical Center • Martin General Hospital • The McDowell Hospital • ... st - Swain • Mission Health System • Morehead Memorial Hospital • ... Center, Inc ... anover Regional Medical Center • North Carolina Specialty Hospital • Northern Hospital of Surry County • ... unity Hospital • The Outer Banks Hospital • Park Ridge Health • Pender Memorial Hospital • Person Memorial Hospita ... ealthcare • Presbyterian Hospital Huntersville • Presbyterian Hospital Matthews • Presbyterian Orthopaedic Hospital • Randolph ... Rex Healthcare • Rowan Regional Medical Center • Rutherford Regional Medical Center • Sampson Regional Medical Center • Sandhills Re ... al Medical Center • Scotland Health Care System • Select Specialty Hospital-Durham • Select Specialty Hospital-Winston-Salem • Southeastern Regional Medical Center • St. Luke's Hospital • Stanly Regional Medical Center • Stokes-Reynolds Memorial Hospital, Inc. • The Moses H. Cone Memorial Hospital • Thomasville Medical Center • Transylvania Regional Hospital • UNC Hospitals • Valdese Hospital • Vidant Beaufort Hospital • Vidant Bertie Hospital • Vidant Chowan Hospital • Vidant Duplin Hospital • Vidant Edgecombe Hospital • Wake Forest Baptist Medical Center • Vidant Medical Center • Vidant Pungo Hospital • Vidant Roanoke-Chowan Hospital • Wake Forest Baptist Health – Davie Hospital • Wake Forest Baptist Health – Lexington Medical Center • WakeMed • WakeMed Cary Hospital • WakeMed Fuquay-Varina • WakeMed Zebulon/Wendell SNF and Outpatient Diagnostic Center • Washington County Hospital • Watauga Medical Center • Wayne Memorial Hospital • Wesley Long Community Hospital • Wilkes Regional Medical Center • Wilson Medical Center • Women's Hospital of Greensboro • Yadkin Valley Community Hospital

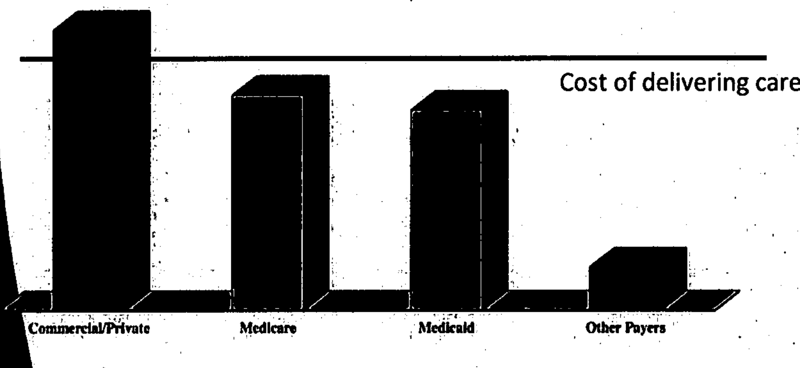
Hospital Perspective

Hugh Tilson, Senior Vice President

North Carolina Hospital Association

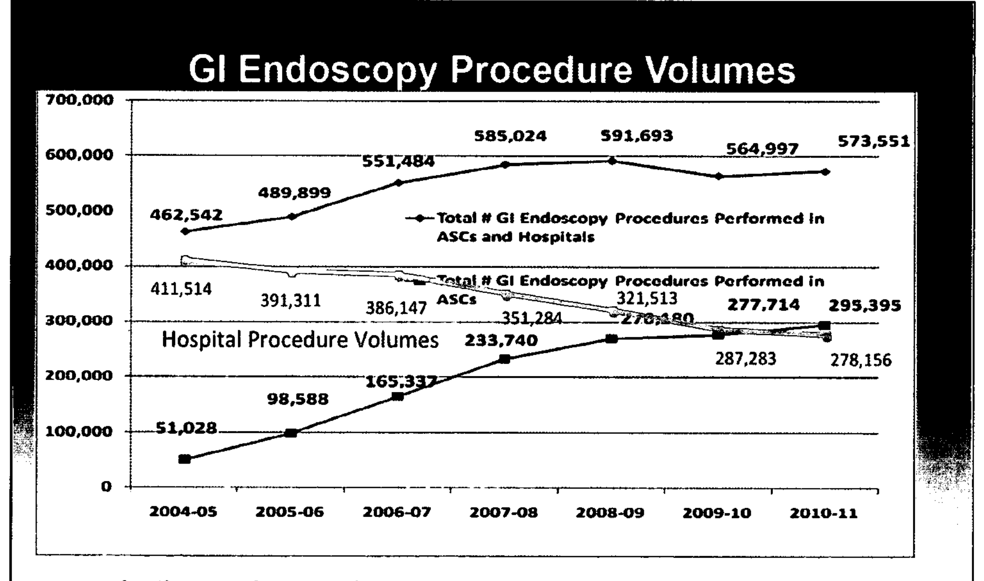
Government Payments Below Costs

3 of 4 hospital patients are paid for by government or have no health insurance. Government sets prices below the cost of caring.



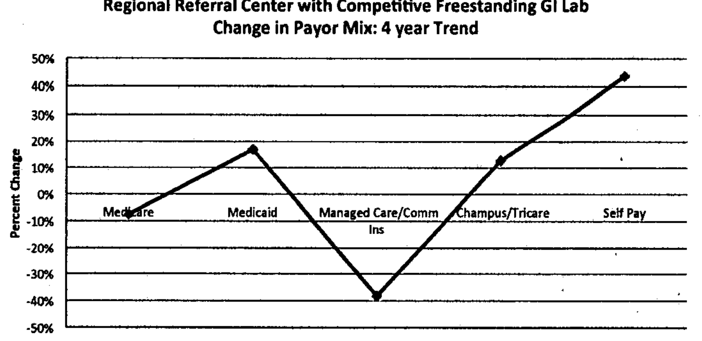
Hospitals depend on commercially insured patients to offset losses caring for government and uninsured patients.

NCHA



Total utilization for GI endoscopy procedures increased by 28 percent over the four years following the change in the CON law. Some of this increase is "normal growth" due to the aging population. Utilization declined in the most recent two years, due to the downturn in the economy.

One Hospital's Experience



Commercially insured patients declined by almost 40%, Medicaid increased by almost 20% and self-pay increased by over 40%

NCHA

Hospitals Treat More Indigent

Freestanding endoscopy centers treat almost twice as many insured patients as hospitals; Government, indigent treated more by hospitals

Hospital Endoscopy - Cases			
Self Pay	Commercial	Govt.	Other
3.6%	40.3%	51.3%	4.8%
GI Endoscopy Centers - Cases			
Self Pay	Commercial	Govt.	Other
<1%	59.3%	34%	5.9%

Source: Truven Health Data (FY 2011 data)

NCHP

5

Implications

Increased utilization:
- Desired with preventive cancer screenings
- Not desired with other surgeries

Transfer agreement: Hospital capacity still required
- ED
- Higher acuity
- Payment categories
- Excess capacity exists – especially for outpatient ORs

Bottom line:
- Movement of services from hospital to other setting
- Hospitals must maintain capacity - cost/case increases
- Increased utilization + higher residual hospital costs = higher total spending

NCHP

Cuts Coming in Next 10 Years

Programs / Actions Causing Cuts	Statewide 10-Year Impact
Hospital Acquired Conditions	($ 72,265,014)
Value-Based Purchasing	$ 2,985,917*
Readmissions Reduction Program	($ 208,627,000)
ACA / CMS Medicare Payment Reductions	($ 4,593,501,000)
Deficit Reduction Sequestration Requirement (2% Medicare Reduction Resulting from Lack of Super Committee Action)	($ 1,259,248,500)
ACA Medicare DSH Reductions	($ 847,659,000)
Effect of Massachusetts' Manipulation of Medicare "rural floor" wage index calculation (stemming from national budget neutrality)	($ 218,000,000)
Bad Debt Reimbursement Restrictions	($ 125,452,600)
Total Known Cuts (June 19, 2012)	**($7,196,314,597)**

*Single year impact only. Ten-year projection not possible. Sources: American Hospital Association, DataGen

NCHA

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10-25-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandy Godwin	CFVHS
GRAHAM FIELDS	PARK RIDGE HEALTH
Denise Gunter	Nelson Mullins
Stephen Korba	compass NC
Catharine Cummer	Duke
Chris Taylor	NCMCC
Jill Rosenblum	NBM Health Planning
CRAIG SMITH	DHSR - CON
Nadine Pfeiffer	DHSR - MFPB
Trey Adams	PDA, Inc.
Sarah Wolfe	McGuire Woods

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES 10-25-2012

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Terri Harris	Smith Moore Leatherwood
BJ Miller	Cone Health
George Smith	Nexsen Pruet
Kathleen Worrell	PDC
Mari Wilder	Novant
Gretchen Kelly	FirstHealth
Alex Mullineaux	CaroMont Health
[illegible] McConnell	Carolinas HealthCare System
Cody Hand	NCHA
Daniel Baum	Troutman Sanders
Elise Quick	Troutman Sanders

VISITOR REGISTRATION SHEET

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Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	BCS
Rob Lamme	RLA
David Barnes	PS
Jesse Goodman	DHHS/DHSR
Ramona Timms	Mission Health
John Metcalf	Mission Health
Alan Skipper	NC Med Soc
Max Mason	Principle LTC
Gary Qualls	K&L Gates
Karl Stein	Raleigh Orthopaedic Clinic
Erica Nelson	NCHA

VISITOR REGISTRATION SHEET

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Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julia Adams	The Arc of NC
DAVID FRENCH	STRATEGIC HEALTHCARE CONSULTANTS
Connie Wilson	NCOA
AIMÉE ESCUETA	NCDOJ
K.D. Sturgis	NC DOJ
Kerry Nicholson	UNC Health Care
Bob Fitzgerald	[illegible]
Drexdal Pratt	DHHS / DHSR

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 10-25-2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DeDe Murphy	Ascendient
[illegible]	MP
Greg Bass	Carolinas HealthCare System
Mike Vicario	NCHA
Kara Weishaar	NCHA
Danielle Musselwhite	Jason Dears + Assoc
David Stone	The Carolinas Center for Hospice + EOL Care
Robbie Roberts	WakeMed
Matt Wolfe	Parker Poe

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, November 15, 2012
TIME: 10:00 a.m. - 3:00 p.m.
LOCATION: 643 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **7 AM** o'clock on **November 01, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

House Select Committee On the Certificate of Need Process and Related Hospital Issues

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

State Legislative Building
Raleigh, North Carolina

AGENDA

Thursday, November 15, 2012
10:00 am
Room 643, Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Approval of Minutes

III. Certificate of Public Advantage Audit
Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission
K. D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice
David Motsinger, CPA, Partner, Dixon Hughes Goodman LLP

IV. Update on Recent Court of Appeals Decision in *Novant Health v. NC DHHS.*
Jan Paul, Research Division

V. Finalize Recommendations for Committee Report

Final Meeting
Thursday, December 6, 2012
10:00 am Room 544 LOB

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, November 15, 2012

10:00 a.m.

Room 643, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, November 15, 2012 in Room 643, LOB at 10:00 a.m. Representatives Avila, Boles, Collins, Current, Hollo, Randleman, Steen, and Torbett were present. Representative Torbett presided.

Representative Torbett asked for approval of minutes. Representative Current made the motion and Representative Boles seconded. The minutes were approved unanimously.

Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission, K.D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice, and David Motsinger, CPA, Partner, Dixon Hughes Goodman LLP presented the Certificate of Public Advantage Audit (see attached and on committee website). There were questions from Representatives Avila and Collins regarding market share.

Jan Paul, Staff Council presented Update on Recent Court of Appeals Decision in Novant Health v. NC DHHS (see attached and on committee website). There were questions from Representatives Avila, Collins, Current, and Torbett regarding specific harm, AC3 explanation, State Health Medical Facilities Plan, and exemptions for AC3. There were questions from Representatives Avila, Collins, Current and Torbett regarding specific harm, explanation from AC3s when they want to expand, exemption for AC3.

Representative Torbett went over the previous recommendations by the committee (see attached and on committee website). 1. Services Regulated-approved unanimously. 2. Thresholds (Draft Legislation "Adjust CON Monetary Thresholds"(see attached and on committee website))-approved unanimously. 3. Changes to Previously Issued CONS-approved unanimously. 4. SHCC- approved unanimously. 5. SMFP-Craig Smith, CON-the policy AC3 exemption only applies to the Main Campus of the institution. The new policy provides for more involvement of the folks in the community in the process. Todd Hemphill, Bode, Call and Stroupe, LLC- copy of changed AC3 policy says to require an applicant who was a policy AC3 to actually go to the other providers in the community and discuss the issues. Catherine Cummer, Duke University Health System-A few other changes are limitations on the use of the policy, the policy can be used when an academic medical center teaching hospital and show that it needs the expansion of the assets for research, the recruitment of faculty, or the expansion of students or residents. One thing that the policy now says is that if you are using the policy justification of recruiting additional faculty, that really only applies for acquisition of equipment, not for beds and operating rooms, so that has narrowed the scope of the policy. Another thing the new policy does is to make more explicit the documentary evidence needed to show why this particular project is needed for the academic purpose. Finally, the policy, for the first time imposes post implementation of reporting requirement about how you are actually using the policy AC3 assets you've developed for the academic purposes that you sited in the application. I would say it has both increased the collaboration, narrowed the use of it, and really provided some increased rigor for the CON section to evaluate. Noah

Huffstetler, Nelson Mullins- I was council for Novant Health in the recent case that was decided by the court of appeals and I would agree generally with the statements made that this policy has been tightened up some, at least for this year. The plan is adopted on a yearly basis by the SHCC and can be changed at any time. One of the considerations that has arisen earlier in this committees deliberations is the possibility of codifying this language so that it is established once and for all and not subject to change. In response to Representative Current's question, what is required to show the need for a policy AC3 application is simply a letter from a dean of an associated medical school that says we would like to have this for teaching purposes and that was all that was required at the time of this. To answer Representative Avila's question, the troublesome thing about the court of appeals decision is that Novant put in evidence that it would lose between 10 and 20 million dollars in net revenue a year as a result of 8 new operating rooms in the county, where there was already 7 too many. The court basically said that sort of harm is not sufficient to show substantial prejudice. So in practical effect, what it means is the only party that can challenge one of these cases is a disappointed applicant who had an application competing with the AC3 project. The problem there is that, to address Representative Collins question, what policy AC3 does is allow an academic medical center to apply for when no other medical center is able to do so. In the future, for example, in Forsyth County, Baptist Hospital will always be able to apply, Novant cannot apply under that same policy, nor can it challenge the approval of one of these applications, because it doesn't have a completing application, and therein lays the rub. The court says if you have problems with the fairness of this policy, they must be addressed by the legislature, not the courts. Catherine Cummer, Duke University Health System, one of the other changes in last year's modification policy talks about how AC3 assets are going to be dealt with and the methodology need determinations, at least going forward. Representative Steen asked of Noah Huffstetler, Nelson Mullins, the court said that they recognized there was a competitive advantage, but this would have to be settled by the general assembly, is this true for the 2012 policy? Noah Huffstetler, Nelson Mullins, the question of whether or not you could appeal is not affected by any of the changes, that problem still remains. What the court appeared to be saying, is that no matter how severe the monetary impact is on a provider, that alone, is not sufficient to give them standing to appeal and that again is the problem with AC3, because what AC3 allows an academic medical center to do, is to apply in an area in which there is no need and so it will always be a noncompetitive application. What the court seemed to be saying here is that in this situation, just because you are a business competitor of that entity and suffer monetary damages, that are not sufficient to give you a right to appeal and that is not effected by the changes in the policy. Todd Hemphill, Bode, Call, and Stroupe, LLP, I would like to respond to a comment Mr. Huffstetler made, the administrative law judge and agency rejected that and essentially found that Novant would not lose any money and that they did not prove their case. Noah Huffstetler, Nelson Mullins, I would respectfully disagree with my colleague's comments. The approval was made to study and review the new AC3 policy and DHSR would report to HHS oversight. 6. Appeals Process (attached and on committee website draft legislation)-unanimous approval. 7. Related Hospital Issues-unanimous approval. Joe Lanier, Nelson Mullins, on behalf of Caromont Health, which does support recommendation. Our concern is that a public hospital authority, which is a little bit different than a nonprofit hospital, its boundary extends from the county from which it is formed out 10 miles in that county. Outside of that is not considered to be the hospital authority boundary and in order for it to perform services, as sort of a quasi-government unit, it has to obtain the cooperation of a hospital within that county or if no hospital exists, the healthcare agency within that county. Our objection to this is that, as a quasi-governmental entity, allowing them to follow those rules outside the border of the county in its extraterritorial jurisdiction area, does not allow the hospital authority the ability to cooperate fully with the hospital that is already in the county. What we are arguing is that the quasi-local government authority needs to cooperate with the hospital in the neighboring county in order to provide the kind of collaboration between healthcare units that we would like to see. The

other point that we would to make is that a hospital authority as created under 131.E has special powers that non hospital authorities have, including the power of eminent domain, the power of county appropriations that are usually subsidized and it is of concern to us that that type of hospital authority has unfair market advantages. Sandy Sands, Nexsen Pruet, representing Carolinas Health Care, which is one of 3 hospital authorities in this state. The hospital authority act was created in 1943 and the primary reason was so that the hospital in Charlotte, Charlotte Memorial Hospital, which was the charity hospital down there could go forward. This hospital authority can do what it needs to and within 10 miles. There was a fuss down there over the last several years and it appears to me that the hospital in Gaston County is now trying to have the legislature put in an unfair competitive advantage over Carolinas Health Care. We would just like to have a level playing field. 8. COPA-Recommendation of a formation committee to direct COPA business study. Representative Avila suggested COPA is a bigger issue than to make specific recommendations and a committee that can focus on COPA is put in place. Representative Boles suggested that since he is not hearing there is a problem from Drexdal Pratt's office and is comfortable with the report. Lanier Cansler, former member of this body, reported he was very involved in passing the COPA legislation. The reason is a state wide legislation that any hospital can choose to go under; it was passed in order to assist in Buncombe County. The reason for the COPA was to be able to demonstrate there was an advantage to the community of this going together because without it they had to go through a lot of things with anti-trust, etc. to make it happen. The COPA has done exactly what it was meant to do and the Mission Health System has done exactly what they were required to do under the COPA. I would suggest that COPA not be the discussion. If you are concerned about the way our healthcare system is evolving, then have that discussion. Denise Gunter , Western North Carolina Community Healthcare Initiative, reports that COPA is the issue. We need to do a deeper dive. In the Vistnes report problems were found such as regulatory evasion and incentive problems, Mission's expansion, expansion into lower margin service areas, contracting, and what competitors and citizens in the area had to say about unfair competition. Rowena Buffett Timms, Senior Vice President at Mission Health for Government and Community Relations, reports that the COPA was enacted because of an anti-trust monopolistic concern that there might have been at that time. We are below our peer study group at each index which indicates that the public is not being taken advantage of. We don't force, and we couldn't obviously, patients to come to Mission. Our member hospitals are looked at frequently as we're asked to bid on the RFP process. Representative Torbett suggested that if the interested parties cannot work out the problems between themselves by the end of next session then the study committee would be suggested. Representative Boles voted against the recommendation.

Representative Avila presented a copy of a draft bill that she was not prepared to discuss at today's meeting, however, would be at the next meeting (see attached and on committee website).

Representative Torbett adjourned the meeting at 3:00pm.

Representative John Torbett, Co-Chair Presiding

Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

North Carolina Department of
Health and Human Services
Division of Health Service Regulation
Certificate of Public Advantage Program
November 15, 2012

1

Participants

- K. D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice
- David Motsinger, CPA, Partner, Dixon Hughes Goodman, LLP
- Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission

2

Issues

- Evaluation of Mission Health System's:
  - Compliance with the Third Amended Certificate of Public Advantage ("the COPA") for the five fiscal years ending September 30, 2007 through September 30, 2011
  - Compliance with the Margin and Cost per Adjusted Discharge Caps in the COPA for FYE September 30, 2011.

3

Planning

- Determine which items within the COPA are of a nature which can be covered under an audit conducted in accordance with standards prescribed by the American Institute of Certified Public Accountants ("AICPA") or be covered under standards prescribed by AICPA for an Agreed Upon Procedures Report.

4

Planning

- Determine the confidence level that must be derived from the evaluation. Evaluate the pros and cons of each approach including the level of assurance which can be gained from each approach, the costs of each approach and the time required for each approach.

5

Planning

- Execute "engagement letters" for the Market Basket Report and the Compliance Reports which set forth the standards governing the work, the procedures to conducted (including the sampling methodology), the confidence level required, the items to be subjected to the procedures and the costs of the work.

6

The Process

- Dixon Hughes Goodman, LLP conducts the compliance evaluation and preparation of the Compliance Reports and Market Basket Report in accordance with agreed upon terms of the engagements.

7

The End Result

- Reports are delivered to NCDHSR and NCDOJ.
- Copies of the Reports are furnished to Members of the House Select Committee on Certificate of Need Process and Related Hospital Issues on September 13, 2012.
- The Reports are posted on NCDHSR Website on September 13, 2012.
- Presentation of Results of the Compliance Reports and the Market Basket Report to the Subcommittee on November 15, 2012.

8

Other Issues

- Dissemination of report on compliance with cost per adjusted discharge and margin caps for FYE September 30, 2011. Posted on NCDHSR Website.
- Discussion of compliance with caps on cost per adjusted discharge and on margin November 15, 2012.

9

Other Issues

- Compliance procedures will be incorporated as part of Market Basket Report for FYE 2012.

10

Compliance Report
FYE 2011

Mission Health System, Inc.

Agreed Upon Procedures Report

For Year Ending September 30, 2011

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice, and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2011. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows (Numbering below corresponds to Section III of the Third Amended Certificate of Public Advantage):

1. Obtain and read the most recent report from **The Joint Commission** regarding Mission's participation in the Hospital Accreditation Program.

   We obtained and read the most recent reports from the Joint Commission regarding Mission's participation in the Hospital Accreditation Program. The reports indicated that Mission is fully accredited.

2. Obtain Mission's North Carolina Hospital Community Benefits Report and agree the amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

6525 Morrison Boulevard, Suite 500, Charlotte, NC 28211 | T 704.367.7020 | F 704.367.7760 | dhgllp.com

We obtained Mission Hospital's North Carolina Hospital Community Benefits Report and agreed amounts reported to supporting documentation without exception.

Perform the following procedures for a sample of charity care patient discounts granted during the year that results in a 95% confidence level that Mission followed its Financial Assistance and Charity Care Policy:

a. Obtain documentation supporting the charity discount granted from Mission's patient accounting system including the completed application and other supporting documentation.

   We selected a sample of 60 charity care patient discounts granted during the year and obtained documentation supporting the charity care discount granted including the completed application and other supporting documentation.

b. Read the patient's completed Mission Health System Financial Statement. If total amount of charity discount exceeded $2,000, determine that proof of income and assets was performed and the financial statement was signed by the patient.

   For the sample of charity care patient discounts referred to above, we obtained and read the patient's completed Mission Health System Financial Statement. For each of the charity care patient discounts that exceeded $2,000, we determined that proof of income and assets was performed and that the financial statement was signed by the patient. No exceptions were noted during this procedure.

c. Determine that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy.

For the sample of charity care patient discounts referred to above, we determined that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy. No exceptions were noted during this procedure.

d. Determine that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code.

For the sample of charity care patient discounts referred to above, we determined that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code. No exceptions were noted during this procedure.

e. Determine that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted.

We obtained documentation indicating that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted in accordance with the Mission Health System Financial Assistance and Charity Care Policy in place during fiscal year 2011.

f. Determine that the Mission Health System Financial Assistance and Charity Care Policy was reviewed at least annually by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO.

We obtained documentation indicating that the Mission Health System Financial Assistance and Charity Care Policy was reviewed by the Vice President of Revenue Cycle Management and any

revisions, updates, or confirmation of no changes to the policy was approved by the Senior Vice President of Finance and CFO during 2011.

3. Perform the following procedures for a sample of purchases during the year that results in a 95% confidence level that Mission followed its Materials Management Policy and Procedures Manual:

    a. Determine that the equipment or supply item was purchased under a global purchasing contract.

    We selected a sample of 60 purchases during the year and obtained documentation indicating whether the equipment or supply item was purchased under a global purchasing contract.

    b. If the equipment or supply item was not purchased under a global purchasing contract, obtain documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids.

    For the equipment and supply items selected that were not purchased under a global purchasing contract, we obtained documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids. Based on our procedures, we noted 10 instances where documentation was not available to enable us to determine that the equipment or supply item was purchased as outlined in the abovementioned matrix. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

4. See Independent Accountant's Report on Applying Agreed-Upon Procedures for procedures related to Controls on Costs and Margins.

Dixon Hughes Goodman issued an Independent Accountant's Report on Applying Agreed-Upon Procedures dated September 11, 2012 related to Controls on Costs and Margins.

5. Obtain the Hospital's five largest provider contracts (by revenue) and perform the following:

    a. Read the provider contract and determine whether the agreement contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

       We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

    b. Read the provider contract and determine whether the agreement contains a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

       We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

6. Obtain a listing of all contracts between the Hospital and individual physicians or groups of physicians. Excluding contracts with anesthesiologists, radiologists, nuclear medicine physicians, pathologists, psychiatrists, emergency-room physicians, infectious disease physicians, neonatologists, nephrologists, pediatric subspecialists (e.g., pediatric cardiologists); perinatologists, pulmonologists, radiation oncologists, trauma surgeons, cardiologists, cardiovascular surgeons, neurologists, and physicians providing services in Mission Health's community access clinics,

select a sample of physician contracts that results in 95% confidence level regarding whether the agreements contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

We obtained a listing of all contracts between the Hospital and individual physicians or groups of physicians (excluding the aforementioned exempted contracts) and selected a sample of 37 physician contracts to determine whether the physician contracts contained an exclusive provision that requires the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at the Hospital. Based on our procedures, we noted no contracts between the Hospital and individual physicians or groups of physicians(excluding the aforementioned exempted contracts) containing exclusive provisions that require the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

7. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

8. Obtain Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and perform the following procedures:

   a. Agree the data utilized in the numerator and denominator to supporting documentation.

      We obtained the Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and agreed numerator and denominator to supporting documentation without exception.

b. Re-compute the percentage.

We recomputed the Hospital's percentage of physicians in Buncombe and Madison counties under exclusive contracts without exception. Per the Third Amended COPA, Mission Health may employ or enter into exclusive contracts with no more than 30% of the physicians in its primary service area of Buncombe and Madison Counties, except those practicing in the following areas: cardiology, genetics, hospitalist, neuro-hospitalist, and neurology. We noted that Mission employs the only Pediatric Pulmonologist in Buncombe and Madison Counties.

9. Obtain and read the provider agreements with the 5 largest payers (by revenue) and determine whether the agreement contains a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

   We obtained and read the five largest provider agreements (by revenue) noting that none of the agreements contained a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

10. Perform the following procedures for a sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital that results in a 95% confidence level that Mission followed its policy regarding such referrals:

    a. Obtain documentation of Hospital staff informing patient or patient's family of the freedom to choose a particular provider.

    We selected a sample of 60 referrals for durable medical equipment, home health services, and home infusion services made by the Hospital and obtained documentation to determine that Hospital staff

informed patient or patient's family of the freedom to choose a particular provider. No exceptions were noted during this procedure.

b. Determine that the patient's discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient.

For the sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital referred to above, we obtained the patient's discharge plan to determine that the discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient. Based on our procedures, we noted 10 instances where documentation was not available to demonstrate that the patient was notified of a financial interest between the Hospital and particular providers. As a result of the exceptions noted, we were not able to achieve a 95% confidence level that Mission followed its policy regarding such referrals.

11. Obtain the Periodic Report and any Interim Report filed for the year and determine that the respective reports were filed in accordance with the terms of the Certificate of Public Advantage.

We obtained the Periodic Report filed for the fiscal year ended September 30, 2011. This Periodic Report was filed in accordance with the terms of the Certificate of Public Advantage.

12. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

13. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

14. Obtain documentation of the Hospital's status as a non-profit entity.

We obtained correspondence from the Internal Revenue Service dated July 18, 2011 indicating that the Hospital was granted exemption from Federal income tax under Section 501(c)(3) of the Internal Revenue Code in March 1982.

15. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

16. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

17. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

18. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

19. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion, on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 12, 2012

Dixon Hughes Goodman LLP

Cost and Margin Report Fye 2011

Mission Health System, Inc.

Agreed-Upon Procedures Report

For Year Ending September 30, 2011

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NC MEDICAL
CARE COMMISSION

Mission Health System, Inc.

Agreed-Upon Procedures Report

For Year Ending September 30, 2011

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Agreed-Upon Procedures 1

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INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice,
and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2011. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows:

1. Obtain and read Mission's Certificate of Public Advantage Update for the fiscal year ending September 30, 2011. This report will be included as an attachment to the agreed-upon procedures report.

   We obtained and read the aforementioned update and have included it as Attachment "1" to this report.

2. Obtain and read the reconciliation of Mission Health System, Inc. and Mission Hospital, Inc. reported operating margins. This reconciliation will be included as an attachment to the agreed-upon procedures report.

   We obtained and read the aforementioned reconciliation and have included it as Attachment "2" to this report.

3. Agree amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

   We agreed amounts reported to supporting documentation without exception.

4. Re-perform mathematical computations presented in the report.

   We re-performed mathematical computations presented in the report without exception.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion, on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 28, 2012

Dixon Hughes Goodman LLP

ATTACHMENTS

Mission Health System, Inc.

Certificate of Public Advantage Update, FY11
September 2012

Updated

Mission Hospital, Inc.

COPA Peer Hospital Trend (Cost per CMI Adjusted Case)

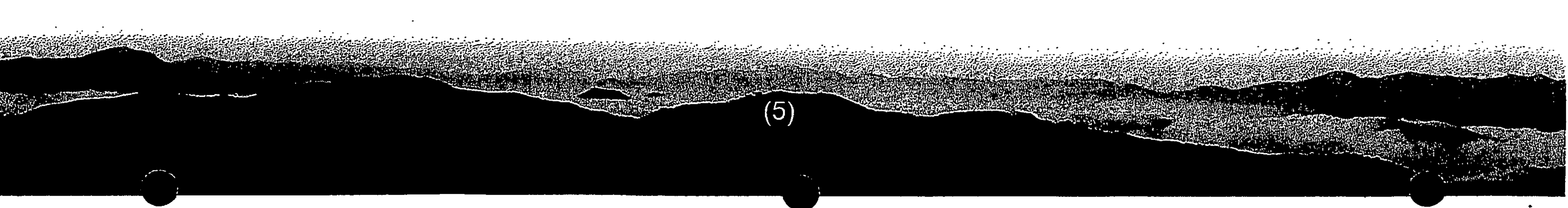
	COPA Average Benchmark Determination								
		PPI	COPA Peer	Thomson	Peer Blend		Mission Hospital		
	PPI %	Adjusted	Median	Median	Average	Yr Chg	Actuals	Yr Chg	Variance
FY07	2.90%	7,437	7,667	7,973	7,692	2.3%	7,338	4.4%	354
FY08	3.20%	7,675	8,022	8,239	7,979	3.7%	7,653	4.3%	326
FY09	3.30%	7,928	9,303	8,042	8,424	5.6%	7,777	1.6%	647
FY10	3.00%	8,166	7,877	8,186	8,076	-4.1%	7,867	1.2%	209
FY11	2.40%	8,362	8,693	8,559	8,538	5.7%	7,961	1.2%	577

Mission Health System, Inc.

COPA Financial Operating Margin Constraint

FY09 - FY11 Operating Margin – Mission Health System

	Net Revenue	Mission Health Operating Margin	Mission Health Margin %	Blended AA Median Plus 1%	Difference	(Payback)/Surplus
FY09	$ 897,742,000	40,319,000	4.49%	5.21%	0.72%	$ 6,463,742
FY10	$ 966,669,000	36,409,000	3.77%	5.79%	2.02%	$ 19,526,714
FY11	$ 1,029,544,000	32,157,000	3.12%	5.47%	2.35%	$ 24,194,284
FY09, FY10, FY11 Cumulative Surplus / (Payback)						$ 50,184,740



Mission Health System, Inc.

COPA Financial Operating Margin Constraint

FY07 - FY11 Operating Margin – Mission Health System

	Net Revenue	Mission Health Operating Margin	Mission Health Margin %	Blended AA Median Plus 1%	Difference	(Payback)/Surplus
FY07	$ 797,603,000	32,837,000	4.12%	4.79%	0.67%	$ 5,343,940
FY08	$ 844,257,000	29,627,000	3.51%	4.28%	0.77%	$ 6,500,779
FY09	$ 897,742,000	40,319,000	4.49%	5.21%	0.72%	$ 6,463,742
FY10	$ 966,669,000	36,409,000	3.77%	5.79%	2.02%	$ 19,526,714
FY11	$ 1,029,544,000	32,157,000	3.12%	5.47%	2.35%	$ 24,194,284
FY07 - FY11 Cumulative Surplus / (Payback)						$ 62,029,459

Mission Health System, Inc.,

Reported Operating Margins

September 30, 2007

Amounts per Attachment "1":		
Operating income	$	32,837,000
Operating margin		4.12%
Amounts per COPA report:		
Operating income		35,437,000
Operating margin		5.03%
Difference	$	(2,600,000)
Reconciling items:		
Non-operating income on Schedule G of Cost Report	$	(6,118,000)
Consolidated entities operating margin		3,518,000
Total reconciling items	$	(2,600,000)

Mission Health System, Inc.,

Reported Operating Margins

September 30, 2008

Amounts per Attachment "1":		
Operating income	$	29,627,000
Operating margin		3.51%
Amounts per COPA report:		
Operating income		27,978,000
Operating margin		3.77%
Difference	$	1,649,000
Reconciling items:		
Consolidated entities operating margin	$	1,649,000

Mission Health System, Inc.,

Reported Operating Margins

September 30, 2009

Amounts per Attachment "1":		
Operating income	$	40,319,000
Operating margin		4.49%
Amounts per COPA report:		
Operating income		42,576,000
Operating margin		5.35%
Difference	$	(2,257,000)
Reconciling items:		
Non-operating income on Schedule G of Cost Report	$	(4,229,000)
Other Adjustment from Schedule G of cost report		(485,000)
Consolidated entities operating margin		2,457,000
Total reconciling items	$	(2,257,000)

Mission Health System, Inc.,

Reported Operating Margins

September 30, 2010

Amounts per Attachment "1":		
Operating income	$	36,409,000
Operating margin		3.77%
Amounts per COPA report:		
Operating income		79,383,000
Operating margin		9.28%
Difference	$	(42,974,000)
Reconciling items:		
Non-operating income on Schedule G of Cost Report	$	(58,109,000)
Other operating revenue not in COPA report		32,369,000
Other Adjustment from Schedule G of cost report		(603,000)
Consolidated entities operating margin		(16,631,000)
Total reconciling items	$	(42,974,000)

Mission Health System, Inc.,

Reported Operating Margins

September 30, 2011

Amounts per Attachment "1":		
Operating income	$	32,157,000
Operating margin		3.12%
Amounts per COPA report:		
Operating income		67,141,000
Operating margin		7.75%
Difference	$	(34,984,000)
Reconciling items:		
Non-operating income on Schedule G of Cost Report	$	(3,878,000)
Other Adjustment from Schedule G of cost report		(1,063,000)
Consolidated entities operating margin		(30,043,000)
Total reconciling items	$	(34,984,000)

Market Basket Report
FYE 2011

Proprietary

AGREED UPON PROCEDURES

For the North Carolina Department of
Health and Human Services

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NC MEDICAL
CARE COMMISSION

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

Independent Accountants' Report
- On Applying Agreed-Upon Procedures -

Department of Health and Human Services
The North Carolina Medical Care Commission
Raleigh, North Carolina

We have performed the procedures enumerated below, which were agreed to by the North Carolina Department of Health and Human Services ("DHHS") and Mission Health System, Inc. in relation to the Certificate of Public Advantage Program under which Mission Health System, Inc. ("Mission") is operating for the fiscal year 2011. Management is responsible for Mission's compliance with the Certificate of Public Advantage Program. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which the report has been requested or for any other purpose.

Our procedures and findings are as follows:

1. *Obtain the data elements listed in Schedule "2" for the Hospitals listed in Schedule "1".*

   We obtained the data elements shown in Attachment #1.

   Note:
   The cost report information was obtained independently of the individual hospitals, except as noted below. Other items listed were obtained directly from each respective hospital.

   Exceptions:
   The cost report information for Spartanburg Regional Medical Center excluded bad debt expense from total operating expenses. The bad debt expense was added to the cost report total operating expenses amount to maintain consistency with the other hospitals.

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The cost report information for Centra Health, Inc., New Hanover Regional Medical Center, Mission Hospital, Palmetto Baptist Hospital, and Spartanburg Regional Medical Center was not obtained independently. The individual hospitals provided copies of the cost reports.

2. *Based on the data elements collected, we will calculate the ratios in Schedule "3".*

   We computed the calculations and reported these amounts in Attachment #2.

   Note:
   Charity care (at cost) and bad debt expense were obtained for information only and were not used to calculate ratios listed.

We were not engaged to, and did not perform an audit, the objective of which would be the expression of an opinion, on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report, including the schedules and attachments, is considered proprietary in nature and is intended solely for the information and use of the North Carolina Department of Health and Human Services and is not intended to be and should not be used by anyone other than the North Carolina Department of Health and Human Services.

Charlotte, North Carolina
September 11, 2012

Dixon Hughes Goodman LLP

Schedule #1

Organization	Hospital
Novant Health	Forsyth Medical Center
Palmetto Health	Palmetto Richland Hospital
Spartanburg Regional Healthcare System	Spartanburg Regional Medical Center
First Health of the Carolinas	Moore Regional Hospital
Wake Medical	Wake Medical - New Bern Avenue Campus
New Hanover Health Network	New Hanover Regional Medical Center
Cape Fear Valley Health System	Cape Fear Valley Medical Center
Centra Health, Inc.	Lynchburg General Hospital and Virginia Baptist Hospital
Mission Health System, Inc.	Mission Hospital

Schedule #2

All data elements listed below will be based on the fiscal year ended 2011.

The information requested below will include hospital activity only and will exclude any psych, rehab, newborns, joint ventures, skilled nursing facilities and investments.

For the Hospitals listed in "Schedule #1", we will obtain the following data elements:

- Cost Report (Gross Inpatient Revenue, Gross Outpatient Revenue, Net Patient Service Revenue, Operating Expenses, Other Revenue)
- Number of Inpatient Discharges, excluding newborns
- Overall Case Mix Index for all patients, excluding newborns
- Total Bad Debt Expense
- Total Charity Care (at cost, per ANDI report)

Schedule #3

All procedures listed below will be based on the fiscal year ended 2011.

Based on the data elements collected in "Schedule #2", we will calculate the following ratios:

- Discharges Adjusted for Case Mix Index, excluding newborns
- Inpatient Revenue per Discharge Adjusted for Case Mix Index ("CMI"), excluding newborns
- Outpatient Revenue per Discharge Adjusted for CMI, excluding newborns (labeled as Equivalent Outpatient Discharge)
- Total Adjusted Discharges Adjusted for CMI
- Total Operating Expenses per Adjusted Discharge Adjusted for CMI
- Operating Margin (Deficit) (Total Net Patient Service Revenue plus Other Revenue less Total Operating Expenses divided by Total Net Patient Service Revenue plus Other Revenue).

Attachment #1 - 2011

Name of Hospital	Inpatient Discharges, excluding newborns	Overall Case Mix Index, excluding newborns	Gross Inpatient Revenue	Gross Outpatient Revenue	Total Operating Expenses	Total Bad Debt Expense	Net Patient Service Revenue	Charity Care (based on cost)	Other Revenue
	40,938	1.4300	1,045,765,632	958,468,673	998,502,538	20,404,049	937,278,901	40,197,952	15,446,989
	27,247	1.5294	1,600,311,465	721,934,605	639,362,290	135,475,000	618,876,046	28,230,052	48,493,316
	26,197	1.4630	942,311,485	619,752,352	564,227,426	46,739,693	561,666,134	29,328,104	7,439,350
	20,175	1.4792	583,453,174	454,913,491	427,714,670	23,339,425	403,119,854	8,441,749	34,977,846
	35,038	1.5774	1,547,028,019	945,312,845	716,774,909	5,064,596	690,430,047	37,687,416	11,260,206
	33,581	1.5945	991,742,064	718,973,902	601,210,996	97,516,500	615,078,045	15,373,389	25,960,901
	32,332	1.3900	1,234,481,891	786,135,878	681,438,738	82,269,000	561,673,124	24,405,000	28,211,488
	27,265	1.3683	617,488,719	360,717,554	550,425,260	20,079,547	501,313,833	17,520,095	45,995,914
Mission Hospital	40,566	1.6347	1,175,510,625	605,102,531	799,638,370	68,622,800	830,643,554	16,186,601	36,134,678

Attachment #2 - 2011

Name of Hospital	Number of inpatient discharges, excluding newborns	Overall Case Mix Index, excluding newborns	Discharges Adjusted for Case Mix Index, excluding newborns	Gross Inpatient Revenue	Inpatient Rev. per Discharge Adjusted for Case Mix Index, excluding newborns	Gross Outpatient Revenue	Equivalent Outpatient Discharge
	40,938	1.4300	58,541	1,045,765,632	17,864	958,468,673	53,654
	27,247	1.5294	41,672	1,600,311,465	38,403	721,934,605	18,799
	26,197	1.4630	38,326	942,311,485	24,587	619,752,352	25,207
	20,175	1.4792	29,843	583,453,174	19,551	454,913,491	23,268
	35,038	1.5774	55,269	1,547,028,019	27,991	945,312,845	33,772
	33,581	1.5945	53,545	991,742,064	18,522	718,973,902	38,817
	32,332	1.3900	44,941	1,234,481,891	27,469	786,135,878	28,619
	27,265	1.3683	37,306	617,488,719	16,552	360,717,554	21,793
Mission Hospital	40,566	1.6347	66,313	1,175,510,625	17,727	605,102,531	34,135
Total w/o Mission	242,773	11.8318	359,443	8,562,582,449	190,939	5,566,209,300	243,929
Avg. w/o Mission	30,347	1.4790	44,930	1,070,322,806	23,867	695,776,163	30,491
Total all entities	283,339	13.4665	425,756	9,738,093,074	208,666	6,171,311,831	278,064
Average of totals	31,482	1.4963	47,306	1,082,010,342	23,185	685,701,315	30,896
Mission over (under) avg. of entities w/o Mission	10,219	0.1557	21,383	105,187,819	(6,140)	(90,673,632)	3,644
Mission over (under) avg. of all entities	9,084	0.1384	19,007	93,500,283	(5,458)	(80,598,784)	3,239

(continued)

Attachment #2 - 2011, continued

Name of Hospital	Total Adjusted Discharges, adjusted for CMI	Total Operating Expenses	Total Operating Expense per Adj. Discharge, adj. for CMI	Net Patient Service Revenue	Other Revenue	Operating Margin (Deficit)
	112,195	998,502,538	8,900	937,278,901	15,446,989	-4.80%
	60,471	639,362,290	10,573	618,876,046	48,493,316	4.20%
	63,533	564,227,426	8,881	561,666,134	7,439,350	0.86%
	53,111	427,714,670	8,053	403,119,854	34,977,846	2.37%
	89,041	716,774,909	8,050	690,430,047	11,260,206	-2.15%
	92,362	601,210,996	6,509	615,078,045	25,960,901	6.21%
	73,560	681,438,738	9,264	561,673,124	28,211,488	-15.52%
	59,099	550,425,260	9,314	501,313,833	45,995,914	-0.57%
Mission Hospital	100,448	799,638,370	7,961	830,643,554	36,134,678	7.75%
Total w/o Mission	603,372	5,179,656,827	69,544	4,889,435,984	217,786,010	-9.40%
Avg. w/o Mission	75,422	647,457,103	8,693	611,179,498	27,223,251	-1.18%
Total all entities	703,820	5,979,295,197	77,505	5,720,079,538	253,920,688	-1.65%
Average of totals	78,202	664,366,133	8,612	635,564,393	28,213,410	-0.18%
Mission over (under) avg. of entities w/o Mission	25,027	152,181,267	(732)	219,464,056	8,911,427	8.93%
Mission over (under) avg. of all entities	22,246	135,272,237	(651)	195,079,161	7,921,268	7.93%

Compliance Reports 2007-2010

Mission Health System, Inc.

Agreed Upon Procedures Report

For Year Ending September 30, 2007

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice,
and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2007. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows (Numbering below corresponds to Section III of the Third Amended Certificate of Public Advantage):

1. Obtain and read the most recent report from **The Joint Commission** regarding Mission's participation in the Hospital Accreditation Program.

   We obtained and read the most recent reports from the Joint Commission as of September 30, 2007 regarding Mission's participation in the Hospital Accreditation Program. The reports indicated that Mission is fully accredited.

2. Obtain Mission's North Carolina Hospital Community Benefits Report and agree the amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

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We obtained Mission Hospital's North Carolina Hospital Community Benefits Report and agreed amounts reported to supporting documentation without exception.

Perform the following procedures for a sample of charity care patient discounts granted during the year that results in a 95% confidence level that Mission followed its Financial Assistance and Charity Care Policy:

a. Obtain documentation supporting the charity discount granted from Mission's patient accounting system including the completed application and other supporting documentation.

   We selected a sample of 60 charity care patient discounts granted during the year and obtained documentation supporting the charity care discount granted including the completed application and other supporting documentation. Based on our procedures, we noted six instances where the completed application or other supporting documentation was not available. As a result of the discounts for which the documentation was not available, we were not able to achieve a 95% confidence level.

b. Read the patient's completed Mission Health System Financial Statement. If total amount of charity discount exceeded $2,000, determine that proof of income and assets was performed and the financial statement was signed by the patient.

   For the sample of charity care patient discounts referred to above, we obtained and read the patient's completed Mission Health System Financial Statement. For each of the charity care patient discounts that exceeded $2,000, we determined that proof of income and assets was performed and that the financial statement was signed by the patient. As a result of the six instances noted above where documentation was not available, we were not able to achieve a 95% confidence level.

c. Determine that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy.

   For the sample of charity care patient discounts referred to above, we determined that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy. No exceptions were noted during this procedure.

d. Determine that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code.

   For the sample of charity care patient discounts referred to above, we determined that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code. No exceptions were noted during this procedure.

e. Determine that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted.

   We obtained documentation indicating that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted in accordance with the Mission Health System Financial Assistance and Charity Care Policy in place during fiscal year 2007.

f. Determine that the Mission Health System Financial Assistance and Charity Care Policy was reviewed at least annually by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO.

We obtained documentation indicating that the Mission Health System Financial Assistance and Charity Care Policy was reviewed by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO during 2007.

3. Perform the following procedures for a sample of purchases during the year that results in a 95% confidence level that Mission followed its Materials Management Policy and Procedures Manual:

   a. Determine that the equipment or supply item was purchased under a global purchasing contract.

      We selected a sample of 60 purchases during the year and obtained documentation indicating whether the equipment or supply item was purchased under a global purchasing contract.

   b. If the equipment or supply item was not purchased under a global purchasing contract, obtain documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids.

      For the equipment and supply items selected that were not purchased under a global purchasing contract, we obtained documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids. Based on our procedures, we noted 14 instances where documentation was not available to enable us to determine that the equipment or supply item was purchased as outlined in the abovementioned matrix. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

4. See Independent Accountant's Report on Applying Agreed-Upon Procedures for procedures related to Controls on Costs and Margins.

   Dixon Hughes Goodman issued an Independent Accountant's Report on Applying Agreed-Upon Procedures dated June 28, 2008 related to Controls on Costs and Margins.

5. Obtain the Hospital's 5 largest provider contracts (by revenue) and perform the following:

   a. Read the provider contract and determine whether the agreement contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

   b. Read the provider contract and determine whether the agreement contains a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

6. Obtain a listing all contracts between the Hospital and individual physicians or groups of physicians. Excluding contracts with anesthesiologists, radiologists, nuclear medicine physicians, pathologists, psychiatrists, emergency-room physicians, infectious disease physicians, neonatologists,

nephrologists, pediatric subspecialists (e.g., pediatric cardiologists); perinatologists, pulmonologists, radiation oncologists, trauma surgeons, cardiologists, cardiovascular surgeons, neurologists, and physicians providing services in Mission Health's community access clinics, select a sample of physician contracts that results in 95% confidence level regarding whether the agreements contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

We obtained a listing of all contracts between the Hospital and individual physicians or groups of physicians (excluding the aforementioned exempted contracts) and selected a sample of two physician contracts to determine whether the physician contracts contained an exclusive provision that requires the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at the Hospital. Based on our procedures, we noted no contracts between the Hospital and individual physicians or groups of physicians(excluding the aforementioned exempted contracts) containing exclusive provisions that require the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

7. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

8. Obtain Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and perform the following procedures:

    a. Agree the data utilized in the numerator and denominator to supporting documentation.

We obtained the Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and agreed numerator and denominator to supporting documentation without exception.

b. Re-compute the percentage.

We recomputed the Hospital's percentage of physicians in Buncombe and Madison counties under exclusive contracts without exception. Per the Second Amended COPA, which was the COPA in effective during fiscal year 2007, Mission Health may employ or enter into exclusive contracts with no more than 20% of the physicians in its primary service area of Buncombe and Madison Counties, practicing in any of the following areas: family practice/internal medicine, general pediatrics, or obstetrics/gynecology.

9. Obtain and read the provider agreements with the five largest payers (by revenue) and determine whether the agreement contains a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

   We obtained and read the five largest provider agreements (by revenue) noting that none of the agreements contained a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

10. Perform the following procedures for a sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital that results in a 95% confidence level that Mission followed its policy regarding such referrals:

    a. Obtain documentation of Hospital staff informing patient or patient's family of the freedom to choose a particular provider.

We selected a sample of 60 referrals for durable medical equipment, home health services, and home infusion services made by the Hospital and obtained documentation to determine that Hospital staff informed patient or patient's family of the freedom to choose a particular provider. Based on our procedures, we noted four instances where documentation was not available to demonstrate that the patient or patient's family was informed of his/her freedom to choose a particular provider. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

b. Determine that the patient's discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient.

For the sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital referred to above, we obtained the patient's discharge plan to determine that the discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient. Based on our procedures, we noted 3 instances where documentation was not available to demonstrate that the patient was notified of financial interests between the Hospital and particular providers. As a result of these exceptions noted, we were not able to achieve a 95% confidence level that Mission followed its policy regarding such referrals.

11. Obtain the Periodic Report and any Interim Report filed for the year and determine that the respective reports were filed in accordance with the terms of the Certificate of Public Advantage.

We obtained the Periodic Report filed for the fiscal year ended September 30, 2007. This Periodic Report was filed in accordance with the terms of the Certificate of Public Advantage.

12. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

13. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

14. Obtain documentation of the Hospital's status as a non-profit entity.

    We obtained correspondence from the Internal Revenue Service dated July 18, 2011 indicating that the Hospital was granted exemption from Federal income tax under Section 501(c)(3) of the Internal Revenue Code in March 1982.

15. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

16. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

17. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

18. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

19. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 12, 2012

Dixon Hughes Goodman LLP

Mission Health System, Inc.

Agreed Upon Procedures Report

For Year Ending September 30, 2008

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice, and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2008. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows (Numbering below corresponds to Section III of the Third Amended Certificate of Public Advantage):

1. Obtain and read the most recent report from **The Joint Commission** regarding Mission's participation in the Hospital Accreditation Program.

   We obtained and read the most recent reports from the Joint Commission as of September 30, 2008 regarding Mission's participation in the Hospital Accreditation Program. The reports indicated that Mission is fully accredited.

2. Obtain Mission's North Carolina Hospital Community Benefits Report and agree the amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

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We obtained Mission Hospital's North Carolina Hospital Community Benefits Report and agreed amounts reported to supporting documentation without exception.

Perform the following procedures for a sample of charity care patient discounts granted during the year that results in a 95% confidence level that Mission followed its Financial Assistance and Charity Care Policy:

a. Obtain documentation supporting the charity discount granted from Mission's patient accounting system including the completed application and other supporting documentation.

   We selected a sample of 60 charity care patient discounts granted during the year and obtained documentation supporting the charity care discount granted including the completed application and other supporting documentation.

b. Read the patient's completed Mission Health System Financial Statement. If total amount of charity discount exceeded $2,000, determine that proof of income and assets was performed and the financial statement was signed by the patient.

   For the sample of charity care patient discounts referred to above, we obtained and read the patient's completed Mission Health System Financial Statement. For each of the charity care patient discounts that exceeded $2,000, we determined that proof of income and assets was performed and that the financial statement was signed by the patient. No exceptions were noted during this procedure.

c. Determine that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy.

For the sample of charity care patient discounts referred to above, we determined that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy. No exceptions were noted during this procedure.

d. Determine that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code.

   For the sample of charity care patient discounts referred to above, we determined that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code. No exceptions were noted during this procedure.

e. Determine that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted.

   We obtained documentation indicating that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted in accordance with the Mission Health System Financial Assistance and Charity Care Policy in place during fiscal year 2008.

f. Determine that the Mission Health System Financial Assistance and Charity Care Policy was reviewed at least annually by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO.

   We were unable to obtain documentation indicating that the Mission Health System Financial Assistance and Charity Care Policy was reviewed by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes was approved by the Senior Vice President of Finance and CFO during 2008.

3. Perform the following procedures for a sample of purchases during the year that results in a 95% confidence level that Mission followed its Materials Management Policy and Procedures Manual:

   a. Determine that the equipment or supply item was purchased under a global purchasing contract.

      We selected a sample of 60 purchases during the year and obtained documentation indicating whether the equipment or supply item was purchased under a global purchasing contract.

   b. If the equipment or supply item was not purchased under a global purchasing contract, obtain documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids.

      For the equipment and supply items selected that were not purchased under a global purchasing contract, we obtained documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids. Based on our procedures,

we noted seven instances where documentation was not available to enable us to determine that the equipment or supply item was purchased as outlined in the abovementioned matrix. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

4. See Independent Accountant's Report on Applying Agreed-Upon Procedures for procedures related to Controls on Costs and Margins.

   Dixon Hughes Goodman issued an Independent Accountant's Report on Applying Agreed-Upon Procedures dated August 20, 2009 related to Controls on Costs and Margins.

5. Obtain the Hospital's five largest provider contracts (by revenue) and perform the following:

   a. Read the provider contract and determine whether the agreement contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

   b. Read the provider contract and determine whether the agreement contains a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

6. Obtain a listing of all contracts between the Hospital and individual physicians or groups of physicians. Excluding contracts with anesthesiologists, radiologists, nuclear medicine physicians, pathologists, psychiatrists, emergency-room physicians, infectious disease physicians, neonatologists, nephrologists, pediatric subspecialists (e.g., pediatric cardiologists); perinatologists, pulmonologists, radiation oncologists, trauma surgeons, cardiologists, cardiovascular surgeons, neurologists, and physicians providing services in Mission Health's community access clinics, select a sample of physician contracts that results in 95% confidence level regarding whether the agreements contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

   We obtained a listing of all contracts between the Hospital and individual physicians or groups of physicians (excluding the aforementioned exempted contracts) and selected a sample of seven physician contracts to determine whether the physician contracts contained an exclusive provision that requires the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at the Hospital. Based on our procedures, we noted no contracts between the Hospital and individual physicians or groups of physicians(excluding the aforementioned exempted contracts) containing exclusive provisions that require the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

7. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

8. Obtain Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and perform the following procedures:

a. Agree the data utilized in the numerator and denominator to supporting documentation.

We obtained the Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and agreed numerator and denominator to supporting documentation without exception

b. Re-compute the percentage.

We recomputed the Hospital's percentage of physicians in Buncombe and Madison counties under exclusive contracts without exception. Per the Second Amended COPA, which was the COPA in effective during fiscal year 2008, Mission Health may employ or enter into exclusive contracts with no more than 20% of the physicians in its primary service area of Buncombe and Madison Counties, practicing in any of the following areas: family practice/internal medicine, general pediatrics, or obstetrics/gynecology.

9. Obtain and read the provider agreements with the five largest payers (by revenue) and determine whether the agreement contains a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

   We obtained and read the five largest provider agreements (by revenue) noting that none of the agreements contained a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

10. Perform the following procedures for a sample of referrals for durable medical equipment, home health services, and home infusion services

made by the Hospital that results in a 95% confidence level that Mission followed its policy regarding such referrals:

a. Obtain documentation of Hospital staff informing patient or patient's family of the freedom to choose a particular provider.

   We selected a sample of 60 referrals for durable medical equipment, home health services, and home infusion services made by the Hospital and obtained documentation to determine that Hospital staff informed patient or patient's family of the freedom to choose a particular provider. Based on our procedures, we noted four instances where documentation was not available to demonstrate that the patient or patient's family was informed of the freedom to choose a particular provider. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

b. Determine that the patient's discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient.

   For the sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital referred to above, we obtained the patient's discharge plan to determine that the discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient. Based on our procedures, we noted four instances where documentation was not available to demonstrate that the patient was notified of a financial interest between the Hospital and particular providers. As a result of these exceptions noted, we were not able to achieve a 95% confidence level that Mission followed its policy regarding such referrals.

11. Obtain the Periodic Report and any Interim Report filed for the year and determine that the respective reports were filed in accordance with the terms of the Certificate of Public Advantage.

    We obtained the Interim Report filed for the fiscal year ended September 30, 2008. This Interim Report was filed in accordance with the terms of the Certificate of Public Advantage.

12. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

13. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

14. Obtain documentation of the Hospital's status as a non-profit entity.

    We obtained correspondence from the Internal Revenue Service dated July 18, 2011 indicating that the Hospital was granted exemption from Federal Income Tax under Section 501(c)(3) of the Internal Revenue Code in March 1982.

15. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

16. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

17. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

18. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

19. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 12, 2012

Dixon Hughes Goodman LLP

Mission Health System, Inc.

Agreed Upon Procedures Report

For Year Ending September 30, 2009

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice, and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2009. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows (Numbering below corresponds to Section III of the Third Amended Certificate of Public Advantage):

1. Obtain and read the most recent report from **The Joint Commission** regarding Mission's participation in the Hospital Accreditation Program.

   We obtained and read the most recent reports from the Joint Commission as of September 30, 2009 regarding Mission's participation in the Hospital Accreditation Program. The reports indicated that Mission is fully accredited.

2. Obtain Mission's North Carolina Hospital Community Benefits Report and agree the amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

   We obtained Mission Hospital's North Carolina Hospital Community Benefits Report and agreed amounts reported to supporting documentation without exception.

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Perform the following procedures for a sample of charity care patient discounts granted during the year that results in a 95% confidence level that Mission followed its Financial Assistance and Charity Care Policy:

a. Obtain documentation supporting the charity discount granted from Mission's patient accounting system including the completed application and other supporting documentation.

   We selected a sample of 60 charity care patient discounts granted during the year and obtained documentation supporting the charity care discount granted including the completed application and other supporting documentation.

b. Read the patient's completed Mission Health System Financial Statement. If total amount of charity discount exceeded $2,000, determine that proof of income and assets was performed and the financial statement was signed by the patient.

   For the sample of charity care patient discounts referred to above, we obtained and read the patient's completed Mission Health System Financial Statement. For each of the charity care patient discounts that exceeded $2,000, we determined that proof of income and assets was performed and that the financial statement was signed by the patient. No exceptions were noted during this procedure.

c. Determine that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy.

   For the sample of charity care patient discounts referred to above, we determined that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy. No exceptions were noted during this procedure.

d. Determine that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code.

   For the sample of charity care patient discounts referred to above, we determined that the patient's account was classified as "charity care" and

the account was written off using the designated general ledger code. No exceptions were noted during this procedure.

e. Determine that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted.

   We obtained documentation indicating that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted in accordance with the Mission Health System Financial Assistance and Charity Care Policy in place during fiscal year 2009.

f. Determine that the Mission Health System Financial Assistance and Charity Care Policy was reviewed at least annually by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO.

   We obtained documentation indicating that the Mission Health System Financial Assistance and Charity Care Policy was reviewed by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO during 2009.

3. Perform the following procedures for a sample of purchases during the year that results in a 95% confidence level that Mission followed its Materials Management Policy and Procedures Manual:

   a. Determine that the equipment or supply item was purchased under a global purchasing contract.

      We selected a sample of 60 purchases during the year and obtained documentation indicating whether the equipment or supply item was purchased under a global purchasing contract.

   b. If the equipment or supply item was not purchased under a global purchasing contract, obtain documentation of the Hospital obtaining bids

as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids.

For the equipment and supply items selected that were not purchased under a global purchasing contract, we obtained documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids. Based on our procedures, we noted two instances where documentation was not available to enable us to determine whether or not the equipment or supply item was purchased as outlined in the abovementioned matrix. As a result of the documentation not being available for these items, we were not able to achieve a 95% confidence level.

4. See Independent Accountant's Report on Applying Agreed-Upon Procedures for procedures related to Controls on Costs and Margins.

   Dixon Hughes Goodman issued an Independent Accountant's Report on Applying Agreed-Upon Procedures dated September 3, 2010 related to Controls on Costs and Margins.

5. Obtain the Hospital's five largest provider contracts (by revenue) and perform the following:

   a. Read the provider contract and determine whether the agreement contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

   b. Read the provider contract and determine whether the agreement contains a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

6. Obtain a listing of all contracts between the Hospital and individual physicians or groups of physicians. Excluding contracts with anesthesiologists, radiologists, nuclear medicine physicians, pathologists, psychiatrists, emergency-room physicians, infectious disease physicians, neonatologists, nephrologists, pediatric subspecialists (e.g., pediatric cardiologists); perinatologists, pulmonologists, radiation oncologists, trauma surgeons, cardiologists, cardiovascular surgeons, neurologists, and physicians providing services in Mission Health's community access clinics, select a sample of physician contracts that results in 95% confidence level regarding whether the agreements contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

   We obtained a listing of all contracts between the Hospital and individual physicians or groups of physicians (excluding the aforementioned exempted contracts) and selected a sample of 15 physician contracts to determine whether the physician contracts contained an exclusive provision that requires the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at the Hospital. Based on our procedures, we noted no contracts between the Hospital and individual physicians or groups of physicians(excluding the aforementioned exempted contracts) containing exclusive provisions that require the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

7. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

8. Obtain Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and perform the following procedures:

a. Agree the data utilized in the numerator and denominator to supporting documentation.

We obtained the Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and agreed numerator and denominator to supporting documentation without exception.

b. Re-compute the percentage.

We recomputed the Hospital's percentage of physicians in Buncombe and Madison counties under exclusive contracts without exception. Per the Second Amended COPA, which was the COPA in effect during fiscal year 2009, Mission Health may employ or enter into exclusive contracts with no more than 20% of the physicians in its primary service area of Buncombe and Madison Counties, practicing in any of the following areas: family practice/internal medicine, general pediatrics, or obstetrics/gynecology.

9. Obtain and read the provider agreements with the five largest payers (by revenue) and determine whether the agreement contains a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

   We obtained and read the five largest provider agreements (by revenue) noting that none of the agreements contained a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

10. Perform the following procedures for a sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital that results in a 95% confidence level that Mission followed its policy regarding such referrals:

    a. Obtain documentation of Hospital staff informing patient or patient's family of the freedom to choose a particular provider.

We selected a sample of 60 referrals for durable medical equipment, home health services, and home infusion services made by the Hospital and obtained documentation to determine that Hospital staff informed patient or patient's family of the freedom to choose a particular provider. Based on our procedures, we noted one instance where documentation was not available to demonstrate that the patient or the patient's family was informed of his/her freedom to choose a particular provider. As a result of the documentation not being available for this item, we were not able to achieve a 95% confidence level.

b. Determine that the patient's discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient.

For the sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital referred to above, we obtained the patient's discharge plan to determine that the discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient. Based on our procedures, we noted six instances where documentation was not available to demonstrate that the patient was notified of a financial interest between the Hospital and particular providers. As a result of these exceptions noted, we were not able to achieve a 95% confidence level that Mission followed its policy regarding such referrals.

11. Obtain the Periodic Report and any Interim Report filed for the year and determine that the respective reports were filed in accordance with the terms of the Certificate of Public Advantage.

We obtained the Periodic Report filed for the fiscal year ended September 30, 2009. This Periodic Report was filed in accordance with the terms of the Certificate of Public Advantage.

12. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

13. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

14. Obtain documentation of the Hospital's status as a non-profit entity.

    We obtained correspondence from the Internal Revenue Service dated July 18, 2011 indicating that the Hospital was granted exemption from Federal income tax under Section 501(c)(3) of the Internal Revenue Code in March 1982.

15. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

16. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

17. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

18. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

19. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 12, 2012

Dixon Hughes Goodman LLP

Mission Health System, Inc.

Agreed Upon Procedures Report

For Year Ending September 30, 2010

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mission Health System, Inc., North Carolina Department of Justice,
and Department of Health and Human Services

We have performed the procedures enumerated below, which were agreed to by Mission Health System, Inc. ("Mission" or the "Hospital"), North Carolina Department of Justice, and Department of Health and Human Services ("DHHS") (the specified parties), solely to assist you in determining Mission's compliance with the terms outlined in the Certificate of Public Advantage ("COPA") agreement between Mission and DHHS for the year ended September 30, 2010. Mission's management is responsible for the Hospital's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows (Numbering below corresponds to Section III of the Third Amended Certificate of Public Advantage):

1. Obtain and read the most recent report from **The Joint Commission** regarding Mission's participation in the Hospital Accreditation Program.

   We obtained and read the most recent reports from the Joint Commission as of September 30, 2010 regarding Mission's participation in the Hospital Accreditation Program. The reports indicated that Mission is fully accredited.

2. Obtain Mission's North Carolina Hospital Community Benefits Report and agree the amounts reported to supporting documentation (e.g., audited financial statements, client supporting schedules, etc.).

   We obtained Mission Hospital's North Carolina Hospital Community Benefits Report and agreed amounts reported to supporting documentation without exception.

   Perform the following procedures for a sample of charity care patient discounts granted during the year that results in a 95% confidence level that Mission followed its Financial Assistance and Charity Care Policy:

   a. Obtain documentation supporting the charity discount granted from Mission's patient accounting system including the completed application and other supporting documentation.

6525 Morrison Boulevard, Suite 500, Charlotte, NC 28211 | T 704.367.7020 | F 704.367.7760 | dhgllp.com

We selected a sample of 60 charity care patient discounts granted during the year and obtained documentation supporting the charity care discount granted including the completed application and other supporting documentation.

b. Read the patient's completed Mission Health System Financial Statement. If total amount of charity discount exceeded $2,000, determine that proof of income and assets was performed and the financial statement was signed by the patient.

For the sample of charity care patient discounts referred to above, we obtained and read the patient's completed Mission Health System Financial Statement. For each of the charity care patient discounts that exceeded $2,000, we determined that proof of income and assets was performed and that the financial statement was signed by the patient. No exceptions were noted during this procedure.

c. Determine that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy.

For the sample of charity care patient discounts referred to above, we determined that the charity discount was approved in accordance with the approval levels reflected in the Hospital's Financial Assistance and Charity Care Policy. No exceptions were noted during this procedure.

d. Determine that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code.

For the sample of charity care patient discounts referred to above, we determined that the patient's account was classified as "charity care" and the account was written off using the designated general ledger code. No exceptions were noted during this procedure.

e. Determine that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted.

We obtained documentation indicating that the Revenue Cycle management team completed regular audits of compliance with authorized signatory approval levels and documentation requirements for charity discounts granted in accordance with the Mission Health System Financial Assistance and Charity Care Policy in place during fiscal year 2010.

f. Determine that the Mission Health System Financial Assistance and Charity Care Policy was reviewed at least annually by the Vice President of Revenue Cycle

Management and any revisions, updates, or confirmation of no changes to the policy were approved by the Senior Vice President of Finance and CFO.

We obtained documentation indicating that the Mission Health System Financial Assistance and Charity Care Policy was reviewed by the Vice President of Revenue Cycle Management and any revisions, updates, or confirmation of no changes to the policy was approved by the Senior Vice President of Finance and CFO during 2010.

3. Perform the following procedures for a sample of purchases during the year that results in a 95% confidence level that Mission followed its Materials Management Policy and Procedures Manual:

   a. Determine that the equipment or supply item was purchased under a global purchasing contract.

      We selected a sample of 60 purchases during the year and obtained documentation indicating whether the equipment or supply item was purchased under a global purchasing contract.

   b. If the equipment or supply item was not purchased under a global purchasing contract, obtain documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids.

      For the equipment and supply items selected that were not purchased under a global purchasing contract, we obtained documentation of the Hospital obtaining bids as outlined in the matrix on page 2 of the Materials Management Policy and Procedure Manual covering the Solicitation of Bids. Based on our procedures, we noted five instances where documentation was not available to enable us to determine that the equipment or supply item was purchased as outlined in the abovementioned matrix. As a result of the information not being available for these items, we were not able to achieve a 95% confidence level.

4. See Independent Accountant's Report on Applying Agreed-Upon Procedures for procedures related to Controls on Costs and Margins.

   Dixon Hughes Goodman issued an Independent Accountant's Report on Applying Agreed-Upon Procedures dated January 10, 2012 related to Controls on Costs and Margins.

5. Obtain the Hospital's five largest provider contracts (by revenue) and perform the following:

   a. Read the provider contract and determine whether the agreement contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan.

   b. Read the provider contract and determine whether the agreement contains a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

      We obtained and read the five largest provider contracts (by revenue) and determined that none of the agreements contained a provision that requires the payer to contract with the Hospital's employed physicians as a precondition to contracting with the Hospital or any of its affiliated facilities.

6. Obtain a listing of all contracts between the Hospital and individual physicians or groups of physicians. Excluding contracts with anesthesiologists, radiologists, nuclear medicine physicians, pathologists, psychiatrists, emergency-room physicians, infectious disease physicians, neonatologists, nephrologists, pediatric subspecialists (e.g., pediatric cardiologists); perinatologists, pulmonologists, radiation oncologists, trauma surgeons, cardiologists, cardiovascular surgeons, neurologists, and physicians providing services in Mission Health's community access clinics, select a sample of physician contracts that results in 95% confidence level regarding whether the agreements contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals.

   We obtained a listing of all contracts between the Hospital and individual physicians or groups of physicians (excluding the aforementioned exempted contracts) and selected a sample of 36 physician contracts to determine whether the physician contracts contained an exclusive provision that requires the physician or group of physicians to render services only at the Hospital, or which requires only one physician or group of physicians to provide particular services at the Hospital. Based on our procedures, we noted no contracts between the Hospital and individual physicians or groups of physicians(excluding the aforementioned exempted contracts) containing exclusive provisions that require the physician or group of physicians to render services only at the Hospital, or which requires

only one physician or group of physicians to provide particular services at Mission Hospitals.

7. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

8. Obtain Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and perform the following procedures:

   a. Agree the data utilized in the numerator and denominator to supporting documentation.

      We obtained the Hospital's calculation of the percentage of physicians in Buncombe and Madison counties under exclusive contracts and agreed numerator and denominator to supporting documentation without exception.

   b. Re-compute the percentage.

      We recomputed the Hospital's percentage of physicians in Buncombe and Madison counties under exclusive contracts without exception. Per the Second Amended COPA, which was the COPA in effect during fiscal year 2010, Mission Health may employ or enter into exclusive contracts with no more than 20% of the physicians in its primary service area of Buncombe and Madison Counties, practicing in any of the following areas: family practice/internal medicine, general pediatrics, or obstetrics/gynecology.

9. Obtain and read the provider agreements with the five largest payers (by revenue) and determine whether the agreement contains a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

   We obtained and read the five largest provider agreements (by revenue) noting that none of the agreements contained a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.

10. Perform the following procedures for a sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital that results in a 95% confidence level that Mission followed its policy regarding such referrals:

    a. Obtain documentation of Hospital staff informing patient or patient's family of the freedom to choose a particular provider.

We selected a sample of 60 referrals for durable medical equipment, home health services, and home infusion services made by the Hospital and obtained documentation to determine that Hospital staff informed patient or patient's family of the freedom to choose a particular provider. Based on our procedures, we noted one instance where documentation was not available to demonstrate that the patient was informed of his/her freedom to choose a particular provider. As a result of the information not being available for this item, we were not able to achieve a 95% confidence level.

b. Determine that the patient's discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient.

For the sample of referrals for durable medical equipment, home health services, and home infusion services made by the Hospital referred to above, we obtained the patient's discharge plan to determine that the discharge plan identifies disclosable financial interests between the Hospital and particular providers on choice lists provided to the patient. Based on our procedures, we noted two instances where documentation was not available to demonstrate that the patient was notified of a financial interest between the Hospital and particular providers. As a result of these exceptions noted, we were not able to achieve a 95% confidence level that Mission followed its policy regarding such referrals.

11. Obtain the Periodic Report and any Interim Report filed for the year and determine that the respective reports were filed in accordance with the terms of the Certificate of Public Advantage.

    We obtained the Interim Report filed for the fiscal year ended September 30, 2010. This Interim Report was filed in accordance with the terms of the Certificate of Public Advantage.

12. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

13. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

14. Obtain documentation of the Hospital's status as a non-profit entity.

    We obtained correspondence from the Internal Revenue Service dated July 18, 2011 indicating that the Hospital was granted exemption from Federal income tax under Section 501(c)(3) of the Internal Revenue Code in March 1982.

15. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

16. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

17. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

18. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

19. No procedures performed for this item of Section III of the Third Amended Certificate of Public Advantage.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is considered proprietary in nature and is intended solely for the information and use of Mission, North Carolina Department of Justice, and DHHS and is not intended to be and should not be used by anyone other than those specified parties.

Charlotte, North Carolina
September 12, 2012

Dixon Hughes Goodman LLP

Recommendations Previously Discussed by Committee	
Services Regulated	• Fully and completely review all new institutional health services regulated under the Certificate of Need Law to determine need and rationale for each included service regulation.
Thresholds	• Increase monetary threshold from 2 million to 4 million dollars.* • Eliminate monetary threshold for expedited review from current of threshold of less than 5 million dollars.* • Increase monetary threshold for major medical equipment from $750,000 to 1.5 million dollars.* • Eliminate replacement equipment from CON process.*
Changes to Previously Issued CONS	• Study ways to make it easier to modify or change an approved CON, particularly in light of an applicant's change in financial situation, and under which instances this should apply.
SHCC	• Codify the SHCC and divide membership appointments amongst the legislative and executive branch. • Upon such codification, require the SHCC to adhere to ethical standards and conflict of interest provisions set by the General Assembly.
SMFP	• Eliminate AC3 policy.
Appeals Process	• Study need for a decrease in appeals process time frames and study methods by which to accomplish this goal. • Prevailing party gets costs and attorney's fees.* • Increase penalties for frivolous lawsuits by increasing bond amount.* • Require separate bonds.* • Eliminate stays.* • Study the redefinition of the term "affected party".
Related Hospital Issues	• Define Hospital Authority territory (previously filed H812).* • Continue to support the NC Office of Rural Health Loan Repayment Program as well as the NC AHEC Residency Programs to encourage physician retention and incentives to practice in rural and underserved areas. • Study the desired future path for the healthcare market in NC, focusing on the encouragement of market-driven competitiveness.
COPA	

*denotes draft legislation

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-15 [v.4] (11/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/13/2012 1:08:55 PM

Short Title:	Adjust CON Monetary Thresholds.	(Public)
Sponsors:	Representative Torbett.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO EXEMPT REPLACEMENT EQUIPMENT FROM CERTIFICATE OF NEED REVIEW REGARDLESS OF COST; TO ELIMINATE THE MONETARY THRESHOLD FOR EXPEDITED CERTIFICATE OF NEED REVIEW; AND TO INCREASE THE MONETARY THRESHOLDS TRIGGERING CERTIFICATE OF NEED REVIEW FOR THE PURCHASE OF MAJOR MEDICAL EQUIPMENT AND FOR CAPITAL EXPENDITURES, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-176(7b) reads as rewritten:

"(7b) 'Expedited review' means the status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.

b. ~~The proposed capital expenditure is less than five million dollars ($5,000,000).~~

c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

d. The agency has not determined that a public hearing is in the public interest."

SECTION 2. G.S. 131E-176(14o) reads as rewritten:

"(14o) 'Major medical equipment' means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~one million five hundred thousand dollars ($1,500,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section."

SECTION 3. G.S. 131E-176(16)b. reads as rewritten:

"(16) 'New institutional health services' means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~four million dollars ~~($2,000,000).~~($4,000,000).

...."

SECTION 4. G.S. 131E-176(22a) reads as rewritten:

"(22a) 'Replacement equipment' means equipment that ~~costs less than two million dollars ($2,000,000) and~~ is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. ~~In determining whether the replacement equipment costs less than two million dollars ($2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~"

SECTION 5. G.S. 131E-184(e) reads as rewritten:

"(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility,
2. Adult care home facility, or
3. Intermediate care facility for the mentally retarded; and

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.
b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents."

SECTION 6. This act becomes effective October 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-5A [v.2] (09/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/7/2012 11:16:27 AM

Short Title: Award Costs In Frivolous CON Contested Cases. (Public)

Sponsors: Representative Torbett.

Referred to:

A BILL TO BE ENTITLED

AN ACT REQUIRING THE COURT TO AWARD COSTS AND A REASONABLE ATTORNEY FEE TO ANY CERTIFICATE OF NEED APPLICANT WHOSE APPROVED NEW INSTITUTIONAL HEALTH SERVICE IS THE SUBJECT OF A CONTESTED CASE PETITION DETERMINED TO BE FRIVOLOUS OR FILED TO DELAY THE APPLICANT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-188(a1) reads as rewritten:

"(a1) On or before the date of filing a petition for a contested case hearing on the approval of an applicant for a certificate of need, the petitioner shall deposit a bond with the clerk of superior court where the new institutional health service that is the subject of the petition is proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the petition, but may not be less than five thousand dollars ($5,000) and may not exceed fifty thousand dollars ($50,000). A petitioner who received approval for a certificate of need and is contesting only a condition in the certificate is not required to file a bond under this subsection.

The applicant who received approval for the new institutional health service that is the subject of the petition may bring an action against a bond filed under this subsection in the superior court of the county where the bond was filed. Upon finding that the petition for a contested case was frivolous or filed to delay the applicant, the court may award the applicant part or all of the bond filed under this ~~subsection.~~subsection and shall award the applicant reasonable attorney fees and costs incurred in the contested case. At the conclusion of the contested case, if the court does not find that the petition for a contested case was frivolous or filed to delay the applicant, the petitioner shall be entitled to the return of the bond deposited with the superior court upon demonstrating to the clerk of superior court where the bond was filed that the contested case hearing is concluded."

SECTION 2. This act becomes effective October 1, 2013, and applies to petitions filed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-4A [v.4] (09/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/13/2012 12:33:17 PM

Short Title:	Increase Bond Requirements for CON Appeals.	(Public)
Sponsors:	Representative Torbett.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT REQUIRING AFFECTED PERSONS SEEKING TO FILE A PETITION FOR A CONTESTED CASE OR AN APPEAL CHALLENGING CERTIFICATE OF NEED APPROVAL TO DEPOSIT A SEPARATE BOND FOR EACH APPROVED APPLICATION THAT IS THE SUBJECT OF THE PETITION OR APPEAL, INCREASING THE AMOUNT OF THE MAXIMUM BOND REQUIREMENT, AND GIVING THE COURT OF APPEALS GREATER DISCRETION IN IMPOSING A HIGHER BOND AMOUNT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-188(a1) reads as rewritten:

"(a1) On or before the date of filing a petition for a contested case hearing on the approval of an applicant for a certificate of need, the petitioner shall deposit a bond for each approved application that is the subject of the petition with the clerk of superior court where ~~the~~ any new institutional health service that is the subject of the petition is proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of ~~the proposed new institutional health service~~each approved application that is the subject of the petition, but may not be less than five thousand dollars ($5,000) and may not exceed ~~fifty thousand dollars ($50,000).~~one hundred thousand dollars ($100,000). A petitioner who received approval for a certificate of need and is contesting only a condition in the certificate is not required to file a bond under this subsection.

The applicant who received approval for ~~the~~ any new institutional health service that is the subject of the petition may bring an action against a bond filed under this subsection in the superior court of the county where the bond was filed. Upon finding that the petition for a contested case was frivolous or filed to delay the applicant, the court may award the applicant part or all of the bond filed under this subsection. At the conclusion of the contested case, if the court does not find that the petition for a contested case was frivolous or filed to delay the applicant, the petitioner shall be entitled to the return of the bond deposited with the superior court upon demonstrating to the clerk of superior court where the bond was filed that the contested case hearing is concluded."

SECTION 2. G.S. 131E-188(b1)(1) reads as rewritten:

"(b1) Before filing an appeal of a final decision granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of this subsection shall not apply to any appeal filed by the Department.

(1) The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of ~~the proposed new institutional health service~~ each approved application that is the subject of the appeal, but may not be less than five thousand dollars ($5,000) and may not exceed ~~fifty thousand dollars ($50,000);~~one hundred thousand dollars ($100,000); provided that the applicant who received approval of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its ~~discretion, not to exceed three hundred thousand dollars ($300,000).~~discretion. A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection."

SECTION 3. This act becomes effective October 1, 2013, and applies to petitions and appeals filed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-7A [v.4] (10/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/13/2012 1:08:33 PM

Short Title: Eliminate Stays in CON Appeals. (Public)

Sponsors: Representative Torbett.

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO PROHIBIT THE STAYING OF A FINAL DECISION IN A CERTIFICATE OF
3 NEED CASE DURING THE PENDENCY OF AN APPEAL, AS RECOMMENDED BY
4 THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND
5 RELATED HOSPITAL ISSUES.
6 The General Assembly of North Carolina enacts:
7 **SECTION 1.** G.S. 131E-188(b) reads as rewritten:
8 (b) Any affected person who was a party in a contested case hearing shall be entitled to
9 judicial review of all or any portion of any final decision in the following manner. The appeal
10 shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal
11 shall be as provided by the rules of appellate procedure. The appeal of the final decision shall
12 be taken within 30 days of the receipt of the written notice of final decision, and notice of
13 appeal shall be filed with the Office of Administrative Hearings and served on the Department
14 and all other affected persons who were parties to the contested hearing. The final decision
15 remains in effect during the pendency of review by the Court of Appeals and the appellant is
16 not entitled to a stay of the final decision pending the outcome of the review. During the
17 pendency of review by the Court of Appeals, the applicant is free to proceed with the
18 development of any approved new institutional health service that is the subject of the final
19 decision. However, the applicant shall not be entitled to recover any damages from either the
20 Department or an appellant for any expenses incurred as a result of proceeding with
21 development prior to a decision by the Court of Appeals.
22 **SECTION 2.** G.S. 150B-48 reads as rewritten:
23 "~~At~~Except as prohibited in G.S. 131E-188(b), at any time before or during the review
24 proceeding, the person aggrieved may apply to the reviewing court for an order staying the
25 operation of the administrative decision pending the outcome of the review. The court may
26 grant or deny the stay in its discretion upon such terms as it deems proper and subject to the
27 provisions of G.S. 1A-1, Rule 65."
28 **SECTION 3.** This act becomes effective October 1, 2013, and applies to appeals
29 filed on or after that date.

2013-MGZ-7A-V-4

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H **1**

HOUSE BILL 812

Short Title:	Hospital Authority Territorial Jurisdiction.	(Public)
Sponsors:	Representative Torbett (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO DEFINE THE BOUNDARIES OF A HOSPITAL AUTHORITY AS THE TERRITORIAL BOUNDARIES OF THE CITY OR COUNTY CREATING THE AUTHORITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-20 reads as rewritten:

"**§ 131E-20. Boundaries of the authority.**

(a) The territorial boundaries of a hospital authority shall include the territorial boundaries of the city or county creating the ~~authority and the area within 10 miles from the territorial boundaries of that city or county.~~ authority. However, a hospital authority may engage in health care activities in a county outside its territorial boundaries pursuant to:

(1) An agreement with a hospital facility if only one hospital currently exists in that county;

(2) An agreement with any hospital if more than one hospital currently exists in that county; or

(3) An agreement with any health care agency if no hospital currently exists in that county.

Provided, however, that if a hospital authority enters into an agreement under subdivision (1), (2), or (3) of this subsection, the hospital authority shall first apply for and obtain a certificate of public advantage pursuant to G.S. 131E-192.1, et seq.

(a1) In no event shall the territorial boundaries of a hospital authority include, in whole or in part, the area of any previously existing hospital authority. All priorities shall be determined on the basis of the time of issuance of the certificates of incorporation by the Secretary of State.

(b) After the creation of an authority, the subsequent existence within its territorial boundaries of more than one city or county shall in no way affect the territorial boundaries of the authority."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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BILL DRAFT 2013-MG-11C [v.1] (10/24)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/15/2012 10:15:04 AM

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors: Representative Avila.

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO AMEND CERTIFICATE OF NEED LAWS PERTAINING TO DIAGNOSTIC
3 CENTERS, SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS,
4 AND MONETARY THRESHOLD REQUIREMENTS THAT TRIGGER CERTIFICATE
5 OF NEED REQUIREMENTS.
6 The General Assembly of North Carolina enacts:
7 **SECTION 1.** G.S. 131E-175 is amended by adding new subdivisions to read:
8 "(13) That the relocation of a hospital's operating rooms to a facility on premises
9 separate from the premises upon which the hospital's inpatient acute care
10 beds and emergency department are located results in a costly and
11 unnecessary economic burden to the public.
12 (14) That physicians who provide single-specialty ambulatory surgery services in
13 unlicensed settings should be afforded an opportunity to obtain a license to
14 provide these services in order to ensure patient safety and the provision of
15 quality care.
16 (15) That the demand for ambulatory surgery is increasing due to advances in
17 technology and anesthesia, and single-specialty ambulatory surgery
18 operating rooms are recognized as a highly effective means of expanding
19 access while achieving cost savings regardless of the availability and
20 potential underutilization of hospital-based operating rooms."
21 **SECTION 2.** G.S. 131E-176 reads as rewritten:
22 **"§ 131E-176. Definitions.**
23 As used in this Article, unless the context clearly requires otherwise, the following terms
24 have the meanings specified:
25 (1) "Adult care home" means a facility with seven or more beds licensed under
26 Part 1 of Article 1 of Chapter 131D of the General Statutes or Chapter 131E
27 of the General Statutes that provides residential care for aged or disabled
28 persons whose principal need is a home which provides the supervision and
29 personal care appropriate to their age and disability and for whom medical
30 care is only occasional or incidental.
31 (1a) **(See note)** "Air ambulance" means aircraft used to provide air transport of
32 sick or injured persons between destinations within the State.

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1 (1b) "Ambulatory surgical facility" means a facility designed for the provision of
2 a specialty ambulatory surgical program or a multispecialty ambulatory
3 surgical program. An ambulatory surgical facility serves patients who
4 require local, regional or general anesthesia and a period of post-operative
5 observation. An ambulatory surgical facility may only admit patients for a
6 period of less than 24 hours and must provide at least one designated
7 operating room or gastrointestinal endoscopy room, as defined in Article 5
8 Part 1 and Article 6, Part 4 of this Chapter, and at least one designated
9 recovery room, have available the necessary equipment and trained
10 personnel to handle emergencies, provide adequate quality assurance and
11 assessment by an evaluation and review committee, and maintain adequate
12 medical records for each patient. An ambulatory surgical facility may be
13 operated as a part of a physician or dentist's office, provided the facility is
14 licensed under G.S. Chapter 131E, Article 6, Part D, but the performance of
15 incidental, limited ambulatory surgical procedures which do not constitute
16 an ambulatory surgical program as defined in subdivision (1c) of this section
17 and which are performed in a physician's or dentist's office does not make
18 that office an ambulatory surgical facility.
19 (1c) "Ambulatory surgical program" means a formal program for providing on a
20 same-day basis those surgical procedures which require local, regional or
21 general anesthesia and a period of post-operative observation to patients
22 whose admission for more than 24 hours is determined, prior to surgery or
23 gastrointestinal endoscopy, to be medically unnecessary.
24 (2) "Bed capacity" means space used exclusively for inpatient care, including
25 space designed or remodeled for licensed inpatient beds even though
26 temporarily not used for such purposes. The number of beds to be counted in
27 any patient room shall be the maximum number for which adequate square
28 footage is provided as established by rules of the Department except that
29 single beds in single rooms are counted even if the room contains inadequate
30 square footage. The term "bed capacity" also refers to the number of dialysis
31 stations in kidney disease treatment centers, including freestanding dialysis
32 units.
33 (2a) "Bone marrow transplantation services" means the process of infusing bone
34 marrow into persons with diseases to stimulate the production of blood cells.
35 (2b) "Burn intensive care services" means services provided in a unit designed to
36 care for patients who have been severely burned.
37 (2c) "Campus" means the adjacent grounds and buildings, or grounds and
38 buildings not separated by more than a public right-of-way, of a health
39 service facility and related health care entities.
40 (2d) "Capital expenditure" means an expenditure for a project, including but not
41 limited to the cost of construction, engineering, and equipment which under
42 generally accepted accounting principles is not properly chargeable as an
43 expense of operation and maintenance. Capital expenditure includes, in
44 addition, the fair market value of an acquisition made by donation, lease, or
45 comparable arrangement by which a person obtains equipment, the
46 expenditure for which would have been considered a capital expenditure
47 under this Article if the person had acquired it by purchase.
48 (2e) Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice
49 offices December 31, 2005.
50 (2f) "Cardiac catheterization equipment" means the equipment used to provide
51 cardiac catheterization services.

1 (2g) "Cardiac catheterization services" means those procedures, excluding
2 pulmonary angiography procedures, in which a catheter is introduced into a
3 vein or artery and threaded through the circulatory system into the heart
4 specifically to diagnose abnormalities in the motion, contraction, and blood
5 flow of the moving heart or to perform surgical therapeutic interventions to
6 restore, repair, or reconstruct the coronary blood vessels of the heart.
7 (3) "Certificate of need" means a written order which affords the person so
8 designated as the legal proponent of the proposed project the opportunity to
9 proceed with the development of such project.
10 (4) Repealed by Session Laws 1993, c. 7, s. 2.
11 (5) "Change in bed capacity" means (i) any relocation of health service facility
12 beds, or dialysis stations from one licensed facility or campus to another, or
13 (ii) any redistribution of health service facility bed capacity among the
14 categories of health service facility bed as defined in G.S. 131E-176(9c), or
15 (iii) any increase in the number of health service facility beds, or dialysis
16 stations in kidney disease treatment centers, including freestanding dialysis
17 units.
18 (5a) "Chemical dependency treatment facility" means a public or private facility,
19 or unit in a facility, which is engaged in providing 24-hour a day treatment
20 for chemical dependency or substance abuse. This treatment may include
21 detoxification, administration of a therapeutic regimen for the treatment of
22 chemically dependent or substance abusing persons and related services. The
23 facility or unit may be:
24 a. A unit within a general hospital or an attached or freestanding unit of
25 a general hospital licensed under Article 5, Chapter 131E, of the
26 General Statutes,
27 b. A unit within a psychiatric hospital or an attached or freestanding
28 unit of a psychiatric hospital licensed under Article 1A of General
29 Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,
30 c. A freestanding facility specializing in treatment of persons who are
31 substance abusers or chemically dependent licensed under Article 1A
32 of General Statutes Chapter 122 or Article 2 of General Statutes
33 Chapter 122C; and may be identified as "chemical dependency,
34 substance abuse, alcoholism, or drug abuse treatment units,"
35 "residential chemical dependency, substance abuse, alcoholism or
36 drug abuse facilities," or by other names if the purpose is to provide
37 treatment of chemically dependent or substance abusing persons, but
38 shall not include social setting detoxification facilities, medical
39 detoxification facilities, halfway houses or recovery farms.
40 (5b) "Chemical dependency treatment beds" means beds that are licensed for the
41 inpatient treatment of chemical dependency. Residential treatment beds for
42 the treatment of chemical dependency or substance abuse are chemical
43 dependency treatment beds. Chemical dependency treatment beds shall not
44 include beds licensed for detoxification.
45 (6) "Department" means the North Carolina Department of Health and Human
46 Services.
47 (7) To "develop" when used in connection with health services, means to
48 undertake those activities which will result in the offering of institutional
49 health service or the incurring of a financial obligation in relation to the
50 offering of such a service.

(7a) ~~"Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~

(7b) "Expedited review" means the status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.

b. The proposed capital expenditure is less than five million dollars ($5,000,000).

c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

d. The agency has not determined that a public hearing is in the public interest.

(7c) "Gamma knife" means equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.

(7d) "Gastrointestinal endoscopy room" means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(8),(9) Repealed by Session Laws 1987, c. 511, s. 1.

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, and/or rehabilitative activity that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical management.

(9b) "Health service facility" means a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

(9c) "Health service facility bed" means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.

(10) "Health maintenance organization (HMO)" means a public or private organization which has received its certificate of authority under Article 67

1 of Chapter 58 of the General Statutes and which either is a qualified health
2 maintenance organization under Section 1310(d) of the Public Health
3 Service Act or:
4 a. Provides or otherwise makes available to enrolled participants health
5 care services, including at least the following basic health care
6 services: usual physician services, hospitalization, laboratory, X ray,
7 emergency and preventive services, and out-of-area coverage;
8 b. Is compensated, except for copayments, for the provision of the basic
9 health care services listed above to enrolled participants by a
10 payment which is paid on a periodic basis without regard to the date
11 the health care services are provided and which is fixed without
12 regard to the frequency, extent, or kind of health service actually
13 provided; and
14 c. Provides physicians' services primarily (i) directly through
15 physicians who are either employees or partners of such
16 organizations, or (ii) through arrangements with individual
17 physicians or one or more groups of physicians organized on a group
18 practice or individual practice basis.
19 (10a) "Heart-lung bypass machine" means the equipment used to perform
20 extra-corporeal circulation and oxygenation during surgical procedures.
21 (11) Repealed by Session Laws 1991, c. 692, s. 1.
22 (12) "Home health agency" means a private organization or public agency,
23 whether owned or operated by one or more persons or legal entities, which
24 furnishes or offers to furnish home health services.
25 "Home health services" means items and services furnished to an
26 individual by a home health agency, or by others under arrangements with
27 such others made by the agency, on a visiting basis, and except for
28 paragraph e. of this subdivision, in a place of temporary or permanent
29 residence used as the individual's home as follows:
30 a. Part-time or intermittent nursing care provided by or under the
31 supervision of a registered nurse;
32 b. Physical, occupational or speech therapy;
33 c. Medical social services, home health aid services, and other
34 therapeutic services;
35 d. Medical supplies, other than drugs and biologicals and the use of
36 medical appliances;
37 e. Any of the foregoing items and services which are provided on an
38 outpatient basis under arrangements made by the home health agency
39 at a hospital or nursing home facility or rehabilitation center and the
40 furnishing of which involves the use of equipment of such a nature
41 that the items and services cannot readily be made available to the
42 individual in his home, or which are furnished at such facility while
43 he is there to receive any such item or service, but not including
44 transportation of the individual in connection with any such item or
45 service.
46 (13) "Hospital" means a public or private institution which is primarily engaged
47 in providing to inpatients, by or under supervision of physicians, diagnostic
48 services and therapeutic services for medical diagnosis, treatment, and care
49 of injured, disabled, or sick persons, or rehabilitation services for the
50 rehabilitation of injured, disabled, or sick persons. The term includes all

1 facilities licensed pursuant to G.S. 131E-77 of the General Statutes, except
2 long-term care hospitals.
3 (13a) "Hospice" means any coordinated program of home care with provision for
4 inpatient care for terminally ill patients and their families. This care is
5 provided by a medically directed interdisciplinary team, directly or through
6 an agreement under the direction of an identifiable hospice administration. A
7 hospice program of care provides palliative and supportive medical and
8 other health services to meet the physical, psychological, social, spiritual and
9 special needs of patients and their families, which are experienced during the
10 final stages of terminal illness and during dying and bereavement.
11 (13b) "Hospice inpatient facility" means a freestanding licensed hospice facility or
12 a designated inpatient unit in an existing health service facility which
13 provides palliative and supportive medical and other health services to meet
14 the physical, psychological, social, spiritual, and special needs of terminally
15 ill patients and their families in an inpatient setting. For purposes of this
16 Article only, a hospital which has a contractual agreement with a licensed
17 hospice to provide inpatient services to a hospice patient as defined in
18 G.S. 131E-201(4) and provides those services in a licensed acute care bed is
19 not a hospice inpatient facility and is not subject to the requirements in
20 G.S. 131E-176(5)(ii) for hospice inpatient beds.
21 (13c) "Hospice residential care facility" means a freestanding licensed hospice
22 facility which provides palliative and supportive medical and other health
23 services to meet the physical, psychological, social, spiritual, and special
24 needs of terminally ill patients and their families in a group residential
25 setting.
26 (14) Repealed by Session Laws 1987, c. 511, s. 1.
27 (14a) "Intermediate care facility for the mentally retarded" means facilities
28 licensed pursuant to Article 2 of Chapter 122C of the General Statutes for
29 the purpose of providing health and habilitative services based on the
30 developmental model and principles of normalization for persons with
31 mental retardation, autism, cerebral palsy, epilepsy or related conditions.
32 (14b) Repealed by Session Laws 1991, c. 692, s. 1.
33 (14c) Reserved for future codification.
34 (14d) Repealed by Session Laws 2001-234, s. 2, effective January 1, 2002.
35 (14e) "Kidney disease treatment center" means a facility that is certified as an
36 end-stage renal disease facility by the Centers for Medicare and Medicaid
37 Services, Department of Health and Human Services, pursuant to 42 C.F.R.
38 § 405.
39 (14f) Reserved for future codification.
40 (14g) "Linear accelerator" means a machine used to produce ionizing radiation in
41 excess of 1,000,000 electron volts in the form of a beam of electrons or
42 photons to treat cancer patients.
43 (14h) Reserved for future codification.
44 (14i) "Lithotriptor" means extra-corporeal shock wave technology used to treat
45 persons with kidney stones and gallstones.
46 (14j) Reserved for future codification.
47 (14k) "Long-term care hospital" means a hospital that has been classified and
48 designated as a long-term care hospital by the Centers for Medicare and
49 Medicaid Services, Department of Health and Human Services, pursuant to
50 42 C.F.R. § 412.
51 (14l) Reserved for future codification.

(14m) "Magnetic resonance imaging scanner" means medical imaging equipment that uses nuclear magnetic resonance.

(14n) Reserved for future codification.

(14o) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~ one million five hundred thousand dollars ($1,500,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~ one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section.

(15) Repealed by Session Laws 1987, c. 511, s. 1.

(15a) "Multispecialty ambulatory surgical program" means a formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.

(15b) "Neonatal intensive care services" means those services provided by a health service facility to high-risk newborn infants who require constant nursing care, including but not limited to continuous cardiopulmonary and other supportive care.

(16) "New institutional health services" means any of the following:

a. The construction, development, or other establishment of a new health service facility.

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~ four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~ four million dollars ~~($2,000,000).~~($4,000,000).

c. Any change in bed capacity as defined in G.S. 131E-176(5).

d. The offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health

1 service that is to be located in the facility, or portion thereof, that was
2 constructed or developed in the project.
3 f. The development or offering of a health service as listed in this
4 subdivision by or on behalf of any person:
5 1. Bone marrow transplantation services.
6 2. Burn intensive care services.
7 2a. Cardiac catheterization services, except cardiac
8 catheterization services provided on equipment furnished by a
9 person authorized to operate such equipment in North
10 Carolina pursuant to either a certificate of need issued for
11 mobile cardiac catheterization equipment or a settlement
12 agreement executed by the Department for provision of
13 cardiac catheterization services.
14 3. Neonatal intensive care services.
15 4. Open-heart surgery services.
16 5. Solid organ transplantation services.
17 f1. The acquisition by purchase, donation, lease, transfer, or comparable
18 arrangement of any of the following equipment by or on behalf of
19 any person:
20 1. Air ambulance.
21 2. Repealed by Session Laws 2005-325, s. 1, effective for
22 hospices and hospice offices December 31, 2005.
23 3. Cardiac catheterization equipment.
24 4. Gamma knife.
25 5. Heart-lung bypass machine.
26 5a. Linear accelerator.
27 6. Lithotriptor.
28 7. Magnetic resonance imaging scanner.
29 8. Positron emission tomography scanner.
30 9. Simulator.
31 g. to k. Repealed by Session Laws 1987, c. 511, s. 1.
32 l. The purchase, lease, or acquisition of any health service facility, or
33 portion thereof, or a controlling interest in the health service facility
34 or portion thereof, if the health service facility was developed under a
35 certificate of need issued pursuant to G.S. 131E-180.
36 m. Any conversion of nonhealth service facility beds to health service
37 facility beds.
38 n. The construction, development or other establishment of a hospice,
39 hospice inpatient facility, or hospice residential care facility;
40 o. The opening of an additional office by an existing home health
41 agency or hospice within its service area as defined by rules adopted
42 by the Department; or the opening of any office by an existing home
43 health agency or hospice outside its service area as defined by rules
44 adopted by the Department.
45 p. The acquisition by purchase, donation, lease, transfer, or comparable
46 arrangement by any person of major medical equipment.
47 q. The relocation of a health service facility from one service area to
48 another.
49 r. The conversion of a specialty ambulatory surgical program to a
50 multispecialty ambulatory surgical program or the addition of a
51 specialty to a specialty ambulatory surgical program.

s. The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if such equipment would otherwise be subject to review in accordance with G.S. 131E-176(16)(f1.) or G.S. 131E-176(16)(p) if it had been acquired in North Carolina.

t. Repealed by Session Laws 2001-242, s. 4, effective June 23, 2001.

u. The construction, development, establishment, increase in the number, or relocation of an operating ~~room~~ room, including a single-specialty ambulatory surgery operating room, or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.

(17) "North Carolina State Health Coordinating Council" means the Council that prepares, with the Department of Health and Human Services, the State Medical Facilities Plan.

(17a) "Nursing care" means:

a. Skilled nursing care and related services for residents who require medical or nursing care;

b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

These are services which are not primarily for the care and treatment of mental diseases.

(17b) "Nursing home facility" means a health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

(18) To "offer," when used in connection with health services, means that the person holds himself out as capable of providing, or as having the means for the provision of, specified health services.

(18a) Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.

(18b) "Open-heart surgery services" means the provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects.

(18c) "Operating room" means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.

(19) "Person" means an individual, a trust or estate, a partnership, a corporation, including associations, joint stock companies, and insurance companies; the State, or a political subdivision or agency or instrumentality of the State.

(19a) "Positron emission tomography scanner" means equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures.

(20) "Project" or "capital expenditure project" means a proposal to undertake a capital expenditure that results in the offering of a new institutional health service as defined by this Article. A project, or capital expenditure project, or proposed project may refer to the project from its earliest planning stages up through the point at which the specified new institutional health service may be offered. In the case of facility construction, the point at which the new institutional health service may be offered must take place after the facility is capable of being fully licensed and operated for its intended use, and at that time it shall be considered a health service facility.

(21) "Psychiatric facility" means a public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(22) "Rehabilitation facility" means a public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent, professional supervision.

(22a) "Replacement equipment" means equipment that costs less than ~~two~~ four million dollars ~~($2,000,000)~~($4,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than ~~two~~ four million dollars ~~($2,000,000),~~($4,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

(23) Repealed by Session Laws 1991, c. 692, s. 1.

(24) Repealed by Session Laws 1993, c. 7, s. 2.

(24a) "Service area" means the area of the State, as defined in the State Medical Facilities Plan or in rules adopted by the Department, which receives services from a health service facility.

(24b) "Simulator" means a machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient.

(24c) ~~Reserved for future codification.~~"Single specialty ambulatory surgery operating room" means a designated operating room located in a licensed ambulatory surgical facility that is used to perform same-day surgical procedures in any one of the single specialty areas identified by the American College of Surgeons. For the purpose of this subdivision, "same-day surgical procedures" includes pain injections by orthopedists, physiatrists, and anesthesiologists.

(24d) "Solid organ transplantation services" means the provision of surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor.

(24e) Reserved for future codification.

(24f) "Specialty ambulatory surgical program" means a formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and authorized by its certificate of need.

(25) "State Medical Facilities Plan" means the plan prepared by the Department of Health and Human Services and the North Carolina State Health Coordinating Council, and approved by the Governor. In preparing the Plan, the Department and the State Health Coordinating Council shall maintain a mailing list of persons who have requested notice of public hearings regarding the Plan. Not less than 15 days prior to a scheduled public hearing, the Department shall notify persons on its mailing list of the date, time, and location of the hearing. The Department shall hold at least one public hearing prior to the adoption of the proposed Plan and at least six public hearings after the adoption of the proposed Plan by the State Health Coordinating Council. The Council shall accept oral and written comments from the public concerning the Plan.

(26) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1002, s. 9.

(27) Repealed by Session Laws 1987, c. 511, s. 1."

SECTION 3.(a) G.S. 131E-178 reads as rewritten:

"**§ 131E-178. Activities requiring certificate of need.**

(a) ~~No~~ Except as otherwise provided in subsections (a1) and (a2) of this section, no person shall offer or develop a new institutional health service without first obtaining a certificate of need from the ~~Department; provided, however, no~~Department.

(a1) Any person proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility, with the existing number of gastrointestinal endoscopy rooms, except for a person who (i) provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed ~~setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:~~setting and (ii) meets all of the following criteria:

(1) The person's license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and

1 (4) The license application includes a commitment and plan for serving indigent
2 and medically underserved populations.
3 All other persons proposing to obtain a license to establish an
4 ambulatory surgical facility for the provision of gastrointestinal endoscopy
5 procedures shall be required to obtain a certificate of need. The annual State
6 Medical Facilities Plan shall not include policies or need determinations that
7 limit the number of gastrointestinal endoscopy rooms that may be approved.
8 (a2) Any person proposing to obtain a license to establish single-specialty ambulatory
9 operating rooms in an ambulatory surgery facility shall be required to obtain a certificate of
10 need, except for a person who (i) provides single-specialty ambulatory surgery procedures in
11 one or more operating rooms located in a nonlicensed setting and (ii) meets all of the following
12 criteria:
13 (1) The person's license application is postmarked for delivery to the Division of
14 Health Service Regulation by December 31, 2013.
15 (2) The applicant verifies, by affidavit submitted to the Division of Health
16 Service Regulation within 60 days of the effective date of this act, that the
17 facility is in operation as of the effective date of this act or that the
18 completed application for the building permit for the facility was submitted
19 by the effective date of this act;
20 (3) The facility has been accredited by The Accreditation Association for
21 Ambulatory Health Care, The Joint Commission on Accreditation of
22 Healthcare Organizations, or The American Association for Accreditation of
23 Ambulatory Surgical Facilities by the time the license application is
24 postmarked for delivery to the Division of Health Service Regulation of the
25 Department; and
26 (4) The license application includes at least all of the following:
27 a. A commitment, plan, and policies and procedures for serving
28 indigent and medically underserved populations.
29 b. Projected charges for the 20 most common surgical procedures to be
30 performed in the proposed single-specialty ambulatory surgery
31 operating rooms.
32 All other persons proposing to obtain a license to establish
33 single-specialty ambulatory operating rooms within an ambulatory surgical
34 facility shall be required to obtain a certificate of need. The annual State
35 Medical Facilities Plan shall not include policies or need determinations that
36 limit the number of single-specialty ambulatory surgery operating rooms that
37 may be approved. However, the Department shall not approve an application
38 for a single-specialty ambulatory surgery operating room in any ambulatory
39 surgical facility within a county in which a licensed critical access hospital,
40 as defined in 42 CFR § 400.202, is located. The annual State Medical
41 Facilities Plan also shall not include policies or need determinations that
42 limit the relocation and replacement of existing operating rooms, including
43 single-specialty ambulatory operating rooms. However, the Department shall
44 not approve an application for the relocation of a hospital's operating room
45 to a facility on premises separate from the premises upon which a hospital's
46 inpatient acute care beds and emergency department are located if approval
47 would result in the hospital obtaining reimbursement for single-specialty
48 ambulatory surgery procedures at a rate higher than the rate paid to
49 ambulatory surgery centers under a government sponsored health insurance
50 or medical assistance program.

(b) No person shall make an acquisition by donation, lease, transfer, or comparable arrangement without first obtaining a certificate of need from the Department, if the acquisition would have been a new institutional health service if it had been made by purchase. In determining whether an acquisition would have been a new institutional health service, the capital expenditure for the asset shall be deemed to be the fair market value of the asset or the cost of the asset, whichever is greater.

(c) No person shall incur an obligation for a capital expenditure which is a new institutional health service without first obtaining a certificate of need from the Department. An obligation for a capital expenditure is incurred when:

(1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the construction, acquisition, lease or financing of a capital asset;

(2) A person takes formal action to commit funds for a construction project undertaken as his own contractor; or

(3) In the case of donated property, the date on which the gift is completed.

(d) Where the estimated cost of a proposed capital expenditure, including the fair market value of equipment acquired by purchase, lease, transfer, or other comparable arrangement, is certified by a licensed architect or engineer to be equal to or less than the expenditure minimum for capital expenditure for new institutional health services, such expenditure shall be deemed not to exceed the amount for new institutional health services regardless of the actual amount expended, provided that the following conditions are met:

(1) The certified estimated cost is prepared in writing 60 days or more before the obligation for the capital expenditure is incurred. Certified cost estimates shall be available for inspection at the facility and sent to the Department upon its request.

(2) The facility on whose behalf the expenditure was made notifies the Department in writing within 30 days of the date on which such expenditure is made if the expenditure exceeds the expenditure minimum for capital expenditures. The notice shall include a copy of the certified cost estimate.

(e) The Department may grant certificates of need which permit capital expenditures only for predevelopment activities. Predevelopment activities include the preparation of architectural designs, plans, working drawings, or specifications, the preparation of studies and surveys, and the acquisition of a potential site."

SECTION 4. G.S. 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same service area will be reviewed together. However, the Department is prohibited from scheduling a review prior to February 1, 2013, for certificate of need applications that propose to establish a licensed single-specialty ambulatory operating room within an ambulatory surgery facility.

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require such information as the Department, by its rules deems necessary to conduct the review. An applicant shall be required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria implemented under G.S. 131E-183 and with duly adopted standards, plans and criteria. The application form for a certificate of need to establish a single-specialty ambulatory surgery operating room within an ambulatory surgery facility shall require the applicant to (i) include a written commitment, plan, and policies and procedures for serving indigent and medically underserved populations, (ii) furnish the projected charges for the 20 most common surgical procedures to be performed in the proposed operating room, and (iii) demonstrate that it is performing or

reasonably expects to perform at least 800 single-specialty ambulatory procedures per licensed single-specialty ambulatory operating room per year.

(c) An application fee is imposed on an applicant for a certificate of need. An applicant must submit the fee with the application. The fee is not refundable, regardless of whether a certificate of need is issued. Fees collected under this section shall be credited to the General Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed fifty thousand dollars ($50,000)."

SECTION 5. G.S. 131E-184(a) is amended by adding a new subdivision to read:

"(10) To develop, acquire, or replace a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000), unless a new institutional health service other than those defined in G.S. 131E-176(16)b. is offered or developed in the building."

SECTION 6. G.S. 131E-184(e) reads as rewritten:

"(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility,
2. Adult care home facility, or
3. Intermediate care facility for the mentally retarded; and

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.
b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents."

SECTION 7. Nothing in this act shall be construed to reflect any legislative intent as to the circumstances under which Medicare or Medicaid certification may be obtained for a provider of ambulatory surgery services.

SECTION 8. This act is effective when it becomes law. Section 4 of this act expires on the effective date of administrative rules adopted consistent with the provisions of this act regarding the number of single-specialty surgery procedures performed or projected to be performed by applicants seeking to establish a licensed single-specialty ambulatory surgery operating room.

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Griffin	Novant Health
Jill Rosenblum	NBM Health Planning
Tracy Colvard	AHHC
MAX MASON	PRINCIPLE LONG TERM CARE, INC.
Laurie Owens	Jason Deans & Assoc.
Jason Deans	Jason Deans + Assoc.
Dee Murphy	Ascendient
LANIER CANSLER	
Christine Craig	WakeMed
[illegible]	NP
Elise McDowell	Troutman Sanders

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Baum	Troutman Sanders
Stephen Kouba	Compass NC
Kathleen Worrell	PDC
Catharine Cummer	DUHS
Doug Heron	DUHS
Kara Weishaar	NCSA
[illegible]	Novant
Pam Scott	Poyner Spruill
Chuck Stone	SEAHC
John Cooper	Compass NC

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Freedy	Novant Health Winston-Salem, NC 27103
Charlene Thomas	Strategic Healthcare Advisors Asheville, NC
GRAHAM FIELDS	PARK RIDGE HEALTH HENDERSONVILLE, NC
Denise Gunter	Nelson Mullins Winston-Salem, NC
John Metzger	Policy Group
TODD HEMPHILL	BODE, CALL & STROUPE. RALEIGH, NC
Susan Fradenburg	Smith Moore Leatherwood
Andrew Blackburn	Southern Strategy Group
Clark Riemer	Civitas
Varsha Gadani	NC Med Society
Chip Baggett	NCMS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kris Horton	DHHS
C S Hollis	TSS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gretchen Kelly	FirstHealth
Susanna Davis	WM
Allison Waller	Nelson Mullins
AIMÉE ESCUETA	NC - ATTORNEY GENERAL'S OFFICE
Robbie Roberts	WakeMed
Gary Qualls	K&L Gates
[illegible]	[illegible]
Greg Bass	Carolinas HealthCare System
[illegible]	NMRS
JOE LANIER	NELSON MULLINS

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 11-15-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	Mission Health -

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2011-2012 SESSION

You are hereby notified that the **House Select Committee on Certificate of Need Process and Related Hospital Issues** will meet as follows:

DAY & DATE: Thursday, December 6, 2012
TIME: 10:00 a.m. - 3:00 p.m.
LOCATION: 544 LOB
COMMENTS:

Respectfully,
Representative Steen, Chair
Representative Torbett, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **8 AM** o'clock on **November 20, 2012**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Viddia Torbett (Committee Assistant)

General Assembly of North Carolina

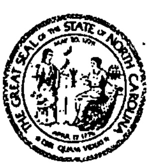
REPRESENTATIVE FRED STEEN
CO-CHAIR
300 N. SALISBURY STREET
ROOM 305
RALEIGH, NC 27603-5925
(919) 733-5881

Viddia Torbett
COMMITTEE CLERK
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868

House Select Committee On the Certificate of Need Process and Related Hospital Issues

State Legislative Building
Raleigh, North Carolina

REPRESENTATIVE JOHN TORBETT
CO-CHAIR
300 N. SALISBURY STREET
ROOM 537
RALEIGH, NC 27603-5925
(919) 733-5868



AGENDA

Thursday, December 6, 2012
10:00 am
Room 544, Legislative Office Building

I. Welcome and Opening Remarks
Representative Fred Steen and Representative John Torbett

II. Approval of Minutes

III. Final Report

MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

Thursday, December 6, 2012

10:00 a.m.

Room 544, LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, December 6, 2012 in Room 544, LOB at 10:00 a.m. Representatives Avila, Boles, Brandon, Collins, Current, Hollo, Randleman, Steen, and Torbett were present. Representative Torbett presided.

Representative Torbett asked for approval of minutes. Representative Steen made the motion and Representative Collins seconded. The minutes were approved unanimously.

Representative Torbett went over the final draft report, with minor changes the report was adopted unanimously by the committee (see attached and on committee website).

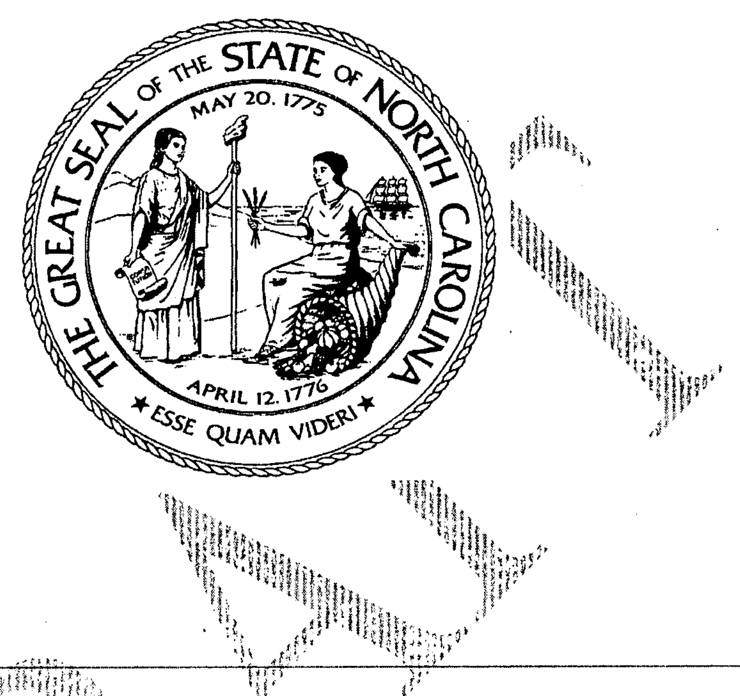
Representative Torbett adjourned the meeting at 11:45 a.m.

Representative John Torbett, Co-Chair Presiding

Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY

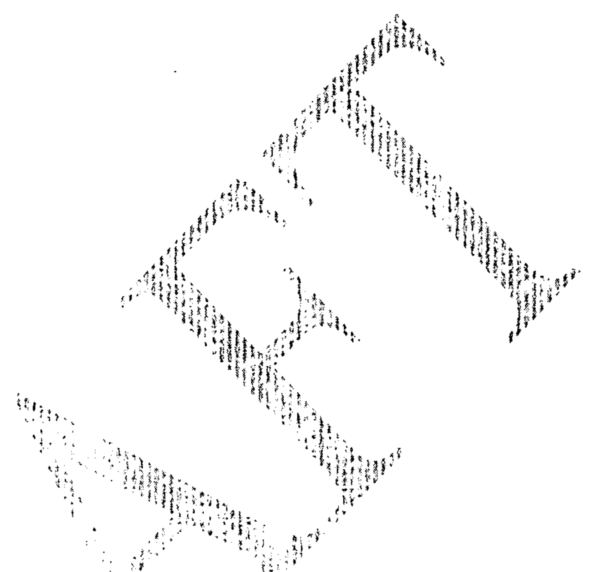


DRAFT

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

FINAL REPORT
TO THE
2013 HOUSE OF REPRESENTATIVES

DECEMBER 2012



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Legislative Proposals

2013-MGz-16
AN ACT TO ELIMINATE THE MONETARY THRESHOLD FOR EXPEDITED CERTIFICATE OF NEED REVIEW; TO INCREASE THE MONETARY THRESHOLDS TRIGGERING CERTIFICATE OF NEED REVIEW FOR CAPITAL EXPENDITURES AND THE PURCHASE OF MAJOR MEDICAL EQUIPMENT; TO EXEMPT REPLACEMENT EQUIPMENT FROM CERTIFICATE OF NEED REVIEW REGARDLESS OF COST; TO REQUIRE AFFECTED PERSONS SEEKING TO FILE A PETITION FOR A CONTESTED CASE OR AN APPEAL CHALLENGING CERTIFICATE OF NEED APPROVAL TO DEPOSIT A SEPARATE BOND FOR EACH APPROVED APPLICATION THAT IS THE SUBJECT OF THE PETITION OR APPEAL; TO INCREASE THE AMOUNT OF THE MAXIMUM BOND REQUIREMENT, AND TO GIVE THE COURT OF APPEALS GREATER DISCRETION IN IMPOSING A HIGHER BOND AMOUNT; TO REQUIRE THE COURT TO AWARD COSTS AND A REASONABLE ATTORNEY FEE TO ANY CERTIFICATE OF NEED APPLICANT WHOSE APPROVED NEW INSTITUTIONAL HEALTH SERVICE IS THE SUBJECT OF A CONTESTED CASE PETITION DETERMINED TO BE FRIVOLOUS OR FILED TO DELAY THE APPLICANT; AND TO PROHIBIT THE STAYING OF A FINAL DECISION IN A CERTIFICATE OF NEED CASE DURING THE PENDENCY OF AN APPEAL, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TRANSMITTAL LETTER

STATE OF NORTH CAROLINA

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

December 2012

TO THE MEMBERS OF THE 2013 HOUSE OF REPRESENTATIVES:

Attached for your consideration is the interim report of the House Select Committee on the Certificate of Need Process and Related Hospital Issues established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Respectfully submitted,

Representative Fred Steen Co-Chair	Representative John Torbett Co-Chair

COMMITTEE AUTHORIZATION

Office of Speaker Thom Tillis
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TO THE HONORABLE MEMBERS OF THE NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on the Certificate of Need Process and Related Hospital Issues (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Section 2. The Committee consists of the 11 members listed below, appointed by the Speaker of the House of Representatives. Members serve at the pleasure of the Speaker of the House of Representatives. The Speaker of the House of Representatives may dissolve the Committee at any time.

Representative Fred Steen, Co-Chair
Representative John Torbett, Co-Chair
Representative Jamie Boles
Representative Mark Hollo
Representative Bill Current
Representative Marilyn Avila
Representative Jeff Collins
Representative Shirley Randleman
Representative Rick Glazier
Representative Martha Alexander
Representative Marcus Brandon

Section 3. The Committee may study all of the following:

(1) The provisions of House Bill 743, First Edition, 2011 Regular Session and House Bill 812, First Edition, 2011 Regular Session.

(2) The legal requirements and process governing Department of Health and Human Services determinations on applications for CON, including an analysis of exceptions granted under policy AC-3 of the State Medical Facilities Plan as implemented by the Department of Health and Human Services.

(3) Issues relating to publicly owned hospitals, including determining the appropriate role of State-owned hospitals and the appropriate manner for public hospital authorities created under G.S. 131E-17 to operate beyond the boundaries of the local government that created the authority.
(4) Whether a hospital operating under a Certificate of Public Advantage should be required to comply with the same rules, policies, and limitations to each county in which it operates.
(5) The extent to which a publicly owned hospital should engage in business with an entity having a Certificate of Public Advantage or operating under an exemption under the CON laws of the State.
(6) Any other matter reasonably related to subdivisions (1) through (4) of this section, in the discretion of the Committee.

Section 4. The Committee shall meet upon the call of its Co-Chairs. A quorum of the Committee shall be a majority of its members.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1.

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2012, by filing a copy of the report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives prior to the convening of the 2013 General Assembly by filing the final report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee terminates upon the convening of the 2013 General Assembly or upon the filing of its final report, whichever occurs first.

Effective this the 24th day of August, 2011

Thom Tillis
Speaker

COMMITTEE MEMBERSHIP

Representative Fred Steen, Co-Chair
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Representative Shirley Randleman
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Joyce Jones – Joyce.Jones@ncleg.net

Fiscal Research Division (919) 733-4910
Lisa Hollowell – Lisa.hollowell@ncleg.net

PREFACE

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. This health care planning process seeks to ensure that rural areas and underserved populations have adequate access to health care; to encourage safety and high quality in the health care services provided; and to reduce health care costs through the elimination of unnecessarily duplicative expensive facilities, equipment, and services. To accomplish these goals, the statutes require the development of annual projections of need for various types of health care facilities and services.[1] The resulting document is known as the State Medical Facilities Plan (SMFP). To implement the SMFP, the General Assembly enacted the Certificate of Need Law,[2] which provides the process by which persons may apply for a license to construct or expand health care facilities or to provide services in accordance with the determined need.

In addition to the SMFP and the CON law, the State has also taken steps to enhance the availability of quality health care services by allowing hospitals and other persons to enter into cooperative agreements for the provision of health care that would otherwise be subject to State antitrust scrutiny.[3] Such agreements are subject to the issuance, by the State, of a Certificate of Public Advantage (COPA). The COPA spells out conditions of operation imposed upon the parties to the agreement that, in theory, should counterbalance any competitive advantage gained in the health care marketplace under the cooperative agreement. Only one COPA has been issued since the enactment of the statute in 1993.

Although the Certificate of Need law has been amended several times since enacted, it has been a number of years since the General Assembly undertook a serious review of the program.[4] Further, there is concern that our Certificate of Public Advantage law has not adequately offset the competitive advantage gained under the cooperative agreement, and it is unclear if Article 9A provides a definitive process to initiate the termination of an agreement.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues was created and charged with the review of the State health planning process, including the State's CON program and the implementation of the COPA law, to determine whether these programs are adequately serving their intended purpose of ensuring the availability of quality, cost effective health care services to North Carolina citizens. The Committee began its work in September of 2011 and filed an interim report on its proceedings with the General Assembly. This report covers the activities of the Committee from September of 2012 through its termination.

---

[1]. G.S. 131E-177

[2] Article 9, Chapter 131E of the General Statutes

[3] Article 9A, Chapter 131E of the General Statutes.

[4] 1991, Legislative Research Commission: Committee on Care Provided by Rest Homes, Intermediate Care Facilities, and Skilled Nursing Homes; Necessity for Certificates of Need; and Continuing Care Issues.

COMMITTEE PROCEEDINGS

Below is a brief summary of the Committee's proceedings. A more detailed record of the Committee's work can be found in the Committee's notebook, located in the Legislative Library. For meetings September 2011 – April 2012, please see the Interim Report dated April 2012.

September 13, 2012

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, September 13, 2012, in Room 544, LOB at 1:00 p.m. First Amy Jo Johnson and Jan Paul, staff attorneys in the Research Division, presented a review of topics before the committee. Next Drexdal Pratt, Director, Division of Health Services Regulation, Department of Health and Human Services gave an update on activities at the Division of Health Service Regulation since the Committee's last meeting. Before adjourning the meeting, Representative Torbett opened the meeting for a period of public comment.

September 27, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, March 15, 2012, in Room 544 of the Legislative Office Building at 10:00 a.m. Craig Smith, Chief, Certificate of Need Section, Division of Health Services' Regulation, Department of Health and Human Services gave a presentation detailing the scope of the Certificate of Need Law and all new health service regulations included within the law. Next, the Committee heard two presentations from Dave French, MBA, MHA, President, Strategic Healthcare Consultants. Mr. French's initial presentation gave a history of the 2005 changes in the Certificate of Need Law that involved GI Endoscopy Centers. The presentation also explored potential cost savings and justifications for making changes to the Certificate of Need Law proposed by Mr. French. Changes suggested would allow for single-specialty ambulatory surgery centers. Mr. French followed this presentation with another detailing the current regulations under Certificate of Need law for diagnostic service centers. Finally, Hugh Tilson, Senior Vice President, North Carolina Hospital Association made a presentation to the Committee discussing various hospital quality improvement activities that have taken place. This presentation included a demonstration of the North Carolina Hospital Association's website, which contains reports on the various activities of which Mr. Tilson spoke.

October 11, 2012

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 11, 2012, in Room 643, LOB at 10:00 a.m. First, Hugh Tilson, Senior Vice President, North Carolina Hospital Association (NCHA) gave a follow-up presentation on the information available via the NCHA website. Next, Lanier Cansler, President, Cansler Collaborative Resources, Inc., Former Secretary, North Carolina Department of Health and Human Resources gave a presentation on planning for the future of healthcare in North Carolina. After the Committee heard from Lanier Cansler, Dr. Thomas Ricketts, Professor, Health Policy and Administration, Deputy Director, Cecil G Sheps Center for Health Services Research gave a

presentation on the supply and demand of physicians in North Carolina. Finally, Earl Jones, Chairman, Good Hope Hospital, Pat Cameron, Chairman, Good Hope Mental Health, Patsy Caron, Mayor of Erwin, and Jim Burgin, Commissioner, Harnett County updated the Committee on the impact of the CON law on the citizens of Harnett County.

October 25, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, October 25, 2012, in Room 544 of the Legislative Office Building at 1pm. The Committee heard three presentations. The first speaker was Noah H. Huffstetler, III, Attorney and Partner at Nelson Mullins. Mr. Huffstetler discussed reasons to maintain the State's Certificate of Need program, noted several improvements that had been made by the Division of Health Service Regulation, Department of Health and Human Services, over the past year, and made a number of recommendations for improvements to the program. The next speaker was Dave French, MBA, MHA, President of Strategic Health Care. His presentation detailed the cost savings and justification for changing the Certificate of Need law to allow single-specialty ambulatory surgical centers. The final speaker, Hugh Tilson, Senior Vice President of the North Carolina Hospital Association, provided the hospital perspective on the changes proposed by Mr. French, and noted hospitals rely on commercially insured patients to cover the cost of providing care to the uninsured and those covered by government programs.

November 15, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, November 15, 2012, in Room 643 of the Legislative Office Building at 10:00 am. First, the Committee heard from the following presenters on the Certificate of Public Advantage Audit:

- Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission
- K. D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice
- David Motsinger, CPA, Partner, Dixon Hughes Goodman LLP

Next, Jan Paul, Staff Attorney, Research Division gave an update on the recent Court of Appeals decision in *Novant Health v. NC DHHS*. Lastly, Chairman Torbett requested that the Committee work on finalizing recommendations for the Committee report. The Committee discussed its recommendations and the Chair directed staff to assemble a draft report for the Committee's consideration at the December meeting.

December 6, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, December 6, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The Committee discussed and voted on a draft of the final report.

FINDINGS AND RECOMMENDATIONS

Finding:

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. The Committee heard a variety of presentations and public comment that touched upon the need for alterations to the new institutional health services covered by Certificate of Need. The Committee finds that an in-depth review of services regulated under the Certificate of Need law is necessary.

Recommendation:

1. **The Committee recommends a full and a complete review of all new institutional health services regulated under Certificate of Need law to determine the need and rationale for each included service regulation.**

Finding:

The Committee heard concerns that the specified capital expenditures amounts for certain projects and activities need to be adjusted based upon inflation. The statutory expenditure thresholds have not been changed since 1993 regarding expedited reviews, major medical equipment, and replacement equipment. The capital expenditure threshold for new institutional health services has been set at two million dollars since 1987. The Committee finds that many of the monetary thresholds are outdated or no longer relevant.

Recommendations:

2. **The Committee recommends the General Assembly increase the capital expenditure threshold for new institutional health services from two million dollars to four million dollars.**

3. **The Committee recommends the General Assembly eliminate the monetary threshold for expedited reviews.**

4. **The Committee recommends the General Assembly eliminate replacement equipment from the Certificate of Need process.**

5. **The Committee recommends the General Assembly increase the monetary threshold for major medical equipment from seven hundred fifty thousand dollars to one and a half million dollars.**

Finding:

The Committee heard from parties who had an approved Certificate of Need application and, due to a change in circumstances, encountered difficulty making alterations to its Certificate of

Need. This need for alterations is only increased during difficult economic situations. The Committee finds that looking into methods by which a modification to an approved Certificate of Need application could be made is prudent.

Recommendation:

6. **The Committee recommends studying ways to make it easier and more efficient to modify or change an approved Certificate of Need, particularly in light of an applicant's change in financial situation, and under which instances this should apply.**

Finding:

Pursuant to G.S. 131E-177, the Department of Health and Human Services is designated as the State Health Planning and Development Agency. The State Health Coordinating Council (SHCC) is responsible for directing the development of the annual State Medical Facilities Plan. The SHCC was established via executive order by the Governor and contains appointments from the Governor. The SHCC is subject to ethics guidelines also established via Governor executive order. The Committee received comment expressing a need for more transparency and accountability by the State Health Coordinating Council and its decisions affecting the development of the State Medical Facilities Plan. The Committee finds, while it is necessary for the State Health Coordinating Council members to have experience and expertise in the health care industry, there are concerns of member conflicts of interest, the potential for undue influence by a single individual, and public perception. The Committee finds that these concerns could be lessened by changing the current appointment process of members to the State Health Coordinating Council.

Recommendations:

7. **The Committee recommends a codification of the State Health Coordinating Council. The appointments to the Council should be divided amongst the legislative and executive branches.**

8. **Upon codification of the State Health Coordinating Council, the members should adhere to ethical stands and conflict of interest provisions set by the General Assembly. These ethical standards should strive to eliminate any appearance of undue influence.**

Finding:

The Department of Health and Human Services is authorized by statute to establish policies and rules for project review. Policy AC-3 of the North Carolina State Medical Facilities Plan exempts from the need determinations of the State Medical Facilities Plan certain projects for which Certificates of Need are sought by academic medical center teaching hospitals. The academic medical center is required to demonstrate that the expansion is necessary and that its need cannot be achieved effectively at any non-academic medical center teaching hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the academic medical center teaching hospital. Presentations and discussion brought into question the issue of

whether the Policy AC-3 was equitable, or whether it created an unfair and unnecessary competitive advantage for academic medical centers. Discussion was centered on eliminating the AC-3 policy, codifying it, or studying it. The Committee was informed that Policy AC-3 was revised in the 2012 State Medical Facilities Plan, which added additional requirements for a Policy AC-3 exemption, and that there has been insufficient time and opportunity to determine whether the policy changes will alleviate or eliminate the issues of concern.

Recommendation:

9. **The Committee recommends that the Division of Health Services Regulation monitor and review Policy AC-3 for a period of one year, and then report and make recommendations to the General Assembly's Legislative Oversight Committee on Health and Human Services.**

Finding:

The Committee heard concerns that the Certificate of Need appeals process is often lengthy, and that some appeals might be brought solely for purposes of delay. The Committee finds that changes in the appeals process should be made in order to streamline the appeals process, to redefine the parties having standing to appeal, and to deter the bringing of frivolous, harassing, or meritless appeals.

Recommendations:

10. **The Committee recommends a study to assess the need for a reduction in the appeals process time frames in Certificate of Need cases and to determine methods by which to accomplish this goal.**

11. **The Committee recommends the General Assembly enact legislation to award the prevailing party costs and attorneys' fees in Certificate of Need contested cases.**

12. **The Committee recommends the General Assembly enact legislation giving the appellate court greater discretion to impose a higher appeal bond amount in Certificate of Need cases.**

13. **The Committee recommends the General Assembly enact legislation requiring the posting of a separate appeal bond for each approved application that is the subject of a petition for contested case hearing or appeal of a Certificate of Need determination.**

14. **The Committee recommends proposed legislation to prohibit the staying of a final decision in a Certificate of Need Case during the pendency of an appeal.**

15. **The Committee recommends an examination and possible redefining of the terms "affected person" and "aggrieved party" in the Certificate of Need laws.**

Finding:

Hospital authorities are authorized pursuant to Article 2 of Chapter 131E of the General Statutes. A hospital authority may be created by resolution of the city council or board of county commissioners upon finding that it is in the interest of the public health and welfare to do so. The boundaries of a hospital authority include the city or county creating the authority and the area within 10 miles from the territorial boundaries of the city or county. Hospital authorities may operate outside of this area pursuant to an agreement with another hospital in the county, or if none, with a health care agency. The statutes grant extensive powers to hospital authorities, including the power of eminent domain.

Recommendation:

16. **The Committee recommends the General Assembly should examine how to define the territorial boundaries of hospital authorities.**

Finding:

North Carolina lags slightly in the number of physicians per capita in the U.S. The supply of physicians, however, is growing faster than the State population and the number of physicians in primary care is also on the increase. Unfortunately, there is a persistent problem with poor distribution of physicians across the State. Two programs that have been successful in increasing the number of physicians in rural and underserved areas are the North Carolina Area Health Education Centers (AHEC) residency program and the State Loan Repayment program. Data shows that North Carolina AHEC trained residents are more likely to practice in the rural areas of the State and are more likely to choose primary care than other specialties. The North Carolina Office of Rural Health and Community Care administers the Loan Repayment Program. That program provides up to $100,000 principle plus interest for loan repayments to new physicians locating their practices in rural areas. A four year commitment is required. The Committee finds that the State needs to encourage new physicians to choose specialties that are in short supply and to locate practices in rural, underserved areas.

Recommendation:

17. **The Committee recommends the General Assembly should continue to support the NC AHEC residency program and the NC Office of Rural Health and Community Care Rural Health Loan Repayment Program.**

Finding:

Health care costs in North Carolina continue to increase despite efforts by the State to control them. Most regulatory efforts, whether aimed at managing care or limiting the expansion of facilities and technology to a State determined level of need, end up simply shifting costs from one area to another that is more profitable. Lanier Cansler, Former Secretary of the North Carolina Department of Health and Human Services noted that if the State wants to seriously address the

issues of affordability and sustainability of healthcare in the State "we must develop a vision of our healthcare delivery system and then every modification to law, reimbursement process, policy, must be focused on achieving that vision."

Recommendation:

18. **The General Assembly should study reform of the health care market and the health care delivery system in North Carolina to increase cost effectiveness and quality of care through the encouragement of market driven competition in the provision of health care services.**

Finding:

A Certificate of Public Advantage (COPA) was issued by the State in 1995 as a condition of allowing the merger of Memorial Mission Hospital and St. Joseph's Hospital to go forward. The entity that emerged from the merger process is Mission Hospital, Inc., operated by Mission Health Systems, Inc. ("Mission"). The COPA agreement was required by the State to offset the anticompetitive effects of the merger on the Western North Carolina health care market. Since 1995, the COPA agreement has been modified twice. Mission has submitted the reports required under the statutes and has been determined to be in compliance with the terms of the COPA agreement. Nonetheless, hospitals, health care providers, and individuals continue to raise concerns about the increase in Mission's market power and whether the COPA agreement has been effective in balancing the anticompetitive effects of the merger. Further in-depth investigation into the economic impact of Mission's COPA on the health care market, especially in light of recent changes in the structure of the health care industry, may be necessary to resolve these issues and ensure the provision of low cost, high quality health care to the people in Western North Carolina.

Recommendation:

19. **The Committee recommends that the hospitals, health care providers, and interested individuals in the region make every effort to resolve their differences regarding the COPA prior to the end of the 2013 Session of the General Assembly. If a satisfactory resolution to the issues is not reached in that time, the Committee recommends that the General Assembly conduct a study of the economic impact of the COPA and the effectiveness of that agreement.**

APPENDIX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H D

BILL DRAFT 2013-MGz-16 [v.6] (11/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/20/2012 3:47:25 PM

Short Title:	Enact CON Committee Recommendations.	(Public)
Sponsors:	Representative Torbett.	
Referred to:		

1 A BILL TO BE ENTITLED
2 AN ACT TO ELIMINATE THE MONETARY THRESHOLD FOR EXPEDITED
3 CERTIFICATE OF NEED REVIEW; TO INCREASE THE MONETARY THRESHOLDS
4 TRIGGERING CERTIFICATE OF NEED REVIEW FOR CAPITAL EXPENDITURES
5 AND THE PURCHASE OF MAJOR MEDICAL EQUIPMENT; TO EXEMPT
6 REPLACEMENT EQUIPMENT FROM CERTIFICATE OF NEED REVIEW
7 REGARDLESS OF COST; TO REQUIRE AFFECTED PERSONS SEEKING TO FILE A
8 PETITION FOR A CONTESTED CASE OR AN APPEAL CHALLENGING
9 CERTIFICATE OF NEED APPROVAL TO DEPOSIT A SEPARATE BOND FOR EACH
10 APPROVED APPLICATION THAT IS THE SUBJECT OF THE PETITION OR
11 APPEAL, TO INCREASE THE AMOUNT OF THE MAXIMUM BOND
12 REQUIREMENT, AND TO GIVE THE COURT OF APPEALS GREATER
13 DISCRETION IN IMPOSING A HIGHER BOND AMOUNT; TO REQUIRE THE
14 COURT TO AWARD COSTS AND A REASONABLE ATTORNEY FEE TO ANY
15 CERTIFICATE OF NEED APPLICANT WHOSE APPROVED NEW INSTITUTIONAL
16 HEALTH SERVICE IS THE SUBJECT OF A CONTESTED CASE PETITION
17 DETERMINED TO BE FRIVOLOUS OR FILED TO DELAY THE APPLICANT; AND
18 TO PROHIBIT THE STAYING OF A FINAL DECISION IN A CERTIFICATE OF
19 NEED CASE DURING THE PENDENCY OF AN APPEAL, AS RECOMMENDED BY
20 THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND
21 RELATED HOSPITAL ISSUES.
22 The General Assembly of North Carolina enacts:
23 **SECTION 1.** G.S. 131E-176(7b) reads as rewritten:
24 "(7b) 'Expedited review' means the status given to an application's review process
25 when the applicant petitions for the review and the Department approves the
26 request based on findings that all of the following are met:
27 a. The review is not competitive.
28 b. ~~The proposed capital expenditure is less than five million dollars~~
29 ~~($5,000,000).~~
30 c. A request for a public hearing is not received within the time frame
31 defined in G.S. 131E-185.

d. The agency has not determined that a public hearing is in the public interest."

SECTION 2. G.S. 131E-176(14o) reads as rewritten:

"(14o) 'Major medical equipment' means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~one million five hundred thousand dollars ($1,500,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section."

SECTION 3. G.S. 131E-176(16)b. reads as rewritten:

"(16) 'New institutional health services' means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~four million dollars ~~($2,000,000).~~($4,000,000).

"

SECTION 4. G.S. 131E-176(22a) reads as rewritten:

"(22a) 'Replacement equipment' means equipment that ~~costs less than two million dollars ($2,000,000) and~~ is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. ~~In determining whether the replacement equipment costs less than two million dollars ($2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~"

SECTION 5. G.S. 131E-184(e) reads as rewritten:

"(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would:

1 a. Be used solely for the purpose of renovating, replacing on the same
2 site, or expanding an existing:
3 1. Nursing home facility,
4 2. Adult care home facility, or
5 3. Intermediate care facility for the mentally retarded; and
6 b. Not result in a change in bed capacity, as defined in
7 G.S. 131E-176(5), or the addition of a health service facility or any
8 other new institutional health service other than that allowed in
9 G.S. 131E-176(16)b.
10 (2) The entity proposing to incur the capital expenditure provides prior written
11 notice to the Department, which notice includes documentation that
12 demonstrates that the proposed capital expenditure would be used for one or
13 more of the following purposes:
14 a. Conversion of semiprivate resident rooms to private rooms.
15 b. Providing innovative, homelike, residential dining spaces, such as
16 cafes, kitchenettes, or private dining areas to accommodate residents
17 and their families or visitors.
18 c. Renovating, replacing, or expanding residential living or common
19 areas to improve the quality of life of residents."
20 **SECTION 6.** G.S. 131E-188(a1) reads as rewritten:
21 **"§ 131E-188. Administrative and judicial review.**
22 (a) After a decision of the Department to issue, deny or withdraw a certificate of need
23 or exemption or to issue a certificate of need pursuant to a settlement agreement with an
24 applicant to the extent permitted by law, any affected person, as defined in subsection (c) of
25 this section, shall be entitled to a contested case hearing under Article 3 of Chapter 150B of the
26 General Statutes. A petition for a contested case shall be filed within 30 days after the
27 Department makes its decision. When a petition is filed, the Department shall send notification
28 of the petition to the proponent of each application that was reviewed with the application for a
29 certificate of need that is the subject of the petition. Any affected person shall be entitled to
30 intervene in a contested case.
31 A contested case shall be conducted in accordance with the following timetable:
32 (1) An administrative law judge or a hearing officer, as appropriate, shall be
33 assigned within 15 days after a petition is filed.
34 (2) The parties shall complete discovery within 90 days after the assignment of
35 the administrative law judge or hearing officer.
36 (3) The hearing at which sworn testimony is taken and evidence is presented
37 shall be held within 45 days after the end of the discovery period.
38 (4) The administrative law judge or hearing officer shall make a final decision
39 within 75 days after the hearing.
40 (5) Repealed by Session Laws 2011-398, s. 46, as amended by Session Laws
41 2011-326, s. 23, effective January 1, 2012, and applicable to contested cases
42 commenced on or after that date.
43 The administrative law judge or hearing officer assigned to a case may extend the deadlines
44 in subdivisions (2) through (4) so long as the administrative law judge or hearing officer makes
45 a final decision in the case within 270 days after the petition is filed.
46 (a1) On or before the date of filing a petition for a contested case hearing on the approval
47 of an applicant for a certificate of need, the petitioner shall deposit a bond <u>for each approved</u>

1 application that is the subject of the petition with the clerk of superior court where ~~the~~ any new
2 institutional health service that is the subject of the petition is proposed to be located. The bond
3 shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of
4 ~~the proposed new institutional health service~~each approved application that is the subject of the
5 petition, but may not be less than five thousand dollars ($5,000) and may not exceed ~~fifty~~
6 ~~thousand dollars ($50,000).~~one hundred thousand dollars ($100,000). A petitioner who received
7 approval for a certificate of need and is contesting only a condition in the certificate is not
8 required to file a bond under this subsection.
9 The applicant who received approval for ~~the~~ any new institutional health service that is the
10 subject of the petition may bring an action against a bond filed under this subsection in the
11 superior court of the county where the bond was filed. Upon finding that the petition for a
12 contested case was frivolous or filed to delay the applicant, the court may award the applicant
13 part or all of the bond filed under this ~~subsection.~~subsection and shall award the applicant
14 reasonable attorney fees and costs incurred in the contested case. At the conclusion of the
15 contested case, if the court does not find that the petition for a contested case was frivolous or
16 filed to delay the applicant, the petitioner shall be entitled to the return of the bond deposited
17 with the superior court upon demonstrating to the clerk of superior court where the bond was
18 filed that the contested case hearing is concluded.
19 (b) Any affected person who was a party in a contested case hearing shall be entitled to
20 judicial review of all or any portion of any final decision in the following manner. The appeal
21 shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal
22 shall be as provided by the rules of appellate procedure. The appeal of the final decision shall
23 be taken within 30 days of the receipt of the written notice of final decision, and notice of
24 appeal shall be filed with the Office of Administrative Hearings and served on the Department
25 and all other affected persons who were parties to the contested hearing. The final decision
26 remains in effect during the pendency of review by the Court of Appeals and the appellant is
27 not entitled to a stay of the final decision pending the outcome of the review. During the
28 pendency of review by the Court of Appeals, the applicant is free to proceed with the
29 development of any approved new institutional health service that is the subject of the final
30 decision. However, the applicant shall not be entitled to recover any damages from either the
31 Department or an appellant for any expenses incurred as a result of proceeding with
32 development prior to a decision by the Court of Appeals.
33 (b1) Before filing an appeal of a final decision granting a certificate of need, the affected
34 person shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of
35 this subsection shall not apply to any appeal filed by the Department.
36 (1) The bond shall be secured by cash or its equivalent in an amount equal to
37 five percent (5%) of the cost of ~~the proposed new institutional health service~~
38 each approved application that is the subject of the appeal, but may not be
39 less than five thousand dollars ($5,000) and may not exceed ~~fifty thousand~~
40 ~~dollars ($50,000);~~one hundred thousand dollars ($100,000); provided that
41 the applicant who received approval of the certificate of need may petition
42 the Court of Appeals for a higher bond amount for the payment of such costs
43 and damages as may be awarded pursuant to subdivision (2) of this
44 subsection. This amount shall be determined by the Court in its ~~discretion,~~
45 ~~not to exceed three hundred thousand dollars ($300,000).~~discretion. A holder
46 of a certificate of need who is appealing only a condition in the certificate is
47 not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of Appeals. If the Court of Appeals does not find that the appeal was frivolous or filed to delay the applicant and does not remand the case to superior court for a possible award of all or part of the bond to the holder of the certificate of need, the person originally filing the bond shall be entitled to a return of the bond.

(c) The term "affected persons" includes: the applicant; any individual residing within the service area or the geographic area served or to be served by the applicant; any individual who regularly uses health service facilities within that geographic area or the service area; any person who provides services, similar to the services under review, to individuals residing within the service area or the geographic area proposed to be served by the applicant; any person who, prior to receipt by the agency of the proposal being reviewed, has provided written notice to the agency of an intention to provide similar services in the future to individuals residing within the service area or the geographic area to be served by the applicant; third party payers who reimburse health service facilities for services in the service area in which the project is proposed to be located; and any agency which establishes rates for health service facilities or HMOs located in the service area in which the project is proposed to be located."

SECTION 7. G.S. 150B-48 reads as rewritten:

"**§ 150B-48. Stay of decision.**

~~At~~Except as prohibited in G.S. 131E-188(b), at any time before or during the review proceeding, the person aggrieved may apply to the reviewing court for an order staying the operation of the administrative decision pending the outcome of the review. The court may grant or deny the stay in its discretion upon such terms as it deems proper and subject to the provisions of G.S. 1A-1, Rule 65."

SECTION 8. This act becomes effective October 1, 2013, and applies to certificate of need applications, contested case petitions, and appeals filed on or after that date.

FINDINGS AND RECOMMENDATIONS

Finding:

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. The Committee heard a variety of presentations and public comment that touched upon the need for alterations to the new institutional health services covered by Certificate of Need. The Committee finds that an in-depth review of services regulated under the Certificate of Need law is necessary.

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<u>Recommendation</u>:

9. **The Committee recommends that the Division of Health Services Regulation monitor and review Policy AC-3 for a period of one year, and then report and make recommendations to the 2013 General Assembly and the General Assembly's Legislative Oversight Committee on Health and Human Services.**

<u>Finding</u>:

The Committee heard concerns that the Certificate of Need appeals process is often lengthy, and that some appeals might be brought solely for purposes of delay. The Committee finds that changes in the appeals process should be made in order to streamline the appeals process, to redefine the parties having standing to appeal, and to deter the bringing of frivolous, harassing, or meritless appeals.

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14. **The Committee recommends a study to determine whether prohibiting the staying of a final decision in a Certificate of Need Case during the pendency of an appeal would expedite the CON process.**

15. **The Committee recommends an examination and possible redefining of the terms "affected person" and "aggrieved party" in the Certificate of Need laws.**

Finding:

Hospital authorities are authorized pursuant to Article 2 of Chapter 131E of the General Statutes. A hospital authority may be created by resolution of the city council or board of county commissioners upon finding that it is in the interest of the public health and welfare to do so. The boundaries of a hospital authority include the city or county creating the authority and the area within 10 miles from the territorial boundaries of the city or county. Hospital authorities may operate outside of this area pursuant to an agreement with another hospital in the county, or if none, with a health care agency. The statutes grant extensive powers to hospital authorities, including the power of eminent domain.

Recommendation:

16. **The Committee recommends the General Assembly should examine how to define the territorial boundaries of hospital authorities.**

Finding:

North Carolina lags slightly in the number of physicians per capita in the U.S. The supply of physicians, however, is growing faster than the State population and the number of physicians in primary care is also on the increase. Unfortunately, there is a persistent problem with poor distribution of physicians across the State. Two programs that have been successful in increasing the number of physicians in rural and underserved areas are the North Carolina Area Health Education Centers (AHEC) residency program and the State Loan Repayment program. Data shows that North Carolina AHEC trained residents are more likely to practice in the rural areas of the State and are more likely to choose primary care than other specialties. The North Carolina Office of Rural Health and Community Care administers the Loan Repayment Program. That program provides up to $100,000 principle plus interest for loan repayments to new physicians locating their practices in rural areas. A four year commitment is required. The Committee finds that the State needs to encourage new physicians to choose specialties that are in short supply and to locate practices in rural, underserved areas.

Recommendation:

17. **The Committee recommends the General Assembly should continue to support the NC AHEC residency program and the NC Office of Rural Health and Community Care Rural Health Loan Repayment Program.**

Finding:

Health care costs in North Carolina continue to increase despite efforts by the State to control them. Most regulatory efforts, whether aimed at managing care or limiting the expansion of facilities and technology to a State determined level of need, end up simply shifting costs from one area to another that is more profitable. Lanier Cansler, Former Secretary of the North Carolina Department of Health and Human Services noted that if the State wants to seriously address the

issues of affordability and sustainability of healthcare in the State "we must develop a vision of our healthcare delivery system and then every modification to law, reimbursement process, policy, must be focused on achieving that vision."

Recommendation:

18. **The General Assembly should study reform of the health care market and the health care delivery system in North Carolina to increase cost effectiveness and quality of care through the encouragement of market driven competition in the provision of health care services.**

Finding:

A Certificate of Public Advantage (COPA) was issued by the State in 1995 as a condition of allowing the merger of Memorial Mission Hospital and St. Joseph's Hospital to go forward. The entity that emerged from the merger process is Mission Hospital, Inc., operated by Mission Health Systems, Inc. ("Mission"). The COPA agreement was required by the State to offset the anticompetitive effects of the merger on the Western North Carolina health care market. Since 1995, the COPA agreement has been modified twice. Mission has submitted the reports required under the statutes and has been determined to be in compliance with the terms of the COPA agreement. Nonetheless, hospitals, health care providers, and individuals continue to raise concerns about the increase in Mission's market power and whether the COPA agreement has been effective in balancing the anticompetitive effects of the merger. Further in-depth investigation into the economic impact of Mission's COPA on the health care market, especially in light of recent changes in the structure of the health care industry, may be necessary to resolve these issues and ensure the provision of low cost, high quality health care to the people in Western North Carolina.

Recommendation:

19. **The Committee recommends that the hospitals, health care providers, and interested individuals in the region make every effort to resolve their differences regarding the COPA prior to the end of the 2013 Session of the General Assembly. If a satisfactory resolution to the issues is not reached in that time, the Committee recommends that the General Assembly conduct a study of the economic impact of the COPA and the effectiveness of that agreement.**

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H D

BILL DRAFT 2013-MG-11D [v.5] (10/24)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
11/30/2012 1:52:16 PM

Short Title:	Amend Certificate of Need Laws.	(Public)
Sponsors:	Representative Avila.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO EXEMPT DIAGNOSTIC CENTERS FROM CERTIFICATE OF NEED REVIEW AND TO AMEND CERTIFICATE OF NEED LAWS PERTAINING TO SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-175 is amended by adding new subdivisions to read:

"(13) That the relocation of a hospital's operating rooms to a location separate from the campus upon which the hospital's inpatient acute care beds and emergency department are located results in a costly and unnecessary economic burden to the public.

(14) That physicians who provide single-specialty ambulatory surgery services in unlicensed settings should be afforded an opportunity to obtain a license to provide these services in order to ensure patient safety and the provision of quality care.

(15) That the demand for ambulatory surgery is increasing due to advances in technology and anesthesia, and single-specialty ambulatory surgery operating rooms are recognized as a highly effective means of expanding access while achieving cost savings regardless of the availability and potential underutilization of hospital-based operating rooms."

SECTION 2. G.S. 131E-176(7a) reads as rewritten:

"(7a) ~~'Diagnostic center' means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~"

SECTION 3. G.S. 131E-176(9b) reads as rewritten:

"(9b) 'Health service facility' means a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; ~~diagnostic center;~~ hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility."

SECTION 4. G.S. 131E-176(16)u. reads as rewritten:

"(16) 'New institutional health services' means any of the following:

…

u. The construction, development, establishment, increase in the number, or relocation of an operating ~~room~~ room, including a single-specialty ambulatory surgery operating room, or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

…."

SECTION 5. G.S. 131E-176(24c) reads as rewritten:

"(24c) ~~Reserved for future codification.~~ 'Single-specialty ambulatory surgery operating room' means a designated operating room located in a licensed ambulatory surgical facility that is used to perform same-day surgical procedures in one of the single-specialty areas identified by the American College of Surgeons. For the purpose of this subdivision, 'same-day surgical procedures' includes pain injections by orthopedists, physiatrists, and anesthesiologists."

SECTION 6.(a) G.S. 131E-178 reads as rewritten:

"**§ 131E-178. Activities requiring certificate of need.**

(a) ~~No~~ Except as otherwise provided in subsections (a1) and (a2) of this section, no person shall offer or develop a new institutional health service without first obtaining a certificate of need from the ~~Department; provided, however, no~~Department.

(a1) Any person proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility, with the existing number of gastrointestinal endoscopy rooms, except for a person who (i) provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed ~~setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:~~setting and (ii) meets all of the following criteria:

(1) The person's license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of

1 Healthcare Organizations, or The American Association for Accreditation of
2 Ambulatory Surgical Facilities by the time the license application is
3 postmarked for delivery to the Division of Health Service Regulation of the
4 Department; and
5 (4) The license application includes a commitment and plan for serving indigent
6 and medically underserved populations.
7 All other persons proposing to obtain a license to establish an
8 ambulatory surgical facility for the provision of gastrointestinal endoscopy
9 procedures shall be required to obtain a certificate of need. The annual State
10 Medical Facilities Plan shall not include policies or need determinations that
11 limit the number of gastrointestinal endoscopy rooms that may be approved.
12 (a2) Any person proposing to obtain a license to establish single-specialty ambulatory
13 operating rooms in an ambulatory surgery facility shall be required to obtain a certificate of
14 need, except for a person who (i) provides single-specialty ambulatory surgery procedures in
15 one or more operating rooms located in a nonlicensed setting and (ii) meets all of the following
16 criteria:
17 (1) The person's license application is postmarked for delivery to the Division of
18 Health Service Regulation by December 31, 2013.
19 (2) The applicant verifies, by affidavit submitted to the Division of Health
20 Service Regulation within 60 days of the effective date of this act, that the
21 facility is in operation as of the effective date of this act or that the
22 completed application for the building permit for the facility was submitted
23 by the effective date of this act;
24 (3) The facility has been accredited by The Accreditation Association for
25 Ambulatory Health Care, The Joint Commission on Accreditation of
26 Healthcare Organizations, or The American Association for Accreditation of
27 Ambulatory Surgical Facilities by the time the license application is
28 postmarked for delivery to the Division of Health Service Regulation of the
29 Department; and
30 (4) The license application includes at least all of the following:
31 a. A commitment, plan, and policies and procedures for serving
32 indigent and medically underserved populations.
33 b. Projected charges for the 20 most common surgical procedures to be
34 performed in the proposed single-specialty ambulatory surgery
35 operating rooms.
36 All other persons proposing to obtain a license to establish
37 single-specialty ambulatory operating rooms within an ambulatory surgical
38 facility shall be required to obtain a certificate of need. The annual State
39 Medical Facilities Plan shall not include policies or need determinations that
40 limit the number of single-specialty ambulatory surgery operating rooms that
41 may be approved. However, the Department shall not approve an application
42 for a single-specialty ambulatory surgery operating room in any ambulatory
43 surgical facility within a county in which a licensed critical access hospital,
44 as defined in 42 CFR § 400.202, is located. The annual State Medical
45 Facilities Plan also shall not include policies or need determinations that
46 limit the relocation and replacement of existing operating rooms, including
47 single-specialty ambulatory operating rooms. However, the Department shall
48 not approve an application for the relocation of a hospital's operating rooms
49 to a location separate from the campus upon which the hospital's inpatient
50 acute care beds and emergency department are located if approval would
51 result in the hospital obtaining reimbursement for surgery procedures at a

rate higher than the rate paid to ambulatory surgery centers under a government sponsored health insurance or medical assistance program.

(b) No person shall make an acquisition by donation, lease, transfer, or comparable arrangement without first obtaining a certificate of need from the Department, if the acquisition would have been a new institutional health service if it had been made by purchase. In determining whether an acquisition would have been a new institutional health service, the capital expenditure for the asset shall be deemed to be the fair market value of the asset or the cost of the asset, whichever is greater.

(c) No person shall incur an obligation for a capital expenditure which is a new institutional health service without first obtaining a certificate of need from the Department. An obligation for a capital expenditure is incurred when:

(1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the construction, acquisition, lease or financing of a capital asset;

(2) A person takes formal action to commit funds for a construction project undertaken as his own contractor; or

(3) In the case of donated property, the date on which the gift is completed.

(d) Where the estimated cost of a proposed capital expenditure, including the fair market value of equipment acquired by purchase, lease, transfer, or other comparable arrangement, is certified by a licensed architect or engineer to be equal to or less than the expenditure minimum for capital expenditure for new institutional health services, such expenditure shall be deemed not to exceed the amount for new institutional health services regardless of the actual amount expended, provided that the following conditions are met:

(1) The certified estimated cost is prepared in writing 60 days or more before the obligation for the capital expenditure is incurred. Certified cost estimates shall be available for inspection at the facility and sent to the Department upon its request.

(2) The facility on whose behalf the expenditure was made notifies the Department in writing within 30 days of the date on which such expenditure is made if the expenditure exceeds the expenditure minimum for capital expenditures. The notice shall include a copy of the certified cost estimate.

(e) The Department may grant certificates of need which permit capital expenditures only for predevelopment activities. Predevelopment activities include the preparation of architectural designs, plans, working drawings, or specifications, the preparation of studies and surveys, and the acquisition of a potential site."

SECTION 7. G.S. 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same service area will be reviewed together. However, the Department is prohibited from scheduling a review prior to February 1, 2013, for certificate of need applications that propose to establish a licensed single-specialty ambulatory operating room within an ambulatory surgery facility.

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require such information as the Department, by its rules deems necessary to conduct the review. An applicant shall be required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria implemented under G.S. 131E-183 and with duly adopted standards, plans and criteria. The application form for a certificate of need to establish a single-specialty ambulatory surgery operating room within an ambulatory surgery facility shall require the applicant to (i) include a written commitment, plan, and policies and procedures for serving indigent and medically underserved

1 populations, (ii) furnish the projected charges for the 20 most common surgical procedures to
2 be performed in the proposed operating room, and (iii) demonstrate that it is performing or
3 reasonably expects to perform at least 800 single-specialty ambulatory procedures per licensed
4 single-specialty ambulatory operating room per year.
5 (c) An application fee is imposed on an applicant for a certificate of need. An applicant
6 must submit the fee with the application. The fee is not refundable, regardless of whether a
7 certificate of need is issued. Fees collected under this section shall be credited to the General
8 Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount
9 equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in
10 the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed
11 fifty thousand dollars ($50,000)."
12 **SECTION 8.** G.S. 131E-184(a) is amended by adding a new subdivision to read:
13 "(10) To develop, acquire, or replace an institutional health service that obtained
14 certificate of need approval prior to the effective date of this act as a
15 diagnostic center. For the purpose of this subdivision, 'diagnostic center'
16 means a freestanding facility, program, or provider, including but not limited
17 to, physicians' offices, clinical laboratories, radiology centers, and mobile
18 diagnostic programs, in which the total cost of all the medical diagnostic
19 equipment utilized by the facility that cost ten thousand dollars ($10,000) or
20 more exceeds five hundred thousand dollars ($500,000), unless a new
21 institutional health service other than those defined in G.S. 131E-176(16)b.
22 is offered or developed in the building."
23 **SECTION 9.** Nothing in this act shall be construed to reflect any legislative intent
24 as to the circumstances under which Medicare or Medicaid certification may be obtained for a
25 provider of ambulatory surgery services.
26 **SECTION 10.** This act is effective when it becomes law. Section 7 of this act
27 expires on the effective date of administrative rules adopted consistent with the provisions of
28 this act regarding the number of single-specialty surgery procedures performed or projected to
29 be performed by applicants seeking to establish a licensed single-specialty ambulatory surgery
30 operating room.

Draft Bill 2013-MG-11C

AN ACT TO AMEND CERTIFICATE OF NEED LAWS PERTAINING TO DIAGNOSTIC CENTERS, AND SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS

BILL SUMMARY AND EXPLANATION

The draft bill makes several changes to the Certificate of Need law.

Section 1. GS 131E-175 is amended by adding new subdivisions to read:

> "(13) That the relocation of hospital-licensed operating rooms to a location separate from the campus upon which the hospital's inpatient acute care beds and emergency department are located results in costly and unnecessary economic burden on the public.
> (14) That physicians who provide single-specialty ambulatory surgery services in unlicensed settings should be afforded an opportunity to obtain a license to provide these services in order to ensure patient safety and the provision of quality care.
> (15) That demand for ambulatory surgery is increasing due to changes in technology and advances in anesthesia, and single-specialty ambulatory surgery operating rooms are recognized as a highly effective means of expanding access while achieving cost savings regardless of the availability and potential underutilization of hospital-based operating rooms."

Explanation of Section 1: GS 131E-175 is amended to expand the CON Findings of Fact regarding relocations of licensed hospital operating rooms to other facility locations that result in the expansion of high cost surgical services. Hospital-based operating rooms are reimbursed at 40 percent higher rates by government payors and insurers as compared to ambulatory surgery operating rooms in freestanding licensed ambulatory surgical centers. Physicians providing single-specialty ambulatory surgical services in an unlicensed setting are provided with an opportunity to obtain licensure and certification. Single specialty ambulatory surgery centers can be staffed efficiently and operated at high capacity to enhanced patient access to safe, convenient, and cost-effective services in full compliance with licensure rules and accreditation standards.

SECTION 2. G.S. 131-176 (7a) reads as rewritten:

> ~~(7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater."~~

SECTION 3. G.S. 131E-176(9b) reads as rewritten:

(9b) "Health service facility" means a hospital, long term care hospital, psychiatric facility, rehabilitation facility, nursing home facility, adult care home, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility for the mentally retarded, home health agency office, chemical dependency treatment facility, ~~diagnostic center~~, hospice office, hospice inpatient facility, hospice residential care facility, and ambulatory surgical facility.

SECTION 4. G.S. 131E-176(16)u reads as rewritten:

"(16) 'New institutional health services' means any of the following:

...

u. The construction, development, establishment, increase in the number, or relocation of an operating room , including a single-specialty ambulatory surgery operating room, or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

SECTION 5. G.S. 131E-176(24c) reads as rewritten:

"(24c) ~~Reserved for future codification~~ 'Single-specialty ambulatory surgery operating room' means a designated operating room located in a licensed ambulatory surgical facility that is used to perform same-day surgical procedures for any one of the single-specialty areas as defined by the American College of Surgeons. For the purpose of this subdivision, "same – day surgical procedures include pain injections by orthopaedists, physiatrists, and anesthesiologists."

Explanation of Sections 2, 3, 4 and 5:

The (7a) definition of "diagnostic centers" is deleted because the CON regulation of this type of an institutional health service is not effective. This regulation is often misinterpreted, ignored and unenforceable. The equipment cost threshold of $500,000 does not take into consideration the fact that equipment is depreciated over time and new technology, such as digital equipment, has a higher cost. This portion of the CON law is a barrier for physicians to obtain modern imaging equipment including x-ray, ultrasound, mammography, and CT scanners.

The bill amends the definition of (9b) "health service facility" to delete diagnostic centers from the list of types of CON regulated facilities.

Also, the bill amends the definition of (16) "new institutional health services" to add single-specialty ambulatory surgery operating room to explain that changes in the number and location

of these single-specialty operating rooms in licensed facilities are subject to the same CON regulatory process as operating rooms and gastrointestinal procedure rooms.

A new definition is added in (24a) to differentiate the single-specialty ambulatory surgery operating room from the generic "operating room".

SECTION 6 G.S. 131E-178 reads as rewritten:

"§ 131E-178. Activities requiring certificate of need
(a) ~~No~~ Except as otherwise provided in subsections(a1) and (a2) of this section, no person shall develop a new institutional health service without first obtaining a certificate of need from the ~~Department; provided, however, no~~ Department,

(a1) Any person proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility, with the existing number of gastrointestinal endoscopy rooms, except for a person who (i) provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed ~~setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:~~ setting and (ii) meets all of the following criteria:

(1) The person's license application is postmarked for delivery to the Division of 43 Health Service Regulation by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Health 45 Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for 50 Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and

(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.

Explanation of Sections 6. G.S. 131E-178 (a), (a1) (1), (2), (3) and (4):

This original language in this section of the bill reflects the changes that occurred in 2005 when the legislature amended CON law to allow existing gastrointestinal endoscopy procedure rooms in unlicensed settings to seek licensure if certain conditions were met. The changes in the text of this section of the bill are made to rephrase and simplify the legal writing.

The next section of the bill adds new text with similar conditions for the single-specialty ambulatory surgery operating rooms.

SECTION 6 G.S. 131E-178 reads as rewritten:

" (a2) Any person proposing to obtain a license to establish single-specialty ambulatory surgery operating rooms in an ambulatory surgery facility shall be required to obtain a certificate of need, except for a person who (i) provides single-specialty ambulatory surgery procedures in one or more operating rooms located in a nonlicensed setting and (ii) meets the following criteria:

(1) The person's license application is postmarked for delivery to the Division of Facility Services by December 31, 2013.

(2) The applicant verifies, by affidavit submitted to the Division of Facility Services within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Facility Services of the Department; and

(4) The license application includes at least all of the following:
a. A commitment, policies and procedures and plan for serving indigent and medically underserved populations.
(b) Projected charges for the 20 most common surgical procedures to be performed in the proposed single-specialty ambulatory surgery operating room."

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of single-specialty ambulatory surgery procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of single-specialty ambulatory surgery operating rooms that may be approved. However, the Department shall not approve an application for any ambulatory surgery facility within a county in which a licensed critical access hospital, as defined in 42 CFR§ 400.202, is located.

The annual State Medical Facilities Plan shall not include policies or need determinations that limit the relocations and replacement of existing operating rooms, including single-specialty ambulatory surgery operating rooms. However, the Department shall not approve an application for the relocation of a hospital's operating rooms to a facility on premises separated from the premises upon which a hospital's inpatient acute care beds and emergency department are located if approval would result in the hospital obtaining reimbursement for surgery procedures at a higher rate than the rate paid to ambulatory surgery centers under a government sponsored or medical assistance program."

Explanation of Section 6 G.S. 131E-178 (a2), (1), (2), (3) and (4) and subsequent text above:

The bill provides an opportunity for persons with existing unlicensed operating rooms to obtain licensure as a single-specialty ambulatory surgical facility without having to obtain CON approval if the criteria are met within the specified timeframe. This section of the bill is modeled after the 2005 changes to the CON law that allowed facilities with unlicensed gastroenterology procedure rooms to become licensed ambulatory surgical facilities.

The bill also states that all other persons must seek CON approval to develop single-specialty ambulatory surgery operating rooms in a licensed facility. The bill prohibits the Department from approving an application in any of the 23 counties that have a critical access hospital. Critical Access Hospitals are the smallest facilities and often have limited financial resources.

The bill states that the State Medical Facilities Plan should not limit relocations and replacements of existing operating rooms, including single-specialty operating rooms. However, the Department shall not approve the relocation of hospital operating rooms to a separate campus location that would allow the higher "hospital-based" reimbursement rates as opposed to the lower ambulatory surgical facility rates.

Explanation of Section 6 G.S. 131E-178 (b), (c), (d) and (e): This portion of the draft bill includes no changes from the existing CON law. This information is provided in the bill so that the proposed amendments can be read in the context of the CON capital costs.

SECTION 7 GS 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of complete applications. The schedules shall provide that applications for similar proposals in the same service areas will be reviewed together. However, the Department is prohibited from scheduling a review prior to February 1, 2013, for certificate of need applications that propose to establish a licensed single-specialty ambulatory operating room within an ambulatory surgery facility.

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require information as the Department, by its rules, deems necessary to conduct the review.

An applicant shall be required to furnish only that information necessary to determine whether the proposed new institutional health services is consistent with the review criteria implemented under G.S. 131E-183 and with the duly adopted standards, plan and criteria. The application for a certificate of need to establish a single-specialty ambulatory surgery operating room within an ambulatory surgery facility shall require the applicant to (i) include a written commitment, plan and policies and procedures for serving indigent and medically underserved populations, (ii) furnish the projected charges for the 20 most common surgical procedures to be performed in the proposed operating rooms and (iii) demonstrate that it is performing or reasonably expects to perform at least 800 single-specialty procedures per licensed single-specialty ambulatory operating room per year.

(c) An application fee is imposed on an applicant for a certificate of need. An applicant must submit the fee with the application. The fee is not refundable, regardless of whether a certificate of need is issued. Fees collected under this section shall be credited to the General Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed fifty thousand dollars ($50,000)."

Explanation of Section 7 GS 131E-182(a), (b) and (c): This section of the CON law specifies that Certificate of Need applications for single-specialty ambulatory surgical operating rooms will have due dates no earlier than February 2013 assuming that the bill has passed prior to this date. The initial CON dues dates for single-specialty operating rooms need to be delayed several months after any changes to the CON law to allow the Department and potential applicants adequate time to respond.

The bill requires that the applications for single-specialty ambulatory surgery operating rooms must document their commitment to serve indigent and medically underserved patients, provide projected charges and meet the performance standard of 800 annual procedures. The 800 annual procedures are recommended to allow adequate time to perform more complex cases and achieve financial viability. Setting a higher standard could potentially limit physicians from providing hospital coverage due to time constraints.

SECTION 8. G.S. 131E-184(a) is amended by adding a new subdivision to read:

"(10) To develop, acquire, or replace an institutional health service that obtained CON approval as a diagnostic center prior to the date of this bill; the institutional health service was defined as a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all medical diagnostic equipment utilized by the facility which costs ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars, unless a new institutional health service other that those defined in G.S. 131E-176(16)b is offered or developed in the building.

Explanation of Section 8 GS 131E-184: The draft bill adds a new type of exemption from CON regulation to remedy the potential unintended consequences of deleting "diagnostic centers" from the list of institutional health services. Even though the definition of diagnostic centers is being eliminated, there are still facilities that will continue to be categorized as institutional health services because they previously obtained CON approval as a diagnostic center. This new exemption allows these previously-approved diagnostic centers to be exempt from having to submit another CON application in order to change ownership, relocate or replace their equipment.

SECTION 9. Nothing in this act shall be construed to reflect any legislative intent as to the circumstances under which Medicare or Medicaid certification may be obtained for a provider of ambulatory surgery services.

Explanation of Section 9: This bill provides a means for single-specialty ambulatory surgery operating rooms to be developed in licensed facilities. The bill does not seek to change Medicare / Medicaid requirements.

SECTION 10. This act is effective when it becomes law. Section 7 of this act expires on the effective date of administrative rules adopted consistent with the provisions of this act regarding the number of single-specialty surgery procedures performed or projected to be performed by applicants.

Explanation of Section 10: Included in Section 7 of this bill are information requirements and performance standards that relate to single-specialty ambulatory surgery operating rooms. After the bill is enacted, the Department is expected to promulgate administrative rules that are consistent with these initial requirements.

NORTH CAROLINA GENERAL ASSEMBLY

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES

FINAL REPORT
TO THE
2013 HOUSE OF REPRESENTATIVES

DECEMBER 2012

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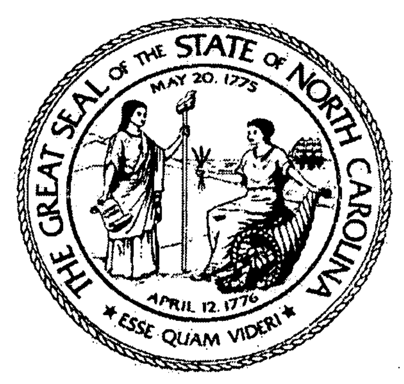
2013-MGz-16
AN ACT TO ELIMINATE THE MONETARY THRESHOLD FOR EXPEDITED CERTIFICATE OF NEED REVIEW; TO INCREASE THE MONETARY THRESHOLDS TRIGGERING CERTIFICATE OF NEED REVIEW FOR CAPITAL EXPENDITURES AND THE PURCHASE OF MAJOR MEDICAL EQUIPMENT; TO EXEMPT REPLACEMENT EQUIPMENT FROM CERTIFICATE OF NEED REVIEW REGARDLESS OF COST; TO REQUIRE AFFECTED PERSONS SEEKING TO FILE A PETITION FOR A CONTESTED CASE OR AN APPEAL CHALLENGING CERTIFICATE OF NEED APPROVAL TO DEPOSIT A SEPARATE BOND FOR EACH APPROVED APPLICATION THAT IS THE SUBJECT OF THE PETITION OR APPEAL, TO INCREASE THE AMOUNT OF THE MAXIMUM BOND REQUIREMENT, AND TO GIVE THE COURT OF APPEALS GREATER DISCRETION IN IMPOSING A HIGHER BOND AMOUNT; AND TO REQUIRE THE COURT TO AWARD COSTS AND A REASONABLE ATTORNEY FEE TO ANY CERTIFICATE OF NEED APPLICANT WHOSE APPROVED NEW INSTITUTIONAL HEALTH SERVICE IS THE SUBJECT OF A CONTESTED CASE PETITION DETERMINED TO BE FRIVOLOUS OR FILED TO DELAY THE APPLICANT, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

2013-MG-11D
AN ACT TO EXEMPT DIAGNOSTIC CENTERS FROM CERTIFICATE OF NEED REVIEW AND TO AMEND CERTIFICATE OF NEED LAWS PERTAINING TO SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS.

TRANSMITTAL LETTER

STATE OF NORTH CAROLINA

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES



December 2012

TO THE MEMBERS OF THE 2013 HOUSE OF REPRESENTATIVES:

Attached for your consideration is the interim report of the House Select Committee on the Certificate of Need Process and Related Hospital Issues established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Respectfully submitted,

Representative Fred Steen
Co-Chair

Representative John Torbett
Co-Chair

COMMITTEE AUTHORIZATION

Office of Speaker Thom Tillis
North Carolina House of Representatives
Raleigh, North Carolina 27601-1096

HOUSE SELECT COMMITTEE ON THE CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES.

TO THE HONORABLE MEMBERS OF THE NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on the Certificate of Need Process and Related Hospital Issues (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1) and Rule 26 of the Rules of the House of Representatives of the 2011 General Assembly.

Section 2. The Committee consists of the 11 members listed below, appointed by the Speaker of the House of Representatives. Members serve at the pleasure of the Speaker of the House of Representatives. The Speaker of the House of Representatives may dissolve the Committee at any time.

Representative Fred Steen, Co-Chair
Representative John Torbett, Co-Chair
Representative Jamie Boles
Representative Mark Hollo
Representative Bill Current
Representative Marilyn Avila
Representative Jeff Collins
Representative Shirley Randleman
Representative Rick Glazier
Representative Martha Alexander
Representative Marcus Brandon

Section 3. The Committee may study all of the following:

(1) The provisions of House Bill 743, First Edition, 2011 Regular Session and House Bill 812, First Edition, 2011 Regular Session.

(2) The legal requirements and process governing Department of Health and Human Services determinations on applications for CON, including an analysis of exceptions granted under policy AC-3 of the State Medical Facilities Plan as implemented by the Department of Health and Human Services.

(3) Issues relating to publicly owned hospitals, including determining the appropriate role of State-owned hospitals and the appropriate manner for public hospital authorities created under G.S. 131E-17 to operate beyond the boundaries of the local government that created the authority.

(4) Whether a hospital operating under a Certificate of Public Advantage should be required to comply with the same rules, policies, and limitations to each county in which it operates.

(5) The extent to which a publicly owned hospital should engage in business with an entity having a Certificate of Public Advantage or operating under an exemption under the CON laws of the State.

(6) Any other matter reasonably related to subdivisions (1) through (4) of this section, in the discretion of the Committee.

Section 4. The Committee shall meet upon the call of its Co-Chairs. A quorum of the Committee shall be a majority of its members.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1.

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit an interim report on the results of the study, including any proposed legislation, on or before May 1, 2012, by filing a copy of the report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the House of Representatives prior to the convening of the 2013 General Assembly by filing the final report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative Library. The Committee terminates upon the convening of the 2013 General Assembly or upon the filing of its final report, whichever occurs first.

Effective this the 24th day of August, 2011

Thom Tillis
Speaker

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PREFACE

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. This health care planning process seeks to ensure that rural areas and underserved populations have adequate access to health care; to encourage safety and high quality in the health care services provided; and to reduce health care costs through the elimination of unnecessarily duplicative expensive facilities, equipment, and services. To accomplish these goals, the statutes require the development of annual projections of need for various types of health care facilities and services.[1] The resulting document is known as the State Medical Facilities Plan (SMFP). To implement the SMFP, the General Assembly enacted the Certificate of Need Law,[2] which provides the process by which persons may apply for a license to construct or expand health care facilities or to provide services in accordance with the determined need.

In addition to the SMFP and the CON law, the State has also taken steps to enhance the availability of quality health care services by allowing hospitals and other persons to enter into cooperative agreements for the provision of health care that would otherwise be subject to State antitrust scrutiny.[3] Such agreements are subject to the issuance, by the State, of a Certificate of Public Advantage (COPA). The COPA spells out conditions of operation imposed upon the parties to the agreement that, in theory, should counterbalance any competitive advantage gained in the health care marketplace under the cooperative agreement. Only one COPA has been issued since the enactment of the statute in 1993.

Although the Certificate of Need law has been amended several times since enacted, it has been a number of years since the General Assembly undertook a serious review of the program.[4] Further, there is concern that our Certificate of Public Advantage law has not adequately offset the competitive advantage gained under the cooperative agreement, and it is unclear if Article 9A provides a definitive process to initiate the termination of an agreement.

The House Select Committee on the Certificate of Need Process and Related Hospital Issues was created and charged with the review of the State health planning process, including the State's CON program and the implementation of the COPA law, to determine whether these programs are adequately serving their intended purpose of ensuring the availability of quality, cost effective health care services to North Carolina citizens. The Committee began its work in September of 2011 and filed an interim report on its proceedings with the General Assembly. This report covers the activities of the Committee from September of 2012 through its termination.

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[1]. G.S. 131E-177
[2] Article 9, Chapter 131E of the General Statutes
[3] Article 9A, Chapter 131E of the General Statutes.
[4] 1991, Legislative Research Commission: Committee on Care Provided by Rest Homes, Intermediate Care Facilities, and Skilled Nursing Homes; Necessity for Certificates of Need; and Continuing Care Issues.

COMMITTEE PROCEEDINGS

Below is a brief summary of the Committee's proceedings. A more detailed record of the Committee's work can be found in the Committee's notebook, located in the Legislative Library. For meetings September 2011 – April 2012, please see the Interim Report dated April 2012.

September 13, 2012

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, September 13, 2012, in Room 544, LOB at 1:00 p.m. First Amy Jo Johnson and Jan Paul, staff attorneys in the Research Division, presented a review of topics before the committee. Next Drexdal Pratt, Director, Division of Health Services Regulation, Department of Health and Human Services gave an update on activities at the Division of Health Service Regulation since the Committee's last meeting. Before adjourning the meeting, Representative Torbett opened the meeting for a period of public comment.

September 27, 2012

The House Select Committee on the Certificate of Need Process and Related Hospital Issues met Thursday, September 27, 2012, in Room 544 of the Legislative Office Building at 10:00 a.m. Craig Smith, Chief, Certificate of Need Section, Division of Health Services Regulation, Department of Health and Human Services gave a presentation detailing the scope of the Certificate of Need Law and all new health service regulations included within the law. Next, the Committee heard two presentations from Dave French, MBA, MHA, President, Strategic Healthcare Consultants. Mr. French's initial presentation gave a history of the 2005 changes in the Certificate of Need Law that involved GI Endoscopy Centers. The presentation also explored potential cost savings and justifications for making changes to the Certificate of Need Law proposed by Mr. French. Changes suggested would allow for single-specialty ambulatory surgery centers. Mr. French followed this presentation with another detailing the current regulations under Certificate of Need law for diagnostic service centers. Finally, Hugh Tilson, Senior Vice President, North Carolina Hospital Association made a presentation to the Committee discussing various hospital quality improvement activities that have taken place. This presentation included a demonstration of the North Carolina Hospital Association's website, which contains reports on the various activities of which Mr. Tilson spoke.

October 11, 2012

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 11, 2012, in Room 643, LOB at 10:00 a.m. First, Hugh Tilson, Senior Vice President, North Carolina Hospital Association (NCHA) gave a follow-up presentation on the information available via the NCHA website. Next, Lanier Cansler, President, Cansler Collaborative Resources, Inc., Former Secretary, North Carolina Department of Health and Human Resources gave a presentation on planning for the future of healthcare in North Carolina. After the Committee heard from Lanier Cansler, Dr. Thomas Ricketts, Professor, Health Policy and Administration, Deputy Director, Cecil G Sheps Center for Health Services Research gave a

presentation on the supply and demand of physicians in North Carolina. Finally, Earl Jones, Chairman, Good Hope Hospital, Pat Cameron, Chairman, Good Hope Mental Health, Patsy Caron, Mayor of Erwin, and Jim Burgin, Commissioner, Harnett County updated the Committee on the impact of the CON law on the citizens of Harnett County.

October 25, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, October 25, 2012, in Room 544 of the Legislative Office Building at 1pm. The Committee heard three presentations. The first speaker was Noah H. Huffstetler, III, Attorney and Partner at Nelson Mullins. Mr. Huffstetler discussed reasons to maintain the State's Certificate of Need program, noted several improvements that had been made by the Division of Health Service Regulation, Department of Health and Human Services, over the past year, and made a number of recommendations for improvements to the program. The next speaker was Dave French, MBA, MHA, President of Strategic Health Care. His presentation detailed the cost savings and justification for changing the Certificate of Need law to allow single-specialty ambulatory surgical centers. The final speaker, Hugh Tilson, Senior Vice President of the North Carolina Hospital Association, provided the hospital perspective on the changes proposed by Mr. French, and noted hospitals rely on commercially insured patients to cover the cost of providing care to the uninsured and those covered by government programs.

November 15, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, November 15, 2012, in Room 643 of the Legislative Office Building at 10:00 am. First, the Committee heard from the following presenters on the Certificate of Public Advantage Audit:

- Christopher B. Taylor, CPA, Assistant Secretary, North Carolina Medical Care Commission
- K. D. (Kip) Sturgis, Assistant Attorney General, North Carolina Department of Justice
- David Motsinger, CPA, Partner, Dixon Hughes Goodman LLP

Next, Jan Paul, Staff Attorney, Research Division gave an update on the recent Court of Appeals decision in *Novant Health v. NC DHHS*. Lastly, Chairman Torbett requested that the Committee work on finalizing recommendations for the Committee report. The Committee discussed its recommendations and the Chair directed staff to assemble a draft report for the Committee's consideration at the December meeting.

December 6, 2012

The House Select Committee on Certificate of Need Process and Related Hospital Issues met Thursday, December 6, 2012, in Room 544 of the Legislative Office Building at 10:00 am. The Committee discussed and voted on a draft of the final report.

FINDINGS AND RECOMMENDATIONS

Finding:

The development of health care facilities and provision of health care services in North Carolina has been subject to State-level regulation and determinations of need since the late 1970's. The Committee heard a variety of presentations and public comment that touched upon the need for alterations to the new institutional health services covered by Certificate of Need. The Committee finds that an in-depth review of services regulated under the Certificate of Need law is necessary.

Recommendation:

1. **The Committee recommends a full and a complete review of all new institutional health services regulated under Certificate of Need law to determine the need and rationale for each included service regulation.**

2. **The Committee recommends the General Assembly enact legislation exempting diagnostic centers from Certificate of Need Review and amending the Certificate of Need laws pertaining to single-specialty ambulatory surgery operating rooms.**

Finding:

The Committee heard concerns that the specified capital expenditures amounts for certain projects and activities need to be adjusted based upon inflation. The statutory expenditure thresholds have not been changed since 1993 regarding expedited reviews, major medical equipment, and replacement equipment. The capital expenditure threshold for new institutional health services has been set at two million dollars since 1987. The Committee finds that many of the monetary thresholds are outdated or no longer relevant.

Recommendations:

3. **The Committee recommends the General Assembly increase the capital expenditure threshold for new institutional health services from two million dollars to four million dollars.**

4. **The Committee recommends the General Assembly eliminate the monetary threshold for expedited reviews.**

5. **The Committee recommends the General Assembly eliminate replacement equipment from the Certificate of Need process.**

6. **The Committee recommends the General Assembly increase the monetary threshold for major medical equipment from seven hundred fifty thousand dollars to one and a half million dollars.**

Finding:

The Committee heard from parties who had an approved Certificate of Need application and, due to a change in circumstances, encountered difficulty making alterations to its Certificate of Need. This need for alterations is only increased during difficult economic situations. The Committee finds that looking into methods by which a modification to an approved Certificate of Need application could be made is prudent.

Recommendation:

7. **The Committee recommends studying ways to make it easier and more efficient to modify or change an approved Certificate of Need, particularly in light of an applicant's change in financial situation, and under which instances this should apply.**

Finding:

Pursuant to G.S. 131E-177, the Department of Health and Human Services is designated as the State Health Planning and Development Agency. The State Health Coordinating Council (SHCC) is responsible for directing the development of the annual State Medical Facilities Plan. The SHCC was established via executive order by the Governor and contains appointments from the Governor. The SHCC is subject to ethics guidelines also established via Governor executive order. The Committee received comment expressing a need for more transparency and accountability by the State Health Coordinating Council and its decisions affecting the development of the State Medical Facilities Plan. The Committee finds, while it is necessary for the State Health Coordinating Council members to have experience and expertise in the health care industry, there are concerns of member conflicts of interest, the potential for undue influence by a single individual, and public perception. The Committee finds that these concerns could be lessened by changing the current appointment process of members to the State Health Coordinating Council.

Recommendations:

8. **The Committee recommends a codification of the State Health Coordinating Council. The appointments to the Council should be divided amongst the legislative and executive branches.**

9. **Upon codification of the State Health Coordinating Council, the members should adhere to ethical standards and conflict of interest provisions set by the General Assembly. These ethical standards should strive to eliminate any appearance of undue influence.**

Finding:

The Department of Health and Human Services is authorized by statute to establish policies and rules for project review. Policy AC-3 of the North Carolina State Medical Facilities Plan exempts from the need determinations of the State Medical Facilities Plan certain projects for which Certificates of Need are sought by academic medical center teaching hospitals. The academic medical center is required to demonstrate that the expansion is necessary and that its need cannot be achieved effectively at any non-academic medical center teaching hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the academic medical center teaching hospital. Presentations and discussion brought into question the issue of whether the Policy AC-3 was equitable, or whether it created an unfair and unnecessary competitive advantage for academic medical centers. Discussion was centered on eliminating the AC-3 policy, codifying it, or studying it. The Committee was informed that Policy AC-3 was revised in the 2012 State Medical Facilities Plan, which added additional requirements for a Policy AC-3 exemption, and that there has been insufficient time and opportunity to determine whether the policy changes will alleviate or eliminate the issues of concern.

Recommendation:

10. **The Committee recommends that the Division of Health Services Regulation monitor and review Policy AC-3 for a period of one year, and then report and make recommendations to the 2013 General Assembly and the General Assembly's Legislative Oversight Committee on Health and Human Services.**

Finding:

The Committee heard concerns that the Certificate of Need appeals process is often lengthy, and that some appeals might be brought solely for purposes of delay. The Committee finds that changes in the appeals process should be made in order to streamline the appeals process, to redefine the parties having standing to appeal, and to deter the bringing of frivolous, harassing, or meritless appeals.

Recommendations:

11. **The Committee recommends a study to assess the need for a reduction in the appeals process time frames in Certificate of Need cases and to determine methods by which to accomplish this goal.**

12. **The Committee recommends the General Assembly enact legislation to award the prevailing party costs and attorneys' fees in Certificate of Need contested cases.**

13. **The Committee recommends the General Assembly enact legislation giving the appellate court greater discretion to impose a higher appeal bond amount in Certificate of Need cases.**

14. **The Committee recommends the General Assembly enact legislation requiring the posting of a separate appeal bond for each approved application that is the subject of a petition for contested case hearing or appeal of a Certificate of Need determination.**

15. **The Committee recommends a study to determine whether prohibiting the staying of a final decision in a Certificate of Need Case during the pendency of an appeal would expedite the CON process.**

16. **The Committee recommends an examination and possible redefining of the terms "affected person" and "aggrieved party" in the Certificate of Need laws.**

Finding:

Hospital authorities are authorized pursuant to Article 2 of Chapter 131E of the General Statutes. A hospital authority may be created by resolution of the city council or board of county commissioners upon finding that it is in the interest of the public health and welfare to do so. The boundaries of a hospital authority include the city or county creating the authority and the area within 10 miles from the territorial boundaries of the city or county. Hospital authorities may operate outside of this area pursuant to an agreement with another hospital in the county, or if none, with a health care agency. The statutes grant extensive powers to hospital authorities, including the power of eminent domain.

Recommendation:

17. **The Committee recommends the General Assembly should examine how to define the territorial boundaries of hospital authorities.**

Finding:

North Carolina lags slightly in the number of physicians per capita in the U.S. The supply of physicians, however, is growing faster than the State population and the number of physicians in primary care is also on the increase. Unfortunately, there is a persistent problem with poor distribution of physicians across the State. Two programs that have been successful in increasing the number of physicians in rural and underserved areas are the North Carolina Area Health Education Centers (AHEC) residency program and the State Loan Repayment program. Data shows that North Carolina AHEC trained residents are more likely to practice in the rural areas of the State and are more likely to choose primary care than other specialties. The North Carolina Office of Rural Health and Community Care administers the Loan Repayment Program. That program provides up to $100,000 principle plus interest for loan repayments to new physicians locating their practices in rural areas. A four year commitment is required. The Committee finds that the State needs to encourage new physicians to choose specialties that are in short supply and to locate practices in rural, underserved areas.

Recommendation:

18. **The Committee recommends the General Assembly should continue to support the NC AHEC residency program and the NC Office of Rural Health and Community Care Rural Health Loan Repayment Program.**

Finding:

Health care costs in North Carolina continue to increase despite efforts by the State to control them. Most regulatory efforts, whether aimed at managing care or limiting the expansion of facilities and technology to a State determined level of need, end up simply shifting costs from one area to another that is more profitable. Lanier Cansler, Former Secretary of the North Carolina Department of Health and Human Services noted that if the State wants to seriously address the issues of affordability and sustainability of healthcare in the State "we must develop a vision of our healthcare delivery system and then every modification to law, reimbursement process, policy, must be focused on achieving that vision."

Recommendation:

19. **The General Assembly should study reform of the health care market and the health care delivery system in North Carolina to increase cost effectiveness and quality of care through the encouragement of market driven competition in the provision of health care services.**

Finding:

A Certificate of Public Advantage (COPA) was issued by the State in 1995 as a condition of allowing the merger of Memorial Mission Hospital and St. Joseph's Hospital to go forward. The entity that emerged from the merger process is Mission Hospital, Inc., operated by Mission Health Systems, Inc. ("Mission"). The COPA agreement was required by the State to offset the anticompetitive effects of the merger on the Western North Carolina health care market. Since 1995, the COPA agreement has been modified twice. Mission has submitted the reports required under the statutes and has been determined to be in compliance with the terms of the COPA agreement. Nonetheless, hospitals, health care providers, and individuals continue to raise concerns about the increase in Mission's market power and whether the COPA agreement has been effective in balancing the anticompetitive effects of the merger. Further in-depth investigation into the economic impact of Mission's COPA on the health care market, especially in light of recent changes in the structure of the health care industry, may be necessary to resolve these issues and ensure the provision of low cost, high quality health care to the people in Western North Carolina.

Recommendation:

20. **The Committee recommends that the hospitals, health care providers, and interested individuals in the region make every effort to resolve their differences regarding the COPA prior to the end of the 2013 Session of the General Assembly. If a satisfactory resolution to the issues is not reached in that time, the Committee recommends that the General Assembly conduct a study of the economic impact of the COPA and the effectiveness of that agreement.**

APPENDIX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-16 [v.8] (11/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/7/2012 10:59:31 AM

Short Title:	Enact CON Committee Recommendations.	(Public)
Sponsors:	Representative Torbett.	
Referred to:		

1 A BILL TO BE ENTITLED
2 AN ACT TO ELIMINATE THE MONETARY THRESHOLD FOR EXPEDITED
3 CERTIFICATE OF NEED REVIEW; TO INCREASE THE MONETARY THRESHOLDS
4 TRIGGERING CERTIFICATE OF NEED REVIEW FOR CAPITAL EXPENDITURES
5 AND THE PURCHASE OF MAJOR MEDICAL EQUIPMENT; TO EXEMPT
6 REPLACEMENT EQUIPMENT FROM CERTIFICATE OF NEED REVIEW
7 REGARDLESS OF COST; TO REQUIRE AFFECTED PERSONS SEEKING TO FILE A
8 PETITION FOR A CONTESTED CASE OR AN APPEAL CHALLENGING
9 CERTIFICATE OF NEED APPROVAL TO DEPOSIT A SEPARATE BOND FOR EACH
10 APPROVED APPLICATION THAT IS THE SUBJECT OF THE PETITION OR
11 APPEAL, TO INCREASE THE AMOUNT OF THE MAXIMUM BOND
12 REQUIREMENT, AND TO GIVE THE COURT OF APPEALS GREATER
13 DISCRETION IN IMPOSING A HIGHER BOND AMOUNT; AND TO REQUIRE THE
14 COURT TO AWARD COSTS AND A REASONABLE ATTORNEY FEE TO ANY
15 CERTIFICATE OF NEED APPLICANT WHOSE APPROVED NEW INSTITUTIONAL
16 HEALTH SERVICE IS THE SUBJECT OF A CONTESTED CASE PETITION
17 DETERMINED TO BE FRIVOLOUS OR FILED TO DELAY THE APPLICANT, AS
18 RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON CERTIFICATE OF
19 NEED PROCESS AND RELATED HOSPITAL ISSUES.
20 The General Assembly of North Carolina enacts:
21 **SECTION 1.** G.S. 131E-176(7b) reads as rewritten:
22 "(7b) 'Expedited review' means the status given to an application's review process
23 when the applicant petitions for the review and the Department approves the
24 request based on findings that all of the following are met:
25 a. The review is not competitive.
26 b. ~~The proposed capital expenditure is less than five million dollars~~
27 ~~($5,000,000).~~
28 c. A request for a public hearing is not received within the time frame
29 defined in G.S. 131E-185.
30 d. The agency has not determined that a public hearing is in the public
31 interest."

SECTION 2. G.S. 131E-176(14o) reads as rewritten:

"(14o) 'Major medical equipment' means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~one million five hundred thousand dollars ($1,500,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section."

SECTION 3. G.S. 131E-176(16)b. reads as rewritten:

"(16) 'New institutional health services' means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~four million dollars ~~($2,000,000).~~($4,000,000).

...."

SECTION 4. G.S. 131E-176(22a) reads as rewritten:

"(22a) 'Replacement equipment' means equipment that ~~costs less than two million dollars ($2,000,000) and~~ is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. ~~In determining whether the replacement equipment costs less than two million dollars ($2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~"

SECTION 5. G.S. 131E-184(e) reads as rewritten:

"(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:
   1. Nursing home facility,
   2. Adult care home facility, or
   3. Intermediate care facility for the mentally retarded; and

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.

b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.

c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents."

SECTION 6. G.S. 131E-188 reads as rewritten:

"**§ 131E-188. Administrative and judicial review.**

(a) After a decision of the Department to issue, deny or withdraw a certificate of need or exemption or to issue a certificate of need pursuant to a settlement agreement with an applicant to the extent permitted by law, any affected person, as defined in subsection (c) of this section, shall be entitled to a contested case hearing under Article 3 of Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department makes its decision. When a petition is filed, the Department shall send notification of the petition to the proponent of each application that was reviewed with the application for a certificate of need that is the subject of the petition. Any affected person shall be entitled to intervene in a contested case.

A contested case shall be conducted in accordance with the following timetable:

(1) An administrative law judge or a hearing officer, as appropriate, shall be assigned within 15 days after a petition is filed.

(2) The parties shall complete discovery within 90 days after the assignment of the administrative law judge or hearing officer.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.

(4) The administrative law judge or hearing officer shall make a final decision within 75 days after the hearing.

(5) Repealed by Session Laws 2011-398, s. 46, as amended by Session Laws 2011-326, s. 23, effective January 1, 2012, and applicable to contested cases commenced on or after that date.

The administrative law judge or hearing officer assigned to a case may extend the deadlines in subdivisions (2) through (4) so long as the administrative law judge or hearing officer makes a final decision in the case within 270 days after the petition is filed.

(a1) On or before the date of filing a petition for a contested case hearing on the approval of an applicant for a certificate of need, the petitioner shall deposit a bond for each approved

application that is the subject of the petition with the clerk of superior court where ~~the~~ any new institutional health service that is the subject of the petition is proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of ~~the proposed new institutional health service~~each approved application that is the subject of the petition, but may not be less than five thousand dollars ($5,000) and may not exceed ~~fifty thousand dollars ($50,000).~~one hundred thousand dollars ($100,000). A petitioner who received approval for a certificate of need and is contesting only a condition in the certificate is not required to file a bond under this subsection.

The applicant who received approval for ~~the~~ any new institutional health service that is the subject of the petition may bring an action against a bond filed under this subsection in the superior court of the county where the bond was filed. Upon finding that the petition for a contested case was frivolous or filed to delay the applicant, the court may award the applicant part or all of the bond filed under this ~~subsection.~~subsection and shall award the applicant reasonable attorney fees and costs incurred in the contested case. At the conclusion of the contested case, if the court does not find that the petition for a contested case was frivolous or filed to delay the applicant, the petitioner shall be entitled to the return of the bond deposited with the superior court upon demonstrating to the clerk of superior court where the bond was filed that the contested case hearing is concluded.

(b) Any affected person who was a party in a contested case hearing shall be entitled to judicial review of all or any portion of any final decision in the following manner. The appeal shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal shall be as provided by the rules of appellate procedure. The appeal of the final decision shall be taken within 30 days of the receipt of the written notice of final decision, and notice of appeal shall be filed with the Office of Administrative Hearings and served on the Department and all other affected persons who were parties to the contested hearing.

(b1) Before filing an appeal of a final decision granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of this subsection shall not apply to any appeal filed by the Department.

(1) The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of ~~the proposed new institutional health service~~ each approved application that is the subject of the appeal, but may not be less than five thousand dollars ($5,000) and may not exceed ~~fifty thousand dollars ($50,000);~~one hundred thousand dollars ($100,000); provided that the applicant who received approval of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its ~~discretion, not to exceed three hundred thousand dollars ($300,000).~~discretion. A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of Appeals. If the Court of Appeals does not find that the appeal

1 was frivolous or filed to delay the applicant and does not remand the case to
2 superior court for a possible award of all or part of the bond to the holder of
3 the certificate of need, the person originally filing the bond shall be entitled
4 to a return of the bond.
5 (c) The term "affected persons" includes: the applicant; any individual residing within
6 the service area or the geographic area served or to be served by the applicant; any individual
7 who regularly uses health service facilities within that geographic area or the service area; any
8 person who provides services, similar to the services under review, to individuals residing
9 within the service area or the geographic area proposed to be served by the applicant; any
10 person who, prior to receipt by the agency of the proposal being reviewed, has provided written
11 notice to the agency of an intention to provide similar services in the future to individuals
12 residing within the service area or the geographic area to be served by the applicant; third party
13 payers who reimburse health service facilities for services in the service area in which the
14 project is proposed to be located; and any agency which establishes rates for health service
15 facilities or HMOs located in the service area in which the project is proposed to be located."
16 **SECTION 7.** This act becomes effective October 1, 2013, and applies to certificate
17 of need applications, contested case petitions, and appeals filed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MG-11D [v.6] (10/24)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/7/2012 10:52:29 AM

Short Title:	Amend Certificate of Need Laws.	(Public)
Sponsors:	Representative Avila.	
Referred to:		

1 A BILL TO BE ENTITLED
2 AN ACT TO EXEMPT DIAGNOSTIC CENTERS FROM CERTIFICATE OF NEED
3 REVIEW AND TO AMEND CERTIFICATE OF NEED LAWS PERTAINING TO
4 SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS.
5 The General Assembly of North Carolina enacts:
6 **SECTION 1.** G.S. 131E-175 is amended by adding new subdivisions to read:
7 "(13) That the relocation of a hospital's operating rooms to a location separate
8 from the campus upon which the hospital's inpatient acute care beds and
9 emergency department are located results in a costly and unnecessary
10 economic burden to the public.
11 (14) That physicians who provide single-specialty ambulatory surgery services in
12 unlicensed settings should be afforded an opportunity to obtain a license to
13 provide these services in order to ensure patient safety and the provision of
14 quality care.
15 (15) That the demand for ambulatory surgery is increasing due to advances in
16 technology and anesthesia, and single-specialty ambulatory surgery
17 operating rooms are recognized as a highly effective means of expanding
18 access while achieving cost savings regardless of the availability and
19 potential underutilization of hospital-based operating rooms."
20 **SECTION 2.** G.S. 131E-176(7a) reads as rewritten:
21 "(7a) ~~'Diagnostic center' means a freestanding facility, program, or provider,~~
22 ~~including but not limited to, physicians' offices, clinical laboratories,~~
23 ~~radiology centers, and mobile diagnostic programs, in which the total cost of~~
24 ~~all the medical diagnostic equipment utilized by the facility which cost ten~~
25 ~~thousand dollars ($10,000) or more exceeds five hundred thousand dollars~~
26 ~~($500,000). In determining whether the medical diagnostic equipment in a~~
27 ~~diagnostic center costs more than five hundred thousand dollars ($500,000),~~
28 ~~the costs of the equipment, studies, surveys, designs, plans, working~~
29 ~~drawings, specifications, construction, installation, and other activities~~
30 ~~essential to acquiring and making operational the equipment shall be~~
31 ~~included. The capital expenditure for the equipment shall be deemed to be~~

1 ~~the fair market value of the equipment or the cost of the equipment, whichever is greater.~~"
2
3 **SECTION 3.** G.S. 131E-176(9b) reads as rewritten:
4 "(9b) 'Health service facility' means a hospital; long-term care hospital; psychiatric
5 facility; rehabilitation facility; nursing home facility; adult care home;
6 kidney disease treatment center, including freestanding hemodialysis units;
7 intermediate care facility for the mentally retarded; home health agency
8 office; chemical dependency treatment facility; ~~diagnostic center;~~ hospice
9 office, hospice inpatient facility, hospice residential care facility; and
10 ambulatory surgical facility."
11 **SECTION 4.** G.S. 131E-176(16)u. reads as rewritten:
12 "(16) 'New institutional health services' means any of the following:
13 …
14 u. The construction, development, establishment, increase in the
15 number, or relocation of an operating ~~room~~ room, including a
16 single-specialty ambulatory surgery operating room, or
17 gastrointestinal endoscopy room in a licensed health service facility,
18 other than the relocation of an operating room or gastrointestinal
19 endoscopy room within the same building or on the same grounds or
20 to grounds not separated by more than a public right-of-way adjacent
21 to the grounds where the operating room or gastrointestinal
22 endoscopy room is currently located.
23 …."
24 **SECTION 5.** G.S. 131E-176(24c) reads as rewritten:
25 "(24c) ~~Reserved for future codification.~~'Single-specialty ambulatory surgery
26 operating room' means a designated operating room located in a licensed
27 ambulatory surgical facility that is used to perform same-day surgical
28 procedures in one of the single-specialty areas identified by the American
29 College of Surgeons. For the purpose of this subdivision, 'same-day surgical
30 procedures' includes pain injections by orthopedists, physiatrists, and
31 anesthesiologists."
32 **SECTION 6.(a)** G.S. 131E-178 reads as rewritten:
33 **"§ 131E-178. Activities requiring certificate of need.**
34 (a) ~~No~~ Except as otherwise provided in subsections (a1) and (a2) of this section, no
35 person shall offer or develop a new institutional health service without first obtaining a
36 certificate of need from the ~~Department; provided, however, no~~Department.
37 (a1) Any person proposing to obtain a license to establish an ambulatory surgical facility
38 for the provision of gastrointestinal endoscopy procedures shall be required to obtain a
39 certificate of need to license that setting as an ambulatory surgical facility, with the existing
40 number of gastrointestinal endoscopy rooms, except for a person who (i) provides
41 gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located
42 in a nonlicensed ~~setting, shall be required to obtain a certificate of need to license that setting as~~
43 ~~an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms,~~
44 ~~provided that:~~setting and (ii) meets all of the following criteria:
45 (1) The person's license application is postmarked for delivery to the Division of
46 Health Service Regulation by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and

(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.

(a2) Any person proposing to obtain a license to establish single-specialty ambulatory operating rooms in an ambulatory surgery facility shall be required to obtain a certificate of need, except for a person who (i) provides single-specialty ambulatory surgery procedures in one or more operating rooms located in a nonlicensed setting and (ii) meets all of the following criteria:

(1) The person's license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2013.

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and

(4) The license application includes at least all of the following:

a. A commitment, plan, and policies and procedures for serving indigent and medically underserved populations.

b. Projected charges for the 20 most common surgical procedures to be performed in the proposed single-specialty ambulatory surgery operating rooms.

All other persons proposing to obtain a license to establish single-specialty ambulatory operating rooms within an ambulatory surgical facility shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of single-specialty ambulatory surgery operating rooms that

may be approved. However, the Department shall not approve an application for a single-specialty ambulatory surgery operating room in any ambulatory surgical facility within a county in which a licensed critical access hospital, as defined in 42 CFR § 400.202, is located. The annual State Medical Facilities Plan also shall not include policies or need determinations that limit the relocation and replacement of existing operating rooms, including single-specialty ambulatory operating rooms. However, the Department shall not approve an application for the relocation of a hospital's operating rooms to a location separate from the campus upon which the hospital's inpatient acute care beds and emergency department are located if approval would result in the hospital obtaining reimbursement for surgery procedures at a rate higher than the rate paid to ambulatory surgery centers under a government sponsored health insurance or medical assistance program.

(b) No person shall make an acquisition by donation, lease, transfer, or comparable arrangement without first obtaining a certificate of need from the Department, if the acquisition would have been a new institutional health service if it had been made by purchase. In determining whether an acquisition would have been a new institutional health service, the capital expenditure for the asset shall be deemed to be the fair market value of the asset or the cost of the asset, whichever is greater.

(c) No person shall incur an obligation for a capital expenditure which is a new institutional health service without first obtaining a certificate of need from the Department. An obligation for a capital expenditure is incurred when:

(1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the construction, acquisition, lease or financing of a capital asset;

(2) A person takes formal action to commit funds for a construction project undertaken as his own contractor; or

(3) In the case of donated property, the date on which the gift is completed.

(d) Where the estimated cost of a proposed capital expenditure, including the fair market value of equipment acquired by purchase, lease, transfer, or other comparable arrangement, is certified by a licensed architect or engineer to be equal to or less than the expenditure minimum for capital expenditure for new institutional health services, such expenditure shall be deemed not to exceed the amount for new institutional health services regardless of the actual amount expended, provided that the following conditions are met:

(1) The certified estimated cost is prepared in writing 60 days or more before the obligation for the capital expenditure is incurred. Certified cost estimates shall be available for inspection at the facility and sent to the Department upon its request.

(2) The facility on whose behalf the expenditure was made notifies the Department in writing within 30 days of the date on which such expenditure is made if the expenditure exceeds the expenditure minimum for capital expenditures. The notice shall include a copy of the certified cost estimate.

(e) The Department may grant certificates of need which permit capital expenditures only for predevelopment activities. Predevelopment activities include the preparation of architectural designs, plans, working drawings, or specifications, the preparation of studies and surveys, and the acquisition of a potential site."

SECTION 7. G.S. 131E-182 reads as rewritten:

1 "(a) The Department in its rules shall establish schedules for submission and review of
2 completed applications. The schedules shall provide that applications for similar proposals in
3 the same service area will be reviewed together. However, the Department is prohibited from
4 scheduling a review prior to February 1, 2013, for certificate of need applications that propose
5 to establish a licensed single-specialty ambulatory operating room within an ambulatory
6 surgery facility.
7 (b) An application for a certificate of need shall be made on forms provided by the
8 Department. The application forms, which may vary according to the type of proposal, shall
9 require such information as the Department, by its rules deems necessary to conduct the review.
10 An applicant shall be required to furnish only that information necessary to determine whether
11 the proposed new institutional health service is consistent with the review criteria implemented
12 under G.S. 131E-183 and with duly adopted standards, plans and criteria. The application form
13 for a certificate of need to establish a single-specialty ambulatory surgery operating room
14 within an ambulatory surgery facility shall require the applicant to (i) include a written
15 commitment, plan, and policies and procedures for serving indigent and medically underserved
16 populations, (ii) furnish the projected charges for the 20 most common surgical procedures to
17 be performed in the proposed operating room, and (iii) demonstrate that it is performing or
18 reasonably expects to perform at least 800 single-specialty ambulatory procedures per licensed
19 single-specialty ambulatory operating room per year.
20 (c) An application fee is imposed on an applicant for a certificate of need. An applicant
21 must submit the fee with the application. The fee is not refundable, regardless of whether a
22 certificate of need is issued. Fees collected under this section shall be credited to the General
23 Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount
24 equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in
25 the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed
26 fifty thousand dollars ($50,000)."
27 **SECTION 8.** G.S. 131E-184(a) is amended by adding a new subdivision to read:
28 "(10) To develop, acquire, or replace an institutional health service that obtained
29 certificate of need approval prior to the effective date of this act as a
30 diagnostic center. For the purpose of this subdivision, 'diagnostic center'
31 means a freestanding facility, program, or provider, including but not limited
32 to, physicians' offices, clinical laboratories, radiology centers, and mobile
33 diagnostic programs, in which the total cost of all the medical diagnostic
34 equipment utilized by the facility that cost ten thousand dollars ($10,000) or
35 more exceeds five hundred thousand dollars ($500,000), unless a new
36 institutional health service other than those defined in G.S. 131E-176(16)b.
37 is offered or developed in the building."
38 **SECTION 9.** Nothing in this act shall be construed to reflect any legislative intent
39 as to the circumstances under which Medicare or Medicaid certification may be obtained for a
40 provider of ambulatory surgery services.
41 **SECTION 10.** This act is effective when it becomes law. Section 7 of this act
42 expires on the effective date of administrative rules adopted consistent with the provisions of
43 this act regarding the number of single-specialty surgery procedures performed or projected to
44 be performed by applicants seeking to establish a licensed single-specialty ambulatory surgery
45 operating room.

1

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maria Wilding	Novant Health
Barbara L. Freedy	Novant Health
AIMÉE ESCUETA	NCDOJ- ATTORNEY GENERAL'S OFFICE
K.D. Sturgis	
Carrie Hanger	Smith Moore Leatherwood
KRIS HORTON	DHHS
Robbie Roberts	WakeMed
Bob Fitzgerald	WakeMed
John Metcalf	Mission Health
Jason Deans	Jason Deans + Assoc.

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jill Rosenblum	NBM Health Planning
Alan Skipper	NC Med Soc
David Dyer	BBH-Design, P.A.
Karl Stein	Raleigh Orthopaedic Clinic
Noah Huffstetler	Nelson Mullins
Todd Hemphill	Bode, Call & Stroupe
Gary Qualls	K&L Gates
Lee Gary Zerman	UNCHCS
Rolene Simmons	Mission Health
Drexdal Pratt	DHHS/DHSR
Jesse Goodman	DHHS/DHSR

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison Waller	Nelson Mullins
Lee-Ann Perryman	CSS
Tom Akins	Leading Age NC
Alex Badger	CSS
Connie Wilson	NCOA
Cathy Wright	self
Erica Nelson	NCHA
Jay Nichols	CR
Greg Barr	CHS
Brad Adcock	BCBSNC

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	NP
Martha Ann McConnell	CHS
Elise McDowell	Troutman Sanders
Daniel Baum	Troutman Sanders
Andrew Blackburn	Southern Strategy Group
Clark Riemer	Civitas
Mike Vicario	NCHA
Lacy Hastings	CaroMont Health
Alex Mullinaux	CaroMont Health
Catharine Cummer	DUHS
Kathleen Worrell	PDC

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Tilson	NCHA
BJ Miller	Cone Health
Gretchen Kelly	FirstHealth
Joe Lanier	Nelson Mullins
Andy Chase	KMA
John Cooper	Compass NC
Jimm Bunch	Park Ridge Health
Charlene Thomas	Strategic Healthcare Advisors
Denise Gunter	Nelson Mullins
Amy Whited	NC Med Soc

VISITOR REGISTRATION SHEET

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED PROCESS AND RELATED HOSPITAL ISSUES — 12-06-12

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Korbey	CompassNC
Chris Taylor	DHSR
CRAIG SMITH	DHSR
Debra Murphy	Ascendient
Trey Adams	PDA, Inc.
Susan Kelley	Poyner Spruill
Doug HERON	DUKE
Ken Melton	K.M.A.
John Bode	BCS