Comments in Opposition from Novant Health, Inc.
Regarding WakeMed CON Application
for Three Additional Shared Use Operating Rooms at WakeMed Cary Hospital (Project I.D. # J-8463-10)
Submitted February 15, 2010 for March 1, 2010 Review

In accordance with N.C.G.S. Section 131E-185(a1)(1), Novant Health, Inc. submits the following comments regarding the CON Application of WakeMed for Three Additional Shared Use Operating Rooms at WakeMed Cary Hospital (Project I.D. #J-8463-10).

I. Introduction

The following CON applications were submitted on February 15, 2010 in response to the need determination identified in the *2010 State Medical Facilities Plan* (*2010 SMFP*) for three surgical operating rooms in Wake County:

- J-8463-10: WakeMed for Three Additional Shared Surgical Operating Rooms at WakeMed Cary Hospital
- J-8468-10: Rex Hospital, Inc. d/b/a Rex Healthcare for Two Outpatient Surgical Operating Rooms in a Hospital-Based Ambulatory Surgery Center at Rex Healthcare of Holly Springs
- J-8469-10: Rex Hospital, Inc. d/b/a Rex Healthcare for One Additional Shared Surgical Operating Room at Rex Hospital
- J-8467-10: Duke University Health System d/b/a Raleigh Hospital for Two Additional Shared Use Surgical Operating Rooms
- J-8471-10: Novant Health's Holly Springs Surgery Center for a Freestanding Ambulatory Surgery Center with Three Outpatient Surgical Operating Rooms

II. WakeMed's Proposal

Project Description

WakeMed seeks approval to develop three new shared use inpatient/outpatient surgical operating rooms at WakeMed Cary Hospital[1], with a total project cost of $5,867,854. WakeMed's CON Application was filed on February 15, 2010 for the March 1, 2010 review cycle. The project will renovate 3,304 square feet within WakeMed Cary Hospital, which accommodate the proposed three additional shared surgical operating rooms.

Upon project completion, WakeMed Cary Hospital will have a total inventory of twelve shared surgical operating rooms and two dedicated C-sections rooms.

[1] CON Application J-8463-10, page 12

Impermissible Amendment of the WakeMed Cary CON Application While Under Review

In addition, on March 24, 2010, while the WakeMed Cary OR CON Application was under review by the Agency, WakeMed announced it had reached a deal with Surgical Care Affiliates ("SCA") of Birmingham, Alabama to "take over surgical services management at WakeMed Cary Hospital....As part of that deal, 142 WakeMed Cary Hospital workers will become SCA employees as of May 17, [2010]. WakeMed and Surgical Care Affiliates will enter into a formal agreement on March 31, 2010. See the March 24, 2010 news article in Raleigh News and Observer (Blog) entitled "*WakeMed partners with outpatient surgery chain*"; March 24, 2010 Triangle Business Journal article, "*WakeMed cuts deal with Surgical Care Associates to gain surgery share*"; March 24, 2010 News Release on WakeMed web site, *WakeMed Partners with Surgical Care Affiliates to Enhance Ambulatory Surgery Program*"; March 25, 2010 article in Becker's ASC Review entitled *"North Carolina's WakeMed Partners with Surgical Care Affiliates to Enhance Ambulatory Surgery Program."* The articles are included in Attachment 1 to these Comments.[2]

WakeMed and SCA signed a letter of understanding in October 2009 that set up a framework for the two parties to explore partnership opportunities. Thus, WakeMed was aware of the pending change in the management of the WakeMed Cary Surgical program before WakeMed's February 15, 2010 CON Application was filed to add three new ORs at WakeMed Cary pursuant to the need determination in the *2010 SMFP*. See the October 29, 2009 news release on the WakeMed web site called *"WakeMed and Surgical Care Affiliates Enter into Venture for Ambulatory Surgery"*; PRNewswire article release by Surgical Care Affiliates on October 30, 2009, *"WakeMed and Surgical Care Affiliates Enter into Venture for Ambulatory Surgery"*; and October 30, 2009 article in Becker's Hospital Review, *"Surgical Care Affiliates, WakeMed Discuss Potential Partnership."* The articles are included in Attachment 1 to these Comments.

WakeMed failed to mention this pending change of management or the financial impact of bringing in a for-profit management company on for the WakeMed Cary hospital surgical program in its February 15, 2010 CON Application to add three new ORs. In addition, the WakeMed Cary CON application exhibits do not include any type of draft agreement or any specification of the SCA management fee, to be included as an operating expense in the WakeMed Cary ProForma financial projections for this CON Application to add three new ORs.

For example, in response to CON Application Question I.10 which asks: "*Will the facility be operated by the owner?*", WakeMed responded with a "YES." See the WakeMed Cary CON Application at page 3. However, as of May 17, 2010, it appears

[2]These articles also indicate that Surgical Care Affiliates will also be taking of the management of WakeMed's North Healthplex Surgical Program. It is not clear whether this change in management for WakeMed North is consistent with the CON conditions of approval for the surgical program at WakeMed North.

that WakeMed, the owner of the ORs, will no longer manage the WakeMed Cary surgical program. Again in response to CON Application Question I.10(c), which asks: *"Will the owner or lessee contract the management of the facility?"*, WakeMed responded with a "NO." WakeMed also failed to specify the name of the management company as requested in CON Application Question I.1(c). See the WakeMed Cary CON Application at page 3. Thus, WakeMed's responses to these questions are incomplete at best and incorrect at worst.

Based on the articles on WakeMed's web site and in the local media, SCA and WakeMed signed a Letter of Understanding on October 30, 2009, which was more than 90 days before WakeMed filed this CON application in February 2010 to add three ORs at WakeMed Cary. WakeMed simply failed to account for this material change to its application, when it had the prior knowledge to anticipate and to do so. WakeMed has impermissibly amended its application during the review cycle and the Agency should not consider this application and should remove it from the review of the competing applications for the 3 new ORs in Wake County based on a need determination in the *2010 SMFP*. The articles are included in Attachment 1 to these Comments.

By virtue of the consummation of this transaction, while the WakeMed Cary application is under review by the Agency, WakeMed has impermissibly amended its CON Application while it is under review by the CON Agency. In such cases, the Agency has no choice but to remove the impermissibly amended CON Application from the review cycle and not consider it as part of Agency decision making regarding the three new Wake County ORs identified in the *2010 SMFP*. See the relevant case law on this point, which is included as Attachment 2 to these Comments. The guiding precedent on the amendment of a CON application while it is under review is set forth in the North Carolina Court of Appeals case, *Presbyterian Orthopaedic Hospital v. North Carolina Department of Human Resources, Division of Facility Services, Certificate of Need Section, 122 N. C. App. 831, 470 S.E.2d 529, (June 4, 1996)*.

III. CON Review Criteria

The following comments are submitted based upon the CON Review Criteria found at G.S.131E-183. While some issues impact multiple Criteria, they are discussed under the most relevant review Criteria and referenced in others to which they apply.

G.S. 131E-183 (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.

A. *SMFP* Policy GEN-3 – Basic Principles

The plain language of "SMFP Policy GEN-3: Basic Principles" requires that:

"A certificate of need applicant applying to develop or offer a new institutional health service for with there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan, as well as addressing the needs of all the residents in the service area. (Emphasis added)

As discussed in detail in the context of Criterion (3) below, WakeMed failed to adequately demonstrate the quantitative and qualitative need for the project, and therefore failed to document how its projected volumes incorporate the Basic Principles in meeting the need identified in the *2010 SMFP* for three new ORs in Wake County. Consequently, the WakeMed Cary Hospital Application is not conforming to Policy GEN-3, and does not conform to Criterion (1).

B. Operating Room Need Methodology – Results in Overstated Surgical Volume

As discussed in detail in the context of Criterion (3) below, surgical volume is overstated. As a result, the projected utilization is unreasonable and cannot be used to justify WakeMed's total operating rooms in Wake County. Therefore, the WakeMed Cary Hospital Application is non-conforming to Criterion (1).

For these reasons, the proposed project is non-conforming to Policy GEN-3: Basic Principles and Basic Assumptions included in the Operating Room Need Methodology.

G.S. 131E-183 (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.

The proposed project is non-conforming to Criterion (3) because it overstates a need at WakeMed Cary Hospital for expanded surgical services. As such, WakeMed fails to justify a need for 12 shared surgical operating rooms (9 existing ORs and 3 proposed new

ORs). WakeMed Cary Hospital seeks approval to add three new ORs based on a need determination for Wake County included in the *2010 SMFP*.

A. WakeMed Cary Hospital Service Area Definition – Population to Be Served by the Proposed Project Not Clearly Defined

On page 79 of the WakeMed Cary Hospital Application, WakeMed states that WakeMed Cary Hospital has a three-county primary and secondary service area consisting of Wake, Harnett, and Johnston Counties. On page 36, WakeMed states that "those three counties contribute the vast majority (approximately 90%) of surgery cases at WakeMed Cary [Hospital]."

For purposes of comparison, on pages 60-61 of the WakeMed Apex Day Surgery Center CON Application filed in September 2006, WakeMed provided the following table showing the zip codes comprising WakeMed Cary Hospital's service area.

WakeMed Cary Hospital Service Area

ZIP Code	Municipality
27511	Cary
27513	Cary
27592	Willow Springs
27603	Raleigh
27606	Raleigh

There is no attempt by WakeMed to reconcile past and present service area definitions for WakeMed Cary Hospital.

Adding to the complexity, WakeMed employs a methodology to project WakeMed System surgical volume that uses 'the WakeMed System's geographic market area' consist[ing] of a 16-county region in central and eastern North Carolina, from which approximately 97 percent of WakeMed surgery patients originate."[3]

B. WakeMed Capacity Issues

On pages 80 and 83 WakeMed Cary discusses capacity issues and patient satisfaction issues as reasons three additional operating rooms are needed at WakeMed Cary. However, WakeMed Cary has misinterpreted the SMFP definition of capacity and in fact the operating rooms at WakeMed Cary not operating at 99% of current OR capacity. Based upon the information included on page 62 of the SMFP, capacity of an operating room equals the number of hours the OR is staffed and available for surgical procedures which according to the *SMFP* is nine hours per day 260 days per year or 2,340 hours per

[3]CON Application J-8463-10, page 35

operating room. For planning purposes, the *SMFP* utilizes an 80% planning threshold, or 1,872, to identify future need in a county.

Therefore, based upon the capacity definition in the SMFP, the utilization of WakeMed Cary's nine shared operating rooms is considerably less than 99% as shown in the following table.

WakeMed Cary 2009 Surgical Services Utilization

	2009
Operating Rooms	9
Capacity per rooms (Total available staffed hours)	2,340
Total Capacity	21,060
Inpatient Surgery (Less C-Section cases)	1,947
Outpatient Surgery	7,273
Weighted Surgical Hours (3.0 hrs per inpt and 1.5 hrs per outpt)	16,751
Current Surgical Services Utilization	79.5%

Source: SMFP; 2010 LRA

The nine operating rooms at WakeMed Cary are operated at 79.5% of capacity assuming a nine hour day as reflected in the previous table. However, as reflected on page 13 of the WakeMed Cary Application, the nine operating rooms at WakeMed Cary currently operate a total of 124 hours per week or an average of 13.8 hours per day, considerably more than the nine hours per day assumed by the *SMFP* and considerably more than operational hours reported in the WakeMed Cary 2010 LRA. In addition, average case time reported in the WakeMed Cary 2010 LRA for inpatients is less than the SMFP planning guideline of 3.0 hours per case. As a result, it does not appear that the operational issues and satisfaction issues reflected on pages 80 and 81 of the WakeMed Cary Application are related solely to operating room capacity.

C. WakeMed Uses an Overstated Surgical Use Rate to Project Future Surgical Volume

WakeMed utilizes a methodology to project future operating room need for the WakeMed System and from there, each of the following facilities: WakeMed Cary Hospital, WakeMed Raleigh, WakeMed North, and WakeMed Raleigh Surgery Center.

On pages 30 through 35 of the WakeMed Cary Hospital CON Application, WakeMed compares major sources of surgery data: License Renewal Applications and Thomson Reuters Inpatient and Ambulatory Surgery Databases. Tables II.7 and II.8 on pages 31 and 33 are compared in the following table.

Comparison of Wake County Surgery Use Rates
October 2003 – September 2008

Wake County Surgery Use Rates, FY 2005-2008 Using Data Obtained from Annual Licensure Renewal Applications All Surgical Cases, Including Cases Performed in C-Section Rooms, Dedicated Open Heart Operating Rooms, and Procedure Rooms					
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**
Total Surgery Cases from License Renewal Apps	Not provided	67,269	66,242	69,125	75,188
Total Wake County Population	Not provided	756,873	791,087	829,418	864,429
Total Surgery Use Rate per 1000 Pop	Not provided	88.88	83.74	83.34	86.98
Wake County Surgery Use Rates, FY 2005-2008 Using Data Obtained from Thomson Inpatient and Ambulatory Surgery Databases All Surgical Cases, Include Cases Performed in C-Section Rooms, Dedicated Open Heart Operating Rooms, and Procedure Room Cases to the extent reported to Thomson by facilities, Excluding Endoscopy Cases, Cardiac Cath/Cardiac Angioplasty Cases, and Endovascular Cases					
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**
Total Surgery Cases from Thomson	67,067	70,135	74,478	80,622	83,513
Total Wake County Population	724,865	756,873	791,087	829,418	864,429
Total Surgery Use Rate per 1000 Pop	92.52	92.66	94.15	97.20	96.61

Differences between the data included (and excluded) from each data source are reflected in the previous table.

On page 31, WakeMed notes that "the most conspicuous element in the [LRA data] table is the apparent declining surgery use rate per 1000 population from 2005 through 2007, followed by an unexpected and substantial, increase in 2008. [...] this jump in 2008 may be related to year-to-year changes in how Wake County facilities report procedure room cases." WakeMed concludes that "the data in the License Renewal Applications are not considered reliable for purposes of assessing market utilization rates and market demand trends."

However, WakeMed fails to note that the OR Need Method in the *2010 SMFP* is based on the OR data reported to the state in the Hospital and ASC Annual Hospital Licensure Renewal Applications. In fact, the need for the three new ORs for which WakeMed Cary is seeking CON approval, is based on the LRA data and not on the Thomson OR case data. In addition, the SHCC Operating Room Methodology Work Group reviewed the Thomson Ambulatory Surgery Database in 2007 and determined that the surgical data

included in the database was too expansive and included surgical procedures that were clinically appropriate for non-operating room procedure room, emergency rooms, and a variety of other locations in ambulatory surgical facilities and hospitals. The Work Group determined that the Thomson data was not appropriate for planning purposes as it overstated "surgical cases" as defined in the CON Criteria and Standards for Operating Room Projects at 10A NCAC 14C.2101 (14).

On page 35, WakeMed opines that

> [u]nlike the License Renewal Applications, the Thomson data indicates that surgery use rates in Wake County *grew* during the period FY 2004-2007. Conversely, while FY 2008 Wake County surgery case volumes grew, the FY 2008 use rate per 1000 population declined by 0.6%. This FY 2008 moderation in demand for surgery is consistent with the onset of the economic recession, and with healthcare industry news which reported a decline in a demand for surgeries, particularly elective cases.[4] By comparison, the License Renewal Application data suggest a sharp increase in the FY 2008 surgery use rate in Wake County. [*Emphasis in the original.*]

WakeMed concludes that "the Thomson market database clearly presents a more rational and reasonably expected pattern of utilization for calculating Wake County surgery use rates." WakeMed "opted to utilize Thomson data through FY 2008, given that full FY 2009 data was not available for inclusion in this Application."[5] In fact, the Thomson Ambulatory Surgery Database results in an overstated, aggressive methodology utilized by WakeMed Cary to project future operating rooms needed.

Interestingly, WakeMed did not use the total Wake County Surgery Cases from Thomson presented in Table II.8 on page 33, as shown in the previous table, in its "Operating Room Need Methodology." Instead, in Step 2 of that Methodology, WakeMed defined its own formulation of surgery cases from the Thomson market database for years FY 2004 – FY 2008, excluding C-Section cases performed in C-Section rooms and open heart cases performed in Open Heart Rooms.

A comparison of Wake County data from License Renewal Applications (Table II.7, page 31) and WakeMed's selected inpatient and outpatient surgery cases from the Thomson Databases (Step 2, pages 40-41) are presented in the following table.

Differences between the data included (and excluded) from each data source are identified in the following table.

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[4] WakeMed cites Bernstein, Jill, *Impact of the Economy on Health Care*, published by The Robert Wood Johnson Foundation, August 2009.

[5] CON Application J-8463-10, page 35

Comparison of Wake County Surgery Use Rates
October 2003 – September 2008

Wake County Surgery Use Rates, FY 2005-2008 Using Data Obtained from Annual Licensure Renewal Applications All Surgical Cases, Including Cases Performed in C-Section Rooms, Dedicated Open Heart Operating Rooms, and Procedure Rooms					
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**
Total Surgery Cases from License Renewal Apps	Not provided	67,269	66,242	69,125	75,188
Total Wake County Population	Not provided	756,873	791,087	829,418	864,429
Total Surgery Use Rate per 1000 Pop	Not provided	88.88	83.74	83.34	86.98
Wake County Surgery Use Rates, FY 2005-2008 Using Data Obtained from Thomson Inpatient and Ambulatory Surgery Databases All Surgical Cases, Excluding Cases Performed in C-Section Rooms, Dedicated Open Heart Operating Rooms, and Procedure Room Cases to the extent reported to Thomson by facilities, Excluding Endoscopy Cases, Cardiac Cath/Cardiac Angioplasty Cases, and Endovascular Cases Calculated by WakeMed in Step 4 of Methodology					
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**
Total Surgery Cases from Thomson	62,339	65,141	69,242	75,187	77,933
Total Wake County Population	724,865	756,873	791,087	829,418	864,429
Total Surgery Use Rate per 1000 Pop	86.00	86.07	87.53	90.65	90.16

Source: WakeMed Cary Application, pages 31 and pages 40-41

The most notable difference in the previous table is that the WakeMed selected cases from the Thomson Database result in another set of Wake County surgery use rates which exclude C-Sections, open hearts and procedure rooms. Even with these exclusions, those use rates remain higher than the LRA-based use rates that include C-Section, open heart, and procedure room cases; which results in more aggressive projections.

WakeMed then uses linear regression to **further inflate** each of the 16-county's surgery use rate over a 7-year period (from FY 2008 to FY 2015) in Step 5 of the Operating Room Need Methodology. In Step 6, WakeMed projects each of the 16-county's annual total surgery cases through FY 2015 using the aggressive surgical use rates based upon the inflated Thomson data.

Surgery cases and surgical use rates in Wake, Harnett, and Johnston Counties, the three-county service area of WakeMed Cary Hospital, are shown in the following table.

WakeMed Cary Hospital - Service Area Counties
Projected Surgery Volume and Surgery Use Rate
Based upon the "Geographic 16-County" Analysis

Growth of Total Surgery Volume				
County	**FY 2008**	**FY 2015**	**2008-2015**	**CAGR 2008-2015**
Wake	77,933	110,939	42.4%	5.2%
Harnett	9,623	11,688	21.5%	2.8%
Johnston	13,815	19,061	38.0%	4.7%
Growth of Total Surgery Use Rate per 1000 Population				
County	**FY 2008**	**FY 2015**	**2008-2015**	
Wake	90.16	99.69	10.6%	1.4%
Harnett	87.77	87.98	0.2%	0.0%
Johnston	84.89	93.2	9.8%	1.3%

Source: WakeMed Cary Application pages 41-43

Based on the data in the above table, WakeMed projects that the Wake County surgery use rate will increase by 10.6%, from 90.16 surgical cases per 1000 population in FY 2008 to 99.69 surgical cases per 1000 population in FY 2015[6]. That means that surgery cases will increase by approximately 9.5 cases per 1000 population. A 10.6% inflation of the Wake County surgery use rate, results in a **42.4% increase** in total Wake County surgery cases during the same time period (FY 2008 – FY 2015), an increase of 33,016 cases. Harnett County's projected surgery use rate increases is a mere 0.2%; however, it results in a 21.5% increase in that county's surgery cases in FY 2008 – FY 2015. Increases of the magnitude, shown in the previous table, are unreasonable, and not adequately explained and documented by WakeMed. WakeMed discusses a quantitative approach to demonstrate need, but fails to explain assumptions that tie it to factors in the delivery of surgical care in Wake County. Furthermore, WakeMed fails to discuss why there is such a wide variation in surgical use rates in the WakeMed Cary Three County Service Area. WakeMed fails to support its OR Use Rate volume projections with qualitative data.

D. WakeMed Projections Inflate Overall Inpatient Surgical Utilization at WakeMed Facilities

In Step 3 of the WakeMed projections, inpatient and outpatient volumes are combined to calculate total surgical use rates in Step 4. As a result, subsequent linear aggression analysis in Step 5 results in overstating the growth of inpatient surgery by compounding the growth at a higher rate than historical growth. Inpatient surgical volume in the "16 County WakeMed Service Area" has increased at a substantially lower growth rate than outpatient surgery since 2004 as illustrated in the following table.

[6]CON Application J-8467-10, page 45

WakeMed "16 County WakeMed Service Area" Total All Counties

	2004	2005	2006	2007	2008	CAGR
Inpatient	45,482	46,365	48,328	47,771	47,863	
Annual Growth		1.9%	4.2%	-1.2%	0.2%	1.3%
Outpatient	149,041	150,180	157,629	171,126	177,996	
Annual Growth		0.8%	5.0%	8.6%	4.0%	4.6%
Total Surgery	194,523	196,545	205,957	218,897	225,859	
Inpatient Percent of Total	30.5%	30.9%	30.7%	27.9%	26.9%	

Source: WakeMed Cary Application, page 41

Furthermore, as illustrated in the above table, the total percent of surgical volume represented by inpatient cases has declined over the five year period and has continued this downward trend in each of the last three years of reported data. Using the same linear regression analysis used by WakeMed for total surgery to determine future inpatient outpatient surgical split would have resulted in continuing this downward trend.

However, in Step 11 of the WakeMed application WakeMed splits the projected 2013, 2014 and 2015surgical volume for each of its surgical facilities using the historical FY 2009 inpatient/outpatient split for each WakeMed facility. Therefore, in addition to growing inpatient cases at a higher growth rate, WakeMed uses an inflated inpatient outpatient split to determine the surgical split at each facility.

Since inpatient cases are weighted at 3.0 hours per case and outpatient cases are weighted at 1.5 hours per case the impact of inflating inpatient surgical cases is significant. As a result, WakeMed has overstated its surgical projections using unreasonable and overstated use rate assumptions and inpatient/outpatient split assumptions.

E. WakeMed Projections Increase Market Share

In addition to using the most aggressive surgical use rates, inflating the surgical use rates annually over seven years and overstating inpatient surgical growth, WakeMed also projected a 3.0% increase in market share for WakeMed as a result of the new WakeMed Raleigh Surgery Center. In Step 8, on pages 49 and 50, WakeMed calculates 2008 market share for each surgical facility. For WakeMed Cary and WakeMed North market share remains constant. However, combining the market share for WakeMed and WakeMed Raleigh Surgery Center reflects a 3.0% increase in market share for 2013 to 2015. WakeMed did not provide any discussion or documentation regarding this projected increase in market share.

Since the proposed three additional operating rooms at WakeMed Cary result in an increase in total operating rooms in Wake County, WakeMed must project future need for all WakeMed existing and approved surgical facilities, including the four operating rooms approved for southern Wake County in 2005, which have been relocated to WakeMed in a subsequent CON in 2009, as required by the CON Criteria and Standards. As a result, WakeMed has overstated its surgical projections using unreasonable and

overstated use rate assumptions; unreasonable inpatient/outpatient split assumptions; and inflated market share assumptions.

F. Projected WakeMed Volume Exceed Historical WakeMed Surgical Growth Rates

WakeMed System historical inpatient and outpatient surgical utilization is shown in the following table.

WakeMed System
Historical Surgical Growth Rates
October 2005 – September 2009

FFY	2006	2007	2008	2009	CAGR FFY 2006 – FFY 2009
C-Section Cases	2,025	2,079	2,133	2,109	1.4%
% Change		2.7%	2.6%	-1.1%	
Open Heart Cases	981	894	924	834	-5.3%
% Change		-8.9%	3.4%	-9.7%	
Inpt Cases w/o C-Section Cases and Open Heart	8,447	8,921	9,157	8,952	2.0%
% Change		5.6%	2.6%	-2.2%	
Outpt Cases	20,399	20,566	19,947	20,450	0.1%
% Change		0.8%	-3.0%	2.5%	
Total Cases	31,852	32,460	32,161	32,345	0.5%
% Change		1.9%	-0.9%	0.6%	
Total Cases w/o C-Section Cases and Open Heart	28,846	29,487	29,104	29,402	0.6%

Source: Historical LRAs

As shown in the previous table, inpatient cases without C-Section and open heart cases grew at a compound annual growth rate of 2.0% in the last four fiscal years. However, the trend turned negative from 2008 to 2009 experiencing a negative 2.2% loss in inpatient surgeries, excluding C-Section and open heart cases. During that period, outpatient surgery compound annual growth rate grew by only 0.1% with volatile up and down utilization as illustrated in the previous table. Total surgical volume excluding C-Section and open heart cases has only grown at a compound annual growth rate of 0.6% in the last four fiscal years.

WakeMed System
Projected Surgical Growth Rates
October 2009 – September 2015

	2009	2010	2011	2012	2013	2014	2015	CAGR FFY 2009 – FFY 2015
Inpatient Cases w/o C-Section and Open Heart	9,553	9,242	9,948	10,691	11,283	11,898	9,553	4.5%
% Change		-3.3%	7.6%	7.5%	5.5%	5.5%	6.8%	
Outpatient Cases	19,188	22,664	24,952	26,482	27,522	28,568	19,188	8.3%
% Change		18.1%	10.1%	6.1%	3.9%	3.8%	3.9%	

Source: CON Application J-8463-10, Table II.5. and Table II.6., page 29

Overall projected surgical case utilization for all WakeMed surgical facilities as presented in the WakeMed Cary CON application is shown in the previous table. Inpatient surgery is projected to increase at a compound annual growth rate of 4.5%, which is considerably higher than the historical CAGR of 2.0%. Outpatient surgery is projected to grow at a CAGR of 8.3%, which is over **eighty** times greater than the historical CAGR 0.1%. That dichotomy is further evidence of the unreasonableness of WakeMed's need methodology, which results in overstated surgical volume.

Based on the above analysis, WakeMed does not demonstrate a quantitative need for the proposed three additional shared surgical operating rooms at WakeMed Cary Hospital. The WakeMed Cary Hospital Application should be denied due to non-conformity with Criterion (3).

G. WakeMed Determined Southern Market Did Not Need Additional Operating Rooms in 2009

In 2005, WakeMed Apex received CON approval for four operating rooms to be located in a freestanding ambulatory surgery center in Apex, in Southern Wake County, Project I.D. #J-7350-05. These operating rooms were not developed in accordance with the approved CON. In 2008, WakeMed determined that the southern Wake County market did not need additional operating rooms and proposed the four ORs approved in Project I.D. #J-7350-05 be relocated to the Brier Creek area of western Wake County, Project I.D. # J-8051-08. That application was subsequently denied. Again in June, 2009, WakeMed determined that the southern Wake County market did not need additional operating rooms and proposed that the four ORs approved in Project I.D. #J-7350-05 be relocated to the WakeMed Raleigh campus, Project I.D. #J-8364-09. That CON Application was approved in November 2009. If additional operating rooms are needed in the southern Wake County market at WakeMed Cary it is unclear why WakeMed did not propose relocating some or all of the WakeMed Apex ORs to Cary.

H. Blue Ridge Surgery Center is a Related Entity

WakeMed announced on March 24, 2010 that it would enter into a surgical services management agreement with Surgical Care Affiliates ("SCA"), effective March 31, 2010. According to the recent announcement from WakeMed regarding this partnership, included in Attachment 1, "The first part of the SCA agreement involves WakeMed purchasing a controlling interest in the general partnership that operates the Blue Ridge Surgery Center located on Lake Boone Trail in Raleigh. The Blue Ridge Surgery Center is managed by SCA and features six operating rooms and one procedure room, and includes 41 physician partners and over 100 physicians who perform surgeries in numerous specialties, including Orthopedics, ENT/Otolaryngology, Podiatry, Ophthalmology and more, The facility will now be jointly owned by WakeMed, these physician partners and SCA." As a result of this agreement, Blue Ridge Surgery Center (BRSC) is now a "related entity" as defined in the CON Criteria and Standards for Operating Room Projects at 10A NCAC 14C .2100. Therefore, WakeMed should have included discussions regarding the utilization of, and projections for, BRSC. The following table show current utilization of BRSC.

Blue Ridge Surgery Center Historical Utilization

Surgical Provider	2007	2008	2009
Outpatient Surgical Cases	5,296	5,474	5,904
Weighted Surgical Hours (Cases x 1.5 hrs per case)	7,944	8,211	8,856
OR Need @ 1,872 Hours per OR	4.2	4.4	4.7
Current OR Inventory	6	6	6
OR Surplus	-1.8	-1.6	-1.3

Source: Annual LRAs

The above table shows that BRSC is currently underutilized and has been for the last three years. WakeMed did not provide any discussions or assumption regarding future utilization of BRSC, therefore, the Application is non-conforming to the CON Criteria and Standards for Operating Room Projects at 10A NCAC 14C .2100.

I. Impact of Physician Investment in Rex Cary Surgical Center

As discussed in the Rex's Holly Springs Surgery Center CON Application, Project I.D. #J-8468-10, several physician groups listed on page 260 are identified by Rex as having become physician investors in the existing Rex Cary ASC. Many of these surgeons currently practice in Cary (i.e., Cary Urology letters at CON Application pages 285; Mann Ear Nose & Throat Clinic at CON Application pages 290-295; Carolina Ear Nose & Throat at CON Application page 296; North Carolina Urological Associates at CON Application pages 297-300); Physicians for Women at CON Application page 302; Triangle OB/GYN at CON Application pages 303 & 306; North Carolina Center for Reproductive Medicine at CON Application page 304-305.) Letters from these

physicians indicated the potential shift of over 4,000 outpatient cases annually from non-Rex surgical facilities to Rex Cary. While the specific non-Rex surgical facilities are not referenced the expansion of the surgical staff at Rex Cary Outpatient Surgical Center probably will have a negative impact on outpatient surgical utilization at WakeMed Cary.

G.S. 131E-183 (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.

As discussed in detail below, there is an alternative that would be more effective and less costly than the proposed project. That alternative is not discussed in the WakeMed Cary Hospital Application.

In September 2006, WakeMed received approval to add four ambulatory surgery operating rooms at WakeMed Apex Day Surgery Center.[7] WakeMed Apex Day Surgery Center was to be operational in October 2009.

On July 23, 2008, WakeMed was denied approval to change the location to the Brier Creek area of Raleigh of four operating rooms previously approved for WakeMed Apex.[8] On November 20, 2009, WakeMed received approval to develop a multispecialty ambulatory surgical facility with a total of eight multispecialty operating rooms and three procedure rooms (WakeMed Raleigh Surgery Center). Four non-operational operating rooms originally approved for WakeMed Apex Day Surgery Center, and four shared surgical operating rooms from WakeMed Raleigh Hospital will be relocated to WakeMed Raleigh Surgery Center.[9] WakeMed Raleigh Surgery Center will be located in 31,000 square feet of space on the second floor of a new building on Sunnybrook Road in Raleigh (1/3 of a mile from the WakeMed Raleigh Hospital).

In the WakeMed Raleigh Surgery Center Application Section VIII.1, Project Capital Cost Schedule, page 147, WakeMed, project the total capital cost for the project to be $33,120,541, which includes $1,193,500 in site preparation costs, $13,597,247 for construction costs, $12,832,480 for movable equipment, $170,500 for furniture, $1,311,900 for A & E fees, $ 1,061,581 financing costs, $1,213,235 for interest during construction, and $1,740,099 for other miscellaneous and contingency costs.

More than **four years after initial approval**, those four original operating rooms are not yet operational. WakeMed projects that those four original operating rooms will be operational in July 2011 at the WakeMed Raleigh Surgery Center.

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[7] Project I.D. # J-7350-05

[8] Project I.D. # J-8051-08

[9] Project I.D. # J-8364-09

On page 66 of the WakeMed Apex Day Surgery Center CON Application, WakeMed proposed the following zip code service area for WakeMed Apex Day Surgery Center.

WakeMed Apex Day Surgery Center
Proposed Service Area

Zip Code	City
27502	Apex
27519	Cary
27523	Apex
27526	Fuquay Varina, (Wake County portion only)
27539	Apex
27540	Holly Springs
27562	New Hill

On pages 60-61 of the WakeMed Apex Day Surgery Center CON Application, WakeMed provided the following table showing the zip codes comprising WakeMed Cary Hospital's service area.

WakeMed Cary Hospital
Service Area

ZIP Code	Municipality
27511	Cary
27513	Cary
27592	Willow Springs
27603	Raleigh
27606	Raleigh

The previous two tables show that the WakeMed Apex Day Surgery Center surgical operating rooms were approved originally for a population base in southern Wake County.

WakeMed stated the following in WakeMed Raleigh Surgery Center CON Application Section III.8, page 100:

> Apex will be adequately served by the WakeMed system as a result of this project. In fact, as evidenced by the split of current volume within the Apex Zip Code by facility, Apex residents already travel across the region for ambulatory surgery services. Given that residents travel so freely, and that, through the proposed project, WakeMed [Raleigh Surgery Center] will have adequate capacity to provide needed services, it is expected that the needs of those in Apex will be adequately served by WakeMed [Raleigh Surgery Center] as a result of the proposed project.

The Agency, however, noted on page 37 of the Findings for the WakeMed Raleigh Surgery Center CON Application:

> Residents of the Apex area choosing ambulatory surgery services at WakeMed Cary would have a drive time of 5 minutes and 10 miles distance. Choosing Ambulatory surgery service at WakeMed Raleigh Surgery Facility would mean a drive time of 23 minutes and 25 miles.

The alternative that makes more effective use of approved inventory would be to relocate three of four surgical operating rooms originally approved for WakeMed Apex Day Surgery Center and now approved for WakeMed Raleigh Surgery Center to WakeMed Cary Hospital, and to reclassify those rooms as shared surgical operating rooms at WakeMed Cary Hospital.

That alternative reduces driving time and distance by more than half for the residents of southern Wake County, and provides those residents with access to the originally approved WakeMed Apex Day Surgery Center. Access actually increases by reclassifying approved ambulatory surgical operating rooms as shared rooms because both inpatient and outpatient surgical cases can be performed in shared rooms.

The relocation/reclassification alternative would involve the same project cost as proposed by the WakeMed Cary Hospital Application, and would result in a downsized version of the WakeMed Raleigh Surgery Center, thereby reducing the approved project cost of $33,120,541.

Having not proposed the aforementioned alternative, the WakeMed Cary Hospital Application does not conform to Criterion (4).

G.S. 131E-183 (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.

As discussed above the comment pertaining to Review Criterion (3), WakeMed's surgical case volume projections are unreasonable and unreliable and insufficient documentation of assumptions was provided by the applicant. Since these OR case volume projections are the are used in the Form B WakeMed System projected Statement of Revenue and Expense, in the Form C WakeMed Cary Hospital Surgical Services (Inpatient & Outpatient Surgeries) Component projected Statement of Revenue and Expense, in the Form D WakeMed Cary Surgical Services Gross Revenue Worksheet, and in the Form E WakeMed Cary Surgical Services Net Revenue Worksheet, these CON ProForma Forms B through E financial projections are unreliable. Thus, they are non-conforming with Criterion (5).

In addition, as discussed above in Section II of these Comments (*"Impermissible Amendment of the WakeMed Cary CON Application While Under Review"*), WakeMed

announced on March 24, 2010 that it would enter into a surgical services management agreement with Surgical Care Affiliates ("SCA"), effective March 31, 2010 to assume the management of the WakeMed Cary Surgical programs. The WakeMed Cary surgical program FTEs will become employees of SCA. See articles in Attachment 1 to these Comments. WakeMed's CON ProForma financial projections and ProForma assumptions for this application, include no reference to or expense item in the Form B and Form C Statements of Revenue and Expense to account for the any payments or management contract fee for SCA. Thus, WakeMed's CON ProForma financial projections are flawed in such a manner that the Agency cannot determine if the project is financially feasible, based on the absence of a large expense item, the SCA management fee.

Based on the articles on WakeMed's web site and in the local media, SCA and WakeMed signed a Letter of Understanding on October 30, 2009, which was more than 90 days before WakeMed filed this CON application in February 2010 to add three ORs at WakeMed Cary. WakeMed simply failed to account for this material change to its application, when it had the prior knowledge to anticipate and to do so. WakeMed has impermissibly amended its application during the review cycle and the Agency should not consider this application and should remove it from the review of the competing applications for the 3 new ORs in Wake County based on a need determination in the *2010 SMFP*.

G.S. 131E-183 (6)

The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

The following table is complied based on Tables IV.1 through 4 on pages 102 through 105 of the WakeMed Cary Hospital CON Application. It shows the current and projected operating room inventory by facility for the WakeMed System.

WakeMed System
Current/Approved and Projected Operating Room Inventory by Facility

Type of Operating Room (current operating rooms)	WakeMed Raleigh Campus	WakeMed Cary Hospital	WakeMed North Healthplex	WakeMed Raleigh Surgery Center*	Total
Dedicated Open Heart Surgery	4	0	0	0	4
Dedicated C-Section	3	2	1	0	6
Other Dedicated Inpatient Surgery	0	0	0	0	0
Dedicated Ambulatory Surgery	0	0	4	8	12
Shared-Inpatient/Ambulatory Surgery	14	9	0	0	23
Total of Surgical Operating Rooms	**21**	**11**	**5**	**8**	**45**
Type of Operating Room (projected operating rooms)	**WakeMed Raleigh Campus**	**WakeMed Cary Hospital**	**WakeMed North Healthplex**	**WakeMed Raleigh Surgery Center**	**Total**
Dedicated Open Heart Surgery	4	0	0	0	4
Dedicated C-Section	3	2	1	0	6
Other Dedicated Inpatient Surgery	0	0	0	0	0
Dedicated Ambulatory Surgery	0	0	0	8	8
Shared-Inpatient/Ambulatory Surgery	14	12	4	0	30
Total of Surgical Operating Rooms	**21**	**14**	**5**	**8**	**48**

** Eight ambulatory surgical operating rooms at WakeMed Raleigh Surgery Center were approved to become operational in July 2011. Four of the eight approved rooms will be relocated from WakeMed Raleigh Campus to WakeMed Raleigh Surgery Center.*

As shown in the previous table, WakeMed seeks approval to increase its operating room inventory from 45 to 48 with the addition of three new shared surgical operating rooms at WakeMed Cary Hospital.

The following is an analysis of the utilization of surgical operating room inventory of each facility and the WakeMed System based on data reported in the 2010 Hospital License Renewal Applications of WakeMed Raleigh Campus and WakeMed Cary Hospital. The 2010 LRA contains the most recent publicly available data. WakeMed undoubtedly had access to the FFY 2009 data in its 2010 LRA which it submitted to the state in December 2009 per the state's deadline. But WakeMed chose not to discuss this information in its February 15, 2010 CON application for this project, even though it was the most current information available.

A. WakeMed Raleigh Campus

The following table shows surgical operating room utilization at WakeMed Raleigh Campus.

WakeMed Raleigh Campus
Operating Room Utilization
October 2008 – September 2009

	FFY 2009
Inpatient Cases*	7,005
Inpatient Hours (x 3.0)	21015
Outpatient Cases	9,334
Outpatient Hours (x 1.5)	14,001
Total Hours	35,016
Total Operating Rooms Needed at 1,872 Hours/Year	**18.7**
Total Operating Rooms**	21
OR Surplus/Deficit	**-2.3**

Source: 2010 LRA
**Cases do not including C-Section Cases performed in 3 dedicated C-Section rooms, open heart cases performed in 4 dedicated open-heart rooms. Trauma cases were not excluded because those cases cannot be ascertained from data reported in the 2010 LRA.*
***Total = (18 shared ORs - 1 shared OR because WakeMed Raleigh Campus is a Level I trauma center) + (4 ORs approved for relocation from WakeMed Apex to WakeMed Raleigh Surgery Center) - (4 O-H ORs).*
4 of the 18 shared ORs have been approved for relocation from WakeMed to WakeMed Raleigh Surgery Center.
Deficits appear as positive number; surpluses as negative numbers

The previous table shows a **surplus of two** surgical operating rooms at WakeMed Raleigh Campus.

B. WakeMed North

The following table shows utilization of the four ambulatory surgical operating rooms at WakeMed North.

WakeMed North
Operating Room Utilization
October 2008 – September 2009

	Oct 2008 – Sept 2009
Outpatient Cases	3,843
Outpatient Hours (x 1.5)	5,765
Total Operating Rooms Needed at 1,872 Hours/Year	**3.1**
Total Operating Rooms	4
OR Surplus/Deficit	**-0.9**

Source: 2010 LRA
**WakeMed Raleigh reports that WakeMed North has 4 ambulatory surgical operating rooms, which rooms are licensed under WakeMed Raleigh Campus.*
Deficits appear as positive number; surpluses as negative numbers

The previous table shows a **surplus of one** surgical operating room at WakeMed North.

In a footnote on page 26 of the WakeMed Cary Hospital CON Application, WakeMed states that upon completion of Project No. J-7843-07, an addition of 20 acute care beds and one dedicated C-Section room,"[t]he 4 existing operating rooms will, **by default, convert from dedicated ambulatory surgery to shared operating rooms.**" **[Emphasis added.]** It is not clear whether this assertion by WakeMed is consistent with the Agency conditions of approval for WakeMed's CON Project I.D. #J-7843-07.

In Section II., pages 59-61 of the WakeMed Raleigh Surgery Center CON Application, WakeMed states the following in reference to its operating room methodology assumptions, to include:

> - WakeMed North's percent of market surgeries will be stable, with a slight added increase as a result of the CON-approved inpatient beds opening in FY 2012. These new inpatient beds will be oriented to provide women's services. **A large percentage of these services will be obstetrics and will not utilize the four operating rooms at North.** However, one of inpatient women's services to be offered is gynecological procedures, and **that is expected to create a moderate increase in inpatient surgical case demand amounting to 180 cases beginning in FY 2012 and 260 cases in FY 2013. [Emphasis added.]**

In view of the upcoming change of identity of WakeMed North to a full service women's hospital, it is reasonable to expect that the number of outpatient surgical cases performed on men and children will decline. That decline has not been addressed by WakeMed in the WakeMed Cary Hospital CON Application. It also will likely not be addressed because it appears to be WakeMed's position that it is not necessary to submit a CON application for approval to convert four dedicated ambulatory surgery operating rooms to four shared use inpatient/outpatient ORs at WakeMed North.

Based on the aforementioned, it is reasonable to expect that the surplus of surgical operating rooms at WakeMed North may increase.

C. WakeMed Cary Hospital

The following table shows the historical utilization of existing operating rooms at WakeMed Cary Hospital.

WakeMed Cary Hospital
Operating Room Utilization
October 2008 – September 2009

	Oct 2008 – Sept 2009
Inpatient Cases*	1,947
Inpatient Hours (x 3.0)	5,841
Outpatient Cases	7,273
Outpatient Hours (x 1.5)	10,910
Total Hours	16,751
Total Operating Rooms Needed at 1,872 Hours/Year	**8.9**
Total Operating Rooms*	9
OR Surplus/Deficit	**-0.1**

Source: 2010 LRA
**Cases do not including C-Section Cases performed in 3 dedicated C-Section rooms*
***WakeMed Cary Hospital reports that all of its existing operating rooms are shared inpatient/outpatient operating rooms.*
Deficits appear as positive number; surpluses as negative numbers

The previous table shows that WakeMed Cary has **no need for** an additional surgical operating room. The WakeMed Cary Hospital Application **proposes to add three** shared surgical operating rooms when there is a surplus in all other WakeMed System facilities.

An alternate way to look at this, which comes to the same conclusion, is explained below:

- In the base year immediately prior to the opening of the three new ORs at WakeMed Cary (the 12 months ending 9/20/2012 or FFY 2012), WakeMed Cary is projected to perform 10,616 inpatient and outpatient surgical cases (excluding cases performed in the dedicated C-Section and dedicated open heart ORs).
- By the end of Project Year 2 (FFY 2015, 10/1/2104 -9/302015), WakeMed Cary has projected 12,112 inpatient and outpatient surgical cases (excluding cases performed in the dedicated C-Section and dedicated open heart ORs).
- The growth in OR cases between the end of the base year prior to the addition of three new ORs (FFY 2012) and the end of Project Year 3 (FFY 2015) is 1,496 surgical cases or approximately 500 OR cases per year.
- If the 1,496 OR cases are divided by existing 9 WakeMed Cary ORs (excluding C-Section and Open Heart dedicated ORs), assuming WakeMed Cary is not approved to add 3 new ORs, then each of the existing nine ORs is performing, on average 166.2 more OR cases per year per OR.
- When the 166.2 OR annual cases per OR are divided by 260 days per year (the number of days each year that ORs are assumed to be in operation per the SMFP OR Need Method), this shows that over the four year time period (base year to the end of Project Year 3), there is only an increase of 0.64 OR cases per OR per day. This type of modest increase does not justify the addition of three new ORs at WakeMed Cary.

WakeMed Cary has failed to demonstrate the need for three new ORs.

D. WakeMed System

The following table shows the utilization of all operating rooms at all WakeMed locations.

WakeMed System
Operating Room Utilization
October 2008 – September 2009

	Oct 2008 – Sept 2009
Inpatient Cases*	8,952
Inpatient Hours (x 3.0)	26,856
Outpatient Cases	20,450
Outpatient Hours (x 1.5)	30,675
Total Hours	57,531
Total Operating Rooms Needed at 1,872 Hours/Year	**30.7**
Total Operating Rooms**	34
OR Surplus/Deficit	**-3.3**

Source: 2010 LRAs
**Cases do not including C-Section Cases performed in 3 dedicated C-Section rooms, open heart cases performed in 4 dedicated open-heart rooms. Trauma cases were not excluded because those cases cannot be ascertained from data reported in the 2010 LRA.*
***Total = (18 shared ORs - 1 shared OR because WakeMed Raleigh Campus is a Level I trauma center) + (4 ORs approved for relocation from WakeMed Apex to WakeMed Raleigh Surgery Center) - (4 O-H ORs). 4 of the 18 shared ORs have been approved for relocation from WakeMed to WakeMed Raleigh Surgery Center.*
Deficits appear as positive number; surpluses as negative numbers

The previous table shows that: **3.3 of 34** existing surgical operating rooms or 9.7% are surplus surgical operating room capacity. Those surgical operating rooms were underutilized during the most recent complete federal fiscal year (FFY 2009, 10/1/2008 – 9/30/2009) prior to the February 15, 2010 submission of the WakeMed Cary Hospital Application.

In the CON Criteria and Standards for Operating Room (10A NCAC 14C .2100), there is no explicit prohibition disqualifying an applicant with underutilized surgical operating rooms from applying for new operating rooms, even if to do so would further exacerbate that applicant's existing surplus of surgical operating rooms.

WakeMed proposes to increase its existing and approved surgical operating room inventory by **three** to a total of **48** surgical operating rooms system-wide. The proposed addition of three shared surgical operating rooms at Wake Med Cary Hospital is an unnecessary duplication of existing and approved surgical capacity, which does not conform to Criterion (6).

G.S. 131E-183 (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.

When compared to the to the cost to implement the new Wake County ORs proposed by Novant's Holly Springs Surgery Center and by WakeMed Cary, the Construction Cost Per Square Foot is higher for the WakeMed Cary three new ORs. The comparative Construction Cost per Square Foot for all five competing applications is listed below. WakeMed Cary's construction cost per square foot is the second highest among the five applicants and is $207/SF more than the lowest cost applicant proposing to implement the ORs in a hospital setting.

Construction Cost Per SF

- DRH for 2 New ORs: $360/SF
- Novant's Holly Springs Surgery Center for 3 new ORs: $246/SF
- Rex's Hospital-Based Holly Springs ASC for 2 new ORs: $339/SF
- Rex Hospital for 1 new OR: $570/SF
- WakeMed Cary for 3 new ORs in the hospital: $567/SF

In addition, WakeMed Cary's Total Capital Cost per SF, for the implementation of the three new ORs is the highest of among the five competing applicants and is also the highest among the three applicants proposing to place new ORs into service in the hospital setting:

- DRH for 2 New ORs: $726/SF
- Novant's Holly Springs Surgery Center for 3 new ORs: $635/SF
- Rex's Hospital-Based Holly Springs ASC for 2 new ORs: $631/SF
- Rex Hospital for 1 new OR: $1,063/SF
- WakeMed Cary for 3 new ORs in the hospital: $1,776/SF

Thus, WakeMed Cary's "cost, design, and means of construction" does not represent the most "reasonable alternative," and should be found non-confirming with Criterion (6).

G.S. 131E-183 (13)

The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and members of the 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 identified in the State Health Plan as deserving of priority.

Charity Care Policies

In addition, the comparison below of Wake Med's Charity Care policy with that of Novant Health's for Holly Springs Surgery Center shows that WakeMed Charity Care Policy coverage is less generous. WakeMed's Charity Care policy, found in CON Application Exhibit 28, provides for a 100% of Forgiveness of Debt for households with income up to 200% of the Federal Poverty Level. Novant Health's Charity Care Policy provides 100% Forgiveness of Debt for households up to 300% of Federal Poverty Level. See CON Application Exhibit 9 for a copy of the Novant/HSSC Charity Care policy. For example, at WakeMed Cary a family of four with annual household income of $44,100 can qualify for 100% Forgiveness of Debt for surgical services bills from WakeMed Cary and at Novant Health's Holly Springs Surgery Center a family of four with annual household income of $66,150 can qualify for 100% Forgiveness of Debt for surgical bills from HSSC. Under Novant's Charity Care policy, a family of four can have annual household income that is $22,050 greater than that permitted under the WakeMed Charity Care policy and still qualify for 100% discount or Forgiveness of Debt. Novant's Charity Care policy provides greater coverage or Forgiveness of Debts for Families with household incomes between 201% and 300% of the Federal Poverty Level as illustrated below.

Annual Household Income % of FPL	WakeMed/WakeMed Cary		Novant's Holly Springs Surgery Center	
	Discount off Charges	Family of 4 Annual Household Income	Discount off Charges	Family of 4 Annual Household Income
276%-300%	20%	$60,858-$66,150	100%	$60,637-$66,150
250%-275%	40%	$55,125 - $66,149	100%	$55,125 - $66,149
225%-249%	60%	$49,163- $55,124	100%	$49,163- $55,124

A comparison of the Section VI and CON ProForma payor mix information, from both the WakeMed Cary and Novant Health's Holly Springs Surgery Center shows that as measured by surgical case payor mix information for the medically underserved populations identified in Statutory Review Criterion (13), that HSSC's access for the medically underserved is comparatively superior

In addition, a recent third party independent report[10] has confirmed the following regarding the Novant Charity Care Policy, based on a comparative review of North Carolina Health System Charity Care policies:

- Several hospitals and health systems deserve special recognition for providing charity care levels that exceed the cost of living for their region, including ***Novant Health,*** UNC Health Care, University Systems of Eastern NC, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System, and Margaret Pardee Memorial Hospital.
- …Winston-Salem and Charlotte-based Novant Health has the most sound and clear policy of any hospital system in North Carolina. At Novant any uninsured patients with an income less than 300% of federal poverty level, or $66,150 for a family of four, qualifies for a 100% discount on hospital bills. This recognizes the realities of modern family finances.
- „Novant sets its 100 percent discount rate at 300 percent of federal poverty guidelines. Novant's policy also does well when compared to the LIS [Living Income Standard produced by the NC Justice Center's Budget & Tax Center]. In Mecklenburg County, where Novant runs the well-regarded Presbyterian Hospital, the LIS for a two adult and two child family is 220.7 percent of federal poverty level.
- A few hospitals are more generous and provide discounts that match the LIS for a two adult and two child family for the county in which the hospital is located. Novant's policy exceeds the LIS in every county where the system operates.
- We applaud those hospitals that post comprehensive policies on line for their openness and accountability. ***Novant Health***, UNC Health Care, University Health Systems of Eastern NC, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System, and Margaret Pardee Memorial Hospital stand out as providing excellent charity care policies.

[10]NC Justice Center, NC Health Access Coalition (Vol 2, No 2—February 2010), "*How Charitable are North Carolina Hospitals" A Look at Financial Assistance Policies for the Uninsured."*

Access for Medically Underserved Populations

Medically Underserved Payor Mix Comparison
WakeMed Cary and Holly Springs Surgery Center
Project Year 2

Payor Category for Medically Underserved	WakeMed Cary (3 New ORs)	Novant's Holly Springs Surgery Center (3 New ORs)
Self-Pay	2.92%	6.97%
Medicare	26.23%	31.08%
Medicaid	4.96%	9.12%
SubTotal Medically Underserved	*34.11%*	*47.17%*

Source: WakeMed Cary CON App Response to Question VI.14 (page 132)
Novant's Holly Springs Surgery Center CON App Response to Question VI.14 (page 115)

This data shows that Novant's Holly Springs Surgery Center is the comparatively superior applicant in terms of providing access to medically underserved populations as measured by the Charity Care Policy and the Payor Mix data for surgical cases provided to medically underserved populations.

IV. CON Criteria and Standards for Operating Room – 10A NCAC 14C .2100

The proposed project is non-conforming to the Criteria and Standards for Operating Rooms as follows:

10A NCAC 14C .2103 Performance Standards

10A NCAC 14C .2103(b)(1)(A) and (c)(1)(A)

As discussed in detail in the context of Criterion (3), WakeMed based its projections on unreasonable assumptions, which result in overstated projections. Overstated projections have been used to demonstrate a need for the proposed three additional shared surgical operating rooms. WakeMed has not demonstrated a need for the proposed total of 12 shared surgical operating rooms. As a result, WakeMed Cary has not shown that its projections conform to the performance standard set forth in 10A NCAC 14 .2103(b)(1(A) and .2103(c)(1)(A).

Furthermore, WakeMed failed to disclose and discuss the partnership with SGA, which results in WakeMed owning part of BRSC. As a result, BRSC is a "related entity" which was not considered in the WakeMed Cary Application.

Consequently, the WakeMed Cary Hospital Application should be denied for failure to conform to the Criteria and Standards for Operating Rooms.

V. Conclusion

The CON Application submitted by WakeMed fails to conform to key Criterion reflected in G.S. 131E-183. The project fails to document the need for the proposed three additional shared use inpatient/outpatient surgical operating rooms at WakeMed Cary Hospital. When an applicant has failed to demonstrate need in conformity with CON Statutory Review Criterion (3) it is also found derivatively non-conforming with CON Statutory Review Criteria (1), (4), (5), (6) and (18a).

Most crucially, WakeMed, by entering into a management agreement with Surgical Care Affiliates for the WakeMed Cary surgical program, impermissibly amended its CON application while that application is still under review by the Agency. WakeMed proposes to place the three new ORs at WakeMed Cary and the management of the surgical program at WakeMed Cary has changed while the CON application is under review. Thus, the WakeMed application for three new ORs at WakeMed Cary must be dismissed from this review cycle by the Agency. See the discussion above in Section II of this issue and the reference to the relevant North Carolina Court of Appeals case.

File: WakeCountyNovantCIOForWakeMed Cary ORs FINAL.03.31.2010.doc

Current Releases

WakeMed Partners with Surgical Care Affiliates to Enhance Ambulatory Surgery Program

RALEIGH, N.C. (March 24, 2010) – WakeMed Health & Hospitals and Surgical Care Affiliates (SCA) will enter into a formal agreement on March 31, 2010 to further enhance existing ambulatory surgery services throughout the WakeMed system.

WakeMed and SCA have been exploring a formal relationship for nearly 16 months as part of the long-term WakeMed Cary Hospital and overall WakeMed ambulatory strategy. The goal of this new partnership is to grow WakeMed's outpatient surgery business by providing WakeMed's surgical patients and physicians with outstanding service, including greater efficiencies, consistent practices across the system, and increased capacity for outpatient surgery throughout Wake County.

The first part of the SCA agreement involves WakeMed purchasing a controlling interest in the general partnership that operates the Blue Ridge Surgery Center located on Lake Boone Trail in Raleigh. The Blue Ridge Surgery Center is managed by SCA and features six operating rooms and one procedure room, and includes 41 physician partners and over 100 physicians who perform surgeries in numerous specialties, including Orthopaedics, ENT/Otolaryngology, Podiatry, Ophthalmology and more. The facility will now be jointly owned by WakeMed, these physician partners and SCA. This purchase provides WakeMed with significant gains in the Wake County ambulatory surgery market share and new opportunities for long-term growth.

The second part of this new relationship includes a management services agreement with SCA. Specifically, SCA will begin managing surgical services operations for WakeMed Cary Hospital and WakeMed North Healthplex Day Surgery program. SCA has a long track record of managing and operating successful surgery programs. While WakeMed has significant experience in inpatient surgery operations, SCA brings even more efficiencies and experience in the operation of outpatient surgery centers.

Cary Hospital Management Agreement:

Effective May 17, 2010, 142 WakeMed Cary Hospital Surgical Services employees will transition to working directly for SCA. In fiscal year 2009, WakeMed Cary Hospital performed a total of 14,006 surgeries,11,342 of which were outpatient. This partnership is expected to provide WakeMed with even greater opportunities for efficiencies and improved services and satisfaction for our customers.

North Healthplex Management Agreement:

At North Healthplex, Surgical Services employees will continue to work for WakeMed, with the exception of the manager. The reason North Healthplex employees will not work directly for SCA is because North Healthplex is not a stand-alone hospital, but is legally considered an extension of the Raleigh Campus. In fiscal year 2009, North Healthplex performed 4,438 surgeries, all of which were outpatient. The WakeMed Raleigh Campus surgical services are not impacted by this agreement.

"Partnering with Surgical Care Affiliates supports WakeMed's long-term ambulatory growth strategy and will help us to continue to meet the outpatient surgery needs of this community," explains Dr. Bill Atkinson, president & CEO. "With the purchase of Blue Ridge and the management services agreement, we are well positioned for volume growth in our ambulatory surgery program while further enhancing the service we provide to our surgical patients and physician partners."

"We are honored to be selected to enter into this relationship with the WakeMed system", said Andrew Hayek, president and CEO of Surgical Care Affiliates. Surgical Care Affiliates' commitment is to bring the best practices from our surgical facility operations across the country to the WakeMed system. We believe that this relationship will enhance WakeMed's position as the premier health system in Raleigh and further position Surgical Care Affiliates as the partner of choice for health systems and physicians in providing surgical services.

About Surgical Care Affiliates
Surgical Care Affiliates is committed to being the partner of choice for physicians, hospitals, and health systems in delivering high quality surgical services. SCA's centers operate with outstanding clinical outcomes and patient satisfaction. SCA operates 124 ambulatory surgery centers and surgical hospitals across the country with approximately 4,000 full time teammates and approximately 2,000 physician partners across the country. For more information on SCA, visit www.scasurgery.com.

About WakeMed Health & Hospitals
WakeMed Health & Hospitals, one of the first hospital systems in the country, is a private, not-for-profit health care organization based in Raleigh, N.C. The 870-bed system comprises a network of health care facilities throughout Wake and Johnston Counties, including: a Level I Trauma Center and tertiary referral hospital and rehabilitation hospital in Raleigh, a community hospital in Cary, comprehensive outpatient centers and freestanding emergency departments in North Raleigh and Apex, seven outpatient rehabilitation sites, two skilled-nursing and outpatient facilities, a 100+-physician multispecialty practice, and home health services. The system includes accredited Chest Pain Centers and Joint Commission-certified Stroke Centers. Throughout the system, there are an additional 60 beds under construction and 41 newly approved by the state. WakeMed also provides management services for Betsy Johnson Regional Hospital in Dunn, NC. Centers of excellence include cardiac and vascular care, women's and children's services, physical rehab, emergency and trauma, orthopaedics, neurosciences, home care and numerous wellness and community outreach programs. WakeMed's team of 7,750 employees, including but not limited to nurses, technologists and medical support staff, 1,000 volunteers and more than 1,000 affiliated physicians serve the residents of North Carolina using the most advanced technologies and facilities to ensure the finest in health care.

Triangle Business Journal - March 24, 2010
/triangle/stories/2010/03/22/daily40.html

Attachment 1

TRIANGLE BUSINESS JOURNAL

Wednesday, March 24, 2010, 6:57pm EDT | Modified: Thursday, March 25, 2010, 12:01am

WakeMed cuts deal with Surgical Care Affiliates to gain surgery share

Triangle Business Journal - by Jeff Drew

WakeMed Health & Hospitals has reached an agreement on a partnership with **Surgical Care Affiliates** designed to grow WakeMed's outpatient surgery business.

MEDIA

The deal, announced Wednesday, has two main parts.

1. WakeMed will become majority owner of the **Blue Ridge Surgery Center**, an SCA-managed operation with six operating rooms, one procedure room and 41 physician partners.

2. Birmingham, Ala.-based SCA will take over surgical services management at WakeMed Cary Hospital and at the WakeMed North Healthplex Day Surgery program. As part of the deal, 142 WakeMed Cary Hospital workers will become SCA employees as of May 17. The surgical-services employees at WakeMed North will continue to work for WakeMed.

Financial terms were not released for the agreement, which came after 16 months of negotiations. The companies signed a letter of understanding in October that set up the framework for the two parties to explore partnership opportunities.

With its purchase of the controlling interest in the Blue Ridge Surgery Center, WakeMed grows its market share in outpatient surgery. The surgery center, located on Lake Boone Trail in Raleigh near WakeMed rival Rex Hospital, employs more than 100 doctors who perform surgeries in specialties ranging from orthopedics and podiatry to ears, nose, throat and eyes.

"Partnering with Surgical Care Affiliates supports WakeMed's long-term ambulatory growth strategy and will help us to continue to meet the outpatient surgery needs of this community," said WakeMed President and CEO Bill Atkinson. "With the purchase of Blue Ridge and the management services agreement, we are well positioned for volume growth in our ambulatory surgery program while further enhancing the service we provide to our surgical patients and physician partners."

With 7,500 employees, WakeMed is one of the largest employers in the Triangle area. SCA manages surgical services at dozens of facilities nationwide.

Reporter e-mail: jdrew@bizjournals.com.

Attachment 2

WakeMed partners with outpatient surgery chain

Wake County's largest hospital system will join forces with an Alabama company that runs a chain of outpatient surgery centers across the country as it continues to expand its surgery business.

Under the partnership announced today, WakeMed will buy a controlling interest in the Blue Ridge Surgery Center now run by Surgical Care Affiliates, just down the street from rival Rex Hospital in west Raleigh. And SCA will help WakeMed manage its outpatient surgery centers in Cary and Raleigh.

About 140 WakeMed employees in Cary will transfer to SCA in May. No job cuts are expected, said WakeMed CEO William Atkinson, left.

SCA also will help WakeMed develop a new outpatient center adjacent to its main campus in Raleigh. Construction on that $60.7 million facility, which has already won state regulatory approval, is expected to begin by early 2011.

Demand for outpatient surgery centers is increasing as Wake County's population continues to grow. Efforts to control medical costs under health-care reform also are expected to increase demand for such centers, which are cheaper to run than full, inpatient hospitals.

With the SCA partnership and the new surgery center planned in Raleigh, WakeMed expects to go from doing about 26,000 outpatient surgeries a year to nearly 39,000.

"We're now beginning to invest heavily in ambulatory surgery centers," Atkinson said. "They bring some expertise in dealing with these types of centers."

SCA runs a chain of 129 centers, including six in North Carolina, and can help WakeMed reduce costs for supplies and standardize the quality of its outpatient care, said W. Stan Taylor, WakeMed's vice president of corporate planning.

Financial terms of the deal weren't disclosed. The two organizations began negotiations more than a year ago. The deal gives SCA a stronger foothold in the fast-growing Wake County market.

"Surgical Care Affiliates' commitment is to bring the best practices from our surgical facility operations across the country to the WakeMed system," said SCA CEO Andrew Hayek, in a prepared statement.

SCA was formed in 2007 when an investment firm bought the outpatient surgery division of HealthSouth, a publicly traded health-services company also based in Birmingham.

About the blogger

Assistant Business Editor Alan M. Wolf joined the N&O in 1999 covering the business of health care. He became an editor in 2001, and helps oversee the paper's daily business coverage and Sunday Work&Money section. He lives in Clayton with his wife and two children. Reach him at 919-829-4572 or e-mail him.

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Attachment 1

North Carolina's WakeMed Partners with Surgical Care Affiliates to Enhance Ambulatory Surgery Program

By Staff | March 25, 2010

Tags: North Carolina | Surgical Care Affiliates | WakeMed

Raleigh, N.C.-based WakeMed Health & Hospitals has entered into a formal agreement with Surgical Care Affiliates to expand WakeMed's ambulatory surgery services, according to an SCA news release.

Under the agreement, WakeMed will purchase a controlling interest in Blue Ridge Surgery Center in Raleigh, which is operated by SCA. The facility will be jointly owned by WakeMed, physician partners and SCA. Secondly, SCA will manage the surgical service operations for WakeMed Cary (N.C.) Hospital and WakeMed North Healthplex Day Surgery program.

Effective May 17, 2010, WakeMed Cary Hospital surgical services employees will transition to working directly for SCA. At North Healthplex, surgical services employees will continue to work for WakeMed, with the exception of the manager. The reason North Healthplex employees will not work directly for SCA is because North Healthplex is not a stand-alone hospital, but is legally considered an extension of the Raleigh campus, according to the release.

"Partnering with Surgical Care Affiliates supports WakeMed's long-term ambulatory growth strategy and will help us to continue to meet the outpatient surgery needs of this community," Bill Atkinson, MD, president & CEO of WakeMed, said in the release. "With the purchase of Blue Ridge and the management services agreement, we are well positioned for volume growth in our ambulatory surgery program while further enhancing the service we provide to our surgical patients and physician partners."

Andrew Hayek, president and CEO of Surgical Care Affiliates, adds, "We are honored to be selected to enter into this relationship with the WakeMed system. Surgical Care Affiliates' commitment is to bring the best practices from our surgical facility operations across the country to the WakeMed system. We believe that this relationship will enhance WakeMed's position as the premier health system in Raleigh and further position Surgical Care Affiliates as the partner of choice for health systems and physicians in providing surgical services."

Read the release on the WakeMed and SCA partnership.

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WakeMed Partners with Surgical Care Affiliates to Enhance Ambulatory Surgery Program

Triangle -

RALEIGH, N.C. (March 24, 2010) – WakeMed Health & Hospitals and Surgical Care Affiliates (SCA) will enter into a formal agreement on March 31, 2010 to further enhance existing ambulatory surgery services throughout the WakeMed system.

WakeMed and SCA have been exploring a formal relationship for nearly 16 months as part of the long-term WakeMed Cary Hospital and overall WakeMed ambulatory strategy. The goal of this new partnership is to grow WakeMed's outpatient surgery business by providing WakeMed's surgical patients and physicians with outstanding service, including greater efficiencies, consistent practices across the system, and increased capacity for outpatient surgery *throughout Wake County.*

The first part of the SCA agreement involves WakeMed purchasing a controlling interest in the general partnership that operates the Blue Ridge Surgery Center located on Lake Boone Trail in Raleigh. The Blue Ridge Surgery Center is managed by SCA and features six operating rooms and one procedure room, and includes 41 physician partners and over 100 physicians who perform surgeries in numerous specialties, including Orthopaedics, ENT/Otolaryngology, Podiatry, Ophthalmology and more. The facility will now be jointly owned by WakeMed, these physician partners and SCA. This purchase provides WakeMed with significant gains in the Wake County ambulatory surgery market share and new opportunities for long-term growth.

The second part of this new relationship includes a management services agreement with SCA. Specifically, SCA will begin managing surgical services operations for WakeMed Cary Hospital and WakeMed North Healthplex Day Surgery program. SCA has a long track record of managing and operating successful surgery programs. While WakeMed has significant experience in inpatient surgery operations, SCA brings even more efficiencies and experience in the operation of outpatient surgery centers.

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Posted on:
Thursday, March 25, 2010 08:03 AM

Current Releases

WakeMed and Surgical Care Affiliates Enter into Venture for Ambulatory Surgery

RALEIGH, N.C. (October 29, 2009) – WakeMed Health & Hospitals and Surgical Care Affiliates (SCA) have entered into a Letter of Understanding (LOU) under which the two organizations will explore partnership opportunities.

These opportunities may include WakeMed becoming a majority partner in the entity that operates Blue Ridge Surgery Center with SCA continuing to manage the operations. SCA may be engaged to manage the daily operations of WakeMed's outpatient surgery locations. The two organizations also will evaluate the option of working together to grow existing outpatient surgery offerings and develop new projects. The organizations expect to execute definitive agreements by the end of February 2010.

"WakeMed excels at running large inpatient surgery programs, and Surgical Care Affiliates has extensive knowledge of outpatient surgery businesses. We are exploring this partnership to share our specialized expertise in different surgery environments," commented Dr. Bill Atkinson, WakeMed president and CEO. "Increasingly, new technology and advanced procedures are enabling more surgeries to be completed in an outpatient setting. The outpatient surgery model enhances access and convenience for our patients. We are pleased to be working with the physician partners and SCA on this potential ambulatory care venture in Wake County."

Andrew Hayek, President and CEO of SCA, said, "We are excited about the opportunity to partner with this extraordinary health care system to provide quality, efficient healthcare in the Raleigh community. Together with our physician partners, we can make a tremendous positive impact on the patient experience."

WakeMed currently offers outpatient surgery at three locations including WakeMed North Healthplex, WakeMed Cary Hospital and WakeMed Raleigh Campus. In fiscal year 2009 WakeMed completed 28,053 outpatient surgery procedures. SCA through its partnership with 38 surgeons at the Blue Ridge Surgery Center performed 8,500 outpatient procedures in the last 12 months.

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(Logo: http://www.newscom.com/cgi-bin/prnh/20080812/CLTU111LOGO)

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Attachment 1

Surgical Care Affiliates, WakeMed Discuss Potential Partnership

Written by Staff | October 30, 2009

Tags: North Carolina | partnership | Surgical Care Affiliates | WakeMed

Raleigh, N.C.-based WakeMed, a 870-bed, non-profit hospital and healthcare system, is exploring a potential partnership with Surgical Care Affiliates, which manages ASCs throughout the country, according to a report in *The News & Observer*.

Possible outcomes of a merger could be SCA managing WakeMed's three outpatient centers in Raleigh and Cary, N.C., or WakeMed purchasing a majority stake in SCA's Blue Ridge Surgery Center, according to the report.

Under a partnership, WakeMed would be able to use SCA's experience to expand its number of outpatient centers in the region and allow WakeMed to access a broader base of physicians and a partner experienced in managing outpatient centers, according to the report.

WakeMed is currently planning on building a $60.7 million outpatient center next to its flagship hospital in Raleigh, and the company filed plans with the state in June.

Both companies expect to make a decision regarding an agreement by February.

Read the *News & Observer's* report about the potential WakeMed/SCA partnership.

Comments

Loading comments...

Court of Appeals of North Carolina.
PRESBYTERIAN-ORTHOPAEDIC HOSPITAL,
Petitioner-Appellant,
v.
NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, DIVISION OF FACILITY SERVICES, CERTIFICATE OF NEED SECTION,
Respondent-Appellee,
and
Mercy Hospital, Inc., Intervenor-Respondent-Appellee,
and
Stanly Memorial Hospital, Inc., Intervenor-Respondent-Appellee.
No. COA94-1358.

June 4, 1996.

Hospital appealed decisions of Department of Human Resources Division of Facility Services denying its application to develop rehabilitation unit, approving another hospital's application and conditionally approving a third hospital's application, downsizing its application from 20 to ten beds. The Court of Appeals, Eagles, J., held that: (1) petitioner hospital's application was properly denied as proposing insufficient staff for the unit; (2) genuine issue of material fact as to whether grant of certificate of need for ten beds to respondent hospital instead of 20 beds originally applied for was financially feasible precluded summary judgment and required contested case hearing; and (3) respondent hospital's action, after its application was complete and while review of competing applications was in progress, of changing its management company for the proposed unit constituted impermissible material amendment of its application.

Affirmed in part, and reversed and remanded in part.

West Headnotes

[1] Health 198H ⚿239

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk236 Licenses, Permits, and Certificates
198Hk239 k. Grounds and Defenses. Most Cited Cases
(Formerly 204k1 Hospitals)
Hospital's application for certificate of need to develop rehabilitation beds was properly denied as proposing insufficient staff for the unit. G.S. § 131E-183(a)(5, 7).

[2] Administrative Law and Procedure 15A ⚿472

15A Administrative Law and Procedure
15AIV Powers and Proceedings of Administrative Agencies, Officers and Agents
15AIV(D) Hearings and Adjudications
15Ak469 Hearing
15Ak472 k. Elements and Essentials in General. Most Cited Cases
"Contested case hearing" is full adjudicatory hearing during which parties have opportunity to present arguments on issues of law and policy and to present evidence on issues of fact. G.S. § 150B-25(c).

[3] Health 198H ⚿242

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk236 Licenses, Permits, and Certificates
198Hk242 k. Proceedings on Application. Most Cited Cases
(Formerly 204k1 Hospitals)
Genuine issue of material fact as to whether grant by Department of Human Resources Division of Facility Services of a certificate of need for ten ad-

ditional rehabilitation beds to hospital instead of the 20 beds originally applied for was financially feasible precluded summary judgment and required contested case hearing. G.S. §§ 131E-183, 150B-25(c).

[4] Health 198H ⇐241

198H Health
198HI Regulation in General
198HI(C) Institutions and Facilities
198Hk236 Licenses, Permits, and Certificates
198Hk241 k. Application. Most Cited Cases
(Formerly 204k1 Hospitals)

Hospital's action, after its application for certificate of need to develop rehabilitation beds was complete and while review of competing applications was in progress, of changing its management company for the unit constituted impermissible material amendment of its application. N.C.Admin. Code title 10, r. 3R0306.

****832 *531** Appeal by petitioner from final decision entered 6 June 1994 by Director John M. Syria of the North Carolina Department of Human Resources Division of Facility Services. Heard in the Court of Appeals 13 September 1995.

The 1993 State Medical Facilities Plan identified a need for twenty rehabilitation beds in Health Service Area III, an eight county area in western North Carolina including Mecklenburg and Stanly Counties. Petitioner Presbyterian-Orthopaedic Hospital (hereinafter Presbyterian) and intervenor-respondents Mercy Hospital, Inc. (hereinafter Mercy) and Stanly Memorial Hospital, Inc. (hereinafter Stanly) applied to the Certificate of Need Section of the North Carolina Department of Human Resources (hereinafter respondent) for certificates of need to develop rehabilitation beds at their respective hospitals. Presbyterian and Mercy each submitted applications to develop twenty additional rehabilitation beds and Stanly submitted an application to develop a ten bed rehabilitation unit. Respondent denied Presbyterian's application, approved Stanly's application, and conditionally approved Mercy's application, downsizing Mercy's application from twenty beds to ten beds.

On 30 July 1993, Presbyterian filed a petition for a contested case hearing with the Office of Administrative Hearings (hereinafter OAH) challenging the denial of its application and the approval of Mercy's and Stanly's applications. The Administrative Law Judge (hereinafter ALJ) allowed Mercy's and Stanly's motions to intervene. Presbyterian subsequently moved for summary disposition, arguing that respondent materially changed Mercy's application in violation ***532** of G.S. 150B-23 and that Stanly unlawfully amended its application after filing. Presbyterian argued that respondent exceeded its statutory authority by downsizing Mercy's ****833** project from twenty beds to ten beds because Mercy could not demonstrate that a ten bed project would conform with the review criteria set out in G.S. 131E-183. Presbyterian argued that Stanly unlawfully amended its application "by dismissing its management company, which was the cornerstone of its application, and by changing plans regarding its psychiatric bed conversion and construction."

Respondent, Mercy, and Stanly all filed motions with the OAH for partial summary judgment arguing that respondent properly denied Presbyterian's certificate of need. Respondent, Mercy, and Stanly all argued that Presbyterian's application failed to meet mandatory statutory and regulatory criteria because Presbyterian's application proposed insufficient staff for the rehabilitation unit and Presbyterian's application failed to justify the proposed new construction in light of its historical underutilization of its acute care beds.

In his recommended decision, the ALJ granted all parties' motions for summary judgment, concluding that none of the hospital applicants should receive certificates of need. The Director of the Division of Facility Services entered a final agency decision in which he adopted the ALJ's recommended decision that Presbyterian should be denied a certificate of

need, but ordered that Mercy and Stanly be granted certificates of need, in effect granting summary judgment in favor of Mercy and Stanly.

Presbyterian appeals.

Parker, Poe, Adams & Bernstein L.L.P. by Renee J. Montgomery and James C. Thornton, Raleigh, for petitioner-appellant.

Attorney General Michael F. Easley by Assistant Attorney General Sherry L. Cornett, Raleigh, for respondent-appellee.

Petree Stockton, L.L.P. by Noah H. Huffstetler, III and Sharon L. McConnell, Raleigh, for intervenor-respondent-appellee Mercy Hospital, Inc.

Maupin Taylor Ellis & Adams, P.A. by Robert L. Wilson, Jr. and James E. Gates, for intervenor-respondent-appellee Stanly Memorial Hospital, Inc.

***533** EAGLES, Judge.

I.

Our review of final agency decisions is governed by G.S. 150B-51(b). Pursuant to G.S. 150B-51(b):

[T]he court reviewing a final decision [of an administrative agency] may affirm the decision of the agency or remand the case for further proceedings. It may also reverse or modify the agency's decision if the substantial rights of the petitioners may have been prejudiced because the agency's findings, inferences, conclusions, or decisions are:

(1) In violation of constitutional provisions;

(2) In excess of the statutory authority or jurisdiction of the agency;

(3) Made upon unlawful procedure;

(4) Affected by other error of law;

(5) Unsupported by substantial evidence admissible under G.S. 150(b)-29(a), 150B-30, or 150B-31 in view of the entire record as submitted; or

(6) Arbitrary or capricious.

Here, Presbyterian argues that the ALJ in his recommended decision and the Director of the Division of Facility Services in his final agency decision erred in determining that Presbyterian should be denied a certificate of need. Presbyterian argues that there are genuine issues of material fact regarding: (1) the utility of Presbyterian's proposal for new construction versus conversion of under utilized existing space and (2) the adequacy of staffing proposed for Presbyterian's project. We first address the construction issue.

In its recommended decision, the ALJ found that Presbyterian's application failed to demonstrate why its proposal for new construction was more cost-efficient than conversion of existing under utilized space. At the time of Presbyterian's application, the State Medical Facilities Plan provided that "[c]onversion of under utilized hospital space to other needed purposes shall be considered to be more cost-efficient than new construction, unless shown otherwise." N.C. Admin. Code. tit. 10, r. 3R.3050(a)(2) (Jan.1993). ***834** Based on this language, the ALJ determined that if a hospital had under utilized space, ***534** yet it proposed new construction, the hospital was required to justify the new construction. Based on the utilization targets in place at the time of Presbyterian's application, the ALJ determined that the target occupancy rate for Presbyterian was 75% but that Presbyterian's " occupancy was no more than 18% in the 12 months preceding the review and no more than 31% since 1989." Having concluded from its statistics that Presbyterian had under utilized space, the ALJ determined that Presbyterian was required to show that its new construction was more cost-efficient than conversion of existing space and that Presbyterian had failed to justify its proposal for new construction in its application.

An application for a certificate of need for a proposed project must comply with "applicable

policies and need determinations in the State Medical Facilities Plan." G.S. 131E-183(a)(1). The application also must comply with the review criteria set out in G.S. 131E-183(a). G.S. 131E-183(a)(12) provides in part that "[a]pplications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative." The ALJ granted summary judgment, concluding that Presbyterian had also failed to present any evidence that would create a genuine issue of material fact as to Presbyterian's conformity with these criteria.

Summary judgment is only appropriate when no genuine issues of material fact exist. G.S. 1A-1, Rule 56(c). Here, Presbyterian presented the deposition testimony of Richard E. Salerno, Administrator and CEO of Presbyterian. Mr. Salerno testified that Presbyterian was not able to structure the rehabilitation unit within existing space without new construction because all of the space in the hospital was dedicated to other health care purposes and moving weight-bearing walls prohibited construction in existing space. Mr. Salerno also testified that the new construction would better meet patient needs. This deposition testimony creates a genuine issue of material fact as to whether Presbyterian showed that its proposal for new construction was the most reasonable alternative for developing its rehabilitation unit.

We note, however, that an application must comply with *all* review criteria. Accordingly, we must now determine whether a genuine issue of material fact exists regarding the adequacy of staffing for Presbyterian's proposed project.

[1] In its recommended decision, the ALJ found that Presbyterian's application failed to show that its proposed*535 staffing for the rehabilitation unit conformed to applicable criteria. To operate a rehabilitation facility in North Carolina and to satisfy the review criteria of G.S. 131E-183(a), including G.S. 131E-183(a)(5) and G.S. 131E-183(a)(7), Presbyterian had to show that it would dedicate sufficient staff to provide three hours of therapy per patient per day in the rehabilitation unit. The ALJ found that Presbyterian's application only showed that there would be sufficient staff to provide 1.27 hours of therapy per patient per day. Presbyterian argues that it presented a forecast of evidence which demonstrated that its proposed staff would be able to provide 3.2 hours of therapy per patient per day. However, several witnesses for Presbyterian testified conceding that Presbyterian's application did not demonstrate on its face that it could provide three hours per patient per day. Presbyterian's completed and filed application failed to show that Presbyterian intended to combine therapists from its acute care unit and the proposed rehabilitation unit to reach the required hours of therapy, in effect "pooling" resources. After careful review of the record, we agree with the ALJ and the final agency decision that Presbyterian's application fails to show that it satisfies the mandatory staffing criteria. Accordingly, we conclude that the ALJ did not err in recommending summary judgment against Presbyterian and that the Director of the Division of Facility Services did not err in the final agency decision by concluding as a matter of law that Presbyterian should be denied a certificate of need.

****835 II.**

Presbyterian argues that the Director of Facility Services erred by granting summary judgment in favor of Mercy and Stanly after the ALJ had recommended summary judgment against Mercy and Stanly. Presbyterian contends there were genuine issues of material fact regarding Mercy's and Stanly's applications and that there should have been a contested case hearing where the parties could present evidence and cross-examine witnesses regarding these genuine issues of material fact. Here, the parties merely presented a forecast of evidence through deposition testimony and affidavits.

[2] A "contested case hearing" is a full adjudicatory hearing. *Charlotte-Mecklenburg Hosp. Authority v.*

N.C. Dept. of Human Resources, 83 N.C.App. 122, 125, 349 S.E.2d 291, 292-93 (1986). During a contested case hearing, parties have "an opportunity to present arguments on issues of law and policy and ... to present evidence on issues of fact." G.S. 150B-25(c); ***536***Britthaven Inc. v. N.C. Dept. of Human Resources,* 118 N.C.App. 379, 382, 455 S.E.2d 455, 459, *disc. review denied,* 341 N.C. 418, 461 S.E.2d 754 (1995). The parties also have an opportunity to cross-examine witnesses. G.S. 150B-25(d).

We first address Presbyterian's argument as it relates to Mercy. In the ALJ's recommended decision denying Mercy's application for a certificate of need, the ALJ found that all of the information in Mercy's application was based on the financial feasibility of adding twenty beds, not ten beds. The ALJ also made a finding that Samuel H. Robinson, the project analyst for respondent who reviewed the applications of Presbyterian, Mercy, and Stanly, was:

unsure about the adjustments that would be made in Mercy's staffing with the development of 10 beds, instead of 20 beds. The project analyst also was uncertain about the impact of the Agency decision on some of Mercy's projected expenses, and admitted that some of the assumptions that he used in attempting to determine the financial feasibility of a 10 bed Mercy proposal may have been invalid.

In contrast, in the final agency decision, the Director of the Division of Facility Services found that respondent "reasonably and properly determined that the 39 bed unit which would result from the Agency's conditional approval of Mercy's application ... would be financially feasible."

[3] Before issuing a certificate of need to an applicant, the Department of Human Resources must determine that the application is consistent with criteria set out in G.S. 131E-183, including the financial feasibility of the project. G.S. 131E-183(a)(5). From our review of the record before us here, it is clear that the parties forecast evidence to support both the ALJ's recommended decision and the final agency decision on the issue of the financial feasibility of the Mercy application. On this record, we conclude that there is a genuine issue of material fact as to whether respondent's grant of a certificate of need for ten beds to Mercy instead of the twenty beds originally applied for is financially feasible. Because we have determined that a genuine issue of material fact exists as to the financial feasibility of Mercy's project, we hold that the final agency inappropriately granted summary judgment in favor of Mercy. This case must be remanded for a contested case hearing regarding Mercy's application.

***537** [4] Presbyterian next argues that the Director of Facility Services erred in granting summary judgment in favor of Stanly. Presbyterian argues that after Stanly's application was complete and while the review of the competing applications was in progress, Stanly began discussions with a different management company, the Charlotte Institute of Rehabilitation, (hereinafter CIR) for CIR to become its management company and that Stanly subsequently informed Milestone that Milestone would not be the managing company for the rehabilitation unit. Presbyterian contends that Stanly's actions constituted an impermissible material amendment of its application because all of the information in Stanly's application listed Milestone as Stanly's prospective management company and the project analyst relied on Stanly's representations in its application in deciding ****836** to award a certificate of need to Stanly. We agree.

An applicant may not amend an application for a certificate of need once the application is deemed complete. N.C. Admin. Code tit. 10, r. 3R.0306 (Dec.1994); *In re Application of Wake Kidney Clinic,* 85 N.C.App. 639, 643, 355 S.E.2d 788, 790-91, *disc. review denied,* 320 N.C. 793, 361 S.E.2d 89 (1987). Here, all of Stanly's logistical and financial data in its completed certificate of need application was based on having Milestone as Stanly's management company. Yet, the record contains a letter dated 14 July 1993 from the president of Milestone

expressing his disappointment in Milestone not being chosen by Stanly as its management company for the ten bed rehabilitation project. John Sullivan, Stanly's President and Chief Operating Officer, testified that he telephoned Milestone's president before 14 July 1993 and told him that Stanly would probably be working with a management company closer to Stanly "if and when [Stanly was] allowed to develop the beds." We conclude that the combination of the 14 July 1993 letter and Mr. Sullivan's telephone conversation with Milestone's president that occurred prior to the 14 July 1993 letter, taken in context, is sufficient evidence to show that Stanly had decided not to use Milestone as its management company before Stanly's certificate of need application was approved and that Stanly's actions constituted a material amendment to its application.

The final agency decision concluded that Stanly could present data to the Agency if Stanly decided to change management companies. We disagree. Stanly cannot be awarded a certificate of need contingent on CIR's management proposal data conforming to Milestone's data because in a certificate of need case, the hearing officer may only consider the evidence contained in an applicant's certificate *538 of need application which was before the Certificate of Need Section when it made its initial decision. *In re Application of Wake Kidney Clinic,* 85 N.C.App. at 643, 355 S.E.2d at 791. The ALJ properly came to this conclusion in its recommended decision. Accordingly, we conclude that the Director of Facility Services erred in its final agency decision by concluding that Stanly should be granted a certificate of need.

In summary, this case is remanded to respondent for remand to the OAH for an ALJ to conduct a contested case hearing regarding Mercy's certificate of need application. We reverse the portion of the final agency decision that awarded Stanly a certificate of need because Stanly materially changed its application after its application was completed in violation of the North Carolina Administrative Code, N.C. Admin. Code tit. 10, r. 3R.0306 (Dec.1994). We affirm the portion of the final agency decision that denied Presbyterian a certificate of need because Presbyterian failed to meet mandatory staffing criteria in its certificate of need application.

Reversed and remanded in part; affirmed in part.

LEWIS and JOHN, JJ., concur.

N.C.App.,1996.
Presbyterian-Orthopaedic Hosp. v. North Carolina Dept. of Human Resources, Div. of Facility Services, Certificate of Need Section
122 N.C.App. 529, 470 S.E.2d 831

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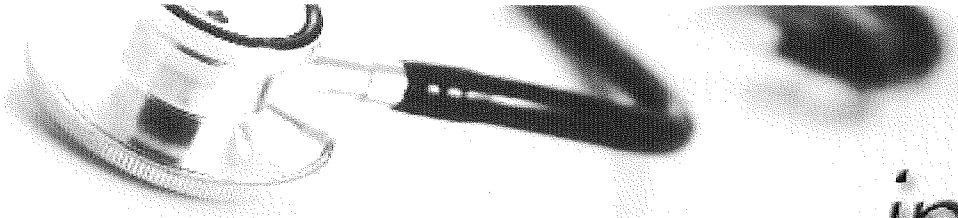

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NC HEALTH ACCESS COALITION
P.O. Box 28068
Raleigh, NC
27611-8068

DIRECTOR: Adam Searing
919/856-2568
www.ncjustice.org

How Charitable are North Carolina Hospitals?

A Look at Financial Assistance Policies for the Uninsured

BY ADAM LINKER, HEALTH POLICY ANALYST

EXECUTIVE SUMMARY

- Hospitals serve as critical safety-net providers for people seeking medical care. In fiscal year 2008, North Carolina hospitals provided $694 million in free care.
- All 112 hospitals in North Carolina maintain websites, and 72 hospitals, or 63 percent, currently post some information about financial assistance policies online.
- Out of 112 hospitals 39, or 35 percent, post comprehensive charity care policies online.
- Several hospitals and hospital systems deserve special recognition for providing charity care levels that exceed the cost of living for their region, including Novant Health, UNC Health Care, University Health Systems of Eastern North Carolina, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System and Margaret R. Pardee Memorial Hospital.
- Every hospital in the state should post a comprehensive charity care policy online, including income eligibility levels, asset limits, and catastrophic discounts.
- Hospitals should strive to provide free care to families earning less than 200 percent of federal poverty level and provide some discount to families earning less than 300 percent of federal poverty level. Hospitals should consider benchmarking charity care policies to a reasonable cost-of-living index like the Living Income Standard.

Background on hospital charity care

MEDICAL DEBT BURDENS many low- and middle-income families in North Carolina. Most families in the state and around the country receive health insurance benefits through work, which leaves them especially vulnerable during a recession, when unemployment is high. Although some economic indicators show that the economy is creeping toward recovery, North Carolina's unemployment rate still exceeds 10 percent. Because the state has shed thousands of jobs, North Carolina had the nation's largest jump in the percentage of the population without insurance from 2007 to 2009. According to one estimate the recession has increased the number of uninsured in North Carolina to nearly 1.8 million.[1]

When people lose health insurance or purchase inadequate coverage with high deductibles, they are more likely to struggle with medical debt. There is some evidence that trouble paying medical bills is a widespread problem. One of the most comprehensive studies of medical debt nationwide found that

more than 62 percent of all bankruptcies in 2007 were related to medical debt and that 92 percent of medical debtors had bills in excess of $5,000.[2]

Hospitals stand at the center of the state's health care system. Especially during times of economic distress, many uninsured and underinsured patients seek medical treatment in hospital emergency rooms. Hospitals, especially nonprofit hospitals, provide an enormous amount of free care in North Carolina. Many hospitals in the state operate as critical safety-net providers to families in economic free fall.

There are some obligations on hospitals to provide free care to all North Carolinians. Federal law – specifically the Emergency Medical Treatment and Active Labor Act – requires that hospital emergency rooms provide at least some care regardless of a patient's ability to pay. Many hospitals also are granted nonprofit status; most North Carolina hospitals are nonprofit. Nonprofit status allows hospitals to issue tax-exempt bonds and reap millions in sales tax and property tax exemptions.

Although hospitals do not gain nonprofit status based solely on providing charity care, community benefit is one overarching consideration when deciding whether a hospital deserves a nonprofit designation. The most direct community benefit that hospitals provide is charity care. Charity care is free care given to patients without any expectation of payment. It is distinct from other community benefits such as grants to community health clinics.

Nonprofit hospitals in North Carolina are at the forefront of providing, publicizing, and reporting community benefit programs and services. The North Carolina Hospital Association (NCHA) maintains a website where all major hospitals in the state are beginning to post their charity care policies.[3] In addition, the NCHA is gathering and posting standardized reports on what community benefits North Carolina hospitals are providing to the state.

The NCHA reports that hospitals provided $694 million in free care to indigent patients in fiscal year 2008. That is a critical benefit to struggling families. And just as hospitals provide an important benefit to the state, the state provides tax benefits to nonprofit hospitals. In fiscal year 2006-2007, for example, hospitals received more than $213 million in sales tax breaks alone.[4]

Again, there is not a direct trade-off between tax benefits and community benefits. But along with tax exemptions and nonprofit status come certain expectations of transparency and accountability. Every hospital in North Carolina maintains a website, and every hospital has adopted a charity care policy. The NCHA recommends that every hospital post its charity care policy online.

While the NCHA asks that every hospital post a charity care policy it does not provide guidance on what specific information should appear online. As consumer advocates, the NC Health Access Coalition believes that every hospital should note the existence of a charity care policy along with specific contact information where patients can seek financial counseling. In this report we recognize all of the hospitals that provide some charity care information online.

Furthermore, we believe that hospitals should at least provide income guidelines for determining whether or not a patient qualifies for charity care. Many factors are included in financial assistance determinations, but income is the first step in screening patients for charity care. If a hospital provides free care to all uninsured patients under 100 percent of the federal poverty level, for example, that policy should appear on the hospital's website.

The more information a hospital provides online the better. We hope that every hospital in the state will post financial counseling contact numbers, income guidelines, asset tests, and catastrophic discounts to keep patients, physicians, and advocates fully informed.

Transparency of hospital charity care policies in North Carolina

Out of 112 hospitals in the state, the websites of 72 list some charity care information online as requested by the North Carolina Hospital Association. Several of the hospitals that list information online only note the existence of a charity care policy along with a phone number for financial assistance. Other hospitals include more details but do not list specific income ranges and charity care discounts.

Out of 112 hospitals, 39 provide what we call a "comprehensive" policy online. These hospitals post qualifying income guidelines for financial assistance. This helps patients understand their potential financial obligations before seeking hospital care. Some of these hospitals also include catastrophic discounts and interest-free payment policies on their websites. **(See attached chart for complete list of charity care policies.)**

Several large hospitals still include only rudimentary information online. These organizations should work to provide as much financial assistance information as possible to patients.

Nonprofit hospitals have a clear obligation to provide information to taxpayers on financial assistance policies because North Carolina residents provide tax benefits to these health care providers. But for-profit hospitals should also post charity care policies online. Tenet Healthcare Corporation, for example, operates two hospitals in North Carolina. Tenet settled a lawsuit in 2005 where the company agreed to provide certain benefits to uninsured patients. Those provisions should appear on the websites of Tenet hospitals.

Because hospitals can post charity care policies at any time patients should check regularly for changes. We will reissue this report in six months to track any updates to hospital charity care policies.

Adequacy of hospital charity care policies in North Carolina

An examination of posted charity care policies shows that financial assistance programs vary widely across the state. We can see that Winston-Salem- and Charlotte-based Novant Health has the most sound and clear policy of any hospital system in North Carolina. At Novant any uninsured patient with an income less than 300 percent of the federal poverty level, or $66,150 for a family of four, qualifies for a 100 percent discount on hospital bills. This policy recognizes the realities of modern family finances.

It is important that charity care policies not bankrupt a hospital. Hospital administrators often note that without a margin there is no mission. In other words, a hospital that is forced to close its doors can no longer deliver any community benefits. But it is also crucial that these policies account for the cost of living in different communities. In general, 200 percent of the federal poverty level, or $44,100 per year for a family of four, is required to maintain a minimally comfortable life without saving or paying hefty medical bills.

All hospitals in the state should strive to set the free care minimum at 200 percent of the federal poverty level. We recognize that 200 percent of federal poverty level is an unobtainable target for some rural hospitals that operate on thin margins. And for large, wealthy hospital systems in expensive parts of the state a goal of 200 percent of federal poverty level is not ambitious enough. But this number provides a good guide for how much it costs for a family to subsist in most regions of the state.

While providing a 100 percent discount for uninsured families making less than 200 percent of the federal poverty level is important, it is also critical that financial assistance policies provide some help for those making higher incomes – at least up to 300 percent of the federal poverty level. Well-insured patients get a discount on hospital bills because insurance companies negotiate payment rates for particular services. Uninsured and underinsured patients should get a similar advantage.

Designing a charitable charity care policy

Hospitals should consider benchmarking charity care policies to how much it costs for an average family to live in the region where the hospital is

located. Federal poverty level has major shortcomings for understanding how much a family must spend to survive. The federal poverty level for a family of four, for example, is $22,050 per year. That amount is insufficient to cover the costs of transportation, day care, housing, and food in North Carolina. It's not even close.

A more sophisticated – although still conservative– measure of family expenses is the Living Income Standard (LIS) produced by the North Carolina Justice Center's Budget & Tax Center.[5] This calculation constructs county-level budgets for four representative family types. The budgets are built from seven essential expenses – housing, food, childcare, health care, transportation, taxes, and other necessities. Excluded from the budget are savings, cell phones, restaurant meals, entertainment, cable television, and gifts.

The LIS budget leaves no room for large medical bills. Families making a living income are still only living on the edge. One trip to the emergency room could tip these families into financial ruin. Mitigating the number of families facing foreclosure or bankruptcy due to bills for inpatient care is one of the most important community benefits hospitals can provide.

Consulting the LIS shows that families in most counties require a minimum income level of 200 percent of federal poverty level to pay for necessities. There are, however, numerous counties of the state that require a higher income level to live – those near Charlotte; in the Triangle area of Raleigh, Durham, and Chapel Hill; in the Triad area near Greensboro, High Point, and Winston-Salem; and in the coastal plains surrounding Wilmington. There are also lower cost areas in the state where families can live on less than 200 percent of federal poverty level.

It is not our recommendation that North Carolina hospitals peg charity care policies to the LIS. But the LIS provides a reasonable guide for how much it costs to live in different regions of the state. And hospitals should consider using a cost-of-living index to establish financial assistance policies.

Many hospitals in North Carolina clearly recognize the shortcomings of the federal poverty guidelines and set financial assistance policies much higher than 100 percent of the federal poverty rate.

As noted previously, Novant sets its 100 percent discount rate at 300 percent of federal poverty guidelines. Novant's policy also does well when compared to the LIS. In Mecklenburg County, where Novant runs the well-regarded Presbyterian Hospital, the LIS for a two adult and two child family is 220.7 percent of the federal poverty level.

Currently, of the 39 hospitals that list comprehensive charity care policies online, 22 provide a 100 percent discount to uninsured families earning 200 percent of federal poverty level or more. Most of those hospitals are owned by a few nonprofit systems, including Novant, Duke University, and WakeMed Health & Hospitals.

A few hospitals are even more generous and provide discounts that match the LIS for a two adult and two child family for the county in which the hospital is located. Novant's policy exceeds the LIS in every county where the system operates. UNC Health Care provides a 100 percent discount at 250 percent of federal poverty guidelines, which is more generous than Orange County's LIS of 236.7 percent of federal poverty guidelines for a two adult and two child household.

In Henderson County, where the LIS is 189.8 percent of federal poverty level, Margaret R. Pardee Memorial Hospital in Hendersonville has a charity care policy that provides a 100 percent discount at 220 percent of federal poverty level. Iredell Memorial Hospital, where the LIS is 200 percent of federal poverty level, provides a 100 percent discount at 192 percent of federal poverty level. And University Health Systems of Eastern Carolina provides a 100 percent discount

at 200 percent of federal poverty level, which exceeds the LIS for the region where the system operates.

Other large nonprofit hospital systems provide the full discount at 200 percent of federal poverty level but fall short of matching the region's cost-of-living requirements. Duke University Medical Center provides a 100 percent discount at 200 percent of the federal poverty level, but the LIS in Durham County is 227.2 percent of federal poverty level, and in Wake County, where Duke also operates a hospital, the LIS is 246.6 percent of federal poverty guidelines. WakeMed, which operates several hospitals in Wake County, provides the same discount rate as Duke.

Eight hospitals that post charity care policies online provide a 100 percent discount at 150 percent of the federal poverty level. Another six hospitals posting charity care policies provide a 100 percent discount at 125 percent or 120 percent of federal poverty level. Only one hospital posting a comprehensive policy, Southeastern Regional Medical Center, has a charity care policy matching the federal poverty level.

It is heartening that a majority of hospitals in North Carolina post notice of a charity care policy online. We applaud those hospitals that post comprehensive policies online for their openness and accountability. Novant Health, UNC Health Care, University Health Systems of Eastern Carolina, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System, and Margaret R. Pardee stand out as providing excellent charity care policies. Other hospitals like Duke University Medical Center and WakeMed Health & Hospitals have good policies that could be strengthened in the future.

Conclusion

It is encouraging that a majority of North Carolina hospitals post some charity care information online, although fewer than half of the state's hospitals post comprehensive policies. This step would help struggling families understand discount programs at nearby hospitals before seeking care.

Hospitals that have posted policies online should be commended. Many of the large nonprofit hospitals in the state have fair policies that provide free care to patients with incomes less than 200 percent of the federal poverty level. The charity care policies of a few hospitals even take into account the cost of living in nearby communities.

In North Carolina high unemployment is causing people to lose insurance at high rates. Many uninsured patients seek care at free clinics and hospital emergency rooms. Hospitals are filling an important role as safety-net providers contributing a large amount of free care. Charity care should not bankrupt a hospital, but policies must be available to the public and should consider the living costs of families. The North Carolina Hospital Association has made impressive strides toward meeting these goals. With encouragement, North Carolina hospitals could serve as national models of openness and accountability.

Recommendations:

- **All hospitals should post comprehensive** charity care policies online. The policies should include information on asset limits, income guidelines, and catastrophic discounts.
- **Most hospitals should move toward** providing a 100 percent discount to families earning less than 200 percent of the federal poverty level and some discount to families earning less than 300 percent of the federal poverty level.
- **Hospitals should consider adopting a** more nuanced measure of poverty – such as the Living Income Standard – to calculate charity care policies.
- **Hospitals should thoroughly screen** patients, including those entering through the emergency room, to check eligibility for public programs or charity care discounts.

HOSPITAL CHARITY CARE POLICIES

HOSPITAL	Is some charity care information available online?	Is comprehensive policy available on website?	Financial assistance policy	LIS Budget for four-person family (two adults, two children) as % of FPL
Alamance Regional Medical Center	Y	N		200.40%
Albemarle Hospital	Y	N		201.60%
Alleghany Memorial Hospital	Y	N		182.90%
Angel Medical Center	Y	N		189.20%
Annie Penn Hospital	Y	Y	100% at 125% FPL; discount up to 200% FPL	180.80%
Anson Community Hospital	Y	N		175.10%
Ashe Memorial Hospital	Y	Y	100% discount at 150% FPL	179.90%
Beaufort County Hospital	N	N		189.60%
Bertie Memorial Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	185.90%
Betsy Johnson Regional Hospital	Y	N		189.70%
Bladen Healthcare	N	N		181.90%
Blowing Rock Hospital	N	N		207.70%
Blue Ridge Regional Hospital	Y	N		196.60%
Brunswick Community Hospital	Y	Y	100% discount at 300% FPL	203.80%
Caldwell Memorial Hospital	Y	Y	100% discount at 125% FPL	183.90%
Cannon Memorial Hospital	N	N		193.80%
Cape Fear Valley	N	N		189.10%
CarolinaEast Medical Center	Y	N	some discount for less than 200% FPL	187.50%
Carolinas Medical Center	Y	N		220.70%
Carolinas Medical Center Mercy	Y	N		220.70%
Carolinas Medical Center Northeast	Y	N		214.80%
Carolinas Medical Center Pineville	Y	N		220.70%
Carolinas Medical Center Union	Y	N		214.20%
Carolinas Medical Center University	Y	N		220.70%
Carteret County General Hospital	Y	Y	100% discount at 125% FPL; discount up to 300% FPL	195.60%
Catawba Valley Medical Center	Y	Y	100% discount at 150% FPL; discount up to 250% FPL	183.90%
Central Carolina Hospital	N	N		195.70%
Chatham Hospital	Y	N		220.60%
Chowan Hospital	Y	Y	100% discount at 200% FPL	195.70%
Cleveland Regional Medical Center	N	N		197.70%
CMC Lincoln	Y	N		196.60%
Columbus Regional Healthcare System	Y	N		184.70%
Community Care Partners	Y	N		189.80%
Crawley Memorial Hospital	N	N		197.70%
Davie County Hospital	Y	N		191.10%
Davis Regional Medical Center	N	N		200.70%
Duke Raleigh Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	246.60%
Duke University Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	227.20%
Duplin General Hospital	N	N		181.90%
Durham Regional Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	227.20%
FirstHealth Montgomery Regional Hospital	N	N		187.60%
FirstHealth Moore Regional Hospital	N	N		194.80%
FirstHealth Richmond Memorial Hospital	N	N		185.90%
Forsyth Medical Center	Y	Y	100% discount at 300% FPL	199.70%
Franklin Regional Medical Center	N	N		215.00%
Frye Regional Medical Center	N	N		183.90%
Gaston Memorial Hospital	Y	N	some discount for Gaston County residents	206.60%
Grace Hospital	Y	Y	100% discount at 120% FPL; discount up to 250% FPL	182.30%
Granville Health System	Y	N	discount between 200% FPL and 300% FPL	194.10%
Halifax Regional Medical Center	Y	N		185.10%
Harris Regional Hospital	Y	Y	100% discount at 150% FPL; discount up to 300% FPL	194.60%
Haywood Regional Medical Center	N	N		181.20%
Heritage Hospital	Y	Y	100% discount at 200% FPL	191.00%
High Point Regional Health System	Y	Y	100% discount at 200% FPL; discount up to 400% FPL	208.20%
Highlands-Cashiers Hospital	N	N		191.10%
Hoots Memorial Hospital	N	N		189.10%
Hugh Chatham Memorial Hospital	Y	Y	100% discount at 150% FPL; discount up to 200% FPL	181.00%
Iredell Memorial Hospital	Y	Y	100% discount at 192% FPL	200.70%
J. Arthur Dosher Memorial Hospital	Y	N		203.80%
Johnston Memorial Hospital	N	N		213.80%

HOSPITAL CHARITY CARE POLICIES (cont.)

HOSPITAL	Is some charity care information available online?	Is comprehensive policy available on website?	Financial assistance policy	LIS Budget for four-person family (two adults, two children) as % of FPL
Kings Mountain Hospital	N	N		197.70%
Lake Norman Regional Medical Center	N	N		200.70%
Lenoir Memorial Hospital	N	N		187.40%
Lexington Memorial Hospital	Y	N		186.80%
Margaret R. Pardee Memorial Hospital	Y	Y	100% discount at 220% FPL; discount up to 400% FPL	189.80%
Maria Parham Medical Center	Y	N		188.20%
Martin General Hospital	N	N		182.50%
Medical Park Hospital	Y	Y	100% discount at 300% FPL	199.70%
Mission Hospital	Y	N		189.80%
Morehead Memorial Hospital	N	N		180.80%
Moses Cone Hospital System Greensboro	Y	Y	100% at 125% FPL; discount up to 200% FPL	208.20%
Murphy Medical Center	N	N		176.00%
Nash Healthcare System	Y	Y	100% at 150% FPL; discount up to 250% FPL	193.00%
New Hanover Regional Medical Center	Y	N	some discount for less than 200% FPL	214.00%
North Carolina Baptist Hospital	Y	N		199.70%
Northern Hospital of Surry County	N	N		181.00%
Onslow Memorial Hospital	N	N		184.60%
Our Community Hospital	N	N		185.10%
Park Ridge Hospital	N	N		189.80%
Pender Memorial Hospital	N	N		189.20%
Person Memorial Hospital	N	N		182.80%
Pitt County Memorial Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	187.50%
Presbyterian Healthcare	Y	Y	100% at 300% FPL	220.70%
Presbyterian Hospital Huntersville	Y	Y	100% at 300% FPL	220.70%
Presbyterian Hospital Matthews	Y	Y	100% at 300% FPL	220.70%
Pungo District Hospital Corporation	N	N		189.60%
Randolph Hospital	N	N		198.50%
Rex Healthcare	Y	Y	100% at 250% FPL; some co-pays required	246.60%
Roanoke-Chowan Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	184.40%
Rowan Regional Medical Center	Y	Y	100% at 300% FPL	201.30%
Rutherford Hospital	N	N		193.50%
Saint Luke's Hospital	Y	Y	100% at 150% FPL; discount up to 400% FPL	196.00%
Sampson Regional Medical Center	Y	N		181.70%
Sandhills Regional Medical Center	N	N		185.90%
Scotland Memorial Hospital	N	N		193.10%
Southeastern Regional Medical Center	Y	Y	100% at 100% FPL; discount up to 300% FPL	188.60%
Stanly Regional Medical Center	Y	Y	100% at 150% FPL discount up to 300% FPL	192.60%
Stokes-Reynolds Memorial Hospital	N	N		191.10%
Swain County Hospital	Y	Y	100% discount at 150% FPL; discount up to 300% FPL	187.00%
The McDowell Hospital	Y	N		192.90%
The Outer Banks Hospital	Y	Y	100% discount for less than 200% FPL	218.40%
Thomasville Medical Center	Y	Y	100% at 300% FPL	186.80%
Transylvania Community Hospital	Y	N		186.90%
UNC Hospitals	Y	Y	100% at 250% FPL; some co-pays required	238.60%
Valdese General Hospital	Y	Y	100% at 120% FPL; discount up to 200% FPL	182.30%
WadeMed Cary Hospital	Y	Y	100% at 200% FPL; discount up to 300% FPL	246.60%
WakeMed	Y	Y	100% at 200% FPL; discount up to 300% FPL	246.60%
Washington County Hospital	N	N		191.40%
Watauga Medical Center	N	N		207.70%
Wayne Memorial Hospital	Y	N		183.60%
Wilkes Regional Medical Center	N	N		185.90%
Wilson Medical Center	Y	N		196.10%

1 See "North Carolina's Increase in the Uninsured: 2007-2009" March 2009, a report prepared by the North Carolina Institute of Medicine and the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Available online at http://www.nciom.org/data/DS_2009-01_UninUnemp.pdf.

2 See "Medical Bankruptcy in the United States, 2007: Results of a National Study", The American Journal of Medicine, August 2009. Available online at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

3 Information is available under "Community Benefits Report" at www.ncha.org.

4 Tax refund information is available on the North Carolina Department of Revenue's website at http://www.dornc.com/publications/abstract/2008/table35b.pdf.

5 For a more thorough explanation of the Living Income Standard see "Making ends meet on low wages: the 2008 North Carolina Living Income Standard" available online at http://www.ncjustice.org/?q=node/243.

NC JUSTICE CENTER'S
Health Access Coalition

Adam Searing, *Project Director*
adam@ncjustice.org

www.nchac.org

NORTH CAROLINA JUSTICE CENTER

Opportunity and Prosperity for All

224 S. Dawson Street • P.O. Box 28068 • Raleigh, NC 27611
919/856-2570 voice • 919/856-2175 fax • www.ncjustice.org • contact@ncjustice.org