RECEIVED
By Kelli Fisk at 4:25 pm, Jul 31, 2009

Petition Title: Revision to Single Specialty Ambulatory Surgery Demonstration Project in Draft 2010 SMFP

Petitioner:

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

Request: The request is to revise the Single Specialty Ambulatory Surgery Demonstration Project in the following manner:

1. Permit organizations located in geographic areas in North Carolina, other than the "Charlotte Area," "Triad," and "Triangle" to submit pilot demonstration CON applications.

2. Do no limit the number or type of pilot demonstrations so that a true assessment of improvements in quality, access, and value can be determined in a variety of communities, not limited to the most populous ones in the State of North Carolina.

3. In order to address the concern of rural hospitals and the continued fragility of our nation's health care system in rural areas, the pilot demonstration counties should be limited to:

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

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

4. Develop an approach that documents cost savings to patients and payers. An integral part of such an approach should be (i) a reimbursement ceiling limit equal to 250% of Medicare allowable reimbursement by CPT code for private payers and (ii) a charge limit to under- and uninsured patients equal to Medicare reimbursement or less by CPT code.

5. Only permit pilot demonstration ASCs in counties where it can be documented that the existing health care facilities are high cost versus the proposed 250% of Medicare reimbursement by CPT code ceiling limit. All costs for outpatient surgery at these ASCs should be accessible on the Internet, available to patients upon request, and essentially transparent to patients on all levels.

Adverse Effects: Excessive costs for outpatient surgery services for patients will continue to result in many North Carolina counties without implementation of this petition's premises/objectives. The Single Specialty Ambulatory Demonstration Project fails to address cost considerations. Controlling health care costs is a core tenet of CON legislation and public policy and has a direct effect on improving patient access.

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

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

Petition
State Health Coordinating Council ("SHCC")

Revision to Single Specialty Ambulatory Surgery Demonstration Project

Proposed By:
Affordable Health Care Facilities, LLC
July 31, 2009

Preamble and Background

Affordable Health care Facilities, LLC ("AHCF") has submitted petitions to the SHCC previously in 2008 and 2009. The March 2008 submission in large part resulted in the development of the Single Specialty Ambulatory Surgery Demonstration Project via the Single Specialty Ambulatory Surgery Work Group that was formed by the SHCC. In March 2009, AHCF submitted an updated petition, "New CON Methodology Related to Single Specialty Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice," that sought to address specific short comings of the work group's effort. The March 2009 petition was rejected.

This petition, "Revision to Single Specialty Ambulatory Surgery Demonstration Project," addresses specific shortcomings of the Single Specialty Ambulatory Surgery Demonstration Project as currently proposed in the draft 2010 SMFP. AHCF readily acknowledges the importance of the North Carolina State Medical Society ("NCMS") and the North Carolina Hospital Association ("NCHA") working together to adjust CON law and regulation to better meet the Quality, Access, and Value principles developed by the SHCC and set forth in the SMFP. The SHCC itself, however, is composed of individuals with many conflicts of interest.

CON law and the SMFP have not adequately slowed our state's growth in health care costs. Indeed, CON law was originally developed in the early 1970s as part of the National Health Planning Act to control capital costs related to cost-based reimbursement for government health care programs (e.g. Medicare) and to ensure access. If a state did not have a CON law, the state would lose federal funds related to reimbursement of government health care programs. In 1986, the National Health Planning Act was repealed by Congress because cost-based reimbursement was no longer in effect and was replaced by a system of prospective reimbursement.

North Carolina, unlike other states, did not repeal its CON law despite the lack of need for such a law under the original requirements for federal funds reimbursement. In many respects, current North Carolina CON law is an anachronism of the past and promotes monopoly behavior by health care facilities in the state, especially in relation to reimbursement demanded of patients and private payers for outpatient surgery facilities.

Further, it can be substantiated by fact that North Carolina's CON law is not truly based on "need" and has not adequately controlled health care costs. Rather, current CON law represents an artificial barrier to entry of potentially lower cost competitors, especially in the outpatient ASC market. In the January 26, 1973 ruling by the North Carolina Supreme Court for Aston Park Hospital, Inc., it is stated:

> **We find no such reasonable relation between the denial of the right of a person, association or corporation to construct and operate upon his or its own property, with his or its own funds, an adequately staffed and equipped hospital and the promotion of public health. Consequently, we hold that G.S. 90-291 is a deprivation of liberty without due process of law, in violation of Article I, Section 19 of the Constitution of North Carolina insofar as it denies Aston Park the right to construct and operate its proposed hospital except upon the issuance to it of a certificate of need.**
>
> **Such requirement establishes a monopoly in the existing hospitals contrary to the provisions of Article I, Section 34 of the Constitution of North Carolina and is a grant to them of exclusive privileges forbidden by Article I, Section 32.**
>
> **In so holding we do not substitute our judgment for that of the Medical Care Commission as to the extent, if any, of the present need for additional hospital bed capacity in the City of Asheville. It may prove that Aston Park will not be able to recruit the professional and quasi-professional staff necessary to enable it to operate the proposed hospital so that its revenues will be sufficient to meet its expenses. Thus, the proposed hospital may never be able to commence operations or, if it commences them, it may be compelled for financial reasons to close. The Constitution of this State does not, however, permit the Legislature to confer upon the Medical Care Commission the power of a guardian to protect Aston Park from possible bad financial judgment. Nor does it permit the Legislature to grant to the Medical care Commission authority to exclude Aston Park from this field of service in order to protect existing hospitals from competition otherwise legitimate.**

The Aston Park ruling raises sufficient question as to the constitutionality of current North Carolina CON law on a number of bases. The current monopoly or oligopoly position of licensed health care facilities in North Carolina is a real concern in relation to the welfare of the citizens of North Carolina given no effective price competition for outpatient surgery services.

The DHSR has acknowledges anecdotally the existence of a "medical arms race" among the state's health care facilities, especially hospitals which are high cost settings. Therefore, CON legislation and the SMFP have failed at the core tenet of controlling health care costs. With rising health care costs, access becomes under more pressure, because access is in large part determined by affordability. So it can be argued that a failure to control rising health care costs results in decreased patient access to health care services.

The Dartmouth Atlas of Health Care (http://www.dartmouthatlas.org/) shows that the rate of growth in Medicare spending per enrollee in North Carolina exceeds the national average.[1] For private payers, most every hospital in North Carolina has negotiated reimbursement in the form of a "discount off of charges" for all outpatient care.[2] For the non-Medicare population, outpatient services represent the vast majority of health care expenses incurred by patients. The result is an ever increasing rise in health costs for patients and private payers because hospitals routinely raise their charges each year. The SMFP has not adequately addressed these health care cost management issues, such as the states of West Virginia and Maryland have pursued through state government enacted price controls. The proposed petition provides a market based solution based on increased competition in the outpatient ASC sector to force the development of lower cost outpatient surgery services and increased access.

In discussing the quality principle, AHCF again turns to research of the Dartmouth Institute for Health Policy & Clinical Practice. In the research article, Health Care Spending, Quality, and Outcomes," the following is stated

> **Perhaps the most counter-intuitive finding is that higher spending does not necessarily lead to better access to health care (see box), or better quality of care. Patient outcomes can actually suffer, because having more physicians involved increases the likelihood of mistakes (too many cooks spoil the soup), and because hospitals are dangerous places to be if you do not absolutely need to be there**.[3]

The vast majority of outpatient facilities in North Carolina are HOPDs associated with hospitals, not free standing ASCs. As stated in the above research, hospitals are "dangerous places" for healthy asymptomatic patients to receive care. The proposed petition provides for the development of new free standing ASC facilities that can be accessed by patients at a lower cost with increased levels of safety and quality of care.

---

[1] The DHSR can review AHCF's prior petition from March 2009 for additional data on this subject and review the Dartmouth Atlas of Health Care website.

[2] Private payers can confirm this assertion. Dr. Bradley, the medical director of BCBSNC, also may be able to provide confirmation.

[3] Health care Spending, Quality, and Outcomes, February 27, 2009, page 3, http://www.dartmouthatlas.org/atlases/Spending_Brief_022709.pdf.

The argument presented in the draft 2010 SMFP that "locating facilities in high population areas with a large number of operating rooms and existing ambulatory surgery providers prevents the facilities from harming hospitals in rural areas, which need revenue from surgical services to offset losses from other necessary services such as emergency department services," is weak from numerous perspectives.

First, hospitals can horizontally integrate and hire surgeons to control the rate of ASC development. This hiring of surgeons and other physicians by hospitals is occurring at an increasing rate in North Carolina and other states, especially in rural areas. Such horizontal integration presents its own difficulties in terms of monopoly considerations related to health care delivery and negotiation of participation agreements with private payers.

Second, each year hospitals in North Carolina receive direct payments from the federal government to cover uncompensated care. Please refer to **Exhibit A** attached for a list of "Disproportionate Share" payments to North Carolina hospitals in FY 2008. These payments go a long way toward covering the cost of uncompensated care for North Carolina hospitals, whether they are located in rural areas or not.

This petition does recognize that rural areas should be excluded from any and all ASC pilot demonstrations however. The proposed petition provides a specific metric as to eligible counties based on population and existing hospital metrics.

Due Process and Legal Challenge

As an ASC development company, AHCF seeks to develop approximately ten (10) ASCs in the state of North Carolina, some of which are in counties other than the "Charlotte Area," "Triad," or "Triangle" as limited in the draft 2010 SMFP. AHCF under this petition will only develop ASCs in counties with documented high costs to patients. As stated previously, high costs are a major driver in limiting patient access to health care services.

In candor, AHCF does not believe that it was provided fair and open due process in relation to its previously submitted petitions. Though promised indirectly by SHCC members, the Single Specialty Ambulatory Surgery Work Group did not really involve AHCF, much less other outside organizations, in its deliberations and analysis. Many of the work group meetings were held via conference call with an inability for third party participation.

Based on observable fact and experience, it appears that only through legal challenges can the SMFP be adjusted or a CON be issued in North Carolina. Dr. Christenbury, Novant Health, and other entities have proven this point rather well over the years via their CON related litigation. It seems that if an entity wishes a CON and has the principles of quality, access, and value clearly in its favor, it will eventually receive a CON, given sufficient and excessive financing costs and what one may call "staying power" through the legal process. The process of receiving a CON in North Carolina seems increasingly to be via a lawsuit and the court system. This alternative may be the only one left for deserving applicants such as AHCF.

In May 2008, A Hope Women's Center, P.A. and Raleigh Orthopedic Clinic, P.A. filed a lawsuit against the State of North Carolina, the DHSR, and the SHCC related to due process and other considerations. This lawsuit is now under appeal. AHCF believes that the SHCC should take significant pause as to how it handles petitions, given this lawsuit and the Aston Park North Carolina Supreme Court ruling referenced earlier.

A more open system of competition based on quality, access, and value is required to slow the growth of health care costs in North Carolina. Just using demographics and current volume to determine absolute "need" deprives North Carolina citizens of lower cost health care services and competition. Capital costs for ASCs are recaptured through the proposed capping of reimbursement proposed in this petition for under- and uninsured patients and private payers. So adding ASC rooms and facilities is a risk factor for CON applicants but does not represent a "premium" cost to patients and private payers if in fact reimbursement controls are in effect. We believe that this petition provides the basis for such an approach in an important cost management area for under- and uninsured patients and private payers – outpatient surgery and ASCs.

Summary

In closing, hospitals will not be "harmed" financially by this proposed petition. Given (i) the disproportionate share payments; (ii) the capability to hire surgeons; and (iii) the materially higher reimbursement being received currently for outpatient surgical services, hospitals are well insulated from any "harm." The proposed petition provides important market-based competition that can dramatically begin to lower costs, improve quality of care, and improve access for the citizens of North Carolina. The proposed transparency of all outpatient surgery costs at pilot demonstration ASCs to patients is perhaps the strongest vehicle leading to improved Quality-Access-Value management. Such transparency is also a key requirement of this petition and previous ones submitted by AHCF that has not been adopted and in many respects has not even been addressed by the Single Specialty Ambulatory Work Group or the SHCC as a whole.

When a state maintains a methodology for needed ASC rooms that fixes an absolute number on the basis of certain population and other demographics and volume, a state is encouraging monopoly behavior and stifling competition. The result is higher costs, access problems (especially with private payers increasing co-pays and requiring higher co-insurance), and fewer quality alternatives. The time has come for North Carolina to adopt an SMFP that addresses the core issue of excessive health care costs, rather than enforce a plan that merely protects entrenched vested interests through a "need" formula that has never controlled costs effectively. The SHCC needs to address the vested interests of its members in a way that (i) allows its members to work on these issues in an open and transparent way and (ii) involves the participation of organizations such as AHCF.

Exhibit A- Disproportionate Share Payments to North Carolina Hospitals FY 2008

Provider Number	Provider Name	Oct. 2007 - Sept. 2008				
			DSH Payments			
		Teaching Hospital DSH/ Enhanced	UCC DSH	HMO	Enhanced Payments	Total Payments
Teaching Public						
3400028	Cape Fear Valley Medical Center	$2,980,862	$1,442,775	-	$16,849,461	$21,273,098
3400040	Pitt County Memorial Hospital	4,677,760	2,485,662	-	-	7,163,422
3400113	Carolinas Med Center	8,741,151	5,280,754	290,896	41,563,331	55,876,132
3400141	New Hanover Regional Med Center	4,935,085	2,370,298	-	13,161,914	20,467,297
Subtotal - Teaching Public		21,334,858	11,579,489	290,896	71,574,706	104,779,949
Teaching Private						
3400002	Mission Hospitals Inc.	2,917,539	-	-	14,756,859	17,674,398
3400014	Forsyth Memorial Hospital	2,420,145	-	1,218	7,846,676	10,268,039
3400030	Duke University Hospital	7,597,618	-	-	17,402,775	25,000,393
3400047	The NC Baptist Hospital	4,258,844	-	-	18,840,829	23,099,673

3400069	WakeMed	6,284,484	-	-	15,221,620	21,506,104
3400091	The Moses H Cone Hospital	3,990,519	-	82,545	13,705,598	17,778,662
Subtotal - Teaching Private		27,469,149	-	83,764	87,774,357	115,327,270
Public						
3400001	CMC Northeast Medical Center		904,913	4,172	5,914,358	6,823,443
3400003	Northern Hospital Of Surry		231,958	-	951,847	1,183,805
3400017	Margaret R Pardee Memorial Hospital		452,995	-	2,341,893	2,794,888
3400021	Cleveland Regional Med Center		503,208	-	3,142,004	3,645,212
3400024	Sampson Regional Medical Center		139,971	-	1,345,662	1,485,633
3400027	Lenoir Memorial Hospital		467,500	-	2,691,851	3,159,351
3400032	Gaston Memorial Hospital		1,143,740	14,057	8,030,242	9,188,039
3400037	Kings Mountain Hospital Inc		176,114	4,804	963,155	1,144,073
3400038	Beaufort County Hospital		369,282	-	1,977,666	2,346,948
3400042	Onslow Memorial Hospital		413,697	-	3,330,824	3,744,521
3400051	Watauga Medical Center		206,665	-	1,425,212	1,631,877
3400055	Valdese General Hospital		-	-	858,454	858,454
3400064	Wilkes Regional Medical Center		169,048	-	1,311,042	1,480,090
3400068	Columbus Regional Healthcare Sys		190,492	-	1,440,040	1,630,532

3400071	Betsy Johnson Regional Hospital		251,253	-	3,260,692	3,511,945
3400084	Anson County Memorial Hospital		-	-	284,757	284,757
3400090	Johnston Memorial Hospital		497,883	-	2,879,891	3,377,774
3400098	Mercy Hospital Inc.		729,386	59,293	2,771,410	3,560,089
3400099	Roanoke Chowan Hospital		186,711	-	1,862,498	2,049,209
3400107	Heritage Hospital		162,462	-	2,119,678	2,282,140
3400109	Albemarle Hospital		373,154	-	2,662,331	3,035,485
3400120	Duplin General Hospital Inc		135,891	-	989,650	1,125,541
3400121	J Arthur Dosher Mem Hospital		86,320	-	154,343	240,663
3400127	Granville Hospital		57,609	-	921,981	979,590
3400130	Union Regional Medical Center		461,781	1,817	2,109,876	2,573,474
3400131	Craven Regional Medical Center		766,335	-	3,614,386	4,380,721
3400142	Carteret General Hospital		165,821	-	2,033,354	2,199,175
3400143	Catawba Valley Medical Center		560,201	-	4,332,003	4,892,204
3400145	Lincoln Medical Center		287,745	-	1,958,845	2,246,590
3400147	Nash General Hospital		465,700	-	7,444,162	7,909,862
3400166	Carolinas Medical Center-University		550,124	71,017	2,128,394	2,749,535
3403026	Charlotte Institute Of Rehabilitation		73,297	72	1,902,040	1,975,409
Subtotal - Public						

			11,181,256	155,230	79,154,541	90,491,027
Private						
3400004	High Point Memorial Hospital		-	26,368	3,737,032	3,763,400
3400008	Scotland Memorial Hospital Inc		-	-	1,505,353	1,505,353
3400010	Wayne Memorial Hospital Inc		-	-	3,679,955	3,679,955
3400011	Spruce Pine Hospital		-	-	414,317	414,317
3400012	Angel Medical Center Inc		-	-	405,019	405,019
3400013	Rutherford Hospital Inc		-	-	1,901,056	1,901,056
3400015	Rowan Regional Medical Center		-	-	2,617,167	2,617,167
3400016	Harris Regional Hospital, Inc		-	-	968,515	968,515
3400020	Central Carolina Hospital		-	-	1,919,365	1,919,365
3400023	Park Ridge Hospital		-	-	850,999	850,999
3400025	Haywood Regional Medical Center		-	-	683,290	683,290
3400035	Firsthealth Richmond Memorial Hospital		-	-	1,291,987	1,291,987
3400036	Franklin Regional Mem Hospital		-	-	736,678	736,678
3400039	Iredell Memorial Hospital Inc		-	-	1,772,029	1,772,029
3400041	Caldwell Memorial Hospital Inc		-	-	934,120	934,120
3400049	North Carolina Specialty Hospital		-	-	134,987	134,987
3400050	Southeastern Regional Medical Center					

			-	-	6,230,139	6,230,139
3400053	Presbyterian Hospital		-	24,573	8,664,451	8,689,024
3400060	Morehead Memorial Hospital		-	-	501,695	501,695
3400070	Alamance Regional Medical Center		-	-	2,177,911	2,177,911
3400073	Duke Health Raleigh Hospital		-	-	1,278,262	1,278,262
3400075	Grace Hospital Inc		-	-	1,277,080	1,277,080
3400085	Thomasville Medical Center		-	1,320	923,816	925,136
3400087	The Mcdowell Hospital, Inc		-	-	305,479	305,479
3400096	Lexington Memorial Hospital Inc		-	-	1,355,674	1,355,674
3400097	Hugh Chatham Memorial Hosp Inc		-	-	424,005	424,005
3400106	Sandhills Regional Medical Center		-	-	398,915	398,915
3400114	Rex Hospital		-	-	1,767,143	1,767,143
3400115	Firsthealth Moore Regional Hospital		-	-	3,588,802	3,588,802
3400116	Frye Regional Medical Center		-	-	3,006,696	3,006,696
3400119	Stanley Regional Medical Center		-	55,410	1,106,060	1,161,470
3400123	Randolph Hospital		-	-	1,373,085	1,373,085
3400126	Wilson Medical Center		-	-	2,589,187	2,589,187
3400129	Lake Norman Regional Medical		-	-	665,878	665,878
3400132	Maria Parham Medical Center		-	-	1,682,747	1,682,747

3400133	Martin General Hospital		-	-	320,440	320,440
3400144	Davis Regional Medical Center		-	2,676	929,561	932,237
3400148	Medical Park Hospital Inc.		-	-	265,311	265,311
3400151	Halifax Regional Medical Center		-	-	1,480,670	1,480,670
3400153	Presbyterian Orthopaedic		-	-	279,825	279,825
3400155	Durham Regional Hospital		-	-	3,361,174	3,361,174
3400158	Brunswick Community Hospital		-	-	941,732	941,732
3400159	Person Memorial Hospital		-	-	256,544	256,544
3400160	Murphy Medical Center Inc		-	-	494,389	494,389
3400171	Presbyterian Hospital Matthews		-	-	1,124,285	1,124,285
3400173	WakeMed For Western Wake Medical		-	-	1,277,581	1,277,581
3400183	Presbyterian Hospital Huntersville		-	-	1,013,295	1,013,295
Subtotal - Private			-	110,346	74,613,701	74,724,047
Public CAH						
3401304	Bertie Memorial Hospital		55,219	-	-	55,219
3401315	Bladen County Hospital		94,589	-	-	94,589
3401307	Pender Memorial Hospital		89,172	-	-	89,172
3401318	Chowan Hospital					

			111,280	-	-	111,280
3401324	The Outer Banks Hospital		206,919	-	-	206,919
Subtotal - Public CAH		-	557,179	-	-	557,179
Private CAH						
3401302	Our Community Hospital Inc		-	-	-	-
3401303	Firsthealth Montgomery Memorial Hospital		-	-	-	-
3401305	Swain County Hospital, Inc		-	-	-	-
3401308	Hoots Memorial Hospital		-	-	-	-
3401310	Pungo District Hospital		-	-	-	-
3401311	Chatham Hospital		-	-	-	-
3401313	Davie County Hospital		-	-	-	-
3401314	Washington County Hospital		-	-	-	-
3401316	Highlands Cashiers Hospital		-	-	-	-
3401317	Stokes-Reynolds Memorial Hospital		-	-	-	-
3401319	Transylvania Community Hospital		-	-	-	-
3401320	Alleghany County Memorial Hospital		-	-	-	-
3401321	Blowing Rock Hospital		-	-	-	-
3401322	St Lukes Hospital		-	-	-	-
3401323	Charles A. Cannon Jr. Memorial					

Hospital		-	-	-	-
3401325 Ashe Memorial Hospital Inc		-	-	-	-
Subtotal - Private CAH	-	-	-	-	-
Total	$48,804,007	$23,317,924	$640,236	$313,117,305	$385,879,472