NORTH CAROLINA MEDICAL SOCIETY
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Dan A. Myers, MD, Chair
State Health Coordinating Council
NC Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

The North Carolina Medical Society (NCMS) is pleased to submit the following comments on the 2010 Draft State Medical Facilities Plan (SMFP).

We support the single specialty ambulatory surgery demonstration project that appears in Table 6D of the Draft 2010 SMFP. We commend the members of the work group, the Acute Care Services Committee and the State Health Coordinating Council (SHCC), and Division of Health Service Regulation (DHSR) staff for the significant amount of time, effort and consideration given to the development of this demonstration project. The proposal includes a number of innovations that would enhance health services regulation in our state if they are proved—in other words, if the demonstration project is successful—and adopted system-wide.

We have a number of comments and observations about the proposed demonstration project, all of which are made with the intention of improving, not challenging, the demonstration project.

1. The project is proposed for three specific areas of the state, chosen for their size and with the intent of minimizing negative impact on the area hospitals. Protecting existing providers is a double-edged sword, however. When a protected provider fails, as has occurred in this state within the last 24 months, the community is left without a facility to provide crucial services. Multiple facilities under separate ownership and control is beneficial to communities and to our health care system. This is a policy goal that should receive more attention from the SHCC and this demonstration project would be a good place to make progress toward that goal. We believe there are areas of the state that could benefit from inclusion in the demonstration and respectfully request that further consideration be given to this possibility.
2. Priority should be given to demonstration facilities owned wholly by physicians. The recommendation states that preference will be given to projects that are owned wholly or in part by physicians. We agree that physician ownership is critical. We also are concerned that the financial involvement of a hospital or other entity will limit the SHCC's ability to evaluate the demonstration participants' commitment to charity care, quality, and access. Research by the Center for Studying Health System Change has shown that hospital ownership of physician practices tended to reduce the amount of charity care provided by the physicians. Mixed ownership will complicate evaluation of the demonstration data, and therefore priority should be given to facilities owned wholly by physicians.
3. The indigent care minimum of seven percent of total revenue is an ambitious goal. We believe this goal is not being achieved by many of the facilities that now hold operating room

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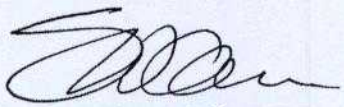
certificates. We welcome the establishment of a common or uniform standard against which all certificate holders can eventually be evaluated.

4. Physician maintenance of hospital privileges is driven by a wide array of factors. One of the them, economic credentialing, is acknowledged in the proposed demonstration project as an exception to the requirement that physicians maintain privileges and take unassigned call in the emergency department of at least one local hospital. There are, however, other situations beyond the physician's control that could make it impractical for them to maintain privileges including the use of exclusive contracts and closed service lines by the hospital. These situations and others that are not related to a physician's competency or professional conduct also should mitigate the requirement that hospital privileges be maintained (one example is the common practice of exempting physicians from call who have taken call for 20 or 25 years and have reached a certain age). It also should be noted that there are examples of hospitals excusing surgeons on their medical staff from unassigned call duty even though they are privileged to use the hospital's operating rooms. Finally, the proliferation of freestanding EDs exacerbates the problem of unassigned call coverage for everyone. The SHCC should consider this as it evaluates the future of freestanding EDs in our state.
5. The agency should not be constrained to wait five years to begin its evaluation of the demonstration facilities' performance. While we agree the demonstration facilities should be allowed five years to show compliance with the outlined performance standards, valuable information to guide policy decisions may be available well before that and should be evaluated as soon as possible.
6. We agree with others commenting on the Draft SMFP that common performance measures should be spelled out up front so the facilities know how they will be evaluated.
7. The work group specifically requested that the NCMS and the NCHA work together to assist the demonstration facilities in developing quality measures and increasing access to the underserved. The NCMS is committed to helping accomplish those goals.

We believe the issues raised in paragraphs 2, 4, 5 and 6 of this letter are particularly important to the success of the demonstration project.

In closing, we support the demonstration project recommendation and look forward to working with the SHCC and the Agency on any issues that arise during the term of the demonstration. We appreciate the opportunity to comment on the Draft SMFP. If there are any questions, please let us know.

Sincerely,



Stephen W. Keene
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