PETITION TO THE NORTH CAROLINA STATE HEALTH COORDINATING COUNCIL REGARDING STATE MEDICAL FACILITIES PLAN POLICY AC-3

Novant Health, Inc. (Novant) hereby petitions the North Carolina State Health Coordinating Council (SHCC) to repeal State Medical Facilities Plan (SMFP) Policy AC-3, or in the alternative, to revise Policy AC-3 (hereafter referred to as Policy AC-3). There are three reasons why Novant is filing this Petition. First, Policy AC-3 is no longer necessary; second, it gives academic medical centers an unfair advantage; and third, it is inconsistent with the North Carolina's health planning process which is set forth in the annual SMFP and based on the work of the DHSR Medical Facilities Planning staff and the SHCC. This Petition was prompted by a recent Policy AC-3 CON application (discussed below) which illustrates how Policy AC-3 is subject to being misused.

Identification of Petitioner

Novant is a non-profit corporation that operates the following hospitals in North Carolina: Forsyth Medical Center, Medical Park Hospital, Thomasville Medical Center, The Presbyterian Hospital, Presbyterian Hospital Huntersville, Presbyterian Hospital Matthews, Presbyterian Orthopaedic Hospital, Rowan Regional Medical Center, Brunswick Community Hospital and Franklin Regional Medical Center. In the Spring of 2011, Novant will open Kernersville Medical Center, a 50-bed community hospital in Kernersville. Two of Novant's hospitals, Forsyth Medical Center and The Presbyterian Hospital, are full-service, tertiary hospitals that offer many of the same services that are found in the state's four academic medical center teaching hospitals: Duke University Hospital, North Carolina Baptist Hospital, UNC Hospitals, and Pitt County Memorial Hospital.

Novant may be contacted about this Petition through its counsel, at the following addresses:

Denise M. Gunter
Nelson Mullins Riley & Scarborough LLP
380 Knollwood Street
Suite 530
Winston-Salem, NC 27103
(336) 774-3322
denise.gunter@nelsonmullins.com

POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS[1]

Policy AC-3 provides in pertinent part:

> *"Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 provided the projects comply with one of the following conditions:*
>
> 1. *Necessary to complement a specified and approved expansion of the number or types of students, residents or faculty, as certified by the head of the relevant associated professional school; or*
>
> 2. *Necessary to accommodate patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or*
>
> 3. *Necessary to accommodate changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.*
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> *A project submitted by an Academic Medical Center Teaching Hospital under this Policy that meets one of the above conditions shall also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital.*

[1] *See* 2010 SMFP, Chapter 4, at pages 23-24.

Any health service facility or health service facility bed that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that health service facility or health service facility beds in the North Carolina State Medical Facilities Plan.

In the State of North Carolina, only four facilities are permitted to use Policy AC-3: Duke University Medical Center, Pitt County Memorial Hospital, UNC Hospitals and North Carolina Baptist Hospital (collectively referred to in this Petition as the Academic Medical Centers or AMCs).

As the plain language of the policy shows, these four hospitals receive a substantial benefit not available to any other healthcare provider in North Carolina because they are the only ones allowed to deviate from the need determinations in the SMFP. This benefit extends to all kinds of SMFP-limited services such as beds, operating rooms and medical equipment (such as PET scanners, MRI scanners, linear accelerators and cardiac catheterization units) regardless of capital cost. The preferential treatment that the AMCs receive may have been warranted years ago when there was a vast difference in the services provided by AMCs and other hospitals. As set forth in this Petition, the healthcare landscape has changed dramatically and the time has now come to eliminate or substantially revise this exemption and treat all providers the same with respect to healthcare assets subject to the need determinations in the SMFP.

Reasons for Proposed Adjustment

I. Policy AC-3 is No Longer Necessary.

A. Healthcare has changed dramatically since 1983.

The origins of Policy AC-3 can be traced back to the 1983 SMFP and Policy B.5.:

> A hospital that has been designated an Academic Medical Center Teaching Hospital may receive a special exemption from the State Medical Facilities Plan, if justified. Requests for additional resources made by a formally designated Academic Medical Center Teaching Hospital which are subject to Certificate of Need review will be evaluated in the context of the overall requirements of the academic medical center and in the context of the special characteristics which distinguish the academic medical center teaching hospital from other acute care facilities.

See Exhibit A. Since 1983, only the four AMCs have been designated as academic medical center teaching hospitals and therefore only these four AMCs have received this "special exemption" from the SMFP.

Except for a numbering change[2], this "special exemption" was essentially unchanged in the SMFPs from 1983 to 1989. *See* Exhibit B. In 1990, the "special exemption," then known as Policy B.6., underwent some language changes, but the philosophy remained the same: these four AMCs were exempted from the need determinations in the SMFP. *See* Exhibit C. In the 1997 SMFP, Policy B.6. became Policy AC-3. *See* Exhibit D.

Beginning in the 1999 SMFP, the SHCC added the requirement that the AMC demonstrate that the AMC's teaching or research need for the proposed project cannot be achieved effectively at any non-AMC which currently provides the same service for which the exemption is requested and which is within 20 miles of the AMC (hereafter, the 20 Mile Provision). *See* Exhibit E. Also in the 1999 SMFP, the SHCC provided:

> Any service, facility or equipment that results from a project submitted under this Policy after January 1, 1999 shall be excluded from the inventory of that service, facility or equipment in the State Medical Facilities Plan.

[2]In the 1984 SMFP, Policy B.5. was renumbered as Policy B.6.

See Exhibit E.

This provision created a situation where the AMCs were not required to report to the State in their annual hospital licensure renewal applications the beds, operating rooms or medical equipment that had been CON-approved for that AMC through Policy AC-3. *See* Exhibit E.

The word "equipment" was deleted from the above-quoted paragraph beginning in the 2001 SMFP. *See* Exhibit F. Thus, beginning in 2001, AMCs that own and operate medical equipment that is CON-approved through the Policy AC-3 CON application process are required to report to the State this equipment and its annual procedure volumes on the annual hospital licensure renewal application. Otherwise, Policy AC-3 has remained unchanged from the 2002 SMFP through the proposed 2011 SMFP. *See* Exhibit G.

In 1983, when the "special exemption" for AMCs was born, healthcare was obviously radically different from what we know today. Technology and pharmaceuticals (including medicines, contrast agents and chemotherapy mixtures), healthcare delivery systems, payment mechanisms and competition have all evolved over the last twenty-seven years.

For example, in the early 1980s, more care was provided in the hospital instead of in an outpatient setting. The AMCs were normally the first facilities to obtain the latest medical technology (*e.g.*, MRI scanners) and the first ones to perform medically-complex procedures such as open heart surgery. Over time, those circumstances have changed. Much more care is provided on an outpatient basis As shown in recent SMFPs, the "service gap" between AMCs and non-AMCs is much smaller today than it was in 1983. Many non-AMCs in this State provide open heart surgery and own technology such as MRI scanners, cardiac catheterization units, linear accelerators, PET scanners, and robotic surgical devices. Physicians own MRI

scanners and ASCs. Services such as PET and MRI are provided on a mobile basis to a variety of host sites, such as hospitals, physician offices, and diagnostic centers. Cardiac catheterization services are also offered at outpatient sites and at a variety of smaller or rural hospitals to improve local access to this important diagnostic service. Lithotripsy, which was once believed to be the province of academic medical centers, is routinely performed in mobile lithotripters.

Geographically, healthcare services have become much more widely distributed throughout North Carolina. For example, a patient is no longer required to travel to a major metropolitan area for radiation therapy, as many smaller communities in North Carolina now have linear accelerators. *See* Exhibit H (Table 9E of the draft 2011 SMFP). Through SMFP Policy Gen-3, healthcare providers are also required to demonstrate that their services are economically accessible as well. Of course, with the enactment of healthcare reform in early 2010, further changes are expected.

AMCs have also changed over time. While AMCs may have once been perceived as devoted solely to teaching and research and the treatment of the most complex cases, this is no longer the case. AMCs compete directly with non-AMCs (and this includes tertiary hospitals, community hospitals, ASCs, physician offices and diagnostic centers) for all kinds of patients.

Comparing a hospital like Forsyth Medical Center with an AMC such as North Carolina Baptist Hospital (NCBH) is especially revealing, as it shows that the "service gap" at that level is indeed very small. Forsyth Medical Center, which is just three miles away from NCBH, provides nearly every service that NCBH provides.[3] The two hospitals have large,

[3]The major difference is that Forsyth does not have a trauma center designation and Forsyth does not provide burn intensive care services, gamma knife treatments, and transplant services. Due to the evolution of linear

multi-county service areas and compete vigorously for patients. Forsyth and NCBH both have large and growing medical staffs. Both hospitals have large cancer programs. Both offer open heart and cardiac catheterization services. FMC provides one of the state's largest Neonatal Intensive Care programs. Forsyth also serves as a teaching site for some of Wake Forest University Baptist Medical Center's residency programs.[4] According to the time period covered by the draft 2011 SMFP, Forsyth and its affiliates in Forsyth County provided significantly more acute days of care, outpatient surgeries, adult open heart surgeries, radiation oncology treatments, MRI scans, PET scans and cardiac catheterizations than did NCBH. Yet Forsyth *always* remains subject to the need determinations in the SMFP while NCBH does not.

While it is true that the case mix index (CMI) of the AMCs is higher than the CMI of the tertiary hospitals, the case mix differential does not, standing alone, justify treating AMCs differently from other providers. In fact, Policy AC-3 does not discuss CMI at all. If higher CMI alone were relevant, then Presbyterian Orthopaedic Hospital, which has a significantly higher CMI than Duke, UNC, Pitt and NCBH, should be singled out for special treatment in the SMFP.[5]

Given all of the changes in healthcare since the 1980s, and given that the distinctions between certain tertiary hospitals and AMCs are becoming less relevant, it is appropriate to question whether a policy designed specifically for AMCs in 1983 needs to remain in the SMFP in 2011.

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accelerator technology, FMC's cancer center does offer stereotactic radiotherapies on one of its linear accelerators.

[4]Other tertiary, non-AMC hospitals in North Carolina such as Mission, New Hanover and Moses Cone, have residency programs.

[5]According to Solucient data for CY 2009, Presbyterian Orthopaedic Hospital's weighted CMI is 2.3038. Duke's weighted average CMI was 1.8988 with normal newborns and 1.9934 without. UNC's weighted average CMI was 1.5924 with normal newborns and 1.7043 without. Pitt's weighted average CMI was 1.6838 with normal newborns and 1.7912 without. NCBH's weighted average CMI was 1.8424 with normal newborns and 1.8432 without.

B. The AMCs Do Not Need Policy AC-3.

Relatively few Policy AC-3 CON applications are filed. In 2009, 177 CON applications were filed in North Carolina. According to the CON Section's monthly reports, none of the 177 applications filed in 2009 is expressly identified as having been filed pursuant to Policy AC-3.[6] In 2010, of the 94 CON applications that have been filed so far, only 2 Policy AC-3 CON applications have been filed so far this year.

The relative lack of activity under Policy AC-3 suggests that the AMCs do not rely heavily on Policy AC-3 to address their teaching and research needs or other healthcare activities. Rather, the AMCs more commonly rely on the "normal" SMFP process that determines needs for additional beds, operating rooms and various types of equipment, and they regularly compete in CON reviews that are established by SMFP need determinations. AMCs, like every other provider, also have the ability to petition the SHCC for adjusted need determinations. In recent years, the SHCC has been receptive to requests in its review of petitions for special need determinations. (*e.g.*, CMC-Union petitioned during summer 2009 for 25 new acute beds in Union County and those beds are part of a need determination in the 2010 SMFP; Mission Hospitals petitioned during summer 2009 for 9 new acute beds in Buncombe County and those beds were added to the 2010 SMFP as a need determination for 9 new beds in Buncombe County)

It should also be noted that N.C. Gen. Stat. § 131E-179 specifically exempts from CON review the offering of a new institutional health service to be used solely for research. N.C. Gen. Stat. § 131E-179(c) even allows the new institutional health service to be used for

[6]Two CON applications filed by Duke and UNC in 2009 may have used Policy AC-3, although there is no express reference to Policy AC-3 in the monthly reports. These are J-8385-09 (Duke proposed to acquire a heart lung bypass machine for pediatric patients) and J-8388-09 (UNC proposed to add 10 NICU beds).

patient care provided on an occasional and irregular basis and not as part of the research program. For example, if an AMC needs a PET scanner for research, the AMC could seek an exemption under N.C. Gen. Stat. § 131E-179, and could even use the PET scanner for occasional patient care. Thus, elimination or modification of Policy AC-3 will not unduly hamper the research or patient care activities of the AMCs.

As the foregoing demonstrates, there is no longer a reasonable basis for treating AMCs differently from other providers relative to the need determinations in the SMFP.

II. Policy AC-3 Gives Academic Medical Centers an Unfair Advantage.

Policy AC-3 gives AMCs three unfair advantages not available to their non-AMC competitors.

First, Policy AC-3 allows the AMC to avoid the need determinations in the SMFP and thwart the beneficial aspects of competition.[7] Since typically multiple competing CON applications are filed for healthcare assets that are the subject of SMFP need determinations, Policy AC-3 allows AMCs to choose to avoid this type of competitive review, to the detriment of the AMCs' competitors in the service area. If an AMC wants additional beds or operating rooms, for example, it *always* has the ability to apply for them, even if the county in which the AMC is located has a significant surplus of these assets. Using Policy AC-3, an AMC could build an ambulatory surgery center (ASC) in a county that has a surplus of operating rooms. The AMC can use its new ASC to draw patients from competitors. The competitors' option for responding to the competition created by the new ASC is limited when there is no need for additional operating rooms in the county where the AMC proposes to build the new surgery center.

[7] *See* N.C. Gen. Stat. § 131E-183(a)(18a), which pertains to the requirement that the applicant must "demonstrate the expected effects of the proposed services on competition in the proposed service area."

Second, any health service facility or health service facility bed that results from an AC-3 CON application is not included in the inventory in the SMFP. Using the ASC example above, none of the volumes generated by that ASC will be counted toward future operating room need in that county. This in turn could suppress the need for additional operating rooms. Thus, the AMC not only gets an initial significant advantage but also has the ability to foreclose its competitors from expanding their own facilities in the future. Further, when a need is generated under the SMFP for a new institutional health service, the AMC also has the opportunity to apply in that review. Alternatively, the AMC can forego the SMFP-scheduled review and argue that its Policy AC-3 created capacity makes additional services by other providers an unnecessary duplication of existing services.

Third, Policy AC-3 can be used for *any* SMFP-limited service such as beds, operating rooms and linear accelerators. Policy AC-3 projects are not limited to teaching or research activities; they can be used for *anything*. For example, there is no requirement that the ASC in the above example ever be used for the training of any medical students or residents.

The process by which an AMC receives an exemption under Policy AC-3 is relatively easy. The AMC needs to demonstrate conformance with one of the three conditions in Policy AC-3 and comply with the 20-Mile Provision. With regard to the 20-Mile Provision, the AMC can rely on its own analysis; all it needs to say is that no non-AMC within 20 miles is able to meet the need. As far as Novant is aware, an AMC that files a Policy AC-3 application is rarely, if ever, told that it did not meet the requirements of Policy AC-3.[8]

A recent example of the relative ease by which AC-3 approval can be obtained, and how Policy AC-3 can be misused, is illustrated in the CON application filed by NCBH for an

[8]Novant's research further indicates that Policy AC-3 applications are rarely disapproved.

8-operating room ambulatory surgery center project, Project I.D. G-8460-10 (the NCBH Project).[9] The NCBH Project, with an estimated capital cost of approximately $39 million, was filed in January 2010 pursuant to Policy AC-3. The CON Section issued its decision on this application on June 10, 2010 and made its decision in less than the allotted 150 days for CON application review. Seven of the eight operating rooms in the NCBH Project are new operating rooms for Forsyth County; the eighth room is a relocation of an existing operating room. In addition, NCBH's Policy AC-3 CON Application proposed two more operating rooms, with one for simulation training and one for robotics and micro-surgery training. In Forsyth County, Novant also offers robotic surgery, as does Moses Cone Hospital and High Point Regional Hospital in nearby Guilford County.

The 2010 SMFP contains no need for additional operating rooms in Forsyth County; in fact, there is a surplus of 5.52 operating rooms in Forsyth County. To satisfy the requirements of Policy AC-3 for the NCBH Project, NCBH simply provided a letter from the Dean of its affiliated medical school stating that the Project is *'necessary to complement a specified and approved expansion of the number of types of students, residents, or faculty.'* No recruitment plan for students, residents or faculty was filed with the CON application, so there was no way for the CON Section to verify the statements in the letter.

With respect to the 20-Mile Provision, NCBH simply reported:

> *Given the combination of facilities and services required to provide the surgical services, simulation operating rooms, training facilities, equipment, and the fact that the resources are already in place at NCBH, the clinical model the Surgical Services department has developed, and the deep involvement of Wake Forest University reasearchers [sic], NCBH has concluded that expanding the campus to accommodate the outpatient surgery center on the NCBH campus would benefit our patients and their*

[9]Novant has appealed the Agency's decision on the NCBH Project.

families, our clinicians, and our researchers far more than establishing the expanded OR and training capacity at another off-campus location. Since all Wake Forest University Faculty provide clinics and have their offices housed on the NCBH campus it would not make sense to relocate services off campus away from where faculty currently practice.

This answer does not address the specific requirement of Policy AC-3 that the AMC demonstrate that no non-AMC within 20 miles could meet the need. As reflected on page 4 of the Agency Findings, the Agency accepted this representation without question, even though NCBH did not answer the specific mandatory[10] requirement of Policy AC-3. *See* Exhibit I.

In comments that Novant filed against the NCBH Project, Novant pointed out that in 2009, NCBH's affiliate, Wake Forest University Health Sciences, had acquired Plastic Surgery Center of North Carolina, a facility with three underutilized operating rooms. *See* Exhibit J. According to the 2010 SMFP, in the time period October 1, 2007 through September 30, 2008, Plastic Surgery Center of North Carolina performed only 411 cases. The SMFP therefore classified Plastic Surgery Center as "underutilized." *See* Exhibit K.

According to the draft 2011 SMFP, Table 6A, Plastic Surgery Center of North Carolina performed significantly fewer cases (only 148) in FFY 2009 (Oct. 1, 2008 – Sept. 30, 2009) than in the prior year. The draft 2011 SMFP again identifies Plastic Surgery Center of North Carolina as an "underutilized facility." *See* Exhibit L. Applying the SMFP Operating Room Need Method formula and based on the FFY 2009 data, Plastic Surgery Center of North Carolina needs 0.12 operating rooms[11] and thus has a surplus of 2.88 operating rooms. The

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[10]This provision of Policy AC-states, in part: "A project submitted by an Academic Medical Center Teaching Hospital under this Policy... *shall* also demonstrate that the Academic Medical Center Teaching Hospital's teaching or research need for the proposed project cannot be achieved effectively at any non-Academic Medical Center Teaching Hospital provider which currently offers the service for which the exemption is requested and which is within 20 miles of the Academic Center Teaching Hospital." (emphasis added).

[11]Calculation: (148 cases X 1.5 hours per case) = 222 weighted OR case hours/1872 hours per OR per year = 0.12 ORs needed.

three operating rooms at Plastic Surgery Center of North Carolina were also identified as underutilized in the 2009 SMFP (page 72) and the 2008 SMFP (page 56). *See* Exhibits M and N. There is no evidence in the Agency's findings on the NCBH Project that the CON Section considered the chronic underutilization of the three operating rooms at Plastic Surgery Center of North Carolina. *See* Exhibit I. Furthermore, there is no explanation in the NCBH CON Application that it considered the alternative of relocating any of the Plastic Surgery Center operating rooms to the new proposed 8-operating room surgery center or otherwise using these rooms to satisfy a need. *See* Exhibit O.

Despite these facts, NCBH was conditionally approved to develop seven new operating rooms in a county that has a surplus of more than five (5.52) operating rooms. The draft 2011 SMFP, Table 6B (based on FFY 2009 data) shows that Forsyth County still has a surplus of 4.95, or almost five operating rooms. *See* Exhibit L. Had Forsyth Medical Center filed an application in 2010 proposing to develop seven new operating rooms, its application would have been summarily disapproved because it failed to comply with the SMFP.

The NCBH Project proposes to serve mainly patients from Forsyth County and other North Carolina counties in Health Service Area II and North Carolina counties near or adjacent to Health Service Area II. At its new ASC, NCBH projects to perform only outpatient surgical procedures such as cataract surgery, arthroscopic knee surgery, tonsillectomy, ear drum openings and cystoscopy. *See* Exhibit P. These are routine outpatient surgical procedures that are performed at existing non-AMCs and ambulatory surgery centers within 20 miles of NCBH, such as Forsyth Medical Center, FMC's Hawthorne Surgery Center, and Medical Park Hospital. Furthermore, when FMC's Kernersville Medical Center, a new community hospital in eastern Forsyth County with 50 beds and 4 operating rooms opens in

2011, it will offer such outpatient surgical procedures as those proposed by NCBH for its new 8-operating room surgery center. There is nothing in the Policy AC-3 surgery center application to suggest that NCBH's seven new operating rooms will be used to accommodate a teaching or a research need that is unique to AMCs.

There is no need in the draft 2011 SMFP for additional operating rooms in Forsyth County, because there is a surplus of operating rooms in Forsyth County as discussed above.

Novant estimates that the NCBH Project could take away approximately one third to one half of Medical Park Hospital's outpatient surgical cases. Using 2009 outpatient surgical volumes for Medical Park Hospital, the estimated range of lost cases is 3,497 to 5,298 cases. The NCBH Project will also take patients away from Kernersville Medical Center, a new community hospital with four operating rooms under construction that the Agency approved before it approved the Project. Kernersville Medical Center is scheduled to open in the Spring of 2011. At this time, Novant estimates that the lost revenue attributable to the NCBH Project ranges from $7.8 million to $11.9 million.

The advantage that NCBH receives as a result of its AMC status is not the result of ordinary competition. Rather, Policy AC-3 has given NCBH an unfair advantage that allows NCBH to add substantial and unnecessary operating room capacity in Forsyth County solely because NCBH is an AMC.

III. Policy AC-3 Is Inconsistent with North Carolina's Health Planning Process.

North Carolina's health planning process and its CON program are designed to ensure that only new institutional health services that are actually *needed* are built.

To determine which new institutional health services are needed, the SHCC and the Staff of the Medical Facilities Planning Section of DHSR spend countless hours each year developing the SMFP. Based on a thorough analysis of data and input from providers, the SMFP sets forth the need for new beds, operating rooms and certain types of medical equipment such as PET scanners, MRI units, linear accelerators, and cardiac catheterization labs. The general rule is that a provider who files a CON application proposing to develop an SMFP-limited service cannot be approved *unless* there is a need for the service explicitly specified in the annual SMFP. *See, e.g.*, N.C. Gen. Stat. § 131E-183(a)(1)("The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health office that may be approved.").

As the NCBH Project shows, Policy AC-3 can be used to turn the careful health planning process upside down and inside out. In a county where there is a significant surplus of operating rooms, NCBH has been given the green light to spend approximately $39 million to add seven new operating rooms. This result is inconsistent with the findings of the General Assembly in N.C. Gen. Stat. § 131E-175(4):

> That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.

IV. Further Reasons for the Proposed Adjustment

A. A statement of the adverse effects on providers or consumers of health services that are likely to ensue if the change is not made.

As illustrated above, the most notable adverse effect on providers is that non-AMCs are treated differently than AMCs. AMCs receive a significant advantage which can then be used to preclude other providers from expanding their own services. As illustrated by the NCBH Project, Policy AC-3 allows AMCs to develop new institutional health services even in cases where there is a surplus. This creation of unnecessary duplication harms providers, consumers and the health planning process, as recognized by N.C. Gen. Stat. § 131E-175(4).

B. A statement of the alternatives to the proposed change that were considered and not found feasible.

As explained in this Petition, Novant has proposed two alternatives: repealing Policy AC-3 entirely or modifying it. The modifications are suggested below. Novant does not believe that maintaining the status quo is a feasible option for the reasons explained in this Petition.

V. Evidence that the proposed change would not result in unnecessary duplication of health resources in the area.

This Petition does not request any additional health resources; rather, it is intended to prevent unnecessary duplication of services.

VI. Evidence that the requested change is consistent with the three Basic Principles governing the development of the N.C. State Medical Facilities Plan: Safety and Quality, Access and Value.

This Petition is consistent with the three basic principles governing development of the SMFP.

First, elimination of an exemption from need determinations in the SMFP will not diminish safety and quality, and it will not harm the research activities of AMCs. As noted above, research activities are exempt from CON review under N.C. Gen. Stat. § 131E-179.

Second, elimination of Policy AC-3 will not diminish geographic or economic access to healthcare. The purpose of Policy AC-3 is to promote teaching and research, not improve geographic or economic access to healthcare. There is no reason to believe that any AMC will be less able to meet the needs of those facing geographic or economic barriers to healthcare if Policy AC-3 is eliminated. If, however, an AMC believes that specific geographic and economic barriers exist such that an SMFP-limited service such as beds or operating rooms needs to be added to the SMFP, it can always petition the SHCC to add the need in the annual SMFP, and then all interested providers would be given the opportunity to compete to serve the need.

Third, elimination of Policy AC-3 will not hamper an AMC's ability to deliver value-driven healthcare. If anything, elimination of Policy AC-3 may reduce the unnecessary duplication of healthcare resources.

If the SHCC decides to modify Policy AC-3, the annual reporting requirement discussed below in Paragraph 3.d. specifically requires the AMC to demonstrate that its project is consistent with the three basic principles.

Proposed Adjustment

For all of the foregoing reasons, Novant respectfully requests that the SHCC repeal or modify Policy AC-3. The following is a list of suggested modifications for consideration:

1. Policy AC-3 may not be used to add beds, operating rooms or equipment in counties where the then-current SMFP shows a surplus of these assets.

2. Providers who are approved for Policy AC-3 projects must report all Policy AC-3 assets (beds, operating rooms and equipment) on the appropriate annual license renewal

application or registration form for the asset. The information to be reported for the Policy AC-3 assets should include: (1) inventory or number of units of AC-3 CON approved beds, operating rooms or equipment; (2) the annual volume of days, cases or procedures performed for the reporting year on the Policy AC-3 approved asset; and (3) the patient origin by county. None of this data would be used in the annual SMFP need determination formulas but it would allow providers who are not eligible for the Policy AC-3 exemption to keep better track of the Policy AC-3 assets that compete with them. It would also provide a more complete picture of the total CON-approved assets available to serve patients in North Carolina.

3. All Policy AC-3 CON applications must contain written statements from all providers of comparable services in the 20 mile radius of the AMC indicating they cannot meet the need described in the Policy AC-3 CON application.

4. An AMC that is awarded a CON pursuant to Policy AC-3 must submit annual reports to the Medical Facilities Planning Section and the CON Section for each of the first five operating years of the project that shall include:

a. the number of persons treated by the new institutional health service for which the Policy AC-3 CON was approved;

b. the number of insured, underinsured and uninsured patients served by type of payment categories;

c. a detailed description of how the new institutional health service is operating in compliance with the representations the applicant made in its application;

d. a detailed description of how the new institutional health service promoted the three basic principles of the SMFP: safety and quality, access and value;

e. a detailed description of how the new institutional health service complemented a specified and approved expansion of the number or types of students, residents or faculty; or

f. a detailed description of how the new institutional health service accommodated patients, staff or equipment for a specified and approved expansion of research activities, as certified by the head of the entity sponsoring the research; or

g. a detailed description of how the new institutional health service accommodated changes in requirements of specialty education accrediting bodies, as evidenced by copies of documents issued by such bodies.

These reporting requirements, which are modeled after the rules that were adopted for the 2009 linear accelerator demonstration project, for development of a multidisciplinary prostate health center, and the 2010 single specialty ambulatory surgery center demonstration project, serve two purposes: (1) the Medical Facilities Planning Section receives data that can be used for further study and analysis of the viability of Policy AC-3; and (2) the CON Section receives information so that it can determine whether the applicant is in material compliance with the representations made in its application. Given the substantial benefits afforded by Policy AC-3, these reporting requirements should not be unduly burdensome for the AMCs.

5. Special rules should also be written by the CON Section for the review of Policy AC-3 applications which are designed to ask specific questions concerning how the project accommodates the purported teaching and research need or the requirement of the specialty education accrediting bodies. The Agency would then make a determination of whether a Policy AC-3 CON Application is conforming or non-conforming with each of the Policy AC-3 CON Regulations, as part of the Agency's findings, just as the Agency does in all its non-Policy AC-3 findings.

Novant appreciates the opportunity to present its views on Policy AC-3 and thanks the SHCC and DHSR staff in advance for their careful consideration of the information presented in this Petition.

Respectfully submitted this 2d of August 2010.

Denise M. Gunter
Nelson Mullins Riley & Scarborough LLP
380 Knollwood Street, Suite 530
Winston-Salem, North Carolina 27103
Telephone: (336) 774-3322
Facsimile: (336) 774-3372
denise.gunter@nelsonmullins.com

EXHIBITS FOR NOVANT HEALTH, INC.'S
PETITION TO THE STATE HEALTH COORDINATING COUNCIL
REGARDING POLICY AC-3

Exhibit	Name
A	Excerpt from 1983 SMFP showing Policy B.5.
B	Excerpts from 1989 SMFP showing Policy B.6.
C	Excerpt from 1990 SMFP showing Policy B.6.
D	Excerpt from 1997 SMFP showing Policy AC-3
E	Excerpt from 1999 SMFP showing Policy AC-3
F	Excerpt from 2001 SMFP showing Policy AC-3
G	Excerpt from draft 2011 SMFP showing Policy AC-3
H	Table 9E from draft 2011 SMFP
I	Findings from Project I.D. No. G-8640-10
J	Comments that Novant filed against Project I.D. No. G-8640-10
K	Excerpt from 2010 SMFP
L	Excerpt from draft 2011 SMFP
M	Excerpt from 2009 SMFP
N	Excerpt from 2008 SMFP
O	Excerpt from CON Application for Project I.D. No. G-8640-10
P	List of Top 20 Procedures in CON Application for Project I.D. No. G-8640-10