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PETITION

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The Methodology for Projecting Operating Room Need in Chapter 6 of the North Carolina State Medical Facilities Plan ("NCSMFP" or "The Plan") is outdated.

Statement of Requested Change:

Since 2006, the Council has allocated a mere 35 additional Operating Rooms ("OR") in The Plan. Incredibly, between 2006 and 2015, the excess ORs also increasd by 35, from 227 to 262, notwithstanding the fact that North Carolina experienced a projected 20% population growth during that time. There is an illusory OR surplus in North Carolina, and it is the direct result of the outdated standard methodology for calculating OR need in this State. The standard methodology that perpetuates the status quo of excess OR capacity should not be maintained.

This petition requests that the North Carolina State Health Coordinating Council undertake a serious – and long overdue – review of its methodology for calculating operating rooms needed in the NCSMFP and change the standard methodology used to calculate OR capacity. Among other things, the Council should consider data from the owners of grandfathered/CON approved operating rooms/suites and take into better account the growing patient population of North Carolina. Applications for new ORs should be allowed and accepted only from those who do not demonstrate an ownership surplus of ORs, by county in the NCSMFP.

1. In 2006, when the endoscopy utilization was separated from surgical cases, an excess of 227 ORs was published in the NCSMFP. Ten years later, in the current 2015 NCSMFP, an excess of 262 ORs are presented. Under the standard methodology, owners (e.g. hospitals) are unduly protected from the expansion of free-standing ambulatory surgery centers. As a result, the Three Basic Principles of the Plan are not afforded the best consideration, to the detriment of the millions of North Carolinians; and yet the surplus continues to grow around the State.

2. In calculating OR capacity, fourteen (14) facilities that are underutilized (as defined) are excluded from the adjusted planning inventory of ORs, along with three (3) facilities considered demonstration projects. The NCSMFP does not consider how many of the current 262 surplus ORs are dormant or underutilized. All other rooms (964 of the total of 1,226) are calculated to run at 80% of capacity to establish OR rooms needed in 2017 per Chapter 6 of the Plan. The results speak for themselves – every time an OR has been allocated since 2006, the surplus of ORs has concomitantly risen by one, despite a rapid increase in the population served.

3. Between 2006 and 2015, 35 operating rooms have been allocated or determined needed in The Plan, by virtue of the standard methodology. Of those 35 rooms allocated since 2006, ***only eight*** have been approved for non-hospital based owners without special operating criteria. An additional six allocated ORs were physician owned demonstration projects operated under restricted criteria. All fourteen non-hospital based ORs are operational.

4. The same cannot be said for the twenty-one (21) ORs allocated to hospitals. Eleven of the ORs awarded to hospitals have not become operational, including five allocated in 2006. So why should hospital ORs that sit dormant or non-operational for years, be taken into account at all under the standard methodology for calculating OR capacity? The status quo for determining OR capacity must change.

Attached is a 10-year analysis of the 35 operating rooms and current status.

Statement Regarding Adverse Impact on Consumers:

This proposal allows improved scheduling, day-of-surgery convenience, avoidance of hospital-based air-borne pathogens, and cost savings for both the tax payer and users of free-standing ambulatory surgical services.

Statement of Alternatives if Request not Implemented:

The alternative is to maintain the status quo of illusory excess OR capacity, with no realistic hope for efficient and effective independently owned and operated free-standing surgery centers in the future.

Evidence That the Proposed Change Will Not Duplicate Resources:

Based on the attached schedule it takes years before a free-standing operating room becomes operational. Assuming an applicant can somehow get past the surplus OR blockade, an applicant still faces the daunting task of adjusting The State Plan, file pursuant to published criteria and standards, participate in the CON review proces, and undertake construction and licensing, resulting in four to five years to become operational (assuming there is no appeal). The rigorous process to establish an ambulatory surgery center is so lengthy that changing demographic trends and payment mechanisms most assuredly ensure that resources are not duplicated. It also stands to reason that duplication cannot occur when so many recently allocated ORs are non-operational, dormant or occasionally utilized.

Evidence that the requested change Will Be Consistent with Three Basic Principles:

Free standing surgery centers avoid hospital-based pathogens, improve patient satisfaction, allow better scheduling, improve parking convenience, save the overall health system tax dollars and lower patient population co-pays and out-of-pocket deductibles.

Very Truly Yours,

Howard, Stallings, From, Hutson,

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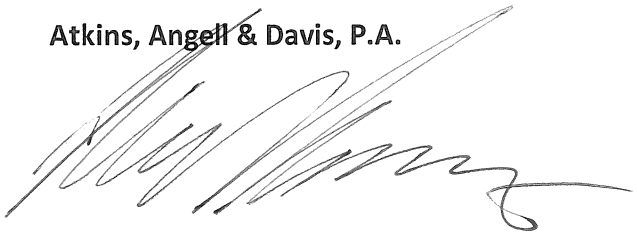

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NC STATE MEDICAL FACILITY PLAN OPERATING ROOM NEED DETERMINATIONS

2006 THROUGH 2015

NCSMFP Year	County	County Allocations	Status
2006	Cumberland	1	CFVHS – not open 2015
	Columbus	1	Columbus County Hlth Sys – not open 2015
	Johnston	1	Johnston Memorial – operational 2010
	New Hanover	2	New Hanover Regional – not open 2015
	Person	1	Person County Hospital – operational 2008
	Rowan	1	Rowan Regional Med Ctr – operational 2007
	Watauga	1	Watauga Medical Ctr – operational 2007
	Wayne	1	Wayne Memorial Hospital – not open 2015
2007		0	
2008	Pitt-Green	6	Vidant Health – operational – 2009
	Wake	4	Raleigh Orthopaedic Surgery Ctr – operational -2013*
2009	Franklin	1	Novant Hlth Same Day Surgery- not open – 2015
	Johnston	1	Johnston Memorial – not open – 2015
	Randolph	2	Central Piedmont Surgery Ctr, LLC – operational – 2011*
	Union	1	Union West Surgery Center – operational – 2011*
2010	Forsyth	2	Piedmont OP Surgery Ctr, LLC – operational – 2012 - DP
	Wake	2	Triangle Orthopaedic Surgery Ctr, LLC – operational – 2013-DP
	Mecklenburg	2	University Surgery Ctr, LLC – operational – 2014 – DP
	Wake	3	Holly Springs Surgery Ctr – not open - 2015
2011	Catawba	1	Graystone Eye Surgery Ctr – operational – 2011*
2012		0	
2013	Dare	1	The Outer Banks Hospital – not open - 2015
2014		0	
2015		0	
	Total	35	

* Unrestricted, non-hospital-based

DP – Demonstration Project - restricted

Data considered in the proposed State-wide Petition Discussions, March 2, 2015:

Population 2004 (2006 Plan) Population 2017 (2015 Plan) Absolute number	8,541,263 10,231,255 1,689,992(1)	Percent change: 19.8%
ORs Needed 2006 Plan ORs Available 2006 Plan	970 1,197	Excess: 227
ORs Needed 2015 Plan ORs Available 2015 Plan	964 1,226	Excess: 262
		Growth in excess: 35
		Percent change: 15.4%
ORs allocated over 10 years (year-by-year)	35	Percent of 2006 availability: 2.9% (35/1,197)
ORs allocated and operational Over 10 years	24	(24/1,197) Percent of 2006 availability: 2.0%
Physicians operational	14	
Hospitals operational	10	
Hospitals non-operational	11 (included in excess Inventory)	

Classification of allocated ORs over 10 years	Hospitals: 21 Physicians unrestricted: 8 Physicians restricted: 6 (Demonstration Projects)

NC Office of Demographics shows higher numbers on its website: Population 2004 Population 2017 Absolute number	 8,542,420 10,255,463 1,713,043	 Percent change: 20.1%