Talking Points Comments on TE-4 Policy

Nancy Lane, President PDA

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Thank you for the opportunity to comment today.

I am Nancy Lane, President of PDA, a national health care consulting firm headquartered in Raleigh NC. I have been in the health planning business for more than 35 years and have lectured on the topic at Yale, Duke, NYU Stony Brook, mentored for the University of Minnesota and the University of North Carolina, testified before the US Congress, and advised a board of 13 US Governors. I have helped to draft health planning legislation, regulation, and guidelines at the state and federal level.

I am also an employer who purchases health insurance for my employees. I have seen first-hand what happens when my employees cannot get access in Wake County to the MRI equipment they need and must go out of county to get outpatient scans. Competition and access are important to me.

1. I have listened to all of the public hearings this summer and wish to weigh in as a health planner.
2. TE-4 is a good starting point, brought forth through the proper NC State Health Plan process, as required. It can be improved.
3. Moving the mobile MRI elements to a separate policy would add clarity and allow for separate debate on two very distinct issues.
4. History and context are important to good policy debate. The MRI methodology in the Proposed 2021 SMFP is a capacity methodology and it is based only on one year of use information.
5. Regardless of population growth in a service area – which is primarily one county, the Plan generates need for a new MRI fixed scanner only when the capacity of all scanners- mobile and fixed exceeds a set threshold. The more scanners in the area, the higher the threshold.
6. If capacity is constrained and service area, for example Wake County, residents are sent out of county for scans, the methodology will not show need in the county where people live.
7. Wake County has the same population as Mecklenburg County, but it has fewer fixed MRI units and one quarter of its fixed units are tied up in grandfathered mobile contracts that can leave at any time.
8. I have watched the MRI methodology unfold in North Carolina since 1993. Yes, for 27 years. Initially, the SHCC was concerned about unnecessary duplication of a new technology, then, under leadership of folks like Steve Nuckolls, the SHCC realized that once a mobile unit established a market, the Plan needed a mechanism to convert those mobiles to fixed, and it developed a process for hospitals to do that.
9. Now we are in an era of outpatient care and most of MRI is outpatient. We need a new mechanism for converting established mobiles to fixed and for freeing the mobile capacity to establish new sites.

10. By separating TE-4 into two policies, with TE-4 for conversion of existing sites where the MRI service is already fixed and inside buildings, we can eat the elephant one bite at a time.
11. When a service agreement has been in place for more than nine years and demonstrated consistent high utilization, it is time to make that unit part of the permanent health care delivery system.
12. A separate TE-5 policy could provide a mechanism for converting mobile MRI units that are working under long standing service agreements to operator-controlled units.

Thank you for your time and attention. I will follow up with a formal written version of my comments. I am willing to answer any questions you may have.